Medical Laboratories and the Public-Private Debate

I first became aware that something was seriously wrong in our medical laboratory system in the 1990s while working as a home care nurse in eastern Ontario. I was part of a team administering intravenous antibiotics in patients' homes. Occasionally a patient exhibited dangerous symptoms that might have been a reaction to the drug; in these cases a prompt analysis of blood levels of the drug was required. MDS, a for-profit multinational health care corporation, had been awarded the contract to provide laboratory services to home care patients in Kingston, but using MDS meant sending the blood sample to Toronto for analysis. Some of these tests are uncommon, and often we would not get a result for a few days. This was unacceptable. We had to know whether or not it was safe to give the next dose later that day. So we simply sent the blood to the local hospital laboratory, where processing was done quickly and results were immediately available.

Unfortunately, because of government policy, the hospital received no money for providing this clearly superior service. Instead the service was paid for out of its general operating budget, reducing the funds available for other in-hospital services. MDS was unhappy because we were taking lucrative fee-for-service work away from them. The home care agency, the Community Care Access Centre, was unhappy because we were breaking the rules and, in our own small way, sabotaging the for-profit delivery of health services. But the nurses, patients and doctors were happy because we got the results we needed when we needed them.

Laboratories are central to the practice of mainstream medicine in Canada. They play a role in 80 percent of medical diagnoses. Most Canadians have had at least one intimate relationship with a medical laboratory in their lifetime, probably many more. Newborn babies have mandatory blood tests, children have their throats swabbed, healthy adults have stool and blood screening, and anyone with a significant illness has bodily fluids and/or tissue samples analyzed. In each instance, a wrong laboratory result can have dire consequences.

The last decade has seen a series of scandals involving the incorrect interpretation of women's pathology tests, a laboratory test to identify abnormalities in cells. The results were missed breast cancer diagnoses and incorrectly identified cancers. These laboratory errors caused many women to receive dangerous treatments they did not need and many others to be denied lifesaving treatment

they did need. Many of the women affected did not live long enough to receive the compensation and apologies they deserved.

These tragic cases illustrate how important laboratory testing is. An incorrect drug screening test can cost a worker their job. A mislabelled blood sample could result in the administration of blood thinners to the wrong patient, increasing the risk of a stroke. An improperly collected or stored bacterial culture can result in an effective antibiotic treatment being delayed. Failure to collect water samples properly or report results, as happened in Walkerton Ontario, can result in serious harm to thousands of people. Yet labs tend to receive only passing mention in discussions of our health care system.

That the laboratory sector maintains a low profile is all the more surprising given the centrality of the services it provides. Laboratory workers comprise the third largest group of health care professionals, and medical laboratories consume over $4 billion of public money every year. Laboratory services have been called the touchstone of modern medical practice. Laboratory results are key to medical authority and foundational to medicine's evolution.

And labs are not strangers to controversy. There are regular accusations of fraud, over use, excessive cost and medical misconduct levelled against laboratories, but generally speaking what happens to our blood, sputum, stool or tissue samples after they leave our bodies does not concern us. Laboratory services are accepted as an integral, yet hidden, part of our health care system. Most people give little thought to who owns the labs, how their services are paid for, how they are organized or how the delivery of these services affects our public health care system. These services are unique among the key elements of our public acute care system in that for-profit multinational corporations play a central role in their delivery.

While largely unnoticed, for-profit medical laboratories have not been absent from the debate on the future of medicare. Their existence has been used to argue that greater private involvement in our health care system is more efficient and effective than relying on non-profit public services. Contrary to these arguments, which are driven by a naive belief in the superiority of markets and the profit motive, this book shows that in the case of Canada's medical laboratory services, the exclusive use of public, non-profit organizations would be the best way to increase access, control costs, integrate services, improve quality and enhance the democratic control of health care.

The Public-Private Debate

One of the central policy debates in Canada is over the future of universal health care for medically necessary services. Although medicare continues to enjoy enormous popular support (IPSOS 2006), as it has since its inception, 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 public expenditure on health care is approximately $135 billion; it accounts for over 40 percent of Ontario program spending. Robert Evans, writing in 1993, commented tongue-

in-cheek, "there has always been a crisis in Canadian health care," (35) 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 costs to the "wealthy and healthy" and increase the benefits to the for-profit health care corporations.

These threats to our public health care system are being challenged by a broad-based coalition of community and labour organizations, whose members argue that our current system is sustainable, provides security for citizens and embodies what is best about social reform: it is inclusive and collective and it places need before ability to pay. Universal health care is essential to a functioning democracy (Leys 2001).

While the main issue in these debates is often universal public insurance for essential health care services, the question, as Robert Evans (1997) notes, is really closed: most observers in health policy and political circles agree medicare is more cost-effective and efficient than the alternatives. Even ideological free market supporters, such as Prime Minister Steven Harper, have stopped directly attacking universal health insurance.

There is less unanimity on the question of private delivery. Private corporate interests have increased their pressure for more for-profit clinics to provide a variety of services: MRIs and CT scans, cataract surgeries, joint replacements, family medical services, home care and the construction and operation of hospitals. Armine Yalnizyan (2004) 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.

The history of the development of medical laboratory services in Canada goes to the heart of the debate on the private delivery of publicly insured medical services. In medical laboratories, we have a forty-year case study on the use of for-profit companies to provide an essential medical service. The results are clear: these companies are more expensive and they have fought integration, undercut democracy and negatively impacted access and quality in our health care system. They are a threat to the sustainability of universal health care.

A study of Canada's community laboratory services provides a comparison between non-profit institutions and private corporations in the delivery of the same service. The evolution of community laboratory services is the story of the development of three multinational health service corporations — MDS/LifeLabs, CML and Dynacare — and the intentional undermining of public, non-profit laboratory services.

This analysis takes seriously Colin Leys' admonition: "the impacts of economic forces need to be studied not only at the level of politics in general but also in specific markets" (2001: 81): in this case the public market for medical laboratory services.

Medical laboratories started as non-profit facilities in our public health services and the public hospital system. After the introduction of medicare in 1968, for-profit laboratory corporations expanded rapidly in five provinces.

Government policies created a market for their services, public money funded their growth, and institutions were established to consolidate their political power. Government policy in favour of the greater use of private laboratories was strongly supported by actions of the medical profession.

The structure of Canadian federalism provides a national and provincial context for exploring the specific impacts of changes in global capitalism on Canada's community laboratory services. The shift to a more corporate laboratory service paralleled the development of global capital markets and the rise of neoliberalism as a political project to undercut collective services, such as health care, and increase opportunities for private profit. The publicly funded development of commercial laboratories has also increased international economic integration by both facilitating the expansion of Canadian companies onto the international stage and allowing American capital to buy into Canada.

What Is Public and What Is Private?

Discussion of the use of private corporations is made more difficult both by terminology and by the reality of the Canadian health care system. The fact that Canada's health care system is a mix of for-profit, non-profit and public is obvious. Many private, for-profit companies, such as laboratory giants LifeLabs (formerly MDS), Gamma-Dynacare and Canadian Medical Laboratories (CML), make the bulk of their money from public funds and often do not charge patients directly for their services. On the other hand, hospitals are legally private, non-profit corporations that regularly contract out some of their services to for-profit companies and occasionally charge patients directly for care. This blurring of the lines between the public and private reflects the penetration of the market into this core government program. It muddies the waters of popular debate and is often used as a lever to increase market involvement. How the terms *public* and *private* are used is as much a political matter as a semantic one.

Most Canadians perceive public health care services to be those they receive as a right of citizenship under the *Canada Health Act*; this includes most laboratory services. While this perception is helpful in maintaining broad access and support for universal health insurance, it hides questions of ownership and control: a bias reflecting capitalist societies' tendency to focus on individual consumers rather than the social system of production.

The confusion is reinforced by a classification system common among academics that uses a juridical approach to categorize health care institutions as either public, those directly part of the civil service, or private, including non-profit hospitals, doctors and for-profit providers (Deber 2004). While the governance structure of institutions can be important, in this context the classification 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. Duncan Sinclair, former chair of Ontario's Health Service Restructuring Commission, used this approach in a CBC radio interview on March 29, 2007 to downplay the significance of moving ancillary services out

of hospitals. The governance approach also ignores the increasing centralization of health care decision-making in most provinces; hospitals and other health services are coming more and more under direct government control, regardless of their legal incorporation.

A distinction central to this book, one that is important to understanding our medical laboratory system and crucial to the future of our health care system, is the distinction between corporations that operate for private profit and providers that are non-profit, operating within some broadly defined notion of public good. In this book, references to private labs and other private health care services are references to for-profit corporations, i.e., companies that need to pay dividends to their investors.

Non-profit entities include those run directly by the government as well as non-profit corporations such as hospitals, the Victorian Order of Nurses, community health centres and the Centre Local de Services Communautaires in Quebec. While there are significant differences within this group, they share a primary interest in delivering health care for collective benefit rather than to make a return on investment. Profit is not part of their decision-making equation.

One group that is central to the story of the for-profit laboratories does not neatly fit into this dichotomy: unincorporated private practice physicians. Most likely, the goals of most of these practitioners are to maximize their personal income within the funding incentives, deliver a service and pay their bills. There are, of course, some who use their position as a springboard to corporate medicine and the exploitation of insurance schemes for extraordinary private gain and power. This practice is very evident in the history of private laboratories. There are, for example, the cases of Dr. John Mull, a pathologist who parlayed his practice into Canadian Medical Laboratories, Dr. T.A. Kasper, who founded Kasper Laboratories in Alberta, and Dr. Cam Coady and the consortium of pathologists who founded BC Biomedical laboratories.

The dynamic of turning their profession into an investment opportunity continues with the likes of Doctors Brian Day and Robert Ouellet, both recent past presidents of the Canadian Medical Association, who used their medical credentials to found for-profit corporations and make significant amounts of money from the public purse. It is a predictable outcome of the individual autonomous practice model dominant among Canadian physicians.

Doctors as a group have also used their influence to systematically work against public, non-profit options, whether fighting universal health insurance, demanding the right to extra-bill patients or calling for more innovation (for which read: more for-profit participation) in the Canadian health care system. One lesson from the evolution of laboratory services is that private practice physicians who bill fee-for-service are more likely to challenge the collective provision of health care than those primarily associated with public hospitals, who are much more likely to support a universal, integrated, accessible health care system.

How Medical Laboratories Work

To understand the political economy of Canada's medical laboratory industry it helps to have a general knowledge of how patients are classified and what the key components of the medical laboratory system are. A central concern in policy debates on medical laboratories is how services are provided to different types of patients. Three common classifications of patients are: inpatients, who are assigned a bed in a hospital; outpatients, who receive medical services in a hospital but are not assigned a bed; and community patients, who receive medical services in the community, most often from a family physician. For the purposes of this book, patients are usually divided into only two groups: inpatients, who receive their laboratory services while staying in the hospital, paid for out of the hospital's budget; and community patients, including both outpatients and community patients, who may, depending on the province, have the option of having their laboratory work done in a hospital or by a for-profit corporation. The primary debate on for-profit provision of laboratory work focuses on how and where community patients should have their samples processed and how these should be paid for.

Schematically, laboratory work consists of taking a sample, transporting it to a lab, analyzing it and conveying useful results back to the health care provider and patient. Since most samples are small they can easily be transported to a facility for evaluation. The path a sample takes depends upon the patient, the laboratory and the professionals involved. Patients in hospitals usually have their blood taken by a nurse and then it is sent to an on-site laboratory for processing. The results and interpretation are quickly available to the attending medical staff. Patients in the community often have their blood taken in a specimen collection centre (SCC), or bleeding station, often located in a building that also houses doctors. Most of these samples are transported to a central processing facility, usually in another city. Fax, mail, phone and computer are used to inform the physician of the results. Another option, both in hospitals and the community, is point-of-care testing, in which a sample is tested in a doctor's office or at the bedside. The relationships between specimen collection, testing, reporting and interpreting are more complicated than these simple schemata suggest. But how these basic elements are delivered, financed and coordinated are the central concerns of medical laboratory policy considered in this book.

An important aspect of medical laboratory work not covered in this book is public health services. This decision was made primarily for space reasons. Public health laboratories provide an invaluable public service but account for less than 5 percent of laboratory expenses, and to do justice to some of the complexities in their development would have taken more pages than are possible in this volume.

Most data in this book come from research for my master's thesis on the political economy of Ontario's medical laboratory industry (Sutherland 2007). The findings rely on extensive research in the Archives of Ontario and on confidential interviews with key informants. Ontario also occupies a large space

in this book because the corporations that dominate private medical laboratory services in Canada have their roots in Ontario. The policies of successive Ontario governments, of all political stripes, under the rubric of public medical and hospital insurance, have allowed these companies to flourish. Understanding this process in Ontario helps one to understand many of the developments that have taken place in other provinces.

Fifty years ago most community specimens were analyzed by public institutions (hospitals and public health laboratories) or by doctors in private practice. Today, in many provinces, for-profit corporations play a significant role. This transformation has been particularly profound in Ontario, where over 90 percent of community lab services are provided by three multinationals.

Cost and Integration

This book evaluates the impact of for-profit corporations on the delivery of laboratory services, focusing on system cost and integration. Reducing the cost of laboratory services has been a central policy goal of all provinces with for-profit laboratories since the introduction of medicare. This study is restricted to the cost to the government of providing medically necessary laboratory services. It does not include, for instance, other social costs incurred by using for-profit companies, e.g., workers who are paid less or costs to smaller communities as a result of having laboratory services centralized in a few large population centres. While these are important societal considerations and need to be studied, they are outside the scope of this book. This book does not simply assume that cost reduction is the ultimate good. Clearly, there are other social goals that would justify a government choosing more expensive alternatives. Providing adequate pay and working conditions, good access for all patients and superior quality easily come to mind.

Along with cost control, the integration of laboratory services has been a key policy objective of all provincial governments; the Ontario government has had this objective since 1960. In this book integration is usually used in the positive sense of maximizing the efficient use of resources and, from the patients' perspective, of coordination for improved quality and accessibly. But 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 creating barriers between practising physicians and laboratory specialists. The interactions between resources spent on services, their quality, accessibility and democracy are an important part of this story. For example, quality considerations were central to early initiatives by governments to regulate private corporations and played a role in their consolidation.

A reason to focus on cost is that supporters of more for-profit involvement in laboratory services claim that it will reduce cost. In essence this is a critique of that position. Cost control and integration of laboratory services are two policy prescriptions with broad support across the country, and yet they have never been successfully implemented. The focus on cost and integration also

provides an opening through which we can explore an alternative approach to understanding government policy, the interaction of governments with for-profit providers and the struggle over resources at the centre of the analysis.

This study of Canada's medical laboratory services pays special attention to three themes important to understanding how a few small for-profit laboratories led to the rise of multinational for-profit laboratory corporations. The first theme is the interactions between for-profit corporations and government, both in terms of how governments have favoured these services and how companies have influenced decision-making. The second theme covers how the medical profession, and more broadly the practice of biomedicine, has been instrumental in setting the conditions for private delivery, giving it legitimacy and covering up its failings. Third, we look at changes in laboratory policy over the last forty years, which provides insights into how changes in the global economy impact the delivery of local services.

Outline of the Book

The first chapter describes the development of a strong national non-profit laboratory system before the *Medical Care Act* of 1968 and some of the influences, largely from the medical community, that limited its reach and laid the basis for the development of a for-profit sector. These non-profit services were primarily delivered through public health departments and in hospitals, which continue to be the backbone of our medical laboratory system.

Chapter Two examines the changes in Ontario government policy from 1968 to 1990 that facilitated the rise of for-profit laboratory corporations from the few small private labs that were allowed to exist before medicare. At the same time that Ontario's Conservative governments were establishing structures that facilitated for-profit growth, they were concerned about this expansion. Chapter Three describes the support given in Ontario to non-profit community laboratory services. Compared to private laboratories, these public sector organizations were better able to control costs and improve service integration.

Chapter Four examines the developments in laboratory services in Ontario from 1990 to 2010. During this period we saw the height of neoliberal influence. The federal government reduced funding to provinces for health care, and the NDP government in Ontario, faced with a recession and escalating public debt, negotiated directly with the for-profit laboratory companies to cut provincial payments for laboratory services. The trade-off was increased control and financial security for the large private laboratories.

Chapter Five provides descriptions of the three largest for-profit laboratory corporations in Canada — LifeLabs (formerly MDS), Canadian Medical Laboratories (CML) and Gamma-Dynacare, a wholly owned subsidiary of the second largest laboratory services corporation in the United States, the Laboratory Corporation of America (LabCorp) — and what they have done with our health care dollars. The genesis of all three can be directly traced back to the corporatization of private doctors' practices.

Chapter Six outlines medical laboratory services in the other nine provinces, focusing on connections between funding, ownership and delivery. Six provinces, British Columbia to Quebec, use a mix of public and private laboratories for community patients. There has recently been a small move away from using for-profit corporations; instead governments have been focusing on restructuring non-profit services along "business lines," hampering the delivery of public laboratory services and possibly easing the way for more privatization in the future.

Chapter Seven addresses the argument that for-profit laboratories have been so successful because they provide more cost-effective service and help meet governmental goals of greater service integration. While problems of business secrecy and structural differences between hospital and community laboratory systems make direct comparisons difficult, the arguments and available data make a compelling case that for-profit laboratory services cost at least 25 percent more than using non-profit institutions. As well as being more expensive, private corporations have played an active role in undercutting integration initiatives. Using a fully integrated non-profit laboratory system to deliver all services would likely save the Canadian health care system at least $250 million in 2010.

Chapter Eight continues to challenge the argument that for-profit companies provide a better service by considering the effects of using these corporations on quality and access. Chapter Nine returns to the debate on the use of for-profit corporations to deliver publicly funded health care. The history of laboratory services in Canada provides evidence that for-profit delivery works against the sustainability, accessibility, quality and democratic control of our public health care system. It is recommended that fee-for-service payments for laboratory services be ended and that a transition to a fully integrated public non-profit laboratory service begin.