

Private Health Facilities in Saskatchewan: Marginalization through Legalizationⁱ

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Abstract

This paper explores how the passage of Saskatchewan's Health Facilities Licensing Act in 1996 created both a legal framework for private health facilities in the province as well as erecting significant barriers to virtually insure that no such facilities could effectively operate. This is done within the context of discovering how placing barriers to privatization has contributed to reform of the health care system and the conditions in which reform will be permitted. Data for the study were collected from a series of eleven key informant interviews including elected officials, civil servants, health care professionals, academics, members of key stakeholder organizations which both supported and opposed the legislation.

Introduction

One would be hard pressed to find a single issue that is more divisive within the health care debate than that of the role of private financing and private delivery of health services. But despite a number of wide-ranging provincial studies (see, for example: Quebec, 2000; Saskatchewan, 2001; Alberta, 2002), a Royal Commission (Canada, 2002a) and a Senate committee report (Canada, 2002b) in the past decade, there is also probably no single issue that is still so poorly understood by the public, stakeholders and governments. The recent Supreme Court decision that found Quebec's ban on the purchase of private insurance for services already insured under provincial insurance to be a violation of the Quebec Charter of Rights has reignited the debate in important ways while also doing little to clarify some of the key issues that are stake (Marchildon, 2005; Flood et al., 2005; McIntosh, 2006; Premont, 2007). The reality is that, like many health services themselves, the private sector has different roles in different provinces. While Quebec had legislated a complete ban on the purchase of insurance for those

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services already covered, some other provinces have no such legislation. This includes Saskatchewan which prides itself on being 'the birthplace of medicare'. Some provinces (e.g. British Columbia and Alberta) have already allowed significant growth in private for-profit facilities that offer everything from advanced diagnostic testing to a range of surgical procedures. Some of these initiatives have been actively encouraged by provincial governments while others have been tolerated or quietly encouraged insofar as they are deemed as providing a 'release valve' for the pressures on the publicly financed system.

What is at issue, here, has less to do with the delivery of health services, but, rather the financing or payment for those services. Much of health care in Canada is privately delivered. General practitioners or family physicians along with a host of other health providers operate as private deliverers of health services to their patients. What makes the Canadian health care system 'public' is the extent to which those private deliverers of care are paid from the public purse. The Canadian system is characterized, in Naylor's succinct phrase, as one of "private practice, public payment" (Naylor, 2003).

This is not to say that the private delivery of health care does not raise important and serious questions. As Deber (2004) has noted, private delivery can come in many forms. There may be little concern about a single or multi-physician primary care clinic as a threat to the 'public' nature of Canadian medicare, but there may very significant concern about a publicly traded corporation with a fiduciary duty to maximize profit operating a Canadian hospital. The important distinction in Canada is less about public versus private than it is about not-for-profit and for-profit delivery. To the extent that hospitals remain private institutions in Canada (and this is debatable in those provinces that have regionalized systems) they are almost always not-for-profit institutions operating under mandates determined by governments both legislatively and through funding arrangements (Fuller, 1998; Armstrong and Armstrong, 2003; Deber, 2004)

But it is confusion between private delivery and private payment that muddies so much of the debate around the role of the private sector in Canadian health care. When politicians and activists rail against private health care's erosion of the public system, it is not, one assumes, the private primary care clinic that is their target. Rather they are concerned with the growing reliance on private payment to insure access to necessary services, especially when a patient is waiting for those services. When private MRI clinics allow patients to get diagnostic tests without waiting in a public queue those patients can receive faster treatment by virtue of their ability to pay out-of-pocket for the diagnostic test. Thus, the length of their wait for a medically necessary service is not determined by their need but by their ability to pay for privately delivered services.ⁱⁱ

Such facilities, including those that offer a growing range of surgical procedures, operate under different legal and regulatory rules in each province (Marchildon, 2007: 61-71). While they are all private-for-profit facilities, they are operated by health providers who are themselves regulated by their profession and, as far as the delivery of health services is concerned, no different than a private medical practice operated by a licensed physician (Deber, 2004). However, the presence of clinics with non-health professional investors (e.g. shareholders) raises exactly the concerns expressed by Deber in terms of the conflict between the investors' desire for profit maximization and the physicians' responsibility for the provision of appropriate care.

But, on the financing side, they often rely on a mix of both private and public payment in order to continue operation. A private clinic offering MRI scans may have a contract with the local regional health authority (RHA) to provide services for which the clinic is paid on a fee-for-service basis out of public funds by the RHA while also offering the same service to individual patients (perhaps from other provinces) who pay either directly out-of-pocket or with private insurance. That same clinic may also receive a significant portion of their revenue from a provincial Workers' Compensation plan that, despite being a public agency, has the authority to use its resources to speed treatment for injured workers so that they can return to the labour market more quickly (Canada, 2002a: 8, 64; Gildiner, 2006).

It is this mix of public and private payment – combined with the promise of 'faster' and 'better' service – that is seen as the threat to the notion of access on the basis of need rather than ability to pay that lies at the heart of the Canadian model of health care. Does allowing the private purchase of medically necessary insured services provide a 'safety valve' for an overburdened public system? Or does it constitute a significant erosion of the principles of medicare that undermines the public system by siphoning resources away from the system in a manner that will only further entrench health inequities across the country.

Different provinces have responded in different ways to the regulation of private health facilities. This study focuses on the unique response of the government of Saskatchewan, which passed legislation governing the licensing of private health facilities in 1996. What makes the response unique is the fact that while the legislation provides a clear process for the approval, licensing and regulation of such facilities, it imposes a set of rules that would, in all likelihood, render such facilities unable to make a profit for their operators. The *Health Facilities Licensing Act, 1996* (HFLA) relies on a very strict separation between facilities that receive funds from the public purse and those that receive private revenue and does not allow facility operators to receive revenue from both. Private facilities must receive all revenue from private sources (either out-of-pocket payments by individuals or from private insurance) and limits those facilities to charging for services at the same rate as the public fee-schedule used to reimburse physicians and other providers.

The purpose of this paper is to gain an understanding of why this legislation was implemented in Saskatchewan and why it creates barriers to opening a private facility. This is done within the context of discovering how placing barriers to privatization has contributed to reform of the health care system and the conditions in which reform will be permitted. Data for the study were collected from a series of eleven key informant interviews including elected officials, civil servants, health care professionals, academics, members of the Radiology Associates of Saskatchewan (RAS), members of the College of Physicians and Surgeons of Saskatchewan (CPSS) and members of the Saskatchewan Medical Association (SMA). All participants were affected in some way by the Act: some because of an interest due to professional status and others because of their involvement in the policy process.

As will be discussed in more detail below, the rationale for this particular legislative action is multifaceted. In part it was driven by political considerations. The series of reforms instituted by the New Democratic Party (NDP) government of Roy Romanow in the early 1990s created significant upheaval in the system and appeared driven by, at times, competing agendas (Adams, 2000; McIntosh and Marchildon, 2009). Regionalization, the closure and conversion of fifty facilities in smaller communities, a renewed focus on health promotion and disease

prevention and cuts to the provincial drug plan had champions and critics both inside and outside of the NDP's political base. From this perspective, legislation limiting the role of private facilities within the province shored up the government's position as a defender of Tommy Douglas' legacy.

At the same time, there is evidence that within the government caucus and cabinet there was a perception that the liberalization of trade in goods and services represented by the North American Free Trade Agreement (NAFTA) and the Agreement on Internal Trade (AIT) required a regulatory and legislative response that would clarify the terms and conditions of any potential private sector investment in health service delivery. Finally, the lack of focused opposition to the government's legislative move (either from within the legislature where the Official Opposition was going through its own political transformation or from interests outside the legislative process) meant the legislation itself went virtually unnoticed by the public and the media.

The result, then, is the creation of a legislative and regulatory framework that, depending on one's perspective, can be described as either a principled defense of a publicly financed and administered health care system or as a cynical and disingenuous move to stifle meaningful reform of a failing system. The HFLA uses the very rhetoric of the potential threat of privatization to marginalize any threat that private facilities might pose to the public health care system by requiring such facilities to be fully private in their financing and operation. Rather than ban such facilities out-right, the legislation forces them to operate entirely without any public funds (including WCB cases) or access to publicly provided infrastructure. In this sense, the legislation forces private clinics to truly demonstrate that 'private is better' by refusing them any public subsidy whatsoever. Thus, any facility that would be licensed under the HFLA would likely be unprofitable for its investors given the limited market that exists in Saskatchewan. And that raises interesting questions about the extent to which the private facilities operating in other jurisdictions rely, in fact, on what could be considered a *de facto* public subsidy in order to turn a profit. Answers to such questions could change the terms of debate over private financing in the future.

The Health Facilities Licensing Act: Context and Content

The 1996 passage of the *Health Facilities Licensing Act* (HFLA) came after five years of budget cuts, facility closures and changes to the health care system that saw a restructuring of the governance philosophy, infrastructure and funding formulae. The early years of the Romanow government, first elected in 1991, were marked by significant fiscal restraint as the province inherited a \$14B debt from its Conservative predecessors. On the health care front the government felt compelled to scale back the province's generous public drug plan by significantly raising deductibles and by closing or converting 50 small rural hospitals (McIntosh and Marchildon, 2009: 338-340).

Yet, at the same time, the Romanow government launched an ambitious health care reform agenda meant to modernize the governance, financing and delivery of health care. Independent hospital and facility boards were replaced with Health Districts charged with the organization and coordination of service delivery across 32 geographic regions in the provinceⁱⁱⁱ. Health District funding was based on the implementation of a new formula meant to take into account the health needs of the population being served (McIntosh, Ducie et al., 2009) and District

boards were charged with reorienting the delivery of services towards health promotion, disease prevention and population health goals. Further, the government pushed for new primary health care delivery models based on interdisciplinary teams of providers that could care for patients across the full continuum of care needs and lessen the reliance on hospital-based care (McIntosh and Marchildon, 2009: 339-342).

Whatever the success of the Romanow reforms, and the successes were real (Lazar et al., forthcoming), they were also exhausting for the government and the public. The Romanow health policy agenda was curiously bifurcated. On the one hand there were the cuts to health and social services driven by an impending fiscal crisis within the province (which would be exacerbated by cuts in federal transfers following the creation of the Canada Health and Social Transfer (CHST) in the 1996/97 fiscal year) (Canada, 2002a: 313) and the closure of facilities in rural Saskatchewan. On the other hand was the proactive health reform program – primary health care, regionalization and needs-based funding, alternative funding for physician services, etc. – all falling under the rubric of the “wellness agenda”.

By the mid-point of Romanow’s second term in office, the public was simultaneously supportive, confused and angry over the future of health care in the province. The theoretical outlines of the wellness agenda garnered significant support for its emphasis on prevention and population health outcomes, support that would be echoed on a national scale a few years later in the ‘citizens’ dialogues’ conducted by the Romanow Commission (Canada, 2002a; Maxwell et al., 2002). But anger and confusion emanated from the decision to close and/or convert small rural facilities and the elimination or down-grading of some services. From the left, critics saw the wellness agenda as a smokescreen for budget-cutting and neo-liberal restraint. From the right, the agenda failed to seriously take on the so-called fiscal sustainability issues that plagued the system.

Beyond the internal dynamics of the province, national and international developments focused attention on the role of both private delivery and private financing of health care services. Trade liberalization agreements, both national (the AIT) and international (NAFTA, WTO), not only proliferated but expanded in scope in the mid- to late-1990s. No longer focused exclusively on liberalizing trade in goods, such agreements increasingly focused on trade in services as a reflection of the changing nature of advanced capitalist economies. Health and social services are thus conceptualized, like automobiles and soft-wood lumber, as commodities that can be subjected to the same desire to decrease legal and regulatory barriers to their free flow across national boundaries (Sanger and Sinclair, 2004; Johnson, 2004).

Put simply, the concern expressed by many defenders of the Canadian model of medicare was that agreements like NAFTA would force provincial governments to open up their health systems to privately operated facilities on the same terms that govern public facilities. The spectre of private insurers and private hospital corporations from the United States flooding into Canadian provinces eroding the public nature of health care in Canada and challenging the notion that ‘need’ supersede ‘ability to pay’ drove critics of the trade agreements to insist on protections for Canada’s model of health and social service delivery and financing. And, within limits, the defenders of Canada’s medicare model won the day.

According to both trade lawyer Jon Johnson (2004) and the Canadian Centre for Policy Alternatives (CCPA) (Sanger and Sinclair, 2004), the terms of NAFTA Chapter 11 provides

relatively strong protection for the existing social and health service delivery and financing regimes in Canada. The challenge, though, is what could happen should the government attempt to significantly change or expand the existing public system. For example, home care services in Canada were at this time primarily delivered by private-not-for-profit entities (such as the Victorian Order of Nurses) often under contract to provincial governments and requiring some co-payment on the part of the service recipient. These services are not part of the core medicare bargain that fully insures doctor and hospital services but are part of a second tier of services that mix public subsidy with private insurance and out-of-pocket payments (Marchildon, 2006). The movement of large for-profit enterprises into this market would be allowable under the terms of NAFTA and any attempt by a government to forestall such a move (or to bring home care into the core of fully insured services) would require compensation to those private entities that would be pushed out of the marketplace.

Thus, in light of these international and national developments in the area of trade in services it became important for provincial governments to establish a clear regulatory framework for the operation of private facilities. As was noted earlier, Saskatchewan had no legal or regulatory limitation on the offering of private insurance for publicly insured services and no legal framework for the operation of private for-profit health facilities. The relatively small size of the Saskatchewan market (less than 1 million people dispersed in relatively small cities, towns and rural municipalities in an area the size of France) and its lack of a significant private sector entrepreneurial elite likely made the province an unappealing place for large scale corporate health care investment. The only legal limitation it had on the development of a parallel for-profit delivery and financing health system was its prohibition on physicians' ability to practice in both the public financed system and a private system simultaneously (McIntosh, 2006). The ban on so-called 'dual practice' physicians meant that it would be impossible for more than a hand full of physicians to opt-out of the public financing of their services and still generate sufficient income to remain in practice. The government's response to this legal and regulatory void was the *Health Facilities Licensing Act*.

In the same way that Saskatchewan does not ban physicians from opting out of the provincial health insurance system, the HFLA does not prohibit privately operated health facilities. The legislation allows clinics to be operated insofar as they meet the regulatory standards set by the Saskatchewan College of Physicians and Surgeons and on the condition that they rely entirely on private payment for the services they provide. In other words, any clinic set up in the province can not have a dual revenue stream from both public and private sources. As with physicians, a facility must choose either public or private payment as its sole source of revenue. The upshot of this legislation is that private for-profit facilities are perfectly legal in Saskatchewan, but the stipulation of a complete reliance on private revenue renders it highly unlikely that any such clinic would be able to make a profit.

The HFLA lays out what appears, on the face of it, a relatively straightforward process whereby a person (or corporation) looking to set up a private facility can obtain a license for the proposed facility. However, to prevent the proliferation of private facilities, the application for licensure must go through the Health Minister, who forwards the application to the accreditation program operator (the CPSS) who reports to the Minister whether the facility conforms to provincial health facility standards. The Regional Health Authority (RHA)^{iv} where the proposed facility is to be located is responsible for the determination of need for the facility in the region, based on the subjective determination of the RHA and the Health Minister. If the proposed

facility meets provincial standards and sufficient need is assessed for such a facility, the license is granted.

Some of the physicians interviewed for this study noted that the power given to the Minister of Health with respect to the licensing of such facilities was, in their view, excessive. As one commented, "[I]t was absolute power...it basically allowed the Minister to determine, based on a very broad set of criteria, whether or not there would be [a private facility] and some of it was smudgy enough like need, that it allowed the Minister to essentially say no to any and all requests for private clinics". At the same time, this authority vis a vis private facilities is no different in form or substance than that given to the Minister and the government vis a vis the establishment of publicly financed hospitals hospitals.

Furthermore, once a license is granted for a private facility, it must be renewed nine months prior to its expiry date; which again, is an action carried out by the Minister. To receive a renewed license, the applicant must comply with the regulations of the *Health Facilities Licensing Act* and any other legislation that is appropriate concerning the creation of any new business. At the renewal point, there must also be a continued need for the facility, the facility must be an "effective and efficient use of public resources" (HFLA, Section 7(2)) and the Minister may refuse a license renewal if the criteria are not deemed to be satisfied. These conditions appear to provide a broad interpretive scope for the Minister which could be used to shut down any private clinic in the province.

The *Health Facilities Licensing Act* also prevents facilities from charging extra fees for so-called "Cadillac services" which are deemed to be superior to those offered by the public plan:

Any amount paid by or on behalf of a [patient], whether paid to the person providing the diagnostic or therapeutic medical procedure or another person, is deemed to be a fee if the licensee or the person who provides the procedure at a health facility required the payment as a condition of providing those procedures." (HFLA, Section 12(4)a)

To make certain that extra fees are not being collected, the licensee must provide the Minister with an annual financial statement to prove compliance with the legislation. The key informant interviews indicated that most interests understood the need for this type of provision to be placed within the act.

Saskatchewan's *Medical Care Insurance Act* and the *Health Facilities Licensing Act*, working together, make it virtually impossible for physicians to obtain substantial benefit from practicing outside the public system. While the *Medical Care Insurance Act* states that a physician can act outside the public system and that patients are obliged to pay for their services, the *Health Facilities Licensing Act* prohibits any payment greater than what the public system would pay (this prohibits extra-billing). This produces a non-inviting climate for private health care clinics in the province as such provisions make it extremely difficult to turn a profit.

The Development and Passage of the HFLA

Despite the limitations that the *Act* puts on physicians, it was accepted and applauded by government and union actors. One elected official described it as "a broad consensus" amongst

political actors, the civil service, trade unions and even some of the professional organizations. For the unions the possibility of private healthcare facilities meant an increase in non-unionized healthcare positions which in turn would lead to a decrease in the overall percentage of healthcare workers who are unionized.

While all interests on the government side of things, including elected officials and civil servants, were content with the *Act*, interests from the Radiology Associates and from the Saskatchewan Medical Association (SMA) were less enthusiastic. One such person interviewed used the word “contempt” when describing the feelings of some professional associations about the *Act*:

we have standards that we have to live up to with the College of Physicians and Surgeons...We can't practice substandard medicine...It's the practice of medicine basically and to have the government have a whole other set of regulations on top of that it's kind of...when is enough, enough?...Now we're regulated by or we would be regulated by the Health Facilities Act, there's the College review process that has to do with our licensure...How many of these hoops do you have to jump through?

The Saskatchewan Medical Association, while privately unhappy with the legislation, chose not to make its displeasure public (perhaps in part because the legislation was presented by the government as protecting medicare and shoring up the other reforms being undertaken within the provinces). At the same time, knowing that at least some elements within the SMA would be opposed to the legislation the government “did advise [the SMA about the legislation] and we met and we...had several meetings and discussions and in the end, they made it clear they [Government] were going to introduce the legislation, but we did get some changes to it that we could live with.”

The *Health Facilities Licensing Act* is the product of a relatively short policy process. According to one informant, “compared to many legislative agendas, this moved forward relatively quickly.” However, while the actual policy did not undergo a lengthy policy-making process, “the government had a sense that this was the road they would like to go down...much before the actual tabling of the *Act*...at least for a year or more we [the SMA and Government] were in discussions. There was some length of time during which the government contemplated this before they moved forward.”

However, the time between the decision made and the actual tabling of the *Act* was relatively short, according to most of our participants: “the actual decision to proceed with this particular piece of legislation ...moved quickly when I think the government got a sense that there was an impending plan by private investors to develop a private MRI unit.” Another possibility that was discussed was the creation of an MRI facility by a First Nations community which might have put a reserve-based private facility out of the reach of provincial regulatory control.

Furthermore, once the *Act* made it to the floor of the legislature, debate was short and simple and the *Act* was passed without much determined opposition. At this point in time, the NDP held 42 out of the legislature's 58 seats and the two opposition parties (the Liberals with 11 seats and the Conservatives with 5 seats)^v were, in the view of one key informant, as concerned about positioning themselves relative to each other as they were about opposing government policy. And health policy is particularly problematic insofar as centrist and even right-of-centre

voters have traditionally tended to favour public oversight and administration of health care delivery, thus making both opposition parties “very cautious about the [possibility] that they may get trapped on the wrong side of the health debate”.

One thing that was not entirely clear to many of the key informants was where the legislation originated inside the government. To the extent that the legislation seems to have been driven by a philosophical belief in the preservation of publicly administered health care as well as by the need for a NDP government to restore some of its political *bone fides* after being forced to make significant cuts in public expenditures, some of the key informants clearly saw the Premier’s fingerprints on the HFLA. Others, though, tended to see the HFLA as an initiative driven by then Minister of Health Eric Cline and given shape and substance by long-time deputy-minister of health Duane Adams. Key informants from inside the government agreed, though it certainly had strong support from the Premier and the Minister’s cabinet colleagues.

On one level, whether the HFLA was the brain-child of the premier or his minister is irrelevant. As one key informant noted, Premiers’ can set a tone for their government in such a way that ministers and senior civil servants know what is expected of them and know the overall policy direction the premier wants to pursue. And good ministers and deputy-ministers will proactively pursue policy innovations that move in that direction. And it is clear is that, according to the key informants interviewed, this was legislation that was conceived and pushed forward to not just fill a regulatory gap but to fill that gap in a manner that met the political objectives of the government.

This view is further substantiated by activities on the intergovernmental front that occurred in the eighteen months preceding the passage of the HFLA. A 1994 meeting of the federal-provincial-territorial Ministers of Health resulted in a statement committing the Ministers to maintaining a health system consistent with the five principles of the *Canada Health Act*: comprehensiveness, universality, accessibility, affordability, and public administration. This statement, according to one key informant, was necessitated by the federal government’s concern over the growing number of private for-profit facilities opening across the country and their potential to erode the principle of access based on need rather than ability to pay and committed the Ministers to take the steps needed to regulate the evolution of private clinics and maintain the publicly funded system.

Thus, for those participants outside of the government, the legislation was often seen as being, for those critical of the government, ideologically driven and, for those supportive of the government, reflective of the government’s social democratic tendencies. As one physician remarked, “our perception at the time was that it was driven ideologically. But I was always not entirely sure that it wasn’t driven partly with the knowledge that at some point they might have to go this route in certain areas”. An SMA staffer also agreed that this decision was based largely on political philosophy:

Why I say that is the quality part of it would easily be covered and has been subsequently in other ways. So although they would argue that it was to assure good quality...[and the] need for some Act that might govern private facilities one can argue wasn't just ideological in the context of [the] private/public [debate]. But I think the motivation for this Act was almost entirely ideological.

A member of the College of Physicians and Surgeons agreed: “it was an agenda driven by the fact that the government of the province and the day felt strongly that the preferred way to deliver services is through publicly owned, publicly governed facilities but that if there are going to be other facilities, they ought to be subject to fairly rigorous government regulation”.

A similar view came from one elected official, though with a more positive interpretation of the legislation:

[C]ertainly there was some discussion about the details and how you would define what was covered by the Act and...what wasn't covered but we had a pretty clear idea because to us, certainly in the New Democratic Party and the Department of Health in Saskatchewan, the principle of a single-tiered system and a single-payer system and the avoidance of a two-tiered system is a very fundamental principle. And so from that principle the structure of the Act followed...quite logically.

Perhaps to counter the charge that the legislation was ‘ideologically driven’ and the argument that the goals of the legislation could be achieved through existing regulatory means, the government emphasized the fact that the legislation was designed to insure the quality of services provided regardless of whether they were paid for publicly or privately. There is evidence that not-for-profit and publicly funded health services tend to be of higher quality than those funded privately (Devereaux et al., 2002: 1399-1406) and, in the words of one key informant, “the government wanted to be in a position to control those facilities in the public interest” and to insure the quality that generally accompanies a public system. But opponents to the legislation argued that it was less about control over quality than it was about control more generally – a desire to limit the growth of private facilities and to control costs by controlling access to services.

According to a government official, the government's ultimate goal in implementing the *Health Facilities Licensing Act* was:

to prevent the erosion of the public system by shutting the door to...private facilities that might engage in cream skimming and professional luring away at the expense of the general public who might not be able to afford to get into the bidding war with everybody else to see who was going to get the fastest cataract removal or hip replacement.

A number of factors were in play at the time to give government reason to believe that it was only a matter of time before private facilities were to trickle into Saskatchewan. Some originated within the province, such as government's past experience with medical laboratories, the possibility that a free-standing abortion clinic (possibly operated by Dr. Henry Morgenthaler) might be in the offing, and the threat of a private cataract clinic operated by an Alberta-based physician. Other factors, however, reached beyond the borders of the province as Saskatchewan was looking at what was happening in Alberta with respect to private facilities (Church and Smith, 2006). Furthermore, there was a concern that the opening of a few private clinics would lead to a massive influx of American clinics due to provisions in the North American Free Trade Agreement (NAFTA).

A few years prior, in the early 1990s, private medical laboratories were permitted in the province. This proved to be problematic as the number of laboratories swelled to a point where the province could not support such a large number and thus needed controls on the number of labs. Government implemented the *Medical Laboratory Licensing Act* in 1994 to counteract the swelling number of labs. In the words of one key informant:

With the *Medical Laboratory Licensing Act* there was ...the rationalization of the laboratory system that the government would only license those outlets that were necessary to provide the service to the public, so they didn't want to fund a lot of redundancy...And so carrying those principles over to the [*Health Facilities Licensing Act*] I think there was some concern...if you didn't have a vehicle for controlling how many of these outlets that you had, you would run the risk of excess capacity and then you'd have the cost somehow, you know, transferred over to the public system one way or another through negotiations or other vehicles. So I think it was...an issue of concern, not just that there would be one such a facility come in, but if they began to proliferate you would have no mechanism for controlling it if you didn't do legislation like this.

Many participants cited medical laboratories as a starting point for the *Health Facilities Licensing Act* because of the similarities in the cases – the question of private ownership of facilities, the need to regulate quality of care and the conditions of operation. These would all be part of the licensing and re-licensing procedure to insure provincial standards are met.

While the government was drawing on past experiences, it was also drawing on what it perceived as threats to the public system. Some participants mentioned that there may have been the possibility of a Morgentaler-style abortion clinic opening in the province. Elected officials, however, denied such a claim and asserted that this was not part of the Cabinet's deliberations on the HFLA. One participant from outside the government also dismissed this possibility because "there is a bylaw, under the *Medical Practice Act* which is the Act that governs the College of Physicians and Surgeons, that says that abortions in this province can be conducted only in accredited hospitals...And the purpose of this bylaw, in essence, is to prevent free standing abortion clinics like Morgentaler's from being established in Saskatchewan." So given that there is already legislation restricting such a facility from being opened in the province of Saskatchewan, it is difficult to make the point that the *Health Facilities Licensing Act* had the purpose of restricting this type of facility.

But there were concerns about other private facilities that may have been in the planning stages, in particular the possibility of a private ophthalmology clinic opening up in the province. In the words of one participant:

[T]here is an ophthalmologist who does cataract surgeries in Saskatoon...And like most surgeons he was concerned...about getting enough operating time, operating room time. And he had a plan [in the early 1990s] to open up a free-standing clinic to provide cataract surgeries. This physicians ... saw a business opportunity here where he could really control OR time because he would own it, would be able to put through a lot of cataracts this way, and the initial business plan was that he would do the public cases in the hospital and then he'd have a private clinic and put some private cases in his clinic...And at the

time it was unclear as to whether such an activity would be legal or illegal in the province.

There were also developments in Alberta that were of some concern to the government of Saskatchewan. While private clinics had existed in Alberta for some time (Nameth, 1994: 14-15), the most well known being the Gimbel eye clinics that offered private cataract surgeries, there was some concern that Alberta might go further in allowing the construction of privately financed and operated hospitals to be built in the province. As one elected official explained:

[P]eople started going to the Gimble clinics in Calgary to get their eyes done – to get their cataracts removed and so that became an issue because Alberta, up until sometime in 1996, allowed their facilities to extra bill. And we were grappling with a long and difficult waiting list for cataract removal, a problem that ironically has gone away using the public system...So we thought that since there was a national debate between the federal government and the government of Alberta as to whether private facilities should be able to extra bill...we would be proactive and say that as a matter of both principle and in our view the efficacy of the health care system that we would have a regime whereby private facilities operating outside the public system would be licensed by the public system and would work in accordance with certain rules that the public system operated, including no extra billing.

And the concern of facilities moving in from other provinces (or developed by physicians in Saskatchewan wanting to replicate an Alberta model) were compounded by the concern that such facilities would be difficult to forestall once they were established because of the terms of the North American Free Trade Agreement (NAFTA). In the words of one of the representatives of a major stakeholder organization:

[W]hen you look at the environment that was occurring at the time and the rationale for introducing the private facilities legislation, NAFTA had just come in, there was some significant concern that any sort of liberalization outside of the *Canada Health Act* would result in the loss in perpetuity of the ability to manage that part of the public sector and would open up the, basically the market place to untold numbers of private facilities dispensing a lot of medical care that would previously have been hospital-based...So the NAFTA environment was something we heard a lot from stakeholders^{vi}.

While recognizing that NAFTA may have been a concern, other key informants discounted it as a key factor in the passage of the legislation. At best they argued that the fear of an influx of private capital operating outside of the publicly administered system was theoretical at best. The small population of the province and the fact that it is relatively dispersed in small urban and rural centres meant that there was unlikely to be a sufficiently large enough market for privately purchased health services to justify the necessary investment. And multiple private investors would have to bid up the cost of health human resources and lower the price of services to the public in order to compete. So while the HFLA may have closed off a threat of foreign private investment, it is not at all clear that this threat was at all immanent.

But the mere possibility of such a development meant that the legislation appealed to some key political constituencies that may well have been dismayed by some of the cost-cutting measures of the early Romanow years. Whatever the weight given to possible role of NAFTA as a spur to the HFLA, it is certainly one of the incidental forces which intersected in the mid-1990s contributing to the need for government to address the issue of private for-profit health facilities.

Conclusions

Both the documentary and key informant evidence point to a multiplicity of factors driving the development and passage of the Health Facilities Licensing Act in Saskatchewan. Institutionally, there was a clear regulatory void when it came to the operation of health care facilities outside of the public system. The province's past experience with medical laboratories gave some impetus to the idea that a framework was needed to regulate the number of such facilities and to insure the quality of the services they were to provide and better that such a framework be in place prior to these issues becoming a political headache for the government. And regardless of how likely any one of the potential sources of private investment were, whether it was a single physician in Saskatoon, the expansion of Alberta-based cataract surgery clinics or even foreign investors operating under the auspices of NAFTA, the combination of those possibilities provided a clear rationale for the legislation on the part of the civil service and the government.

While the opposition to the legislation was decidedly muted, it was not entirely silent. Inside the legislature, the two opposition parties were too focused on their own survival to serve as a coalescing point for any interests opposed to the HFLA. Ultimately, most Conservative MLAs would join the new Saskatchewan Party and the Liberal party would be split apart by the decision of some caucus members to join a coalition government with the NDP following the 1999 election. Those stakeholder interests that questioned either the rationale for the legislation or the specifics of the regulatory framework itself proved either unable or unwilling to launch a public fight with the government. Indeed, this may well be because they themselves were divided on the issue. Though some of the key informants interviewed expressed some support for idea of a parallel private system as a legitimate 'safety-valve' in a predominantly publicly financed system, none of the major stakeholders took public stands against the legislation, preferring to air their concerns in private meetings with the government. In the same way that one key informant noted the reluctance of the Opposition to come out 'on the wrong side of the health care debate', stakeholder organizations within the health care system rely on public support to legitimize their role in protecting their own interests within that system. For the medical association or other professional organizations to come out against a bill ostensibly designed to protect the public nature of the systems' financing could well have undermined the public's generally strong support of health professionals' role within health care in the province.

Finally, there are the political considerations that clearly factored into the legislation's adoption. In the first instance, the approach to private facility regulation outlined in the HFLA is entirely consistent with the ideological predispositions of a moderate centre-left social democratic political party like the Saskatchewan NDP. And it is entirely consistent with the government's desire to protect and extend the party's and the province's legacy as the so-called 'birthplace of

medicare'. Indeed, in his role as head of the Commission on the Future of Health Care in Canada in 2002, Romanow would describe Saskatchewan's development of medicare as "a courageous initiative by visionary men and women that changed us as a nation..." (Canada, 2002a: xxi).

And it is no less true that the government, having made difficult choices to cut health and social spending early in its mandate to meet the increasing demands from both inside and outside the province that it restore fiscal responsibility to government operations, likely needed something that would restore its social democratic bone fides with its political base. The closure and conversion of small rural facilities, whatever the wisdom of that decision, did further damage to the government's image. So, in the context of the growing concerns over the sustainability of Canada's health care system and the perceived threat that international economic liberalization had for the future of Canada's social union, it would have been hard-pressed to find a better way to reinforce its commitment to publicly financed and administered health care in the province. And it did so in a fashion entirely consistent with the traditions of the Saskatchewan NDP; there is no outright ban on private facilities, only the insistence that any private facility be financed entirely privately and in a manner that does not undercut the operation of publicly financed facilities. However, the *Health Facilities Licensing Act* was not picked up on a large scale by the media or the public. So by flying largely under the public radar screen, the *Act* did not create the rallying point that government could have been looking for.

What is perhaps most interesting about the legislation is that, with the possible exception of the ophthalmology clinic that might have gone ahead in Saskatoon, the HFLA was almost entirely pre-emptive in nature. At that point in time the impact of the NAFTA was unclear, and the potential market for private facilities in a province like Saskatchewan was extremely limited. Yet, the government – in the form of key bureaucratic and political actors – acted very quickly to forestall the development of private clinics.

As such, it appears that the key rationale for the HFLA was philosophical and political. Private payment for publicly insured services was antithetical to the government's world view and certainly ran counter to its traditional uncompromising defense of medicare as one of the NDP's most important legacies. At the same time, there were clear political advantages to the legislation as well. While the threat of wide-scale proliferation of private facilities was hypothetical at best, the legislation certainly allowed a government often criticized as much by the left-wing of its own party as by the right of centre opposition to shore up some of its political base. The federal NDP had vociferously opposed the NAFTA and the prospect of legislation such as Alberta's Bill 11 was certainly heating up the debate over the role of private payment and delivery of health services, such that the HFLA set the Romanow government up as a defender of medicare, despite the significant cuts in the early 1990s.

And while such political calculations can not be dismissed entirely, the legislation did in fact fill a regulatory void that even the legislation's critics admitted needed to be filled. Viewed within the context of the Romanow government's overall health reform agenda – the regionalization, the 'wellness' agenda, the restructuring of public facilities – the HFLA is consistent with the government's stated objectives of modernizing medicare. While critics would argue that the HFLA in fact froze in place an out-dated vision of health care delivery – one that needed to be reformed with a greater reliance on private payment – the legislation served to fill a regulatory gap that had been unanticipated decades earlier and did so in a manner consistent with the stated vision of the province's political leaders.

Endnotes

- ⁱ The authors would like to thank the Canadian Institutes of Health Research, Health Canada and the Saskatchewan Population Health and Evaluation Research Unit at the University of Regina for the financial support provided for this research. We would also like to thank Courtney England for her research assistance on this paper. In addition the journal's anonymous reviewers provided a number of important and helpful suggestions to strengthen the paper's argument.
- ⁱⁱ It is fair to say that much of the debate over public versus private delivery and finance in Canada has been driven by the concern about the length of wait times in the public not-for-profit systems in the provinces. To the extent that lengthy waits in the publicly administered system undermine public confidence in that system, it provides an opening for those calling for greater levels of private payment and for-profit delivery (CHSRF, 2005; McIntosh, 2007; Armstrong, 2009)
- ⁱⁱⁱ In addition, a 33rd health district was created in the far North of the province that was jointly funded and administered by the province, the federal government and First Nations governments. Now called the Athabasca Health Authority, it remains a unique experiment in tri-partite collaboration for the delivery of health services for populations that cross the federal-provincial constitutional divide.
- ^{iv} When the legislation was first introduced Saskatchewan had, as noted, 32 health districts. These districts were amalgamated into 12 Regional Health Authorities in 2001/02. The HFLA regulations were amended to reflect this change in system governance.
- ^v In 1997, four members of each of these caucuses would leave their respective parties and form the Saskatchewan Party which became the Official Opposition.
- ^{vi} At the same time, one has to recognize that technology was driving much of what was happening in terms of moving procedures out of hospitals or allowing them to be done on an out-patient basis. Improvements in technology and surgical procedures meant many procedures that once required full-fledged hospital environments could be done in smaller free-standing surgical clinics and no longer required significant post-operative recovery in a hospital.

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