For-Profit Provision of Medical Services: The Case of Newfoundland and Labrador

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Since the 1980s, a cacophony of voices on the political right have heralded the call for privatizing certain features of Canada's health systems. These politicians, academics, researchers and businesspeople have argued that the publicly funded and administered health systems are inefficient, fail to provide necessary medical services to patients in a timely fashion, deny choices to patients seeking the most modern treatments and drug therapies and entrench the power of key bureaucrats and stakeholders in dictating how and what decisions will be made. Champions of privatization such as former Ontario Premier Mike Harris, Alberta Premier Ralph Klein, former Reform Party leader Preston Manning and the board of directors of the Fraser Institute argue that changes to the health systems will allow Canadians to have faster access to better care at lower cost.[1] Yet, would such a goal be achieved through widespread privatization of health services? Would Canadians be better off with the choice of paying for medically necessary services if such a policy allowed for quicker service and greater efficiencies to the health system?

The clarion call for privatization has been met with harsh criticism from those on the left. For some Canadians, publicly funded and administered health care is viewed as part of the nation's core identity. Our health system guarantees that all persons, regardless of ability to pay, will have access to necessary health services at no cost. However, what many people do not realize is that the Canadian health system does have a substantial component that is private; approximately 31 percent of all health costs are borne by individuals and employers for such items as prescription drugs, physiotherapy and transportation costs[2]. Several items such as prescription drugs and dental care were never parts of the original Medicare bargain.

On June 9, 2005, the Supreme Court of Canada, in a 4-3 decision, ruled that the province of Quėbec could not prevent individuals from seeking medical services through private, for-profit medical clinics or in other venues. The Supreme Court based its ruling on section 7 of the Canadian Charter of Rights and Freedoms which upholds the right to life. The plaintiff in the case argued that having to wait months for a medical procedure constituted a threat to his life and the Supreme Court agreed; timely access to medical procedures must be preserved and if the marketplace can provide these more efficiently than the public sector, so be it. For those who are horrified at the prospect of a greater private role in the health systems of the country, one interpretation of the Court's ruling is to argue that our largely public system of medical delivery is in difficulty because it is not adequately meeting people's needs. The Court may have reasoned that if governments cannot provide necessary medical services to their own citizens in a reasonable manner, what harm could come from permitting for-profit concerns from filling the gaps? The difficulty with this kind of reasoning is that the main beneficiaries of privatized health care are the wealthy and economically powerful who can afford the expense of by-passing publicly managed wait lists to receive a particular surgical procedure or treatment[3]. The economically, socially and politically marginalized in the population would not be in a position to access these market-value priced medical services and

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[1] . Mike Harris and Preston Manning, "A Canada more strong and free," Globe and Mail, April 14, 2005, p. A 19.

[2] . Stephen Tomblin, "Implications for public and private health care," Gazette, June 30, 2005 p. 12.

[3] . Ibid.

would continue to rely on the public health system to meet their needs. The desire by some in the population to allow for a larger private role in health care delivery is premised on the fact that the marketplace is more efficient than the public sector. Yet, would the marketplace respect or even acknowledge the medical needs of those who are most vulnerable? A fair question given recent events in Louisiana.

In Newfoundland and Labrador, the provincial government has publicly committed itself to upholding the Medicare model. The provincial Minister of Health stated that "as it [the SCOC ruling] relates to our province, all I can say is that this government is firmly entrenched in its belief that what is in the best interest of Newfoundlanders and Labradorians is a well-funded and well-respected public health care system."[4] While the government publicly supports Medicare in the province, advocates for the public health system urge vigilance. Kathleen Connors, chairwoman of the Canadian Health Coalition, stated that "they [the SCOC], in fact, guaranteed the right of people with money to access health care, but didn't guarantee the right of the poor and disadvantaged. And that throws Canadian values out the window."[5] Similarly, when the Canadian Medical Association voted in August, 2005 to support a resolution calling for Canadians to be able to purchase private health insurance for medically necessary services, many in support of Medicare argued that the genie was out of the bottle. At the same conference, CMA delegates also voted to support a resolution that medical care be accessible to all persons based on need and not ability to pay. The CMA votes reflect the frustration expressed by doctors and patients at the difficulties encountered in 13 health systems that exist across the country. Frustration is targeted at the federal government because of its reductions in spending and insistence that there be greater accountability and transparency in how health care dollars are spent. The aftermath of the CMA conference was visible. Doctors across the country reaffirmed their commitment to Medicare[6] while other health professionals such as nurses supported organized labour's disappointment with the CMA's resolutions. For the time being, in Newfoundland and Labrador at least, the possibility of a greater role for the private sector in the health system exists in theory rather than reality.

The purpose of this paper is to summarize our team's findings with respect to the privatization of medical and hospital services in Newfoundland and Labrador. The first part of the paper will present a brief overview of what has occurred with respect to this policy area. Next, we will review answers provided by key informants to questions covering three areas of policy: the government agenda, the decision agenda and policy choice for privatization of medical and hospital services. What emerges from this review is that, with respect to formal legislative and institutional change, Newfoundland and Labrador is a "no go" case. However, this is not to suggest that reform has been entirely absent in the province in this health sub-field. Rather, reform, when it has occurred, can

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4 . Rosie Gillingham, "Province committed to public system," The Telegram June 11, 2005, p. A3.
5 . Ibid.
6 . According to one poll, 88 percent of doctors "favour a health-care system where core services are funded by government which includes a guarantee of timely access to services, backed by adequate new resources rather than the status quo or system of private pay, insurance option." See Deana Stokes Sullivan, "NLMA boss defends CMA stand," The Telegram August 24, 2005, p. A4.

be classified as being informal and outside the bounds of legislatures and other institutions.

Privatization of Medical and Hospital Services in Newfoundland and Labrador

Privatization with respect to health care embodies the following characteristics:

$ the transfer of service provision from public and non-profit to private and for-profit organizations;
$ the transfer of responsibility for service payment to individuals;
$ the transfer of care work from institutions to private households and communities;
$ the transfer of care work from paid to unpaid workers;
$ the adoption of for-profit management strategies for health care delivery and
$ payment for health care services or the provision of health care services.[7]

In the 1990s, the province de-listed several medical services that were previously covered under the Provincial Medical Care Plan (MCP). Under the Medical Insurance Act, the province has the authority to control coverage for medical procedures that do not fall under the Canada Health Act such as prescription drugs, optometry, and some physician services.[8] For example, in 1988 the former Department of Health reduced the amount of eye care coverage under MCP when it went from providing a medical eye exam for patients every 12 months to every 24 months. In 1990, the government, responding to lobbying from optometrists and patients, brought back 12 month coverage for those under 18 years of age and those over the age of 64. However, this was changed again when the province de-listed vision care altogether from MCP. Beginning in 1991, the NLMA announced that it would begin to bill patients for services not covered under MCP but for which patients had not generally been charged in the past. These services included

$ medical exams for employment or a driver's licence;
$ medical advice over the phone;
$ absent from work forms and
$ the costs of dressings and bandages for casts and splints.[9]

MCP also operates a dental health plan (DHP) for children up to the age of 12 years. Services covered under the DHP include six month dental exams; cleanings every 12 months; fluoride applications every 12 months; x-rays and fillings and extractions. However, the costs of these services are not entirely paid for by the plan. Most dentists charge fees in excess of those paid by the government. Below is a list of services not covered by the Medical Care Insurance Act:

$ medical advice provided to a patient over the phone;
$ dispensation of drugs or medical appliances by a physician;

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7 . Ingrid Botting, *Health Care Restructuring and Privatization from Women's Perspective in Newfoundland and Labrador*. St. John's: Coasts Under Stress Project, July, 2000, 8.
8 . *Ibid*, 35.
9 . *Ibid*, 35.

- $ the preparation of records, reports, certificates or letters;
- $ time and expenses in travelling to consult with a patient;
- $ ambulance services and other forms of transportation;
- $ cosmetic plastic surgery;
- $ acupuncture;
- $ testimony in court;
- $ visits to optometrists for new or replacement glasses;
- $ dental fees for routine extractions performed in hospital;
- $ medical exams for drivers;
- $ reversal of sterilization procedures;
- $ in vitro fertilization, and
- $ vaccinations for travel purposes.[10]

There has not been much debate in Newfoundland and Labrador on privatizing medical services or relocating services from hospitals to for profit centres or clinics. As early as 1986 in the Government's Green Paper on health care spending, both the Ministers of Finance and Health were of the view that privatization was not an option to reduce medical expenses. Historically, privatization has not played a major role in the health system in Newfoundland and Labrador and physicians have rarely extra-billed patients for services.[11] Since 1990, private, for profit clinics have been established to provide the following services:

- $ physiotherapy;
- $ laser eye surgery;
- $ chiropractic services;
- $ therapeutic massage services;
- $ cosmetic surgeries (hair removal, botox treatments)
- $ abortion services (Morgentaler clinic).

With the exception of physiotherapy and abortion, the above services are not covered under the Newfoundland Hospital Insurance Plan. Costs for physiotherapy are covered if a patient is referred to a hospital. However, wait lists can be as long as four months in St. John's and longer outside the metropolitan area. With respect to abortion services, a Morgentaler clinic has been in operation in St. John's since 1992. Abortion is covered by Medicare but patients are required to pay a facility fee at the clinic but not at a hospital.[12]

Services such as MRI and CAT scans are provided by the health system through hospital facilities. There are no private for profit clinics that provide these services.

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[10] . *Ibid*, 39.

[11] . Government of Newfoundland and Labrador. *A Green Paper on Our Health Care System Expenditures and Funding*. Jointly released by the Honourable J.F. Collins (Minister of Finance) and the Honourable Hugh Twomey, M.D. (Minister of Health). St. John's: Government of Newfoundland and Labrador, January 1986, 14.

[12] . Health Canada. *Health System Reform: Newfoundland*. Materials sent by John Lavis, n.d.

In sum, there has been little debate about privatization in Newfoundland and Labrador. People who use the private for profit clinics generally have all or a large portion of the costs paid for via supplemental health insurance through their employers. To my knowledge, no specific legislation has been introduced since 1990 explicitly calling for a privatization of hospital services such as MRI and CAT scans. In fact, in the Strategic Health Plan,

"The Government of Newfoundland and Labrador believes that the private purchase of the medically necessary services covered under Medicare will not result in an improved health care system in this province".[13]

With respect to physiotherapy, there has been an increase in the number of private physiotherapy clinics and an increase in the amount of money people are paying out of pocket for these services. Concerns over access to physiotherapy were first raised in the early 1980s when the Newfoundland and Labrador Branch of the Canadian Physiotherapists' Association presented a brief to the Royal Commission on Hospital and Nursing Home Costs. In the early 1980s, the majority of physiotherapists were employed in large urban centres or in hospitals. Only two physiotherapists were employed by Community Services. Government had instituted a hiring freeze at the same time and there was increasing pressure to perform more day surgeries, close hospital beds and integrate disabled children into the school system. All of these practices made access to physio services difficult especially in rural areas. As well, many physiotherapists have migrated to the private sector because wages are far higher than in the public health system ($65 per hour versus $23 per hour in the public system).[14]

One final issue focuses on user fees. Prior to the passage of the Canada Health Act in 1984, the province charged patients $5 per night for hospital stays. The fee was eliminated in 1984 but the Department of Health was opposed to this policy. Nonetheless, patients are required to pay user fees for a variety of services provided in hospital including ambulance costs, some crutches, extra x-rays from the lab department and photocopies of health records.[15] As well, some patients with employer or third-party medical coverage are sometimes required to pay a user fee for a semi-private or private room. The amount of money generated through user fees is staggering. As Botting notes, in 1997-98, the Health Care Corporation of St. John's was owed $4.6 million in unpaid user fees.[16]

Privatization of medical services has affected Workers' Compensation programs in Newfoundland and Labrador. These programs are exempt from the Canada Health Act

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[13] . Government of Newfoundland and Labrador, Department of Health and Community Services. *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador.* St. John's: Office of the Queen's Printer, 2002, 26.

[14] . Botting, *op.cit*, 45.
[15] . *Ibid*, 50.
[16] . *Ibid*, 51.

meaning that provinces can require that workers' compensation insurance be administered on a non-profit basis or it can allow private for profit insurers to be responsible. Some provinces have passed legislation reducing benefit levels in order to force workers back to work more quickly.[17] Since 1984, the Newfoundland and Labrador Workplace Health and Safety Compensation Commission (WHSCC) has made several important changes to the way the system operates. In 1990, the WHSCC was faced with a financial crisis related to the wage replacement system and the number of industrial illnesses which required compensation. The Board decided to undertake an organization review to reduce unnecessary program expenditures. In 1991, the province made changes to the Act to reduce benefit levels for injured workers and levied a surcharge on employers. As well, the WHSCC has been able to get injured workers back on the job more quickly by queue jumping. In the early 1990s, the WHSCC arranged for 797 injured workers to receive priority appointments with surgeons by paying a premium fee.[18] Between 1990 and 1998, the WHSCC began to focus on the promotion and prevention of workplace accidents as a result of budget cuts. In 1995, the Commission introduced an "experience rating" for employers. This policy is designed to lower premiums paid by employers if they have fewer reported injuries. The consequence of this policy is that employers try to deal with the injured workers outside the system so that their premiums will not increase.

There has been a move toward contracting out some services such as dietary and housekeeping functions to private sector firms who receive a flat fee for the services performed while maintaining standards set by hospitals. In the case of Newfoundland and Labrador, such services were contracted out on the basis of improving efficiencies by lowering costs as well as assisting in the recruitment of nutritionists as health care providers.[19] Another area concerns the privatization of ambulance services and the requirement of patients travelling to St. John's to pay their own way for necessary medical services. These are discussed below.

The incidence of privatization is most obvious with respect to non-medical services being contracted out to private for-profit businesses. The services most affected include dietary, laundry and housekeeping in hospitals and health information. As well, both DNA and HIV testing have been contracted out as well.[20] There is a direct connection between reductions to health spending, the government's downloading of responsibility to regional health associations and contracting out of services. In 1997, Elizabeth Marshall, Newfoundland and Labrador's Auditor General, raised questions about the St. John's Health Care Corporation's plan to restructure its services with no capital investment by government.[21] The CEO of the Corporation argued that savings resulting

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[17] . *Ibid*, 56.
[18] . *Ibid*, 57.
[19] . Newfoundland Hospital and Nursing Home Association. *Matching Realities and Dreams: Report of the Health System Funding and Delivery Committee*. St. John's, 1992, 41-42.

[20] . Botting, *op.cit.*, 58.
[21] . Marshall was tapped by Progressive Conservative party leader (and now Premier) Danny Williams to seek nomination as the candidate from the district of Topsail in the 2003 provincial election. Marshall won her seat and was appointed Minister of Health and Community Services. However, she resigned in early

from the contracting out of hospital services would allow for the costs of restructuring to be covered. However, such was not the case as the Corporation was running a deficit of $18.7 million and had to be bailed out by the province.[22]

In 1996, many RHAs in the province began to contract out services such as laundry, housekeeping and dietary. Nova Services was hired to manage dietary and central laundry services and Versa Services has managed housekeeping for the St. John's Health Care Corporation since 1996. In 1998, the Corporation purchased property in St. John's to locate a central kitchen to service all city hospitals. Food services in many hospitals have been contracted out to Tim Hortons. These examples of privatization have resulted in job losses and quality of services provided. In one case, the provincial government was forced to do a policy U-turn with respect to dietary services. In 1997, Lakeside Homes in Gander entered into an arrangement whereby food services would be contracted out to a central kitchen serving other facilities in the area. Lakeside Homes is a senior citizens centre. Shortly after food preparation was privatized, residents began to complain about the quality of the food being served. Intense lobbying by residents and food service workers resulted in an independent review of the planning and preparation of food services for the facility. The review noted that the quality of food service and preparation had declined because of privatization but did not favour reinstating the kitchen. However, it became obvious that residents were not satisfied and the government reinstated Lakeside's kitchen.[23]

Health information systems and genetics programs have also fallen victim to privatization. The creation of SmartHealth, a health information system, is a joint venture between the Ross Perot owned EDS Canada and the Royal Bank of Canada. The problem is that the provincial government has not passed privacy legislation to protect persons whose information will be collected and disseminated by private corporations. A similar situation exists with respect to genetics research. For-profit corporations have set up operations in the province to collect information for genetic research and product development. The provincial government has encouraged such growth in research with little in the way of restrictions being placed on these corporations. These examples demonstrate that while many medically necessary services are publicly provided in the province, privatization by stealth has occurred in non-medical areas.

Some ambulance services and costs have been off-loaded by the provincial government either to private businesses or directly to individuals. Since all tertiary health procedures are carried out in St. John's, patients living outside the capital have to travel for major surgeries, radiation treatment and other tests. This makes it difficult for patients to have access to medical procedures and local newspapers are filled with horror stories about people who have suffered because of the centralized system for tertiary care. Those patients who are required to travel by commercial airlines to access medical services may

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2004 because the Premier overrode her decision concerning contract negotiations with home support workers in Corner Brook. Marshall is now a backbench MHA (Member of the House of Assembly).

[22] . Botting, *op.cit.*, 59.

[23] . *Ibid*, 61. See also Government of Newfoundland and Labrador, Department of Health and Community Services. *News Release (November 12, 1997).*

qualify for financial assistance under the Medical Transportation Program. Under the Program, patients pay a $500 deductible in any 12 month period from the date of initial travel. Once the deductible is paid, the remaining expenses are shared 50/50 between the government and the patient. The Minister of Health noted that "Government recognizes the increasing costs of transportation which people incur for medical reasons. In an attempt to lessen expenses in this area funding has been but in place to help provide more accessible quality health care at a lower cost to patients and their families."[24] The problem with the program is that patients travelling to St. John's from Labrador often have to pay in excess of $1000 for air fare. As well, low income patients may find it impossible to pay the deductible. Ground transportation faces similar problems. Because of contracting out, many private ambulance companies will no longer service rural areas and fewer government paid ambulances results in less accessible and longer waiting times.

Two Research Questions

Question 1: How much reform has occurred in privatization over the last decade?

Answer: Nothing dramatic or radical but rather incremental. With respect to privatization, non-medical services (dietary, laundry, housekeeping, genetics research, health information and transportation) have been the most dramatic examples of contracting out services to for-profit businesses. These changes have been overshadowed by the main driver of reform in Newfoundland and Labrador: regionalization. Privatization and contracting out has been justified on the basis of cost savings and efficiencies although benefits are not always realized (see the example of Lakeside Homes policy U-turn). Transportation costs have increased with less support from government because regionalization has resulted in all tertiary procedures being performed in St. John's. Quality of services provided has suffered in some cases because of contracting out and certainly job losses have resulted too. In sum, "Although the provincial government has maintained its commitment to supporting a publicly funded health care system, privatization has crept in through the back door in terms of *who* pays for certain medical services, in terms of *who* provides those services, and in terms of *who is able to freely access* services."[25]

Question 2: Under what conditions has health-care reform occurred in Newfoundland and Labrador over the last decade?

Answer: The provincial government has identified seven significant directions for changing health care delivery:

$ revisiting and improving the concept of regionalization with a strong commitment to health programming based on population health status;
$ better community-based health services to provide for a more balanced and equitable health system;

[24] . Botting, *op.cit.*, 48.
[25] . *Ibid*, 109.

$	a focus on health outcomes;
$	better emphasis on health promotion and disease prevention with individuals taking more responsibility for their own health;
$	promoting a health system where evidence-based decision-making is the norm and specific clinical data is supported by a coordinated and integrated information technology system;
$	a revised human resource plan to plan for the appropriate use of health providers, and
$	increased emphasis on appropriate use of health services and drug therapies.[26]

The bottom line is that health care reform in Newfoundland and Labrador has been driven by two factors: financial concerns and the desire to create efficiencies in service delivery. However, it can be argued that the specific reforms produced by the above factors were not cast within a long term policy framework. Rather, many of the reforms were adopted at a time when the health care system was in crisis and specific groups of persons were demanding change. As well, the reaction of government was sometimes myopic in that substantive policy change was not initiated. In fact, in both the Tobin and Grimes governments, the province embarked on a process of extensive consultation with policy stakeholders, interest groups and community groups to devise ways of improving the health system. Little in the way of change has yet to be enacted based on these consultations. Was this merely an exercise in public relations or a legitimate attempt to address real concerns with respect to health care? Nonetheless, the province has been hurt by the deep cuts in federal transfer payments for health and social services spending and this has further made the reform process difficult. One factor that has not been present is ideology. There has not been an overt desire expressed by governments or citizens to wholeheartedly adopt neo-conservative and market driven solutions to health care delivery such as the case in Alberta and Ontario. There has not been a large scale attempt to privatize medical services such as MRI and CT Scans in Newfoundland and Labrador because of the small population and economies of scale.

Privatization of Medical and Hospital Services: the Government Agenda

The issue of privatizing and introducing for-profit medical and hospital services in Newfoundland and Labrador has dimly pierced the policy radar. Since the 1990s, no government has passed legislation, held public hearings or commissioned research to study this issue in a formal manner. Why, then, has the province not embraced the option of delivering health care through for-profit clinics and businesses? The main reasons include:

- widespread poverty and regional economic disparity within the province;
- no groups acting as policy champions;
- province's political culture;
- limited policy capacity of the provincial Department of Health and Community Services;
- the lack of support among physicians for privatization of medical and hospital

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[26] . Health Canada. *Health System Reform: Newfoundland*.

services, and
- changes to fiscal federalism.

A significant driver for the lack of for-profit delivery of medical and hospital services in the province is the level of poverty in the province. Historically, Newfoundland and Labrador has the highest rates of unemployment, child poverty, illiteracy, obesity, diabetes and heart disease in the country. Levels of taxation are high, public services are typically minimal and the population is geographically dispersed. Even before Medicare arrived in Newfoundland and Labrador in 1968, few, if any, residents could afford to pay physicians for medical care: "the physician billings were always a challenge, so that - and, you know, we're talking early 1950's and prior to that - the poverty in this province really meant that any kind of private billing or private set-ups were anathema."[27] Only a tiny fraction of the population, located mainly in St. John's, could afford to pay for medical and hospital procedures out of pocket. This has severely limited the appeal of for-profit delivery in the province. As one informant noted,

"this is still a very poor province and we have probably a larger group of people with money than we used to in the 1950's; as you know, I was a member of the Royal Commission last year [the Royal Commission on Renewing and Strengthening our Place in Canada, 2003], and that Commission showed us in spades we're still the poorest province in the country. St. John's is wealthier, obviously, and has more people going to it; but outside St. John's - and I'm talking not far outside St. John's either - from there out, you have people struggling to survive, and you have people who are unemployed, under-employed with... so in that it [for-profit health care] has never been raised in those settings as an issue, and the alternate is true actually."[28]

A second factor identified by informants as to why for-profit delivery of medical and hospital services was not adopted in Newfoundland and Labrador focuses on the lack of champions for the issue. Several informants noted that there were no public groups supporting or advocating for privatization of health delivery in the province and there were virtually no senior civil servants and politicians willing to place the issue onto the government's agenda. A former provincial health minister recalled that "[t]here didn't seem to be any publicly centred group that was promoting or pushing that that really made the radar screen in Newfoundland and Labrador. I don't recall outside groups lobbying the government and saying give us a chance at this [for-profit delivery]."[29] This same individual, in speaking about discussions within the government's caucus, noted "there was nobody in the Liberal ranks - and we had a pretty conservative Liberal group, fiscally conservative - but even in that group, there weren't any champions that were saying let's start doing some private health care."[30] However, there was at least one attempt to introduce the idea of allowing MRI and other diagnostic services to be delivered privately in the province. The idea was raised by a member of the executive board of the province's medical association: "Well, I planted the seed with the former

[27]. Respondent 3.
[28]. Respondent 3.
[29]. Respondent 4.
[30]. Respondent 4.

Deputy [Minister] about (bringing in)? some private MRI, and he didn't rule it out but he never really pursued it because (he can't)?. They're [the government of the day] so preoccupied with ...(other stuff)?."[31] The Deputy Minister of the day confirmed that he had been approached about the possibility of allowing diagnostic services to be delivered via for-profit facilities:

"We had several approaches from private sector operators of MRI services and diagnostic imaging services generally. Some had local physicians involved. Others didn't. Some were local entrepreneurs without physician involvement. Some were entrepreneurs or well-established businesses from elsewhere in the world. They were basically pitching a business idea on the premise that it would save us [the government] money and it would have higher through-put and they put it forward for analysis. There were other examples of private delivery of services that came forward; but, you know, generally, from the outside is where it comes."[32]

The problem with permitting for-profit delivery of health care is that it prevents the government from being able to control the costs of services. The same Deputy Minister noted that "If they're [for-profit operators] allowed to satisfy the entire market demand with government as the payer, then we've lost control of our budget; and if we try to restrict the amount of supply that we allow them to provide and just pay them a unit cost, then it becomes a messy tangle of how they define their cost, what they want government to pay for, add-on charges."[33]

Newfoundland and Labrador's political culture has been described as being unique and distinct (along parallel lines as that of Quebec). The distinctiveness of the province's political culture derives from its long experience as a British colony[34], its status as an independent Dominion prior to entry into Confederation in 1949[35] and an identity that has its own linguistic distinctiveness, myths, heroes, music, art, literature, poetry and the like. The culture reflects feelings of toughness, independence and resilience in the face of tremendous geographic, economic and physical barriers to settlement and communication. The challenges inherent in living on the island have bred an intense "sense of place" among Newfoundlanders where there have always been strong attachments to one's locality. Much of this derives from the isolation of outport communities that dotted the coastline of the island. Outport life was and continues to be insular, remote although often scenic and serene. The insularity of Newfoundland itself is due to its geography (it is an island), a lack of immigration and cultural pluralism and the historic dominance of the fishery. Newfoundland's culture is one based in large part on an oral tradition which encompasses folklore, storytelling and public speaking. This is

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31 . Respondent 9.
32 . Respondent 5.
33 . Respondent 5.
34. Newfoundland was discovered by John Cabot in 1497 and claimed by Sir Humphrey Gilbert in 1583 as Britain's first colony.
35. The colony of Newfoundland was granted representative government in 1832, responsible government in 1855 and became a Dominion on par with Canada, Australia, and New Zealand as a result of the Statute of Westminster in 1931. As an independent Dominion, Newfoundland contributed greatly to the Empire's war effort in World War 1 ultimately leading to the loss of lives and incurring huge financial debts.

indicative of the lack of formal education for many Newfoundlanders until the province entered Confederation in 1949. Particular institutions have been privileged within Newfoundland's political culture. These include churches, families and communities as well as ethnic self-help and benevolence groups. These characteristics have shaped how Newfoundlanders and Labradorians view themselves and their health system. As one informant stated, "I think the public tends to place a high value on a public system. I think it's a part of the culture here. I think people think of health as one of those rights and they put a high value on that."[36] Another informant noted that "in this province the resistance to privatization of medical services would be very strong"[37] as a result of political culture. Certain features of the province's political culture, such as a lack of a participatory and democratic tradition, have affected how people respond to change. One informant argued that "I don't think it's [for-profit medicine] really been on people's consciousness. I mean people haven't really sat down and thought about, well, if we had a private or a parallel private system, you know, it would reduce the waiting time - that sort of thing. I don't think people have really been all that engaged."[38]

Another set of reasons mitigating against reform concerns the lack of support by physicians to private, for-profit delivery of health care and the limited policy capacity of the provincial government to thoroughly study the issue. Several variables are at play here. In the province, the Newfoundland and Labrador Medical Association (NLMA) has explicitly supported public health care while acknowledging that its members are free to opt out of the system. Provincial governments have not embraced the ideology of privatization to the same extent as has occurred in Klein's Alberta or Harris' Ontario. The lack of fiscal resources and the province's dependence on Ottawa means that there is not a large policy capacity to be proactive with respect to health reform. The most important driver for all health reforms in Newfoundland and Labrador is crisis. Crisis forces governments to respond with policy measures but these are reactive rather than strategic and proactive. Our informants offer their thoughts below.

"There hasn't been a whole lot of discussion about privatization."[39]

"I think in this province is that from the government's side, the resources in terms of government operations are so limited in the Department of Health that I would say we're barely able to manage things that are of a day-to-day urgent nature. You don't see a lot of pro-active, strategic thinking, I find, on the government's side here, not as much as you would, say, in Ontario or Alberta."[40]

Another significant reason for the lack of reform in this area had to do with the changes in fiscal federalism in the 1990s. Newfoundland and Labrador historically has the highest level of dependence on federal funds to sustain its social programs. The key

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[37]. Respondent 3.
[38]. Respondent 9.
[39]. Respondent 9.
[40]. Respondent 9.

change with respect to health was the introduction of the Canada Health and Social Transfer by the federal government in 1994. The CHST reduced federal funding for health forcing provincial governments to scramble to make up the shortfall. An informant noted that "My sense of it [for-profit medicine] would be that it would have come forward as an option to even be discussed mostly following the federal changes in transfer payments in the mid-1990s when they went from the established program financing for health care and post-secondary education and social services to the combined CHST."[41] The driver that prompted the provincial government to acknowledge for-profit medicine as a policy alternative was the CHST and the reduction in federal health spending: "my recollection of it is clearly driven by the CHST thing, the hundred-million-dollar drop in revenues from the federal government … those kinds of things drove it instead of, you know, the philosophic bent and ideology."[42] The government agenda did not produce any formal legislation or institutional change to the health system with respect to privatization of medical and hospital services. Discussion was limited, in camera, and lacked any sort of citizen engagement and dialogue. Many of these themes emerge on both the decision and policy choice agendas.

Privatization of Medical and Hospital Services: the Decision Agenda

Since no formal legislative or institutional changes have occurred with respect to the privatization of medical and hospital services in Newfoundland and Labrador, the decision agenda is small. However, it is important to realize that the government did make some decisions while rejecting others during the 1990s about privatization of health delivery. For example, the government initiated several public-private partnerships for the construction and administration of long-term care facilities in Corner Brook, Burgeo and St. John's. The province provided some of the funding while the construction and management was executed by the private sector. Why this type of arrangement rather than wholesale for-profit health delivery? An informant notes that

> "well, if you were going to have private public partnering in the truest sense and if it was going to be built and operated and run by the private sector, and financed and the whole thing, how were you going to accommodate and limit the profit that would have to be in it for the private sector to get involved? You had to make some comparisons to how that was going to be seen to be equivalent to or a better deal for the taxpayers than doing it publicly. And that was the only time in which I saw any attention paid at all to try to look at, you know, that profit motive type of the equation. Before that, it was just a matter of, you can build it and you can have the private sector build it. They could do it and finance it at rates roughly equivalent to what the government could do and you were doing it more because you had already sort of maxed out your borrowing capacity as a government, so you can either delay the project or get someone else to do them so you could have parallel projects going at the same time; and as long as the financing of it was in the same ballpark, then the political decision was, yeah, it made sense to go ahead and do it rather than have this one wait 10 years until you could afford to borrow again."[43]

[41] . Respondent 4.
[42] . Respondent 4.
[43] . Respondent 4.

The decision to undertake private-public partnerships allowed the Liberal government to construct long-term care facilities more quickly to accommodate need than waiting until the province's fiscal capacity was such that it could borrow money to do the projects publicly.

Other options were rejected. The Liberal government in the 1990s (Clyde Wells) did briefly consider imposing user fees for services as a means of offsetting rising health costs. However, this was categorically rejected. An informant recalls that "there was some thought that maybe you'd have to pay $5 and that raised such hackles and became so abhorrent that the notion that anything to do with the health care system you would have to pay for and that it would then generate a profit for somebody that was supposed to be... so, you know, I think it was so strongly ingrained that that's as much for some people as saying the EI system is part of being in Canada."[44] A key factor in not adopting privatization of medical and health services is the small population of the province and problems concerning economies of scale. Outside of St. John's, the population is widely dispersed and considerably less affluent thus making a for-profit enterprise difficult to sustain. As well, advocates (generally corporations external to the province) failed to demonstrate conclusively that they could offer health services more efficiently and cheaply than the public sector. A former Deputy Minister of Health recalls that "it [Newfoundland] is a small market and so many health services which require a large population to operate efficiently are difficult to deliver on a small market. Second point is opportunity or the context at the specific time when it's proposed. Finally, and probably fundamentally the most important reason, is that the advocates in the cases that I've been involved in had not been able to clearly prove their case - that they can offer these services in this market at a less expensive rate; and so if it can't be done... if it can't help our bottom line, then, you know, we're going to keep on providing it as a public sector."[45]

As noted above, there are several businesses in the province that do provide for-profit medical services. These are mostly located in St. John's and survive because there is a critical mass of consumers willing to pay out of pocket. "We have private companies that take money for private services. My partner is needle phobic and there are companies in St. John's and for $30 a professional nurse will come in and take your blood and take it down to the hospital for my partner, right?"[46]

Another reason why privatization of medical and hospital services is not on the decision agenda in Newfoundland and Labrador is that people expect the health system to look after them without incurring out of pocket expenses. Much of this is derived from the idea that when Newfoundland entered Confederation in 1949, it would be entitled to the benefits of the Canadian welfare state, including health. People have been accustomed to having the government take care of them whether for health, unemployment, education, old age pensions and the like. However, informants noted that Newfoundlanders and

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[44] . Respondent 4.
[45] . Respondent 5.
[46] . Respondent 7.

Labradorians have not been challenged on the issue of private, for-profit delivery of health services. An extended quotation from an informant captures this fact rather eloquently:

“Tomblin: Would you say that most groups and organizations within the province would be opposed to privatization of health care services?

Informant: Let me answer it this way. I was asked a question one time… as to whether or not the people of the province had racial prejudices or biases. My answer was that they didn't know because they had never been challenged by it. They've never lived in an environment where their neighbours were of different races and so on. Basically, other than St. John's, we've got a pretty homogenous society; and you don't know unless you live it. And it's the same kind of thing here, I guess - they've never really been asked the question; and I don't think they've sat around and had it as part of their discussion as to whether or not that's [for-profit delivery of health care] a good public policy. I don't think people have challenged themselves.”[47]

People do not expect to be required to pay for medical services in their health system in the province and this is a significant factor as to why government has not formally made a policy decision on the issue.

Finally, there is concern that having a parallel private health system in the province would draw physicians, nurses and other health professionals away from services delivered publicly. An informant stated that “I think there's some fear here that having parallel systems will erode the ability [to deliver services publicly] because physicians can only do so much work. Somebody is doing an OR list or a clinic list done on their site, that would be preferred presumably because the information will be better; and therefore... because there's a physician shortage, therefore there will be less available to the public sector.”[48]

The government has not decided to formally embrace or adopt for-profit delivery of medical and hospital services in Newfoundland and Labrador. Simply put, “it's very difficult to get any kind of rational, logical, sensible debate going about paying for something in the health care.”[49]

Policy Choice: Privatization of Medical and Hospital Services

There are several factors that account for the policy choices made by the government of Newfoundland and Labrador with respect to the privatization of medical and hospital services. One explanation concerns the pragmatic issue that for-profit health care is difficult to sustain given the small population and socio-economic status of the province’s people. Several informants mentioned this as a reason why private, for-profit health care is not on the agenda. One informant, one of the key players in the health system from the

[47] . Respondent 4.
[48] . Respondent 10.
[49] . Respondent 4.

1980s until 2000, noted “there are some very pragmatic issues here. You can't even get a private industry 20 miles outside of St. John's, let alone talk about private health care outside of St. John's. Just the economics from the privatizer side, apart from St. John's, would make it impossible here.”[50] Another informant noted “from a business perspective a company coming in to do business in Newfoundland in health care would be very difficult because we are, you know, a half a million people spread all over a huge land mass, so it's not like you can come to St. John's and get the bang for your buck right in this one core area and I would think that perhaps the business process unless they see a benefit to coming in and doing business, I can't imagine they would be able to cover their expenses.”[51]

A second explanation concerns public opinion and political acceptance of the status quo. The discussions about private, for-profit medicine in the province attract the ire of several key groups of opinion makers including physicians, health care unions, nurses, academics, and some politicians. Political leaders have had difficulty persuading the general public that it might be beneficial to the health system to allow market solutions to determine delivery of select services. A former Minister of Health, in response to the question of why the government did not choose to adopt private, for-profit health, commented “I think [it was]basically political acceptability more than anything else. When you approached the issue and always in terms of government decision-making, you have to judge the political acceptability of it to the populace and the people generally; and a couple of times that a government that I had led and was part of as a health minister even approached any one of these issues the preponderance of public opinion was very negative.”[52] The same informant recalled that there was tremendous hostility on the part of the public to private health care delivery due to the perception that businesses would rather seek to maximize profits than to assist patients: “There was some lack of confidence or trust that you could have someone in the private sector do it and that there would be anything other than a profit motive driving it, so that even if you're putting very stringent controls in for staffing levels and so on, that unless the government monitored that more closely than anything else they ever monitored, that the owners, the private sector owners, to maximize profit, would find a way to drop a nurse here or drop a bit of service off there.”[53] Still another informant echoed similar concerns with respect to physicians stating that, “In order for a private system to work, there has to be a critical mass of people who are willing to avail themselves of the private service, figuring they're either going to get their service faster or they're going to be given to them by a more qualified physician ”[54]

A third explanation is that the current Progressive Conservative government, elected in October, 2003, may be open to studying and implementing private, for-profit delivery of some forms of hospital and medical services other than long-term care: “So the policy

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[50] . Respondent 3.
[51] . Respondent 8.
[52] . Respondent 4.
[53] . Respondent 4.
[54] . Respondent 9.

choice may still be to go with some form of private delivery as long as it can meet the other parameters of equity and efficiency."[55] The emphasis on equity and efficiency is crucial to whether or not privatization of medical care will occur in the province. The current government, as well as previous Liberal administrations dating from 1989, followed the idea that unless there was solid empirical evidence that a private sector concern could deliver and manage a health service more cheaply and efficiently than the government, for-profit care would not be an option. So far, the evidence has not supported the establishment of for-profit health in the province. As an informant remarked, "there's an openness in this [the Williams] government, and in the previous government too [Grimes] - private delivery of services where it makes sense - but there's not a culture of we must do this, we must strengthen the private sector."[56]

Political culture also exercises influence over the choice of policy in Newfoundland and Labrador and privatization of medical care is no exception. This explanation suggests that Newfoundlanders are generally satisfied with their health system and tend not to complain because they are more likely to compare themselves to people worse off than themselves rather than to those who seek better health care. Arguments in support of privatization that suggest adoption would lead to a much improved health system simply fall by the wayside among the public. As an informant stated, "we have a large rural component. We have an aging population. We're like an old sleepy dog. As long as I get the Alpo I don't care. The paradox in Newfoundland and Labrador is that we always consistently rate our health status the highest in Canada. Well, like an old dog we should be the sickest and, you know, if we're trying to get funds to do a study on that, the working hypothesis is that Newfoundlanders don't compare themselves with trauma. Newfoundlanders tend to compare themselves to someone that's worse off and therefore we have it pretty good."[57] Instead of seeking better, Newfoundlanders are content with what they have as long as their health needs are met.

Conclusion

The privatization of medical and hospital services is a "no go" case with respect to formal legislative and institutional change in Newfoundland and Labrador. Champions of privatization are few in the province. Unlike Alberta or Ontario, there is not a groundswell of political and popular support for market-based solutions to health care delivery. Newfoundlanders and Labradorians, as demonstrated by the values of the province's political culture, want publicly funded and accessible health services where out of pocket expenses are kept to a minimum. As a former Premier put it, "I don't sense that there's any group in Newfoundland and Labrador that's out there about to take it upon itself to go around and try to change public opinion to make private delivery of health care an acceptable political option in the province."[58] Other than experiments with public-private partnerships in the area of long-term care, there has not been anything approaching an Alberta-style call for health privatization.

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[56]. Respondent 5.
[57]. Respondent 7.
[58]. Respondent 4.

APPENDIX 1 CODING LIST FOR CASE STUDY

federalism'
access'
'data
'demand',
doctors'
'fair',
fiscal'
'funding'
'government',
'hospital',
ideas'
information'
'advocacy',
'lists'
'lobbying',
'lobby
'management'
medical'
minister
'money',
need'
'nurses'
'Ontario'
agenda
'opposition',
'patients'
perception
'physicians
policy
'pressure
'quality',
equity
'reports
resources'
Alberta'
'Romanow
rural'
'think tanks'
tool'
'privatization
profit
'efficiency
'public'
'long term care'

'nursing home'
'board',
'budget
Canada'
control'
'culture'.

APPENDIX 2 CODING TABLES FOR CASE STUDY

NOTES ON TABLES AND METHODOLOGY

The terms employed for the tables are drawn from the coding report found in Appendix 1. Codes were devised based on the template from 21 October 2003 (revised) and the report distributed to the research team by John Lavis (23 November 2004). Tables are listed numerically as follows: prefix 1 are ideas; prefix 2, interests; prefix 3, external factors and prefix 4, institutions. The percentage figure in the column "# of mentions" refers to the percentage of all text units analyzed that the concept represents. For our case, there were a total of 1231 text units employed in the analysis.

TABLE 1.1 REFORM AS A MEANS TO CONTROL COSTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 1.2 QUALITY OF DATA USED TO EVALUATE REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	100
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 1.3 REFORM AS A MEANS OF CREATING EFFICIENCY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	1	50
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	50
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 1.4 IDEAS ABOUT EQUITY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 1.5 IDEAS ABOUT REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	3	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	3 (0.24%)	100

TABLE 1.6 INFORMATION FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	66.7
5	Civil Servant	0	0
7	Interest Group	1	33.3
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	3 (0.24%)	100

TABLE 1.7 IDEAS ABOUT MANAGEMENT OF REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	33.3
5	Civil Servant	0	0
7	Interest Group	1	66.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 1.8 IDEAS ABOUT POLICY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	60
5	Civil Servant	1	20
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	20
	TOTAL	5 (0.4%)	100

TABLE 1.9 IDEAS ABOUT PRIVATIZATION

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	40
4	Politician	0	0
5	Civil Servant	2	40
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	20
10	Health Professional	0	0
	TOTAL	5 (0.4%)	100

TABLE 1.10 IDEAS ABOUT FOR-PROFIT MEDICINE

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	6	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	6 (0.49%)	100

TABLE 1.11 IDEAS ABOUT QUALITY OF PRIVATIZED SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 2.1 ADVOCACY FOR PRIVATIZED MEDICAL SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 2.2 AGENDA FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	40
4	Politician	3	60
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	5 (0.4%)	100

TABLE 2.3 POLITICAL CULTURE AND REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	25
4	Politician	0	0
5	Civil Servant	1	25
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	2	50
10	Health Professional	0	0
	TOTAL	4 (0.32%)	100

TABLE 2.4 DEMAND FOR PRIVATIZED SERVICES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	2	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.32%)	100

TABLE 2.5 INTERESTS OF DOCTORS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	20
5	Civil Servant	1	20
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	1	20
10	Health Professional	2	40
	TOTAL	5 (0.4%)	100

TABLE 2.6 LOBBYING FOR REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	66.7
5	Civil Servant	1	33.3
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	3 (0.24%)	100

TABLE 2.7 INTERESTS OF PRIVATE LONG-TERM CARE FACILITIES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	27.3
5	Civil Servant	7	63.6
7	Interest Group	0	0
8	Civil Servant	1	9.1
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	11 (0.89%)	100

TABLE 2.8 INTERESTS IN MEDICAL GROUPS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	4	100
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	4 (0.32%)	100

TABLE 2.9 INTERESTS OF NURSES IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	20
4	Politician	4	80
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	5 (0.4%)	100

TABLE 2.10 PRIVATE, FOR-PROFIT NURSING HOMES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	3	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	3 (0.24%)	100

TABLE 2.11 INTERESTS OF PATIENTS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	100
	TOTAL	1 (0.08%)	100

TABLE 2.12 PERCEPTION OF REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	1	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 2.13 INTEREST OF PHYSICIANS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	2	13.3
4	Politician	0	0
5	Civil Servant	3	20
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	6	40
10	Health Professional	4	26.7
	TOTAL	15 (1.2%)	100

TABLE 2.14 PUBLIC OPINION AND REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	11	34.4
5	Civil Servant	6	18.8
7	Interest Group	0	0
8	Civil Servant	1	3.1
9	Interest Group	8	25
10	Health Professional	6	18.7
	TOTAL	32 (2.6%)	100

TABLE 2.15 INTERESTS OF RURAL AREAS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	3	50
4	Politician	1	16.6
5	Civil Servant	0	0
7	Interest Group	1	16.6
8	Civil Servant	0	0
9	Interest Group	1	16.6
10	Health Professional	0	0
	TOTAL	6 (0.49%)	99.8

TABLE 3.1 ALBERTA REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	5	35.7
4	Politician	2	14.3
5	Civil Servant	3	21.4
7	Interest Group	3	21.4
8	Civil Servant	0	0
9	Interest Group	1	7.1
10	Health Professional	0	0
	TOTAL	14 (1.1%)	99.9

TABLE 3.2 CANADA

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	4	33.3
4	Politician	6	50
5	Civil Servant	0	0
7	Interest Group	2	16.7
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	12 (0.97%)	100

TABLE 3.3 FEDERALISM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 3.4 GOVERNMENT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	28	63.6
5	Civil Servant	13	29.5
7	Interest Group	1	2.3
8	Civil Servant	0	0
9	Interest Group	2	4.6
10	Health Professional	0	0
	TOTAL	44 (3.6%)	100

TABLE 3.5 ONTARIO REFORMS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	3	33.3
4	Politician	4	44.4
5	Civil Servant	1	11.1
7	Interest Group	1	11.1
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	9 (0.7%)	99.9

TABLE 3.6 EXTERNAL REPORTS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 3.7 ROMANOW REPORT

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	100
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 3.8 THINK TANKS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 4.1 HEALTH BOARDS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	3	100
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	(0.24%)	100

TABLE 4.2 BUDGETS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	50
5	Civil Servant	1	50
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 4.3 FISCAL

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 4.4 FUNDING

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 4.5 MINISTER OF HEALTH

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 4.6 HOSPITALS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	3	75
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	25
	TOTAL	4 (0.32%)	100

TABLE 4.7 MONEY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	4	28.6
4	Politician	5	35.7
5	Civil Servant	2	14.3
7	Interest Group	2	14.3
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	7.1
	TOTAL	14 (1.14%)	100

TABLE 4.8 RESOURCES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	2	100
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100