

Carleton University

**Biting the Hand that Feeds You:
The Political Economy of Ontario's Community Laboratory Services**

**A thesis submitted to
The Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Master of Arts**

Institute of Political Economy

**by
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Ottawa, Ontario

December 2007

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Your file *Votre référence*

ISBN: 978-0-494-36816-9

Our file *Notre référence*

ISBN: 978-0-494-36816-9

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Abstract

This historical case study examines the development of Ontario's community medical laboratory services from 1968 to 2006. This study found that to adequately account for the broad shifts in government medical laboratory policy towards private capital accumulation over collective needs it is necessary to take account of the changing balance of class power as a result of capital's strategy to expand world capital markets and integrate production globally. Particular attention is paid to how the dominant sectoral ideology, biomedicine, interacts with other forces to reinforce individualism, structures of authority and creation of needs that support the dominant power relations and facilitate capital accumulation. This study challenges the assertion that increasing private sector involvement in health care is the solution to many of the system's problems. Rather it argues that for-profit delivery of community laboratory services increases cost, decreases system efficiency and undermines universal public health insurance.

Acknowledgments

I would like to thank my thesis committee, Hugh Armstrong and Lisa Mills for their support and many helpful suggestions. The research for this study would not have been possible without public funding from the Graduate Student Scholarship and Carleton University that allowed me to take time off work. Similarly the information gathered depended upon the generous input of dozens of individuals involved in medical laboratory services and the invaluable help of the archivists in the Ontario archives: thanks to all of you.

I would like to dedicate this work to my parents, Ralph and Eleanor Sutherland, for inspiring me to stand up for what believe; and to my grandchildren, Brianna Ramsey and Ronnie Johnson, in the hope that we may find a way to build a community that serves human needs rather than private greed.

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Chapter One: Introduction

Right-wing attacks on Canada's health care system based on its alleged inability to reform and its unsustainable costs set the stage for this historical case study of the political economy of one of the many paradoxes of Canadian medicare: Ontario government policy on community medical laboratory services. Why did our public health care system fund the development of three for-profit multinational laboratory service corporations which increased health care costs and worked against government policy objectives at the same time as government policy led to the demise of not-for-profit alternatives that were more responsive to public policy goals and delivered similar services at less cost?

Ontario's community medical laboratory sector provides services to patients not in hospital. It is usually identified as the business of MDS, Dynacare and CML, for-profit medical laboratories where most people have their blood taken after seeing their family doctor. This thesis examines the development of these health care services from 1968, the date Hospitals In-Common Laboratory (HICL)¹ was founded to 2006. This time frame roughly coincides with the introduction of universally funded medical insurance in Ontario and ends with the consolidation of for-profit control over community laboratory services. A second development that took place during this period was the shift in capitalist strategies for capital accumulation from the Keynesian welfare state to the neo-liberal welfare state and global economic integration through free capital markets, free trade and deregulation.

Two questions focused the examination of this paradox. First, how has the provision of the community medical laboratory services in Ontario come to be dominated by three multinational corporations? What were the forces and mechanisms affecting this development? Like Porter's work on Canada's unemployment insurance system, this is

¹ HICL was the most significant of the NFP alternatives providing community laboratory services and its history provides one of the empirical foci of this thesis.

an “historical study of political, social and economic forces as they manifest themselves through particular state policies.”²

Second, what has been the impact of for-profit involvement on the cost and progress towards the integration of Ontario’s community medical laboratory system, two primary public policy concerns?

This project intervenes in two related debates pertinent to advanced capitalist societies: policy formation and the role of for-profit corporations in the delivery of health care. First, this thesis argues that class struggle based in the property relations of capitalism, and the relationship of the state to that struggle, are crucial to understanding social policy outcomes, including the provision of health care. This perspective is needed to adequately account for the broad shifts in government policy towards private capital accumulation over collective needs in medical laboratory services caused by the changed balance of class power with the development of world capital markets and globally integrated production. A class-based approach respects the underlying fact that property relations in production, the dynamics of capital and resistance to private accumulation are central to developed capitalist state policies and brings them back into the conversation. The point is, to use Baxter and Western’s shorthand, “class counts.”³

Of particular interest is the dynamic of capital to expand into non-market sectors, in this case public medical laboratory services. This case study of the community medical laboratory sector in Ontario reveals that the lack of clear boundaries around the provision of a collective service facilitates its being undermined by capital. It indicates how a series of small changes, as well as seminal ones, in the context of an underlying acceptance of a role for private enterprise, the treatment of all business as equal, the privileged position of private enterprise compared to public concerns and the resources of larger corporations to influence and take advantage of small policy decisions, can strengthen for-profit alternatives over collective ones. Special attention is paid to how the dominant ideology is manifest in specific sectoral ideologies, in this case biomedicine,

² Ann Porter, *Gendered States: Women, Unemployment Insurance, and the Political Economy of the Welfare State in Canada, 1945-1997*, Toronto: University of Toronto Press, 2003, p. 14.

³ Janeen Baxter and Mark Western, *Reconfigurations of Class and Gender*, Stanford: Stanford University Press, 2001.

and how biomedicine interacts with other forces to reinforce individualism and structures of authority and need that support the dominate power relations and facilitate capital accumulation.

On a more practical level this thesis intervenes in one of the central policy debates in Canada: the role of for-profit delivery in Canada's public health care system. While Medicare continues to enjoy enormous popular support,⁴ it is under attack. This is not surprising. Health care in Canada is big business, as it is in most advanced capitalist countries. Canada's total yearly expenditures on health care are approximately 148 billion dollars:⁵ it accounts for 39% of Ontario government spending.⁶

Robert Evans, writing in 1993, commented tongue-in-cheek, "there has always been a crisis in Canadian health care."⁷ And the reasons are always the same: cutbacks, shortages, and spiralling costs. The main perpetrators of this crisis rhetoric continue to be those who wish to lower the cost to the "wealthy and healthy" and increase benefits to the for-profit health care industry. Countering these forces the collective provision of health care is advocated by a broad coalition of community and labour organizations who argue that Canada's current system is sustainable, provides security for citizens and embodies what is best about social reform: it is inclusive, collective and places need before ability to pay. Leys⁸ argues that collective services are essential to a functioning democracy.

The main issue in these debates has been universal access through public insurance: a question that Evans⁹ notes is really closed: it is more cost-effective and

⁴ Hugh Armstrong, "Social Cohesion and the Privatization of Health Care," *Canadian Journal of Law and Society*, 16:2 (2001), pp. 65-81.

⁵ Canadian Institute of Health Information, downloaded April 1, 2007, http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_topic_macrospend_e&cw_topic=Health%20Spending&cw_subtopic=Macro%20Spending.

⁶ Public Accounts of Ontario, 2005-2006, Annual Report and Consolidated Financial Statements, Ministry of Finance, downloaded April 20, 2007, http://www.fin.gov.on.ca/english/budget/paccts/2006/06_ar.html.

⁷ Robert Evans, "Health Care Reform: 'The Issue From Hell'," *Policy Options*, July/August 1993, p. 35.

⁸ Colin Leys, *Market-Driven Politics: Neo-liberal Democracy and the Public Interest*, London: Verso, 2001.

⁹ Robert Evans, "Going for the Gold: The Redistributive Agenda Behind Market Based Health Care Reform," *Journal of Health Politics, Policy and Law*, 22:2 (April, 1997).

efficient.¹⁰ Increasingly, as this reality is more broadly accepted, for-profit corporations and the wealthy are interested in the expansion of commercial delivery of services: a practice which has less opposition. Flood and Choudry point out that the *Canada Health Act (CHA)*, “neither impedes nor encourages reform or innovation in the delivery of health care.”¹¹ They argue that the, “CHA should be reformed to actively encourage innovation and evidence-based reform,”¹² including the option of for-profit delivery.

A contentious issue central to the expansion of for-profit delivery is the increasing use of for-profit clinics to provide a variety of publicly insured services: MRIs, CT scans, enhanced access to doctors, cataract surgeries and joint replacements. 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.¹³ At the same time one of the main arguments for the increase is the assumption that the “private sector is both more effective and more efficient than the public sector.”¹⁴ Despite the increasing role of private delivery in the current evolution of health care its effects have not been well studied. This study explores an area of service delivery covered by universal insurance that has been largely in private sector hands for four decades, community medical laboratory services in Ontario.

Not only is the community laboratory services market relatively understudied, but it also contains an historical experiment, a comparison between significant non-profit options and the performance of private corporations in the delivery of the same service. The policy story in the evolution of community laboratory services is the shift in government support from non-profit alternatives to three multinational health service corporations: MDS, CML and Dynacare.

¹⁰ There is agreement in the academic and policy community, though obviously this assumption continues to be challenged by certain political groups and legally with the Chaoulli decision and for these reasons it requires continued progressive political attention.

¹¹ Colleen Flood and Sujit Choudhry, “Strengthening the Foundations: Modernizing the Canada Health Act,” in Tom McIntosh, Pierre-Gerlier Forest, and Gregory Marchildon, eds., *The Governance of Health Care in Canada: Romanow Papers, Volume 3*, Toronto: University of Toronto Press, 2004, p. 361.

¹² Colleen Flood and Sujit Choudhry, “Strengthening the Foundations,” p. 361.

¹³ Amine Yalnizyan, “Can We Afford to Sustain Medicare? A Strong Role for Federal Government,” Ottawa: Canadian Federation of Nurses Unions, 2004.

¹⁴ Pat Armstrong and Hugh Armstrong, *Wasting Away: The Undermining of Canadian Health Care, second edition*, Toronto: Oxford University Press, 2003, p. 2.

Sixty years ago almost all medical laboratory work in Ontario was done in public facilities: hospitals and public health laboratories. During the 1960s and 70s the for-profit sector expanded and governments experimented with a variety of non-profit options to provide community laboratory work. By the 1990s the for-profit sector had gained complete dominance of community service provision, a privileged position in policy-making, and the state had mandated openings for the private sector to move into the delivery of inpatient laboratory services, previously the sole domain of public hospitals.

This study challenges the assertion that increasing private sector involvement in health care is the solution to many of 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 the delivery of health care. T.H. Marshall addressed the question: Can basic human equality, "when enriched in substance and embodied in the formal rights of citizenship, [be] consistent with the inequalities of social class?"¹⁵ He argued that the paradox of his affirmative answer can be overcome by "common sense ... in the world of action."¹⁶ The world of action represented in the evolution of Ontario's community laboratories indicates a deeper tension between the provision of universal social services and capitalism.

This project takes seriously Leys' admonition that that, "the impacts of economic forces need to be studied not only at the level of politics in general but also in specific markets"¹⁷: in this case the public market for laboratory services. Detailed knowledge of contentious issues is helpful in day-to-day struggles as well as in enriching and validating our theoretical understanding.

Nomenclature: Public, Non-profit, For-profit and Private

The fact that Canada's health care system is a mix of for-profit, not-for-profit and public actors is obvious; how to label the system's various components is less clear. I

¹⁵ T.H. Marshall, *Citizenship and Social Class, and Other Essays*, Cambridge: Cambridge University Press, 1950, p. 73.

¹⁶ T.H. Marshall, *Citizenship*, p. 120.

¹⁷ Colin Leys, *Market-Driven Politics*, p. 81.

use the term “public health care system” in two ways. First, it is used to refer to the health care services that Canadians receive as a right of citizenship under the *Canada Health Act*, recognizing that this includes services from for-profit corporations. This is a commonly accepted use of the term and one that supports the fight to maintain a universal publicly funded health care system. Second, in the context of the delivery of services, I will use it to refer to not-for-profit and public facilities that deliver health care as opposed to for-profit corporations. This accepts that some public facilities charge for some of their services and use for-profit corporations to help them deliver the services.

This blurring of the lines between the public and private reflects the penetration of the market into a core government program and is used as a lever for further market involvement. In popular debate you often hear that we really do not have a public health care system, 35% is already paid for privately and that is working well, so why not more for-profit involvement?¹⁸ The implicit assumption being made is that all the problems are in the 65% that is public.

A classification system common in academic debate uses a juridical approach to group health care institutions into public, those directly part of the civil service, and private, including non-profit hospitals, doctors and for-profit providers.¹⁹ While the governance structure of institutions can be important, in this context it is often used to undercut the progressive use of the term “privatization” because it defines most current health care delivery as private, making privatization a non-issue.²⁰ This juridical approach also ignores the increasing centralization of decision-making in Ontario’s health care system bringing hospitals more and more under direct government control, regardless of their legal incorporation.

¹⁸ James Wallace, “The Status Quo is Killing Us,” *The Kingston Whig Standard*, Thursday, August 11, 2005, pp. 1, 8, 11.

¹⁹ Raisa Deber, “Delivering Health Care: Public, Not-for-Profit, or Private?” in Tom McIntosh, Pierre-Gerlier Forest and Gregory P. Marchildon, eds., *Romanow Papers, Volume 1: The Fiscal Sustainability of Health Care in Canada*, Toronto: University of Toronto Press, 2004, pp. 233-298.

²⁰ This argument was given by Duncan Sinclair, former Chair of the Health Service Restructuring Commission, on the CBC Radio show, *Ontario Morning*, March 29, 2007, to downplay the significance of moving ancillary services out of hospitals.

Nomenclature: Inpatient, Outpatient and Community Patient

A central concern in policy debates on laboratory services is how services to different types of patients are paid for. Three common classifications of patients are: inpatients, that is, patients who are assigned a bed in a hospital; outpatients, patients who receive medical services in a hospital but are not assigned a bed; and community patients, patients who receive medical services in the community, most often from a family physician. For the purposes of this study patients will usually be divided into two groups: inpatients who receive their laboratory services paid for out of the hospital's global budget while staying in the hospital; and community patients, including both outpatients and community patients, who usually have the option of having their laboratory work done in a hospital or by a fee-for-service provider. The debate is over where the laboratory work for community patients, people residing outside of acute care hospitals, should be done and how it should be paid for.

Data Collection

Where possible this study has relied upon data from primary sources. A key source of primary data from before 1986 is the Archives of Ontario's collection of material from the Ontario Ministry of Health (MOH).²¹ Government rules restrict the transfer of files to the Archives for twenty years so the Archives does not have files from after 1986. The Laboratories Branch of the Ministry was approached and asked for specific information and certain files. Some were given, and a freedom of information request has been made for the rest. At the time of writing access has been granted to some files, others are pending and some have been denied, notably documents revealing the exact amount paid to for-profit laboratories for their services.

Files were obtained from the Ontario Public Service Employees Union (OPSEU) and the Ontario Health Coalition (OHC). The Ontario Medical Association (OMA), Hospitals In-Common Laboratory (HICL), and the Ontario Association of Medical

²¹ The acronym MOH is used throughout this thesis to refer to the Ministry in the Ontario provincial government that has had primary responsibility for medical laboratories recognizing that this Ministry has had numerous names. It is currently called the Ministry of Health and Long Term Care.

Laboratories (OAML) were approached for specific files and limited access was given. Numerous interviewees provided access to their personal files. A literature search and a search of selected Ontario newspapers was done.

Interviews with selected informants provided further data and added context to the documentary information. Informants were approached because of their personal involvement in various aspects of the community laboratory sector. Interviewees included senior managers in the Ministry, the for-profit and not-for-profit sector; medical laboratory specialists; and technical professionals. Some interviewees were still employed; others were retired. Most of those interviewed chose to remain anonymous and most allowed taping. 17 interviews were completed and are identified by number sequenced in the order given. Only two people approached refused to be interviewed. Two other interviews were not carried out due to scheduling difficulties.

Difficulties in Data Collection

The presence of commercial corporations in the laboratory sector created significant problems for data collection. Section 17(1) of the *Freedom of Information and Privacy Act* formalizes the barrier. This section excludes from public discussion information that contains scientific, technical, commercial or labour-relations information provided in confidence to the government by a third party when disclosure of that information might harm the company. This restriction applies to material held in the provincial archives and lasts for as long as necessary to protect the third party from economic harm. It is justified by the claim that companies would not willingly provide the government with information if they felt it would be released to the public.²²

One consequence of this restriction is that access to the files of the legal department of the Ministry of Health for any time in the last fifty years was denied. These files may contain the first contracts with HICL, information on negotiations with the Ontario Association of Medical Laboratories about the regulations to close the

²² Information and Privacy Commission order PO-2145, Appeal PA-020292-1, May 20, 2003, downloaded January 8, 2007, <http://www.accessandprivacy.gov.on.ca/english/order/prov/PO-2145.htm>.

laboratory market or set hard funding caps, and a wide variety of other information relevant to understanding public policy and the laboratory sector.

Section 17(1) has also been used by the for-profits to restrict information on the location of laboratories and specimen collection centres, matters that by regulation are to be decided by the government based on certain public interest criteria.²³ This legal restriction was also used to prohibit the release of information on how much each private laboratory was paid by OHIP, which violates the spirit of the government's mandatory post-contract-award notification policy. Starting in October 2006 all contracts valued at over twenty-five thousand dollars for goods and one hundred thousand dollars for services and construction are to be made public through the province's tendering system.²⁴ All of the for-profit laboratory companies are paid more than either of these amounts in a year, yet exactly how much any one is paid is confidential. A Freedom of Information request was made for these figures, as well as for other data that the Ministry would not provide. As of July 15, 2007, the time of writing, no decision had been made on whether to supply this information.

A quirk of the freedom-of-information process allowed the senior managers in the Laboratories Branch to delay and limit access to information on the current structure of the laboratory industry in Ontario. A freedom of information request made by an unknown applicant was used as an excuse by the MOH Laboratories Branch to refuse to supply information on the current state of integration between Ontario's laboratories. Eventually they provided a list of regional contacts who provided some of the sought after information.

Theoretically information could be obtained directly from the private corporations, but this is guarded closely. A researcher in 2002 examining public-private partnerships in the laboratory industry was allowed access to corporate files only on the condition that the information be kept confidential, including which companies and

²³ Information and Privacy Commission order PO-665, Appeal P-9300610, April 15, 1994, Inquiry Officer Laurel Cropely. This case relates to a request for information on CML's desire to relocate three laboratory specimen collection centres. Downloaded August 12, 2005, http://www.ipc.on.ca/scripts/index_.asp?action=31&P_ID=4935&N_ID1&PT_ID=2233.

²⁴ Personal Communication, Jean Vrooman, Special Assistant to Leona Dombrowsky, MPP, Hastings-Frontenac-Lennox & Addington, February 20, 2007.

hospitals were involved. Even then she was not given access to financial records.²⁵ Even though the three main laboratory corporations have all been publicly traded for at least part of their history limited information is available because their Ontario laboratory operations are only a division within a larger health care conglomerate.

While the policies protecting the for-profit laboratories proved the greatest barrier to data collection the non-profit laboratory providers were not always forthcoming. HICL provided access to a limited number of files relating to their early years and were cautious about providing information on current negotiations with the government. Yet, in government documents information on services provided, costs, employment and facilities is richer for the non-profits than for the private sector, where little if any information is available on private companies especially for the last few decades.²⁶ In 1982 the Ontario Council on Health Task Force commented that, “the Hospitals In-Common Laboratory is the only laboratory funded on a fee-for-service basis for which staffing information has been provided.”²⁷

Business secrecy not only creates problems for research and public discussion of important policy decisions, it also creates problems for meeting policy goals. During the most recent provincial integration initiatives one laboratory argued in a brief to the Information and Privacy Commissioner that: “A competitor, if aware that particular tests were not performed by [that lab], could take commercial advantage of this information by offering to provide a complete spectrum of all tests including those test [*sic*] that [the lab] does not perform, thereby resulting in direct loss to [the lab’s] revenues.”²⁸ If for-profit companies are not willing to share information on which ones do which tests then the prospects for integration of services by these organizations is very limited. The lack

²⁵ Brenda Gamble, *The Commercialization of Hospital-Based Medical Laboratory Services: A Comparative Case Study in Ontario Documenting and Analyzing the Implications for Patients, Providers and the Health Care System*, Thesis, Masters of Science, Graduate Department of the Institute of Medical Sciences, University of Toronto, 2002.

²⁶ It should be noted that when the first studies on the private laboratories were done in the 1960s they provided detailed information on ownership, corporate connections, operations and services of different companies.

²⁷ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 139.

²⁸ Information and Privacy Commission order PO-2145, Appeal PA-020292-1, May 20, 2003, Part 1: Type of Information.

of information provided by the for-profit laboratories in the various regionalization processes was also noted in numerous interviews.²⁹

The licensing and quality programs administered by the Ontario Medical Association tightly guard their data on the industry. The argument from the Laboratory Proficiency Testing Program (LPTP), now the Quality Management Program–Laboratory Services (QMP-LS), is that if you want laboratory directors to cooperate, “in order to preserve the educational and peer review characteristics of the program, it must maintain confidentiality on all communications with laboratory directors.”³⁰ Not only is this information not available to the public, but the MOH complained that it was not receiving access to this information in the mid-80s³¹ and the OMA withheld data from the Ontario Council on Health Task Force on Laboratory Services in 1982.³² The general information reported by the LPTP (and now the QMP-LS) in their annual reports has also changed. In the 1970s the information was aggregated by ownership type. Information was available on the quality of commercial laboratories compared to hospital laboratories, and it was broken down by size, so infractions in smaller laboratories could be compared to those in larger ones. Currently only the aggregated figure for all laboratories is provided.

Other data collection problems were more prosaic. Information that would have been public if it could have been found was lost in the government archives or never made it there. Then there was the simple problem that some information relevant to this thesis is not being collected by anyone, for example, tracking which hospitals provide which kind of community laboratory services is not done. And there is no requirement for hospitals to provide this information if requested. There is a twenty-year restriction on access to Cabinet documents that limits access to internal government decision-making papers. Finally, there were many uncatalogued files in the Archives that may

²⁹ Interview 1, Interview 8 and a personal communication from a Regional Laboratory Coordinator who wished to remain confidential.

³⁰ “Assistant Deputy Minister’s Briefing Book: Ontario Medical Association Laboratory Proficiency Testing Program (OMA-LPTP),” 1985.

³¹ “Assistant Deputy Minister’s Briefing Book: Ontario Medical Association Laboratory Proficiency Testing Program (OMA-LPTP),” 1985.

³² Minutes of the Task Force on Lab Services, Oct 26 1981, Ontario Council on Health. The OMA refused to provide the Task Force with information on the quality and efficiency of laboratory services available in the various types of labs.

have provided useful information but would have been too costly and time consuming to search: costly because an archivist would have had to be paid to search the files first to determine if there was any information that was protected by the *Freedom of Information Act*; time consuming because, assuming they were released, there were large volumes of unsorted files. This category included files such as the correspondence of the General Manager of OHIP from 1972 to 1984.

Regardless of these difficulties numerous individuals and organizations had extensive files on important events in the development of the laboratories that were made available. Similarly the Ontario Archives staff were very helpful and a significant amount of information was found there. Luckily numerous individuals with first-hand knowledge of events going back as far as the founding of HICL provided context and confirmation of information. While not all the relevant facts were found, the information presented is a reasonably complete recounting of the major events based on significant amounts of uncontested information, sufficient for valuable discussion and the drawing of tentative conclusions.

Why Only Cost and Integration?

The main parameter used to evaluate the impact of for-profit corporations on the delivery of laboratory services in Ontario is system cost. This is further restricted to the cost to the government of providing medically necessary laboratory services rather than, for instance, including costs to workers who are paid less, or costs to communities as a result of having laboratory services centralized in a few larger population centres. While these are important societal considerations, and need to be studied, they were outside the scope of this research to develop in any systematic fashion.

There are a few reasons for the focus on cost. The first, as mentioned, is a straightforward need to limit the scope of the research. In-depth consideration of other common parameters for evaluation of public services, quality, accessibility and democracy, would have been useful but would require significant separate research. Where these parameters impact on the development of community laboratory services they are presented as part of the story. For example, quality considerations were central

to early initiatives by the government to regulate the industry, and played a role in its consolidation. These problems and the government's response are outlined in this thesis. But while the technical accuracy of tests and the appropriateness of tests ordered in relation to different ownership structures is important they are not considered in any comprehensive fashion. Similarly considerations of accessibility and democracy will be part of this thesis when they impact on relevant government decision-making but not developed as topics in their own right.

Second, cost and the efficient use of systemic resources, even in a limited sense, are important considerations for supporters of public health care. While these need to be weighed in tandem with a larger set of progressive values, they must be among the factors that determine the ability to provide essential services. Also cost, to the extent that it is a surrogate for the use of resources, acquires greater significance in the face of increasing environmental concerns and global inequality. Environmental limits and some approximation of international social equity make a strong mutually reinforcing case for increasing efficiency and reducing the use of resources in advanced capitalist countries. While this is a topic for another paper these restraints argue strongly against growth-oriented strategies and make the use of resources, initially approximated by cost, more important in considering collective solutions in the public interest.

At the same time this thesis does not simply assume that it is beneficial to reduce cost. Clearly there are other social goals that would justify the government's choosing more expensive alternatives. Providing adequate pay and working conditions, good access for all patients and superior quality easily come to mind. Similarly integration is not an unqualified good. Centralizing services can decrease access, hurt the ability of smaller community hospitals to provide basic laboratory services and decrease quality of care by making it more difficult for practicing physicians and laboratory specialists to interact.

Third, reduced cost is one of the central reasons given by supporters of more for-profit involvement in laboratory services. A senior manager in the for-profit system commented that, "there is nothing in the nature and structure of the public sector to become more efficient."³³ In essence this is an internal critique of that position.

³³ Interview 12.

Finally, cost control is one of two policy prescriptions advocated by panels of experts at regular intervals during the thirty-eight years covered in this study, yet its implementation has been difficult. The other is integration of services, partially in the aid of cost control, but also to provide better quality and access. Specific comment will also be made on the effect of the for-profit industry on the integration of laboratory services. Highlighting cost control and integration is a way of challenging what Deborah Stone calls the “rationality project,”³⁴ i.e., the argument that there is a rational technical solution that provides the best answer to any problem facing society. Paraphrasing Stone’s turn of phrase, the rationality project seeks to rescue policy-making from politics. Cost control through integration was often seen as the rational choice to address the rising costs of medical laboratory services, but it was not implemented and real policy outcomes worked against this prescription. The focus on cost and integration provides an opening to explore an alternative approach to understanding policy in advanced capitalist societies that places the dynamics of capital accumulation and struggle over resources at the centre of the analysis.

Introduction to the Laboratory Industry

Schematically the process of laboratory work consists of taking a sample, analysing it and conveying useful information back to the health care provider and patient. Since most samples are small they can easily be transported to a facility for evaluation. How these steps interconnect depends upon the patient, the laboratory and the professionals. Patients in hospitals usually have their blood taken by a nurse and then sent to a laboratory on-site for processing. Information and interpretation is readily available to the attending staff. Patients in the community most often have their blood taken in a specimen collection centre (SCC), usually located in a building with family doctor services. Most of these samples are transported to a central facility, increasingly in another city, where they are processed. Fax, mail, phone and computers are used to inform the physician of the results. Another option, both in the hospitals and the

³⁴ Deborah Stone, *Policy Paradox: The Art of Political Decision Making, Revised Edition*, New York: Norton & Company, 2002.

community, is point-of-care testing, where a sample is tested in a doctor's office or at the bedside. The relationships between specimen collection, testing and reporting are more complicated than this simple schematic suggests, but how these elements are delivered, financed and coordinated for community patients is the central policy issue considered in this thesis.

Chapter Outline

Chapter Two develops some theoretical concerns important to this study. The relationship of the class struggle to policy outcomes is explored through the relative autonomy of the state, the dominant ideology and a subset, the sectoral ideology of biomedicine. Chapters Three and Four focus on the period 1968 to 1990. In 1968 HICL performed its first tests and Ontario passed the *Medicare Act* introducing mandatory universal medical insurance including coverage of medically necessary laboratory tests. The year the NDP government under Bob Rae was elected, 1990, marks the shift in power towards for-profit dominance of the community laboratory sector. Chapter Three follows the development of non-profit options for delivering community laboratory services between 1968 and 1990. Chapter Four chronicles the development of the for-profit industry.

Chapter Five covers developments in the community laboratory sector from 1990 to 2006. It describes numerous Ministry attempts to restructure the laboratory sector with the outcome of increased integration among hospitals and the dominance of the community services by three for-profit corporations. The shift of community work from hospitals to the commercial sector is described as are incursions by the private corporations into the provision of hospital services. Chapter Six examines the specific impact of the commercial laboratory industry on system costs and integration. It is argued that the use of for-profit corporations has increased the cost and complexity of Ontario's medical laboratory services. Chapter Seven discusses the links between class struggle and policy outcomes arguing that change in the balance of class forces is a central element in policy formation. Questions raised by the findings of this research are also presented.

Chapter Two: Class, State, Ideology and Policy – The Divided Society

Methods of analysis of policy formation are intimately tied to understandings of the state and the process of political change. In this sense the waning of progressive politics, to say nothing of revolutionary struggle, in advanced capitalist countries can be correlated with the decrease of the use of class as a concept relevant to policy formation. This chapter develops the importance of the relationship between class and state policy as a necessary perspective to understanding medical laboratory policy.

On one level the inclusion of class struggle and strategies for private capital accumulation in policy discussions is apparent. In 1978 Nicos Poulantzas made this simple observation: “For it is obvious that we are hemmed in more and more tightly by a state whose most detailed practices demonstrate its connection with particular and extremely precise interests [the interests of specific capitalists].”³⁵

This is just as true, if not more so, today, and widely recognized in popular culture. Farm aid preferentially goes to big agribusiness corporations,³⁶ inaction on climate change benefits the oil and automotive corporations,³⁷ restrictions on the Internet favour media corporations, as do policies permitting or encouraging corporate concentration,³⁸ loosening regulatory regimes on medicines helps big pharmaceutical companies³⁹ and Halliburton is a major beneficiary of the war in Iraq.⁴⁰ A daily reading of the newspaper adds more examples. State policy in advanced capitalism favours specific corporate interests, often directly countering broad popular preferences and scientific knowledge. Al Gore relates in his movie, *An Inconvenient Truth*, that he

³⁵ Nicos Poulantzas, *State, Power, Socialism*, London: Verso, 1978, p. 12.

³⁶ “Farmers Hit by BSE Get Part of a \$995 Million Aid Package,” *Union Farmer Monthly* 55(2) (March/April 2004), p. 1.

³⁷ Achim Brunnengraber, “The Political Economy of the Kyoto Protocol,” in Leo Panitch and Colin Leys eds., *The Socialist Register 2007: Coming to Terms with Nature*, London: Merlin Press, 2007.

³⁸ Jeff Chester, “The End of the Internet?” *The Nation*, Wednesday, 01 February, 2006, downloaded from <http://www.truthout.org/cgi-bin/artman/exec/view.cgi/48/17469>.

³⁹ Michael McBane, *Ill-Health Canada: Putting Food and Drug Company Profits Ahead of Safety*, Ottawa: Canadian Center for Policy Alternatives, 2005.

⁴⁰ Michael Dobbs, “Halliburton's Deals Greater Than Thought,” *Washington Post*, Thursday 28 August, 2005, downloaded from http://www.truthout.org/docs_03/082903B.shtml.

thought the US Senate would act when presented with the facts about global warming. This did not happen.

Yet consideration of the basic dynamics of capitalism, the accumulation and reproduction of capital, and struggles against exploitation, and their connection to state policies are shunned in much academic and activist discourse. This is particularly noticeable in discourse around welfare and cultural policies, including health care policy.

In the late 1960s and early 1970s there was a lively discussion on the nature of the state in advanced capitalist societies and its relationship to class struggle. A debate between Nicos Poulantzas and Ralph Miliband⁴¹ was its symbolic centre. The vibrancy of that debate contrasts noticeably with the discussions around the state today. In progressive movements, to the extent that the question of the state is raised at all, the issue is whether or not the nation state is a worthy target of political action; but the more common approach is to treat the nation state as irrelevant. The “movement of movements” has been critiqued for its focus on local and regional “reforms within capitalism,” and its inability to contest national state power.⁴² Harden argues that one of the main lessons to be drawn from post-9-11 developments and recent anti-globalization actions is the need for activists to address state power. He points out that, “there have already been harsh lessons learned from a failure to do so.”⁴³ Similarly the question of class struggle has been swamped by globalization, post-modern identity politics and the politics of oppression. Acker comments that, “as solutions to conceptual and theoretical problems proved elusive, feminist debates about class almost disappeared.”⁴⁴

Many recent discussions in the welfare state literature accept the state as an important site of political action, but see it as a neutral social institution not one

⁴¹ The debate consisted of four articles in the *New Left Review (NLR)*: Nicos Poulantzas, “The Problem of the Capitalist State,” *NLR*, 58 (Nov.-Dec. 1969), pp. 67-78; Ralph Miliband, “The Capitalist State: Reply to Nicos Poulantzas,” *NLR*, 59 (Jan.-Feb. 1970), pp. 53-60; Ralph Miliband, “Poulantzas and the Capitalist State,” *NLR*, 82 (Nov.-Dec. 1973), pp. 83-92; Nicos Poulantzas, “The Capitalist State: A Reply to Miliband and Laclau,” *NLR*, 95 (Jan.-Feb. 1976), pp. 63-83.

⁴² Emir Safer, “Beyond Civil Society,” in Tom Mertes, ed., *A Movement of Movements*, London: Verso, 2004, pp. 248-261.

⁴³ Joel Davison Harden, “Ruthless Empire(s), Activist Subcultures, or New Solidarities? Choices for Today’s Global Radicals,” *Studies in Political Economy*, 76 (Autumn 2005), p. 149.

⁴⁴ Joan Acker, *Class Questions: Feminist Answers*, London: Rowman & Littlefield, 2006, p. 3.

grounded in class interests.⁴⁵ They have at best a limited acceptance of class struggle and the dynamics of capital accumulation as key to understanding social welfare policy and change. The policy process is concerned more with independent mechanisms within the state that affect policy: for example, path dependency, scale, policy ideas and veto points. To the extent that class is considered, it is not class rooted in production and struggles over exploitation, but class defined in a more Weberian sense, by social hierarchies, status and socio-economic groups. Even within this understanding of class Korpi and Palme felt the need to reassert the importance of socio-economic class and power resource theory after a decade of the “waning” of the class-based political perspective.⁴⁶

The perspective that class struggle based in the property relations of capitalism and the relationship of the state to that struggle as crucial to understanding social policy outcomes is present in contemporary political economy. Armstrong, Armstrong and Coburn suggest that, “this whole [societal institutions] is shaped, but not determined, by the mode of production, that is by the means of producing and reproducing for socially determined needs.”⁴⁷ Porter provides a privileged space for the “central concern” of the relationship between production and social reproduction and calls for greater attention to the, “historical dynamic of capital accumulation and ... the role of the state.”⁴⁸ These approaches respect the underlying fact that capital, the power of capital, and the dynamics of capital are central to understanding developed capitalist societies. The point is, to use Baxter and Western’s shorthand, “class counts.”⁴⁹ This thesis hopes to provide information and insight on the importance of class and its relationship to state policy and bring class back into the conversation.

⁴⁵ Here are some examples of discussions that explain welfare state policies and changes as inevitable rational responses to industrialization, institutional structures, policy ideas and path dependency: Daniel Beland, “Ideas and Social Policy: An Institutional Perspective,” *Social Policy & Administration*, 39(1), February 2005, pp. 1-18; Christopher Peirson, “Late Industrializers and the Development of the Welfare State,” Social Policy and Development Programme Paper Number 16, United Nations Research Institute for Social Development, September 2004; and Paul Pierson, “Irresistible Forces, Immovable Objects: Post Industrial Welfare States Confront Permanent Austerity,” *Journal of European Public Policy*, 5:4, pp. 539-60.

⁴⁶ Walter Korpi and Joakim Palme, “New Politics and Class Politics in the Context of Austerity and Globalization: Welfare State Regress in 18 Countries, 1975-95,” *American Political Science Review*, 97(3), 2003, p. 426.

⁴⁷ Pat Armstrong, Hugh Armstrong and David Coburn (2001), eds., *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*, Don Mills: Oxford University Press, 2001, p. vii.

⁴⁸ Ann Porter, *Gendered States*, p. 19.

⁴⁹ Janeen Baxter and Mark Western, *Reconfigurations of Class and Gender*.

It is widely accepted by those concerned with class politics that the capitalist state's relative autonomy from the dominant class is needed to create the conditions for the reproduction and expansion of capital accumulation.⁵⁰ The state also needs to incorporate the conflicts between and within classes in its workings and its policy outcomes. These complex and seemingly paradoxical relationships are multi-levelled, and historically and spatially specific. This chapter develops these themes. It is concerned with understanding the factors that mediate the manifestation of the class struggle in specific circumstances and how these in turn impact that struggle. Of particular interest is the interaction between private accumulation and non-market sectors, and one relatively understudied factor, the interaction of the dominant ideology in health care, biomedicine, with capital accumulation and the state processes that affected policies in the medical laboratory sector.

The State and Policy – Contained Contradictions and Antagonisms

Poulantzas argues that rather than an arm of the dominant class, the state is, “the strategic site of organization of the dominant class in its relationship to the dominated classes.”⁵¹ The state operates to maintain capitalist relations by being relatively autonomous from the dominant power bloc. Ideologically the state needs to be seen as a neutral body controlled by officials working in the best interest of the country. Practically, relative autonomy gives the state latitude to work compromises between different factions and classes. In her analysis of the Canadian state, Mahon found that, “it is precisely because of this relative independence that the civil servant is able to negotiate the compromises essential to the maintenance of the basic interests of the dominant class.”⁵²

The existence of two main competing class interests and compromise are recognized in capitalist state functioning and policy outcomes. Deborah Stone captures

⁵⁰ Ralph Miliband, *Class Power and State Power*, London: Verso, 1983, Chapter Four; and Rianne Mahon, “Canadian Public Policy: The Unequal Structure of Representation”, in Leo Panitch, ed., *The Canadian State: Political Economy and Political Power*, Toronto: University of Toronto Press, 1977, pp. 165-198.

⁵¹ Nicos Poulantzas, *State, Power Socialism*, p. 148.

⁵² Rianne Mahon, “Canadian Public Policy,” p. 173.

this fact nicely in her work on the policy process in the United States.⁵³ She argues that all aspects of the process from the identification of problems to policy outcomes are infused with the politics of two competing meta-ideas of how society works: one a political community acting with collective will, the other a market society based on self-interested individuals. While Stone describes a central bi-polar conflict in policy development and outcomes she does not identify a motivation for these two positions or explain why their relationship might change over time.

Gary Teeple presents a similar phenomenon, but roots it in the dominant class struggle between capitalists and workers. For Teeple:

[Bourgeois democratic] Reforms are, therefore, paradoxical in nature. They are, on the one hand, a form of resistance to the capitalist mode of production, necessary for the protection of the working classes and nature. On the other hand they comprise an important element in maintaining capitalism, the object of their corrective purpose, not to mention in bolstering the legitimacy of the state. Such paradox inhabits all reforms.⁵⁴

To do this the state incorporates the “contradictions and antagonisms,” to use Mahon’s formulation, of all classes and fractions of classes:⁵⁵ that is, it incorporates the dominant contradiction between capital and labour, but also between fractions of classes, for instance between capitalists that provide national laboratory services and finance capital that prefers lower state expenditures.⁵⁶

The state and policy understood in this way accepts an inherent conflict within capitalist society. Policy outcomes involve a compromise between two conflicting options: the needs of capital and the needs of the population. But the impact these compromises and policy outcomes have within capitalism is not neutral or generally beneficial. They will tend to benefit private capital interests and maintain the dominant relations of production over collective social benefit. Contradictions based in the fundamental structure of property relations and the dynamics of capital accumulation

⁵³ Deborah Stone, *The Policy Paradox*.

⁵⁴ Gary Teeple, *Globalization and the Decline of Social Reform*, Toronto: Garamond Press, 1995, p. 21.

⁵⁵ Rianne Mahon, “Canadian Public Policy,” p. 169.

⁵⁶ While not the focus of this paper it is also important to note that other forms of oppression and resistance also manifest in policy are not reducible to the class struggle. These struggles interact with the class struggle and are also represented in state structures and policy outcomes.

imply ongoing policy instability. A corollary is that any gains in social rights of citizenship within capitalism will be challenged as part of the ongoing struggle over power and resources.

This analysis has strategic and tactical implications for the left. The fact that policies for, and methods of delivery of, collective services exist, at least partially, to meet the needs of corporate profit makes them less effective as public services and vulnerable to attack. Without being explicit about the difficulties in the provision of services while defending them, we end up supporting services that have problems and our support becomes both problematic for the public and a tool for those who want to undercut the services. A similar problem is discussed later in this chapter when the role of biomedicine is considered.

Maintaining Hegemony

How does the state both structurally incorporate the interests of different classes and class fractions and maintain the dominant power relationship? This seeming paradox can be understood through an analysis of the external and internal limitations on the state that permit many options but limit outcomes. The extent of these limitations depends upon the balance of economic, political and ideological power between the classes.

The external factors that limit the state's actions are commonly recognized. The ability of capital to strike or flee can create unmanageable chaos. The ability of capital to mobilize resources to support its interests is significant. It is very difficult in these circumstances for the state to be neutral in the class struggle. Poulantzas argues that the dominant classes have "the capacity to allocate the means of production for given ends and to dispose of the products thereby obtained, and these powers in the relations of production are bound up, as constitutive powers, with the political and ideological relations which consecrate and legitimize them and which are present in these economic

relations.”⁵⁷ Workers on the other hand, separated from the control of the means of production and the results of their efforts, individually have little power.

While this is the basis, and most blatant representation, of restrictions on state action, other processes are at work. Mahon describes a process of unequal representation within the state that prioritizes policy choices that maintain the dominant power bloc and gain the acquiescence of the dominated.⁵⁸ This process works in tandem with the ideology of capitalism, which sets limits on acceptable state actions, and infects the state with structures that demobilize the population. Poulantzas, for example, identifies three aspects of the dominant ideology: individualism, deference to technical decision-making and the rule of law, which are incorporated into the state and effectively limit policy outcomes.⁵⁹ Taking a more instrumental approach, Miliband describes how the composition of state personnel limits the capitalist state’s field of action.⁶⁰

A related element of the Poulantzas-Miliband debate of the 1970s concerned the power of the relatively autonomous state. The difference in their positions rests in the different levels of abstraction needed to understand state functioning. For Poulantzas the state has power only to the extent that it maintains the dominant relations of production. The state “possesses no power of its own.”⁶¹ Miliband, while accepting the concept of relative autonomy, takes exception to the idea that the state has no power.⁶² He describes the relationship between the dominant class and the state as a “partnership” in which the parties represent separate forces with coinciding interests. As an example he points to the role of self-interest in determining the actions of key power brokers. There is some truth to this. Who has not run into a bureaucrat or politician whose primary policy interest appears to be securing his or her own position, or less cynically, just enforcing the rules? Both can have a small but real policy effect. On one level the class struggle conceptually underlies all other social institutions and is the source of power; on another there are the day-to-day machinations of state policy. This difference also has significant political implications.

⁵⁷ Nicos Poulantzas, *State, Power Socialism*, p. 35.

⁵⁸ Rianne Mahon, “Canadian Public Policy.”

⁵⁹ Nicos Poulantzas, *State, Power Socialism*, part one.

⁶⁰ Ralph Miliband, *The State in Capitalist Society*, London: Weidenfeld and Nicolson, 1969.

⁶¹ Nicos Poulantzas, *State, Power Socialism*, p. 148.

⁶² Ralph Miliband, *Class Power and State Power*.

Miliband's approach downplays a key conceptual point highlighted by Poulantzas. It detracts from the reality at the heart of the matter: the question of struggle between classes and within classes. At one level there is a primary need for the popular masses, both in workplaces and in the community, to engage in mass organizing and struggle to both expand the range of options available through the capitalist state and to eventually change the state. This represents the differential of possible outcomes between the dominated who must struggle for more and the powerful that the state defends by maintaining order.

The truth behind Miliband's point is that there are complex factors within the capitalist state that are historically specific, both in form and in relative importance, that are part of the strategic field of state power and that affect specific policy outcomes. These work within the broader structural confines of the state, have an influence on specific outcomes and, in turn, affect the class struggle and limitations on state action. Poulantzas makes a nod to this complexity when he mentions the concept of a "micropolitical" process. While not well developed it describes a process that, "at an initial short term level... appears to be phenomenally incoherent and chaotic." It is a process within the state that navigates the intra-state contradictions, filters options, prioritizes, excludes actions and produces a, "certain coherence [at the] conclusion of the process," though within "quite clearly marked structural limitations."⁶³

Poulantzas' focus on delineating a general theory of the capitalist state limits the detail on the "micropolitical physiology" of the advanced capitalist state. This is unfortunate because elsewhere he discusses the presence of popular struggles within the state, how these struggles have long-term effects upon the state and that they are a necessary, though not sufficient condition for the socialist transformation of the state. Yet, despite an inviting introduction into mass mobilization and state policies, he does not deal with the specifics of how to maximize impact within the state.⁶⁴

⁶³ Nicos Poulantzas, *State, Power Socialism*, p. 135.

⁶⁴ Nicos Poulantzas, *State, Power Socialism*, particularly part two and part five.

The work of Miliband and much of the recent welfare-state literature partially fills this gap. They point to some of the processes involved in state policy-making.⁶⁵ These are phenomena that anyone who has been involved in specific policy struggles has come up against: self-interested bureaucrats and politicians, the appeal to national interest, path dependency, precedent, policy learning, veto points and other institutional processes that affect specific policies. These factors, while they are largely limited by the dominant relations of production, also affect the historical and geographical manifestations of the dynamics of capital accumulation and the class struggle. For example, a specific structure clearly delimiting collective health care services might mitigate the effects of a shift in economic power to private alternatives allowing progressive forces a base to develop and advocate for more public options. In other words how these phenomena are structured will be affected by the class struggle and dialectically interact with that struggle.

The existence of these processes is also important to the state. They provide material manifestation of the ideology of neutrality and democracy that is crucial to its legitimacy. At the same time, without understanding these as mechanisms primarily to protect the integrity of capital accumulation and reproduction, it is often difficult to answer the question of why a certain policy path was chosen, a particular policy learned or certain recommendations systematically ignored, particularly when the outcome favours private capital accumulation over broadly popular options that protect the public interest. These processes and their outcomes can also work in favour of the subordinate classes. Effectively working within these structures is important tactically when struggling for the best policy outcome and can increase working class power. When real gains are made, even if they are limited and contested, it is also easy to believe that working within the state can solve the problems of exploitation and oppression. But it can not. Working class and popular mobilization are the basis of power within the state and necessary for finding solutions that work for the collective good.

⁶⁵ This includes the literature that builds on the work of Esping-Anderson and explains welfare state policy in terms of social democratic elected politicians, path dependency theorists who identify the power of established institutions to defend their interests, and policy learning theorists who understand how policy initiatives in one area affect other government initiatives.

The difference between these levels of analysis is another manifestation of the long-standing tension between reform and revolution. A hundred and fifty years ago Marx argued that the Communist Party ought to support bourgeois democratic reforms as part of the revolutionary movement because they would benefit the working class and build the strength of the popular forces.⁶⁶ Members of the working class live their lives on a day-to-day basis. They face problems that need to be addressed in the short term, and partial solutions can often be found. Yet the transformative change required to properly address many of these issues is uncertain and the process could negatively affect “getting by” in the short term. How to link these two positions to their mutual advantage is a long-standing political problem for the left. The answer probably cannot be found in theory, but lies in a deft mixing of theory and practice, good social analysis of the current context and issues, and an acknowledgement of the effects of the basic dynamics of capitalism.

Nonetheless the success of the capitalist state depends on incorporating opposition struggles within state processes that have a strong bias to supporting the established order and denying the inherent class nature of the state and society. Colin Leys’ recent analysis of the links between changing capitalist strategies for accumulation and political control and specific policy outcomes challenges these notions. In his study *Market-Driven Politics* Leys looks for “causal chains”⁶⁷ to bridge the gap between global economic forces and policies affecting the specific markets of broadcasting and health care in Britain. His study helps identify how changes in economic power affect policy outcomes. One starting point for Leys is that, “the dynamism of markets is constant, what changes is the ability of the state to reckon with them.”⁶⁸ He is particularly interested in the dynamic that for-profit enterprises, especially when under financial pressure, will try to expand into non-market spheres such as public services. How this dynamism is manifest in a concrete instance will be impacted by the relative power of the classes and affect that balance of power. Leys describes how Thatcher played a central role in

⁶⁶ Karl Marx and Frederick Engels, “The Manifesto of the Communist Party,” 1848, in *Karl Marx and Frederick Engels: Selected Works, Volume One*, Progress Publishers, Moscow, 1969.

⁶⁷ Colin Leys, *Market-Driven Politics: Neoliberal Democracy and the Public Interest*, London: Verso, 2001, p. vii.

⁶⁸ Colin Leys, *Market-Driven Politics*, p. 215.

establishing the global market under the influence of national economic and political pressure to increase capital accumulation and undercut progressive political forces.

After analyzing what is novel about the contemporary global economy – capital mobility, global financial markets, transnational corporations and advanced communications – Leys examines how these developments manifest within a nation state. Leys pays particular attention to the structure of government (the constitutional arrangements, the bureaucracy and electoral system), state involvement in the economy, British culture, and political institutions, specifically political parties, as factors that mediate the effect of changes in global capital accumulation on British government policies involved in the commodification of public broadcasting and the National Health Service (NHS). Connecting these concerns with concepts such as path dependency, policy learning and corporate linkages, while the topic of another work, might provide a more complete understanding of how the broader struggle is linked to specific policy outcomes.

When the power of capital increases, as in the new global economy, Leys hypothesizes that the nature of specific social services also influences the rate of, “penetration of non-market spheres by market forces.”⁶⁹ He argues that factors that make non-market, public services more open to commodification include: porous boundaries between the public and for-profit sectors, strong demand for the service, a weak public service ethos and ease of setting up private services.⁷⁰ Leys does not argue that certain structural characteristics of states or programs insulate them from the dynamics of capital, only that that they can provide an institutional buffer for a period of time when the balance of power in the relations of production shifts. This is a variation on the argument put forward by Esping-Anderson on the impact of the different types of welfare states on the ability to sustain redistributive policies.⁷¹ These interesting proposals provide a basis for collective action by indicating how a social program such as the NHS

⁶⁹ Colin Leys, *Market-Driven Politics*, p. 87.

⁷⁰ Colin Leys, *Market-Driven Politics*, p. 87.

⁷¹ Gosta Esping-Anderson, “Power and Distributional Regimes,” *Politics and Society*, 14(2), 1985, pp. 223-256. In his conclusion he says that, “we find that social democracy has been least challenged and weakened in those nations where its accomplishments have gone the furthest.”

can be structured to make it less vulnerable to erosion by market forces.⁷² His goal is to present collective needs against the interests and logic of global capitalism.

These factors provide a basis for collective action, but two related factors that provide openings for private accumulation alternatives to undercut the provision of collective services are not included. As mentioned earlier social services are paradoxical. The fact that policies and methods of delivery for collective services exist, at least partially, to meet the needs of corporate profit makes them less effective as public services and vulnerable to attack. Addressing these weaknesses in the services need to be explicitly and independently part of the process of political change. Another aspect of any market is the translation of the dominant ideology into a specific sectoral ideology that helps facilitate capital accumulation. Yet in Leys' work the impact of ideology on health care services is not developed. This thesis will try to address some of that gap by paying particular attention to the role of biomedicine, the dominant sectoral ideology, in the evolution of medical laboratory services Ontario.

Ideological Institutions and the State

The disagreements between Poulantzas and Miliband also include important considerations on the nature of ideology and how it relates to policy and political strategy. Both note the expansion of the state in advanced capitalism, a tendency that has not abated since their famous debate. Miliband calls it the "statization" of the political sphere.⁷³ Poulantzas notes that:

Now it is true that the present-day capitalist state, which must at any event be broadly conceived, concentrates the various forms of power to an ever-increasing extent. Intervening more and more in every sphere of social reality ... We can see it too in the state penetration of the spheres of so-called collective consumption (transportation, housing, health, national assistance, and leisure) – areas in which the ideological-symbolic powers materialized in such constructions as municipal flats or cultural centers directly expand state relations. In each of these rather different examples the relations of class powers and the State are becoming closer.⁷⁴

⁷² Colin Leys, *Market-Driven Politics*.

⁷³ Ralph Miliband, "The Capitalist State: Reply to Nicos Poulantzas."

⁷⁴ Nicos Poulantzas, *State, Power Socialism*, p. 37.

Poulantzas defines the state as, “the factor of cohesion of a social formation and the factor for reproducing the conditions of production of a system.”⁷⁵ From this definition it is easy to see the state as composed of a broad range of institutions, some that have a primarily repressive role and others that have a principally ideological role, including the church, political parties, schools and the mass media. Health care institutions easily fit in this list.

Among the reasons that Poulantzas gives for including ideological apparatuses in the state is that they fulfill the role of the state as a force for social cohesion. The implication is that the transition to socialism requires changing both the state repressive and ideological apparatuses. They go hand in hand.⁷⁶ For Poulantzas the more repressive state apparatuses perform ideological as well as repressive functions. Similarly, primarily ideological institutions also have a repressive role. If ideological institutions are part of the capitalist state then they embody the class struggle and are internally contradictory.

Miliband draws a distinction between the state and political institutions, the same institutions that Poulantzas considers ideological state institutions, placing narrower boundaries around the state. The boundary between these two for Miliband is that institutions in the political system, “retain a very high degree of autonomy; and are therefore better able to conceal the degree to which they belong to the system of power of capitalist society.”⁷⁷ Panitch draws heavily on Miliband to separate the bureaucratic institutions of the state from the political system. He argues that this boundary allows us to problematize how political institutions form part of the system of power and also how class conflict can gain expression through voluntary organizations of the working class. Second, delimiting the institutions of the state, “leads us away from assuming that election to government power is equivalent to the acquisition of state power. ...[rather it is]... the balance of forces within the various institutions of the state, such as the bureaucracy, the judiciary, and the military, in terms of the classes they represent and the values they hold ... [that] ... will determine how far governmental power is circumscribed

⁷⁵ Nicos Poulantzas, “The Problem of the Capitalist State,” p. 73.

⁷⁶ Nicos Poulantzas, “The Problem of the Capitalist State,” p. 78.

⁷⁷ Ralph Miliband, “The Capitalist State: Reply to Nicos Poulantzas,” p. 59.

by state power.”⁷⁸ This formulation ignores the power of institutions in the political sphere to control the government.

The similarities between these two positions prove useful in understanding health care. Both Miliband and Poulantzas agree that ideological institutions “belong to the system of power.”⁷⁹ Though their reasons are different they both see a continuum of institutions from the repressive to the ideological. For Miliband this has been brought on by the progressive “statization” of political institutions, i.e., greater state intervention due to the continuing crisis of capitalism. For Poulantzas they are part of the same institution, the state.

Both agree that repressive and ideological institutions need to be challenged and changed in the process of transformation to democratic socialism. Yet it is here that two points of difference arise. Poulantzas sees ideology embodied in institutions. Ideology does not consist merely of ideas or representations: “it also involves a series of material practices, embracing the customs and lifestyle of the agents and setting like cement in the totality of social, including political and economic practices ... the dominant ideology that is embodied in the state apparatuses.”⁸⁰ In turn, one of the state’s functions is to, “elaborate, inculcate and reproduce” that ideology.

For example, Poulantzas develops the core idea that state power is exercised by representatives and technical experts not the mass of the population. This is based in the capitalist division of labour, the “relative separation of the political from the economic,” and illustrates how this aspect of the dominant ideology finds expression in the structures and processes of the state. It becomes “a knowledge-power relationship” where experts make decisions. It structures the exercise of state power to consider popular struggles in the compromise while excluding them from the centres of decision-making.⁸¹ “This relationship between the state and the intellectual/manual division of labour implicit in capitalist relations of production is therefore one stage in the process whereby the state is

⁷⁸ Leo Panitch, “The Role and Nature of the Canadian State,” in Leo Panitch, ed., *The Canadian State: Political Economy and Political Power*, Toronto: University of Toronto Press, p. 7.

⁷⁹ Ralph Miliband, “The Capitalist State: Reply to Nicos Poulantzas,” p. 59.

⁸⁰ Nicos Poulantzas, *State, Power Socialism*, p. 28.

⁸¹ Nicos Poulantzas, *State, Power Socialism*, p. 60.

brought into relations with classes and class struggle under capitalism.”⁸² He makes a similar argument with respect to the key ideological constructs of individualism and the rule of law.

This understanding is broader and deeper than Miliband’s view of “political socialization,” which is more of an educational function, a process of indoctrination, carried out by political institutions.⁸³ It is implicit in the teachings of the church, political parties, the education system and the media. It can range from subtle to explicit endorsements of free enterprise. Institutions are part of the system of power, but the implication is that changing what they say is sufficient, rather than redressing the process, structure and ideology embodied in the institutions.

The second, related difference between Poulantzas and Miliband is most starkly seen in Panitch’s reading of Miliband. Panitch describes how the extent to which a government effectively controls the power of the state will depend on the balance of forces within the various institutions of the state but this not include political institutions or institutions of the “broader public sector”, e.g. hospitals and schools.⁸⁴ While this reading may be stronger than Miliband intends, it suggests a limited structural understanding of the extent to which the class struggle impacts all aspects of life within capitalism, including the political and ideological. It downplays the extent to which these institutions limit the options of the government and the need to critique and change these as part of the process of revolutionary political change. While it is important to understand that some state institutions, such as the army and the bureaucracy, are not only more repressive, but also more central to maintaining state power, there is a continuum to more ideological institutions, such as political parties, hospitals and churches, that play important roles in maintaining the existing order at the same time as they are all contested ground. The point, though, is that these more ideological institutions do limit the exercise of governmental power.

This approach can be seen practically in the lack of explicit consideration by Colin Leys of how ideology in the practice of health care shaped the British National

⁸² Nicos Poulantzas, *State, Power Socialism*, p. 61.

⁸³ Ralph Miliband, *The State in Capitalist Society*.

⁸⁴ Leo Panitch, “The Role and Nature of the Canadian State,” p. 7.

Health Service, which misses key dynamics in understanding the vulnerability of the NHS to right-wing attacks, one of his conceptual goals. Accepting that collective services within capitalism contain the contradictory influences inherent in the class struggle, including dominant sectoral ideologies, suggests a further hypothesis for Leys' proposal on what makes collective services less vulnerable to market forces, that is, the extent of popular agreement on how to improve them as collective services. Simultaneously, strengthening this factor would improve the success of popular struggles.

A discussion of biomedicine illustrates how sectoral ideologies and related institutional characteristics can provide important supports to dominant power structures. How do common understandings of health limit state policy options? How does biomedicine reinforce capital accumulation over more collective approaches to health care? As these practices become relatively autonomous from ownership and control in the economy they become issues that need to be dealt in their own right. These are simultaneously policy questions and questions of strategy.

Biomedicine and Capitalism

Health care in advanced capitalist countries has become big business and big government. Private pharmaceutical companies and medical technology companies are among the largest in the world. Health care expenditures are often the largest component of government budgets. The state controls the health care system, either directly or through regulation, more than most markets. It is also big politics. It has potential as a great source of private profit, is necessary for a well-functioning workforce and is fought for as a basic right. In Canada it is regularly the top issue for voters. Daily media coverage dwells on how the health care system is simultaneously failing to meet health needs, for example, not providing timely cancer treatment, and not affordable.

A core debate is often framed as public, non-profit vs. for-profit, two-tier health care. While this is a key issue it does not address the dominant ideology that, through real manifestations in the practice of medicine, helps frame the discussion and limits acceptable alternatives. This raises the question: Does the practice of health care matter

in the transition to socialism? The argument made in this section is that the biomedical model, the dominant paradigm of health care, is entwined with the process of capital accumulation and its ideological stabilization, as well as its tendency to crisis and its inability to meet human needs. It plays a role in, “shoring up relations of domination by making them appear just inevitable or in some other way palatable.”⁸⁵

Armstrong and Armstrong identify five assumptions key to biomedical practice: illness is primarily biological; the body is a series of parts that can be fixed; cure is the focus of health care; scientific proof is its basis; and the doctor is the authority.⁸⁶ These tenets rest upon key aspects of capitalist ideology: individualism, neutral science and divesting authority to experts. The focus of allopathic health care is the individual patient as the site of illness and the primary physician as the source of treatment. This is reinforced by a method of scientific inquiry that reduces the causes of illness to organisms attacking a patient or body part breakdown,⁸⁷ and a structure of authority that passes control to experts. Without addressing this interconnected web of needs, professional power, use of science, knowledge and a conception of health, as well as systemic control in the process of change, the project of providing a collective democratic program for meeting health care needs risks coming undone. This is not to question the dominant role of the relations of production in shaping society, it is central, including to ideologies, but one of the lessons from the 20th century for socialists, and historical materialist analysis, has to be that the “muck of ages” does not wash off easily. So, yes, the practice of health care is important.

The critique of biomedicine is not an abstract one. It is grounded in the many ill health effects created by capitalism. Communities are defending themselves against pollution, workers against occupational dangers, patients against lack of respect, women against sex-blind medicine, and the frail elderly and dying against lack of care. With these struggles different understandings of health and health care are developing but the

⁸⁵ Susan Stokes, “Hegemony, Consciousness and Political Change in Peru,” *Politics and Society*, 19(3), 1991, p. 267.

⁸⁶ Pat Armstrong and Hugh Armstrong, *Wasting Away*, Second Edition, pp. 19-22.

⁸⁷ For an insightful discussion of the relationship between individualism and scientific inquiry under capitalism as it relates to preventative health care see: Sylvia Noble Tesh, *Hidden Arguments: Political Ideology and Disease Prevention Policy*, London: Rutgers University Press, 1988, particularly Chapter Seven.

focus here is on biomedicine, which seeks to provide reassurance that health care is being maximized while health under capitalism is problematic.

It is also important “not to throw out the baby with the bathwater.” This is not an attack on all the science, drugs and interventions developed under the biomedical model. Many medical advances, some universally obvious, such as insulin, antibiotics and vaccines, have improved health. Pat Armstrong points out that quantitative data have also been very useful in supporting concerns of women.⁸⁸ Standard protocols can be used in public institutions as part of the care process to aid clinical judgement and the realization of patient preference.⁸⁹ One approach to addressing these apparently contradictory views, developed by Armstrong and Armstrong,⁹⁰ is to consider many of them, for example expert knowledge versus democratic process, as tensions that will always exist, but are manifest in particular ways in specific historical contexts. The argument being made here is that the biomedical model makes it more difficult to create a new balance in these tensions that supports progressive change.

The impact of biomedicine can produce progressive results. The prominence given to doctors has allowed doctors to become advocates for more collective responses to health, including access to health care as a basic right, and to be critics of corporate medicine, which threatens physician autonomy and quality. This is the case in medical laboratory services as documented in this study and in the many campaigns where physicians have been leaders, such as the campaigns against smoking, air pollution and carcinogens in toys. While these have had success, the resources put into these campaigns and the slow and often timid regulation changes that result are minuscule compared to the wait-times strategy, which targets a small number of high-technology procedures.⁹¹

⁸⁸ Pat Armstrong, “Evidence-based Health-Care Reform: Women’s Issues,” in Pat Armstrong, Hugh Armstrong and David Coburn, eds., *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*, Don Mills: Oxford University Press, 2001, pp. 121-146.

⁸⁹ Marc Berg, “Problems and Promises of the Protocol,” *Social Science and Medicine* 44(8), 1997, pp. 1081-88.

⁹⁰ Pat Armstrong and Hugh Armstrong, *Wasting Away*, Second Edition, pp. 19-22.

⁹¹ I have not dealt with the increasingly ambiguous role of doctors in controlling medical practice, a control being slowly taken away by the health bureaucracy and corporations. It seems unlikely that this substitution would fundamentally change the functioning of the biomedical model and its ideological

Biomedicine, Cure and Standardization

Cure and care are part of any health care system, but the systematic preference for curing over caring is both central to the biomedical model and beneficial to capital. Duffin, in her *History of Medicine*, states that one of the core ideals of current medical practice is, “the rights of individuals to the pursuit of a cure.”⁹² Cure focuses on the individual both as the source of the health problem and as the site of intervention. Allopathic medicine assumes that the cause of illness is an outside invader or an internal malfunction, both of which can be identified by science and then fixed through increasingly elaborate technological interventions.⁹³ A strong argument will be made that one of the reasons for the expansion of laboratory services is their quantitative, scientific, technical, standardized nature.

Swartz cites the individual focus of current health care practices as basic to our health insurance system. Medicare, “presupposes that health is something that can be bought and sold,”⁹⁴ and that the social problem is its cost to individuals lacking health. Health becomes a problem located in the sphere of personal consumption and dominated by the consumption of physicians’ services. The implication for Swartz is that the limitations on the progressive reform of only providing health insurance are so tight that fighting for health care access, let alone practice reform, is a dubious proposition. This argument seems to suggest the unpleasant conclusion that socialists should support suffering to stimulate revolutionary action. However Swartz does point to a serious problem in the biomedical model: it shields the ill health effects of capitalism from public scrutiny. Poland et al. argue that, “a highly individualistic, mechanistic view of health and disease may be attributed to the coincidence of such a view with the

support for capitalism, though it could expose more directly the tension between the creation of expanding social needs and their equitable satisfaction.

⁹² Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction*. Toronto: University of Toronto Press, 2001, p. 87.

⁹³ For a fuller discussion of the elements of the biomedical model see Pat Armstrong and Hugh Armstrong, *Wasting Away*, Second Edition, Chapter Two.

⁹⁴ Donald Swartz, “The Politics of Reform: Conflict and Accommodation in Canadian Health Policy,” in Leo Panitch, ed., *The Canadian State*, p. 335.

perspective of those who wished to avoid viewing the determinants of health status as lying in [social factors].”⁹⁵

The focus of health care on the individual, besides shielding the ill health effects of capitalist production and distribution, provides openings for capital accumulation by providing more commodities for market, and more markets for commodities. It expands the need for acute care. It is as if capitalism causes illness to create a market for health services and then develops a system of medicine that facilitates the commodification of care. Illich makes the point this way: “What need is there to worry about a murderous environment when doctors are industrially equipped to act as life savers!”⁹⁶ Putting the question of causation aside, the web of interconnection that benefits the capitalist mode of production is strong.

While the practice of biomedicine favours acute care over prevention, it would be incorrect to assume that preventative medicine is necessarily incompatible with capitalism. The first major health care policy initiatives, largely driven by the medical profession, were focused on controlling communicable diseases. As well as improving the living standards of the working class these state interventions provided a healthy workforce for the large factories and decreased social discontent.⁹⁷ Tesh argues, in the main, preventative health care has been dominated by individualism and scientific reductionism and has not challenged the dominant power structures.

In acute care services biomedicine’s focus on identifying invading organisms and body part breakdown as the cause of an individual’s illness, and a method of science based on randomized controlled studies to find solutions, promotes standardization of clinical practice., Leys argues if a process can be, “broken down and ‘reconfigured’ as discrete units of output that can be produced and packaged in a more or less standardized way,” it facilitates commodification and market solutions.⁹⁸ Standardization facilitates the costing of each service, creation of mass markets for mass-produced goods, and cost

⁹⁵ Blake Poland, “Wealth, Equity and Health Care: A Critique of a ‘Population Health’ Perspective on the Determinants of Health,” *Social Science and Medicine*, 46:7 (1998), p. 797.

⁹⁶ Ivan Illich, *Limits to Medicine: Medical Nemesis: the Expropriation of Health*, New York: Penguin Books, 1977, p. 202.

⁹⁷ Sylvia Noble Tesh, *Hidden Arguments*.

⁹⁸ Colin Leys, *Market-Driven Politics*, p. 84.

control through managing health care workers' actions. A similar dynamic is at work in the focus on high-technology medical solutions. These require products that are currently supplied by for-profit corporations, most of which are large transnationals such as General Electric.

The logic of capital accumulation and its social illogic can be seen dramatically in Ontario's home care program. At the same time as paid supportive community care is being decreased, formal home care programs are being extended to place more acutely ill people in the community. This increases the unpaid work for women in the home: the patients they care for are sicker with greater personal needs. It also means more high-tech work for professionals – intravenous medications, complicated dressings – work that is more easily standardized, more related to cure, and more easily commodified.

A similar process can be seen in the approach to public health and preventative medicine. The prevailing paradigm, “results in disproportionate emphasis on downstream, individually oriented interventions which have limited effectiveness on whole population health.”⁹⁹ Interventions focused on at-risk individuals provide more opportunities for technological solutions that can be provided as a commodity. The individual becomes the cause of the problem, the focus of intervention, and yet is removed from control and denied the individualized of treatment implicit in care.

The links between cure, standardization, and a particular use of science and technology are supported by the biomedical model and facilitate capital accumulation. Simultaneously, capitalism, buttressed in part by the biomedical model of health, is increasingly unable to meet the need for care, the problems faced by caregivers, and the population's health needs.

The negative effects of capitalism and standardization are evidenced in the central practice of care. Browne states that, “care is a relationship arising both out of the need for care and the need to care.”¹⁰⁰ It is essentially a unique human relationship that takes place in the context of broader structures such as the family, the state and the market, and

⁹⁹ John McKinlay, “Paradigmatic Obstacles to Improving the Health of Populations – Implications for Health Policy,” *Salud Publica de Mexico*, 40(4), 1998, p. 376.

¹⁰⁰ Paul Leduc Browne, “The Social Division of Care in a World of Commodities,” in Paul Leduc Browne, ed., *The Commodity of Care: Home Care Reform in Ontario*, Ottawa: The Canadian Center for Policy Alternatives, 2003, p. 5.

is increasingly mediated by technology. “The [capitalist] logic of redistribution,”¹⁰¹ undermines the basic relationship of care both by standardizing it according to the needs of the market, and marginalizing it, overwhelmingly disadvantaging women and care recipients.

Care work has historically been done, and continues to be done, primarily by women on an informal, unpaid basis. The forces of the market and declining collective support for health care in institutions have further shifted care into the home with increased detrimental financial and social effects on caregivers, care recipients and families, especially those without resources to hire care help.¹⁰²

While this description of the changes in care work is based on a discussion of home care, it is also increasingly clear that families and friends, mostly women, are also expected to play a greater role in providing care within institutions, to similar negative effect.¹⁰³ Simultaneously, women also perform most of the paid care work. Reform strategies tend to focus on the management of the system rather than, “the interests of those who directly provide or receive care.”¹⁰⁴ The result is often standardization and formulas for practice that provide increased management control of the work process in hospitals, further disadvantaging women as workers¹⁰⁵ at the same time that health care is being structured to the advantage of capital. As well it downloads social costs onto the working class decreasing their share of available resources.

In any move to a more equitable system, one where caregiving is truly voluntary, not forced upon women, individually specific, valued and meets people’s need for care,¹⁰⁶ assumptions inherent in the biomedical model need to be challenged. To build upon this cornerstone of inequality, sexism and the undermining of care, to accept it as is, unchallenged and unchanged, or as something to be corrected after the revolution, as has sometimes been suggested in the case of sexism, is a dubious proposition.

¹⁰¹ Paul Leduc Browne, “The Social Division of Care,” p. 11.

¹⁰² Pat Armstrong and Olga Kits, “Caregiving in Historical Perspective,” in Paul Leduc Browne, ed., *The Commodity of Care*, p. 46.

¹⁰³ Pat Armstrong and Hugh Armstrong, *Wasting Away*, p. 77.

¹⁰⁴ Pat Armstrong, “Evidenced-based Health-Care Reform,” p. 132.

¹⁰⁵ Pat Armstrong, “Evidenced-based Health-Care Reform,” pp. 156-157.

¹⁰⁶ These suggestions are from a ten-point policy framework on what needs to be done to value care work outlined by Pat Armstrong and Olga Kits in “Caregiving in Historical Perspective.”

Biomedicine and Need

Another component identified by Leys as necessary for the commodification of services is that, “people must be induced to want to buy them.”¹⁰⁷ Health care is conceived of as an “armoury of ‘magic bullet(s),’” magic bullets you can sell. There is an interactive process between the creation of needs, the extension of the market to meet those needs and the ideology of allopathic medicine creating openings and legitimation for those markets.

Marx makes numerous points about need within capitalism; in fact Heller says that the concept of need underlies Marx’s main theoretical advancements.¹⁰⁸ Three concepts seem particularly relevant to this discussion. First, needs and the means of satisfying them are, “the product of historical development.”¹⁰⁹ Second, the labourer, “exists to satisfy the needs of self-expansion of [capital], instead of, on the contrary, material wealth existing to satisfy the needs of development on the part of the labourer,”¹¹⁰ and, third, capitalism’s tendency to crisis denies workers the ability to fulfill these needs. Workers respond by individual and collective action to increase their ability to meet their needs, which, in turn will change as a result of the process of collective struggle.

The creation of expanding health needs depends upon a concept of health and illness that requires more and more intervention. Illich argues that, “the dominant image of death determines the prevalent concept of health.”¹¹¹ He examined “bourgeoisie death,” the concept of death that arose within industrialized societies, and found that it is one that occurs when we are healthy. So the focus becomes treatment in the hopes of avoiding being “condemned to die an unnatural [i.e., unhealthy] death.”¹¹² The corollary of this bourgeois understanding of death is an exclusionary conception of health as “non-disease.”¹¹³ Hadler, a physician and epidemiologist, captures this concept in the title of

¹⁰⁷ Colin Leys, *Market-Driven Politics*, p. 4.

¹⁰⁸ Agnes Heller, *The Theory of Need in Marx*, New York: St. Martin’s Press Inc., 1976.

¹⁰⁹ Karl Marx, *Capital: A Critical Analysis of Capitalist Production, Volume 1*, Moscow: Progress Publishers, 1974, p. 168.

¹¹⁰ Karl Marx, *Capital*, p. 582.

¹¹¹ Ivan Illich, *Limits to Medicine*, p. 179.

¹¹² Ivan Illich, *Limits to Medicine*, p. 198.

¹¹³ John McKinlay, “Paradigmatic Obstacles,” p. 371.

his book, *The Last Well Person*.¹¹⁴ He denaturalizes the, at best, questionable, yet accepted, treatments for a wide variety of illnesses, not questioning the underlying science, but analyzing them from a different perspective. He also argues that our approach to health care results in the medicalization of the worried well, which is an expanding social problem. The pharmaceutical industry is the most heavily studied in this regard and has been charged with promoting, “diseases to fit drugs.”¹¹⁵ This expansion of health needs to use more medical technologies¹¹⁶ is a profitable dynamic reinforced by a model of health and treatment that focuses on the individual and technological interventions to allow us to die a “natural death.” We have created a structure of need in health care that is not related to health, but justified by the need to be “healthy,” and built on blocks supplied by the biomedical model of health. It is driven by the needs of capital accumulation, but these needs become part of the “muck of ages,” and a problem for creating sustainable health care policies that produce health and not profit. This medical-technical definition of the concepts of health and health care denies their fundamental political character.

The expansion of need comes with its own internal contradictions. As the need in the working class grows for more and more extensive treatment, costs rise. In a publicly financed system this expanding social demand comes into conflict with private taxpayers, be they individuals or corporations. O’Connor captures the dynamic of the conflict between rising social costs and the private appropriation of profit in his analysis of the fiscal crisis of the state.¹¹⁷ In more privatized contexts, the problem rests with individual corporations. They have to pay higher wages to meet the subsistence needs of their workers, which are being boosted by another section of capital. One solution is to restrict access to cure to those who can pay. But then capitalism is exposed as being unable to meet social needs.

The dynamic here is double-edged for those working for change. In this context, to argue that capitalism cannot meet social needs, means on one level supporting the

¹¹⁴ Nortin Hadler, *The Last Well Person: How to Stay Well Despite the Health-Care System*, Montreal: McGill-Queen’s University Press, 2004.

¹¹⁵ Marcia Angell, “Excess in the Pharmaceutical Industry,” *Canadian Medical Association Journal*, 171(12), 2004, pp. 1451-1453.

¹¹⁶ “Medical technology” includes drugs.

¹¹⁷ James O’Connor, *The Fiscal Crisis of the State*, New York: St. Martins Press, 1973.

need created by capital that is at best unreasonable and motivated by profit, and at worst unhealthy. The problem becomes more acute if concerns about global inequality and environmental limits are taken into account. One approach to solving this conundrum starts with the recognition that health, care needs, and medical practice are socially determined and can be reconstructed. They need to be submitted to a democratic political process, one that starts with involving individuals and collectives in health care, challenging the power structure in health care, and opening up spaces for the experiences of women and other marginalized groups to be part of the process. As mentioned earlier, the material basis for this struggle exists, it is happening, and to be effective it will involve a critique of the biomedical model of care.

Biomedicine and Progressive Policy

Leys argues that the provision of public services, such as health care, is a requirement of a genuine democracy.¹¹⁸ It should be seen as a right of citizenship and as such can be the focus of struggle for progressive democrats. The implication is that the progressive struggle is not a class struggle aimed at ending capitalist exploitation, but a fight for the acquisition of rights. As far as this goes he is correct. But by not addressing the practice of health care, its philosophy and power structure, he limits the possibility for the success of these struggles and their ability to support broader movements for social change. The policy options advocated are effectively undercut by the background acceptance of an approach to health and health care. An example provided by Leys illustrates this point. He argues that one of the main concerns of progressive democrats must be the raising of productivity in public services: for example, that more productive health care for the elderly might be increased human contact instead of more alarm systems, or for pregnant women more trained midwives rather than more foetal monitors.¹¹⁹ In both of these cases, the technology-expert bias of allopathic medicine works against the more productive alternatives.

¹¹⁸ Colin Leys, *Market-Driven Politics*.

¹¹⁹ Colin Leys, *Market-Driven Politics*, p. 222.

Wood, in her historical-materialist exploration of the evolution of democracy, found that the essential constituting idea of modern capitalist democracy is the “alienation of power,” the transfer of power from citizens to representatives.¹²⁰ The similarity to the power relation in health care under the biomedical model is obvious: power over health is transferred to experts. Poulantzas makes a similar point when discussing the separation of manual and technical labour as a central element of the dominant ideology: “power is ideologically legitimized in the modality of scientific techniques, as if it flowed automatically from a rational scientific practice.”¹²¹ These comments apply equally well to the scientific advances in medicine. This is not to argue that everyone should become a doctor and self-treat (though in the age of the Internet this is becoming more common). Rather, the power relationship needs to change such that individuals’ inputs are valued and taken seriously. Duffin argues that after the invention of the stethoscope patients were, “no longer the chief authority on their well-being,”¹²² authority was transferred to technology and experts. In an ironic twist, as medical diagnosis and treatment become more reliant upon test results, the authority of the doctor as expert is undercut by the sterile quantitative measure. The biomedical model and the structure of power relations in health care support the dominant powers in society and reinforce a depoliticized population.

The biomedical model of medicine, while providing some health care benefits, works to shore up “relations of domination” within capitalism and undercut health by shielding the determinants of health. It provides an ideological framework that facilitates capital accumulation over health and that reinforces tendencies inherent in capitalism that make it unable to meet health needs. The real manifestations of the biomedical model in the practice of medicine, both professionally and politically, are important elements in the development of the medical laboratory sector in Ontario.

This discussion of ideology in a specific institutional practice, its basis in the dominant ideology and support for the dominant relations of production relates back to

¹²⁰ Ellen Meiksins Wood, *Democracy Against Capitalism: Renewing Historical Materialism*, Cambridge, MA: Cambridge University Press, 1995, p. 217.

¹²¹ Nicos Poulantzas, *State, Power Socialism*, p. 55.

¹²² Jacalyn Duffin, *History of Medicine*, p. 207.

the starting point: a consideration of the factors involved in policy formation that need to be addressed in social change and their link to the class struggle.

Conclusion

The argument developed in this chapter is that understanding state policy in advanced capitalist countries requires consideration of the influence of the dominant class struggle between workers and owners. A class-based approach respects the underlying fact that property relations in production, the dynamics of capital and resistance to private accumulation are central to developed capitalist state policies as evidenced by the shift in focus of Ontario's medical laboratory policy between 1968 and 2006.

The state and policy understood in this way accepts an inherent conflict within capitalist society. Policy outcomes involve a compromise between two conflicting options: the needs of capital and the public good. But the impact of policy outcomes is not neutral or universally beneficial. There will be winners and losers, creating ongoing policy instability. Outcomes will tend to benefit the private interests of capitalists over the public good. A corollary is that any gains in social rights of citizenship within capitalism, like universal health insurance, will be challenged as part of the ongoing struggle over power and resources. The expansion of for-profit laboratories has been destabilizing to public hospital services and undermines the fiscal stability of the system.

There are different levels of understanding the relationship between state policy and the class struggle. At one level, the state embodies the balance of power in the relations of production, incorporating all aspects of the class struggle but producing outcomes that support the dominant class. The drive for accumulation and resistance also play themselves out in policy through complex processes within the state. They provide the basis for conflicts within the state, policy options and contested outcomes. They affect how problems are approached, which ones are pursued and the outcomes. The focus on doctors' ordering of laboratory tests and the quality of laboratories rather than

the structure of ownership and the usefulness of the technology allowed the for-profit expansion at the same time as appearing to address community needs.

How the dominant ideology is represented in specific sectors influences policy towards support of capital accumulation. Biomedicine is the dominant ideology in the health sector in Ontario and an integral part of the practice of health care and the making of health policy. How it is embodied in institutions, how it frames discussions, for instance through a particular scientific understanding of health, and its role in supporting atomization and depoliticization, all create a climate where the expansion of laboratory services is favoured and often unquestioned.

Without addressing this interconnected web of needs, professional power, use of science, knowledge and a conception of health, as well as systemic control in the process of change, the project of providing a collective democratic program for meeting health care needs risks coming undone. Capitalism has created a structure of need in health care that is not related to health, but driven by the needs of capital accumulation. This creates a problem for progressive change as these needs become part of the “muck of ages” and undermine sustainable health care policies that produce health and not profit.

The following political economic history of community laboratory services in Ontario provides insight on how the balance of power in the relations of production impacts policies in a specific sector and how the influence of the biomedical approach facilitates solutions that promote private capital accumulation

Chapter Three: Non-Profit Alternatives: 1968-1990

1968 to 1990 was a volatile time in Canadian and Ontario politics. The Conservative provincial government nationalized part of the medical insurance industry to meet Ontario's commitments under the *Medicare Act*. Concerns about inflation provided the rationale for wage and price controls nationally and provincially. The increase in federal spending on social programs¹²³ contributed to passing the *Established Program Financing Act* in 1977 that reduced transfer payments to provinces' social services, including health care. The Canadian Health Coalition was formed in 1979 as part of the fight against extra-billing, which culminated in the *Canada Health Act* in 1984. Doctors called two strikes in Ontario: one in 1971 over the percentage of the OMA fee schedule that would be covered under universal health insurance, and one in 1986 against Ontario's enforcement of the *Canada Health Act*.

Numerous factors provided fertile ground for the greater use of non-profit services to provide community laboratory services. In the late 1960s most outpatient and community laboratory services were still provided by non-profit hospitals and public health laboratories. Driven by popular struggles and formalized in the *Hospital Insurance and Diagnostic Services Act (HIDSA)*, a strong non-profit hospital sector, with competent professional management and laboratory specialists, had grown. This involved the provincial government in health care funding that expanded to cover the provision of medical services after the passage of the *Medicare Act*. With the large increase in public funding for-profit laboratories rapidly expanded, raising concerns about quality, cost control, fraud and conflict of interest. These concerns created an omnipresent wariness of private laboratories and support for the greater use of hospitals to provide community laboratory services in the bureaucracy, among politicians, in the policy community and in the media.

¹²³ H. Minoto and P. Cross, "The Growth of the Federal Debt," *Canadian Economic Observer*, Statistics Canada, June 1991, pp. 3.1-3.18.

Hospital Insurance and Diagnostic Services Act

The development of a non-profit hospital and laboratory system took place in Canada in the first half of the last century. Funded by public revenues, community donations, and fee-for-service and insurance payments, hospitals became the centre of our medical services. They were formed as non-profit institutions due to their financially precarious nature and their initial role in providing care for indigent populations. They were also designed to meet the medical community's need for access to patients for training and, as medical science improved, provided a place for those with financial resources to receive new treatments.¹²⁴ The existence of these institutions also provided a home for laboratory services. One personal account describes these developments in northwestern Ontario:

Our first Hospitals Laboratory was equipped by Medical Staff, the Hospitals grudgingly giving us, about 1932, a room four by ten. A little later the Hospital employed one technician and she was given a room 10 x10 with minimum equipment. These facilities, with the addition of another technician in 1948, was [*sic*] all the room provided until 1953. During these latter years Blue Cross started to pay the Hospitals for Laboratory service and then the use rapidly developed. [These developments complemented an] excellent Provincial Laboratory at Fort William ... This Laboratory has had a continuous record of service since 1919. [capitals in original]¹²⁵

The *HIDSA* was enacted by the federal government in 1957 and brought into force in Ontario in 1959. It established a cost-sharing program between the federal and provincial governments to develop a national non-profit hospital system to provide access to a full range of inpatient hospital care. To meet these requirements hospitals were expected to provide good quality diagnostic services.¹²⁶ The role of non-profit provision of laboratory services had been enhanced in the five years prior to the *HIDSA* by a series of federal grants to improve the provision of diagnostic services in non-profit facilities. The funds were used to buy equipment, expand facilities and train workers.¹²⁷

¹²⁴ Donald Swartz, "The Politics of Reform," p. 328.

¹²⁵ Letter from Walter P. Hogarth to M. Dymond, Minister of Health, December 29, 1965.

¹²⁶ The term "diagnostic services" is used to refer to laboratory and radiological services, which are usually treated similarly, except for the provision to community patients in Ontario, which is part of this story.

¹²⁷ "Laboratory & Radiological Services," extract of minutes, OMA. Committee on Federal Health Grants, January 8/54, makes specific reference to the non-profit focus of this program and a document "Laboratory and Radiological Services Grant," dated December 23, 1953, outlines details of the grant program.

The diagnostic facilities in hospitals complemented Ministry of Health public health laboratories, established in 1882,¹²⁸ that by 1958 comprised eighteen laboratories distributed around the province.¹²⁹ As well as fulfilling their responsibilities around communicable diseases these laboratories worked in conjunction with the hospital system to provide diagnostic support to community doctors in all aspects of their medical practice. Before 1968 public health laboratories provided most of these tests to doctors for free.

Hospital Regionalization Initiatives

During the 1960s cost concerns, international developments and technological changes put pressure on hospitals to rationalize and regionalize their operations, including their laboratory services.

Trends in the United States towards regional and centralized laboratory structures were noted favourably in Ontario. A senior Ministry official toured laboratories in the United States and wrote a report with recommendations that became part of the Ontario Council of Health (OCH) Sub-committee on Regional Laboratory Services deliberations.¹³⁰ The summary in the report looks like a template for the Hospitals In-Common Laboratory developed by the Toronto hospitals. Documents circulated to the OMA pathology section cited American examples of coordination, and many hospitals and commercial laboratories often sent samples to the USA for processing.¹³¹ With the expansion of the scientific basis for medicine these technical modalities of diagnosis acquired increasing importance and there was pressure from the medical community for access to them. Machines were being developed that could either analyse multiple samples at the same time, or perform several tests on one sample simultaneously, or do a combination of both. Under pressure from the Ontario government to control costs the

¹²⁸ *Task Force on Laboratory Services*, 1982, p. 397.

¹²⁹ J.T. Phair and R.D. DeFries, "The Ontario Department of Health," *Canadian Journal of Public Health*, 50(5), May 1959, pp. 183-194.

¹³⁰ J.C. Baldwin, "Feasibility Study of Centralized Laboratories." This study was attached to a memo from Helen Bain, Senior Research Officer, Ministry of Health, to members of the Sub-committee on Regional Laboratory Services, May 23, 1968.

¹³¹ L.A. Jentz, "Some Aspects of Laboratory Centralization." This paper was circulated to members of the OMA Section on Clinical Pathology by L.S. Mautner, Chairman, April 9, 1968.

high cost of these automated technologies gave further impetus to hospitals to coordinate their laboratory resources.

Ontario's hospital costs had increased from 199 million dollars in 1961 to 594 million dollars in 1968, a 300% increase.¹³² During the 1960s the Ontario Hospital Services Commission (OHSC), the government body responsible for administering Ontario's hospitals, supported programs to regionalize hospital services.¹³³ The introduction of global budgeting for hospitals in 1969 added more pressure for hospitals to rationalize the use of their resources and/or increase income.

Hospitals responded with numerous initiatives, which had varying degrees of success but illustrate that the public sector was willing and able to change its method of delivery and produce more efficient and innovative services. Two of the most successful initiatives involving community laboratory work were the Hospitals In-Common Laboratory (HICL)¹³⁴ based in Toronto and the Hamilton Health Sciences Laboratory Program (HHSLP).

Hospitals In-Common Laboratory

HICL started as a project between Toronto General Hospital and Mount Sinai Hospital¹³⁵ to pool some of their lower volume tests so that they would have enough volume to justify buying the newest technology.¹³⁶ The hospital laboratory specialists who

¹³² "Report of the Joint Advisory Committee of the Government of Ontario and the Ontario Medical Association on Methods to Control Health Care Costs," December 29, 1977, p. 17, table titled "Expenditure of the Ministry of Health."

¹³³ L.A. Jentz, "Some Aspects of Laboratory Centralization." A paper presented to the OMA section on Clinical Pathology, May 10, 1968. "It is important to note that present feasibility studies and planning of such [regional] facilities in Ontario are being actively subsidized by the Ontario Hospital Services Commission."

¹³⁴ When this project was started it was called In-Common Laboratory and changed its name to HICL in 1974. It will be referred to throughout the thesis as HICL.

¹³⁵ The Ottawa Civic Hospital was involved in the early steps of HICL's formation but due to distance they withdrew from this effort and concentrated on their own regional project.

¹³⁶ Unless otherwise noted information on HICL before 1970 comes from 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. This is a master's level thesis written by one of the people involved in HICL's formation. Interest in HICL project is also shown by the existence of another contemporaneous thesis: Arthur Slutsky, *Design and Control of a Central Biochemistry Laboratory*, a thesis submitted for the degree of Master of Applied Science, University of Toronto, 1972.

spearheaded the program also saw HICL as an opportunity to free themselves from the more routine tests allowing them more time to work on the challenging and “interesting” tests.¹³⁷ The project was described as the “nucleus of a practical laboratory system which, under the control of participating hospitals, could compete with ‘industry’ and thereby help continue development of laboratory medicine in spite of increased budgetary constraints.”¹³⁸ In 1968 the new joint laboratory performed its first test on urea.

The project was developed through a series of meetings involving more than twenty individuals.¹³⁹ They met twice a month through 1967-68 to work out the details of the HICL. The meetings were open to all interested parties and attendance was taken. The openness of the process shows a similarity to classic community development models and served a similar purpose. It developed a broad base of support to protect the project in the face of opposition from for-profit laboratories and parochial hospital interests.¹⁴⁰ Alan Pollard, a clinical biochemist and one of the participants in the formation of HICL, described it as an “environment of innovation” where pathologists, clinical chemists, administrators and other hospital staff came together to experiment with ways to make hospital laboratory services more effective and efficient.¹⁴¹

Government support for the project came early. The laboratory was initially funded by special grants from the OHSC which were funnelled through Toronto General Hospital.¹⁴² These grants covered operating costs, set-up costs and the purchase of equipment. Channelling the funds through hospitals left them in charge and ensured that HICL’s expenses fell under the *HIDSA* cost-sharing agreement. 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.

¹³⁷ Interview 13.

¹³⁸ “In-Common Laboratory – New Mount Sinai, Toronto General and Ottawa Civic Hospitals: Progress Report #30,” November 24, 1969 at 4:30 p.m. This comment was attributed to Dr. Stawbridge, Chief Pathologist at the New Mount Sinai Hospital.

¹³⁹ “Progress Reports” were distributed for each meeting, in essence these were minutes. They contained lists of who attended.

¹⁴⁰ Alan Pollard, “The In Common Laboratory, Toronto,” *Clinical Biochemistry*, 8:393, 1975, pp. 391-399.

¹⁴¹ Allan Pollard, “The In Common Laboratory, Toronto,” p. 392.

¹⁴² Executive Committee Minutes, OHSC, Feb 5-6, 1969, item 2958, a report credited to Dr. Twiss.

By 1971 twenty-two hospitals were using HICL services – 166 by 1981.¹⁴³ As the transportation network between hospitals developed many community hospitals started shipping more esoteric, rare or experimental tests through HICL to one of the large teaching hospital laboratories. This became known as “the grid,” a service still provided by HICL.

While HICL had broad support among Toronto hospitals, the University of Toronto and the Ministry, the laboratory was opposed by some who were later identified as “paid consultants to a private laboratory.”¹⁴⁴ The Progress Report from the November 24, 1969 In-Common Laboratory Organizing Committee recorded a motion from Dr. J.C. Hill asking that the project be cancelled. The motion was seconded by Dr. R. Ogilvy who later became a laboratory director for MDS. Dr. Pantalony, who also became a director for MDS, and Mr. M. O’Sullivan, who was the medical director for two private Toronto laboratories, supported the motion. The motion was defeated. Those opposing the continuation of the In-Common Laboratory expressed concerns about loss of services in hospitals.¹⁴⁵

The argument about centralized control had broad support among pathologists and meshed nicely with the interests of the for-profit laboratories. The pathology section of the Ontario Medical Association continued to raise a “hue and cry” about increasing support of HICL through 1969 to 1971.¹⁴⁶ They were concerned that HICL would become an “irreversible” monolith “unresponsive to local community health needs and to the requirements of good patient care.”¹⁴⁷ They were really attacking any centralized or independent initiatives to develop laboratory services out of pathologists control and arguing for a, “voluntary cooperative regionalization that ensures maximum local autonomy, initiative, flexibility and incentive and that any system which antagonizes or

¹⁴³ “Historical Account: Supplement #2,” Report of the Chairman of the Board and President to the Annual General Meeting, June 3, 1981, Hospitals In-Common Laboratory Inc., Don Mills.

¹⁴⁴ Ted Freedman, *A Review of the Experience*, p. 131.

¹⁴⁵ “In-Common Laboratory – New Mount Sinai, Toronto General and Ottawa Civic Hospitals: Progress Report #30,” November 24, 1969. The names of those opposed to the motion were cross referenced to names of medical directors from a 1974 list prepared by the Laboratory Licensing Branch.

¹⁴⁶ “In-Common Laboratory – Toronto,” memo from W.F. Lumsden, Director of Hospitals Programs, to D.J. Twiss, Commissioner of Hospitals, October 13, 1971.

¹⁴⁷ “Regionalization of Hospital Laboratory Services: A Brief Prepared by the Executive of the Section on Clinical Pathology of the Ontario Medical Association.” Board Reference #767-1(12.69), p. 3. Attached to a memo from the OMA to all members of the OMA Section on Clinical Pathology, January 20, 1970.

coerces specialists in laboratory medicine can not hope to succeed.”¹⁴⁸ In this context they did support other non-profit initiatives such as the Hamilton project outlined below.

These conflicts within the medical community over HICL illustrate tensions based in the individualism and scientific professionalism central to biomedicine and its relationship to capitalism. On the one hand, hospitals provide specialists scope to practice scientific medicine and significant control over their practice and the provision of laboratory services, practices denied by for-profit laboratories as they became larger, a point brought out more clearly in Chapter Five. On the other hand, as will be developed in the next chapter, doctors, primarily pathologists, demanding their right as autonomous practitioners and arbiters of quality fought to own laboratory services which played a key role in the development of the for-profit laboratories. Nonetheless, some pathologists were central to the development of non-profit alternatives and they became more unified as a force in defence of hospital laboratories as the larger commercial laboratories became their employers and a force against professional control of laboratory services.

In 1974 the government stopped funding the HICL project, “in effect [it was forced into] competition with the private laboratories.”¹⁴⁹ If hospitals wanted to continue to use the service, they would have to pay for it out of their global budgets¹⁵⁰ – which hospitals did. The service had proved useful, both as a way of handling bulk tests for hospitals without enough volume, and as way of coordinating esoteric tests. Despite the government shifting the funding solely to the hospitals, the Policy and Priority Advisory Committee, on April 22, 1974, commented that, “the In-Common Laboratory Program has been very successful in providing a better service at a much lower cost [than the private labs]. The committee felt that such a program should be encouraged and maintained in operation.”¹⁵¹ The government covered an unexpected deficit from HICL of \$70,000 in 1974 before stopping funding for the program.¹⁵²

¹⁴⁸ “Regionalization of Hospital Laboratory Services: a brief prepared by the executive of the Section on Clinical Pathology of the Ontario Medical Association.” Board Reference #767-1(12.69), p. 1. Attached to a memo from the OMA to all members of the OMA Section on Clinical Pathology, January 20, 1970.

¹⁴⁹ Allen Pollard, “The In Common Laboratory.”

¹⁵⁰ Hospitals that had been using HICL’s services were given a one time increase to their global budgets to offset the cost of having to fund these services internally.

¹⁵¹ PPAC Minutes, April 22, 1974, item 5.

¹⁵² MOH PPAC Minutes, May 9, 1974, item 3.

The HICL became a self-supporting, separate entity that had a good relationship with the hospitals. It also provided a structure capable of directing community work to hospital laboratories, which it started to do in 1976.

The HICL Moves into the Community

The next major event for HICL was the opening of a specimen collection centre using a hospital laboratory to process the community specimens. In June of 1976 A.D.S. Laboratories Ltd. in Bramalea went bankrupt, leading to a suspension of their licence to operate a laboratory.¹⁵³ A.D.S. appealed the suspension. The owners of the building that leased space to A.D.S. appealed to their MPP, Premier Bill Davis, for help. Self-described supporters of Davis, they wanted him to hasten the process of obtaining a new laboratory for their building. “Now we are caught between a very contentious trustee who says he cannot decide whether to continue with the appeal [of the laboratory suspension] or not, and a government department who says no new laboratory licence can be contemplated until the appeal is heard.”¹⁵⁴

Immediately after A.D.S. went into bankruptcy, the chairman of the board of HICL wrote to Gary Chatfield, the Assistant Deputy Minister (ADM) of Health, proposing that HICL collect the outpatient work in the Brampton area and, “flow the bulk of the work to the [local] hospital and the remainder through our grid.”¹⁵⁵ He argued that this was a situation where, “the HICL could really demonstrate its ability to work as a non-profit laboratory.” In a friendly push to “Gary,” the HICL Chairman made the case that, “the time has come I believe, Gary, when the Ministry must make a decision,” and asked that the licence for A.D.S. be transferred to HICL – which it was.

This became HICL's first licensed collection centre. The fact of the specimen collection centre feeding samples to a hospital laboratory was not unique. Other hospitals provided this service. What was unique was that HICL would receive money from OHIP for each test, as a for-profit laboratory would, and then pay a hospital to

¹⁵³ Letter from Winifred Millar to William Davis, MPP, September 30, 1976.

¹⁵⁴ Letter from Winifred Millar to William Davis, MPP, September 30, 1976.

¹⁵⁵ Letter from R.M. McLuckie, Chairman of the Board, HICL, to G. Chatfield, Assistant Deputy Minister of Health, June 22, 1976.

process the tests. Dr. Arsenault, current President of HICL, said that HICL did not wish to compete with the hospital laboratories, so it negotiated an agreement that it would bill OHIP at a percentage of the rate it usually paid for community laboratory services. "It tries to strengthen small hospital laboratories to do their own tests wherever possible."¹⁵⁶ In 1977 HICL started billing OHIP at thirty cents per LMS unit,¹⁵⁷ equal to 84.5% of the fee schedule used by the for-profit laboratories. This per unit rate was not changed until 1984 when it rose to thirty-two cents per LMS unit, or 71% of the rate paid to the for-profit laboratories.¹⁵⁸ During that time the LMS unit rate for the for-profits had risen from 35.5 cents to 46.3 cents, a 30% increase. In 1986 the rate for HICL was renegotiated to 75% of the fees paid to the commercial sector.¹⁵⁹

The HICL's billing practices were also different from the for-profits', though this time to its and the government's favour. It was allowed to bulk bill OHIP for its services rather than billing for each individual test. It had to keep the same documentation as the other laboratories for auditing purposes, but bulk billing resulted in decreased clerical costs for the Ministry and probably for HICL.¹⁶⁰ This indicates a level of trust in the non-profit sphere that did not exist towards the for-profits, leading to higher administrative charges for the government when dealing with for-profit corporations.

A briefing note to the Minister of Health describes how the Ministry had been "receptive" to HICL's community outreach and, "has approved of their establishment of specimen collection centers in locations where private applicants have been, or would be, refused approval."¹⁶¹ They were also monitoring HICL's "economic performance closely to ensure that costs do not exceed, and are in fact less than, private laboratory reimbursement levels." Support for HICL was still evident in the Ministry in 1981. A briefing note from the Provincial Coordinator of Laboratory Services noted that the

¹⁵⁶ "Meeting with Representative of Hospitals In-Common Laboratory Inc.," minutes of Ontario Council of Health Task Force on Laboratory Services Meeting, August 31, 1981, item 81-63.

¹⁵⁷ LMS refers to the minimum unit of payment in the community laboratory sector. It is described in greater detail in Chapter Four.

¹⁵⁸ "Ministers Briefing Book: Laboratory Services Branch," May 21, 1985, p. 49.

¹⁵⁹ "Laboratory Services Review Discussion Paper #2: System," June 1993.

¹⁶⁰ "Bulk Billings for Hospital Out-Patient Radiology," report attached to a memo from W. B. Nichols, Assistant Deputy Minister, Finance and Information Services to S. Birkenmayer, Policy Secretariat, February 5, 1974.

¹⁶¹ "Briefing Material for Minister's Meeting with Ontario Association of Medical Laboratories," September 19, 1977. Attached to a memo from Paul J. Plant, Acting Director Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977.

benefits of HICL included: allowing hospitals to augment their own work increasing "test cost efficiency"; coordination between community laboratory work and inpatient work for both patients and physicians; consultation services for physicians; and a "dependable" laboratory system for hospital administrators. At that time HICL was paying "well over 5 million dollars to hospitals for work processed."¹⁶² HICL led the way as a non-profit alternative in the expanding community laboratory market that met the goals of decreasing cost and increasing system integration.

Hamilton Health Sciences Laboratory Program¹⁶³

Hamilton developed a program quite different from HICL that also used hospitals to provide laboratory services to the community. Preliminary work establishing the program began in 1965 under the auspices of the Hamilton and Burlington hospitals. It was coordinated by associated academic faculty at McMaster University and through the District Health Council.¹⁶⁴ The government took administrative steps in 1970 to purchase capital equipment for the Hamilton initiative because, "this is a pilot project to which the Commission wished to give financial support."¹⁶⁵ They also made the decision to purchase the equipment outright because it would be easier to gain federal cost-sharing. The program established community laboratory services in March 1973. These involved seven collection stations, at home specimen collection and collection from the surrounding rural area and nursing homes.¹⁶⁶

Starting in 1972 the province funded the program as a five-year pilot project. Intense negotiations followed the end of this funding with allegations that the HHSLP

¹⁶² "Re: Hospitals In-Common Laboratory Inc.," Memo from C.L. Brubacher, Provincial Laboratory Services Coordinator, to Dr. D. Surplis, Special Assistant to the Minister of Health, April 10, 1981.

¹⁶³ The HHSLP in the last round of regionalization changed its name to the Hamilton Regional Laboratory Medicine Program.

¹⁶⁴ Minutes of the Sub-Committee on Laboratory Systems, Ontario Council of Health, Nov. 6, 1969.

¹⁶⁵ "Capital Equipment costs – Hamilton Regional Laboratories," OHSC/OHIC Executive committee minutes, June 21, 1972, item 4513. "Mr. McGavin recommended that the capital equipment costs of the new Hamilton Regional Laboratories be provided on an outright purchase basis. He added that in order to do this the province must for go federal sharing. The justification for doing this was the fact that this is a pilot project to which the commission wished to give financial support. Approved."

¹⁶⁶ M.C. Brain, R.A. Hagger, S. Moore, and R.W. Cameron, "The Hamilton District Program in Laboratory Medicine: A Progress Report on Integration," *CMAJ*, April 12, volume 114, 1976, p. 725.

took an “emotionally coercive position”¹⁶⁷ by publicly threatening that if more funding was not made available the community work they do would end up being provided in the private sector at greater cost. By 1990 the HHSLP had settled into a stable funding arrangement with the Ministry where a, “secondary minor mechanism was approved for a capped maximum (2%) incremental ‘growth’ allowance to meet a proportion of the costs of additional workload for community services.”¹⁶⁸

By 1980 it was believed that the program processed about 40% of the tests ordered by community physicians, “but it was difficult to arrive at a precise figure because there are commercial laboratories in Toronto who have paid personnel working in physicians’ offices in Hamilton and other centres to pick up specimens which are then processed in the large Toronto laboratories.”¹⁶⁹ By 1990-91 the HHSLP serviced 160,000 community patients and made 21,000 house calls.¹⁷⁰

The HHSLP differed from HICL in that it was run by a group of hospitals rather than by a separate non-profit corporation that cooperated with hospitals. Second it was funded primarily from the hospitals’ global budgets with small financial top ups from the province, compared to HICL which received a fee-for-service rate that was a percentage of that paid to the for-profit laboratories and then purchased services from hospitals. Both provided public sector models that were cheaper than using commercial laboratories¹⁷¹ and provided integration of inpatient and community laboratory services. They were both effectively controlled by laboratory specialists within non-profit corporate structures and funded by the state. They are evidence that the public sector was prepared to develop, and capable of developing, services to meet emerging social needs. They also indicate that within the broad category of collective responses to health care needs there is a range of options that may have different effects for quality, access, and

¹⁶⁷ “Hamilton Laboratory Funding Proposal,” memo from P.J. Plant, Chief, Laboratory and Specimen Collection Center Inspection Service, to C.L. Brubacher, Director, Inspection Branch, April 5, 1978.

¹⁶⁸ M.J. McQueen and A.J. Baily, “Hamilton Health Sciences Laboratory Program: A Provider Developed Model for Hospital, University and Community Services,” *Healthcare Management Forum*, Fall/Autumn, 1993.

¹⁶⁹ “Meeting with Representatives of the Hamilton Health Sciences Laboratory Program,” Report on the meeting of the Task Force on Laboratory Services, Ontario Council of Health, November 30, 1981, items 81-84.

¹⁷⁰ M.J. McQueen and A. J. Baily, “Hamilton Health Sciences Laboratory Program.”

¹⁷¹ A full discussion of HHSLP’s financial situation is presented in Chapter Six.

democracy. Some will also make greater or lesser use of for-profit services: for instance, the HHLSP has used for-profit partners, though always in a minor role.

Other Hospital–Community Initiatives

Throughout the 1970s many hospitals started to integrate their laboratory services. Many of these initiatives developed into long-term cooperation focused on meeting inpatient needs but unlike HICL and HHSPL, most did not find ways of expanding services to the community.

In 1967 Ottawa started to centralize laboratory services. The program received funding from the Ministry of Health until 1976 and since then has been supported by Ottawa-area hospitals out of their global budgets.¹⁷² In March 1972 an inter-hospital laboratory services program in Huron and Perth Counties brought together hospitals in Clinton, Exeter, Goderich, Listowel, Palmerston, St. Mary's, Seaforth, Stratford and Wingham.¹⁷³ Kingston began to regionalize its services, eventually developing the Eastern Ontario Laboratory Network, a network that services the small hospitals around Kingston using Kingston General Hospital's expertise.¹⁷⁴ Cochrane developed a district laboratory service in which "7 or 8 hospitals send everything to one laboratory."¹⁷⁵ Hospitals in Kenora and Rainy River Districts developed a coordination program to share technologists.¹⁷⁶ Sudbury was also working on coordination of local services.¹⁷⁷

Through the 1970s there were numerous proposals to the MOH from hospitals to expand their outpatient services or requests for financial assistance to keep them in-house. In 1973 Sensenbrenner Hospital in Kapuskasing wanted to take over the

¹⁷² "Laboratory Coordination Program Ottawa–Carleton: Policy Manual," attached to the Task Force on Laboratory Services minutes, December 15, 1980.

¹⁷³ J.L. Penistan, Director Department of Pathology, Stratford General Hospital, "Inter-Hospital Laboratory Service," Report to Hospital Administrators, October 1971.

¹⁷⁴ David J. More, K. Sandip and Paul N. Manley, "Promoting, Building and Sustaining a Regional Laboratory Network in a Changing Environment," *Clinical Leadership & Management Review*, September/October 2000, pp. 205-210.

¹⁷⁵ Report of Meeting of the Task Force on Laboratory Services, Ontario Council of Health, January 19, 1981, items 81-84.

¹⁷⁶ "Laboratory Program Announced for Kenora and Rainy River Districts," news release, Ministry of Health, October 10, 1979.

¹⁷⁷ "Report of a Meeting of the Sub-Committee on Laboratory Systems," Ontario Council of Health., July 27, 1970, item 98.

operations of Northern Laboratories, a for-profit laboratory, and become the major supplier of laboratory services for Kapuskasing and District. This required additional capital funding and special arrangements for operating costs, but was also expected to lead to a decrease in total laboratory costs of \$101,000 per year. There was internal ministry support for this project, which moved community work from the for-profit to the non-profit sector.¹⁷⁸

The Niagara Regional Hospital submitted a proposal for additional outpatient work.¹⁷⁹ Hanover Hospital wished to take over work from a local private laboratory. Mississauga General Hospital asked for and was refused permission to operate a laboratory in a neighbouring private medical clinic. Peterborough Hospital wanted funding to process samples from a medical clinic that did not want to send their work to a commercial laboratory. Lennox and Addington County Hospital was funded to prevent, “a shift of hospital laboratory work to the private sector in the community with a resultant savings to the ministry.” The Laurier Avenue Family Medical Unit received extra funding to have the Ottawa General Hospital process all of its laboratory work¹⁸⁰ The Ottawa Civic Hospital also received extra funds to process the community specimens from their Family Practice Unit.¹⁸¹

The Brant Laboratory Advisory Council of the DHC wrote to the Ministry in 1977 suggesting that the only two laboratories in the area be at the two main hospitals and that, “all other facilities ... become Collection Stations ... sub-licensed to either [of the two hospitals].” To make this program work they requested more money in the global budgets to cover the incremental costs for the two hospitals and that these funds come out of the savings “created by elimination of the per-test billing.”¹⁸²

¹⁷⁸ “Laboratory Services–Kapuskasing,” memo from J.C. Baldwin, Area Planning Co-ordinator, Health Services to the Hospital Planning Committee, August 1, 1973.

¹⁷⁹ “Laboratory Co-ordination Activities as of June, 1978,” report attached to a memo from M. Fournier to Dr. Aldis, June 26, 1978. The comments on the Niagara, Mississauga, Hanover, Peterborough, and Lennox and Addington County Hospitals were all taken from this report. The report also mentioned that Trenton Hospital was considering a proposal to go into direct competition with the private sector for the community work and St. Joseph’s Hospital will be submitting proposals for additional outpatient funding.

¹⁸⁰ Minutes from Management Committee, MOH, June 12, 1976.

¹⁸¹ Family Practice Unit Laboratory, Ottawa, Management Committee, minutes, February 24, 1976, item 8 (17-6/76).

¹⁸² Letter from J.D. Greig, Chairman, Laboratory Service Committee, Brant District Health Council, to Milton Orris, Area Planning Coordinator, Ministry of Health, March 8, 1977. Per-test billing refers to work that would have gone to for-profit laboratories.

These many initiatives highlight three points. First, hospitals and other non-profit organizations were taking innovative steps to integrate. Second, some of these involved providing outpatient services at less cost than the for-profit laboratories though none of these, unlike HICL and the HHSRP, developed into ongoing projects. Finally, they indicate responsiveness within the Ministry to requests from hospitals to process community laboratory work.

The upsurge in hospital interest in more funding for community laboratory services at that time was due to increased funding restrictions as the government tried to control health care costs, a process that culminated in the anti-inflation program in 1976, and was exacerbated by the passage of the federal government's *Established Programs Financing Act* that reduced federal transfers to the provinces for social programs, including health care. The end of the anti-inflation program in 1978 marked the beginning of a significant shift in the provincial government's approach to providing health care services. A memo from Dennis Timbrell, the Minister of Health, to Hospital and Other Ministry Funded Agencies states:

Much of the problem for past inflationary pressures has been attributed to increases in the costs of public programs ... The role of the public sector in the economic process has changed fundamentally. We are entering a period of reduced government growth accompanied by a greater recognition of the need to stimulate the growth of the private sector.¹⁸³

Cost control pressures both spurred the growth of public non-profit alternatives and, as documented in Chapter Four, provided a contextual shift that, given the background acceptance of the value of private enterprise, made it harder to shut down the commercial laboratories even though they were a much bigger part of the problem and easier to attack than public services.

Laboratory Outpatient Pilot Project (LOPPP)

The spate of proposals from community doctors and hospitals for maintaining and expanding hospital-based community services, as well as the continuing increase in

¹⁸³ Memo dated June 8, 1978, on Ministry of Health letterhead.

private sector service costs, prompted the government to undertake a coordinated pilot program to expand hospital community services.

Under the lead of Miville Fournier, the recently hired first Coordinator of Diagnostic Services, the Laboratory Services Planning Team, a group of Ministry officials representing the different branches of government concerned with laboratory services, prepared a provincial policy paper on the funding of hospitals for community laboratory services. After multiple submissions to Management Board¹⁸⁴ it gained Cabinet approval. The Ministry and representatives of the hospitals negotiated details of the terms and conditions for the Laboratory Outpatient Pilot Program¹⁸⁵ that were made operational in Regulation 796/80 on September 19, 1980.

The goals of the program were to optimize the use of spare capacity in hospitals, decrease the flow of outpatient work away from hospitals and gain data on the costs of using hospitals to provide outpatient services. The program compared laboratory use in a pre-pilot period to a pilot period when hospitals could bring in extra community work and be paid on a fee-for-service basis for each test. Hospitals were to be paid at 75% of the OHIP rate for all work done, with adjustments depending on the increase in volume at the hospital. Regional statistics on overall laboratory use and physician referrals were kept. Twenty hospitals participated in the program. While the pilot was to run for a year most participating hospitals were only involved for eight or nine months.

The Ministry's evaluation report of the LOPPP identified significant methodological problems with the study. There was no adequate way of tracking whether work shifted from the private sector to the public sector. The study data made it difficult to measure cost effects. Finally, they noted that "in order to facilitate major workload changes it may have been preferable to have had a longer time frame."

¹⁸⁴ "Laboratory Services Planning Team," memo from Miville Fournier, Coordinator Diagnostic Services, to M.C. McEwan, et al., July 27, 1978; and a memo from W. Bain, Director Institutional Operations Branch to J.K. Maynard, Executive Director Institutional Division, Sept 5, 1978, with attached report: "Policy Paper on Alternative Funding Arrangements for Out-patient Laboratory Work Carried out by Hospital Laboratories," Ministry of Health, September 1, 1978. This was written earlier by M.L.Fournier, Coordinator Diagnostic Devices, Personal Health Division, and distributed within the Ministry in a confidential draft with an attached memo showing support from senior administrative consultants for the creation of a pilot project to expand hospital outpatient services.

¹⁸⁵ This information and the information in the next three paragraphs is based on the "Laboratory Out-Patient Pilot Project: Evaluation Committee Report." This report is undated and the version I have is a copy of one released after a FOI request. It contains blacked-out sections.

Hospitals needed more than eight months to change doctors' referral patterns. For both doctors and hospitals, the lack of long term commitment to the program probably decreased the likelihood of change. This was especially true for hospitals. No money was available to set up community collection networks, and one hospital that did, Laurentian in Sudbury, was left buying out a lease when the program suddenly ended: punishing this hospital's initiative. Along with the methodological problems, evaluating the program for this thesis faced the added difficulty that most of the numbers in the final report relating to the private sector were deleted despite the fact that most of them were likely aggregated figures that did not identify individual companies or physicians.

In the end the provincial evaluation concluded that the study found "mixed results" of cost savings and volume increases. It would have been fair to say the data were unreliable, but the results summarized in the report's text were less ambiguous. All but three hospitals had volume increases. During the study hospitals experienced an equivalent or greater increase in physician referrals than private labs, which is a change from the pattern of the previous ten years where community laboratory utilization far exceeded that of hospitals. And numerous examples were cited in which hospital marginal cost increases, "were below OHIP rates paid to private laboratories." There were none reported that were higher. It is arguable that these results may not have been based on good data, but they were not mixed. The evaluation indicates that hospitals, with a financial incentive, could increase their volume of community work, physicians would use the service and it would cost less.

The LOPPP worked well in Sudbury because the hospital went out and actively recruited community laboratory work. It set up community collection stations that were convenient to doctor's offices and invested in a transportation system. "We [the hospital] made lots of money ... [and] ... we made a dent in the work going to the private labs," recalls Dr. Bonin, a pathologist at Laurentian Hospital during that time.¹⁸⁶ And because the LOPPP rules stipulated that any increase in payments above costs were to be split fifty-fifty with the province, the province saved about \$103,000 during the nine months of the Laurentian Hospital experiment, which primarily reflected referrals from

¹⁸⁶ Interview August 14, 2006.

nine community doctors.¹⁸⁷ Dr. Bonin could not remember why the program was cancelled, but with a strong indication that work would shift from the for-profit laboratories to hospitals with the right funding incentive and the growing influence of the commercial sector on government policy the threat to private profit was likely part of the reason.

Four years later, while defending its increased reliance on for-profit laboratories, Ministry officials commented that, “although it appeared that some hospitals were able to increase their performance of out-patient laboratory tests at an apparent lower cost per unit than is currently paid by OHIP, the evaluation of the project [LOPPP] yielded mixed results and no firm conclusions were drawn.”¹⁸⁸ Even though most arguments and the data available indicated that private laboratories were driving increased costs and utilization,¹⁸⁹ without firm proof that the hospitals could do it better, the benefit of the doubt went to the commercial labs. The LOPPP was probably going to provide that proof when the plug was pulled.

Public Support and Private Concerns

For twenty years the dominant belief in health policy circles, the MOH and the political parties was that increasing the use of hospital facilities to process community laboratory work was the most cost-effective approach. The corollary of this position was a general suspicion about the commercial laboratories’ ability to deliver cost-effective, integrated and quality service.

In 1970 the Ontario Council of Health Laboratory Systems Sub-committee identified numerous problems in hospital outpatient laboratory services and related them largely to the lack of provincial funding.¹⁹⁰ It then turned its attention to the private sector:

¹⁸⁷ Jonathon Forbes, “Test Case: Private vs. Public Laboratories,” Ontario Public Service Employees Union, 1996.

¹⁸⁸ “Globe and Mail Request for Interview on Private Laboratories,” Laboratory Services Branch, May 8, 1984.

¹⁸⁹ For more detail supporting this position see Chapter Six.

¹⁹⁰ “Report of the Ontario Council of Health on Health Care Delivery Systems: Laboratory Systems – Supplement no. 7,” Ontario Department of Health, 1970, p. 16.

Laboratories operating under private auspices are proliferating rapidly, sometimes in areas where the need for such facilities might be questioned. This has been encouraged by the methods of financing under prepaid medical insurance, and because hospitals have been unable to provide the necessary services. This proliferation has contributed to inefficient use of manpower and to rising costs. Useful support is obtained from privately organized laboratories [laboratories owned by physicians] whose primary objective is service. Of concern, however, is the intrusion of large-scale commercial operations into the laboratory system, since the impact of these on the system is unknown.¹⁹¹

The 1982 Council of Health Task Force on Laboratory Services concluded that, “if laboratory services are allowed to develop as a profit center, they have the potential of becoming a counterproductive driving force in terms of overall health care.”¹⁹²

In the mid-1960s there were already strong words about the private laboratories from the Deputy Minister of Health: “Private laboratory practice could be most easily controlled by refusal to provide public monies for laboratory work performed outside hospitals or public health laboratories, which would be conducted at cost, removing any profit motive of quantity over quality.”¹⁹³

In the early 70s the bureaucracy considered different options for funding community laboratory services as a way of controlling private sector costs and moving more work into hospitals. Global budgeting,¹⁹⁴ tendering¹⁹⁵ and funding laboratory services through regional bodies¹⁹⁶ were considered but for a variety of technical and political reasons not implemented. The search for an alternative funding mechanism for community services indicates a significant dissatisfaction with the fee-for-service method. A Ministry consultant on hospital administration, reviewing how to reduce costs for clinical laboratory services, recommended that:

¹⁹¹ Report of the Ontario Council of Health on Health Care Delivery Systems: Laboratory Systems – Supplement no. 7,” Ontario Department of Health, 1970, p. 16.

¹⁹² “Report of the Task Force on Laboratory Services,” Ontario Council of Health, 1982, p. 288.

¹⁹³ Letter from K.C. Charron, Deputy Minister, to J.B. Neilson, Chairman, OHSC, February 3, 1966.

¹⁹⁴ “Proposal on Separate Global Budgets for Public Hospital Laboratories,” memo from R.E. Krock, Director Hospital Operating Standards, to E.P. McGavin, Acting Executive Director, Treatment and Rehabilitation Finance, October 6, 1972.

¹⁹⁵ “Control of Private Laboratory Costs Through Tendering,” Management Consulting Services, Ministry of Health, July 1976.

¹⁹⁶ Letter from W. Lumsden, Director Hospital Programs to Ronald J.C. McQueen, Agnew, Peckham and Associates Ltd., October 22, 1970.

HOSPITALS RECEIVE 100% CAPITAL GRANT IN RESPECT OF OUTPATIENT FACILITIES. IT IS FURTHER RECOMMENDED THAT RULES BE ESTABLISHED UNDER THE PUBLIC HOSPITALS ACT TO PREVENT PRIVATE LABORATORIES FROM DOING ONLY THE "GRAVY WORK," THUS SLOUGHING OFF COMPLEX AND COSTLY TESTS ONTO HOSPITALS AND PUBLIC LABORATORIES. [capitals in original]¹⁹⁷

A 1977 briefing note for the Minister in preparation for a meeting with the Ontario Association of Medical Laboratories (OAML), the organization representing the for-profit providers, states that the OAML's primary concern is that the hospital sector not be favoured over the private sector. The note goes on to say the Ministry would favour initiatives that promise to maximize "already paid for" resources in public hospitals. If hospitals were successful in attracting community referrals to their laboratories, "we [the Ministry] would consider the realization of their goals to be in the public interest."¹⁹⁸ Paul Plant, Chief of the Laboratory and Specimen Collection Inspection Service, reiterates this position in 1978 commenting on a funding proposal from the Hamilton Program: "there is a wide measure of agreement within the Ministry that hospitals should be funded on an incremental cost basis of the use of spare capacity for provision of out-patient laboratory services to the community."¹⁹⁹

A Ministry report summarizing the problems facing the laboratory industry in 1980 highlighted the problem as "growth in utilization" and the solution is, "mainly related to restricting growth in an open-ended program while encouraging effective utilization of present hospital-based facilities."²⁰⁰ This recommendation was followed by

¹⁹⁷ "Suggestions for Cost Reductions in the Department of Clinical Laboratories," memo from A.D. Karapita, Consultant Hospital Administration, to R. E. Krock, Director Hospital Operating Standards, November 6, 1972.

¹⁹⁸ "Briefing Material for Minister's Meeting with Ontario Association of Medical Laboratories," September 19, 1977, memo from Paul J. Plant, Acting Director, Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977.

¹⁹⁹ "Hamilton Laboratory Funding Proposal," memo from Paul Plant, Chief, Laboratory and Specimen Collection Inspection Service, to C.L. Brubacher, Director, Inspection Branch, April 5, 1978.

²⁰⁰ Minutes from the GM/ED, October 16, 1980, attached as an appendix to the November 12, 1980 Management Committee minutes.

a note of caution and political realism that, “affecting volumes in private laboratories comprise a visible, significant policy change which cannot be undertaken lightly.”²⁰¹

A succession of Ministers of Health expressed concerns about private laboratories or support for using hospitals facilities. In 1967 the Honourable M.B. Dymond said: “I am one of those who believe that the charges for lab services are outrageously out of proportion and out of reason.”²⁰² One of the strongest statements supporting hospitals came from Robert Welsh, the Provincial Secretary for Social Development, in a memo to the Minister of Health in which he said that: “There are existing capabilities in public health laboratories and in hospitals which are good and often inexpensive. I suspect we do not want to put private laboratories out of business, and that we do want to provide a ‘grandfather clause.’ But we certainly need to prevent cost gouging whether by private laboratories or through some of the arrangements you identified in which medical practitioners often have a pecuniary interest.”²⁰³

In the context of a general concern about the medical profession over-billing OHSIP, in 1971 Alan Lawrence, Minister of Health, in a speech to the OMA addressed the need for the profession to take its responsibilities seriously and better police ethical violations and waste in the health care system. He specifically mentioned laboratories: “Why do you [the medical profession] permit physicians to have an interest in laboratories, and why does significantly greater use (and cost) of laboratory services arise in circumstances where physicians have financial interest in the laboratories being used?”²⁰⁴ In 1977 Dennis Timbrell, Minister of Health, is reported to have said to the OMA executive that, “it is in the public interest that laboratory work, all of which is paid from public funds, be done at the lowest cost facility. This could be a hospital or private lab ... However, the problem is surplus unused but paid for capacity in some public hospitals, and it should be possible to get work done there at a lower net cost to the

²⁰¹ Minutes from the GM/ED, October 16, 1980, attached as an appendix to the November 12, 1980 Management Committee minutes.

²⁰² “Charges for Laboratory Services,” memo from M.B. Dymond, Minister of Health, to K.C. Charron, Deputy Minister, December 4, 1967.

²⁰³ “Cost Control of Medical Laboratories,” memo from Robert Welsh, Provincial Secretary for Social Development, to R. Potter, Minister of Health, May 17, 1972.

²⁰⁴ “Partnership in Progress,” remarks by the Honourable A.B.R. Lawrence, Minister of Health, to the Ontario Medical Association, Friday May 14, 1971. The higher utilization rate referred to is based on an August 1970 OHSIP laboratory utilization study.

taxpayer.” The memo goes on to say that Timbrell, “stressed that there is no competition – there is one price and one customer.”²⁰⁵

Both of the opposition parties raised concerns about the laboratory industry in the legislature. Liberal leader Stuart Smith pointed out the potential for abuse created by the method of payment to private laboratories.²⁰⁶ Morton Schulman, NDP member for High Park, called the private medical laboratories, “the biggest racket going in the medical profession.”²⁰⁷ In the same exchange Schulman suggested expanding the provincial laboratory facilities to do all the laboratory work in the province. This is one of the few proposals on record that implied the end of the commercial laboratory business. In 1976 the Ontario Public Service Employees Union (OPSEU) also called on the government to close the private laboratories and move all the work into the public system.²⁰⁸

At this time most players in the government, the political parties, the bureaucracy, the policy community, the medical profession and the media were suspicious of the commercial laboratories and yet, with the exception of the NDP and OPSEU, all were uncritically supportive of the free market. This provided an opening both for non-profit alternatives and for toleration of the private laboratories.

The medical profession also expressed support for the well-being of hospitals and mistrust of the commercial sector. A 1968 study on the feasibility of centralized laboratory services, written after a tour of centralized labs in the United States, started by attacking the “socialist” state in Canada and went on to recommend a centralized structure built around non-profit hospitals, identifying one of the dangers as being “industrial laboratories working on a cost plus basis taking over here in Canada,” and arguing that the hospital model “allows us the opportunity to provide better control of the costs, better control of quality and offer a complete service.”²⁰⁹

²⁰⁵ “Memorandum re: Meeting with Executive of Ontario Medical Association – Wednesday, June 2/76 – 1530 Hours,” in file “Integration of Lab License Program with OMA Quality Program, Ontario Archives, series RG10 – 18, barcode 112932, Box 2, file 0-128173.

²⁰⁶ Hansard, March 15, 1976, p. 365.

²⁰⁷ Quoted in the *Globe and Mail*, October 21, 1970, from a comment made in Parliamentary committee discussing the health estimates. Manthorpe, Jonathan, “Control of medical labs planned; Schulman describes them as rackets.”

²⁰⁸ Press Release, March 5, 1976, Ontario Public Service Employees Union.

²⁰⁹ J.C. Baldwin, “Feasibility Study of Centralized Laboratories,” p. 11. Attached to a memo from Helen Bain, Senior Research Officer, Economics. Research and Planning Branch to Members of the Subcommittee on Regional Laboratory Services, The Ontario Council on Health, May 23, 1968.

The Clinical Pathology Section of the OMA prepared a brief on the “Regionalization of Hospital Laboratory Services.”²¹⁰ This document is very anti-government and cries for the autonomy of specialists, though it does this within the context of local hospitals getting together and organizing the delivery of their services. This support for hospitals was based on a preference for local control, which meant control by physicians, preferably pathologists, who dominate hospital laboratory decision-making, a right to status and power conferred on them by concepts central to biomedicine. They were simultaneously concerned about losing control to hospital bureaucrats and arguably have been a force working against the democratization of health care institutions.

This concern about doctors being told what to do is also expressed in a common professional opposition to larger for-profit laboratories. The OMA supported businesses run by physicians, preferably laboratory specialists, and opposed the large commercial corporations. Dr. J.G. Hill, the one who had moved a motion to close HICL, commented on a draft report to the OCH, “there should be a distinction of categories, i.e., private laboratories and large commercial laboratories.”²¹¹ This position is developed further in the next chapter and this support of physician-controlled private laboratories and opposition to the commercial laboratory industry nonetheless provided an essential opening for the expansion of the for-profit industry.

Laboratory specialists most often expressed this ambivalence about the commercial laboratories politically by promoting competition between hospitals and commercial laboratories as way of increasing work for the hospitals. In a brief to the OCH Task Force on Laboratory Services the Ontario Society of Clinical Chemists advocated, “the development of a funding mechanism which is equitable to both the private and hospital laboratories in order to encourage competition.”²¹² This approach was implicit in the structure of the LOPPP and the other funding mechanisms that were designed to channel community work into the hospitals. The difficulty with this

²¹⁰ “Regionalization of Hospital Laboratory Services: a Brief prepared by the executive of the Section on Clinical Pathology of the Ontario Medical Association,” Board Reference #767-1(12.69), p. 3. Attached to a memo from the OMA to All Members of the OMA Section on Clinical Pathology, January 20, 1970.

²¹¹ “Meeting with Representatives of Professional Organizations,” item 98, Report of a Meeting of the Subcommittee on Laboratory Systems, July 27, 1970, Ontario Council of Health.

²¹² “Brief of the Ontario Society of Clinical Chemists,” Report of The Task Force on Laboratory Services, Ontario Council of Health meeting, August 31, 1981, items 81-63.

approach is that it would further blur the lines between the for-profit and the hospital sector threatening the research, quality and professional status that laboratory specialists in hospitals were trying to protect. The uncritical acceptance of competition within health care eventually worked in favour of the larger labs, especially with the rise of the new global economy.

Summary

1968 to 1990 saw a proliferation of non-profit alternatives for the provision of community laboratory services. These projects were often driven by hospitals trying to find ways to increase their incomes, to reduce their expenditures, and to meet their obligations as the main health care provider in a community within an environment of increasing government concern over cost control. They often received support from the Ministry: HICL and the HHSLP were concrete programs that developed during this period.

These developments took place despite a Conservative provincial government strongly committed to free enterprise. The existence of a well-developed hospital sector provided a strong institutional base of support for increasing the use of hospitals for community lab work. Increased pressure on governments to control costs made even hardened free enterprisers such as Dennis Timbrell look to non-profit solutions. The medical profession committed to independence, personal income growth and professional control rebelled against corporate medicine and pathologists' de facto control of hospital laboratories also made them boosters of greater use of hospital laboratories.

Even though none of the concerns about escalating costs, poor quality and avarice on the part of the private laboratories changed over these twenty years, the attitude and actions of the decision-makers, and the outcomes in policy did. By the mid-1980s, after the abrupt ending of the LOPPP, new non-profit initiatives stopped: only the HHSLP and HICL were still expanding their community services. In 1984, the Laboratory Services Branch, in response to an investigative reporter for the *Globe and Mail*, commented that competition would not be allowed between the hospitals and the private laboratories, a regular demand from hospitals and within the Ministry, "until such time as a funding

mechanism for out-patient laboratory services provided by hospitals has been established.”²¹³ This switching of the blame to the hospitals reflects the for-profits’ allegations that the hospitals were competing unfairly. It is clear that the government’s openness to non-profit solutions was waning by the end of this period, after being a surprisingly strong supporter through the 60s and 70s. This is the mirror image of the success of the commercial laboratory corporations during the same time period: the subject of the next chapter.

²¹³ “Globe and Mail (sic) Request for Interview on Private laboratories,” Laboratory Services Branch, May 8, 1984, p. 3. The reporter was Peter Moon.

Chapter Four: The Privates Consolidate: 1968-1990

Widespread concerns about fraud, low quality and over utilization in the for-profit laboratory industry did not keep it from growing. This chapter outlines the factors that fuelled this commercial expansion. I intend to demonstrate that the interplay between national programs, a Conservative provincial government, a strong non-profit hospital sector, the medical profession, concerns about quality and an emerging industry in the context of a changing balance of class power as a result of a shift to a global capital economy are central elements in explaining the growth and consolidation of commercial laboratory corporations. The policies pursued and their effect on the community laboratory sector provides a basis for linking specific policy initiatives to broader social dynamics of struggle.

Some of these factors are paradoxical, exhibiting contradictions inherent in state actions. Attempts to control excesses in the for-profit sector, licensing, quality control and limits on conflict of interest, spurred the development of corporate medical laboratories. Similarly, federal legislation aimed at creating a public health insurance system contributed to the emergence of a for-profit medical industry. And an individualistic, technology-driven medical profession with an antipathy to both public health care and corporate medicine aided the development of the latter. These results are often the flip side of developments that supported public delivery options. In a capitalist society, institutions, policies and their implementation are not neutral. There can be compromise solutions, but there will be winners and losers, and they will tend to favour the dominant property relations. The policy outcomes will not be permanent as exploitation, oppression and the struggles against them continue.

1968 to 1990 was a volatile time of change in Canadian and Ontario politics. Concerns about inflation provided the rationale for wage and price controls nationally and provincially. Increasing federal debt brought about *The Established Program Financing Act* in 1977 that reduced transfer payments to provinces' social services, including health care. The Canadian Health Coalition was formed in 1979 as part of the

fight against extra-billing that culminated in the *Canada Health Act* in 1984. Doctors called two strikes in Ontario: one in 1971 over the percentage of the OMA fee schedule that would be covered under universal health insurance, and one in 1986 against Ontario's enforcement of the *Canada Health Act*.

As with the development of non-profit medical laboratory alternatives, federal legislation was pivotal in the development of the corporate laboratory sector. The introduction of medical insurance funded the emergence of the commercial sector. Its interaction with hospital funding and the medical profession worked to exclude hospitals from community laboratory work, contributing to the growth and consolidation of private medical laboratories.²¹⁴

The Insurance Honey Pot

It is unlikely that for-profit laboratories would have grown without medical insurance, first non-governmental for-profit and non-profit plans, then government programs with voluntary subscription and finally universal public insurance, to pay their bills and fund their profits. Laboratory expenditures increased rapidly with the expansion of insurance coverage. It was estimated that 90-95% of laboratory work was covered by medical insurance before medicare.²¹⁵ Physician Services Insurance (PSI), a large non-profit insurer founded after the Second World War and run by the medical profession, reported that, "in 1962 costs [for laboratory service claims] doubled, by 1964 they had more than doubled again, and between 1965 and 1968 costs quadrupled. The cost per participant per month in 1957 was a third of a cent, and in 1968 it was seventeen cents, an increase of more than 5000%."²¹⁶

The establishment of the Ontario Medical Services Insurance Plan (OMSIP) in 1966, a government-run voluntary insurance plan partially established to head off the

²¹⁴ This result was not the norm in Canada. Most provinces relied on and continue to rely upon public facilities to process the bulk of community laboratory work. The for-profit sector nursed in Ontario has moved out into the other provinces and taken over increasing proportions of their laboratory services, but this is a story for another paper.

²¹⁵ Chemical Engineering Research Consultants, "Private Clinical Laboratories in Ontario," a study for the Committee on the Healing Arts, Toronto: Queen's Printer, 1969, p. 14.

²¹⁶ "Abuse of Labs Being Studied," Physician Services Insurance. A column in the *Ontario Medical Review*, June 1969, p. 275.

drive towards universal state insurance, fed into the frenzy. "OMSIP had been established a year before and private and commercial laboratories were mushrooming with thoughts of large assured profits."²¹⁷ A study of OMSIP billing data found that the utilization of commercial laboratories that were not associated with a medical clinic or group practice increased 225% from 1967 to 1968, compared with 104% for hospital outpatient billing and 97% for clinic laboratories. This increase in the commercial labs was almost entirely due to the increasing number of patients seen.²¹⁸ Of the 112 for-profit labs in 1967, 15% were founded before 1950, while 50% were established between 1963 and 1967.²¹⁹

The government was aware of the connection between the growth of for-profit laboratories and publicly funded insurance. In 1966 Dr. Charron, Deputy Minister of Health, officially responding to recommendations of the Laboratory Committee Report commented that, "private laboratories could most easily be controlled by refusal to provide public monies for laboratory work performed outside hospital or public health laboratories, which would be conducted at cost removing any profit motive of quantity over quality."²²⁰ Regardless, the government did not play a role advocating for public delivery of insured medical services.

In 1966 90% of the community laboratories were owned by physicians, the remaining 10% were owned by "chemists, technicians, non-profit making groups and municipalities."²²¹ Most of these were still sole proprietorships but corporate chains were starting to emerge. The largest of these was Pathologists' Services with sixteen laboratories in Toronto, which was a bit like a franchise company with individual labs owned by pathologists under the "supervision" of three pathologists, two of whom were on staff at Toronto's Doctors' Hospital. They all used similar procedures: training and staff were interchangeable. "A percentage of each analysis fee is given to Pathologists'

²¹⁷ "Laboratory Licensing: Background Information," report attached to a memo from W.J.A. Percy, Director, Laboratory Services Branch, to G.J. Chatfield, General Manager, Direct Services Division, Ministry of Health, September 12, 1973.

²¹⁸ Boyd, E.A.D., "Laboratory Utilization Study," OHSIP, July 1, 1969.

²¹⁹ Chemical Engineering Research Consultants, "Private Clinical Laboratories in Ontario," p. 7.

²²⁰ Letter from K.C. Charron, Deputy Minister of Health, to J.B. Neilson, Chairman, Ontario Hospital Services Commission, February 3, 1966.

²²¹ Chemical Engineering Research Consultants, "Private Clinical Laboratories in Ontario," p. 7.

Services in payment for supplies and for professional assistance.”²²² All the chains were controlled by physicians. Thirty-three per cent of private labs were incorporated.²²³

The passage of the federal *Medicare Act* in 1968, implemented in Ontario in 1969 with the establishment of the Ontario Health Services Insurance Plan (OHSIP), was a complement to the universal insurance program for hospital services. It mandated universal insurance for medically necessary services ordered by doctors, including laboratory tests. As in all other provinces the universal government program left in place the dominant structure of paying for medical services on a fee-for-service basis to solo practice physicians. The “historic compromise” that removed adamant physician opposition to universal medical insurance left their professional autonomy and small business practices intact.²²⁴ With the split between financing and delivery of medical care the population gained access to services ordered by physicians. Providers gained access to guaranteed payment for those services. OHSIP merged with OHSC to form the Ontario Health Insurance Plan (OHIP) in 1972, an organization to administer a unified public health insurance plan. Separate funding regimes for hospitals and medical services were kept and continue to the present.

When the *Medicare Act* was passed the private laboratory industry had a strong beachhead providing 8% of laboratory services in 1967²²⁵ and they took full advantage of the opening provided by the new universal medical insurance program. The number of tests per capita in Ontario increased from 1.1 in 1966 to 9.6 in 1976, an increase of 872%.²²⁶ The cost of fee-for-service laboratory work “rose by 6.5 million dollars or 25% in 1971 over 1970 excluding the population and price increases which occurred over the same period.”²²⁷ Describing the growth in laboratory testing from 1966 to 1981 the Task Force on Laboratory Services concluded, “although demand has increased in both the hospital and private laboratories the increase in the private laboratory sector has been

²²² Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 13.

²²³ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario.”

²²⁴ For a fuller discussion of these developments see Pat Armstrong and Hugh Armstrong, *Wasting Away*, Second Edition, Chapter Three, and Donald Swartz, “The Politics of Reform,” for a more detailed history of hospitals and their relationship to organized medicine.

²²⁵ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario.”

²²⁶ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 91.

²²⁷ “Report of the Task Force on Cost Controls for Medical Laboratories,” October 1972, Ministry of Health.

substantially greater.”²²⁸ Evidence of for-profit corporations “high-grading” laboratory work existed in 1969. It is estimated that these private laboratories performed 8% of all the laboratory work and 12 to 15 % of the biochemistry, urinalysis and haematology, the simpler tests.²²⁹

While medical insurance enabled the expansion of for-profit services it was the allopathic approach that encouraged doctors to expand their practices in this direction. The expansion of knowledge in patho-physiology, the increasing reliance on quantitative tests for disease diagnosis and management, and the introduction of laboratory screening as an approach to preventive health care²³⁰ all contributed to increased reliance on laboratories. Clinical evaluation was losing its importance to laboratory results.²³¹ The Task Force on Laboratory Services identified the introduction of universal medical insurance, economic growth, increased population and number of physicians, an increase in the number of available tests, automation, new micro techniques, increased reliance on laboratory tests by doctors and increased expectations from patients for laboratory testing as factors involved in the increase.²³² These factors laid the basis for the rapidly rising use of laboratory investigations, but the concern about over utilization focused on the behaviour of the private sector.

The push from the private sector to expand the utilization of laboratory services and to tie pathologists into private sector growth is evidenced in a prospectus from Cybermedix, “seeking capital for expansion,”²³³ circulated among pathologists in 1970. They were inviting people to be involved in, “the glamour and excitement of a ‘growth industry’,” the health care industry. One of their corporate objectives was, “to maintain and operate a series of fully automated testing laboratories throughout Canada and the United States.” Part of Cybermedix’s pitch was to advocate for automated health

²²⁸ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 96.

²²⁹ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 24.

²³⁰ W.J. Poznanski, “Economy of Laboratory Services,” *Ontario Medical Review*, November 1971, pp. 569-571.

²³¹ Joyce Feinberg, “Discussion Paper on the Organization of Laboratory Services in Ontario,” November 30, 1973. Preliminary draft of an internal Ministry document evaluating the many recommendations made on the laboratory sector.

²³² *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 98.

²³³ “Cybermedix Limited,” prospectus from gordon, eberts and company limited [name not capitalized]. Attached to a letter from M.O. Klotz, Chief Pathologist at the Ottawa Civic Hospital, to J.D. Galloway, Medical Director, St Joseph’s Hospital Hamilton, April 10, 1970.

screening. This was described as a, “two hour examination performed by highly qualified registered nurses and technicians” that completes all the “routine and time consuming” parts of the medical exam. This automated health screening is collated in a computer printout and sent to the doctor prior to the appointment so the exam can be done “in a fraction of the time.”²³⁴

Laboratory services provided an excellent opportunity for the standardization needed to commodify a segment of health care provision. Automation encouraged capital investment. Non-profit and government insurance provided the needed the revenue stream that made the dramatic for-profit expansion possible. Biomedicine provided the justification and structure for satisfying the new need. Commenting on a report for the Committee on the Healing Arts, Dr. Elkerton, head of the Public Health Branch, said that, “prior to insurance making private laboratory practice a lucrative business, most clinical work of an ‘outdoor’ nature was done by hospital and public health laboratories.”²³⁵

Insurance not only funded the expansion of the for-profit sector it helped shape it. Before government became involved, private insurance companies, notably the doctor-owned PSI, used their monetary power to determine which laboratories were appropriate to buy services from. They adopted a simple formula: the laboratory had to be controlled by a licensed medical practitioner. The rationale for this approach is rooted in the practice of biomedicine: it was assumed that doctors as medical authorities would provide only needed and quality laboratory services. Also, the fact that PSI was physician owned helps account for this regulation that increased the control and income of doctors.²³⁶

At the centre of the biomedical practice of medicine good health care is the treatment of particular ailments of individuals by a physician. Physicians’ associations have argued that this therapeutic individual patient-physician dynamic can only happen in an environment in which doctors are responsible only to their patient for their income

²³⁴ “Cybermedix Limited,” p. 8.

²³⁵ L. Elkerton, “Subject: Survey of Private Clinical Laboratories,” comments submitted to the Committee on Healing Arts, May 9, 1968.

²³⁶ Pat Armstrong and Hugh Armstrong, *Wasting Away*. For a discussion of the key elements of biomedical model dominant in Canada see Chapter Two.

and their decisions.²³⁷ It is also assumed that doctors will act altruistically and in the best interests of their patients. Pathologists and radiologists, who had fought for recognition as legitimate medical professionals, were very susceptible to this argument. For these doctors one indicator of being accepted as a professional was being able to run one's own practice rather than being an employee of a hospital or corporation.²³⁸ It was also very financially rewarding. This belief, reinforced by the regulation of the PSI, created a network of physician-owned private laboratory business that provided the fodder for the growth of the commercial laboratories.

This concept of independence did not prohibit them from being employers and using others who did most of their work. Peter Twohig, in his history of labour in Nova Scotia laboratories, documents the history of laboratory workers, most of whom were female, who were channelled into occupations, "that ultimately supported the professional projects of male physicians."²³⁹

Pathologists and the medical profession sought to establish their control of the commercial laboratory industry, all the while legitimizing, and benefiting from, its growth. Their demand for professional independence worked against the expansion of hospital outpatient services.

Hospital Insurance and Doctors

Many pathologists initially saw the public sector both as a competitor and as a potential employer who would control their practices. They felt that laboratory services were medical services that should be provided by independent medical practitioners and not under the control of "lay" institutions, that is, hospitals.²⁴⁰ The important role of public health labs in providing services to the public was bemoaned by a pathologist who

²³⁷ "Editor's View," *Ontario Medical Review*, February, 1968, p. 71. An editorial by Glenn Sawyer which includes the statement: "We believe that the majority of doctors who enter into salaried relationships are well-motivated...Having said that, we wonder if they have thought through the long-term implications of the loss of freedom of action which is bound to come in trying to service two masters – patient and employer."

²³⁸ H.G. Pritzker, "Provision and Payment of Diagnostic Services: A Symposium. The Pathologist Viewpoint," *Canadian Journal of Public Health*, 48, October 1957, pp. 413-424.

²³⁹ Peter Twohig, *Labour in the Laboratory*, Montreal: McGill-Queens University Press, 2005, p. 138.

²⁴⁰ H.G. Pritzker, "Provision and Payment of Diagnostic Services."

commented it was “exceedingly difficult” to run a private office specialist practice, “in most parts of Canada because of the services offered by provincial public health laboratories, at little or no cost to the physician and patient using these services.”²⁴¹

When serious discussions on a national hospital insurance plan began the medical profession led the charge in opposition. Pathologists were specifically concerned because of proposals to cover outpatient diagnostic services. On top of their antipathy to “state medicine” this would have limited their growing private practices providing community laboratory services.

Initial federal and provincial discussions on a hospital insurance program included outpatient diagnostic services as a mandatory benefit. At the 1955 Federal-Provincial Conference, Prime Minister Louis St. Laurent proposed that the next logical step, “might well be the provision of radiological and laboratory services.”²⁴² Ontario countered with a more comprehensive program that included the provision of “in-patient and out-patient diagnostic services.”²⁴³

Taylor writes that, “the question of out-patient diagnostic services was to become a serious issue between the Government and the OMA.” The OMA wanted medical services in the diagnostic field to be treated differently from hospital insurance and paid on a fee-for-service basis directly to physicians, and that, “citizens should be able to receive designated diagnostic medical services ... provided by physicians in or out of hospitals.”²⁴⁴

The Canadian Medical Association’s campaign against government-administered universal hospital insurance was driven by radiologists and pathologists who provided medical services in hospitals.²⁴⁵ They were, “traditionally paid by hospitals on a salary or negotiated contract [and] insisted that they too be paid on a fee-for-service basis.”²⁴⁶

Pathologists wanted hospitals to provide the space and equipment for diagnostic services which they would have complete control over.²⁴⁷ They would be paid on a fee-

²⁴¹ H.G.Pritzker, “Provision and Payment of Diagnostic Services.”

²⁴² Malcolm Taylor, *Health Insurance and Canadian Public Policy: the Seven Decisions that Created the Canadian Health Insurance System*, Montreal: McGill-Queen’s University Press, 1978, p. 131.

²⁴³ Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 131.

²⁴⁴ Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 139.

²⁴⁵ Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 219.

²⁴⁶ Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 190.

²⁴⁷ H.G. Pritzker, “Provision and Payment of Diagnostic Services.”

for-service basis for both inpatient and outpatient services provided. Health system planners and hospital administrators were concerned with the OMA's position because of the extra administrative work, the loss of integrity of inpatient services and the loss of revenue to hospitals from selling laboratory and diagnostic services to community patients. They argued that diagnostics should continue as they had been, "as being part of a day of patient care."²⁴⁸

The *HIDSA* overrode some of the profession's concerns and included diagnostic services as mandatory for inpatients but acquiesced and made outpatient services optional at provincial discretion. Taylor comments on the effect of leaving outpatient services out of the 1958 hospital insurance program: "By deciding not to introduce outpatient diagnostic services as a benefit simultaneously with the introduction of hospital insurance, the government maintained its peace with the Ontario Medical Association, but it thereby, itself, contributed greatly to the demand for unnecessary admission and the resulting demand for more active treatment beds than was genuinely needed for inpatient care."²⁴⁹ He might have added that it also contributed greatly to the emergence of a private laboratory sector.

Nonetheless the *HIDSA* provided incentives for provinces to increase outpatient services with the intention of decreasing the use of more expensive inpatient beds.²⁵⁰ The cost-sharing formula paid the province 47.8 % of the cost of adding outpatient services compared to 32.7% for inpatients.²⁵¹ The Ontario provincial government was very much aware of these provisions. An internal study by an economic consultant to the MOH showed that if the province was able to transfer six million dollars from shareable inpatient services in 1967 to shareable outpatient costs they would receive an extra 918,000 dollars in federal funding or 15% of the six million dollars.²⁵²

In Ontario the medical lobby against insuring outpatient diagnostic services was effective in keeping these services out of the provincial hospital insurance scheme until

²⁴⁸ Quoted in Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 141.

²⁴⁹ Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 158.

²⁵⁰ R. Verbrugge, "An Explanatory Memorandum on the Federal Cost Sharing Formula," internal Ministry of Health document, September 1963, p. 7.

²⁵¹ R. Verbrugge, "An Explanatory Memorandum."

²⁵² Memo from R. E. Verbrugge, Economist Consultant, to E.P. McGavin, Commissioner of Finance, April 29, 1968.

1969.²⁵³ The province acted then because of public pressure and another piece of federal legislation, the 1968 *Medicare Act*. Before 1968 individuals were already complaining about, “being billed for an outpatient service in hospitals even though that person was insured by OMSIP.”²⁵⁴ It was also felt that public criticism would only increase when the full medicare program was introduced. The OHSC Directors meeting, June 24, 1968, mandated that the program be changed so that, “anyone requesting treatment at an outpatient department and is treated by a doctor will be covered under the hospital insurance program with the exception of the administration of take home drugs.”²⁵⁵ When the *HIDSA* started to pay for outpatient services, physicians, primarily pathologists, who already had contracts with hospitals, also started to bill for these outpatient services as separate medical services: this double billing further escalated laboratory costs and pathologist incomes.

Even though their primary intention was to protect their professional autonomy and their incomes, physicians played a significant role in the emergence of a commercial laboratory sector through their support of entrepreneurial laboratory service provision and through pressure to limit the extension of hospital services into the community. These actions by physicians, fuelled by insurance money, privileged by biomedicine and enabled by technological advances, created the rapid growth of the for-profit industry that raised concerns in the Ministry of Health, and among politicians and the public.

Concerns about quality due to the rapid expansion of unregulated for-profit laboratories overlapped with cost concerns. The province took numerous steps to decrease utilization of laboratory services, control costs and improve quality. Central to these in the community was the licensing of laboratories and specimen collection centres, a step that had been recommended by the Committee on Healing Arts, the Ontario Council on Health and the Task Force on Laboratory Services. To control hospital funding the government limited their access to fee-for-service funding for laboratory services, a move which further helped the expansion of the commercial sector.

²⁵³ Malcolm Taylor, *Health Insurance and Canadian Public Policy*, p. 157.

²⁵⁴ Reports from the Chairman: Outpatient Services, Directors Meeting, MOH, Nov. 4, 1966.

²⁵⁵ “Out Patient Services,” OHSC Directors Meeting, June 24, 1968, item 3.

Licensing the Laboratory Sector

Licensing community medical laboratories had been on and off the provincial agenda since 1943. Rising costs and the rapid expansion in the number of private laboratories during the 1960s²⁵⁶ started the final process that led to the licensing of the sector. The provincial government gave three official reasons for the licensing of medical laboratories: ensuring quality services, making laboratory services accessible to all parts of the province and cost control.

There were different perceptions on the relative importance of each of these reasons. Robert Welsh, Provincial Secretary for Social Development, in a memo to the Minister of Health commented that: “Our discussion on Thursday, May 11, made clear that the proposal for licensing medical laboratories, while perhaps worthwhile, was really intended to provide a basis for cost control.”²⁵⁷ W.J. A. Percy, Director of the Laboratory Services Branch, commenting on Welsh’s remark said: “I do not agree with the statement in the first paragraph that licensing of medical laboratories is really intended to provide a basis for cost control.”²⁵⁸ For Percy the pressing issue was ensuring quality services. It seems likely that the program did increase the quality of services,²⁵⁹ but it did not work to control costs.

Licensing of the laboratory sector was initially done through an amendment to the *Public Health Act*, which came into force on November 1, 1972. In 1984 this part of the *Act* was consolidated with its many amendments into the *Laboratory and Specimen Collection Centre Licensing Act*, which is still the primary legislation governing the sector. The *Health Insurance Act* which consolidated the rules for Ontario’s compliance with the *Federal Medicare Act* was also passed in 1972. These two acts provided the

²⁵⁶ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 2: “Indeed it has only been in the last few years, with the increase in private laboratory medicine, that there has been a need for legislation of this kind.”

²⁵⁷ “Cost Control of Medical Laboratories,” memo from Robert Welsh, Provincial Secretary for Social Development, to R. Potter, Minister of Health, May 17, 1972.

²⁵⁸ “Cost Control for Medical Laboratories,” memo from W.J.A. Percy, Director, Laboratory Services Branch, to G.K. Martin, Executive Director, Public Health Division, May 25, 1972.

²⁵⁹ During the first decade of the licensing program five private laboratories were closed for being non-proficient and numerous others complied with regimes to improve their quality. Assistant Deputy Minister’s Briefing Book, MOH, July 24, 1984.

legal basis for directly funding laboratories, introducing initiatives to reduce utilization and establishing a variety of quality assurance programs.

By the end of September 1973, 510 laboratories had been licensed in Ontario (214 in hospitals and 296 privately owned). They were distributed unequally around the province. The commercial laboratories were concentrated in Toronto, which had 51% of the total number of commercial labs. In Toronto there were almost four-and-a-half times as many commercial laboratories as hospital laboratories, in Northern Ontario there were three times more hospital laboratories than commercial laboratories. Licensing of laboratories cemented this unequal distribution of services and over time did little to change it. This high-grading of high-population density areas by the for-profit sector combined with their preference for the easier, more common tests indicates a significant limitation in the ability of the private sector to deliver equitable access to all laboratory services.

Distribution of Medical Laboratories – 1973²⁶⁰

Area	Hospital	Commercial	% Commercial
Metro Toronto	34	150	82
Central	44	60	58
Southwest	28	44	43
Southeast	36	29	45
Northern	42	13	24

Licensing provided the cornerstone for other initiatives to control costs and improve quality, all of which facilitated the emergence of large commercial laboratory corporations. Actions dependent upon licensing, including limiting the number of laboratories, the creation of a government department to license the sector that provided direct ongoing government contact with the for-profit corporations, quality control programs, including programs to limit conflict of interest and overuse, and allowing commercial laboratories to bill OHIP directly, worked in favour of the commercialization

²⁶⁰ "Amendments to the Public Health Act relating to Laboratory Licensing: Summary," Cabinet Submission from the Ministry of Health, November 1, 1973, p. 5.

of the community laboratory industry. The following outlines the emergence of these programs and their effects on private laboratories.

Directly Funding Private Laboratories

Licensing provided the government a way of identifying and limiting the number of facilities that could provide laboratory services and receive public money for the work. But providing laboratories with direct access to medicare money also involved changing the billing structure to remove the requirement that only doctors could bill for community laboratory services. A significant step towards this goal was splitting the fee for laboratory services into technical and professional components. Historically physicians billed their patients directly for their services, including laboratory work. The amount billed was based on the Ontario Medical Association fee schedule and doctors could bill more or less depending upon the patient. If a doctor could not perform the test it was often sent to a public health lab or to a hospital where it was done for free.

The increasing variety and volume of tests led private insurance to cover the costs of increased reliance on these services and the establishment of small laboratories run by physicians to provide the services for a fee. The largest private insurance company in Ontario, PSI, affiliated with the medical profession, paid doctors 90% of the OMA rate for services and did not allow extra-billing of insured services.²⁶¹ It would pay for laboratory procedures only if the laboratory was owned by a physician. This both increased the control of doctors and increased costs.

Private laboratories would sometimes enter arrangements of convenience and make physicians "titular directors" to be able to claim insurance funding.²⁶² A submission to the Committee on the Healing Arts by the managing director of the Doctors' Clinical Laboratory recounted how he had set up a private clinical laboratory as an, "investment of private capital, and like any other form of investment it is hoped that a profit will be realized."²⁶³ He wanted to offer a quality and ethical service to medical

²⁶¹ Hansard, May 7, 1968, p. 2603, comments by Morton Schulman, MPP for High Park.

²⁶² Chemical Engineering Research Consultants, "Private Clinical laboratories in Ontario."

²⁶³ J.C.MacLaurin, Managing Director of Doctors Clinical Laboratory, "Brief for the Committee on the Health Arts: the views and Opinions of a Private Laboratory," undated.

doctors. He felt his service was well received by physicians but to keep his business from failing he had to transfer ownership to physicians. He advocated for individuals being able to run a laboratory and be paid on the quality of the service.

Automation also increased the need for more capital investment in the sector to purchase the new technologies. As well as creating private investment opportunities increased automation changed the role of the doctor in laboratory services. As the procedures became more automated doctors often played no significant role in individual tests. "Only a small portion of medical laboratory practice requires a pathologist's opinion and his supervision of the great bulk is minimal."²⁶⁴ Yet the fee for each test was based on the involvement of a medical professional. This problem was widely recognized. A 1969 study on private laboratories reported that:

There is very little doubt that the OMA Schedule of Fees gives quite a generous fee for the amount of work done. This is partially because the fee includes an allowance for interpretation by a pathologist and this interpretation does not normally take place. The Schedule of Fees for biochemistry and haematology states that: "this schedule of fees is to apply to the practice of Clinical Pathology by or under the direction of a qualified pathologist," and is billable even in the absence of a pathologist.²⁶⁵

Consultants in 1967 commented that, "the OMA tariff has been amply generous for manual methods and will provide 'enormous profits' for automated mass testing unless reviewed."²⁶⁶ A physician writing to the Minister of Health argued for an urgent reconsideration of the OMA tariff on laboratory fees:

Let us consider the basis for the present tariff. They were established on the basis of a physician being in private practice the same as any other physician. Buying his own equipment, providing their own space and keep [*sic*] doing the work themselves then taking their chances on collections. The present situation with almost chain store procedures and the bulk of the work being done by technicians and no bad debts is an entirely different situation.²⁶⁷

In the early 60s the OMA responded to the reality of rising pathology costs, which threatened to increase subscription fees, by instructing the OMA tariff committee to consider separating the technical cost and the professional component of numerous

²⁶⁴ L. Elkerton, "Subject: Survey of Private Clinical laboratories," May 9, 1968. Comments evaluating the Ontario Council on Health consultants report on the private laboratories in the early 1960s.

²⁶⁵ Chemical Engineering Research Consultants, "Private Clinical Laboratories in Ontario," p. 14.

²⁶⁶ Chemical Engineering Research Consultants, "Private Clinical Laboratories in Ontario."

²⁶⁷ Letter from K.C. Charron to J.B. Neilson, Chairman, OHSC, February 3, 1966.

fees.²⁶⁸ Initially the committee responded by increasing the number of laboratory procedures that should be included within the fee for a normal visit to a doctor.²⁶⁹ This recommendation resulted in, “insurance schemes ...not pay[ing] the physician for testing; thus he has little incentive to do the tests himself.”²⁷⁰ This produced a paradoxical effect. Physicians started to establish laboratories and rather than run the tests themselves as part of their visit fee, they would refer patients to laboratories run by themselves and have the laboratory bill for that test. The doctor would pay the bill and submit the receipt to the insurance company for reimbursement. They would receive payment for the visit and the test. As a result the number of laboratories increased and so did the costs.

In 1971²⁷¹ the OMA fee schedule formally incorporated a lower, technical fee for tests that did not involve any professional work. The problem was that there was no incentive for pathologists to bill at the lower rate. They still had to oversee all tests, at least on paper. It was not until commercial laboratories became licensed and legislation allowed them to directly bill OHIP for the technical component of laboratory tests that the technical fee by itself became widely used.

This situation was not unique to laboratory work. As diagnostic work had become more technical a variety of procedures could be performed by lower-cost technicians, often with minimal professional input. For instance, x-rays, ECGs, and pulmonary function tests were usually performed by technologists and separate technical and professional fees were developed for these services during the 1970s. Laboratory work was on one extreme of this phenomenon, being the most amendable to centralization and automation.

Licensing established a structure in which commercial laboratories could directly bill OHIP for the technical component of laboratory work as long as it was ordered by a

²⁶⁸ “Report of Committee on Tariff,” *Ontario Medical Review*, volume 31, 1964, p. 41.

²⁶⁹ “Report of Committee on Tariff,” *Ontario Medical Review*, volume 32, 1965, p. 21.

²⁷⁰ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 23.

²⁷¹ OMA Section on Laboratory Medicine, minutes, Annual Meeting, May 22, 1998 [should be 1971?], p. 5. This may have been the date, but it is also likely that this date is remembered because this was the date pathologists in hospitals were stopped from billing their services as medical services. What is clear is that in 1963 the fees were not divided and by 1971 they were. Reports of the OMA’s tariff committee were vague on when the technical-professional split happened. It is likely that it happened gradually with a few more tests and procedures added each year in the latter half of the 1960s.

physician. Only laboratory medical specialists who provided an interpretation of a result would be allowed to bill for the professional component. This established a direct path for the commercial laboratories to medicare money. Since these technical fees were part of the OMA fee schedule they were fee-for-service: the more tests commercial laboratories performed the higher their income.

While hospitals were also coping with the rapid increase in outpatient and community laboratory work, they were prohibited from accessing medicare money even for the technical component, a development that is described later in the chapter. This resulted in a shift of work from hospitals to the private laboratories.

When the technical-professional split was made each fee, as with all other OMA tariffs, were simply assigned a monetary value. In 1973 the OMA and the Ministry entered into discussions on a proposal to switch to a system called LMS (labour, material and supervision) for laboratory work. The OMA argued that this method would be “simple, logical and could reduce the task of Tariff Committees [professional committees assigned with setting the rate for medical services].”²⁷² The basic LMS unit was, “conceptualized as applying to: (1) the private practice of laboratory medicine.”²⁷³ Once the LMS unit value was set for each test it would be multiplied by a negotiated figure to arrive at the amount paid for each test. When the system was introduced in 1974 the negotiated value of each LMS unit was 33 cents.²⁷⁴

The LMS system has a bias towards manual tests, which may have been part of the reason for-profit laboratories were often behind hospitals in the use of high technology procedures. This problem was identified for the Task Force on Cost Controls for Medical Laboratories: “Inefficient procedures are encouraged as the existing tariff suggests a larger fee if a procedure is done manually rather than by an automated procedure.”²⁷⁵ A 1994 study found that approximately 82% of tests performed in

²⁷² “Proposals for the Revision of the Fee Schedule for Laboratory Medicine for Inclusion in the 1974 O.M.A. Fee Schedule,” report attached to minutes of a meeting between the OMA and the Ministry of Health regarding proposed revisions to the fee schedule for laboratory services, May 1, 1973.

²⁷³ “Proposals for the Revision of the Fee Schedule for Laboratory Medicine for Inclusion in the 1974 O.M.A. Fee Schedule.”

²⁷⁴ “Minister’s Meeting, October 1, 1974,” minutes from a meeting between the Minister of Health and Senior Ministry Staff, item 1 Lab Proficiency (9-128/73).

²⁷⁵ “Distribution of Payments for Laboratory Services,” a working paper prepared for the “Report of the Task Force on Cost Controls for Medical laboratories,” October 1972, Ministry of Health.

hospitals were automated compared to 72% in the private laboratory system.²⁷⁶ This figure underestimates the extent of hospital automation because about 10% of hospital tests are so esoteric that they are not even represented in the laboratory fee schedule used by the commercial laboratories and unlikely to be automated.²⁷⁷

HICL, in comments to the Task Force on Laboratory Services in 1983, outlined how this bias works:

L-225, automated Chemistry has an LMS unit value of 18. According to the Ontario Health Insurance Plan Schedule of Benefits, the maximum number of units which can be charged for any combination of tests done on a single sample on an automated chemical analyzer with simultaneously functioning channels is 18 units. Therefore, generally it is more lucrative for private laboratories to perform tests on a non-automated basis.

For example, when cholesterol and triglycerides are ordered in a hospital setting, these tests can be performed on an automated chemical analyzer. However a private laboratory could run these two tests on an analyzer without simultaneously functioning channels and invoice the Ontario Health Insurance Plan for L055 – cholesterol at 14 units and L243 – triglycerides at 21 units, for a total bill of 35 LMS units [instead of the 18 maximum if they had used a more automated procedure].²⁷⁸

Without an incredible amount of ongoing evaluation it is impossible to have the LMS system reflect the changes in automation, new testing procedures, changes in reagents and material handling systems. Even in 1976, a few years after the introduction of the LMS system, it was understood that for commercial laboratories there were, “no reliable cost data available.”²⁷⁹ Six years later the Task Force on Laboratory Services described the process and outcome: “Changes in both the [OMA laboratory Fee Schedule] listing and LMS units are made by negotiation between MOH, OMA and OAML. Since the procedure is cumbersome, the current schedule contains LMS units

²⁷⁶ “Study on Costs and Implications of Transferring Laboratory Workload,” July 1994, Social Contract Study, Laboratory Services Review, Ministry of Health, p. 5.

²⁷⁷ “Study on Costs and Implications of Transferring Laboratory Workload,” Ministry of Health, July 1994, p. 4.

²⁷⁸ “Re: the report of the Task Force on Laboratory Services 1982 – A tabulation of statements and inferences considered by HICL to be invalid and to require correction in a supplement to the Task Force Report,” enclosure: HICL's letter of January 31, 1984, to the Chairman of Ontario Council of Health.

²⁷⁹ “Study on Laboratory Services,” 1976, p. 33. This is an internal MOH document.

which no longer reflect current methodology and test listings which no longer are state of the art.”²⁸⁰

Whatever the other benefits for the private laboratories, the LMS unit system did create another structural barrier between the community and the hospitals. Hospitals used the DBS measurement system, which was developed by the Dominion Bureau of Statistics and relies on time measurement for each task. DBS measurements were the most widely used in Canada. These two different workload measurement systems come up again and again as one of the reasons why no reliable cost comparisons could be made between for-profit and hospital laboratories. This problem was compounded by a general recognition that the LSM unit system does not reflect the real cost of the service, only a negotiated value.

The separation of the technical component of the laboratory fee did not automatically allow the for-profit laboratories to directly bill OHIP for their services. The government had to amend the general regulation under the 1972 *Health Insurance Act* to allow labs to directly bill OHIP. The *Health Insurance Act* called for payment of “insured services rendered by a physician.”²⁸¹ Laboratory services were not rendered by a physician, but the 1973 amendment permitted payment for tests “performed in licensed laboratories.” Despite the government’s concerns about private laboratories it deliberately enacted a series of laws and regulations that benefited the growth of the industry. Laboratories were given the ability to directly bill OHIP partially as an incentive to cooperate with the licensing program. It also increased their financial viability and limited the role of the medical profession.

No New Laboratories

Limiting the number of laboratories and specimen collection centres (SCCs) and controlling their distribution were seen as central goals of the licensing program and important to controlling costs. In the first nine months after amendments to the *Public*

²⁸⁰ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 274.

²⁸¹ *Health Insurance Act*, Section 22(2).

Health Act allowed licensing there were another 35 applications for new laboratories.²⁸² These applications left the Ministry officials feeling that there was, “insufficient legislative authority to establish a rational system of laboratory services,” and acting on this issue was “urgently required to limit unnecessary and costly expansions.”²⁸³ On November 15, 1973 Cabinet approved a change from “public need” to “public interest” criteria for approving new laboratory license applications. The new rules included, “the utilization of existing laboratories and their capacity to handle increased volume,” and, “the availability of funds,” in the evaluation of new laboratory requests. “Cabinet also agreed that, as a matter of government policy, no new private laboratories should be licensed, but that there should be no public announcement of this decision for the time being.”²⁸⁴ It seems likely that there never was a formal announcement of this policy.²⁸⁵ The public interest criteria were enacted as part of Bill 235, an amendment to the *Public Health Act* passed on June 10, 1974.

Since Cabinet approval of this policy all requests were met with a polite letter from the Director of Laboratory Services stating that there were already too many labs and only under exceptional circumstance would they be opening new laboratories. In fact no new laboratories have been opened in Ontario since Cabinet took that position. This rule was applied “uncompromisingly.”²⁸⁶

Soon after the introduction of the licensing policy numerous attempts were made to circumvent the legislation by physicians either in conjunction with commercial enterprises or by themselves using their offices as unlicensed laboratory or specimen collection centres. This was possible because of a provision that allowed physicians to perform tests on their own patients in their offices without being licensed. One

²⁸² Eight licences were issued, four refused, twelve withdrawn and ten were waiting for a ruling on whether they met the criteria of public need contained in the legislation. “Amendments to the Public Health Act Relating to Laboratory Licensing: Summary,” Cabinet Submission from the Ministry of Health, November 1, 1973.

²⁸³ “Amendments to the Public Health Act Relating to Laboratory Licensing: Summary,” Cabinet Submission from the Ministry of Health, November 1, 1973, p. 4.

²⁸⁴ Ontario Cabinet Meeting of November 15, 1973, Minute no: 3/63/73.

²⁸⁵ A letter from D.W. Corder, Director of the Inspection Branch to the Office of the Ombudsman, on August 25, 1977, stated that there had been no announcement of this policy, however due to the lack of approvals, “the private laboratory industry is well aware of the policy.”

²⁸⁶ “Consolidation of Private Laboratory Operations by Conversions to Specimen Collection Centers: Brief,” attached to a memo from D.W. Corder, Director Inspection Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, October 19, 1976.

commercial company, Labcare Services Limited, offered to provide a technician and handle the billing for a physician to provide in-office testing in exchange for a contract for all the laboratory work on all that doctor's patients.²⁸⁷ This company was immediately reported to the government and the OMA by commercial laboratories²⁸⁸ and a tightening of the regulations stopped this practice.

Over the next few years there were ongoing negotiations between the government and the OMA about what tests doctors and specialists could perform on their own patients without a laboratory licence. Opponents of proposals to enlarge the range of unlicensed work that doctors could perform argued that this would, "permit the operation of dozens, and possibly hundreds, of small private laboratories which would not be subject under the present legislation." Further it was argued that there was, "little difference in principle between ownership of a large laboratory or a small office laboratory."²⁸⁹

In the end the government held firm on limiting the number of tests that could be done by physicians in their office and tightened the rules on who could perform them. This has an ironic turn. As in the 1960s, by not remunerating for many tests that could be done in a doctor's office there was no incentive in a fee-for-service regime for doctors to perform those tests themselves. Why not reduce their workload and send the patient to a laboratory, increasingly a private one, for the test? If the doctor also owned part of the lab, then, as a bonus, they could receive some extra compensation for doing less work. This structure provided incentives that led to the unnecessary expansion of community laboratory services.

The larger laboratories did not challenge the restrictions on opening new laboratories. They were moving in the other direction, consolidating their work in fewer larger laboratories. Even before the introduction of licensing and the freeze on new

²⁸⁷ Letter from A.R. Adams, President, Kipling Medical Laboratories, to H. Sharpe, Director of Laboratory Licenses, October 25, 1973. Attached to the letter is a promotional packet from Labcare Services.

²⁸⁸ Both MDS and Kipling Laboratories, which eventually became part of the Dynacare conglomerate, raised concerns about Labcare's practices. "Ontario Regulation 463/73 – Laboratory Tests Performed by Qualified Medical Practitioners," letter from H. Sharp, Director of Laboratory Licences to G.K. Martin, Executive Director, Community Health Standards Division, February 12, 1974. Within five years MDS would be engaged in a similar practice making deals with doctors to collect specimens in their offices and process the samples.

²⁸⁹ "OMA recommendation to expand the Simple Laboratory Procedures List (Appendix 'A')," memo from H. Sharpe to G.K. Martin, May 10, 1973.

laboratories, the laboratory chains had been buying up smaller operations to increase market share. The pace of these acquisitions and the move to more central laboratories increased under the licensing regime and created a problem for the larger laboratories. They were now stuck with a variety of smaller labs that needed staff and quality control monitoring, adding expense, when what they really wanted was more SCCs where they could collect patient samples to process in their larger, more centralized facilities. To solve this problem pressure was applied to the government to allow the conversion of laboratories into specimen collection centres; effectively circumventing the prohibition on opening new SCCs.²⁹⁰ This proposal also had the support of the licensing program: the fewer laboratories, the fewer locations they had to keep track of. The Ministry of Health Management Committee approved this proposal on December 17, 1976, with the understanding that the specimen collection centres, “are to be located at the same sites [and] are to be assessed individually on the basis of increased efficiency of testing programs and public interest.”²⁹¹ The table “Laboratories and SCCs – 1967-1984” shows that while the number of labs continued to fall during the 70s the number of specimen collection centres increased, improving patient access and increasing the number of tests for for-profit laboratories. This though was only a partial victory for the commercial sector. They were still limited in where they could open new SCCs and this restriction was soon challenged.

Starting in 1979, there was increased pressure on the Ministry to open up the definition of public interest, especially for specimen collection centres, to allow the establishment of new SCCs in more lucrative markets, often close to hospitals and doctors’ buildings. As well as a desire to increase volume of work and profits, this was motivated in part by a desire to challenge the Ministry’s favouring hospitals over the private sector, an issue that made it into the 1985 briefing book for the Minister: “Licensing decisions during the last three to four years have to a significant degree been guided by the availability of funds to support expansion of the existing service delivery system to meet increased utilization. Consequently, most decisions have favoured

²⁹⁰ “Consolidation of Private Laboratory Operations by Conversions to Specimen Collection Centres,” minutes of the Management Committee, Ministry of Health, December 17, 1976, item #1.

²⁹¹ “Consolidation of Private Laboratory Operations by Conversions to Specimen Collection Centres,” item #1.

hospital-based operations in keeping with the Ministry's well publicized intention to explore and maximise utilization of resources in the hospital sector."²⁹²

Laboratories and SCCs – 1967-1984

Year ²⁹³	Hospital Labs	Commercial Labs	SCCs
1967	222	112	N/A
1973 ²⁹⁴	218	296	N/A
1974	227	288	188
1975	228	284	213
1976	223	265	210
1977	223	246	218
1978	222	236	212
1979	221	230	216
1980	222	220	223
1981	222	210	238
1982	219	199	254
1983	219	184	268
1984	221	178	273

The commercial laboratories, led by MDS and the other large chains, pursued numerous strategies to circumvent the limitations on their specimen collection activities. They started using cabinet ministers to lobby for licensing of new specimen collection centres.²⁹⁵ As well as increasing pressure through lobbying, the laboratories engaged in a form of civil disobedience directly challenging the regulations by establishing new unlicensed SCCs. This led to a doubling of the inspections related to suspected unlicensed operations from 1972-1982²⁹⁶ and an increased number of charges for opening unlicensed specimen collection centres.

In November of 1982 MDS entered into an agreement with a physician's office in Elmira to supply a technician to take samples in the office and pay a monthly fee, not a

²⁹² "Ministers Briefing Book: Laboratory Services Branch," May 21, 1985, p. 50.

²⁹³ Unless otherwise noted the information is from reports prepared by the Laboratories Branch of the Ministry of Health and the figures are as of December 31 of that year unless otherwise noted.

²⁹⁴ As at September 30, 1973.

²⁹⁵ Letter from Keith Norton, Minister of Health, to Philip Andrews, Ministry of Energy, January 12, 1984.

²⁹⁶ "Globe and Mail Request for Interview on Private laboratories," Laboratory Services Branch, May 8, 1984.

signed lease, to provide these services.²⁹⁷ This specimen collection centre would be in direct competition with an HICL operation that already served the area. The physicians at the office received a free worker, income and good access for their patients. MDS cornered the market on these physicians' patients. The other benefit to the physicians was, since the lab specimen was taken in their office, they were able to bill OHIP for the venipuncture and then MDS was able to bill again for processing the sample.

[The] apparent duplication of payment [was] brought to the attention of OHIP personnel [by the Laboratory Branch] ... The OMA Central Tariff Committee's response was that the present payment protocol should remain unchanged but offered no reason for their position. The combined effect of the legislative exemption for physicians and the present OHIP payment structure for specimen collection services encourages collaboration between private laboratories and physicians in establishing unlicensed SCC's.²⁹⁸

MDS was charged with opening an unlicensed SCC in Elmira. Six other charges against laboratories, including Bramlea Medical Holdings Limited, Cybermedix and Donway Diagnostics Limited, were laid about the same time. In 1985 MDS was prosecuted for opening an unlicensed specimen collection centre in Sault Saint Marie, "essentially across the street from two hospitals."²⁹⁹

MDS was found guilty at two lower courts on the Elmira charges before having the conviction overturned by the Ontario Court of Appeal. The court ruled that because MDS did not have a lease this was not a specimen collection centre. The arrangement established here was very similar to the one that Labcare tried to establish in 1973 that commercial laboratories and the medical profession worked with the Ministry to stop.

The consequences [of the court ruling] from a pragmatic perspective are that Ministry licensing controls have been rendered illusory and laboratory owners will therefore move expeditiously to establish unlicensed specimen collection centres in physicians' offices. This in turn will result in increased utilization of laboratory services with commensurate escalation in OHIP expenditures.³⁰⁰

²⁹⁷ "Synopsis of Review of Laboratory Utilization and Referral Patterns Regarding Application to Establish New Specimen Collection Center: MDS Health Group Limited, 4 Park Avenue West, Elmira," Ministry of Health, August 15, 1983.

²⁹⁸ "Globe and Mail Request for Interview on Private laboratories," Laboratory Services Branch, May 8, 1984.

²⁹⁹ "Ministers Briefing Book: Laboratory Services Branch," May 21, 1985, p. 94.

³⁰⁰ "Ministers Briefing Book: Laboratory Services Branch," May 21, 1985, p. 99.

Conflict of Interest

Physicians ordering unnecessary tests, either inadvertently or for personal gain, were identified as a component of escalating laboratory costs as early as the 1960s. The physician-controlled insurance company PSI noted that, “laboratories in which physicians have a monetary interest are doing more tests per patient than labs operated by pathologists.”³⁰¹ In the same article the retiring president of the OMA commented that, “we cannot condone a pattern of practice in which the fee for laboratory services is 10 to 15 times the visit fee in routine office visits when diagnoses are simple.”³⁰² OHSIP identified a similar pattern in 1969.³⁰³

Over the next decade strategies, “eliminating or controlling the ordering of medically unnecessary tests,”³⁰⁴ focused on physician-owned laboratories. Both the College of Physicians and Surgeons of Ontario (CPSO) and the Ontario Medical Association (OMA) disagreed with this approach.³⁰⁵ As noted earlier the profession felt that ownership by doctors, particularly laboratory specialists, was essential for quality. It was assumed that most doctors would only order tests that were needed by their patients and those that did not would be dealt with by the CPSO regulations on malpractice. Nonetheless the government amended the regulations under the *Health Disciplines Act* in 1976 (regulation 792/76) to create a category of “conflict of interest” that restricted doctors or their families from receiving benefits from suppliers of medical goods and services. Since the medical profession did not support the approach of penalizing doctors for owning laboratories there was limited action from the College in support of this amendment.³⁰⁶

³⁰¹ Pathologists generally did not assess patients and order diagnostic work.

³⁰² “Abuse of Labs Being Studied,” Physician Services Insurance. A column in the *Ontario Medical Review*, June 1969, p. 275.

³⁰³ E.A.D. Boyd, “Laboratory Utilization Study,” July 1, 1969, internal study commissioned by OHSIP.

³⁰⁴ “Conflict of Interest,” memo from C.L. Brucacher, Director, Inspection Branch, to G.J. Chatfield, ADM Institutional Health Services, December 14, 1977.

³⁰⁵ C. Wysocki, Legal Council in the Ministry, “Background Regarding the Ownership of Medical Laboratories by Legally Qualified Medical Practitioners,” attached to a memo from Dennis Timbrell, Minister of Health, to W. A. Backley, December 9, 1977.

³⁰⁶ “Background Regarding the Ownership of Medical Laboratories by Legally Qualified Medical Practitioners,” briefing document attached to memo from Dennis Timbrell, Minister of Health, to W. A. Backley, December 9, 1977.

The issue of conflict of interest came back on the public agenda when charges were laid against ABKO Laboratories in 1977 for defrauding the Ministry of \$500,000 dollars,³⁰⁷ and an NDP MPP was expelled from the Legislature on an issue related to laboratory corruption.³⁰⁸ The government responded in September 1977 by enacting a regulation O.R. 195/77 under the *Public Health Act* to proscribe “legally qualified medical practitioners from being owners of laboratories or of having any interest therein.”³⁰⁹ The OMA opposed the regulation as, “unnecessary, discriminatory and foster[ing] commercial laboratory ownership.”³¹⁰ This regulation was postponed while it went through a series of backroom negotiations with the medical profession, “relating to the term ‘any interest’ and... clarification of the exemption provisions.”³¹¹ It was postponed one more time and finally repealed in 1979. Dennis Trimbell, the Minister of Health, justified the postponement because the *Health Discipline Act* regulations were further amended on February 1, 1978, so that physicians who are, “shown to have ordered medically unnecessary tests from a diagnostic facility in which the doctor or a family member has a financial interest” would be in a conflict of interest situation.³¹² This put the policing of the profession back under the profession’s control. As important, it reinforced the assumption that individual professional misbehaviour was the source of the problem of over utilization. The medical profession did not fight against this amendment and no mention was found of any doctors having been found guilty of misconduct by the CPSO for violating these provisions.

In preparation for the enforcement of the 1977 regulation the Licensing Branch of the Ministry of Health undertook a survey of physician involvement in commercial laboratory ownership. Determining physician involvement had its own difficulties. By 1977 89% of corporate-owned laboratories were held by shareholders whose identities

³⁰⁷ “ABKO Lab Gave Dr. Tse Kickbacks: Court Told,” *Globe and Mail*, February 2, p. 8.

³⁰⁸ Ed Ziemba, the MPP for High Park, was expelled from the legislature for refusing to reveal his source for an allegation of laboratory industry corruption. “Ziemba Jailed for Refusing to Name Sources in ABKO Lab Fraud Case,” *Globe and Mail*, June 24, p. 1.

³⁰⁹ C. Wysocki, Legal Council in the Ministry, “Background Regarding the Ownership of Medical Laboratories by Legally Qualified Medical Practitioners.”

³¹⁰ “Small Towns will be Hurt by Lab Law, OMA says,” *Globe and Mail*, May 11, 1977.

³¹¹ “Public Accounts Committee re: Possible Conflict of Interest Regarding Ownership of Medical Laboratories,” memo from P.J. Plant, Acting Director, Inspection Branch, to C.J. Chatfield, ADM, Institutional Health Services, November 3, 1977.

³¹² “Minster Announces Control for Medically Unnecessary Laboratory Tests,” news release, Ministry of Health, January 30, 1978.

could not be discerned by the Ministry.³¹³ MDS identified this issue when it reported on physician owners of its labs. It said all their laboratories were 100% owned by MDS Laboratories LTD which trades on the Toronto and Montreal Stock exchange and, “we have no idea whether qualified medical practitioners hold shares in MDS, either directly or indirectly, that conceivably might have an interest conflict because they refer patients to our laboratories.”³¹⁴ This problem is much more acute now with the widespread ownership of shares among professionals, including doctors, in, for example, RRSPs and pension plans. Shareholding dispersed the direct conflict of interest and exchanged it for a societal one of supporting the private sector, especially corporations such as the laboratories that have strong financial histories, pay good dividends and are held in many mutual and pension funds.³¹⁵ A proposal was put forward to enact legislation that would require commercial laboratories with shareholders to list all the shareholders.³¹⁶ It was never acted on.

The Ministry’s 1977 survey of physician ownership found that 84 laboratories, or 34% of the total number of laboratories, were wholly or partially owned by doctors.³¹⁷ There is some indication that the conflict of interest regulation, even though never fully enacted, caused some small physician-owned laboratories to sell to larger commercial companies. Of the 19 laboratories owned by groups of physicians practicing in a clinic thirteen had applied for an exemption to the ownership regulations and five had been sold to other commercial owners.³¹⁸ By 1982 the number of physician-owned laboratories had decreased to 77.³¹⁹ The degree of impact from the conflict of interest provisions is

³¹³ The rest were partnerships or single proprietorships.

³¹⁴ D. M. Phillips, Vice President of MDS Laboratories, letter to D. Corder Director, Laboratory and Specimen Collection Center, June 3, 1977.

³¹⁵ This point was raised in a few interviews when interviewees were asked why the private labs had come to dominate the market and why no governments had challenged them. They said the extent of shareholdings and their prevalence in mutual funds would make putting these companies out of business unpopular. For a fuller discussion see Chapter Six.

³¹⁶ “Conflict of Interest,” memo from C.L. Brucacher, Director, Inspection Branch, to G.J. Chatfield, ADM Institutional Health Services, December 14, 1977.

³¹⁷ “Ownership of Laboratories: Physician Held Interests,” memo from P.J. Plant, Acting Director, Inspection Branch, to G.J. Chatfield, ADM of Institutional Health, September 29, 1977.

³¹⁸ The status of one was not identified. Information in Appendix B “Service and Financial Record of Clinic-Owned Laboratories May 1975-April 1976 and Present License Situation,” attached to “Ownership of Laboratories: Physician held interests,” memo from P.J. Plant, Acting Director Inspection Branch, to G.J. Chatfield, ADM of Institutional Health, September 29, 1977.

³¹⁹ “Peter Moon of Globe and Mail requests Interview on Private Labs,” memo from the Public Relations Department outlining possible answers to questions, May 15, 1984.

impossible to determine, but it seems likely that it contributed to the growth of the larger laboratories.

To accompany the CPSO's new conflict of interest regulation the Ministry changed the licensing form to require the identification of any legally licensed doctors as owners and gave the Ministry authority to report to the College any physician who's ordering habits seemed to be abnormally high. The College would then investigate to see if there were any medically unnecessary tests being ordered.

Another physician-centred initiative, but one that had the short-term positive effect of decreasing the number of tests, was standardizing the order form for community patients. The new form, which forced physicians to check needed tests, left many tests off the pre-printed list, decreasing cues to order, and made doctors verify that the patients were not inpatients. In 1976-77, after the new form was made mandatory, the number of tests fell 8% and payments were down 6.9%. By the next year both had risen above pre-form levels and continued to grow in the double digit range, though at a lower rate than in the first half of the 1970s.

The fee-for-service structure provides a good database of the tests ordered by physicians. This monitoring of individual physician's behaviour became the basis of the first capping program to try and control the costs of community laboratories services. Starting in 1983 the amount that laboratories would be paid for a test would decrease as the number of tests from individual physicians passed certain volume thresholds.³²⁰ If there was any impact from this limitation it was small as the volume of community tests continued to grow at double digit rates through the 1980s.

The confounding and perverse influence of private profit and fee-for-service systems on valuable social goals can be seen in the licensing and conflict of interest initiatives. Increasing access for patients through more SCCs and ensuring that needed tests are ordered would generally be accepted as positive social goals, yet when they are enacted in the context of private profit the positive result is undermined by compromise if not totally lost. The presence of a profit motive makes it difficult to assess the beneficial impact of policies.

³²⁰ "Private Medical Laboratory Utilization Discount System," Ministry of Health internal document explaining the system, June 1992.

Quality Initiatives

The government also used licensing to address the quality problems identified by the Committee on Healing Arts in 1969 when they found that, “it is apparent that there is room for and a need for improvement [in the quality of private laboratories].”³²¹ A requirement of being licensed, which allowed laboratories to process tests and be paid by OHIP, was that they meet certain quality criteria. They had to agree to be inspected, evaluated against established standards and work with an external quality control program to improve their service and correct deficiencies. The Ministry through its licensing branch performed the inspections and the Ontario Medical Association was designated to run the external quality control program, initially called the Laboratory Proficient Testing Program (LPTP). The program was managed by a joint committee of the OMA and the MOH under the authority of the *Public Health Act*. It was intended that the program be self-financing and all laboratories, regardless of size, had to pay the same fee,³²² a small factor favouring larger laboratories.

The LPTP was preceded by a voluntary Inspection and Certification Program established by the Section on Laboratory Medicine of the Ontario Medical Association.³²³ This program, sponsored by the PSI Foundation as a research project, operated between 1970 and 1974, and this history was part of the justification for the government contracting out management of its quality assurance program to the OMA. While the government was aware of a perceived conflict of interest in that the OMA might, “use the program to protect or enhance physicians,” this was dismissed as no greater a risk than using an outside agency, “in fact, it is probably lower because of the desire of the O.M.A. to protect its reputation.”³²⁴ The result was that the profession maintained its control on quality of medical work.

³²¹ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 43.

³²² “Minister Announces New Laboratory Proficiency Testing Program,” news release, Ministry of Health, October 2, 1974. In fact the program has never been self-sufficient and requires subsidies from general government revenues.

³²³ *Laboratory Proficiency Testing Program, Annual Report*, May 1979.

³²⁴ “Continuation of the O.M.A. as the Agency Appointed by the Ministry of Health, to Conduct Proficiency Testing in all Medical Laboratories in Ontario,” undated MOH report in file, “Integration of Lab License Program with OMA Quality Program,” Ontario Archives series RG10 – 18, barcode 112932, Box 2, file 0-128173.

Regular inspections were also seen as part of the government's cost-control program: "Unlicensed laboratory facilities ... are inspected in order to bring them under statutory control. This mechanism helps keep the number of unlicensed laboratory or specimen collection centres to a minimum which subsequently results in cost savings."³²⁵ These inspections may not have helped control costs but they certainly helped spur consolidation.

Several factors can be identified which cause reduction in the number of participants [in the LPTP]. The Minister of Health carefully reviews whether it is in the public interest to grant any new laboratory licences: new laboratory licences are infrequently granted. This accompanied by normal attrition, leads to fewer laboratories. Smaller laboratories appear to be absorbed by larger units. Finally, and most pertinent to LPTP, some laboratories are relinquishing their licences because of the challenge which an external proficiency testing program presents them.³²⁶

MDS notes this as a factor in its movement to fewer laboratory sites, explaining that, "the retention of laboratory staff and facilities and participation in the L.P.T.P. has become a major problem."³²⁷

The combined impact of reporting, new forms, and education programs, while useful in terms of improving quality also had the effect of making it harder for small operators. The larger laboratory corporations could spread the costs out over the whole operation reducing their relative impact. These governmental programs helped spur the consolidation of the industry, creating a powerful force for private health care. Ironically these programs often came with a push from the left for better protection of patients and better use of government funds. Pursuing quality programs probably increased quality³²⁸

³²⁵ "Material for the Minister's Presentation to Select Committee on Health Care Costs on September 15, 1978," prepared by the Laboratory and Specimen Collection Center Inspection Service.

³²⁶ *Laboratory Proficiency Testing Program Annual Report – May 1979*, p. 6.

³²⁷ "Consolidation of Private Laboratory Operations by Conversions to Specimen Collection Centers," brief attached to memo from D.W. Corder, Director Inspection Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, October 19, 1976.

³²⁸ Between 1974 and 1984 the LPTP identified 42 hospital laboratories, 22 private laboratories and 2 publicly owned laboratories as non-proficient and closed one private laboratory as a result. All the other laboratories were subjected to remedial action, including closing certain classes of tests, sale of the laboratory, and conversion to a SCC. "Globe and Mail Request for Interview on Private Laboratories," May 8, 1984. These are notes prepared by the media relations section of the Ministry in response to questions from reporter Peter Moon. Also a study found that performance in microbiology testing had improved in the first 20 years of the LPTP program: H. Richardson, D. Wood, J. Whitby, R. Lannigan and C. Fleming, "Quality Improvement of Diagnostic Microbiology Through Peer-group Proficiency

but in an environment biased towards private accumulation also produced the unintended result of increasing the power of capital in that market. This comment says nothing about the quality produced by private business compared to public operators, only that larger private facilities with quality programs are more reliable than smaller businesses in highly competitive unmonitored markets.

Global Budgets and Limiting Hospital Access to OHIP Money

The licensing of for-profit laboratories was aimed at controlling costs in the community laboratory sector. Cost control in hospitals was also attacked on numerous fronts, two of interest being the 1969 change in hospital funding from line-by-line allocations to global budgets and the targeting of outpatient laboratory services. Global budgets were intended to cover all the costs in hospitals, including laboratory services. This change was not specifically aimed at reducing the cost of diagnostic services – it was designed to allow hospitals more flexibility to provide needed services and control costs in general – but it would have a significant effect on the provision of outpatient laboratory services by hospitals. It meant that hospitals had to balance various services to try to provide the best patient care within their allocated budget. When funding for community laboratory services decreased and eventually stopped, hospitals had little incentive to provide this service since it was not related to their core mandate of providing comprehensive inpatient care.

With the introduction of OHSIP, the universal government insurance plan, in 1969, pathologists and other physicians who treated outpatients were allowed to bill the plan fee-for-service for outpatient work. OHSIP created a second income stream for pathologists in hospitals. Now when they treated outpatients they could bill OHSIP for this medical service on top of their income from the hospital. This significantly increased

Assessment Program. A 20-year Experience in Ontario. The Microbiology Committee," *Archives of Pathology Laboratory Medicine*, 120(5): 445-55, May 1996.

The LPTP also inspected hospital laboratories and encouraged the regional development of hospital laboratory resources as a way of increasing quality. They specifically identified areas were the Northeastern, Northwestern and Renfrew Districts; and Grey and Bruce, Huron, and Perth Counties as having quality issues in laboratories that would be helped by greater integration. Laboratory and Specimen Collection Center Inspection Service, "Ministry of Health Briefing Material: Program Book," April 9, 1979.

the income of pathologists and the costs of laboratory services. As part of its program to control laboratory costs and the incomes of pathologists, the government introduced regulations to stop hospital-based laboratory specialists from directly billing fee-for-service for outpatient laboratory services and it shifted funding for these services from the medical insurance plan, OHSIP (soon to be OHIP), to the hospital funding envelope.

In February 1971 hospitals were switched to bulk billing for all their outpatient laboratory services and the bills were sent to OHSC instead of OHSIP. Each month the hospitals would estimate the amount of outpatient laboratory work and submit a bill to the OHSC based on 90% of the OMA fee schedule for the estimated work. Individual claims were no longer recorded centrally. Periodically the OHSC would audit the hospitals' workload to ensure that the billing was a fair representation of the work being done. Within the global budget framework hospitals were permitted an increase in their budget to reflect the increased cost of providing more outpatient tests. This was acceptable to hospitals through the early part of the 1970s when increases were possible, but became an issue with the anti-inflation constraints of the late 1970s. The bulk billing for laboratory services ended in 1980, after which all laboratory services were paid for out of the hospital's global budget.

The shift to bulk billing was accompanied by a move from medical insurance paying for hospital-based community laboratory services to the hospital budget providing the funding. The first draft of the regulations that allowed community laboratories to directly bill OHIP for services contained a clause that allowed hospitals to bulk bill OHIP for persons other than hospital inpatients. In this draft there is a comment in the margin from the government lawyer saying, "likely can be deleted. Ample authority in the Ministry of Health Act."³²⁹ This suggests that allowing hospitals to receive payment from OHIP for outpatient laboratory services was considered and discarded.

It is quite clear that even though the regulations, as originally worded, technically allowed hospitals to bill OHIP for these services on a fee-for-service basis that was not the intention of the government. The specific permission allowing hospitals to bill OHIP was deleted from the final legislation. The Ministry made all sorts of exceptions to allow

³²⁹ Memo from David Tickell, Senior Counsel to G.E. Fetherston, General Manger, Ontario Health Insurance Plan, December 13, 1972.

payment to hospitals for outpatient services, but the exceptions proved the rule. There was no general right to bill. Certainly no hospitals challenged this. It was expected that these costs would be borne under their global budgets, and as long as the global budgets continued to rise, there was not a lot of pressure to challenge this structure.

There was no formal regulation introduced explicitly barring hospitals from billing OHIP for diagnostic services until 1980 when the regulations under the *Health Insurance Act* were amended to add the words “other than a hospital laboratory,” so that they read:

22(1) a laboratory service is an insured service where the laboratory service is a test within the meaning of section 5 of the Laboratory and Specimen Collection Center Licensing Act and: (a) the test is specifically authorized on Form 2 by a physician... (b) the test is performed in a laboratory, other than a hospital laboratory, licensed under the Laboratory and Specimen Collection Center Licensing Act.³³⁰

The moves to limit hospital access to OHIP money took place within the context of the government trying to constrain hospitals' funding. In 1972, in a consideration of options for paying for laboratory services, one of the stated disadvantages of establishing a system that might provide greater use of hospital laboratories and more revenue to hospitals was that it would establish, “a mechanism to provide public hospitals with additional funds at a time when the government is committed to introducing constraints on hospital expenditures.”³³¹

Bulk billing and the move to OHSC payment achieved three government goals, all related to cost savings. “Considerable” savings were made in clerical costs due to the reduced paperwork with bulk billing.³³² It stopped pathologists from directly billing OHSIP for their outpatient work. Pathologists in hospitals were now only paid through their contractual agreement with the hospital. Finally, moving outpatient laboratory work to the institutional budget under the OHSC meant it was cost-shared with the federal

³³⁰ Regulation 552, 1990 revised statutes, October 1, 1993, Toronto: Queen's Printer. An insured service in this context is one that is a medical service billable on a fee-for-service basis under the *Medicare Act*.

³³¹ “Report of the Task Force on Cost Controls for Medical Laboratories,” October 1972, Ministry of Health, p. 5.

³³² “Bulk Billings for Hospital Out-Patient Radiology,” a discussion document attached to a memo from W. B. Nichols, Assistant Deputy Minister, Finance and Information Services, to S. Birkenmayer, Policy Secretariat, February 5, 1974.

government under the *HIDSA*, which was more lucrative for the province than the cost-sharing under the *Medicare Act*, which covered fee-for-service medical costs.³³³

The government's move to bulk billing for laboratory services was not greeted warmly by the OMA. On behalf of pathologists, the General Secretary of the Ontario Medical Association sent a terse letter to the Minister of Health, Tom Wells, objecting to the government's "unilateral action" in deciding to transfer the benefit of outpatient laboratory services from OHSIP to the OHSC. He stated his Association's position, "that all benefits which had a medical-professional service should be administered under a medical services insurance plan rather than a hospital one."³³⁴ Despite the OMA's objections many pathologists felt the OMA did not do enough to stop the downgrading of their services and 25 years later still referred to the OMA's "sell-out" of pathologists in 1971.³³⁵

In 1975 the Ministry entered into negotiations with the OMA to switch all outpatient services with a professional and technical component, most notably radiology, over to the hospital budget, as they had done with laboratory services in 1971. These changes were needed to bring practices in line with regulations under the provincial *Health Insurance Act*³³⁶ and federal-provincial agreements under *HIDSA* that forbade any direct payment by hospital patients for insured services. There was also concern that, "some billings on a claims basis are being received from physicians for services they have rendered to in-patients."³³⁷ In other words it was alleged that some physicians were being paid twice for the same service. There was also an institutional double-billing cost issue. Hospitals were funded for their diagnostic services within their global budgets. By billing OHIP for the technical component of outpatient services it was argued that

³³³ Minutes of the MOH Policy Committee, March 4, 1975.

³³⁴ Letter from Glen Sawyer, General Secretary, OMA, to T.L. Wells, Minister of Health, January 20, 1971. A few years later Sawyer became the President of the Ontario Association of Medical Laboratories, the commercial industry organization.

³³⁵ Roche Robertson, "Laboratory Finance Reform: Perspectives as of March 18, 1995." This is a personal evaluation by a physician who became Vice-chair of the OMA section on Laboratory Medicine in 1996 and was circulated as a discussion document in the OMA Laboratory Medicine Section.

³³⁶ Regulation 552, section 34, 1990 revised statutes, October 1, 1993, Toronto: Queen's Printer.

³³⁷ "Payment for Diagnostic and Therapeutic Services Provided in Hospital," memo from G. E. Fetherston, General Manager – Health Insurance, to Frank Millar, Minister of Health.

they were receiving money from OHIP for costs that had already been paid.³³⁸ Finally, the Ministry wanted to establish a consistent method of reimbursement for outpatient services by moving to the laboratory service model.

Radiologists and the OMA objected to these changes. They felt that they would increase the hospital's control over professional practice. It would further erode, "the principle that doctors may opt out and set their own fees under certain terms and conditions."³³⁹ Even though most radiologists did not extra-bill for outpatient services, they wanted to maintain the right to do so. It also challenged the principle that these were medical procedures and the doctor performing them should bill directly for them. It again raised questions of professional control and remuneration. In the end the Ministry's goal to stop hospitals from billing OHIP for outpatient radiology services³⁴⁰ was partially adopted. Radiologists continued to bill OHIP directly for the professional services they provided in hospitals and the technical part of the service fell under the hospitals' global budget. This arrangement continues today.

The tighter restrictions on laboratory services can be explained by numerous factors. Pathologists had traditionally had a more diffuse set of contractual arrangements with hospitals than radiologists, who worked primarily on a fee-for-service basis. In 1971 a survey for OHSC found that 92 pathologists were on fee-for-service, 51 were salaried and another 43 worked under a variety of other funding models.³⁴¹ Laboratory services were becoming increasingly technical and less professional, except for certain services, such as surgical pathology, which were largely provided in hospitals. These facts, coupled with the sometimes questioned status of pathologists as medical professionals, probably muted the outcry from pathologists and the support they received from the OMA.

³³⁸ "Program Committee Bulk Billing for Hospital Out-patient Radiology," memo from W.B. Nichols., Assistant Deputy Minister, Finance and Information Services, to S. Birkenmayer, Policy Secretariat. This concern had been raised a year earlier in an Ontario Council of Health report on OHIP.

³³⁹ OMA Executive Board Minutes: Meeting with Minister, November 18, 1975, Board Reference #734-4 (11.75), p. 2.

³⁴⁰ "Diagnostic and Therapeutic Procedures in Hospital: Meeting August 8, 1975," minutes of a meeting in the Minister's office of senior MOH officials.

³⁴¹ "Proposal on Separate Global Budgets for Public Hospital Laboratories," memo from R.E. Krock, Director Hospital Operating Standards, to E.P. McGavin, Acting Executive Director, Treatment and Rehabilitation Finance, October 6, 1972.

The routine nature of the bulk of laboratory work also lent itself to standardization and centralization, both of which helped facilitate a for-profit laboratory sector. Laboratory work also had the unique advantage that the equipment required to take most samples was simple and samples could easily be transported and processed away from the site where they were collected. The actual processing could be centralized and the specimen collection dispersed. This tendency was reinforced by automation that required larger volumes of samples to be cost-efficient, and the development of better road and air transportation. Similarly, the advent of telex meant that results could be sent back to doctors in a timely manner. Radiology diagnostic facilities, on the other hand, had to be widely dispersed to be accessible to patients.³⁴² X-ray machines are large and require special site preparation, and until recently it was more difficult to move the x-rays around. The nature of laboratory work made it easier for large industrial laboratory corporations to develop. While concerns were expressed about unnecessary radiology services,³⁴³ the volume of laboratory services was rising twice as fast as that of radiological examinations and was a greater concern.³⁴⁴ All of these factors made laboratory services more of a target for a government concerned about controlling costs.

Allowing most hospital outpatient services other than laboratories to bill OHIP, besides irritating pathologists, had a significant effect on the delivery of outpatient services. If hospitals took on more outpatient laboratory work it was funded out of the global budget, effectively decreasing funding to the hospital's inpatient services, but if they increased their radiological services to outpatients their funding was increased. Therefore, hospitals had a financial incentive to decrease laboratory work and increase outpatient radiological services, which is what happened. This differentiation also

³⁴² With the advances in optical technology for transmitting images this technical difference with laboratories is lessening. Part of the debate around commercializing MRI services in Ontario was a concern about the ability of the commercial companies to transmit the images anywhere in the world for reading. This would undermine local specialists and remove patient protections in case of a misread. Similarly the move to digital services in most hospital radiology services has meant that images can be sent to specialists for reading, which could lead to a decrease in the quality of radiologists' workplace experience and an opening for more commercial radiology services.

³⁴³ Letter from Iain A. D. Todd, District Director of the OMA, to Richard Potter, Minister of Health, April 25, 1972.

³⁴⁴ Between 1966 and 1968 the number of outpatient radiological examinations increased 31.6% while laboratory services increased 81.4%. "1968 Annual Report," Ontario Hospital Services Commission, p. 21. Between 1920 and 1975 outpatient radiological examinations increased 45% and laboratory services 94%. "Hospital Statistics 1975," Ministry Information System Division, MOH, Table B: Trends in Public Hospital Care 1970-1975.

affected the relative remuneration of radiologists and pathologists. Radiologists are treated as other doctors and rise and fall on OMA–Ministry negotiations. The more work they do the more money they make. Pathologists are left fighting against other hospital services for contract increases within ever tightening global budgets.

Restricting hospitals from billing OHIP for outpatient laboratory services, allowing commercial laboratories direct access to that fee-for-service money, the adoption of the LMS unit measurement system, and a separate database for community laboratory services all created significant bureaucratic barriers to hospital access to community laboratory services and enabled the growth of commercial laboratory corporations. This created a positive feedback loop: the larger the private sector the more powerful the lobby for using commercial laboratories at the expense of the public system.

Over Utilization: The Trouble is Doctors

In the 1970s the government tried to control the problem of over utilization of community laboratory services, performing more tests than are medically necessary, by controlling the number of laboratories and specimen collection centres; changing the test order form; better monitoring; quality control programs; and limiting the doctors' financial interest in laboratories they refer work to. Most of these approaches were premised on controlling the ordering habits of doctors and limiting patient access to laboratories. Treating physicians as the source of the over utilization problem had the support of MDS. In discussing the information that the Ministry needed to monitor the laboratory system, the president of MDS Health Group argued that, "to me the important thing is the ordering pattern of the physicians in the community where the patient originates."³⁴⁵ The bureaucracy shared the opinion that, "the physician [needs to be] recognized as the agent with greatest potential for influencing cost trends."³⁴⁶ The Task Force on Laboratory Services argued that, "the high levels of laboratory utilization are

³⁴⁵ Letter from Wilfred G. Lewitt, President, MDS Health Group Limited, to S.W. Martin, Deputy Minister, Department of Health, July 20, 1973.

³⁴⁶ "Report of the Laboratory Study Committee," attached to a memo from P.J. Plant, Coordinator Diagnostic Services, to G.J. Chatfield Assistant Deputy Minister, Institutional Health Services, September 15, 1976. This was an ad hoc internal ministry committee whose membership included senior officials.

primarily associated with the market demand by physicians in private practice.³⁴⁷ The fact that the number of laboratory tests in the community did not decrease until the government funding to the laboratory corporations was capped in 1993 indicates that the primary source of the problem was not doctors.

This doctor blaming is the corollary of biomedicine's focus on individual physicians as the arbiters of good health care and the system's gatekeepers. When something goes wrong it has to be a problem with physicians. It creates a discourse that diminishes or excludes other factors identified as increasing the volume of laboratory services – the usefulness of new tests,^{348 349} the profit motive of the commercial laboratories,^{350 351} fee-for-service payment mechanisms and the funding of hospitals³⁵² – from being properly addressed. Avoiding these concerns makes it less likely that solutions will be found that would negatively impact the for-profit laboratories.

The Acceptance of the Private Sector

Compared to the discussion in the previous chapter on why there was support for non-profit alternatives, it is easier to understand why policy decisions would err on the

³⁴⁷ Ontario Council of Health, "Report of the Task Force on Laboratory Services," 1982, p. 149.

³⁴⁸ Ontario Council of Health, "Report of the Task Force on Laboratory Services," 1982, p. 280: "The introduction of high technology has contributed to the observed increase in the volume of testing."

³⁴⁹ Ontario Council of Health, "Report of the Task Force on Laboratory Services," 1982, p. 290: "It is safe to conclude that a portion of the existing level of laboratory testing is generated by technology, first to justify the purchase of automated equipment and then to fill the capacity of this equipment and make it more cost effective or profitable. Industrialization of laboratory service has begun. Volume output is an object in itself."

³⁵⁰ Ontario Council of Health, "Report of the Task Force on Laboratory Services," 1982, p. 289: "The legitimate objective of commercial enterprise is to obtain maximum profits and an important method for accomplishing this purpose is to increase sales or volume output."

³⁵¹ Douglas Waugh, "Ontario Council of Health Report of the Task Force on Laboratory Services: Reviewers' Comments," attached to a letter from Douglas Waugh, the Association of Canadian Medical Colleges, to R. Brian Holmes, Chairman, Ontario Council of Health. In his comments on the Task Force's report Dr. Waugh questions whether the recommendations to restrict the growth of private laboratories are "sufficiently strong": "if the proposition is accepted (as it is by the reviewer) that private laboratories are indeed 'volume-driven', then any proposal that would remove, or inhibit the volume incentive from their operation, could be expected to generate vigorous resistance by the laboratory operators and lead to factional squabbles among laboratory professionals."

³⁵² Ontario Council of Health, Report of the Task Force on Laboratory Services, 1982, p. 303: "Both components of laboratory services [private and hospital] are volume driven for different economic reasons. The end result is a sustained need for volume growth, with the balance in favour of the private laboratory because of a fee-for-service payment approach which ensures financial support irrespective of the level of growth."

side of market-based solutions. Ontario had a long-standing Conservative government that was committed to capitalism and the free market. The policy debate was infused with what Bryden called the “ethos of the market,” that competition in the free market would provide the best outcomes,³⁵³ and there is little doubt that this accurately reflected the dominant ideology for much of the population.

In fact this is how the acceptance of the for-profit laboratories was often framed even though there was widespread concern about their negative impact on laboratory services. At best, there was a role for both the public and private sector in the delivery of health care and the balance would be established in open competition or through some form of negotiated regionalization. At worst, the private laboratory industry was not defended as being more cost-effective, or particularly useful but accepted as the “black sheep” of the family, involved in illegal activities, soaking up family resources, and working against other members of the family, but a fact of life that had to be lived with and, if possible, controlled.

The 1965 *Medicare Act* introduced by the province to pre-empt the imposition of a federal universal medical insurance plan, was framed as the introduction of competition between public, non-profit insurance and private companies. Premier Robarts was reported as saying, “if the [private] insurance companies can compete with the rates of non-profit plans ... there is no reason why the consumer should not be allowed to use their plans.”³⁵⁴

The 1970 report of the Sub-committee on Laboratory Systems of the Ontario Council of Health provided the basic structure that would underlie most proposals for regional laboratory services: “[The] organizational structure should facilitate the functional integration of all laboratories dealing with health care delivery (hospital, public health and private), should increase the efficiency of existing laboratory services, and provide a framework for the orderly expansion of these services.”³⁵⁵

³⁵³ Kenneth Bryden, *Old Age Pensions and Policy-Making in Canada*, Montreal: McGill-Queen’s University Press, 1974.

³⁵⁴ “Legislature Gives Third Reading to Ontario’s Medical Care Bill,” *Ontario Medical Review*, July 1965, (32)529.

³⁵⁵ “Report of the Ontario Council of Health on Health Care Delivery Systems: Laboratory systems – supplement no. 7,” Ontario Department of Health, 1970.

Even those who had been attacked by the private sector and were providing a non-profit option did not call for the abolition of the commercial providers. Mr. Walker, Coordinator of Hamilton Health Sciences Laboratory Program, in his presentation to the OHC Task Force on Laboratory Services said they did, “not wish to interfere with private laboratories or see them close down, it would like to compete with them,” he would like to, “avoid appearing to advocate the extinction of private laboratories, but rather advocate to test them in the market place.”³⁵⁶

The 1982 Task Force on Laboratory Services, after raising concerns about the private sector, drew, “the only acceptable conclusion that clinical laboratories should provide a medical service and not a product.” Noting further, “processes that force the laboratory into a profit center or production-industry mould will remove them further from the patient care process.”³⁵⁷ The report then said that the structure of laboratory services is “sufficiently appropriate” and that, “the current major providers of laboratory services should be recognized as having a legitimate and valuable role in the provision of laboratory services.”³⁵⁸ Their solution to the medical services vs. product problem was to encourage increased integration of the existing providers with equitable funding. Medical laboratory services were to be controlled by physicians who are specialists in laboratory medicine³⁵⁹ which was the structure before the emergence of the large corporate chains.

The belief that putting doctors in control was a viable and beneficial solution was common. In a letter from Dennis Timbrell, Minister of Health, explaining the conflict of interest changes brought into regulation in 1977, a distinction was drawn between physicians performing tests in the course of direct patient treatment and those, “undertaken for personal reward or gain by commercially operated laboratories. This distinction is important when considered in the light of the need for continuous monitoring of the accuracy and proficiency with which various laboratory tests are

³⁵⁶ “Meeting with Representatives of the Hamilton Health Sciences Laboratory Program,” report on the meeting of the Task Force on Laboratory Services, Ontario Council of Health, November 30, 1981, items 81-84.

³⁵⁷ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 291.

³⁵⁸ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 292.

³⁵⁹ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 291.

conducted in the commercial sector, and for controlling the costs to taxpayers.”³⁶⁰ The belief that doctors would be able to enforce quality standards in a selfless manner was deeply rooted in the ethics of biomedicine. While it is likely that most doctors act in an ethical manner, clearly some do not, and the record of self policing on conflict of interest is at best, suspect. There is also a denial of the fundamental reality that for-profit corporations had to first and foremost be concerned about making a profit, and, more to the point, an expanding profit regardless of who is in control.

Senior managers in the Ministry of Health recognized this conflict in 1979:

In cases where the owner and the pathologist (laboratory director) are different people the latter must elicit inputs from his employer that subordinate the latter's business interest and objectives, the pathologist must be prepared to place his professional reputation as well as his tenure of employment in jeopardy ...

Due to the corporate nature of ownership presently existing in the private sector, it is extremely difficult to place ultimate responsibility on the owner or to make the pathologist responsible in that he can always say he was carrying out the orders of the owners/owners.³⁶¹

Consolidation of the Laboratory Industry

By the mid-1970s the effects of government policies on the structure of the industry were being noted in the Ministry. A 1977 confidential report, “Monopoly Potential in Private Laboratories in Ontario,” outlines the increasing concentration of the private laboratory industry in Ontario. Forty-seven per cent of the laboratories were controlled by the top ten chains in 1976, an increase from 42% in 1975.³⁶² The report cites the restriction of physician ownership and the willingness of chains to take advantage of their size to put small operators out of business. The larger chains utilize “superior buying powers” to offer better service, use more up-to-date equipment, hire

³⁶⁰ “Re: Physician-Owned Laboratories,” attached to a memo from T.C. Grice, Administrative Officer, MOH, to P.J. Plant, Acting Director Inspection Branch, October 19, 1977.

³⁶¹ G. Gold, P.J. Plant, and H.I. MacKillop, “Review of the Salient Features of the Ontario Laboratory Industry and Policy Options,” Ministry of Health internal document, July 20, 1979, pp. 6-7.

³⁶² P.J. Plant, “Monopoly Potential in Private Laboratories in Ontario,” September 28, 1977, p. 1. Confidential report in the Ministry of Health.

better staff and, “it has been reported that referring physicians have been invited to utilize the services of a particular facility in exchange for free financial consulting.”³⁶³

By 1981 50% of the private laboratories were in “chains,”³⁶⁴ and these chains accounted for 59% of the tests performed by private laboratories.³⁶⁵ “Certainly within the private sector there has been a decline in physician owned laboratories and an increase in lay and corporate ownership to the point where ‘chains’ of laboratories together with those under commercial ownership account for 87% of the volume of the private sector.”³⁶⁶

In 1983 the top five chains received 51% of all community laboratory payments and the largest, MDS, over 26%.³⁶⁷ The commercial laboratories were now providing 38% (1982) of total laboratory services,³⁶⁸ up from 8% in 1967.³⁶⁹ The growth of the private laboratory corporations, particularly the larger chains, spawned the Ontario Association of Medical Laboratories (OAML), an organization created to represent their corporate interests. The organization was formed in 1976 and structured so that the larger the company the more control it would have over the organization. Voting was originally allocated on the percentage of market share,³⁷⁰ currently the board consists of two representatives from each of the three large laboratories and one for all the small labs.³⁷¹ By 1981 the OAML claimed that it represented, “72% of the private laboratories.”³⁷² In 2007 ten of the eleven private laboratories were members of the OAML.³⁷³

³⁶³ P.J. Plant, “Monopoly Potential in Private Laboratories in Ontario,” p. 3.

³⁶⁴ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 105

³⁶⁵ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 106.

³⁶⁶ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 290.

³⁶⁷ “Minster’s Briefing Book: Laboratory Services Branch,” May 21, 1985, p. 22.

³⁶⁸ “Report of the Task Force on Laboratory Services,” Ontario Council of Health, 1982.

³⁶⁹ Chemical Engineering Research Consultants Limited, *Private Clinical Laboratories in Ontario: A study for the Committee on the Healing Arts*.

³⁷⁰ Interview 12.

³⁷¹ Interview 14.

³⁷² “OAML Brief,” report on the Meeting of the Task Force on Laboratory Services, Ontario Council of Health, May 25, 1981, item 81-34:.

³⁷³ Membership in the organization is voluntary even though the contracts it negotiates apply to all community laboratory providers.

Consolidation of Ontario's Commercial Laboratory Industry

Year	# FP Laboratory Companies	% of Provincial Lab Work Going to FP Labs	# of Labs	% Incorporated
1967 ³⁷⁴	83	8	112	33
1974 ³⁷⁵			285	
1993 ³⁷⁶	62	45	159	
2004	11	50	49	100

Interconnections – Profession, Industry, Hospitals and Government

Along with the general acceptance of private enterprise, the laboratory corporations benefited because of their direct influence on the government. The large chains employed many laboratory medicine specialists. "MDS enjoys a considerable degree of influence with the medical profession ... which translates into having an indirect, but nonetheless effective, voice relating to the annual revisions in the LMS unit assignments."³⁷⁷ The report on monopoly potential of private laboratories also notes, "in terms of the industry's interface with the Ministry, it is significant that at round table conferences on licensing issues, reimbursement systems and rationalization, the industry's representatives are almost exclusively from the top ten chain operations."³⁷⁸ The chains not only control the OAML, larger firms also have enough staff to allow them to free up people for these political duties, further ensuring that decisions will be made in favour of the larger private operators.

³⁷⁴ Chemical Engineering Research Consultants Limited. *Private Clinical Laboratories in Ontario*.

³⁷⁵ "Laboratory Services Review Discussion paper #2: System," June 1993, p. 23.

³⁷⁶ "Laboratory Services Review Discussion paper #2: System," June 1993, p. 23.

³⁷⁷ P.J. Plant, "Monopoly Potential in Private Laboratories in Ontario," September 28, 1977.

³⁷⁸ P.J. Plant, "Monopoly Potential in Private Laboratories in Ontario," p.4.

The pressure from the commercial laboratory sector for formal recognition grew over this period. No industry representatives were involved in the production of the Ontario Council of Health 1970 report on the laboratory sector or the 1972 Task Force on Cost Control for Medical Laboratories and this met with no formal complaints. The 1982 Council Task Force also excluded commercial operators though this time the OAML objected: “We [the OAML] are admittedly a ‘special interest’ group – as are the other organizations which were invited to nominate personnel for this committee.”³⁷⁹ The OAML also argued that they should be given better consideration because “the economics have discouraged hospitals from expansion of these laboratory services the private sector has provided much of the increased service associated with these outpatient services, thereby inevitably producing a significant growth in the private sector.”³⁸⁰

The OAML lobbied for and was granted, “an equal voice with other sectors of the industry” on the Laboratory Advisory Committees, committees set up to advise District Health Councils on laboratory policy.³⁸¹ The Provincial Laboratory Advisory Committee, formed in 1977, had a representative from the OAML.³⁸² The OAML increased its presence in negotiations with the government on laboratory issues alongside the OMA, but it was not until the NDP was in government, 1990-95, that they gained a fully independent voice in negotiations with the province.

The for-profit sectors’ formal political presence was probably less important than its informal influence thorough shared personnel with the medical profession, hospitals and the government. In 1977, 34 % of the total number of laboratories had physician owners.³⁸³ But this understates the extent of interconnections between physicians, industry, hospitals and the government. A pathologist could be an owner of a commercial lab and work in a hospital, or direct a hospital laboratory, work for a

³⁷⁹ “Response to the Ontario Council of Health Task Force on Laboratory Services,” Ontario Association of Medical Laboratories, December 15, 1983, p. 311.

³⁸⁰ “Response to the Ontario Council of Health Task Force on Laboratory Services,” Ontario Association of Medical Laboratories, December 15, 1983, p. 11.

³⁸¹ “Briefing Material for Minster’s Meeting with Ontario Association of Medical Laboratories, September 19, 1977,” memo from Paul J. Plant, Acting Director, Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977.

³⁸² “Briefing Material for Minster’s Meeting with Ontario Association of Medical Laboratories, September 19, 1977,” memo from Paul J. Plant, Acting Director, Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977.

³⁸³ “Inspection Branch,” October 21, 1977, annual report item number six under Issues and Problems: “Ownership Regulation – Conflict of Interest,” p. 18.

commercial lab and be active in the OMA. They could be any of these and then work for the government. The Task Force on Laboratory Services found that, “of the 171 physicians in private laboratories, at least 156 also hold single or multiple hospital appointments.”³⁸⁴ The first executive director of the OAML, Dr. Sawyer, was past president of the OMA. The interconnections were very fluid and they could work against hospital laboratories and in favour of the commercial sector.

Dr. F. O’Brian, Director of Laboratory Services at Mackellar General Hospital in Thunder Bay, operated a private laboratory in the area servicing some 55 physicians. In Dr. O’Brian’s presentation to the Ontario Council on Health Sub-committee he talked about increasing cooperation between hospitals, but there was no mention of hospitals increasing their outpatient capacities. This was unusual in that many regional hospital initiatives at that time were working on ways to expand their community services. This conflict problem was recognized by the Provincial Auditor in 1977 who proposed a regulation be introduced, “prohibiting hospital staff doctors, who own laboratories, from in any manner influencing the allocation of any laboratory work to the said laboratory.” The response from the Ministry was the general amendment to the Public Health Act that covered referring work to labs that were owned by physicians. But the actual concern of the auditor about staff doctors in hospitals affecting public hospital policy was not acted on, or even recognized, in the official Ministry response.

Impact of the Commercial Laboratories

Even when the for-profit sector was small it used its influence to undercut the provisions of public, non-profit community laboratory services and worked for policies that prevented competition for community work. Their effectiveness increased with the establishment of the licensing program, which brought the industry into direct contact with the Ministry on a regular basis. It also increased as the industry grew stronger, spearheaded by their sectoral lobby group.

³⁸⁴ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 112.

Starting in 1969 paid consultants to for-profit laboratories tried to stop HICL from advancing and opposition from the OMA pathology section caused the OHSC to delay HICL's expansion into a new facilities.³⁸⁵ A briefing note for the Minister of Health in 1977 cites the main concerns that the OAML has brought to the Ministry and most of them relate to restricting the ability of hospitals to work in the community sector. It wanted hospitals to have the same reporting requirements as its members did, fair cost comparisons between the two sectors, specifically that all the extra costs of running a community collection system be considered, and that regulations and structures treat them fairly.³⁸⁶

The OAML's demand for hard facts and definitive answers was used to delay action that looked like it would expand public hospitals community laboratory services. The lack of hard data was cited many times as a reason for more study, less action. The need for more studies on funding was in part motivated by the need to have enough information that, "the Ministry will be in a position to advocate and 'sell' a particular 'uniform' funding mechanism to the agencies [private providers] involved."³⁸⁷ The existence of the for-profit industry created a situation where it was felt that incontrovertible data were needed to make a decision against the industry and the industry actively worked against the obtaining of those data.

In July 1975 the public accounts committee recommended that, "an independent study be undertaken analyzing the need for cost, location, operation and regulation of private laboratories."³⁸⁸ In response to this request the Deputy Minister of Health questioned the feasibility of such a study and identified critical questions that, "need to be answered before such a study is commissioned."³⁸⁹ These questions included: What will be measured? Are the costs in fact measurable? Are costs comparable between

³⁸⁵ Theodore Freedman, *A Review of the Experience of the In Common Laboratory*.

³⁸⁶ "Briefing Material for Minister's Meeting with Ontario Association of Medical Laboratories," September 19, 1977, a memo from Paul J. Plant, Acting Director, Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977.

³⁸⁷ "Briefing Material for Minister's Meeting with Ontario Association of Medical Laboratories," September 19, 1977, a memo from Paul J. Plant, Acting Director, Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977, p. 13

³⁸⁸ "Report of the Standing Committee on Public Accounts, 1976," memo from W. Alan Blackley, Deputy Minister of Health, to F.N.Scott, Provincial Auditor, April 27, 1977.

³⁸⁹ "Report of the Standing Committee on Public Accounts, 1976," memo from W. Alan Blackley, Deputy Minister of Health, to F.N.Scott, Provincial Auditor, April 27, 1977.

sectors? And what will these figures be used for? In the end no study was undertaken. Suggestions about how to compile more hard data included the idea of setting up a Royal Commission.³⁹⁰ This also was not done.

A senior official in the Laboratory Licensing Branch, and one who supported greater use of hospitals, commented on a funding proposal to allow the HHSLP to do more outpatient work that, “one can be relatively certain, if these questions [about the quality of data] are not addressed now, the Ontario Association of Medical Laboratories, for their own partisan reasons and in self defence – require that the Ministry both be perceived as an impartial and objective evaluator of the results of this pilot project.” Further, the report argued that if the pilot was to have an effect on hospital-private sector realignments it would depend, “on the degree of objectivity with which this pilot study and its terms of reference are set out.”³⁹¹

Similarly, in 1975 the Ministry undertook a “Laboratory Services Review” to determine the unused capacity in hospitals that could be available for community laboratory work.³⁹² The survey was stopped after results were in from 84 hospitals (134 had yet to report). No record of an interim report on the results is available. Stopping the survey was attributed to a conflict with some of the Regional Laboratory Committees over who should be responsible for collecting the data. These committees usually contained representatives of the for-profit laboratories.³⁹³

The private laboratory sector also actively tried to take business away from hospitals. Dr. Warburton, OMA representative to the Provincial Laboratory Advisory Committee (PLAC), commented that the owner of the private laboratory in his region, “is seeking interviews with all local physicians to inform them of his desire to serve them further.” Part of his pitch was that, “surely it will help [the hospital] if we take our work to a private laboratory which can receive appropriate payments for the work we give

³⁹⁰ “Suggestions for Cost Reduction in the Department of Clinical Laboratories,” memo from A. D. Karapita, Consultant, Hospital Administration, to R.E. Krock, Director, Hospital Operating Standards, OHSC, November 6, 1972.

³⁹¹ “Hamilton Laboratory Funding Proposal,” memo from Paul Plant, Chief, Laboratory and Specimen Collection Inspection Service, to C.L. Brubacher, Director, Inspection Branch, April 5, 1978.

³⁹² “Re: Laboratory Services Review,” memo from D. W. Corder, Director Inspection Branch, to M. Orris, Area Planning Coordinator, Central-West Region, June 9, 1977.

³⁹³ *Inspection Branch: Annual Report*, October 21, 1977.

them.”³⁹⁴ Warburton accused the government of being prejudiced against the hospitals and argued that the Ministry policies have a real risk of negative side effects for the hospitals and increased cost to the Ministry. A Ministry investigation of the monopoly potential in the laboratory sector further identifies, “aggressive marketing techniques employed by some of the less ethical elements with the industry, but nothing much can be said on that point except that rumours of ‘kick-back’ payments still persist.”³⁹⁵

Geographical skimming is evident in the heavy concentration of private laboratories in the Toronto and the other more heavily urban areas. MDS used a consulting service to northern hospitals to direct tests to its Sudbury regional laboratory.³⁹⁶ This concentration in the locations easiest to serve left the onus on the public system to meet the needs of rural communities at the same time as the for-profit laboratories made the provision of these services harder. “Even though [smaller] hospitals represent only seven per cent of hospital testing, they are the only sector of the laboratory production system providing a comprehensive network of laboratories throughout the province.”³⁹⁷ Yet, the 1982 Task Force on Laboratory Services was, “concerned that referrals [primarily by private laboratories] of routine testing outside the county reduces the workload in small laboratories and increases it in large laboratories. It is detrimental to the maintenance of a sufficient volume of testing by the smaller laboratories to support appropriate laboratory manpower and methodology (e.g. automation).”³⁹⁸ Focusing on the easier tests also left the burden of research and provision of services to patients with special needs up to the public system.

The private laboratories also played a role in undercutting hospitals in policy discussions. When Mr. R.C. Walker, Chairman of the Coordinating Committee of the HHSLP, made his presentation to the OHC Task Force on Laboratory Services he wanted to start by clearing up “mild misinformation” that had been spread by the private

³⁹⁴ “Presentation to Provincial Laboratory Advisory Committee, Thursday, June 29, 1978,” E. G. Warburton, appended to “Confidential draft: Policy paper on Alternative Funding Arrangements for Out-Patient laboratory Work Carried out by hospital laboratories,” August 11, 1978, Ontario Ministry of Health.

³⁹⁵ P.J. Plant, “Monopoly Potential in Private Laboratories in Ontario,” p. 3.

³⁹⁶ P.J. Plant, “Monopoly Potential in Private Laboratories in Ontario,” p. 2.

³⁹⁷ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 104.

³⁹⁸ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 144.

laboratories about the Hamilton program. He argued the information was, “inaccurate and outdated.”³⁹⁹

The 1985 internal Ministry administrative briefing book contained information on the OAML’s recent political positions. The organization was concerned that Bill 64, which included laboratories, gave the Ministry the power to act expeditiously to protect health and safety and ensure honest operations of facilities; that hospitals and HICL were being permitted to compete against the private sector; that HICL was providing tests that should be covered under the hospitals’ global budgets; that the “public interest” criterion was unfairly favouring hospitals because of the significant “subjective element”; and that there were reduced payments for large numbers of tests from one doctor.⁴⁰⁰ Most of these concerns were aimed at reducing the role of hospitals and HICL in community laboratory services.

As early as 1967 it was recognized that the shortage of trained laboratory workers and pathologists meant the growth of private laboratories was occurring at the expense of hospital laboratories.⁴⁰¹ The chronic shortage of laboratory workers at all levels of skill is an ongoing problem⁴⁰² and exacerbated by the existence of two medical laboratory systems.

Summary

The final report of the 1982 Task Force on Laboratory Services begins by reviewing the recommendations from the Ontario Council on Health 1970 study. Its overwhelming finding is that the major recommendations on integration and funding,

³⁹⁹ “Meeting with Representatives of the Hamilton Health Sciences Laboratory Program,” report on the meeting of the Task Force on Laboratory Services, Ontario Council of Health, November 30, 1981, items 81-84.

⁴⁰⁰ “Ontario Association of Medical Laboratories (OAML),” Assistant Deputy Minister’s briefing book, 1985.

⁴⁰¹ L. Elkerton, “Subject: Study of Private Clinical Laboratories,” p. 2: “In view of the scarcity of trained laboratory workers the development of private laboratories is being pursued at the expense of hospital laboratories, the pathologist directors of which are dividing their own and their staff time to such an extent that quality of service must suffer, as evidenced in a sixty hour week.”

⁴⁰² In 2002 extra money was given to train medical laboratory technologists to address an acute shortage. “Ernie Eves government increase spaces for medical technology students,” news release, Ministry of Health, September 12, 2002. See also *Human Resources, Discussion Paper #3*, June 1993, Laboratory Services Review.

both which would have hindered the development of the commercial industry, had not been implemented, while other recommendations around licensing, which worked to the benefit of the large commercial actors, had been. The Task Force says the reason why, “very little of what was proposed by the Ontario Council of Health in 1970 has come into existence,” is that, “clear direction was not provided for implementation changes in laboratory practice in Ontario.”⁴⁰³ This is certainly part of the reason. Despite strong concern about the for-profit laboratories and a general belief that expanding hospital provision of community laboratory services would be beneficial, the government was unable to formulate or carry through a program to bring this about: a result significantly influenced by the existence of the private sector. Instead government policies, whether intended to address issues of quality, accessibility or cost, usually facilitated the expansion of the commercial sector over public alternatives.

Federal legislation forcing the province to adopt a universal medical insurance program increased access to health care, but also funded the for-profit laboratory service corporations. Government responsibility for the cost of hospital and medical care made cost control a central policy concern, both squeezing hospitals so that they were not able to afford to provide community services and limiting the number of community providers, encouraging consolidation. Licensing the sector, with attendant quality programs, measures to limit physician ownership of laboratories and regulations limiting expansion disproportionately increased the cost for smaller providers and encouraged consolidation. A separate workload measurement and funding system was developed for the community laboratories that increased their income, discouraged automation and further separated them from the hospital sector.

Each of these individual decisions, while often working towards a positive social policy goal such as improving quality, ending conflict of interest or improving accessibility, were implemented in a way that favoured the commercial sector. Similarly, the choice of problems addressed reflected a bias towards the market: by avoiding positive action on funding hospitals, reducing fee-for-service, integrating services, and evaluating the usefulness of new technologies, actions that would likely have harmed the for-profit sector, the sector was further supported.

⁴⁰³ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 25.

This is not to imply that the commercial sector had a free ride from the government. Obviously smaller operators were disadvantaged by the increasing regulation. The Cabinet overrode a Ministry recommendation to increase the LMS unit value in 1977, the government fought the larger laboratories on their plans to place specimen collection centres beside hospitals, a first attempt at capping payments to the sector was made, and the government supported or instigated various non-profit initiatives. Nonetheless the acceptance of the private sector in the delivery of health care, an ideology of medical practice that favoured individual practice, private business, fee-for-service and the use technical medicine, and the shift in societal power towards capital, resulted in a broad preference for solutions that aided private accumulation. This created a positive feedback loop. As the corporate share of the market grew and the size of the individual businesses increased, the sector became more effective at influencing policy to boost for-profit provision and limit the public sector.

By 1990 regulations had limited competition, increased the burden on smaller laboratories so they were under pressure to sell, created conflict of interest rules that drove some of the smaller laboratories out of business, and limited market entry, which increased the value of the smaller laboratories, making it very lucrative for them to sell. In one sense every one of the commercial laboratories was a winner. The big ones were allowed to grow and the small ones were paid well to get out. As well as increasing private control of community laboratory services government policies made it harder for hospitals to deliver these services leading to a shift in work from hospitals to the community and leaving the expanding community laboratory market open for the commercial laboratories.

While there were no policies forcing community work out of hospitals, the cumulative effect of government action can be seen as another dimension of “privatization by stealth,” a term coined by Hugh Armstrong.⁴⁰⁴ Incremental policies made it harder for hospitals and public health laboratories to provide community services, and some of their work shifted to for-profit corporations. But this does not account for the bulk of the growth of the commercial corporations. Rather it points to

⁴⁰⁴ Hugh Armstrong, “Social Cohesion and Privatization in Canadian Health Care,” *Canadian Journal of Law and Society*, Volume 16, no. 2, pp. 65-81.

another dimension of privatization by stealth not developed by Armstrong, that is the structuring of a new area of service provision so that it is delivered by the private sector rather than public facilities. This, as in the case of community medical laboratory services, is also the result of incremental policy decisions.

In summing up its discussion on funding the 1982 Task Force on Laboratory Services commented: "The public sector laboratories will be forced to refer increasing numbers of tests to private laboratories. Direct referral to the private sector will be encouraged as a backlog of tests develops and the speed of processing and reporting test results decreases in the public sector [as a result of funding cuts]. As long as the differences in the level and approach to funding is maintained, the trend of a gradual transfer of work and therefore of funds to the private sector will continue and accelerate."⁴⁰⁵ This accurately predicted the future, which is described in the next chapter.

⁴⁰⁵ *Report of the Task Force on Laboratory Services*, Ontario Council of Health, 1982, p. 140

Chapter Five: For-profit Dominance: 1990-2006

The successful creation of a world capital market, an integrated global economy, and its corresponding political movement, neo-liberalism, were defining characteristics of Canada's political economy from 1990 to 2006. Canada signed the North American Free Trade Agreement, the General Agreement on Trade in Services was completed and the World Trade Organization formed. Free trade pressures on national and provincial governments encouraged privatization, deregulation and private capital accumulation. The 1995 federal budget, which cut 14 billion dollars in government spending, epitomized this approach. A recession lasting from 1989 to 1992 coupled with high interest rates increased government attention on deficits and debts. The federal government, rather than taking new initiatives to improve public health care, reduced transfer payments to the provinces. As well as limiting financial support for provincial health care programs, the federal government was not enforcing the *Canada Health Act*, permitting the rapid expansion of for-profit clinics.

The surprise election of an Ontario NDP government under Premier Bob Rae in 1990 coincided with a rapid increase in the provincial deficit. The Rae government reduced services through the "Social Contract" as their solution to the fiscal crisis. The one billion dollars spent annually on medical laboratory services came under intense public scrutiny and the government reduced spending on the sector. The debate on the future of the industry was formalized in the 1992-1994 Laboratory Services Review (LSR). This study kicked off a decade of provincial programs to regionalize and integrate laboratory services.

Parallel to these processes were initiatives that worked against system-wide integration. The years 1990 to 2006 saw the for-profit laboratories consolidate control over the community laboratory sector, both in service delivery and in public policy. Hospital services, including their laboratory services, were forced into a separate restructuring program through the Hospital Services Restructuring Commission (HSRC). Political debate sharpened on the issue of public vs. for-profit delivery with the commercial sector gaining the upper hand. The shift of community laboratory work out

of hospitals to the for-profit labs continued and the commercial laboratories started to expand their work to include inpatient laboratory services. Attempts to integrate medical laboratory services proved difficult due to the existence of the for-profit laboratory corporations. Cost control in the community laboratory sector was achieved through funding caps, but at the expense of access.

Laboratory Services Review

Payments to the for-profit laboratories had risen 12% per year in the 1980s.⁴⁰⁶ Utilization in the community sector continued to rise faster than in hospitals and peaked in 1991-92 when the government imposed hard funding caps on industry payments.⁴⁰⁷ The total number of services provided by hospitals peaked in 1988-89 also under funding pressures. To save money hospital administrators cut laboratory services to community patients. Laboratory staff became concerned about job security and hospitals, particularly smaller hospitals, about maintaining the volume needed for adequate laboratory services. The shift to more outpatient clinics, day surgeries, and home care for the acutely ill created a greater demand for sharing of test results. According to one estimate, up to 70% of laboratory tests duplicated recent tests, and could be avoided if doctors were able to access all of a patient's test results.⁴⁰⁸

This background of pressures for integration and cost-cutting led to the Laboratory Services Review (LSR), started in 1992 and completed in 1994. LSR was established by Ontario's first New Democratic Party government in 1992. It was headed by Diana Schatz, a microbiologist who founded the Michener Institute. She worked with an external advisory committee composed of representatives from unions, for-profit corporations, hospitals, professional organizations and the HICL. The LSR continued a long tradition of studying the laboratory sector and being bedevilled by its divisions. The report starts off with a caveat that the approaches taken to utilization, cost and system

⁴⁰⁶ "Laboratory Services Review Discussion Paper #2: System," June 1993, p. 5.

⁴⁰⁷ Personal Communication, Horace St. Aubyn, Information Officer, Laboratories Branch, Ministry of Health and Long Term Care, August 26, 2005.

⁴⁰⁸ Interview 8. For a concise presentation of this argument see the report by Kenneth P. H Pritzker, "Diagnostic Laboratory Services: The Private Sector, the Hospital Sector with Particular Reference to Mount Sinai Hospital," November 3, 1994.

development were all limited by the difficulties involved in comparing the hospital and community sectors. Dr. Schatz commented that the LSR avoided taking clear positions on funding and point-of-care testing because of irreconcilable differences within the advisory committee.⁴⁰⁹ Even with these compromises the final report was not endorsed by the unions, HICL, or the Association of Allied Health Professionals.

The LSR commissioned background documents on the existing laboratory system, funding,⁴¹⁰ quality improvement,⁴¹¹ laboratory information systems,⁴¹² human resources⁴¹³ and a framework for a laboratory service delivery system.⁴¹⁴ Most of these briefs were by Canadian health-policy analysts but two, on information technology and system delivery, were written by CLS & GSA Consulting, an American firm involved in managing hospital laboratories and marketing laboratory services. One of their starting assumptions was that private laboratories succeed in the community market because they have readily available capital resources and could meet, “the management requirements inherent in complex logistical outreach environments and in automated, computerized analytical production lines.”⁴¹⁵ No rationale is provided for this assumption. They argue for increased regionalization of services within general guidelines that bring all the stakeholders together. They suggest that the hospital laboratory of the future will be commercialized and integrated with the private sector.

Public hearings in Toronto, Sudbury, London, Hamilton and Ottawa were held on the LSR’s draft report. Summaries of the presentations made at the hearings indicate that the main point of contention was hospitals vs. the for-profit sector as community providers and the related funding issues. Supporters of the for-profit laboratories tried to

⁴⁰⁹ Interview, Diana Schatz, February 21, 2007.

⁴¹⁰ John Marriot, “Review of Laboratory Services Funding: Background/Discussion Paper,” commissioned by and prepared for the Laboratory Services Review Project Ontario Ministry of Health, May 1993.

⁴¹¹ Jonathon Lomas and John Lavis, “A Quality Improvement Infrastructure for Laboratory Services in Ontario,” commissioned by and prepared for the Laboratory Services Review Project, Ontario Ministry of Health, November 1993.

⁴¹² GSA Consulting Group Inc., “The Establishment of a Centralized Data Base and Electronic Communication Links for Laboratory Data,” commissioned by and prepared for the Laboratory Services Review Project, Ontario Ministry of Health, July 22, 1993.

⁴¹³ “Laboratory Services Review Discussion Paper #3, Human Resources,” June 1993.

⁴¹⁴ CLS & GSA Consulting, A Consortium of Laboratory Planning Specialists, “A Conceptual Framework for a Province-wide Laboratory Services Delivery System,” commissioned by and prepared for the Laboratory Services Review Project, Ontario Ministry of Health, February 1994.

⁴¹⁵ CLS & GSA Consulting, A Consortium of Laboratory Planning Specialists, “A Conceptual Framework for a Province-wide Laboratory Services Delivery System,” p. 5.

frame the outcomes of the review and the government's response as a test of the NDP's commitment to maintaining a stable business environment. John Rogers, CEO of MDS Laboratories, in his brief to the Review, defended the virtues of profit in general and argued that the for-profit sector uses its earnings to benefit laboratories, increase access to health services and boost the Ontario economy.⁴¹⁶ Supporters of greater use of the public sector talked about how the funding arrangements harmed hospitals, kept costs high and defeated system goals such as maintaining or improving quality and efficient use of human resources. Most advocated a level playing field between the hospitals and the commercial laboratories and letting them compete for the community work.⁴¹⁷ A few argued for the more radical position of transferring all the work into the public sector.

While these tensions had been evident in the 1982 Ontario Council on Health Task Force on Laboratories, they were of secondary interest. The for-profit providers were not included in the Task Force and its conclusions assumed that the non-profit system would dominate and commercial labs would be peripheral players. The for-profit vs. non-profit debate became one of the defining issues in the LSR consultations. Despite this attention, or maybe because of the clear hostility and division between the sectors, the final report did not provide any specific recommendations on funding issues or who should provide community laboratory services. Instead the recommendations supported devolution of planning to districts, which would then work out solutions involving all of the partners, both for-profit and non-profit. Regional plans would build on the twenty-five hospital-based cooperative efforts that already existed. There were no community laboratory initiatives mentioned. While more explicitly accepting of the private sector these recommendations were very similar to those that came out of the 1970 and the 1982 Ontario Council on Health studies on the laboratory sector. The problems remained but the shift in power to capital in the global economy allowed more prominence for for-profit solutions.

The market-vs.-public-sector debate has even coloured accounts of the history of the Review. The for-profit industry association, the OAML, claims that the review was

⁴¹⁶ John A. Rogers, MDS Health Group Limited, "Laboratory Services Review: Hearings," a brief to the Laboratory Services Review, public meeting, January 21, 1994.

⁴¹⁷ "Hospital Labs in Jeopardy: A Brief to the Laboratory Services Review Committee," Ontario Public Service Employees Union, January 21, 1994, and "Laurentian Hospital Presentation to Laboratory Services Review," Dr. A Mazzuchin, January 17, 1994.

instituted by the NDP government with the intention of closing the private laboratories.⁴¹⁸ The OAML then makes the self-serving claim that it fought off this threat to the laboratory industry. Information from Ministry, government and union informants, some of whom would have preferred that the government had had this motive, all felt that the main driver for the review was concern about cost, and secondarily problems in the more technical aspects of service delivery. There is also nothing in the written record to support the industry's paranoid point of view. If anything, the NDP government was benign towards the for-profit laboratory corporations and the outcomes of this government's actions strengthened them.

The headline in the *Toronto Star* on the release of the LSR summed up reactions and foretold the direction of laboratory services over the next decade: "Provincial report backs private labs: Industry relieved, health care unions furious."⁴¹⁹ The LSR allowed the continuation of existing organizations and ad hoc management plans. It became a victory for the private laboratories, now firmly recognized as a central part of the system. The unions objected to the conclusions because they did not provide more support to the public sector. The MOH and the industry were relieved because the report supported regionalization initiatives that would allow the commercial laboratories greater access to the hospitals and reduce non-profit provision of community laboratory services.

Social Contract Costing Study

While the LSR was examining the laboratory system the provincial government was implementing its "Social Contract" to control government spending. As part of this process a study was undertaken to examine the cost of transferring work that is done in private-sector facilities into hospitals. A senior official in the Ministry of Health advised by a sub-committee of the LSR's external advisory panel wrote the study. Its terms of

⁴¹⁸ "Historical Context," OAML, April 4, 2006. The OAML also took credit for redirecting the mandate of the LSR to look "objectively" at the whole system.

⁴¹⁹ Art Chamberlain, "Provincial Report Backs Private Labs: Industry Relieved Health – Care Unions Furious," *The Toronto Star*, Monday, March 28, 1994, pp. D1-D2.

reference⁴²⁰ were to compare, “the costs of running hospital, public and private laboratories,” rather than determining the marginal increase in cost of having hospitals perform Ontario’s community laboratory work. Using the latter measure would have shown the effect on government’s expenses, most likely in favour of using public facilities. The study’s rather disembodied analysis comparing the relative cost of the sectors along with the major, and probably insurmountable, obstacles in the way of performing this task, worked in favour of the commercial laboratories. This point is developed further in Chapter Six.

The relevant point here is that even though the unions may have wanted this analysis,⁴²¹ the study did not address the question they wanted answered: what is the cost to the system of using public facilities? The framework of the study also suggests that if the NDP’s intention was to close down the commercial labs, as the OAML claims, they were very bad at controlling the process. A couple of interviews suggested that laboratories were low on the list of the NDP health care priorities. It is more reasonable to assume that the LSR and the Social Contract study were driven by the government’s need to control costs, and the implementation was left up to the bureaucracy increasingly influenced by the for-profit companies.

The final Social Contract report did not reach a definitive conclusion due to data and methodological difficulties and the sub-committee was unable to unanimously endorse the report so it was never publicly released. Nevertheless, John Rogers, President and COO of MDS,⁴²² and Jim Wilson, Minister of Health in the Conservative government that replaced the NDP in 1995,⁴²³ referred to the study as a reason for supporting the for-profit laboratory industry. Premier Mike Harris referred to the proven

⁴²⁰ Section 5.2.7 of the Memorandum of Understanding on the Social Contract Sectoral Framework Agreement for the Broader Health Sector as reported in Corey Vermy, “Social Contract Study on Laboratory Services: Draft Report: SEIU Comments.”

⁴²¹ None of the interviewees who were involved in the LSR or in the Social Contract process could remember exactly who asked for this study, but the consensus was that it must have come from one of the unions.

⁴²² Art Chamberlain, “Provincial Report Backs Private Labs: Industry Relieved Health – Care Unions Furious,” *The Toronto Star*, Monday, March 28, 1994, pp. D1-D2.

⁴²³ *Hansard*, February 15, 1996, Health Estimates Debate. Jim Wilson, Minister of Health, responded to a question in the legislature urging more support for the non-profit HICL by saying that: “The NDP dropped this particular notion about public sector labs were always more cost-effective. [*sic*] When they did their own study they got caught by themselves, actually, and showed that certainly in all cases that wasn’t true. So we haven’t actually heard them talk about labs for the last year or so, because they inadvertently did a study and they didn’t know what the result would be before they got it.”

cost-effectiveness of the for-profit laboratories as one of the benefits of more private delivery of health care.⁴²⁴ The report was also used in arguments within the OMA to support more for-profit involvement,⁴²⁵ and MOH officials used it against proponents of equal funding for hospitals.⁴²⁶

As the Conservative government elected in 1995 used the Social Contract study to boost the commercial sector it also used the LSR recommendations as the groundwork for a series of provincial government initiatives aimed at the integration of services and funding to benefit the commercial laboratories.⁴²⁷ The first phase was to implement the LSR's recommendations under the direction of the Ontario Laboratory Services Restructuring Secretariat. A pilot project to force regionalization of laboratory services was tried in 1999 but it failed. The review of this process produced Ontario Regional Laboratory Services Planning (ORLSP), which is currently winding down after some success regionalizing hospital laboratory services but little success at integrating community and hospital laboratories.

Laboratory Services Restructuring – Regional Laboratory Committees

Immediately following the release of the LSR in 1994 the NDP Minister of Health established the Ontario Laboratory Services Implementation Secretariat (OLSIS) to implement the Review's recommendations. The Secretariat was advised by an external advisory council made up of "laboratory service providers, educators, consumers and service planners."⁴²⁸

In 1996 the new Conservative government appointed Dawn Ogram, a lab technologist with experience in private consulting and running a large hospital laboratory, to head OLSIS. She had recently made a speech supporting public-private

⁴²⁴ Richard Brennan and Teresa Boyle, "Tough talk Greets Harris Health Care Musings – Radio Callers, MPPs Object to the Thoughts on Private Run Hospitals," *The Toronto Star*, May 1, 2001, p. A08.

⁴²⁵ "Re: LAB. FUNDING REFORM," letter to Ram Gidwani, Chair, OMA Section of Laboratory Medicine, from Raymond Bonin, Chair, Steering Committee on Hospital Laboratory Finance Reform, December 20, 1995.

⁴²⁶ Steering Committee on Hospital Laboratory Finance Reform minutes, December 2, 1995.

⁴²⁷ Letter from Jim Wilson, Minister of Health, to Raymond Bonin, Chair, Steering Committee on Hospital Laboratory Finance Reform, October 3, 1996.

⁴²⁸ Letter from Margaret Mottershead, Deputy Minister of Health, to Julie Davis, Secretary and Treasurer of the Ontario Federation of Labour, January 24, 1995.

partnerships for the delivery of laboratory services, including hospital facilities. In the same speech she also supported different solutions for different regions. The regional model would facilitate both of these objectives.⁴²⁹ Even though the LSR had recently been completed, she only made passing reference to different funding regimes as a barrier to restructuring.

In 1996 OLSIS began a regional laboratory restructuring process. Providers, professionals and policy-makers in nine regions were brought together to develop integration plans. The goal was to take advantage of the strengths of the public and private sectors through regional coordination. There was repeated stress on “effective partnerships” as central to the success of the process. The services to be integrated included specimen transfer, management, purchasing, human resources, and patient information.⁴³⁰ There was no mention of making maximum use of laboratory facilities. These were all services that could easily be contracted to for-profit providers, and that was what started to happen. There was a feeling in the laboratory community that regional plans would be in place by the end of 1996.⁴³¹ Needless to say this did not happen.

The OLSIS process quickly came into conflict with the Hospital Services Restructuring Committee (HSRC), which was mandated by a different section of the MOH to restructure only hospitals’ services, including their laboratories, within different boundaries. In Sudbury, Laurentian Hospital rejected a request from MDS to discuss restructuring until after the HSRC reported.⁴³² In this region the hospital sector developed a regional integration model and then invited the private sector players to a meeting to see what kind of involvement they wanted.⁴³³ The HSRC created a situation where the hospitals involved in negotiating regional plans with the commercial sector often did not know what their governance structure was going to be, as many were also

⁴²⁹ Dawn Ogram, Technical Director of Laboratories, North York Bransom Hospital, “Laboratory Restructuring in Ontario,” Presentation, February 24, 1995. She mentions favorably the MDS-Hudson Valley Program, a joint venture between MDS and three hospitals in the USA.

⁴³⁰ “Planning Objectives: Laboratory Service Restructuring,” Ministry of Health, June 1996.

⁴³¹ OMA Section on Laboratory Medicine, Council Meeting, minutes, September 20, 1996.

⁴³² Letter from Janice Skot, CEO, Laurentian Hospital, to Jim Reid VP Operations, MDS Laboratories, July 19, 1996.

⁴³³ Undated form letter inviting the private sector laboratories to a meeting on Northeastern Restructuring on June 25, 1997, signed by Dr. A Mazzuchin on behalf of hospital sector laboratories.

undergoing amalgamation. The government made no effort to coordinate these parallel processes dealing with overlapping but different sets of laboratories within overlapping but different sets of boundaries.

The OMA's Laboratory Specialists Section felt that the OLSIS initiatives were generally in-line with good lab practice and expressed concern that laboratory restructuring as being "driven" by the HSRC.⁴³⁴ Specifically, they felt that the HSRC was issuing directives to hospitals about laboratory services without consulting laboratory professionals, and that the HSRC considered laboratory services ancillary services rather than medical services. The laboratory specialists argued for greater integration of services to maximally utilize hospital laboratories, and argued that laboratories needed to be under appropriate medical supervision.⁴³⁵ The failure of commercial laboratories to meet this last criterion made them suspect in the eyes of many pathologists.

OLSIS had, at best, uneven results. In 1997 the OMA Laboratory Specialists Section said it knew of only three (of nine) regions where significant progress towards integration had been made. In the end these regionalization initiatives were put on hold and an attempt was made to force laboratory integration through a Request for Proposal (RFP) process.

Regional Requests for Proposals – Failed Forced integration

The lacklustre performance of the OLSIS efforts was followed by a more forceful approach to integration. After a series of consultations in the summer of 1998,⁴³⁶ from which the unions were excluded,⁴³⁷ and an internal study by consultants Coopers and Lybrand,⁴³⁸ the Ministry decided to ask for RFPs in three regions to deliver all the

⁴³⁴ "Laboratory Restructuring," Ontario Association Section of Laboratory Medicine Newsletter, March 6, 1997.

⁴³⁵ Letter from A. Rocke Robertson, Chair, OMA Section on Laboratory Medicine, to Duncan Sinclair, Chair, HSRC, March 25, 1997.

⁴³⁶ "Laboratory Service Funding Consultation," memo from Robert K. Muir, OHA Chief Operating Officer, to OHA Member Institutions, August 18, 1998.

⁴³⁷ Letter from Leah Casselman, President, OPSEU, and Doug Health, Chair of OPSEU Medical Division, to Dawn Ogram, Director, Laboratory Services Restructuring Secretariat, September 24, 1998.

⁴³⁸ The Ministry refused to release this report citing confidentiality of policy recommendations.

laboratory services for a fixed envelope of funding based on current laboratory expenses. This approach meshed nicely with support in the Ministry for some sort of capitation model to solve the funding problems in laboratory services.⁴³⁹ It also removed the government from directly changing funding of hospitals or for-profit labs, or forcing hospitals to make greater use of the for-profit sector. The government simply set rules for the RFP and told the providers to work it out. This also did not produce results.

Two years before the RFP approach was tried, Paul Gould, CEO of the OAML, put forward a “radical proposal” that there should be a purchaser-provider-regulator split in the provision of laboratory services. He was arguing that companies should be able to competitively bid to provide all the laboratory services in a designated area.⁴⁴⁰ In support of his argument he referred to a publication by the Fraser Institute, a right-wing think tank committed to the privatization of health services. The 1999 RFP process reflected the essence of Mr. Gould’s “radical” idea.

The RFP was issued in January 1999. Bidders had to be licensed providers already in the system and it was mandatory that both public and private sector providers be involved in the consortium submitting the RFP. The Ministry was clear that they wanted a “mixed” system. There would have to be a signature from at least one for-profit laboratory. The contracts were to be for five years. It is important to understand how this RFP limited possible alternatives. It precluded, what many would argue would be the lowest cost and most integrated of solutions, the possibility of a consortium of hospitals developing a non-profit body like HICL to organize collection of community laboratory specimens for processing in hospital laboratory facilities.

In mid-1999 the RFP was withdrawn because none of the proposals met the minimum requirements.⁴⁴¹ A Ministry facilitated evaluation of the RFP process included only generalities on why the various sectors thought that the approach did not work.⁴⁴² Clues as to why the process failed can be gained from the questions that were asked as

⁴³⁹ The idea of a contract based on population served was contained in background papers for the LSR, mentioned in the final report, and had been one of the policy options since the 1970 proposal to establish fixed contracts for the provision of community laboratory services.

⁴⁴⁰ “Integrated Delivery Systems – OAML Perspective on Funding,” Paul Gould, CEO of the OAML, speech to the CLMA Trillium Chapter, April 16, 1997.

⁴⁴¹ The date for accepting the proposals was moved from March 31 to May 31, 1999.

⁴⁴² S. John Page and Barbara Kornovski, *Provincial Group on Laboratory Reform*, submitted to the Ministry of Health and Long Term Care, June 29, 2000.

part of the RFP process. The for-profit providers raised questions such as: “What happens if we lose the bid, who will cover the rents, etc?” and: “How does this affect the market share and the negotiated agreement between the OAML and the MOH?” Hospitals complained that there was not enough time to develop a full proposal.⁴⁴³ The Ministry largely dismissed these concerns but they indicate that both for-profit corporate concerns about losing business and hospital reluctance probably played a role in producing substandard bids. The negative impact of the for-profit sector on integration for the most efficient use of the system’s resources is developed further in Chapter Six.

The evaluation meeting that followed the collapse of the RFP process focused on strategies for laboratory reform. Both the OHA and the OAML rejected the competitive process as helpful in laboratory reform. Instead they favoured a facilitated process driven by the current providers and building on their interests.⁴⁴⁴ The OAML was the most anxious to return to a voluntary regional laboratory strategy. The OAML emphasised as a starting point that hospitals and commercial laboratories be recognized as the primary providers in the sectors they currently control.⁴⁴⁵

Ontario Regional Laboratory Services Planning – Facilitated Hospital Integration

The program that emerged from the ashes of the RFP was named Ontario Regional Laboratory Services Planning (ORLSP) and implemented in October 2000. It was organized in the same nine regions as the previous restructuring effort and built on the work that had already been done. The process was facilitated by consultants from THiNC Health Care. They brought together laboratory service providers in each region, had them agree on the composition of a Regional Steering Committee (RSC), and helped them develop a regional laboratory service plan. The plan was intended to include hospital and community laboratory services, ensure accessibility, limit duplication of operations and services, meet quality standards and ensure, “an appropriate critical mass

⁴⁴³ “Report of the Meeting of the Respondents in Hamilton,” Chris Madill, OPSEU Staff, January 26, 1999.

⁴⁴⁴ This information is taken from the final report of the review process, S. John Page and Barbara Kornovski, *Provincial Group on Laboratory Reform*, submitted to the Ministry of Health and Long Term Care, June 29, 2000.

⁴⁴⁵ S. John Page and Barbara Kornovski, *Provincial Group on Laboratory Reform*, p. 20.

where testing is performed.”⁴⁴⁶ The RSCs were to be composed of representatives of the OMA (laboratory physicians), the OAML (commercial laboratories) and the OHA (hospital laboratories). The process began in three regions: East 1 (the counties around Ottawa-Carleton), Central East (Peterborough area) and Northwest (Kenora and Thunder Bay). These regions were expected to produce final recommendations by March of 2001.⁴⁴⁷ In the fall of 2002 the final three of the nine regions began the process.⁴⁴⁸

Representation on the RSCs was regional from the hospitals, but the private laboratories opted for a province-wide approach. CML and Dynacare had the same person representing their interests on all six RSCs for which membership was obtained. MDS had two people covering three each, with an extra representative on the Toronto RSC. The private labs had broader corporate interests than simply improving services in the region. With more centralized laboratory services they could easily have been interested in moving work out of a region rather than building up local services. Also, the commercial providers negotiate a province-wide agreement; they would have very little interest in developing regional arrangements that might affect their provincial market share.

The May 15, 2001 report from East 1 region sets out integration initiatives for hospital services and steps the community laboratories in the region will take to improve their access and ability to provide “stat” community testing. While the planning process included all the providers it still maintained two distinct systems. There is no discussion in this document of how the two are to integrate.⁴⁴⁹ The OHA summary of the process states that, “many opportunities for the consolidation and sharing of laboratory services between hospital laboratories” were identified but there was no mention of community

⁴⁴⁶ THiiNC Health, “East 1 Regional Laboratory Services Plan: Ontario Regional Laboratory Service Planning,” May 15, 2001. THiiNC Health is a private consulting firm that helped the Regional Steering Committees in all regions produce reports that were then to be submitted to the MOH.

⁴⁴⁷ “Regional Representation to the Regional Steering Committee Ontario Regional Laboratory Service Planning (ORLSP),” memo from Helen Zulys, Consultant, Clinical and Professional Issues, OHA, to Chief Executive Officers and Laboratory Directors/Managers of Hospitals in the Toronto Laboratory Planning Region, December 13, 2002.

⁴⁴⁸ “Re: Regional Representation to the Regional Steering Committee Ontario Regional Laboratory Service Planning (ORLSP),” memorandum from Helen Zulys to Dr. David McLeod, Vice President, Clinical and Professional Services, and Ms. Dawn Ogram, Director, laboratories Branch, MOH, December 13, 2002. Helen Zulys is a Consultant on Clinical and Professional Issues.

⁴⁴⁹ THiiNC Health, “East 1 Regional Laboratory Services Plan: Ontario Regional Laboratory Service Planning,” May 15, 2001.

laboratories.⁴⁵⁰ The ORLSP did facilitate some new hospital integration, for instance microbiology services in the Central West region, but most current hospital integration is the result of initiatives started in the 1960s and 70s, for instance in Hamilton, Ottawa, Stratford and the Northwest.

The main difference between what happened in the 1960s and the later regionalization efforts was that now the private sector was intimately involved in their management. It is unclear, though, that the presence of the for-profit laboratories did little other than help them identify ways they could sell their services to hospitals. One interviewee commented that while the private laboratories come to Regional Steering Committee meetings they were never required to produce reports, while this was mandatory for the hospitals. He reported that hospital representatives on the committee complained that the private labs "listened to our work but they never contributed anything."⁴⁵¹

It could be argued that increasing involvement of the for-profits in the delivery of inpatient services was a kind of integration. During the last fifteen years numerous hospitals have used private sector management. Labcorp's subsidiary Dynacare is managing the Ottawa's regional hospital laboratory. MDS is involved in contracts with ten hospitals in Northern Ontario. Some of these arrangements, for instance in Windsor and the Niagara region ran for a few years and ended. Since 1996, when the for-profit laboratories were allowed to expand their range of tests, they have been providing more reference work for smaller hospitals.

Brenda Gamble examines two joint ventures, another form of integration, between academic health science hospitals and for-profit laboratory corporations that began in 1995. In these cases the hospitals provided most of the management and hired the staff. Case A, which was not working well at the time she was doing her research, used an automated laboratory technology that was provided by the for-profit corporation. The joint venture was to be a demonstration site for the new technology. The hospital paid 50% of the "significant" capital costs. Case B used facilities in the hospital and

⁴⁵⁰ "Laboratory Information System Integration: A Survey of Current and Proposed Local or Regional Models of Connectivity," Ontario Hospital e-Health Council: Hospital Laboratory Information Systems Advisory Group, Ontario Hospital Association, November 2006, p. 5.

⁴⁵¹ Interview 15.

leased equipment. The hospital in Case B reported a 16% saving on laboratory costs, though it is not clear whether this was from better management, lower labour costs or community and uninsured work being done in the joint-venture facility. In either case Gamble was unable to verify the cost figures. Even with a confidentiality agreement she was not allowed to see any financial statements.⁴⁵²

Both the joint ventures studied by Gamble were intended to become regional laboratories and neither, at the time of her research, were making progress towards that goal. This led her to comment that, “reform driven by market incentives (i.e. the establishment of commercial laboratories) [her nomenclature describing the new for-profit joint ventures] could result in the fragmentation of services.”⁴⁵³ While the partners in Gamble’s joint ventures were not identified, Sunnybrook Hospital entered into a joint venture (which has since folded) with Dynacare in 1996. The Toronto Hospital and MDS have a joint venture, the Toronto Medical Laboratory, which provides inpatient laboratory services and consulting to other hospitals, that is ongoing. Her study and the experience of for-profit management contracts indicate that the impact of these initiatives is limited.

After thirteen years of laboratory integration initiatives hospital laboratory service networks have increased, though most of these started long before the current initiatives. During the same time little if any progress has been made on limiting duplication between community and inpatient services, or improving integration of services between community providers. Most communities have one hospital network and two or three competing community providers. The interests of the hospitals and the for-profit providers helped keep the two systems separate – this is discussed further in the next chapter – as did other government initiatives.

Simultaneous with the government’s laboratory integration programs policies were enacted that created stronger for-profit control of the community sector and a more integrated hospital system. As mentioned earlier, the Hospital Services Restructuring Commission (HSRC), created in 1996 to restructure hospital services, played a role in

⁴⁵² Brenda Gamble, *The Commercialization of Hospital-Based Medical Laboratory Services*.

⁴⁵³ Brenda Gamble, *The Commercialization of Hospital-Based Medical Laboratory Services*, p. 120.

integrating hospital laboratories⁴⁵⁴ separate from community laboratories and quickly came into conflict with OLSIS. A similar structural barrier to planning and integration was created in 2004 when Dalton McGuinty's Liberal government established the Local Health Integration Networks (LHINs), a regional structure for delivering health services. The LHINs are charged with rationalizing a variety of health services, including hospital laboratories, but the community laboratory sector is excluded from their mandate. Also the LHINs are organized on fourteen regions compared to the nine used by the Laboratories Branch. One interview charged the LHINs with adding "another level of chaos" to the medical laboratory system.⁴⁵⁵ Along with maintaining a structural division between the sectors, including different funding and administrative regimes, an old tension that works against public-sector delivery of laboratory services is reinforced. The LHINs work within a fixed budget to deliver health services within their mandate. Once again, 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, they might be able to increase their income as their work increases because of the addition of off-loaded hospital services.⁴⁵⁶

The ORLSP also strengthened the division between the inpatient and community services by creating a province-wide remuneration framework for medical laboratory specialists working in hospitals. In 2000 the OMA took over negotiating with the MOH on behalf of the hospital pathologists and reached an agreement increasing pay and

⁴⁵⁴ For example, in Southeastern Ontario onsite hospital laboratory services decreased from ten to five and Eastern Ontario Regional Laboratory network increased the number of hospitals involved and improved its integrated information systems. David More, Sandip K. Sengupta and Paul N. Manley, "Promoting, Building and Sustaining," p. 206. The impact of this hospital laboratory consolidation on accessibility, costs, jobs, and quality has not been studied. The new regional hospital laboratory in Ottawa has taken laboratory work away from Winchester's hospital, reducing its staffing and the volume that helped maintain the efficient use of that laboratory, similarly the regionalization of Quinte's hospitals has moved most laboratory services to Belleville and there is consideration of having only point-of-care testing in the smaller hospitals such as the one in Picton. These developments may not be all negative, but should not be accepted just because they integrate services to reduce cost.

⁴⁵⁵ Interview 16.

⁴⁵⁶ The most recent OAML-MOH agreement includes added funding if the volume of community work processed increases. "MDS Diagnostic Services Announces New Funding Agreement in Ontario," media release, MDS Diagnostic Service, April 7, 2006.

improving working conditions.⁴⁵⁷ The situation with commercial laboratories was a different matter. The OMA Laboratory Medicine Section described the situation of fee-for-service doctors employed in the commercial sector as “deplorable”⁴⁵⁸ and complained regularly about the discounting system used by the for-profit laboratories to reduce payment to the pathologists.

Maintaining Silos – Strengthening the For-profit Laboratories

While government initiatives continued to integrate and consolidate hospital services they also introduced policies that strengthened the for-profit providers and sequestered the community sector as their private preserve. During this cycle of government policy initiatives industry strength increased to a new level. The development of a few large laboratory corporations increased their power both as a political force that could lobby effectively and as an economic force that could threaten significant political fallout from job loss, declining stock values and reduced economic growth if it was harmed.

The 1993 Memorandum of Understanding between the OAML and the MOH marked a shift in power to the for-profit laboratories.⁴⁵⁹ Since 1978 the MOH, the OMA and the OAML had been involved in tripartite negotiations on OHIP payment policies for laboratory services. Early in the 1990s the OAML started to deal, “directly with senior MOH official on contentious issues.”⁴⁶⁰ The 1993 Memorandum formalized this new relationship and removed the OMA for the first time from these important negotiations. The OMA continued to be involved with quality control through the LPTP. The memorandum recognized the commercial labs as joint managers with the government of

⁴⁵⁷ “Laboratory Medicine Funding Framework Agreement Between: The Ontario Medical Association and Her Majesty Queen in Right of Ontario, as represented by the Minister of Health and Long-Term Care,” March 30, 2005. This agreement does not cover pathologists employed by the government or the community laboratories.

⁴⁵⁸ Minutes of the Section Council, Tuesday, February 3rd, 2004, Lab 04/0401, OMA Section of Laboratory Medicine.

⁴⁵⁹ “Ontario Association of Medical Laboratories/Ministry of Health: Memorandum of Understanding,” signed December 17, 1993.

⁴⁶⁰ Laboratory Services Review Discussion Paper #2: System,” June 1993, MOH, p. 11.

the community laboratory services.⁴⁶¹ The Memorandum established a grant of \$500,000 per year to the OAML “to carry out its obligations under this agreement.” The grant was funded through a Rand-like formula with the government collecting the fees for the OAML through a reduction in payments to private laboratories.

The Memorandum substantially limited the fee-for-service system by imposing a hard cap on funding for the sector. It formalized a negotiating process to establish the cap and how it was to be divided among the commercial providers. The for-profit labs still billed on a per-test basis, but their overall income was limited to a share of the industry cap equal to their market share. Rather than simply increasing utilization, the commercial sector now had to balance attracting business to increase market share with limiting access to make sure that the amount of service provided did not exceed what they would be paid for.

Along with entering into an exclusive agreement with the for-profit sector and establishing a secure funding base for their lobbying arm the government agreed to provide the commercial laboratories with ten-and-a-half million dollars over the next three years (1993-1996) for research and restructuring. A key goal of the research portion of the funding was to enhance the export potential of the industry. The agreement implies that most of the results from the research would be proprietary information, further discouraging integration among the commercial laboratories. The restructuring portion was aimed primarily at mitigating the effects of job loss. The funds were administered by the OAML. They were to be matched by the industry and returned to the government if not used.

Establishing exactly how these monies have been used has proved difficult. A request to the Laboratories Branch of the MOH for copies of all the agreements between the MOH and the OAML to determine how much was paid into the fund was referred to the Freedom of Information and Privacy Branch and is currently in that process. A direct request for the amount was similarly delayed. A 2000 financial statement for the OAML indicates that the funding continued until 1999, with the organization receiving three-

⁴⁶¹ “Historical Context,” OAML, April 4, 2006. The OHA and the OMA still played roles in policy development for hospital and general medical laboratory policy.

and-a-half million dollars in that year.⁴⁶² No response was given by the OAML to a direct question about how the money was used. Some of the funds are easily accounted for. On the OAML's website there is a list of small research grants awarded between 1997 and 2003 relating to technical aspects of laboratory testing that totalled 451,381.86 dollars.⁴⁶³ Documents from the MOH detail a further three million, four hundred thousand that had been primarily paid to large consulting firms (e.g., Coopers & Lybrand, PriceWaterhouseCooper and L.J. Stump and Associates) for studies related to laboratory restructuring.⁴⁶⁴ In 2000 the restructuring fund held by the OAML contained twelve million dollars, suggesting that money had not been repaid to the Ministry as per the Memorandum, that public money was being underutilized and that there could be significant sum of unaccounted for public money.⁴⁶⁵ There is no record of how the interest from this account is used. Overall, these funds appear to be a significant public boost for the larger for-profit laboratories and their political arm. One interviewee said: "That [the restructuring money] was a bit of a sop to MDS. ... This was a way for MDS to get a little extra money out of them [the government]."⁴⁶⁶

The Memorandum also set up committees to administer private laboratory licensing, develop laboratory policy, negotiate the fee schedule and look at quality, focusing on utilization. The OAML was on all the committees; the OHA and OMA were excluded from the committees dealing with licensing and utilization in private laboratories. This structured an influence imbalance in favour of the private sector. The OAML had input on policies respecting hospital laboratories through the laboratory restructuring process but the OHA and the OMA had no input into policies that dealt directly with the for-profit laboratories.

⁴⁶² "Ontario Association of Medical Laboratories Audited Financial Statement, September 30, 2000," Kerr M. Chalmers, Chartered Accountant.

⁴⁶³ "Laboratory Restructuring Fund Disbursement Summary," list provided by the Laboratories Branch of the MOH, May 8 2007. This lists includes some grants not listed on the OAML website.

⁴⁶⁴ The exact total was \$3,470,187.99. There were no dates given as to when disbursements were made. A further request has been submitted for this information.

⁴⁶⁵ The audited statement and the memorandum imply that 3.5 million dollars per year had been paid to the OAML for 6 years, which would total 21 million dollars, and only and only about 16 million is accounted for. Some could have been paid back to the Ministry, or maybe it was not paid all from the Ministry, but this is not clear. Requests have been made through the FOI process for more information on this subject.

⁴⁶⁶ Interview 12.

The agreement was hailed in a joint editorial by the OHA and the OAML as meeting the government's need to restrain costs and the private laboratories' need to be "stable and viable."⁴⁶⁷ They state that the memorandum will facilitate a closer relationship between for-profit laboratories and hospitals in line with the recommendations of the Laboratory Services Review. The Toronto Star reported that the OAML agreement traded income for security because the commercial sector was afraid that the government would limit the extent of for-profit laboratories as they had limited private involvement in home care.⁴⁶⁸ Regardless, the agreed intent of the Memorandum was to, "support the continuing viability of a restructured commercial laboratory industry."⁴⁶⁹

While the Memorandum did recognize the possibility that the LSR might transfer work to or from hospitals, the strengthened private system would make it harder both politically and financially to transfer work to the public sector. And while the Memorandum did achieve the objective of cost control, agreements since 1996 under Conservative governments have provided for increases in the total amount paid to the for-profit laboratories and in 2005 the agreement provided an incentive for increased volume.⁴⁷⁰

Labs Respond to Hard Caps – Service Cuts

Following the imposition of hard caps on community laboratory service funding in the 1993 Memorandum of Agreement the larger for-profit laboratories responded by limiting utilization, cutting service, intensification, and expansion into new markets, notably inpatient hospital services. The smaller private laboratories expanded their services to increase their market share thus their share of the funding.

⁴⁶⁷ Paul J. Gould and Dennis R. Timbrell, "Joint Statement on the OAML/MOH Memorandum of Understanding," *OMST Advocate*, May 1994.

⁴⁶⁸ Art Chamberlain, "Provincial Report Backs Private Labs: Industry Relieved, Health-care Unions Furious," *The Toronto Star*, Monday, March 28, 1994, p. D1.

⁴⁶⁹ "Preamble," Ontario Association of Medical Laboratories/Ministry of Health: Memorandum of Understanding, December 17, 1993.

⁴⁷⁰ "MDS Diagnostic Services Announces New Fee Arrangement in Ontario," news release, MDS Inc., April 7, 2006.

In 1994 both MDS and CML sent letters to family doctors and patients advising them that they would no longer be able to pick up specimens from private homes for free; a user fee would now be charged for this service.⁴⁷¹ Physicians reported concern that many of the practices that had facilitated access and reduced physician costs – also the ones that had been the subject of conflict of interest inquiries – such as laboratories renting space in medical buildings, supplying phlebotomists to doctors’ offices and the provision of supplies were being cancelled.⁴⁷² In 1999 when Med-Chem, the fourth largest laboratory, went bankrupt, physicians reported difficulty finding other laboratories to service their patients because, “there appears to be a significant lack of inducement to accept new business.”⁴⁷³ Similarly nursing home residents were harmed by a reduction in services until the government negotiated a separate agreement with the private laboratories to provide service to those patients.⁴⁷⁴ In 2005 MDS’s service to rural areas was identified as part of the reason for its poor stock performance.⁴⁷⁵ a concern raised in the middle of OAML contract negotiations with the government.

The commercial laboratories also pursued programs aimed at decreasing utilization by changing the way physicians ordered tests. In the early 1990s the OAML produced guidelines for physicians using laboratory services. These guidelines were studied by the Institute for Clinical Evaluative Studies and found effective.⁴⁷⁶ The approach of changing physicians’ order forms and issuing protocols had been successful for a short time in the 1970s, but pressure from the laboratories quickly returned increases in utilization to a suspiciously high rate. In the era of hard caps companies have

⁴⁷¹ “Notice to Patients re: Laboratory Housecall (*sic*) Services,” flyer signed by Mary Zadel, Regional Operations Manager, Canadian Medical Laboratories Limited, April 4, 1994, on letterhead with the caption “Health Care is People Care.” And “MDS House Call Service,” similar from Frank E. Thomson, Associate Medical Director, MDS Laboratories, August 15, 1994.

⁴⁷² Michael Thorburn, “Ontario Laboratory Industry in Transition Prompts Physician Concern: Access to Patient Services, Revised Practice Arrangements among Issues Cited,” *Ontario Medical Review*, May 1, 1999, download, March 20, 2007 from <http://www.oma.org/archives/omr/nov/99oaml.htm>.

⁴⁷³ Michael Thorburn, “Ontario Laboratory Industry in Transition.”

⁴⁷⁴ “Standards and Protocols for the Delivery of Laboratory Services in Long Term Care Facilities,” Ontario Association of Medical Laboratories, November 2003.

⁴⁷⁵ Leonard Zehr, “New Leader, New Life for Tired MDS,” *The Globe and Mail*, Saturday, August 20, 2005.

⁴⁷⁶ Carl Van Walraven, Goel Vivek and Ben Chan, “Effect of Population-based Interventions on Laboratory Utilization: A Time-Series Analysis,” *JAMA*, 280(230), December 16, 1998, pp. 2028-2033. Gamma-Dynacare participated in research aimed at limiting test ordering by community physicians: Peter Bunting and Carl van Walraven, “Effect of Controlled Feedback Intervention on Laboratory Test Ordering by Community Physicians,” *Clinical Chemistry*, 50:321-326, December 2003.

been more receptive to participating in programs to limit utilization, though it needs to be noted that after 1998 the volume of laboratory work continued to climb as the revenue cap increased and the most recent agreement includes an incentive to compensate for increased volume.

Simply capping and reducing funding to the community sector did reduce utilization, but it left it up to the for-profit corporations to make the cuts. Some, such as the program to change physician ordering patterns, largely funded by the government, reduced unnecessary tests, but most of the initiatives by the larger laboratories were aimed at reducing the less profitable services, which meant a reduction in access for smaller communities and marginalized patients. This is an analogous situation to the commercial laboratories favouring urban areas and the commercial sector preferentially processing a larger portion of the easier, more common tests: they are primarily interested in making more money rather than meeting community needs.

While the big labs responded to funding caps by cutting services from 1993 to 1996 the smaller for-profit laboratories became more responsive to community needs, filling the gaps left by the major conglomerates and actively competing for a larger share of the laboratory market. Simultaneously hospitals, particularly smaller hospitals, were looking for ways to maintain their laboratory services and make some money to offset reductions in funding. Instead of simply turning their community laboratory services over to the for-profits many were calling on HICL. During the years 1990 to 1996 HICL opened thirteen new specimen collection centres that feed work and income into hospitals. This compares to eight, including the head office, between 1978 and 1989. All of these later openings were in partnership with smaller community hospitals. (See table-“Opening Dates – HICL SCCs”) The LSR final report contains this evaluation of HICL:

HICL has demonstrated that, by providing a common logistic network for specimen collection, specimen transportation and test reporting, sharing arrangements between laboratories can be beneficial, leading to improved volume of testing, automation and increased efficiency.⁴⁷⁷

HICL was increasing its presence as an alternative to the for-profit delivery of community services and the small for-profits were competing directly with the larger private labs. When the industry cap, HICL and the competitive laboratory market started

⁴⁷⁷ *Laboratory Services Review*, p. 12.

to threatened the income of larger laboratories they responded by using the OAML to negotiate an agreement with the provincial government to limit competition in the sector.

Opening Dates – HICL SCCs

Date	Community
May 31, 1996	Perth
May 29, 1995	Kitchener
May 29, 1995	Fergus
Dec. 5, 1994	Winchester
Jan. 24, 1994	New Liskeard
May 31, 1993	Timmins
Jan. 10, 1993	Orillia
July 10, 1991	Napanee
Sept. 17, 1990	Pembroke
July 9, 1990	Huntsville
July 4, 1990	Parry Sound
May 20, 1990	Georgetown
April 5, 1990	Toronto
Dec. 11, 1989	Bracebridge
Nov. 16, 1987	Toronto
March 1, 1985	Brampton
Sept. 29, 1981	Brampton
March 15, 1981	Orangeville
Jan. 3, 1978	Bolton
May 3, 1977	Etobicoke
Oct. 3, 1975	Head Office

Regulation 02/98

Regulation 02/98, an amendment to Regulation 552 of the *Health Insurance Act*, closed the community laboratory sector to competition. Key components of the regulation are:

- continuation of a hard cap on the total paid out to community laboratories;
- the cap would be negotiated between the OAML and the MOH;
- the cap would be divided between the laboratory corporations based on the percentage of the market they held in 1995-96;
- if a company did not meet its quota in a given year, the shortfall would be divided between the other companies. If a company performed more tests than its quota, it would not be paid for them; and
- if there was a consolidation, the new company would acquire the combined market shares of the companies involved.

Regulation 02/98 reflected a proposal drafted by lawyers for the OAML and sent to the Ministry for approval in March 1997.⁴⁷⁸ Dynacare, as a member of the OAML, argued that the regulation was developed between the OAML and the Ministry of Health as a solution to problems caused by the NDP's Social Contract. It would use taxpayers' money wisely for "patient services and testing," and limit the amount of money spent increasing market share.⁴⁷⁹ A spokesperson for MDS said this is not about competitive logic because Ontario's community laboratory sector "is not a free market."⁴⁸⁰ Elizabeth Witmer, Minister of Health, argued that the government was treating all the laboratories fairly and that the policy was being administered at arm's length. A review of Regulation 02/98 by the federal Competition Bureau found that the regulation, "would reduce the incentive to provide good service and would have the effect of suppressing competition

⁴⁷⁸ Paul Gould, CEO of the OAML, memo, April 2, 1997, with attached memorandum: "Outline of Proposal Affecting Laboratories and Specimen Collection Centers and the Government of Ontario re: Industry Cap and Related Matters," Davies, Ward and Beck: Barristers & Solicitors, March 27, 1997.

⁴⁷⁹ "Gamma-Dynacare Medical Laboratories," *Toronto Star*, April 7, 1999.

⁴⁸⁰ John Deverell, "Small Medical Labs Decry Regulations," *Toronto Star*, June 20, 1998, edition 1.

on service levels, quality, turnaround time and reliability.”⁴⁸¹ After 1998, competition between laboratories shifted from fighting for market share by increasing service to fighting for more money from the government and cutting costs to increase profits.

One reason given for the regulation was to control spending.⁴⁸² But cost control was clearly not the issue. As previously noted costs had fallen through the first half of the 1990s and only started to rapidly increase again after the 1998 agreement. A more likely explanation for the agreement is that it stabilized the market position of the dominant for-profit laboratory corporations, which had been losing market share to smaller companies, and guaranteed them a steady revenue stream.

The media and the New Democratic Party noted the connection between the Latner family, principals in Dynacare, one of the big three laboratory companies, and the Conservative government as a factor in the regulation. The Latner family had received numerous beneficial rulings from the Conservatives and these were linked to political donations to the Conservative party and to the presence of Tom Long, a friend of the Latners, in the premier’s office.⁴⁸³

After the introduction of the closed market, the commercial companies continued to consolidate. Med-Chem Health Care, the fourth largest laboratory in Ontario, went bankrupt in 1999 after going, “deeply in debt to finance an ambitious acquisition plan.”⁴⁸⁴ Analysts were quoted as saying that the potential buyers were more interested in the company’s business contracts, a large one being their share of Ontario’s laboratory market, than in its facilities or employees. Regulation 02/98 both protected the income of the big companies and proved to be a force to make them bigger. Med-Chem was purchased by CML,⁴⁸⁵ further concentrating the sector.

⁴⁸¹Kevin Donovan, “Medical Labs Argue Against Payment Limits,” *Toronto Star*, November 26, 1998, edition 1.

⁴⁸²John Deverell, “Small Medical Labs Decry Regulations,” *Toronto Star*, June 20, 1998.

⁴⁸³Other public initiatives that benefited Dynacare included the opening of home care to competitive bidding, which would potentially benefit Comcare, a home care company owned by Dynacare, and the awarding of the contract to build the casino in Niagara Falls to a Latner-owned development consortium.

⁴⁸⁴John Greenwood, “Interest in Med-Chem Simmers as Deadline Looms,” *Financial Post*, March 10, 1999, p. C05.

⁴⁸⁵James Cole, Senior Vice President and Portfolio Manger, “AIC Canadian Focused Corporate Class: A Management Discussion of Fund Performance,” http://www.aic.com/Resources/pdfs/en/can_foc_corp_ann_ENG_2004.pdf, downloaded March 22, 2007.

Regulation 02/98 was the end point of a convoluted policy-accumulation dynamic in the 90s. Government policy to control costs had increased competition which led to a government policy to stop competition and make Ontario's community medical laboratory services one of the more tightly controlled and lucrative sectors in the Canadian economy.⁴⁸⁶ This was a regulation written by the larger for-profit labs for their benefit.

Management Contracts and Joint Ventures

The large for-profit laboratories also responded to the hard funding caps by intensifying their operations and expanding into new markets. Both of these objectives dovetailed nicely with MDS' development of the AutoLab, a patented laboratory automation technology.⁴⁸⁷ While selling the AutoLab had limited success, only three units were sold to American hospital chains, it was used in MDS's internal operations and they were able to cut the number of their laboratories from 26 in 1995⁴⁸⁸ to 12 in 2006.⁴⁸⁹ The AutoLab also became a poster child for showing how innovative Canada's commercial laboratories were and it was the basis of a joint venture between MDS and the Toronto General Hospital. One observer noted that, "our sector managed to achieve a tremendous amount of efficiencies during that period of time having to deal with a significant reduction in payments."⁴⁹⁰

As funding declined and the community market became saturated the commercial sector also expanded into the delivery of inpatient services. MDS took its first steps into the hospital sector in the mid-1980s with management contracts for hospitals in the Niagara Peninsula, and expanded its hospital services in the 1990s.⁴⁹¹ Many of these arrangements were short-term consulting or "change" contracts. MDS managed laboratory restructuring often involved cutting staff and reorganizing to improve quality.

⁴⁸⁶ The consolidation, intensification and price fixing in Ontario's community laboratory sector are consistent with the work of Baron and Sweezy in *Monopoly Capitalism*, *Monthly Review Press*, 1966.

⁴⁸⁷ Interview 12.

⁴⁸⁸ Ian Austen, "Medicare? Gotta Love it," *Canadian Business*, June 1997, pp. 47-55.

⁴⁸⁹ Personal Communication, Horace St. Aubyn, Policy Advisor, Laboratories Branch, Ministry of Health, August 25, 2006.

⁴⁹⁰ Interview 14.

⁴⁹¹ From a slide show presented by MDS to the Manitoba Association of Health Care Professionals, December 21, 1994.

St. Catherine's General Hospital, the Wellesley Hospital in Toronto and most recently a network of ten hospitals in north-eastern Ontario have employed MDS for these restructuring purposes. Some of these contracts, for example with the arrangement with six hospitals in the Niagara region and the joint venture with Toronto General Hospital⁴⁹² became longer term arrangements.

Michael O'Keefe, the COO of the Toronto General Hospital, said he hoped the hospital would gain expertise in automation, computer technology and commercialization of research from their partnership with MDS.⁴⁹³ MDS would benefit from the hospital's laboratory expertise, and from the opportunity to use the hospital site to demonstrate its new automated technology. The hospital would continue to own and staff the lab.

MDS has also developed an integrated patient record system with Princess Margaret Hospital (PMH) that is now available online to all physicians.⁴⁹⁴ This is probably good for patient care. It also creates a great market for MDS, as it provides a strong incentive for PMH patients to have their community blood work done by MDS, and it raises new concerns about conflict of interest and accessibility. Will laboratories now be offering incentives to hospitals to enter into these relationships? Will patients be forced to have their blood taken by only one company if they go to a certain hospital?

Hospital-laboratory partnerships have not always been successful. Timmins and District Hospital signed a letter of intent for a partnership with Dynacare, but this was not pursued after discussions with the laboratory technologists' union.⁴⁹⁵ A joint venture between Sunnybrook Hospital and Dynacare was terminated.⁴⁹⁶ Dynacare continues to manage Ottawa's new regional hospital laboratory but there are indications that the new facility is too small to meet regional needs.⁴⁹⁷ The MDS management contracts with Windsor's hospitals and Wellesley Hospital in Toronto were not renewed.

⁴⁹² "The Toronto Hospital Signs Letter of Intent with MDS," *Labreport: News from the Toronto Hospital Laboratories*, March 1995, 3(1).

⁴⁹³ "The Toronto Hospital Signs Letter of Intent with MDS," *Labreport*.

⁴⁹⁴ *Toronto Medical Laboratories: Annual Report 2004-2005*.

⁴⁹⁵ "Timmins and District Hospital – Partnership with Dynacare," Letter from David Wright, lawyer with Ryder Wright Blair and Doyle, to Jill Morgan, Job Security Officer, OPSEU, June 20, 1996.

⁴⁹⁶ Personal Communication, Patti Route, Chair of OPSEU Laboratory Sector, February 20, 2007.

⁴⁹⁷ Personal Communication, Rick Jenson, OPSEU staff person responsible for the Laboratory Sector, February 20, 2007.

Reduction in Non-profit Community Lab Services

The mixed success of for-profit laboratories in the delivery of inpatient services was not mirrored in their domination of the community sector: it continued unabated. Some hospitals made strategic financial decisions to stop providing community laboratory services. While there is no province-wide database showing which hospitals provide community laboratory services, Brockville,⁴⁹⁸ Belleville,⁴⁹⁹ Cornwall,⁵⁰⁰ Leamington,⁵⁰¹ Winchester,⁵⁰² Perth and Smiths Falls,⁵⁰³ St. Thomas⁵⁰⁴ and Campbellford⁵⁰⁵ have all reduced or closed their outpatient laboratory departments. Invariably this has meant a shift in work to for-profit laboratories. Events in Cornwall indicate how hard these changes may be to track. The hospital closed its community laboratory services and shifted work to a non-profit community health clinic. The clinic then contracted Dynacare to collect and process the work.⁵⁰⁶ There were no arrangements found in which hospitals increased their delivery of community laboratory services in the last ten years.

HICL has also shrunk in the last ten years. After a rapid expansion of community services in the mid-nineties HICL was informed by the Ministry that it would have to end its agreements to use hospital laboratories by January 1997, effectively ending eleven million dollars in payments to the hospital sector⁵⁰⁷ and closing HICL's community SCCs. This policy was the outcome of an agreement between the MOH and the OAML and part of the OAML's initiatives to limit competition in the laboratory sector. A campaign to save HICL's agreements was partially successful. The Ministry agreed to

⁴⁹⁸ Personal Communication, Colin J. Williams, Brockville Health Coalition, February 21, 2006.

⁴⁹⁹ Personal Communication, Pamela Martin, Hastings NDP, March 30, 2007.

⁵⁰⁰ David More, "Trojan Horse: Lab Work by Private Corporation Hides Behind Not-for-profit Clinic," *The Independent Voice*, December 2006/January 2007.

⁵⁰¹ Letter from Terry Nichols, Laboratory Manger, Leamington District Memorial Hospital, to Dr. Raymond Bonin, Chair, Steering Committee on Hospital Laboratory Finance Reform, January 29, 1996.

⁵⁰² This was the report at a public meeting in Winchester on the future of Rural Hospitals that I attended in March 2007.

⁵⁰³ Dave More, "Trojan Horse."

⁵⁰⁴ St. Thomas Elgin General Hospital information bulletin, undated, contact Brenda Lambert, VP. Patient Services. This bulletin announces the closing of their community SCCs on March 31, 2007 and that MDS and CML will pick up these services.

⁵⁰⁵ Personal Communication, Ray Cousineau, Campbellford Health Coalition, November 20, 2006.

⁵⁰⁶ More, "Testing For Profit," 2007, p. 6.

⁵⁰⁷ Carl Braun, "Hospitals In-Common Laboratory Inc.: 2004 Annual Address," Hospitals In-Common Laboratory Inc., 2004.

allow twelve small hospitals, in nine ‘pilot projects’, to enter into joint ventures with a private sector partner to collect community laboratory specimens and have the hospital’s laboratory process the work. HICL became the private sector partner in six of these pilots, MDS in two and Gamma Dynacare in one.⁵⁰⁸ The government agreed to pay the private sector-hospital partnership 86% of the standard OHIP rate for the volume of work performed in 1996. This gross payment stayed the same for the next ten years despite an increase in workload. The fee-for-service laboratories had their payments increase 28% between 1996 and 2004, eight of the same ten years.

As a result of the 1996 changes HICL closed its remaining central laboratory services. The organization still runs “the grid,” which coordinates the use of hospital laboratories for esoteric tests, and operates on an international level. Ending most of HICL’s community work was one more pressure forcing hospitals into partnerships with for-profit laboratories.⁵⁰⁹ The Hamilton Regional Laboratory Medicine Program⁵¹⁰ still runs three community collection stations, down from 10 in 1996, but will be closing its community laboratory services program in the fall of 2007.⁵¹¹

Resistance Movements

Resistance to reductions in hospital laboratory services, reductions in community access and ending competition for community laboratory work spurred numerous campaigns in the 1990s to increase access, competition, jobs and government laboratory budgets. This opposition was present in the deliberations of the LSR, but it also involved broader organizational and legal efforts.

⁵⁰⁸ HICL was the partner in Fergus, New Liskeard, Napanee, Orangeville, Perth and Winchester; MDS in Pembroke and Atikokan and Lake of the Woods (one pilot); Gamma-Dynacare one pilot for Parry Sound, Bracebridge and Huntsville. The agreement with Winchester ended in 2006.

⁵⁰⁹ Michael Watts, “Laboratory Restructuring in Ontario,” *Hospital News*, February 1997.

⁵¹⁰ Was the HHSLP.

⁵¹¹ Personal Communication, Andrea Tajaja, Coordinator Community Laboratory Services, HRLMP, June 4, 2007.

Health Care Workers

The first major response to declining hospital laboratory work came in 1991 when the Ontario Society of Medical Technologists, the professional association of laboratory technologists, passed a position paper on funding laboratory services.⁵¹² The paper, authored by Denis Frazer and Rick Lambert, presented a strong case that using for-profit laboratories is significantly more expensive than using hospital laboratories. They called for the government to allow hospitals to, “compete fairly for outpatient testing.” Not only would this save the government money but it would provide extra income for cash-strapped hospitals. It also would improve hospital management practices by exposing them to competition with the private sector. The data in this document became the basis for many of the arguments in favour of using of the public sector to process community laboratory work.

The Ontario Public Service Employees Union (OPSEU) led the union campaign for greater use of public sector laboratories. They had already demanded a public community laboratory system in 1976⁵¹³ and with the cutbacks in the 90s and the opening provided by the LSR renewed the campaign. The membership was educated about the problems with for-profit laboratories and OPSEU locals raised the issue at the hearings on the reform of the *Public Hospitals Act* as well as the LSR.⁵¹⁴ Ideally they wanted to “nationalize the private laboratories,” but focused on a more limited objective to have hospitals reimbursed for community laboratory work.⁵¹⁵ They emphasised the extra cost due to waste, duplication, profit, unnecessary marketing and conflict of interest.

After the release of the LSR in 1994 the unions organized a delegation, including representatives of HICL, and the Ontario Health Coalition, a public advocacy group, to see Ruth Grier, then Minister of Health. They demanded that the government take

⁵¹² Denis Frazer and Rick Lambert, “Laboratory Out-Patient Funding: Past Present & Future,” presented to the Ontario Society of Medical Technologists, 28th Annual Convention, September 26, 1991.

⁵¹³ Press Release, March 5, 1976, Ontario Public Service Employees Union.

⁵¹⁴ “Care and Quality: Health Care for the People, Not Profit,” A brief concerning the reform of the Public Hospital Act by the Ontario Public Service Employees Union, July 1992.

⁵¹⁵ “Laboratory Services Review Advisory Committee,” memo from the OPSEU Medical Division Executive to All Sector LEC’s, July 12, 1993, and an attachment outlining an \$85,000 campaign to mobilize members for this “high priority” campaign for a “uniformly public system of medical laboratories.”

“strong action in favour of the not-for-profit system of laboratory services.”⁵¹⁶ Minister Grier said she would seek assurance that no “inhibitors” would be placed in the way of the expansion of not-for-profit models and she took a strong position against conflict of interest.⁵¹⁷ She would not take a position against the use of for-profit providers. Her position differed significantly from the Conservative government elected the following year that tried to effectively outlaw HICL.

Hospital Pathologists – the Campaign for Medical Laboratory Funding Reform

The campaign that received the most publicity was spearheaded by pathologists at Laurentian Hospital in Sudbury. They brought together hospital workers’ unions, the Ontario Associations of Pathologists and Medical Microbiologists and many hospitals in the Campaign for Hospital Laboratory Finance Reform. The campaign proposed that hospitals be allowed to charge OHIP 25% less than the rate charged by for-profit labs to provide the same service. Hospitals could then compete with the private sector and give doctors and patients choice in which laboratory service they wished to use. They argued that if the hospitals performed 25% of the community laboratory tests it would save the province twenty-five million dollars per year: money that could be used “for social, welfare, educational and other services in Ontario [that] are being cut.”⁵¹⁸ The funding model developed by HICL was cited to support their case.

Endorsements for Hospital Laboratory Financing Reform were obtained from over seventy-five hospitals⁵¹⁹ and the “overwhelming majority” of OMA Laboratory Section Members.⁵²⁰ OPSEU strongly endorsed the proposal and organized a province-

⁵¹⁶ “Health Care Unions Urge Not-for-profit Labs,” press release, April 19, 1994, Ontario Federation of Labour, Don Mills Ontario.

⁵¹⁷ “Meeting with Ruth Grier on Lab Services,” memo from Hugh Armstrong to Julie Davis, Catherine MacLeod and Adrianna Tetley, April 20, 1994. This is an internal memo from Hugh Armstrong, a staff person with the Ontario Federation of Labour, who had attended the meeting with Minister Grier, reporting on what was said.

⁵¹⁸ “Ontario Government Says No to Saving Tax Dollars,” press release, November 13, 1995, Canada NewsWire.

⁵¹⁹ Letter from the Steering Committee on Hospital Laboratory Reform to the Honourable Jim Wilson, Minister of Health, February 22, 1996.

⁵²⁰ The OMA circulated a survey to its Laboratory Section members in the fall of 1995 to identify support for the Laurentian proposal for hospitals receiving funding for community laboratory work and the LSR recommendations. Of the 67 respondents who were hospital laboratory directors, 39 supported the

wide petition campaign in support. It was part of their fight against the Common Sense Revolution of the first Mike Harris Conservative government.⁵²¹ The campaign also attracted local media and province-wide press.⁵²²

As well as organizing a public campaign, some of the pathologists at Laurentian Hospital in Sudbury challenged the issue legally. The spark for the legal challenge was a 1994 letter from the Deputy Minister of Health that indicated that all pathologists, whether or not they were affiliated with a private laboratory, were entitled to claim professional fees from OHIP,⁵²³ that is, hospital pathologists should be able to bill fee-for-service for their work. This would be a significant change. For twenty-three years the Ministry had maintained that this was not an option. An in-depth legal evaluation of the regulations and legislation found a contradiction in official government policies and practices. One set of policies accepted pathologists' services as insured services that could be billed on a fee-for-service basis, another said they were covered by a hospital's global budget, which precluded further billing. To challenge OHIP's long-standing position some pathologists billed OHIP for their services, and when their bills were rejected they launched a judicial review of the regulations.

When it became clear that the pathologists had a strong case, the government responded by changing the regulatory regime. Enacted on May 1, 1996, and backdated to April 1, 1995, Regulation 111/96 amended Regulation 552 of the *Health Insurance Act* and acknowledged that hospital pathologists, like radiologists, could bill OHIP fee-for-service, but the payment for these services would be "NIL." This blatant policy insult

Laurentian proposal and 7 the LSR. Of the 149 respondents, a majority supported both proposals, but support for the Laurentian proposal was stronger. 130 endorsed the proposal 30 did not. For the LSR 63 endorsed the proposal and 49 did not. This was an informal survey and there are discrepancies in the numbers. The results of the survey are attached to a letter to Raymond Bonin, Chair, Steering Committee on Hospital Laboratory Finance Reform, from R.N. Gidwani, Chairman, OMA Section on Laboratory Medicine, January 29, 1996.

⁵²¹ "Campaign re: Hospital Laboratory Funding Proposal," memo to all LEC's and Unit Stewards in OPSEU's Medical Division from Leah Casselman, President OPSEU, and Wendy Curley, Chair, Medical Division (Sector 10), December 2, 1995.

⁵²² Thomas Walkom, "A 'Common Sense' Dilemma on Medical Lab Testing," *Toronto Star*, November 14, 1995; Denis St. Pierre, "Sudbury Pathologist Takes on Government," *Sudbury Star*, March 12, 1996; and articles in the *Windsor Star* and *Northern Life*. It was reported in Steering Committee on Hospital Laboratory Finance Reform minutes, December 2, 1995, that spokespeople for the campaign were interviewed on local French and English CBC and *As It Happens*.

⁵²³ Letter from Margaret Motterhead, Deputy Minister of Health, to Peter Fraser, CEO of the OMA, May 17, 1994.

was a blow to campaigns to obtain funding for hospitals to provide community laboratory services.

After the passage of regulation 111/96 the OMA Section on Laboratory Medicine started a campaign to have laboratory specialists recognized as medical specialists and treated equally with other physicians.⁵²⁴ Concurrently it decided to support the OLSIS attempts to integrate regional laboratory services and not to support the proposal for hospital laboratory financing reform. It was argued that allowing hospitals to compete with the private sector would incline hospitals to compete with one another for more business, against the trend of more cooperation between hospitals, and hospitals would be more likely to use private sector management practices.⁵²⁵ By the mid-1990s most laboratory medical specialists had become strong advocates for the hospital laboratory system.

These campaigns by professional associations, unions, pathologists, hospitals and public advocacy groups in response to government cutbacks and consolidation of industry power brought to a head a decades-old conflict over how community laboratory services should be provided. The denouement was a definitive ruling by the Harris Conservative government that hospitals would not receive fee-for-service remuneration from OHIP for laboratory work and the creation a for-profit oligopoly in the community laboratory sector.

Small Laboratories

There was one other voice in opposition to government policies favouring the larger laboratory corporations: the smaller for-profit companies. These companies did not share the view of the other campaigns that more work should be going into the public sector but they opposed government policy limiting competition. The small labs, led by Dr. Kurian of Alpha Laboratories, made the argument that they had been taking market share from the larger companies by being more responsive to doctors and patients and

⁵²⁴ "Re: Reg. 111," memo to Council, OMA Section of Laboratory Medicine, from Rocke Robertson, Chair, December 12, 1996.

⁵²⁵ Minutes the Annual General Meeting of the OMA Section on Laboratory Medicine, May 23, 1996; and "Re: Lab Funding Reform," letter to Ram Gidwnai, Chair, OMA Section on Laboratory Medicine, from Murray Treloar, MD, November 29, 1995.

providing services the larger ones were not prepared to offer.⁵²⁶ As part of their campaign they collected dozens of letters from potential customers saying they were unhappy with the service from the larger labs.

Four of the smaller laboratories organized a legal challenge to regulation 02/98. One of the effects of backdating the regulation to 1996 was that any extra money the smaller laboratories had earned by expanding their market share during those two years (1996-1998), and it turned out to be millions of dollars, had to be reimbursed to their larger competitors. The case was heard in divisional court in November 1998.⁵²⁷ The court rejected the appeal saying that the small laboratory companies had, “no vested right in a previous method of distribution.” The court supported the move away from a fee-for-service system. The court refused to interfere with the imposition of a corporate cap. Along with the court challenge, Gerard Kennedy, Liberal MPP, denounced the government’s regulation because it favoured a handful of corporations over doctors, patients and taxpayers.⁵²⁸

In the end all of these campaigns came to nought: three corporations emerged as the big winners of laboratory restructuring in Ontario and non-profit alternatives were diminished. (See Table on Concentration of Laboratory Services)

Concentration of Laboratory Services

	Number of chains	% of community lab volume
1966 ⁵²⁹	4	25
1975 ⁵³⁰	10	51
1993 ⁵³¹	5	70
2005 ⁵³²	3	90

⁵²⁶ To support this argument they collected scores of letters from doctor’s clinics, patients and nursing homes requesting the service of Alpha Labs because of reductions in their service due to cutbacks by one of the larger laboratories.

⁵²⁷ Jim Simpson, “Ontario Courts Dismiss Further Challenges to Gov’t Management of the Health Care System,” *Ontario Medical Review*, November 1, 1999, downloaded January 8, 2007 from <http://www.oma.org/archives/omr/nov/99legal.htm>.

⁵²⁸ “Harris Government Fails Test on Medical Lab Services,” news release, Gerard Kennedy, Liberal Health Critic, May 25, 1998.

⁵²⁹ Chemical Engineering Research Consultants, *Private Clinical laboratories In Ontario*. There were only 4 “chains” in 1966 and they only performed 2% of the total provincial laboratory volume, or 25% of the 8.5% done in for-profit laboratories.

⁵³⁰ P.J. Plant, “Monopoly Potential.” These were the ten largest laboratory companies. There were many more with more than one laboratory.

⁵³¹ “Laboratory Services Review Discussion Paper #2: System,” June 1993, p. 23.

2006 – The Big Three and Other Consequences

Three laboratory corporations, MDS, CML and Dynacare, currently provide over 90% of the community laboratory services in Ontario.⁵³³ MDS, short for its original name, Medical Data Systems, was formed in 1969, “by five former employees of IBM’s medical services division ... to provide health screening services to large Ontario corporations.”⁵³⁴ It provides approximately 31% of the community laboratory services in Ontario.⁵³⁵ The Ministry of Health will not say how much is paid to MDS, or any other laboratory company, even though hundreds of millions of dollars are paid annually to these firms. It considers this to be privileged information.

MDS started its laboratory services by buying Toronto Medical Laboratories, a small chain of laboratories owned by Dr. Ley, the Director of Haematology at Toronto Western Hospital and a professor at the University of Toronto.⁵³⁶ It grew by an aggressive acquisition campaign and by expanding its market. In 2005 it had revenues of 1.8 billion dollars from medical supplies, drug development, and return on one billion dollars in assets in health and life sciences venture capital funds, as well as laboratory services.⁵³⁷ In 1997 it was reported that MDS labs produced one third of the company’s revenue and 40% of its profit.⁵³⁸ In 2006 the medical laboratory division was sold to Borealis Infrastructure Management, an investment arm of the Ontario Municipal Employees Pension Fund, for 1.3 billion dollars.⁵³⁹ MDS Health Services Incorporated wanted to focus on the more growth-oriented parts of its business. MDS’s 2005 annual report states that, “our new strategy is straightforward: focus on life sciences markets to

⁵³² Personal Communication, Horace St. Aubyn, Policy Advisor, MOH, Laboratories Branch, August 23, 2005.

⁵³³ Personal Communication, Horace St. Aubyn, Policy Advisor, MOH, Laboratories Branch, August 23, 2005.

⁵³⁴ Colleen Fuller, *Caring for Profit: How Corporations are Taking Over Canada’s Health Care system*, Vancouver: New Star Books, 1998.

⁵³⁵ “MDS Diagnostic Service Announces New Fee Arrangement in Ontario,” press release, April 7, 2006. downloaded from <http://newsreleases.mdsinc.com>, July 18, 2006.

⁵³⁶ Chemical Engineering Research Consultants Limited, *Private Clinical laboratories In Ontario*, pp. 10-11.

⁵³⁷ Leonard Zehr, “New Leader, New Life for Tired MDS,” *Globe and Mail*, Saturday, August 20, 2005.

⁵³⁸ Ian Austen, “Medicare? Gotta Love It,” *Canadian Business*, June 1997, pp. 47-55.

⁵³⁹ Leonard Zehr, “MDS Reaps Windfall with \$1.3-Billion Sale of Lab Unit,” *Globe and Mail*, November 6, 2006, B1.

drive growth and improve operating performance,”⁵⁴⁰ which defined its approach to the community laboratory business and why it exited this business when the market matured.

Canadian Medical Laboratories (CML) was founded in 1969 in Simcoe, Ontario by Dr. Mull, a pathologist who continues as Chairman and CEO of the company. It has grown into an international corporation with over 250 million dollars a year in revenue and interests in innovative drug development and diagnostic imaging. In 2002 CML stated that it, “enjoys a 30.5% market share” in Ontario.⁵⁴¹ Two years ago CML hived off its laboratory testing and medical imaging services into an income trust to provide, “shareholders with an opportunity of receiving regular monthly cash distributions.”⁵⁴² Income trusts have been in the news recently due to their negative effects on tax revenues and their benefits for investors. In essence the CML income trust structure takes public tax dollars (tax breaks and health care dollars) and funnels them into the bank accounts of private investors. CML’s recent operating profit margin has been about 40%.⁵⁴³ This is largely because of the relatively stable income flow provided under Regulation 02/98.

Dynacare is a conglomerate of many smaller laboratories brought together by the Latner family of Toronto in 1986, using money made from an overheated real estate market. Among the laboratories it consolidated was Kopp Laboratories, which in 1968 was owned by a group of fourteen physicians and operated eight laboratories,⁵⁴⁴ Kipling Medical Laboratories, which was founded before 1966,⁵⁴⁵ and Cybermedix, a commercial laboratory formed in the early 1970s.⁵⁴⁶ It further expanded by purchasing operations in the United States to become the third largest independent provider of

⁵⁴⁰ *MDS 2005 Annual Report.*

⁵⁴¹ *Strengthening Healthcare Services: Canadian Medical Laboratories 2002 Annual Report.*

⁵⁴² “CML Healthcare Announces 2003 Fiscal Year End Results and Proposal to Convert to an Income Trust to Enhance Shareholder Value,” media release, CML, December 16, 2003.

⁵⁴³ James Cole, Senior Vice President and Portfolio Manger, “AIC Canadian Focused Corporate Class: A Management Discussion of Fund Performance,” downloaded from http://www.aic.com/Resources/pdfs/en/can_foc_corp_ann_ENG_2004.pdf, March 22, 2007.

⁵⁴⁴ Chemical Engineering Research Consultants Limited, *Private Clinical laboratories In Ontario*, pp. 11-12.

⁵⁴⁵ The sale of Kipling Medical Laboratories in 1988 provided the initial owners with capital to develop an international biomedical incineration firm.

⁵⁴⁶ Cybermedix was a chain of laboratories in Quebec and Ontario. It changed ownership regularly; at different times being part of a conglomerate with a cable TV network, an all-news radio network, an engineering firm and a meat packing business. It was owned by CML before becoming part of the Latner holdings along with real estate and other health care ventures.

clinical laboratory testing services in North America.⁵⁴⁷ The Latners sold the company to a Chicago-based venture capital firm in 1997. In 2002 LabCorp, the second largest American laboratory service provider, with 2.2 billion dollars in revenue in 2001, purchased Dynacare, which then had revenues of 402 million dollars.⁵⁴⁸

Payments from the public insurance system provided a steady income to these companies and financed their expansion into other health care businesses. The hard caps and negotiated agreements did not decrease the value of the medical laboratory divisions of these conglomerates, as evidenced by their recent sales and profit margins.

Privileged For-profit Position in Decision Making

As mentioned earlier the OAML-MOH Memorandum of Agreement created a situation in which the OHA and OMA were excluded from key decision-making committees affecting the community laboratory sector, but the OAML had a say in regionalization decisions, which mostly affected hospital integration. Numerous informants also noted that for-profit laboratories brought very little information about their operations to the integration discussions, while information on public hospitals was widely available. This secrecy was justified by business confidentiality. Corporate self-interest also impeded greater integration between the commercial laboratories.

After the passage of Regulation 111, lab physicians tried to enlist the OAML in their campaign to have their services recognized as medical services and remunerated on a fee-for-service basis.⁵⁴⁹ In return for its support the OAML asked to have a representative on the Council of the OMA's Laboratory Medicine Section. In response the Laboratory Section asked that they have a representative on the OAML's Clinical Laboratory Practice Committee. The OAML refused because they felt that, "OMA representation on the committee could ... serve only a political agenda and that not the

⁵⁴⁷ "Management's Discussion and Analysis of Financial Condition and Results of Operations," part of a Prospectus filed under the Securities Act of Ontario by Dynacare Inc., November 17, 2000, p. 24.

⁵⁴⁸ "Healthy Takeover Deal for Dynacare," Hamilton: *The Hamilton Spectator*, May 10, 2002.

⁵⁴⁹ "re: Draft Statement on Laboratory Physician Services," letter from Raymond Bonin to Locke Robertson, December 3, 1996.

OAML's."⁵⁵⁰ This attitude reflects the for-profit sector's limited self-interest and lack of concern for goals that do not meet their corporate needs.

In 2000 the OAML felt it had good access to the MOH, boasting of a 40% increase in consultations with Ministry staff on a wide-ranging series of issues.⁵⁵¹

Why the For-profit Sector

In the previous chapters concerns about quality and fraud, the different funding, measurement and payment systems, the specifics of federal programs, and the role of laboratory specialists all helped structure the medical laboratory market so that the for-profit corporations could consolidate and grow. By 1990 the commercial sector was a 450-million-dollar industry dominated by a few large corporations with influence beyond the medical laboratory sector. The background acceptance of the free market and private corporations came to the foreground, governments aggressively pursued downsizing, trade pressures exerted themselves, hospitals started to seek out joint ventures, the direct and indirect costs of removing community services from the for-profit corporations and the simple lobbying power of the commercial corporations all combined to cement their market dominance.

Support for the Free Market

More assertive pro-market forces portrayed the LSR and its outcomes as a test of how anti-business the NDP government would be. At the Toronto LSR hearings Martin Barkin, a former Deputy Minister of Health and Director of Dynacare, issued an implied threat: "Private investors are watching laboratory reform as an indicator of the general investment climate for health industries in Ontario."⁵⁵² The theme was reinforced by

⁵⁵⁰ Letter from Paul Gould, CEO of OAML, to Brian Sheridan, Associate Medical Director of MDS, May 16, 1997.

⁵⁵¹ Virginia Turner, CEO OAML, "Year 1999 – 2000 and the Future 2000 – 2001," speech to the OAML Annual General Meeting, March 29, 2001.

⁵⁵² Louise Kinross, "Summary of Submission to the Public Hearings on the Draft of the Laboratory Services Review: Toronto, January 21, 1994," p. 11. Quote contained in Martin Barkin, Slide Show, "Presentation to Lab Services Review," undated.

MDS, which argued for the many benefits of profits, including increased tax revenues, creation of wealth and jobs, development of new technologies for export and increased investment in the province by health care companies.⁵⁵³ Private-sector consulting firms with strong ties to the business community played a central role in shaping laboratory sector policy.

Even the union supporters felt the need to frame their arguments in a general acceptance of private enterprise. Wendy Curley, head of OPSEU's lab workers division, was quoted in the *Toronto Star* as saying, "I have no problem with private industry, but not when it comes to health care."⁵⁵⁴ As in earlier discussions on providing laboratory services, the general acceptance of the free market precluded the option of closing the for-profit laboratories. The difference after 1990 was that the commercial companies claimed pride of place within the delivery of community medical laboratory services.

Trade and Industrial Strategy

The pressure to recognize the contributions of the for-profit corporations dovetailed nicely with the pressure for industrial strategies to develop strong local industries that could compete in the international marketplace. Martin Barkin began his presentation to the LSR with the assertion that: "Health industries development by the private sector is government policy and is an important industrial strategy."⁵⁵⁵ The bulk of his presentation argued that we can not afford public delivery of health care. He quotes Ruth Grier saying that we must use our health care dollars to, "create a springboard to export markets." MDS is presented as a positive example of a Canadian company that creates jobs and wealth in Canada and expands internationally.

The government established a Health Industries Advisory Council to help attract businesses to Ontario and advise the government on how to invest in this sector.⁵⁵⁶

⁵⁵³ John Rogers, CEO and President of MDS, "Laboratory Services Review Hearings," deputation given on January 21, 1994.

⁵⁵⁴ Art Chamberlain, "Provincial Report Backs Private Labs: Industry Relieved, Health-care Unions Furious," *Toronto Star*, Monday, March 28, 1994, D1

⁵⁵⁵ Martin Barkin, Slide Show, "Presentation to Lab Services Review," undated.

⁵⁵⁶ "Terms of Reference Health Industries Sector Council," attached to a letter from Andrew Szende, Head, Health Economic Development, to Julie Davis Secretary Treasurer, Ontario Federation of Labour, July 20, 1994.

Interhealth, a government agency, would match private sector investment and help, “link private companies, not-for-profit and government to bid on consulting contracts.” Part of the strategy is that, “health service companies can open the door for made-in-Ontario products.”⁵⁵⁷ A newspaper article covering the release of the Health Industry Advisory Council report included a picture of a lab assistant using MDS Health Group’s AutoLab with the caption: “It’s the kind of business new report favours.”⁵⁵⁸ A key component of this strategy was, “increased access to domestic markets as a springboard to developing globally competitive health industry companies.”⁵⁵⁹ In practical terms this meant more access to hospital laboratories for private management services, more for-profit hospital joint ventures and new technologies like the AutoLab.

The strategy of using the health care sector, and specifically laboratories, as an engine of technological innovation was also raised in the early 1980s. The Task Force on High Technology Diagnostic Laboratory Procedures and Equipment reviewed all the commercial information systems available in the United States, there were none in Canada, and found them wanting. They recommended that the Ontario government play an essential role in developing a centralized information system that could be adapted to local hospital needs.⁵⁶⁰ It was seen as a way of both saving money and keeping national control. This nationalist public sector focus contrasts sharply with the reliance on MDS and the private sector in the 1990s. In 2005 the contract for an information system for laboratories in Ontario was let to Capgemini Canada Inc., a subsidiary of a French multinational.⁵⁶¹

⁵⁵⁷ “Health Service Companies get Competitive Edge in International Marketplace,” news release, Ministry of Health. November 16, 1993.

⁵⁵⁸ Art Chamberlain, “Health-care Field Ripe for Jobs, Report Says,” *Toronto Star*, March 16, 1994.

⁵⁵⁹ Attachments to a letter from Andrew Szende, Head, Health Economic Development, Ministry of Health, to Julie Davis, Secretary Treasurer of the Ontario Federation of Labour, July 20, 1994.

⁵⁶⁰ *Final Report of the Task Force on High Technology Diagnostic Laboratory Procedures and Equipment: Part 1 – Data management*, Ontario Council on Health, February, 1981.

⁵⁶¹ “Laboratory Information System Integration: A Survey of Current and Proposed Local or Regional Models of Connectivity,” The Ontario Hospital e-Health Council: Hospital Laboratory Information Systems Advisory Council, the Ontario Hospital Association, November 2006, p. 6.

The Economic Strength of the Commercial Laboratories

There have been numerous reasons floated to explain why the NDP did not take a stronger position on the private labs. Thomas Walkom, a *Toronto Star* columnist, commented that MDS Health Care Group, “is viewed by the NDP government as a model firm – innovative, risk taking, and 20 per cent employee owned.”⁵⁶² The provincial secretary for the NDP, Brian Harling, left politics and took a job with MDS as their political point person, adding to their lobbying strength. But there are broader reasons. Rising debts and deficits coupled with the rising neo-liberal tide to downsize government lead to cutbacks in funding for laboratory services, both in hospitals and the community. The government felt it had to appear business friendly and meet their economic development strategy of promoting strong domestic companies with export potential.⁵⁶³ There were also the negative economic effects of shutting down the commercial laboratories. These factors were often raised by informants who strongly supported greater use of the hospital sector. In 1992 about 3700 workers in Ontario would have been displaced.⁵⁶⁴ Many would have found work in hospitals but there would be some disruption. Stock in these companies, particularly MDS and CML, is widely held in pension and mutual funds. Any move against the companies would reduce the value of these holdings affecting significant portions of the population. This problem is compounded with the recent acquisition of MDS by a public-sector pension fund. The public sector that would benefit from bringing laboratory work into hospitals now faces a small threat to their pension plan if this were to happen. And finally there was a concern raised in the Social Contract study: the cost of buying out the companies and upgrading hospitals to perform the extra work.

The cost of buying out the for-profit laboratories was likely a “red herring.” In denying the legal challenge to Regulation 02/98, the court argued that, “the Ministry was simply seeking an alternative to the fee-for-service system,” and that, “there is little to

⁵⁶² Thomas Walkom, “Kickbacks to Doctors Would be Headache for NDP,” *Toronto Star*, Thursday, July 28, 1994.

⁵⁶³ As noted earlier they actively promoted a domestic health care industry strategy and George Ehring and Wayne Roberts document the government’s attempts to be business friendly in *Giving Away A Miracle: Lost Dreams, Broken Promises and The Ontario NDP*, Oakville: Mosaic Press, 1993.

⁵⁶⁴ This figure includes technicians, technologist, scientist and physicians. “Human Resources: Discussion Paper #3,” Laboratory Services Review, June 1993.

support this claim to a vested right in a previous method of distribution.”⁵⁶⁵ For-profit laboratories are on time-limited contracts with no guaranteed volume of work. Buying out the business would probably not be necessary, except for a possible challenge under various trade agreements. The ownership of Dynacare by Labcorp, an American company, might trigger an action under GATS national treatment and market access rules, requiring compensation because of the effective nationalization of their business.⁵⁶⁶ Although the argument of significant long-term savings is strong, there would likely have been short-term costs and these created difficulties for a government concerned with deficits and its pro-business image.

Conflict of Interest

Concerns about fraud and conflict of interest in the community laboratory sector continued through this period. An article in the *Toronto Star* told the story of a Toronto lab paying up to three thousand dollars to doctors to direct patients their way.⁵⁶⁷ Most conflict situations were more nuanced. For instance, laboratories would lease six thousand feet in a building owned by physicians but only occupy one thousand, allowing the physicians to use the building at little or no cost.⁵⁶⁸ Or, a laboratory would pay one-hundred-and-twenty dollars per square foot rent while other, physician tenants would pay twenty.⁵⁶⁹ It was reported in 1996 that about one hundred doctors were being investigated for taking kickbacks.⁵⁷⁰ Allegations of fraud in the laboratory industry are not limited to Ontario. Since the early 1970s sections of the laboratory industry in the

⁵⁶⁵ Jim Simpson, “Ontario Courts Dismiss Further Challenges to Gov’t Management of the Health Care System,” *Ontario Medical Review*, November 1, 1999, downloaded January 8, 2007 from <http://www.oma.org/archives/omr/nov/99legal.htm>.

⁵⁶⁶ Mathew Sanger, *Reckless Abandon: Canada, the GATS and the Future of Health Care*, Ottawa: Canadian Center for Policy Alternatives, 2001.

⁵⁶⁷ Thomas Walkom, “Kickbacks to Doctors Would be Headache for NDP,” p. A1.

⁵⁶⁸ Thomas Walkom, “Kickbacks to Doctors Would be Headache for NDP.”

⁵⁶⁹ Bruce Thomson, a pathologist in Georgetown, letter to I. Jadusingh, Medical Laboratory Consultants in Calgary, May 12, 1997.

⁵⁷⁰ Lisa Priest, “MDs Cited for Fraud: Some 100 Probed over Kickbacks and Referral Fees,” *Toronto Star*, February 27, 1996, p. A1. Also see Lynne Cohen, “Issue of Fraud Raised as MD Self-Referral Comes Under Spotlight in Ontario,” *Canadian Medical Association Journal*, 1996 (154), pp. 1744-1746, for a more detailed discussion.

United States have been defrauding Medicare and Medicaid:⁵⁷¹ this includes Laboratory Corporation, the current owner of Dynacare, which had to pay civil penalties of 182 million dollars for fraudulently billing health care programs in the United States.⁵⁷²

With the hard caps in place there was less pressure on companies to provide incentives to increase the volume of work. In fact many physicians reported that laboratories had stopped the “perks,” such as free equipment and phlebotomists on site, which had been the focus of much conflict of interest concern.⁵⁷³ Regulation 682 under the *Laboratory and Specimen Center Collection Act*, passed in 1996, placed tighter restrictions on laboratories conferring benefits on physicians who ordered laboratory tests. One section specifically prohibits beneficial rental agreements, though it exempts any lease in effect on the date the amendment passed. A search the College of Physicians and Surgeons of Ontario disciplinary rulings found no convictions under the conflict of interest regulations since 1993.⁵⁷⁴

These restrictions did not stop agreements between clinics and corporations, which when increases in the cap became a matter of routine were once again interested in ensuring market share. An agreement between Gamma Dynacare and YFMC Health Care / Med-Emerg International contained kickbacks to the clinics of 6% of the net OHIP billings as a, “contribution for the cost of collecting specimens” and 15% for non-insured samples.⁵⁷⁵ These structures contain a financial incentive paid for by public health care dollars for the clinic to provide more rather than fewer specimens.

The dual roles of some pathologists working in the public system and for-profit laboratories continued to be a concern. In 1995 forty-seven hospital laboratories shared a

⁵⁷¹ Darlene Berger, “A Brief History of Medical Diagnosis and the Birth of the Clinical Laboratory: Part 4 – Fraud and Abuse, Managed Care and Lab Consolidation,” *Medical Laboratory Observer*, December 1999, downloaded from, http://findarticles.com/p/articles/mi_m3230/is_12_31/ai_58546315.

⁵⁷² “Lab Firm Agrees to Civil Penalty on 182 Million,” *The Wall Street Journal*, Friday, November 22, 1996, p. B6.

⁵⁷³ Michael Thorburn, “Ontario Laboratory Industry in Transition Prompts Physician Concern: Access to Patient Services, Revised Practice Arrangements among Issues Cited,” *Ontario Medical Review*, May 1, 1999, download March 20, 2007 from <http://www.oma.org/archives/omr/nov/99oaml.htm>.

⁵⁷⁴ Obtaining information from before 1993 was not possible for this paper, but numerous informants were asked and none could remember any physicians having been found guilty of misconduct for conflict of interest violations and none were uncovered in my research. There were reports of three physicians being prosecuted in 1970, and in 1996 a newspaper story said there were 100 physicians being investigated for alleged conflicts of interest. In 1971 the Minister of Health, in answer to a question during discussions of the estimates on May 25, said that there had never been a case of fraud found by OHSIP.

⁵⁷⁵ Letter from Ivan Flaschner, Vice President, Corporate Affairs, Gamma Dynacare, to Don Wilson, YFMC/Med-Emerg International, November 8, 1999.

medical director with a for-profit laboratory.⁵⁷⁶ This type of conflict has been a long-standing problem in laboratory services and it was at the centre of a 1996 dispute in Sudbury. The medical director of the Sudbury General Hospital, who was also a director of an MDS laboratory, attempted to transfer most of the hospital's laboratory work to MDS. Opposition from local health professionals and the community thwarted this plan.⁵⁷⁷ In 2007 eighteen hospitals still shared a laboratory director with a commercial laboratory; nine of these were smaller northern hospitals.⁵⁷⁸

Conclusions

The period 1990 to 2006 marked a change in government policies towards the community laboratory sector. There was a shift in the role of the federal government from driving collective health care solutions to budget cutbacks that facilitated the expansion of for-profit health care. Compared to the 1960s and 1970s, the provincial government capped expenses to the entire sector rather than trying to control the behaviour of physicians and individual corporations. Fiscal pressures on the medical laboratory services increased through the 1990s: per capita funding fell from 105 dollars in 1991 to 80 dollars in 1998.⁵⁷⁹

Integration initiatives were aggressively pursued by the province and the commercial sector was given a privileged position. These approaches reflected a shift from centrally supported non-profit approaches, such as HICL and the LOPPP, to a centralized devolution to the regions. The government instead of supporting non-profit alternatives actively ended them.

After the last decade of intense activity to integrate medical laboratory services there is limited integration between the hospitals and the community sector. Hospitals have made progress in coordinating their services, but the commercial laboratories

⁵⁷⁶ List of Laboratory Medical Directors released under Freedom of Information request file number 95502-MOH on January 16, 1996.

⁵⁷⁷ Denis St. Pierre, "Officials Deny Conflict in MDS Proposal," *Sudbury Star*, March 4, 1996.

⁵⁷⁸ "Laboratory Director List," supplied by the Laboratories Branch of the MOH, March, 2007. The decreasing overlap is likely due to the smaller number of commercial laboratories.

⁵⁷⁹ David More, Sandip SenGupta and Paul Manley, "Promoting, Building and Sustaining a Regional Laboratory Network in a Changing Environment," *Clinical Leadership & Management Review*, September/October 2000, pp. 205-210.

continue to compete against each other in most communities.⁵⁸⁰ There has been a further shift in community work from hospitals to for-profit laboratories and some for-profit involvement in the delivery of inpatient work. The results suggest that laboratory restructuring in the 1990s was intended to shift as much work as possible to the for-profit sector. Ironically, even though it may not have been their intention, the NDP government under Bob Rae that put in place much of the framework for this shift.

The political debate around the delivery of community laboratory services was stronger and more public during the 1990s than at any time before or since. A central issue was the role of the for-profit providers. The medical profession, moved from a position of control in the community laboratory system in the 1960s to being marginalized in the new century, became key supporters of expanded hospital services and hospital integration to improve quality and cost effectiveness. The results after ten years of restructuring speak for themselves. Competition in the community laboratory market was legislatively ended guaranteeing three multinational companies control over 90% of the laboratory market.

The government and supporters of the free market say there is a role for public and for-profit providers, yet at each step the for-profit companies have expanded to provide any service where they can profit. The role of the public sector has been to increasingly provide only the more expensive, less profitable services. A stable relationship between the commercial corporations and the public sector does not exist except rhetorically. As the MDS annual report says the objective is to “drive growth.”

In one sense the history described in this study ends where it started. Hospitals and the public sector are taking initiatives to integrate in order to decrease costs and improve quality, and the process is being undermined by the existence of a parallel commercial laboratory sector.

One solution, establishing a non-profit community collection system, transportation networks and moving staff and testing facilities from for-profit corporations would take years. But the experience of HICL and the HHSLP indicate that

⁵⁸⁰ One could argue that the consolidation of the community laboratory sector into three large corporations has increased integration, and this would be correct, though it has done so within the separate corporate entities, and not system wide. For instance you will commonly see a CML collection centre across the street from an MDS centre.

it is both workable and cost effective. What is needed is the political will to accept that the best method of providing medical laboratory services is through a public, non-profit system and begin the process of bringing that about.

Chapter Six: The Cost of Using the For-profit Sector

I have been concerned in this thesis with two main themes. One is the impact of for-profit corporations on the cost and integration of Ontario's medical laboratories as part of a larger discussion on the effects of commercial delivery of publicly funded health care services. The existence of numerous public, non-profit options for provision of the same laboratory service as the commercial sector provides a "natural experiment" to evaluate a question at the heart of an ongoing political debate. The second is the factors that led to the dominance of for-profit corporations in Ontario's community laboratory sector and their relevance to the policy process in advanced capitalist states. The next two chapters will address these two themes in turn.

This chapter will consolidate data and present more in-depth comment on the cost and integration effects of using for-profit corporations to provide community laboratory services. The concern is with the total cost of the laboratory system to the public health care program. As the Minister of Health, Dennis Timbrell, stated in 1977, "there is only one payer." Examining this information is important to understanding the paradox underlying this research: while our public health care system funded the development of three for-profit multinational laboratory service corporations, government policy led to the demise of not-for-profit alternatives delivering similar services. One possible explanation of the paradox is that using for-profit corporations and the market provided a more cost-effective and integrated medical laboratory service. While sound arguments and the data, as presented below, strongly suggest that community laboratory work should be done within the public system, this is the argument made by the commercial industry.

Why Cost?

The limited focus on cost, rather than quality, accessibility and democracy, other common and important measures of the benefits of a government program, is both pragmatic and theoretical. It is a pragmatic because to have broadened the research to

fully consider these other dimensions would have taken far more time than was available. Nonetheless, the research touched on quality, accessibility and democracy in laboratory services as an integral part of its history, and a few observations and questions in each of these areas will be presented at the end of this chapter.

The choice of cost, and secondarily integration, is also based on more substantive considerations. The debate over the cost of various forms of health care delivery has been contentious, and in the case of laboratories has “been inclined towards invective.”⁵⁸¹ Claims of cost-effectiveness have a strong rhetorical appeal and have been central to laboratory policy discussions for the last fifty years. It was an issue for Ontario’s Conservative governments long before the Washington Consensus pushed reducing the size of the state onto the political agenda.

A significant part of the reason for the emotion in the cost debate is the high stakes involved. Canada’s total yearly expenditures on health care are approximately \$148 billion,⁵⁸² accounting for 39% of Ontario government spending.⁵⁸³ Total medical laboratory services still account for 4% - down from 7% in the early 1990s - of the health care budget.⁵⁸⁴ More is spent on medical laboratories than the combined budgets of the Ministries of the Environment, Natural Resources and Agriculture. Capital would benefit from access to these public health care dollars for private accumulation; the public would benefit from a sustainable public health care system. In a policy environment where cost is a central concern, the configuration of services that can be shown to deliver the services at the lowest cost was bound to have significant government support.

The political left has often dismissed cost as the concern of market forces and a tool used to cut services. While this is certainly true, the efficient use of resources, represented by the surrogate indicator costs, is important to progressive forces. Leys

⁵⁸¹ “Briefing Material for Minister’s Meeting with Ontario Association of Medical Laboratories, September 19, 1977,” memo from Paul J. Plant, Acting Director, Inspections Branch, to G.J. Chatfield, Assistant Deputy Minister, Institutional Health Services, September 2, 1977.

⁵⁸² Health Expenditure, by Year, by Source of Finance, by Province/Territory and Canada, 1975-2006 - Current Dollars, Canadian Institute for Health Information, download April 20, 2007, http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_topic_macrospend_e&cw_topic=Health%20Spending&cw_subtopic=Macro%20Spending.

⁵⁸³ Public Accounts of Ontario, 2005-2006, Annual Report and Consolidated Financial Statements, Ministry of Finance, April 20, 2007, download, http://www.fin.gov.on.ca/english/budget/paccts/2006/06_ar.html.

⁵⁸⁴ This includes public health, commercial and hospital laboratories.

argues that, “progressive democrats need to be concerned with raising productivity in public services, as much as (or more than) market fundamentalists,” albeit using different outcomes to measure cost-effectiveness. The Canadian Health Coalition, in its campaign for a national “pharmacare” plan, identifies cost-effectiveness as one of the main characteristics of the plan.⁵⁸⁵

Not only can a detailed understanding of the costs of a service be used to undermine arguments in favour of privatization, but it respects the fact that we, the people, have to make choices about how we use resources. In the current context it is no longer sufficient to make the argument that if the profit motive were removed there would be sufficient resources to meet all the population’s needs. There will be conflicts over resources between health care, environmental clean up, good housing, adequate incomes, a secure food supply and a variety of other pressing goals. Using resources to maximum benefit will make it possible to better address all of these needs. This reality of conflicting need is heightened by the increasing limits placed on public policy by the environment, by the ever-widening disparities within and between countries and the interaction between the two. Any social justice solution to the fact that Canadians use on a per capita basis 300 times as much health care as citizens of Mozambique has to include the most efficient use of our resources.

Integration is different from cost in that it is not a goal in itself, but a policy tool to achieve goals, in the case of laboratories it was primarily intended to decrease cost and increase quality. But it is similarly positioned: it has been a central issue, along with cost, in policy debates and government initiatives for the last fifty years. Understanding why the outcomes of the sequential provincial governments’ integration projects have produced mixed results both lays the ground work for the discussion on state policy in the next chapter and helps understand why it has been difficult to control health care costs.

⁵⁸⁵ “A National Pharmacare Plan: More for Less,” media release, February 22, 2006, Canadian Health Coalition.

The Logic of the Argument

The logic of the argument for using the public sector, hospitals and public health laboratories as the main providers of community services is straightforward. Hospitals need to provide on-site laboratory services. The medical necessity of being able to meet the needs of emergency and intensive-care patients promptly, and the heavy demand from acutely ill inpatients was recognized in Regulation 523, Section 33(1) under the Public Hospitals Act: “A hospital shall be equipped with a clinical laboratory with facilities and staff able to make routine investigations necessary for the treatment of patients in the hospitals.”⁵⁸⁶ By law all Ontario hospitals have to provide on-site laboratory services to meet, at a minimum, routine emergency needs.

Hospitals need laboratories with the capacity to satisfy their daytime inpatient requirements. For most hospitals this means significant unused capacity after hours. Community laboratory work could be done in hospitals with equipment that has already been publicly paid for, at times when it is not being used, in buildings that are already heated and maintained. The cost of processing this extra work becomes the marginal costs of using the existing equipment and space more often: extra staff, more reagents, and wear and tear on the machines and buildings. Increasing volumes in hospitals improves cost efficiency, “because laboratories have relatively high fixed expenses, a reduced volume substantially increases unit costs.”⁵⁸⁷ The ability of Ontario’s hospitals to meet the demand in the community is rarely questioned.⁵⁸⁸ In 1994 former Minister of Health Dennis Timbrell, then head of the OHA, commented, “there is massive reserve capacity in the hospital laboratories ... a fully staffed evening shift could absorb the private laboratories’ workload without difficulty.”⁵⁸⁹

⁵⁸⁶ Regulation 523 under the *Public Hospitals Act*, Toronto: the Hospital Services Commission of Ontario, 1966.

⁵⁸⁷ Edward G. Brenblum, “The Central laboratory: Who needs it?” *Medical Laboratory Observer*, 30(7), July 1, 1998: 60.

⁵⁸⁸ Interviewee 14 did challenge this assumption, arguing that hospitals did not have extra capacity and if they did this was a problem because they should be organizing their services to efficiently meet demand.

⁵⁸⁹ “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 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.

From a system point of view the cost of providing outpatient laboratory services at marginal cost to hospitals needs to be compared to the cost of providing the services in private laboratories. The first point of comparison would be the full unit cost of each test processed in a commercial laboratory because that remuneration is on a fee-for-service basis.⁵⁹⁰ Another comparison would be to consider the real costs of using public money to build and maintain excess capacity in the private sector to provide community laboratory services. This largely unneeded capacity could be justified financially only if other variable costs, particularly labour, were significantly cheaper than in hospitals. While private laboratories do pay less, it is hard to imagine, especially with chronic labour shortages, that these savings would even come close to justifying the extra capital and maintenance costs. And lowering incomes does have real impacts that negatively affect other areas of government finance. As well, any savings in labour and other variable costs would be at least partially offset by the commercial industry's need to pay a return to investors.

In either case, comparing the marginal cost in hospitals with the extra fee-for-service payment to the private sector, or the cost of paying to create excess capacity in the private sector rather using existing excess capacity in the hospitals, the logic of the argument is strongly in favour of using hospital laboratories to provide community laboratory services.

Not surprisingly, this approach is not the one advocated by the private laboratory industry. They want to compare the discrete unit costs of providing a test in a for-profit laboratory to the cost of performing the same test in a hospital, as if hospitals were just being set up to provide laboratory services. While there may be some benefit in looking at these types of questions to find ways of increasing efficiency in laboratory services they are not the central concern here. First, the private sector is generally unwilling, no less so in the laboratory industry, to allow public scrutiny of the component costs of their operations, making these kinds of analyses difficult if not impossible. Second, unit cost comparison doesn't address the actual situation in Ontario. There is only one payer, the

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, is taking the ground out from under the argument that hospitals can provide community laboratory services.

⁵⁹⁰ This is true even in the modified form imposed by the current industry cap system. Private laboratories are paid fee-for-service up to the cap.

government, and a hospital system is already in place. From the point of view of the public payer the abstracted unit cost is not the main concern. What is relevant is the total cost to the system of providing the service.

Minutes from a 1978 meeting between the OMA executive and the Minister of Health summarized the Minister's position:

The Minister commented that it is in the public interest that laboratory work, all of which is paid from public funds, be done at the lowest cost facility. This could be a hospital or private lab ... He also indicated that he does not believe that hospitals or governments do work at less cost than private facilities. However, the problem is surplus unused but paid for capacity in some public hospitals, and it should be possible to get work done there at a lower net cost to the taxpayer. He stressed that there is no competition – there is one price and one customer.⁵⁹¹

A Ministry official put the position a little more strongly: "There is a wide measure of agreement within the Ministry that hospitals should be funded on an incremental cost basis of the use of spare capacity for provision of out-patient laboratory services to the community."⁵⁹²

The self-serving for-profit demand for definitive unit cost comparisons is also disingenuous. The concept of using marginal cost is common in business transactions, for example increasing the quantity of an order usually reduces the per-unit cost. Also, the for-profit corporations adapted well to the government's first attempts to control utilization by decreasing per test payments as the number of tests from individual doctors rose. This program was implemented in 1983 and utilization of community laboratory services continued to increase about 11% per year, well above population growth. The industry made no attempt to constrain the ordering practices of individual physicians probably because their marginal cost was still less than the reduced fee-for-service rate.

⁵⁹¹ "Memorandum re: Meeting with Executive of Ontario Medical Association – Wednesday, June 2/76 – 1530 Hours," in file "Integration of Lab License Program with OMA quality Program Ontario Archives series RG10 – 18, barcode 112932 Box 2 file 0-128173.

⁵⁹² "Hamilton Laboratory Funding Proposal," memo from Paul Plant, Chief, Laboratory and Specimen Collection Inspection Service, to C.L. Brubacher, Director, Inspection Branch, April 5, 1978.

Saving Money with Hospital Laboratories

The logic behind using hospitals as the most cost-effective way of providing community laboratory services is supported by numerous examples of hospitals actually providing the service at less cost. The Hospitals In-Common Laboratory (HICL) and the Hamilton Health Sciences Laboratory Program (HHSLP) are two programs that exemplify this approach. The details of both of these efforts have already been described, but a couple of points need to be highlighted in this argument on costs.

Both of these programs used hospital laboratories with extra funding from the government to provide community laboratory services for less cost than if the services had been provided by the commercial sector. This is most easily seen in the HICL case. For 30 years HICL provided community laboratory services for a fee-for-service that was 75% of the rate paid to the commercial laboratories. At times they were paid as little as 66% of the commercial rate. And the savings to the public system are understated by this figure. HICL paid the hospitals for the tests processed in their labs, injecting about 40% of its income back into the public system.⁵⁹³

HICL's operations also undercut one of the main arguments used by the for-profit industry: that they provide better access to community patients and know how to coordinate community pickup with centralized laboratory services. HICL ran a network of community specimen collection centres, provided in-home pickup and service to nursing home residents. At one point they opened a SCC in a drug store. It could be argued that their non-profit status allowed for greater commitment to providing accessible services than the for-profit industry has. One of the first services to be cut by MDS and CML after the imposition of negotiated hard funding caps in 1993 was home pickup, while HICL maintained their in-home service for five years after their funding was frozen in 1996.

Another difference between HICL and the commercial laboratories was that most of HICL's work was processed in a hospital laboratory near by, usually in the same town, whereas the commercials usually collect samples in one area and ship them to a central

⁵⁹³ The actual amount varied on the individual arrangements with each hospital. The 40% payback to hospitals figure is from an interview with Jean Jacque Arsenault, President of HICL, July 24, 2006. In 1996 this amounted to an income of \$11million for hospitals.

laboratory in another city. Besides undercutting local health services and local economies, and making it harder for community physicians to communicate with laboratory specialists, this long distance transportation, especially when not necessary, is problematic in a time of concern about rising greenhouse gas emissions. But HICL was not the only non-profit service to use hospital laboratories to process community laboratory work.

While the HHSLP community services have recently been reduced and slated for closure, for 33 years it ran a network of community SCCs and processed a significant percentage of the Hamilton area's community laboratory work in hospitals.⁵⁹⁴ The program was funded through the area hospitals' budgets with a small increase available for expanded community laboratory work. Since its inception the program has closely monitored its workload and costs. While admitting the many problems with comparing their operation to the standard private laboratory, they calculate that for every year of operation their costs for community samples were less than if they had been funded on the LMS unit fee-for-service scale used by the for-profit laboratories. In 1990-91 their costs were 26.4 % less than the Ontario provincial government's costing standard, a saving of \$11 million to the system.⁵⁹⁵ It should be noted that for the more labour intensive tests such as anatomical pathology and microbiology their costs were higher than that paid by OHIP, and substantially lower for the more common tests, such as chemistry and haematology.

Both HICL and the HHSLP provide community laboratory services at a fraction of the cost of using the commercial laboratories. While these programs are funded differently and have different governance structures, they both show that the use of hospital laboratories can provide long-term, stable, accessible, flexible and less costly community laboratory services. They provide the strongest argument in favour of using hospital laboratories to process community laboratory work: or, in the negative, against

⁵⁹⁴ M. J. McQueen and A. J. Bailey, "Hamilton Health Sciences Laboratory Program: A Provider Developed Model for Hospital, University and Community Laboratory Services," *Health Care Management Forum*, Fall/Autumn 1993, 6(3), pp. 35-42.

⁵⁹⁵ M. J. McQueen and A. J. Bailey, "A Cost Accounting Prototype in the Clinical Laboratory: The Hamilton Health Sciences Laboratory Program," *Clinical Diagnostics Today*, March 1993 pp. 11-12, 29-33. A request for current information on the percentage and volume of community work done by the Hamilton program was refused. The director of the program said they did not have time to run the data and the program was being phased out.

the proposal that there is a financial benefit to be gained from using for-profit laboratory corporations.

Individual Examples

Some more limited arrangements also support the argument that the public sector is cheaper. In large part these efforts were motivated by a tightening of public payments for health care that saw doctors, hospitals administrators and government officials looking for ways to save money.

In 1973, Sensenbrenner Hospital in Kapuskasing wanted to take over the operations of Northern Laboratories, whose owner was leaving, and become the major supplier of laboratory services for Kapuskasing and district. This would require additional capital funding and special arrangements for operating costs, but also promised a savings of \$101,000 per year in area laboratory costs. There was internal Ministry support for this project.⁵⁹⁶ The Laurier Avenue Family Medical Centre received approval to have its laboratory work performed at the Ottawa General Hospital rather than private laboratories, at a cost savings of \$58,642 per year.⁵⁹⁷ A similar arrangement between the Ottawa Civic Hospital Family Medicine Centre and the Ottawa Civic Hospital promised savings to the Ministry of \$93,000 per year.⁵⁹⁸

Dave More, a hospital laboratory manager, in a Master's project on alternatives for funding medical laboratory services in Ontario, found that maintaining separate markets for inpatient and community laboratory services does not promote cost control, quality or citizen participation. Among the factors he identifies with increased cost are conflict of interest, fee-for-service and fraud, all of which are identified with for-profit provision in Ontario. While he supports the elimination of the for-profit laboratory industry in principle, problems of political feasibility led him to recommend a

⁵⁹⁶ "Laboratory Services – Kapuskasing," memo from J.C. Baldwin, Area Planning Coordinator, Health Services, to the Hospital Planning Committee, August 1, 1973.

⁵⁹⁷ Minutes of the MOH Management Committee, June 15, 1976, item 69 (e).

⁵⁹⁸ Minutes of the MOH Management Committee, February 24, 1976, item 8.

comprehensive health organization model, which if put in place, would probably lead over time to the elimination of for-profit providers.⁵⁹⁹

Unit-cost Analyses

Over the decades attempts have been made to compare the cost of providing individual tests in hospitals to commercial laboratories. While these comparisons have been bedevilled with problems they usually either show a lower cost in hospitals or produce ambiguous results.

In 1973 regulations under the *Public Health Act* were changed to restrict serologic testing for venereal disease to the provincial laboratories. It was argued that this would improve quality due to faster reporting than provided by the private labs, a minimum of delay in follow-up testing and uniformity in testing. "There would also be substantial saving in costs." Specifically, OHIP, "currently pays \$2.70 per test for at least 135,000 serological tests for venereal disease each year, at a total minimum cost of \$365,000. The cost to the government if these tests were carried out in Provincial facilities would be no more than 50% of this amount." Further, the application to Management Board notes that if OHIP reduced its fee, "it is doubtful whether many private laboratories would find it economical to carry out these tests ... [They need to] provide their shareholders with a return on capital invested. This is certainly one instance where the government is providing a service more economically to the tax payer than private enterprise."⁶⁰⁰

On August 19, 1977, the Management Committee of the Ministry of Health agreed to contract out the central public health laboratory cytology service to a private laboratory. They were having difficulty keeping staff: one technologist had just retired, the other had gone on disability, and there was not enough work to keep a cytopathologist on staff. The private lab agreed to perform the tests for \$2.50 each

⁵⁹⁹ David More, *Bang For the Buck: Alternatives for Funding Ontario in Funding Medical Laboratory Services*, a project submitted to the School of Policy Studies in Conformity with the Requirements for the Degree of Master of Public Administration, Queen's University, August 1994..

⁶⁰⁰ "Application to Management Board," attached to memo from S. Dreezer, Manager, Recoverables, Budget and Information Systems to B. Nichols, Assistant Deputy Minister, Finance and Information Services, May 16, 1973.

compared to the OHIP fee of \$4.79 and the cost of \$2.43 when the public health lab did the work.⁶⁰¹ Two points stand out here. First, the private lab was willing to do the work for \$2.29 less than they would have charged OHIP, indicating that the private laboratories may have been paid significantly more than necessary, and second, even at the lower contracted rate using the private service cost slightly more than using the public health laboratory.

Attempts to arrive at system-wide aggregate unit costs have been made, but these comparisons are by far the least accurate. Every study that has looked at the medical laboratory services for the last fifty years has noted that a straightforward comparison of costs between hospitals and for-profit laboratories is fraught with difficulties. First they provide different services. Hospitals need to have stat service, be open 24 hours a day, run teaching and research programs, provide for a large daytime volume with short turnaround time, and provide more esoteric tests. The commercial laboratories have to run community collection stations and maintain a transportation network, but can take longer to process tests and do more routine high volume work. Hospitals and commercial laboratories also use different workload measurement systems and our knowledge of their reported costs is different. The for-profit billing system, especially with the hard caps, provides detailed information on what is paid to the companies, but it probably overestimates their real costs, a figure that is protected by commercial privilege. Obtaining accurate information on hospital costs is also difficult. Samples are often taken by health care workers as part of other duties, overhead is provided as part of running the hospital and the ability to shift costs between programs within the global budget makes separating out the exact costs of providing laboratory services difficult.

Nonetheless these analyses have been part of the debate and tend to show hospitals are cheaper. One of the first cost comparisons between different types of laboratories took place in 1969. OHSIP analyzed utilization figures and found that the average cost per contract for all independent laboratories (commercial) was \$12.29, for six known, self-referred laboratories (owned by physicians as part of their practice) the average cost per contract was \$24.53 and for hospital outpatient laboratories it was \$8.92.

⁶⁰¹MOH Management Committee Minutes, 19 August 1977. The number from the private sector had been provided informally. No final figures were found for the contract. It should be noted that this \$2.43 excluded some support service costs.

In 1976 OPSEU compared the cost of performing particular tests in the Woodstock and North Bay Public Health laboratories to what they would have cost in the private laboratory system. They found that using the commercial sector cost 50% more than the Woodstock lab and 20% more than the North Bay lab.⁶⁰²

Denis Frazer and Rick Lambert, in a 1991 paper for the Ontario Society of Medical Technologists' convention, compared the costs of laboratory tests from 1981-82 to 1988-89. The raw data, total costs divided by number of tests in each sector, show that the average cost of a test in the private sector was 33% higher than the average cost in a hospital.⁶⁰³ They also calculate the real cost of eight common laboratory tests done in a hospital and compare that to the LMS unit costs finding that the cost per sample in a hospital was \$3.14 compared to \$6.22 in the private sector. The hospital calculations did not include any overhead costs because these are fixed costs necessitated by the inpatient laboratory work.⁶⁰⁴ The lack of inclusion of these costs is a common explanation from for-profit supporters of why hospitals sometimes look cheaper.⁶⁰⁵ It is also possible that if Fraser and Lamberts's gross figure comparisons were done today the results would be different. The shift of most community work out of hospitals, leaving only the more expensive tests, and the extensive rationalization and automation of the for-profit laboratory system in the last 15 years might have decreased their relative costs. Regardless the information needed to make this comparison has yet to be provided by the Ministry and the comparison would be just as limited as Fraser and Lamberts figures.

The OAML, the organization representing commercial laboratories, disputed Frazer and Lambert's results. While no detailed studies were found arguing that the commercial sector provided tests at less cost than the hospital sector, Paul Gould, the OAML's CEO, made the following argument in a presentation to the Clinical Laboratory Management Association's (CLMA) Trillium Chapter⁶⁰⁶ in 1997:

⁶⁰² "Opening Remarks for Press Conference," March 4, 1976, Sean O'Flynn, First Vice-President, OPSEU.

⁶⁰³ An attempt was made to repeat and update Fraser and Lambert's analysis but requests for the total yearly costs and volume of tests in hospitals and community laboratories from 1985 to the present were partially filled and then turned over to the Freedom of Information Office. No response had been received at the time of writing. A second request for information about any change in the way of measuring tests over the last 20 years and between sectors was also made, but again, there has been no response yet.

⁶⁰⁴ Denis Frazer and Rick Lambert, "Laboratory Out-Patient Funding."

⁶⁰⁵ Paul Gould, "Private and Hospital Labs are Partners not Competitors," *Clinical Diagnostics Today*, (September) 1992, pp. 6-7.

⁶⁰⁶ The CLMA is an international association of clinical laboratory professionals.

It has been estimated that Ontario's per capita expenditure on laboratory testing exceeds \$85.00 annually. Based on 1995-96 funding levels for privately provided laboratory services divided by the number of patient visits, we know that each patient who visited a private laboratory cost \$33.00. If we factor the private laboratory funding pool by the population of Ontario, we know that \$37.00 was spent per capita in 1995-96. It follows that nearly \$50.00 per capita is spent in hospital laboratory services. What did we get for this amount of money? How cost-effective are hospital laboratory services? On the basis of available data, one could argue, not very. If, as we suspect, some of the associate and ancillary expenses are not included in the calculation of the costs of hospital based laboratory service, then, we conclude that they are even less cost effective that we have been led to believe.⁶⁰⁷

A direct request to the OAML for elaboration of this argument was not answered. Without more detailed information on the source of these figures and their method of calculation it is difficult to make serious comment, though two points beg mention. Since many people in Ontario do not use laboratory services in any year it would seem likely that the per capita cost for the population would be lower than the per patient cost. Also, Gould uses per patient cost compared with the per test cost used by Frazer and Lambert which would change the results. For instance, if hospitals did more tests and/or more complicated tests per patient, which seems likely since their patients are generally sicker, then their costs would be higher.

The government undertook three studies to compare the cost in hospital laboratories with that of the commercial providers: a Woods-Gordon study of the HHSLP, the LOPPP and a study under the NDP's Social Contract legislation. Besides providing mixed results, all three share a degree of secrecy. In 1974 Woods-Gordon was commissioned to carry out an independent study, "to determine and compare the cost of the Hamilton program." Unfortunately I was not able to find a copy of this study. A representative of the Hamilton program, in a briefing to the 1982 Task Force on Laboratory Services, described the methodology of the study: it "'converted' the hospital system into a hypothetical private laboratory and thus the outcome of the study was inconclusive. It came up with incorrect information in that all the Health Sciences Center costs were incorporated in the hospital costs."⁶⁰⁸ Nonetheless, some of the results of the

⁶⁰⁷ Paul Gould, "Integrated Delivery Systems."

⁶⁰⁸ Minutes, Ontario Council of Health Meeting of the Task Force on Laboratory Services, November 30, 1981. This was part of a report by representatives from the Hamilton Coordinated Laboratory Program.

study were reported in an article on the HHSLP.⁶⁰⁹ While the article did acknowledge the methodological difficulties it also showed that in clinical chemistry, haematology and microbiology, the vast majority of tests, the Hamilton program's cost per LMS unit was 22 cents, 28.6 cents and 32.9 cents, respectively, while OHIP paid the private laboratories 37 cents per unit for the same tests.

The LOPPP was established with the goal of seeing whether community work could be shifted to hospitals and what would the cost effects of that be. The only copy of the evaluation report found included sections blacked out by the government for privacy reasons. The evaluation report identified significant methodological problems with the study. Despite the conclusion that the study found "mixed results" on cost, numerous examples were cited where hospital marginal cost increases, "were below OHIP rates paid to private laboratories." There were none reported where it was higher. The evaluation indicates that hospitals, if given a financial incentive, could increase their volume of outpatient work, physicians would use the service and it would cost less.

Increasing restrictions on hospital funding in the early 1990s fostered a movement to bring more community laboratory work into the hospital laboratories, and have the hospitals paid for providing this service. In its search to save money the NDP's Social Contract negotiators asked for a study of the cost implications of transferring work currently being done in private-sector facilities into the hospital and public health laboratories. The final report was never publicly released.

The Social Contract "Study on Costs and Implications of Transferring Laboratory Workload," written to answer this question begins with strong cautions about the results.

The groups [in the external advisory committee] expressed concerns over the fact that various assumptions and generalizations had to be made, in the absence of accurate detailed data, in order to perform the analysis; and the possible biases thus introduced into the interpretation of results.

Before commencing to discuss the results of the study, it is important to caution readers against simplistic interpretation of any of the analysis results, and to point

This study had been referenced as pending in earlier minutes of the MOH program committee in 1975 but no other reference was found to it.

⁶⁰⁹M.C.Brain, R.A. Hagger, S. Moore and R.W. Cameron, "The Hamilton District Program in Laboratory Medicine: A Progress Report on Integration," *CMAJ* (1976) April 12, volume 114, pp. 721-726.

out the need to recognize that there are methodological limitations preventing the generalization of some of the observations.⁶¹⁰

Virtually every figure in the report is shrouded in qualifications such as, “which may not be a true reflection of actual” and, “these assumptions may not be valid in all cases.” Detailed analyses of the study by the OHA⁶¹¹ and the technical director of Laurentian Hospital dispute most of its findings. Dr. Mazzuchin called the report, “TOTALLY UNRELIABLE” (capitals in original).⁶¹² He noted that the authors of the analysis were never identified. No first level analyses or raw data were provided to support the report. And the results of the report were not approved by the committee set up to oversee it or the Laboratory Services Review. Comments from the OHA point out that the study rests on assumptions of similar case mix between the community laboratories and the hospitals, which is clearly not the case, and then attempts to derive real costs per unit, rather than looking at the increased marginal costs of using the hospitals. The Social Contract study did find that the per unit costs in the hospital labs, after decreasing the number of units counted in hospitals and increasing the cost by including a guess of overhead expenses, were higher than in the private laboratories. None of the problems with the report stopped the President of MDS⁶¹³ and government officials⁶¹⁴ from making general references to a study showing lower costs in the commercial labs to defend their 1996 moves to stop competition in the laboratory sector.

An Inflated OMA Tariff

A common explanation of why commercial laboratory tests are more expensive is that they have to make profit for their investors, and the three surviving corporations have been profitable, returning 10% to 40% a year on investment. Also the need for

⁶¹⁰ “Study on Costs and Implications of Transferring Laboratory Workload,” July 1994, Social Contract Study, Laboratory Services Review, Ministry of Health, p. 2.

⁶¹¹ “Response to Laboratory Services Review External Advisory Sub-Committee Social Contract Study Summary Report,” Ontario Hospital Association: Toronto, March 1994.

⁶¹² A. Mazzuchin, “Critique: ‘Report of the Study on Costs and Implications of Transferring Laboratory Workload’ (Social Contract Study, Laboratory Service Review),” December 12, 1995.

⁶¹³ Art Chamberlain, “Provincial Report Backs Private Labs: Industry Relieved Health-Care Unions Furious,” *Toronto Star*, Monday March 28, 1994, pp. D1-D2.

⁶¹⁴ Hansard, February 15, 1996, Health Estimates Debate.

marketing and extra administration has been cited.⁶¹⁵ Another is that the OMA rate structure that laboratory billing was based on was substantially above the real cost of running the tests.⁶¹⁶ The ability of the medical profession to maintain its professional fee schedule during the 1970s and its overlap with the emerging commercial sector probably added greatly to the latter's profitability and helped finance its growth.

Initially laboratories were paid, as all other medical services are, 90% of the OMA's established tariff. The 1977 example of cytology testing previously discussed indicates that the OMA rates might be substantially above the cost of providing the laboratory test. The HHSLP, in requesting permission to charge cost rather than OMA tariff for services between hospitals,⁶¹⁷ "gave the illustration that a hospital must charge to the OMA fee schedule for a test that may be done outside Canada for less; for example, the OMA tariff may be \$30 on a given test, the charge of a firm in California may be \$20, while the actual cost is in the area of \$16."⁶¹⁸

In the early 1970s a dispute took place between the federal government and the province over how much the province should be reimbursed for outpatient tests performed in hospitals. The province was using the OMA fee schedule to calculate its costs while the *HIDSA* regulations said costs must be shared on a real-cost basis. The negotiations concluded that the real cost in hospitals was 60.3% of the OMA fee schedule.⁶¹⁹ It is hard to know what the current relationship between the OMA tariff and the real cost of laboratory work is because, as Chapter Five indicates, the current fee-for-service rates are based on a negotiated settlement that reflects broader political issues more than it does real costs. The gap between the OMA tariff and real costs of running

⁶¹⁵ Denis Frazer and Rick Lambert, *Laboratory Out-patient Funding*.

⁶¹⁶ There is nothing to suggest that the current fee-for-service structure negotiated by the OAML and MOH more closely resembles the real cost of the service, in fact it continues to be primarily an arbitrary settlement amount within a negotiated cap.

⁶¹⁷ Provincial regulations required that laboratory fees be charged uniformly at 90% of the OMA tariff, even in a case where one hospital was using the laboratory services in another hospital to process one of its samples. This caused significant difficulties for regional programs that were trying to coordinate their services to save money by only offering specialized procedures in one lab, rather than providing the service in all hospitals. The hospitals had to charge each other 90% of OMA tariff rate.

⁶¹⁸ Minutes of a meeting between representatives of the Ontario Hospital Services Commission and the Hamilton District Hospital Representatives, Thursday June 8, 1972, at 1030 hours.

⁶¹⁹ R. Verbrugge, "An Explanatory Memorandum on the Federal Cost Sharing Formula," September 1963, internal Ministry of Health document.

the tests, coupled with the fixed fee-for-service rate, created a financial structure that provided substantial profits to many private laboratories.

As well as the extra cost of having commercial corporations provide laboratory services, the government has other, direct costs that are largely due to the existence of for-profit providers. The establishment of a government department to license, monitor and discipline laboratories was driven by problems within the private sector. Similarly the costs associated with unneeded testing are primarily associated with the private sector. Some of the unnecessary tests were the result of blatant fraud,⁶²⁰ others which were not directly illegal had a “passing acquaintance” with the regulations and many were simply facilitated by laboratory corporations that had an incentive to increase volume and doctors that had a bias towards quantitative data. Most of the over utilization was due to tests that were not medically necessary being ordered by physicians, done in for-profit labs and paid for by OHIP.

In the 1960s doctors were noted to set up laboratories to process tests for their own patients, rather than doing them as part of their normal visit.^{621 622} As described in Chapter Four, these practices increased their billings and the number of tests performed. Doctors were found to be sending their tests to a low-cost laboratory, sometimes the free public health laboratory, and then billing medical insurance for the test at the OMA rate.⁶²³ Unnecessary testing is partly a result of a laboratory system that separates ordering family physicians in the community from medical laboratory specialists in the hospitals.⁶²⁴ Excess usage was also spurred by incentives from the for-profit industry that included cut-rate bargains, kickbacks, sweetheart rental arrangements and preferential service provision in exchange for more referrals. In one blatant example a for-profit laboratory “offer[ed] bargain packages to physicians e.g. 25 tests for \$50.00 or even \$25, when 23 of the tests are neither indicated nor necessary.”⁶²⁵ These problems

⁶²⁰ “ABKO Lab Gave Dr. Tse Kickbacks: Court Told,” *Globe and Mail*, February 2, 1977, p. 8.

⁶²¹ E.A.D. Boyd, “Laboratory Utilization Study,” OHSIP, July 1, 1969.

⁶²² Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 23: “It is noteworthy that insurance schemes generally do not pay the physician for testing; thus he has little incentive to do the tests himself.”

⁶²³ Chemical Engineering Research Consultants, “Private Clinical Laboratories in Ontario,” p. 9.

⁶²⁴ David More, *Bang for the Buck*, and Brenda Gamble, *The Commercialization of Hospital-Based Medical Laboratory Services*.

⁶²⁵ “Common objective,” memo from A.G. Gornall, Chair University of Toronto Department of Pathology, to D.J. Twiss, Commissioner of Hospitals, September 22, 1969. In this memo Dr. Gornall draws a

were compounded by the conflict inherent in laboratory specialists working in both systems. Commercial laboratories were cited for using their consultants to divert work to their regional laboratories;⁶²⁶ laboratory directors in hospitals with connections to private laboratories have been accused of directing their hospital's work to their private laboratory;^{627 628} commercial laboratories paid doctors to set up collection stations in their offices to capture their work.⁶²⁹ Over the 40 years covered in this study private companies have been found, accused and rumoured to be providing inducements to physicians to direct more work to their laboratories.^{630 631}

Numerous attempts have been made to arrive at the amount that system costs have increased as a result of the use of for-profit laboratories. The most straightforward figure is \$133 million in 2004, based on HICL's ability to provide the service at 75% of the OHIP rate. This is only an estimate, but it does provide an order of magnitude on the likely cost savings if we integrated all community laboratory work into a non-profit system based on hospital laboratories. Regardless of the exact amount, the conclusion can be drawn that using commercial laboratories to provide publicly funded medical laboratory services is increasing health care costs.

Integration of Services

A second long-term policy objective of the Ontario government and policy analysts has been the regionalization, integration and rationalization of services. While

distinction between professional laboratories, which he considers a problem, and are often owned by pathologists or physicians, and commercial laboratories that perform a useful function if they are regulated and, "serve to keep hospital and government laboratories on their toes."

⁶²⁶ P.J. Plant, "Monopoly Potential in Private Laboratories in Ontario," September 28, 1977, p. 2.

⁶²⁷ Letter from Morton Schulman, to the Honorable Thomas Wells, Minister of Health, February 15, 1971.

⁶²⁸ "INFO BACK: Public Accounts Committee: Possible Conflict of Interest Regarding Ownership of Medical Laboratories," memo from P.J. Plant, Chief, Laboratory and Specimen Collection Center Inspection Service, to G.J. Chatfield, Assistant Deputy Minister, November 25, 1977.

⁶²⁹ "Synopsis of Review of Laboratory Utilization and Referral Patterns Regarding Application to Establish New Specimen Collection Center: MDS Health Group Limited, 4 Park Avenue West, Elmira," August 15, 1983.

⁶³⁰ *Annual report, Inspection Branch*, October 21, 1977, p. 19.

⁶³¹ Thomas Walkom, "Kickbacks to Doctors Would be Headache for NDP," *Toronto Star*, Thursday, July 28, 1994. These inducements have included subsidized staff, office space, equipment and supplies.

this was largely seen as a strategy for cost control, it was also discussed in terms of making the system more responsive and accessible, and improving quality.

Government reports in 1970 and 1994 identified regionalization and integration of laboratory services as a central systemic need. In 1970, the Ontario Council of Health recommended that:

The organizational structure of a regionalized system of laboratory services be developed within the overall plan for regionalized health services.⁶³²

And then in 1994 the Laboratory Services Review repeated:

The future quality, viability and effectiveness of the laboratory services depend on the development of an integrated laboratory services system reflecting actual needs.⁶³³

These regionalization proposals described the existing laboratory system as, “fragmented, with no overall approach being made for the development of facilities and programmes on the basis of area needs. The existing organizational structure does not permit the pooling [of resources].”⁶³⁴ Over the last 30 years the most significant change in both the conclusions of reports to government and the direction of government policy on integration has been the shift from support for hospital-based efforts and suspicion of private concerns, to mandating integration of non-profit and for-profit delivery of services.

On the one hand significant integration of services has taken place. Since the mid-1960s hospitals have developed a variety of solutions to coordinate and integrate their laboratory services. Now most areas in Ontario have some sort of regional hospital-laboratory cooperation.⁶³⁵ 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

⁶³² *Report of the Ontario Council of Health on Health Care Delivery Systems: Laboratory Systems, Supplement No. 7*, Ontario Department of Health, Toronto: Queen’s Printer, 1970.

⁶³³ *Laboratory Services Review*, p. 15.

⁶³⁴ *Report of the Ontario Council of Health on Health Care Delivery Systems*, p. 15.

⁶³⁵ As noted in Chapters Two and Five the MOH will not give out the details of these programs, “because they are voluntary initiatives.” Nonetheless they involve significant amounts of public money and a valuable medical service. This is a statement indicating abdication of governmental responsibility.

other, they negotiate centrally and each corporation internally has integrated services on a province-wide basis. But neither of these integration processes solves the problems of duplication, excess capacity and developing one regionalized system that reflects actual needs.

Numerous difficulties with coordinating, let alone integrating, the public and commercial laboratory systems have been identified: the different purposes, one for profit and the other 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 served to isolate the hospitals and enable the commercial laboratories to freely expand and dominate the community market. "Discordant views on funding," as noted by the laboratory specialists of the OMA, were used by both the private and hospital sectors to slow the process of integration.⁶³⁶

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. These concerns were expressed in the questions commercial companies raised in the 1999 RFP process. Also, interviewee 12 expressed this clearly:

Needless to say the private sector did not like that process [the RFP]. There was lobbying to kill it. ... The major reason for opposition to an RFP from a private sector perspective [was] you start from scratch, you build up a business, you invest in infrastructure, in training staff, buying buildings and equipment [and] then the government comes along ... and someone who does not have any investments in the area if they are successful by undercutting you on an RFP, you have lost the entire investment in that area. You have employees, you have equipment and all of a sudden you do not have any work any more. This is like a high-risk roll of the dice on whether you are going to be in business or not [and] it is just far too risky for anybody.

The for-profit laboratory industry also welcomed being left out of the LHINs process because they feel the, "economics of the community sector requires provincial funding and provincial overview."⁶³⁷ This provincial approach and the tension between regional integration initiatives and laboratory corporations were also evidenced in the industry's membership on the Restructuring Committees. What the Ontario experience

⁶³⁶ Council minutes, OMA Section on Laboratory Medicine, May 30, 1997.

⁶³⁷ Interview 14.

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 and service integration that might bring about. The rise and dominance of the commercial laboratory sector is not related to its ability to satisfy a common desire for cost-effective health services. The research for this thesis also identified concerns about quality, accessibility and democracy from the presence of the for-profit sector in laboratory services.

Quality

There is very little doubt that the quality of laboratory results has significantly improved in Ontario over the last 40 years. The question is: why? Meeting the requirements of a quality control program was one of the factors. But was it the program, the decreased competition or the increase in the size of plants – both partially the result of the LPTP - that allowed companies to increase quality? Simultaneously, quality in hospitals increased. Once again, was it the program or was it changes in hospital laboratory services? Some communities, such as Toronto and Ottawa, have developed larger centralized laboratories, others, such as Kingston, have developed a regional network in which a teaching hospital laboratory provides services to a group of smaller hospitals to improve quality, and in northern Ontario groups of smaller hospitals have linked together to develop common standards, share equipment and skilled staff and improve overall quality. What are the comparative advantages of these approaches and how do they compare to the province-wide centralization that has occurred with the for-profit providers?

This last question raises an issue of concern in Gamble's study on joint laboratory ventures: how does the separation of laboratory specialist from the site of test processing, a norm in the for-profit laboratories, affect quality?⁶³⁸ Further, and of particular concern in the community sector, would a network based in hospitals with its professional staff be able to provide better consulting and backup services to the ordering and prescribing physicians, thus increasing quality? Also, does the ratio of technologist to technicians,

⁶³⁸ Brenda Gamble, *The Commercialization of Hospital-Based Medical Laboratory Services*.

which is considerably higher in hospitals, affect the quality of the results and their dissemination? These questions indicate cause for concern that the ownership structure could affect quality and deserve further research.

Accessibility

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, increasing inequality of access to services. It is clear that 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 or other electronic communication. For-profit laboratories in the face of funding cuts also decreased service to marginalized populations affecting equality of access. It is unclear how this fact of the for-profit laboratory system has affected accessibility, but it is an issue worth studying. It is also a concern that would largely disappear if the local hospital's laboratory were used.

This thesis has highlighted a tension between increasing accessibility and the ordering of unnecessary tests that needs further study. For-profit laboratories, to increase volume, increased specimen collection services in doctors' building, doctors' offices and patients' homes. These services were rightly welcomed by patients, but were also seen as part of the problem of unnecessary testing. Cutbacks in funding both to hospitals, which were forced to close their community access points, and to for-profit laboratories, which decreased home visiting and a variety of other less profitable collection services, hurt access as they decreased volume. Further study is needed to tease out the impact of for-profit corporations on accessibility and unnecessary use of medical services, and the relationship between overuse, private profit and accessibility. These questions are further developed in the discussion of need and biomedicine in the next chapter.

Democracy

Two aspects of democracy have figured prominently in this research. The first is the control of the medical profession. Concerns about the adequacy of their self-policing in monitoring conflict of interest, their unilateral control over quality, their notion of professional autonomy, their dominance in decision-making within public health care institutions, all played a role in the emergence of the for-profit laboratory corporations. A question worth considering is whether greater democratic control of health care institutions would provide both provide greater protection from market forces and increase their responsiveness to a community needs. The second is the broader question of how policy decisions are made in the capitalist state and the impact of the imperatives of private capital accumulation on limiting options and directly affecting decisions. These concerns are at the centre of the theoretical discussion in the next chapter.

Chapter Seven: Class, Biomedicine and State Policy

The previous chapter laid out the findings relevant to the debate on the use of for-profit facilities to provide health care. This study shows that commercial corporations have increased the cost, blocked the efficient use of resources and raised concerns about quality, accessibility and democracy in Ontario's medical laboratory services. The history of this sector also details how non-profit alternatives that could have provided a similar service were limited and eventually ended by government policy. This chapter examines the factors underlying the for-profit takeover of Ontario's community laboratory sector with a focus on class struggle and its relationship to state policy.

The findings in this study support the thrust of Colin Leys' conclusion that as a result of economic globalization British government policies towards public broadcasting and health care became more market-driven and less concerned with providing a public service.⁶³⁹ The link between changes in the balance of power in the relations of production and the direction of government policy is necessary to explain one of the central conundrums of the Ontario case: most significant public alternatives for the delivery of laboratory services were initiated by Conservative governments and the social democratic government under Bob Rae elevated the role of the for-profit sector.

The Conservatives in the 1960s and 70s oversaw the end of the Keynesian welfare state under which relatively strong unions and popular movements had developed and won broader social rights. They had been forced to nationalize significant sections of the health insurance industry. A strong public hospital sector was created that ran high quality medical laboratories and employed medical specialists, technologists and administrators who were interested in improving them. Even with a limited political struggle around community laboratory services there was support for new non-profit and collective approaches to social problems. The details of the programs are outlined in Chapter Three, but what is of interest to this argument is that a Conservative government ideologically committed to private enterprise supported some collective solutions even as it allowed the expansion of for-profit laboratory corporations.

⁶³⁹ Colin Leys, *Market-Driven Politics*.

The NDP government in 1990 faced a different balance of class forces as a result of globalized capital markets and production. Even though they had less ideological concern about government intervention,⁶⁴⁰ the new economic context placed more restraints on government pursuing collective solutions. The new global economy threatened less investment, more unemployment and decreased growth, if the neo-liberal policy framework of downsizing government, fighting deficits by cutting taxes and spending, and relying more on for-profit involvement in government services, was not followed. Linda McQuaig describes how Premier Rae showed the video of the hippopotamus being shot in the New Zealand Zoo as a result of their alleged debt crisis to support the “Social Contract”⁶⁴¹ rather than address the budget deficit through other means. Similarly, the era of international competition demanded that countries had to compete and MDS was identified as a world leader in laboratory services. It would become our champion. The province was under financial pressure from the federal government and threats from the business community to respond in a way that showed they were not anti-business. These developments made pursuing non-profit solutions, especially at the expense of commercial interests, neither a simple nor acceptable option. The NDP did place a social democratic spin on its actions. Labour was included at the table. Promises were made not to impede non-profit programs, but no actions were taken to strengthen them. In fact the opposite took place: the for-profit sector emerged stronger after the NDP government.

As the economic and political power of capital increased, laboratory policy in Ontario changed from centrally supported non-profit approaches, such as the HICL and the LOPPP, to a centralized devolution to the regions that protected and gave a privileged position to the for-profit corporations. A causal explanation of this shift, consistent with Leys’ thesis, is that after globalization and the shift in power to capital, national and provincial state policies would more singularly represent the interest of private capital accumulation, which in Ontario also meant ending the non-profit delivery of community

⁶⁴⁰ It is arguable how much Bob Rae personally favoured nationalizing anything, but he would have been more philosophically open to government intervention than Bill Davis. And Rae was on the right wing of the party. If he had taken the lead to bring services into the public sector he would have faced very little internal party opposition, whereas the Conservatives would have had more significant internal discussion. For a relevant discussion of the Rae government see George Ehring and Wayne Roberts, *Giving Away a Miracle: Lost Dreams, Broken Promises & the Ontario NDP*, Oakville, Ontario: Mosaic Press, 1994.

⁶⁴¹ Linda McQuaig, *Shooting the Hippo*, Toronto: Viking/Penguin Books, 1995.

laboratory services. This also lends support to the argument that one of the reasons for bringing about the current global economy was to thwart collective solutions and progressive political movements.

While this shift in policy supports the thrust of Leys' market-driven argument, the Ontario specifics suggest a more encompassing concept, such as accumulation-driven, might be more useful. Leys' study focused on commodification as the mechanism for the commercialization of well-developed public services. In Ontario, while for-profit laboratories did take some work from hospitals and public health laboratories, most of their growth was from capturing an expanding community market. It was not simply a matter of commodifying existing public services; the state structured a growing service sector so that the work would be provided by for-profit corporations.

This happened in two phases. Initially, in an attempt to control laboratory costs driven by Medicare, a new welfare-state program grounded in the primacy of individual need and directly linked to market forces, Ontario instituted technical fees, a new workload measurement system, direct access to fee-for-service OHIP money and licensing for community services that established a unique community market. In hospitals it further de-commodified inpatient services by placing them under the hospital's global budget and making pathologists employees. This separation created a market into which for-profit corporations could easily expand and be paid by public health care dollars. Simultaneously the government supported public community alternatives because they were better able to control both cost and utilization. Their successful emergence posed a concrete ideological threat to free-market ideology and a practical threat to corporate profits.

The second phase of market structuring in the context of the new global economy and neo-liberalism focused on shutting down the non-profit alternatives and formalizing the for-profit control of the delivery of community services. To a significant degree the for-profit laboratory industry had its genesis in the contradictions inherent in the Keynesian welfare state and was matured by neo-liberalism.

A second reason why the concept of accumulation-driven politics might be useful is that Ontario's medical laboratories do not show, even at the height of support of neo-liberal support, a linear movement to expand for-profit delivery or reliance on the

market. Many of the management contracts and joint ventures have not worked well and reverted to public provision. O'Connor noted similar phenomena in the United States in the 1980s when it became clear that there are limits to the use of for-profit corporations in providing services necessary for social reproduction.⁶⁴² The increased costs harmed the general ability of capital to accumulate. The 1998 Ontario regulation that closed competition and fixed income caps for the community laboratory services captured this dilemma. It was a compromise between different sections of capital that allowed government to control spending, meeting the general needs of capital, while assuring a small number of individual corporations a stable profit. This compromise jettisoned all ideological pretexts of maintaining market competition and focused on how the state could facilitate general and specific capital accumulation. Similarly, the regionalization policies from 1994 to 2006 facilitated the expansion of for-profit laboratories where it was profitable and not too expensive, but did not force the privatization of all public facilities.

While these examples focus on the compromise between fractions of capital the dominant class struggle was not absent. First, the fact of globalization and the attack on public sector options is grounded in a new strategy for accumulation aimed at weakening the working class and expanding private accumulation. Second, there was a significant public struggle in the 1990s, which preserved some HICL operations and helped form a new union-community coalition to preserve public health care which resisted further privatization of hospital services, including laboratories, and built broad popular support for a public health care system.

The link between the dominant class struggle and state policy in this study can be reduced to a simple statement: as the balance of power shifted to capital, policy solutions increasingly favoured private accumulation and took less account of the public's needs. This simple statement though tells us very little about actual policy outcomes or why these policies tip in favour of the dominant class even when resistance movements are stronger, for instance during the 1960s and early 70s, and collective alternatives better met policy goals.

⁶⁴² James O'Connor, *The Crisis of Accumulation*, New York: Blackwell, 1984, p. 245.

The history of Ontario's medical laboratories indicates that at any point in time there were numerous options (and probably many more that were not articulated) that could have been pursued within the constraints created by the balance of class power. The 1970s Conservative governments facilitated three significant public sector proposals, the HICL, HHSLP and LOPPP, two of which produced long-term programs that helped in future struggles for non-profit alternatives. This thesis does not argue that any of these are better or that they include the most desirable public sector option⁶⁴³ only that at any point in time there were numerous possible outcomes. In the 90s there were also numerous options in play. For example, the NDP, for all of its lack of action, did not disband the HICL, but let it continue to expand, drawing a clear policy line between them and Harris Conservatives who, in a very similar environment, for no apparent reason other than eliminating a non-profit competitor, negotiated the HICL out of community laboratory work.

Actual medical laboratory policies in Ontario – decisions on what to prioritize, options and outcomes – were the result of the interaction of numerous factors within the context of the balance of class power. Notably, as documented in Chapters Three, Four and Five, the structure of Canadian federalism; the power of the federal government to implement programs with national standards; the specific hospital and medical insurance legislation and their implementation; Conservative dominance of Ontario politics through the 60s and 70s; a significant social democratic party; quality concerns about for-profit providers; a well-organized medical profession; the nature of laboratory work; and the scientific advances in medicine after World War Two, all played significant roles in the development of the community laboratory market.

In turn these policy outcomes influenced the class struggle, both specific struggles, and the overall balance of class forces. An example illustrates the other side of this dialectical relationship. The combination of a strong public hospital system and a medical insurance system oriented to providing access partially explains the lack of popular struggle around the private delivery of health services in Ontario. The focus on access was reinforced by the medical profession's continuing efforts to limit access

⁶⁴³ In fact the relatively undemocratic structures of most public health care institutions raises the possibility that with more open and democratic governance other public options might have been found which would have better met community needs for accessible, quality, and efficient laboratory services.

through extra-billing. The first incarnation of the Canadian Health Coalition was formed in 1979 to protect and extend access, and it won a significant victory with the proclamation of the *Canada Health Act* in 1984, notably at a time when the power of capital was on the rise and protection for social programs was waning. But, both of these, the hospital network and the focus on access, shifted attention away from private delivery. Not seriously challenged, commercial laboratories thrived in a competitive and lucrative market under medicare. Bills were paid, new scientific advances were expanding the range of products and professional colleagues were controlling demand. With expansion of service and security of funding the laboratory market followed a classic pattern of growth, consolidation, and intensification. As these corporations became stronger they became a force that not only weakened public health care but increased the power of capital.

As important as the factors are that determine the specific historical and spatial manifestation of the class struggle they do not adequately identify the mechanisms that allow states to incorporate all aspects of the struggle yet produce outcomes that support the dominant power relations. In other words, what are the mechanisms that support a class state in advanced capitalism? One of the more obvious and powerful, the threat, and presumed ability, of capital to strike and significantly disrupt the economy, was front and centre in the 1990s. This study also identifies numerous other, more subtle ways that the power and ideology of the dominant class influenced state policy in the medical laboratory market.

Assumptions of commercial private property rights protected proprietary information and limited access to information on the for-profit industry, which both restricted this research and gave the for-profit corporations a privileged position on regionalization committees. Similarly, the assumption that for-profit corporations under the discipline of the market will produce cost-effective and efficient results limited the government's ability to act by privileging the commercial sector over the public sector. For example, in the debate on medical laboratories there was a belief that absolute technical certainty was needed that hospitals were more cost-effective before action could be taken in favour of the public sector. And with the difficulties of comparing hospital and community services any analysis was open to challenge. The proof

demanded to overcome this ideological barrier was held to such a high standard that decisions that would have benefited the public could not be implemented. Yet sound arguments and the data strongly suggest that community work should have been done within the public system.

The overlapping roles of laboratory professionals, being principals in for-profit laboratories and employees of the government or hospitals, played a part in the pro-business bias. This conflict of interest complemented the direct lobbying power of the industry that grew as the industry grew. Ideologically, the belief in what Bryden called the “market ethos”⁶⁴⁴ was prominent in many discussions on the sector: it was a powerful force limiting serious consideration of the option of closing the commercial operations. The dominant ideology is also present in biomedicine, the main paradigm in medicine, and helps shape the practice and institutions of health care to support dominant power relations.

The most obvious impact of biomedicine is the individual focus in medical practice: in terms of both practitioners and patients. It legitimates independent physicians as the arbiters of quality. They have the power to diagnose, prescribe and determine health. The real-world expression of this sectoral ideology both facilitates capital accumulation and takes on a relatively autonomous role interacting with the processes of class struggle and capital accumulation.

After the Second World War, with the expansion of testing options and insurance payments, doctors started to provide laboratory services within their practices. Some set up independent labs and pooled their services or sold them to other doctors. Initially they were successful in demanding that all laboratories be controlled by doctors and that community laboratory work not be covered by hospital insurance, a process which fragmented the system, kept it out of the public hospitals and proved lucrative for many physicians. As more funding options became available and the capital costs increased this non-hospital system became an expanding market for capital investment. The conflict between professional control, corporate control and insurance costs quickly developed and resolved itself in the professional-technical split that allowed commercial operations to provide laboratory services with minimal professional control. The

⁶⁴⁴ Kenneth Bryden, *Old Age Pensions and Policy-Making in Canada*.

professional role become primarily one of running an external quality control program, which then worked to consolidate the power of the for-profit laboratories further undercutting the role of laboratory specialists. The irony goes one step farther. As pathologists lost control in the private sector and the more interesting professional work stayed in hospitals, laboratory specialists became a strong lobby group for expanding public sector delivery, a system where they exercised considerable control and found professionally challenging work. Nonetheless their desire for control and individual billing rights kept them to a demand for competition which accepted for-profit involvement in health care.

The individual consumer focus of biomedicine reinforces political action aimed at increasing access to health services, which served the development of a for-profit laboratory industry well. It helped orient the political struggle to issues of health care consumption, rather than production, which would have called the practices of for-profit laboratories, as well as the capitalist production system into question. The consumption focus provided insurance that paid the bills, deflected political action to questions of access and not delivery, and allowed doctors essentially free reign to order as many tests as they felt would benefit the patient, with limited oversight, often in marginally legal situations, providing a very profitable relationship for the private laboratories.

This lack of effective control also reflects another bias in biomedicine towards technical medicine and the ceding of control to experts. The reductionism of the biomedical model, the assumption that health care is a matter of diagnosis and treatment of isolated individual problems, lends itself well to a reliance on laboratory work. Even though there were concerns about over utilization with an increasing reliance on scientific medicine, doctors were inclined to order more tests as a way of quantifying their diagnosis and treatments, and to accept on faith the need for a wide and growing range of technical diagnostic services. The professional autonomy of physicians and the belief in the value of quantifiable data reinforced the use of laboratory services and their inclusion in public insurance programs over services such as home care. As much as questions of over utilization and inappropriate relationships between laboratories and doctors were raised consistently during the forty years of this study, there was very little in the way of effective regulation or laws enacted to curb these practices. Biomedicine's

belief that doctors are the center of the system helped shift focus away from corporate behaviour and broader social issues as the cause of the problem.

Examining how power and ideology manifest in a specific market provides insights that connect the dominant class struggle to day-to-day policy decisions. It also indicates the complexity of the interactions that make up policy outcomes and how they are intimately tied to dominant power structures. The practice of the dominant sectoral ideology, biomedicine, is one component that interacts with state structures, institutional structures, other forms of oppressions and resistance, characteristics of political parties and professional groups to explain policy. The history of community medical laboratory services in Ontario validates the importance of class and the dynamics of capital in evaluating state actions and points to the complexity of factors involved in specific policy outcomes.

The findings in this study are relevant to many strategic political questions. They reinforce the understanding of reforms within capitalism as paradoxical, containing elements beneficial to the working class but supportive of the dominant classes. This reinforces the need for limiting for-profit involvement in collective services to protect and increase the progressive aspects of reform. For example, the current initiative to implement an Ontario Laboratory Information System to increase information flow between doctors and laboratories could benefit patients, but it could also mean that the commercial providers could start processing a portion of the inpatient laboratory work because staff doctors would be able to access those results through the integrated information system: a result that could further undercut hospital laboratories and probably increase cost. Without for-profit providers an integrated information system would be more clearly beneficial. One policy implication is to support options that benefit patients, in this case an integrated information system, and tie that to the use of non-profit providers.

This study also indicates numerous questions for more research. Chapter Six pointed to questions on the effects of for-profit providers on quality, access and democracy that need more study. More broadly, research is needed to examine the use of public services by the state both as a direct source of capital accumulation and as a way of decreasing the costs of reproduction, and the compromises between these two

accumulation needs. This raises the possibility of a more complex understanding of the relationship between public services, social reproduction and capital accumulation than simply expanding markets to the benefit of capital. It also points to an essential contradiction and instability in advanced capitalist states where attempts to meet social needs through collective services are undercut by both privatization and the use of public services to facilitate private profit rather than collective need which leads to resistance.

This study draws out the need for a greater understanding of the relationship between the abstract dominant ideology and how that it is exhibited in particular sectors of society. With ideological institutions, such as the practice of health care, having a certain relative autonomy from the interests of the dominant class, even though they reflect many of the tenets of the dominant ideology, how should they be addressed in the process of social change? For example, the individualism that kept laboratory services out of hospitals and created a fragmented industry providing a basis for the emergence of commercial laboratories also became a force against corporate medicine. How is individualism both a support for and a force against capitalism? These considerations point to the need to address sectoral ideologies and institutions in the process of social change.

There are many ways of addressing population health care needs that use government resources. The history of Ontario's medical laboratories indicates that one important axis on which to evaluate these options is whether they shift power and resources to the working class or whether they assist private capital accumulation. In other words, class counts.

Glossary

GM/ED – General Manager/ Executive Directors – a committee of senior management in the MOH in the 1970s.

CMAJ – Canadian Medical Association Journal.

CML – Canadian Medical Laboratories – one of the largest for-profit laboratory providers in Ontario.

CPSO – College of Physicians and Surgeons of Ontario – the institution charged with protecting the public from unethical and professional misconduct by physicians.

HICL – Hospitals In-Common Laboratory

HIDSA – Hospital Insurance and Diagnostic Services Act – federal legislation passed in 1958 and adopted in Ontario in 1959 that set up a cost-sharing program for the provision of hospital services.

HHSLP – Hamilton Health Science Laboratory Program – a regional laboratory program started in 1972 run by Hamilton hospitals that also provides community laboratory services.

HSRC – Hospital Services Restructuring Commission – a commission created by the Harris Conservative government in 1996 to consolidate hospital services including their laboratories. It was chaired by Duncan Sinclair.

LHIN – Local Health Integration Network – Ontario's regional health care administrative body established in 2004 which has jurisdiction over hospital laboratories but not over community laboratories.

LOPPP – Laboratory Outpatient Pilot Program – a pilot program in 1981 to provide hospitals with extra money to provide community laboratory services.

LPTP – Laboratory Proficiency Testing Program – a program established by the provincial government in 1974 and run by the OMA to monitor and improve quality in medical laboratories.

LSR – Laboratory Services Review – a review of laboratory services commissioned by the Bob Rae NDP government in 1992.

MDS – One of the largest for-profit laboratory corporations in Ontario, recently bought by The Ontario Municipal Employees Pension Plan.

MOH – Ministry of Health – used as a short hand to refer to the Ministry in the government of Ontario that has responsibility for medical laboratories. It is currently

called the Ministry of Health and Long-term Care and started out as the Department of Health in the 1960s.

OAML – Ontario Association of Medical Laboratories – the organization representing the commercial laboratories.

OHA – Ontario Hospital Association.

OHIP – Ontario Health Insurance Plan – formed in 1972 by a merger of the insurance administrative structures of OHSC and OHSIP. In popular use OHIP has two meanings. It refers to the health insurance plan that covers all residents in Ontario and it refers to the payment plan within the Ministry of Health that only covers medical services. Hospital services are insured through OHIP but paid for under a separate budget within a different department within the Ministry.

OHSC – Ontario Hospital Services Commission – set up to run hospital insurance in Ontario under the *HIDSA*.

OHSIP – the Ontario Health Services Insurance Plan – formed in 1969 in response to the *Federal Medicare Act*, it took over from OMSIP. OHSIP and the OHSC merged in 1972 to form OHIP.

OLIS – The Ontario Laboratory Information System – a system to link laboratory information from all providers in Ontario. It has been in the works for decades and a contract for a pilot project has recently been let.

OMA – Ontario Medical Association – the organization representing physicians.

OMSIP – the Ontario Medical Service Insurance Plan – a voluntary medical services insurance plan set up by the provincial government in 1966, in part an attempt to prevent the movement towards a universal medical insurance plan, which ran until OHSIP was established in 1969.

ORLSP – Ontario Regional Laboratory Services Planning – a program begun in 2001 to facilitate regional plans for laboratory integration.

PPAC – Planning and Program Advisory Committee – an internal MOH committee in the mid-1970s.

PSI – Physicians' Services Incorporated – a non-profit medical insurance company set up in 1947 by the Ontario Medical Association.

QMP-LS – Quality Management Program–Laboratory Services – the quality assurance program that took over from the LPTP.

RSC – Regional Steering Committee – the name of the regional coordinating body under the ORLSP.

SCC – Specimen Collection Centre – a place where laboratory specimens are taken, some times called a blood-letting station.

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