

## ARTICLES

# Strategic Responses to Fiscal Constraints: A Health Policy Analysis of Hospital-Based Ambulatory Physical Therapy Services in the Greater Toronto Area (GTA)

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### ABSTRACT

**Purpose:** Ambulatory physical therapy (PT) services in Canada are required to be insured under the Canada Health Act, but only if delivered within hospitals. The present study analyzed strategic responses used by hospitals in the Greater Toronto Area (GTA) to deliver PT services in an environment of fiscal constraint.

**Methods:** Key informant interviews ( $n=47$ ) were conducted with participants from all hospitals located within the GTA.

**Results:** Two primary strategic responses were identified: (1) "load shedding" through the elimination or reduction of services, and (2) "privatization" through contracting out or creating internal for-profit subsidiary clinics. All hospitals reported reductions in service delivery between 1996 and 2003, and 15.0% (7/47 hospitals) fully eliminated ambulatory services. Although only one of 47 hospitals contracted out services, another 15.0% (7/47) reported that for-profit subsidiary clinics were created within the hospital in order to access other more profitable forms of quasi-public and private funding.

**Conclusions:** Strategic restructuring of services, aimed primarily at cost containment, may have yielded short-term financial savings but has also created a ripple effect across the continuum of care. Moreover, the rise of for-profit subsidiary clinics operating within not-for-profit hospitals has emerged without much public debate and with little research to evaluate its impact.

**Key Words:** delivery, funding, hospitals, physical therapy

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### RÉSUMÉ

**Objectif :** Conformément à la *Loi canadienne sur la santé*, les services de physiothérapie ambulatoire (PT) au Canada doivent être assurés, mais seulement s'ils sont prodigués dans un hôpital. Cette étude a analysé les interventions stratégiques utilisées par les hôpitaux du Grand Toronto pour offrir de tels services dans un environnement de compressions budgétaires.

**Méthode :** Des entrevues réalisées auprès de répondants clés ( $n=47$ ) ont été réalisées à partir de participants de tous les hôpitaux de la région du Grand Toronto.

**Résultats :** Deux interventions stratégiques primaires ont été identifiées : (1) des « coupures » (« load shedding ») dans la charge de travail par l'élimination ou la réduction des services; et (2) une forme de « privatisation » par le recours à des sous-traitants externes ou par la mise sur pied, à l'interne, de cliniques auxiliaires à but lucratif. Tous les hôpitaux ont signalé des réductions dans la prestation de services entre 1996 et 2003, et 15 % des hôpitaux (7 sur 47) ont complètement éliminé les unités de soins ambulatoires. Même si un seul établissement a eu recours à des sous-traitants pour des services, 15 % des établissements (7 hôpitaux sur 47) ont fait savoir qu'ils avaient créé des cliniques auxiliaires à but lucratif dans leur établissement afin d'avoir droit à d'autres formes de financement parapublic ou privé plus profitables.

**Conclusions :** La restructuration stratégique des services, visant principalement à contenir les coûts, a peut-être cédé le pas à des économies à court terme sur le plan financier, mais a également créé un effet d'effritement dans tout le continuum de soins. De plus, la tendance des cliniques à but lucratif

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poursuivant leurs activités dans des hôpitaux à but non lucratif s'est imposée sans véritable débat public et avec très peu de recherche sur leurs répercussions.

**Mots clés :** financement, hôpitaux, physiothérapie, prestation

## INTRODUCTION

It is a popularly held belief that Canada has a national socialized health care system. In fact, however, this is not the case. Canadian health care is defined as a universal system that is publicly funded and privately delivered, and in which the federal responsibility is to provide funding and the provincial/territorial responsibility is to organize and deliver services.<sup>1</sup> The term “socialized health care” implies that some level of government delivers institutional or hospital-based services at a national level; but across Canada, close to 98% of hospitals are private not-for-profit institutions that receive public funding to deliver services to eligible residents in each jurisdiction.<sup>2,3</sup> The principal legislation that underpins the delivery of health services is the Canada Health Act (CHA), which stipulates that in order to receive federal funding, provinces and territories must agree to provide “medically necessary” physician and hospital services to eligible residents. Because most hospitals in provinces and territories are private (not public) not-for-profit institutions, they also have considerable scope to be innovative and flexible in delivering health services so as to maintain federal funding.<sup>4</sup>

The costs of Canada's national health insurance programme reached CAD\$142 billion in 2005, a 7.7% increase from 2004.<sup>5</sup> In 2007, the cost of the health system reached \$160 billion; it has been recently reported that the cost of health care outpaced inflation and population growth for the eleventh consecutive year.<sup>6</sup> Moreover, per capita health expenditures reached \$4,867 in 2007, which, after adjusting for inflation, represented a 5.3% increase from the year before.<sup>6</sup> Hospitals are consistently ranked the largest single expense within the health system; in 2007, for example, 28.7% of the overall national-level expenses (approximately \$45 billion) was spent on hospital services. Based on these trends, since the early 1990s there has been a sense that health care costs are rising, especially as they relate to hospitals.<sup>7</sup> As a result of such escalating costs, hospitals across the country have implemented various reform strategies, which generally attempt to maintain levels of service while decreasing expenditures.<sup>8</sup> Canada, like other developed and developing countries, continues to implement cost-cutting measures in order to ration scarce health care dollars.<sup>9–11</sup>

In late 2002, two influential federally commissioned reports on Canada's health care system were released within a few weeks of each other. In October 2002, the Standing Senate Committee on Social Affairs, Science

and Technology, chaired by Senator Michael Kirby, released its final report, *The Health of Canadians—The Federal Role, volume 6: Recommendations for Reform*.<sup>12</sup> In November 2002, the Commission on the Future of Health Care in Canada, chaired by Roy Romanow, released its final report, *Building on Values: The Future of Health Care in Canada*.<sup>13</sup> While these reports differed in many important respects, both strongly emphasized the importance of a publicly funded hospital-based network across the country. Both reports asserted that the theoretical underpinning of the CHA should be strengthened; however, both also suggested that the CHA can be viewed from multiple perspectives. Some stakeholders emphasize the role of the CHA as a protector of full health coverage for insured services to eligible residents, while others emphasize the CHA's failure to encourage more innovative approaches to health care delivery.<sup>14</sup> As a result, various stakeholders and pressure groups tend to use the language of the CHA, and their perceptions of its intent, to defend their particular interests against other competing interests.<sup>1,15–17</sup>

The province of Ontario has implemented a number of health reform strategies since the early 1990s.<sup>3,4,18</sup> Many of these strategic responses were aimed at reducing overall costs while maintaining service levels. The Ontario Ministry of Health and Long Term Care (MOHLTC) sought to curb health expenditures by implementing overall cost-containment strategies; as a result, hospitals were left to determine how they would respond to fiscal constraints in a period of growing demand for services.<sup>19–22</sup> One option for the hospital sector was to strategically restructure delivery in order to focus only on core competencies and essential functions. Thus hospitals, the single largest category of provincial health expenditures, are continually searching to define which services they *must* provide and which they *do not necessarily have* to provide under the CHA. Fuller,<sup>18</sup> Armstrong et al.,<sup>23</sup> and Sanger<sup>24</sup> have noted that reform strategies aimed at cost containment have occurred, and continue to occur, across the evolving landscape of Canadian health care.

Public funding of physical therapy (PT) services in hospitals is an ambiguous component of the national health continuum.<sup>3</sup> Although there has been little empirical research, anecdotal reports suggests that hospital-based ambulatory PT services in Ontario were vulnerable to strategic restructuring. For instance, the Ontario Physiotherapy Association (OPA) reported that an increasing number of hospitals have privatized the

delivery of PT services, and voiced concerns that this would lead to a crisis in access to quality hospital-based services.<sup>25</sup> Further, there have been reports that as hospitals closed or restructured, the responsibility for providing PT services shifts to the community—which has also experienced massive restructuring in Ontario. In this study we describe the strategic responses of hospitals in the Greater Toronto Area (GTA) as they restructured ambulatory PT services in response to tight cost-control measures imposed by the public payer between 1996 and 2003. This study period was chosen because it coincides with particularly relevant policy events that occurred in the province, including the Health Services Restructuring Commission, which began in 1996 and ended in 2000, and the release of the Kirby and Romanow reports in 2002. Focusing our policy-research lens on this period provided defined temporal parameters for further investigation of strategic restructuring. The process of strategic restructuring has gained momentum since 2003, and the results of this study create a benchmark against which future research findings can be compared.

## METHODS

Ethics approval for this study was obtained through the Research Ethics Board at the University of Toronto. A series of key informant interviews was conducted to supplement the available literature and to explore perceptions of structural changes to hospital-based ambulatory PT delivery. For the purposes of the study, only hospitals located in Region 3 of the Ontario Hospital Association (OHA), also known as the Greater Toronto Area (GTA), were included. The GTA was chosen for analysis because it is an urban area with a highly diverse population of approximately 5 million persons served by a sufficient number of hospitals to allow for comparison. The GTA is also regarded within the industry as the provincial area that has most significantly restructured the delivery of hospital-based PT services; as well, an analysis of hospitals in the GTA was most geographically feasible for the purposes of this research. It is important to acknowledge, however, that the GTA, being a large, multicultural urban setting, is not necessarily representative of the rest of Ontario or of the rest of Canada.

Initially, the study sample included all 59 GTA hospitals listed by the OHA. There were two exclusion criteria. First, all corporate offices listed in the GTA were removed from the sample, since these locations are not settings in which health services (including PT) are funded and delivered. Second, hospitals with a particular focus on mental health were excluded, because they represent a health service that provides care to a very specific population that generally does not include significant PT services. Removing these sites resulted in a more homogeneous sample. After exclusion of the six

corporate offices (exclusion criterion #1) and the six mental-health hospitals (exclusion criterion #2) from the original OHA list, there remained a total of 47 hospital sites in the sample.

## Selection of Key Informants

Key informant interviews are in-depth, semi-structured interviews with people selected for their expert knowledge on a specific topic.<sup>26</sup> Informed by the results from our literature and data search, we conducted a series of 47 telephone interviews in February and March 2003 with key informants at each hospital included in the study who could provide a rich description of the delivery of hospital-based ambulatory PT services. Potential key informants were selected purposively, using the following criteria: (1) working at a specific hospital in the GTA for at least 5 years; (2) responsible for either clinical or operations management; and (3) willing to participate in a telephone interview within relatively tight timelines. The investigators first generated a list and then contacted potential informants who matched the above criteria for each hospital included in the study sample. Initially, potential informants were contacted by telephone or e-mail in order to gauge their interest in participating in a 45-minute semi-structured interview; if the individual agreed, a mutually convenient time was tentatively arranged to conduct the interview. All individuals contacted agreed to participate. The key informant interviews were conducted by telephone, using a semi-structured interview schedule (see Table 1) that enabled the investigators to explore participants' perspectives broadly and to uncover hidden and emerging themes while maintaining the study focus.<sup>26–29</sup> Permission was requested to audiotape the telephone interviews, and all but one informant agreed to this condition. For this interview, the primary investigator kept detailed handwritten notes during the interview. The audiotapes were immediately sent to a research assistant outside the investigative team for transcription.

## Data Analysis

The transcribed interview data were entered into a qualitative data-analysis software package (NVivo, QSR International Pty Ltd., Doncaster, VIC, Australia) for systematic coding. Content analysis, which involves identifying themes and categories prior to coding the data, was used to guide the qualitative description.<sup>27,28</sup> The themes included in the coding were based on collective knowledge, perceptions, and experiences of the researchers that addressed the research objectives.<sup>28</sup> Specifically, the themes were related to macro-level strategic responses, along with sub-themes that describe the themes in much more detail. Although many coding themes were developed for this study, only those related

**Table 1** Semi-structured Interview Guide

1	I would like to begin by asking you some information regarding your background and professional experience.
2	What type of PT services does your facility provide? (i.e., in-patients, out-patients, or assessments such as DACs). <i>Prompts:</i> Has this basket of services provided changed between 1990 and the present? What are the criteria for accessing these services?
3	How are these programmes financed and delivered? <i>Prompts:</i> Do you provide PT services in-house, or do you contract out these services to private providers?
4	How standardized are your assessment and treatment processes? Do you use clinical practice guidelines? Do you perform chart audits to look at care processes?
5	Who determines number of treatments and duration of each treatment session?
6	Are there waiting lists for receiving PT care? If yes, which type of client is placed on the lists, and how are they managed? How long is the average wait time?
7	Do clients with different levels of funding receive different levels of care?
8	Do you often refer clients elsewhere because of funding issues, or do you provide PT services to persons regardless of their funding?
9	Do you bill the client directly, or indirectly through a third party, for PT services? <i>Prompts:</i> How do you extra bill for services? (i.e., direct to the client?)
10	Is your facility accredited by an external organization, or are you planning to be accredited?
11	What is the role of non-regulated providers in your facility? <i>Prompts:</i> Do you use non-regulated professionals to provide direct and indirect care?
12	How does the facility provide staff development ( <i>prompt:</i> continuing professional education, etc.)? How many dollars or hours per year?
13	How might the structure/outcome of care change when PT services are privatized?
14	Whether or not your hospital has contracted out PT services, I'd like to ask you a few questions regarding your opinion on the privatization of PT services in hospital.
15	Are there many hospitals in Ontario that have contracted out PT services? What about the hospitals in the Metro Toronto area? <i>Prompt:</i> Why do you think hospitals may wish to privatize or contract out PT services?

to the description of strategic responses will be presented here.

The primary investigator (ML) performed all the coding, then generated coding reports for the research team to analyze. Once all transcripts had been coded for themes, another individual not involved in the research independently reviewed and recoded 10% of the transcripts (5/47) to validate the coding. The two coders agreed in 90% of cases; once issues with definitions and nomenclature had been resolved for all interviews, the two coders reached 100% agreement. This process has been effectively used before to ensure appropriate data analysis.<sup>3,7,14,30</sup>

## RESULTS

Interviews were conducted with 47 key informants, including 18 physical therapists or professional practice leaders (14 women, 4 men); 18 managers or directors of clinical or operational programmes (12 women, 6 men); and 11 senior managers (5 women, 6 men). The informants ranged in age from 35 to 56 years, and had an

average of 6.4 years' experience at their respective institutions.

Overall, informants reported that health reform strategies subsequent to fiscal constraints implemented across successive Ontario governments had an important impact on ambulatory services delivered across the province. One informant asserted,

I think it [hospital restructuring] began after 1995 when the [Progressive Conservative] Harris government started to screw down very aggressively on money provided to the health care system generally, and to hospitals in particular, [...] and that's when hospitals, I guess, figured that they had no alternative but to start looking for other ways of delivering care, and other ways of generating revenue.

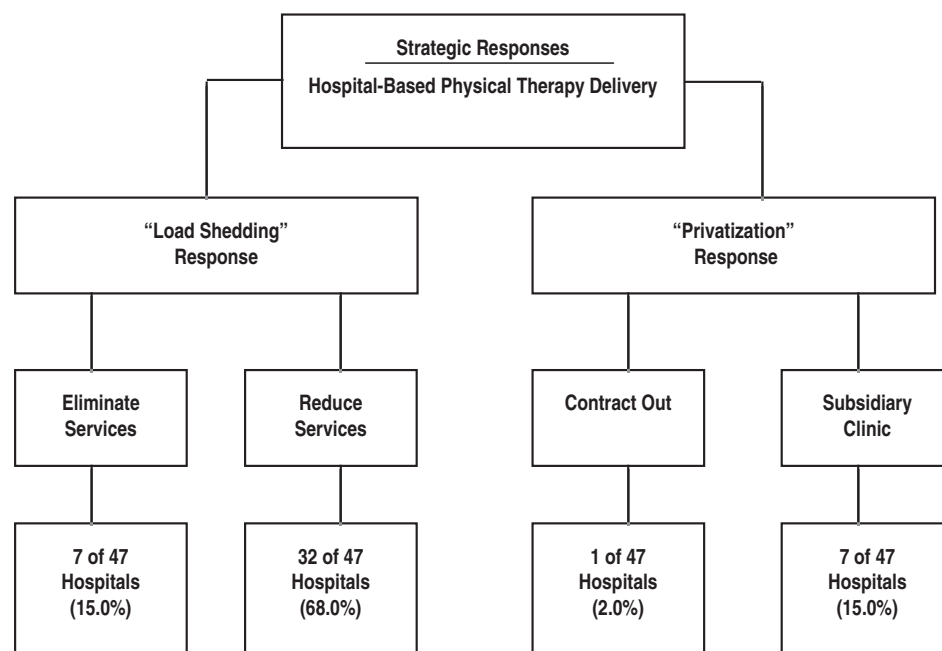
The informants agreed that multiple waves of political change drove different health care agendas. One such feature was a series of recommended closures and amalgamations of formerly independent organizations across the province under the arm's-length Health Services Restructuring Commission (HSRC) (1996–2000).<sup>29</sup> The interview data identified two primary types of strategic response for hospital-based PT delivery in the GTA, along with four sub-types (see Figure 1). The primary categories were consistent with Bendick's classifications of restructuring;<sup>31</sup> the macro-level structuring categories included the "load shedding" response (whereby the hospital may choose to eliminate or reduce only) and the "privatization" response (whereby the hospital may choose to contract out a service or to implement a for-profit subsidiary clinic). Each strategic response is described in more detail in the following sections.

### The "Load Shedding" Response

"Load Shedding" as a strategic response describes a process whereby a clinical service is eliminated and re-assigned to another sector for the funding and/or delivery of services or is simply removed from the list of insured services, creating a new market elsewhere for that same service. Two sub-types of "load shedding" responses were reported by informants in this study: (1) elimination of service delivery and (2) reduction in service delivery.

#### *Elimination of Service Delivery*

The first "load shedding" strategic response is to eliminate ambulatory PT services as an insured service or entitlement within the hospital. In this study, 7 (15.0%) of the 47 hospital sites in the GTA reported completely eliminating their ambulatory PT services between 1996 and 2003. Most of the elimination of services occurred under the auspices of amalgamation: multi-hospital corporations had eliminated services at some of their sites. For instance, a large urban hospital corporation was formed in 1999 by amalgamating two teaching hospitals



**Figure 1** Strategic responses in hospital-based ambulatory physical therapy service delivery in the Greater Toronto Area (GTA).

and one specialized cancer hospital; following this amalgamation, the corporation eliminated all outpatient PT services at two of the three sites and shifted all ambulatory PT services to one site. However, another large free-standing teaching hospital in Toronto's downtown corridor (with only one location) decided to completely eliminate ambulatory PT services in 2003, arguing that this would allow the hospital to focus on other core services. Two other similar free-standing hospitals also completely eliminated services. Our informants indicated that the decision to eliminate services was a last resort, and that the decision was made for financial and not clinical reasons.

### **Reduction in Service Delivery**

Our informants signalled that the most common restructuring strategy used by GTA hospitals was the "reduction" approach. This category of strategic restructuring involved hospital sites' choosing to reduce the volume of ambulatory PT services delivered. In total, 32 of the 47 hospital sites in the GTA (68.0%) used this strategic manoeuvre between 1996 and 2003.

The ways in which hospitals reduced services were noted by respondents as an important element. Strict inclusion or access criteria were used to reduce ambulatory services; for example, between 1996 and 2003 many hospitals in the GTA implemented a requirement that clients be referred by a physician practising within the hospital and/or that clients reside in the hospital's direct catchment area in order to access hospital-based services. Although not a particularly creative or novel approach, implementing strict access criteria across all

hospitals sites was mentioned by participants as a defining feature of the study period.

Some hospitals employed other strategies, such as using acuity as a criterion to ration services or reducing the hours of operation of the ambulatory service. As one informant noted,

The other significant thing is reduction in supply. So anecdotally I know one hospital ... who says "well we only have outpatient services three afternoons a week." So even if there is a department, there's a drastic reduction in the number of full-time-equivalent therapists ...

Although our qualitative data do not allow us to gauge the degree of reduction in service delivery, respondents in this study, ranging from physical therapy practice leaders to senior executives, indicated that such reductions did occur and that they had a direct impact at the client level. Our informants reported that these reductions were part of an overall strategy to cut costs but that they also created a ripple effect across the publicly funded care continuum, especially since demand for services was also reported to rise during the study period. For instance, hospitals' implementing a reductionist strategy for PT services while demand for services was rising meant that individuals who could not receive hospital-based ambulatory services would need to search elsewhere for PT services. In Ontario, as in all other Canadian jurisdictions, individuals have the option to pay out of pocket for PT services, but not all are able or willing to pay. For individuals in the GTA willing or able to pay privately, there were many options in the community; for those who were not able or willing to pay and

needed to find a publicly funded option, however, access to services could no longer be guaranteed, or even presumed. The effects of poor access to publicly funded services and poor availability of publicly funded community-based PT have been reported elsewhere<sup>14,30</sup> and will not be reviewed here; however, it is important to note that the respondents considered the reduction trend likely to continue well into the future and acknowledged that this process may have unknown effects across the care continuum.

### The “Privatization” Response

*Privatization* is defined as the transfer of a one-time public-sector service (or its representative agents) to private companies that often operate on a for-profit basis.<sup>30,31</sup> Two sub-types of “privatization” were reported in this study: (1) contracting out and (2) creating for-profit subsidiary clinics.

### Contracting Out

*Contracting out service delivery* is a process whereby a firm, including a hospital or government, contracts with other not-for-profit and for-profit firms to provide goods and services. The “contracting out” strategy was not widely used in the GTA, where only one hospital contracted out the delivery of outpatient PT services to an external provider. When asked why a hospital would contract out its services, one informant reported,

It’s either to save money or to create a new revenue source, or some combination of the two. That’s the bottom line. Certainly it was in [hospital name]’s case ... it was to save money in the budget.

This specific hospital entered into a contractual agreement with an external provider that assumed the responsibility for delivery of outpatient PT services, along with all operational responsibility, ranging from human resource management to invoicing. In doing so, this hospital continued to offer services but no longer had operational responsibility for delivery. The contractual agreement between the two parties was confidential and proprietary; as a result, the precise details of the arrangement were not available for public scrutiny. In general, however, our informants indicated that there are multiple approaches to contracting out services, including simply renting space to the external provider, purchasing services from the independent contractor at a lower cost, and configuring a profit-sharing arrangement. One informant said,

The motivation for me [to contract out] was threefold. [First] there was going to be some subsidizing of my hospital programmes, [second] to increase productivity ... and [third] to improved service quality.

The same informant also confirmed that the hospital would have chosen to “eliminate” the service, had they not contracted it out, in response to fiscal pressure imposed by senior management.

Although only one hospital in the GTA decided to contract out PT services during the study period, the majority of the others had considered this option before deciding on other strategic approaches. For instance, another hospital located at the periphery of the GTA attempted to contract out services in 2001, but this approach was never implemented because of strong opposition, both internal (e.g., from hospital staff and union) and external (e.g., from the local community). Instead of contracting out, this hospital initiated a subsidiary clinic model (described below).

As noted by O’Looney,<sup>32</sup> the contracting-out process may in theory reduce services by allocating fewer resources to the provider under contract than were previously allocated to the hospital PT department. One issue underpinning the choice to contract out relates to efficiency in service delivery. It is noteworthy that many respondents (35/47, or 74.4%) suggested that hospital-based services are perceived as relatively inefficient, where “efficiency” is defined by the amount of “output” given the amount of “input.” Although few details were provided, one informant reported that

when I worked in the hospital, in the outpatient department, I know that I was inefficient. I didn’t think I was being inefficient at the time, because I didn’t know any better. But when I look now at the private clinics [that I work for within the hospital] I know that I could have been more efficient ...

Other informants echoed these comments:

I cannot not tell you how inefficient and with total disregard for best practice and fiscal restraints hospital-based PT departments run.

Now I certainly believe that hospital departments need to be cleaned up. They probably need somebody from business, independent business company to go in and help them save money and be more efficient with their money.

A minority of informants indicated that contracting out is purported to generate efficiencies assumed to be inherent in the private sector, including mechanisms such as competition, economies of scale, and use of more efficient service-delivery techniques. However, other informants suggested that the primary way in which such “efficiencies” were achieved was through changing labour agreements and employee benefits and using a different staffing mix (generally including fewer regulated professionals and more trained support personnel). In the words of one informant,

sometimes they'll [hospitals] outsource so that they don't have the responsibility for benefits and the benefits costs, the salary costs ... [along with] ... recruitment and retention costs.

### **Creating For-Profit Subsidiary Clinics**

The final strategic restructuring response reported by the informants was that of *creating for-profit "subsidiary" clinics* within the hospital. This strategy involves a process whereby a hospital may choose to create an independent for-profit clinic within the corporate structure. The subsidiary clinic is essentially a private practice owned and operated by the hospital. Although efforts were required to ensure that such clinics did not violate the CHA prohibitions on extra billing of insured persons for insured services, 7 of the 47 hospital sites in the GTA (15.0%) did create for-profit clinics within the not-for-profit hospital during the study period.

According to our informants, the creation of a subsidiary clinic provided an opportunity for the hospital to more easily access funding beyond that provided through the hospital global budget. These additional funding sources include quasi-public streams such as the Workplace Safety and Insurance Board (WSIB) and motor vehicle accident (MVA) insurance, as well as private streams such as private out-of-pocket payments and third-party reimbursements. Many respondents noted that ambulatory PT services have long waiting lists with a high number of clients eligible for other funding streams; thus, the subsidiary clinic model permits access to these more lucrative funding sources. When asked about the rationale behind creating subsidiary clinics, one informant offered the following comment:

... suddenly hospitals were in the business of generating revenue. Rehabilitation services, particularly with changes in WSIB and changes in the auto insurance piece, became revenue-generating opportunity, and hospitals started moving into ways of using rehab services to generate some. Sometimes the funds went back into the rehabilitation services to keep them alive. A lot of time they went back into the hospital as a whole.

Ultimately, the subsidiary model allowed hospitals to diversify their revenue streams. The profits generated by these for-profit initiatives might be directed toward subsidizing the global budget allocated for other hospital-based PT services; however, our informants noted that usually the profits were redirected to the hospital's base budget and not necessarily allocated to PT services. Based on the findings of this study, the rationale for creating subsidiary clinics included both (1) diversifying revenue streams and (2) subsidizing the overall operations of the hospital. The rationale for choosing a subsidiary arrangement over a contracting-

out arrangement may be linked to the notion that in a large populated area (or an area with sufficiently high potential volumes), hospitals can generate sufficient economies of scale to yield a profit. Other informants noted that the subsidiary clinic had become an essential component of adult services. For instance, a senior manager said,

We try and offset other costs for outpatient services to be able to buy more equipment, to keep outpatient services open ... If we weren't billing WSIB, we'd be treating them anyhow—we would be treating them for nothing under the global budget. So you might as well be getting something back to the hospital.

One informant, who at the time was employed in a hospital operating a subsidiary clinic, noted that

"we have used those dollars to enhance our public side. Any enhancement of our public side allows us to free up staff for in-patients," as well as that "our finance department has generally said profit made in this organization is for the entire hospital, not for the programme that produced it."

## **DISCUSSION**

Two main conclusions emerged from this study. First, the data suggest that there were important changes in the delivery of ambulatory PT services in GTA hospitals between 1996 and 2003—specifically, that PT services within hospitals have been significantly restricted, as demonstrated by the fact that 15.0% of hospitals eliminated services and by the fact that all hospitals, in one way or another, reduced service volumes for publicly funded services. According to respondents, these strategic responses were aimed at cost reduction, and, while the responses described were hospital based, they have had unintended ripple effects across the continuum of care. For instance, when services were reduced or eliminated, individuals had to decide whether to (1) go without PT services, if they were not insured by public or private sources; (2) pay out of pocket; or (3) access private third-party insurance they might be eligible to receive.

A previous study reported that partial delisting of community-based PT services resulted in 17.7% of the study sample's going without PT services because they were uninsured, underinsured, or unable to pay privately.<sup>33</sup> After controlling for gender, age, and employment status, the researchers found that individuals who maintained access were more likely to report excellent or very good self-reported health status (SRHS) than were those who did not receive services (Odds Ratio: 10.72; 95% CI: 2.20–52.25). The authors also reported strong

associations between SRHS and utilization rates of hospitals and family physicians. Although the current study addressed hospital-based services, previous data on community-based PT services may be instructive and may reflect elasticity of demand for PT services. Briefly, the theory of elasticity of demand refers to a change in the quantity of services demanded resulting from a change in policy.<sup>34</sup> PT services would thus be considered *inelastic* if individuals were equally able to access services elsewhere following a policy inflection point, and would be considered *elastic* if individuals were not able to access services. Although further research is necessary, the findings from this hospital-based study and from the community-based study by Landry et al.<sup>33</sup> signal that access to publicly funded PT services may be economically elastic in nature.

Second, there has been a rise in for-profit subsidiary clinics operating in hospitals, largely without public debate and with little research to examine the system-wide effects. A previous study identified nine models of PT delivery in Ontario that fall into three categories of ownership structure: public, private not-for-profit, and private for-profit.<sup>30</sup> The study also reported that, between 1996 and 2002, the relative proportion of PTs employed in the not-for-profit sector decreased while the share in the for-profit sector grew (from 40.4% to 45.2%), and concluded that shifting balance in the structure of delivery may be transforming how PT services are provided in the province.<sup>30</sup> Private for-profit providers appear to have increased their market share during the study period; however, the outcomes relative to this shift have not yet been fully explored. The results of the present study confirm that the hospital sector is also experiencing a shift in profit motive. As we have described, contracting-out is not a prevalent model, but the creation of for-profit subsidiary clinics has increased during the study period. Our data do not permit elaboration, but the extent to which the creation of subsidiary clinics is consistent with the rules and regulations of the CHA would be an informative follow-up study, especially given the apparent propensity to create such infrastructures.

Each province, territory, or hospital must decide whether there is sufficient clinical and cost benefit to maintain funding for ambulatory services such as PT in hospitals. Although physical therapists across Canada may believe and assume that PT services are medically necessary to the health of Canadians, other stakeholders do not necessarily share this perspective. Reductions in overall hospital funding have forced policy makers, decision makers, and managers to examine the minimum basket of services they are legally required to provide. The results of this study highlight the fact that, based on rising health care costs, the hospital sector in the GTA has strategically restructured service delivery in order to focus on core competencies and essential

functions. Thus hospitals, the single largest category of provincial health expenditures, are continually defining which services they *must* provide and those they *do not necessarily have* to provide under the CHA. Although there has been little empirical research, our data suggest that publicly funded hospital-based ambulatory PT services in Ontario are vulnerable. The extent to which strategic restructuring has occurred within PT services, and the implications of this process for cost and access, has not yet been determined. The search for such empirical evidence represents the next step in understanding the extent to which strategic restructuring has affected the health and well-being of Canadians at the local, regional, and national levels.

The study period of 1996 to 2003 provided a context to examine strategic responses to fiscal constraints in a particularly important policy period in Ontario. Moreover, our data set the stage for further research, especially given the apparent increase in strategic manoeuvres reported in this study. For instance, a recent cross-sectional telephone survey of hospitals in Ontario found not only that approximately 17% no longer offer PT services but also that the vast majority of hospitals that continue to offer such services have incorporated private funding to finance ambulatory PT services.<sup>35</sup> Moreover, closures of hospital-based PT services continue, described in news releases as necessary in the context of overall cost-cutting measures.<sup>36</sup>

Despite our findings, further research is required to more fully investigate the effects of strategic hospital restructuring on PT service delivery. Empirical research that will gauge the amount of reduction and the impact of the clinical level is also needed.

It is important to note that the strategic responses documented in the GTA may not be fully representative of those that have occurred across Ontario, or in other provinces and territories. In fact, based on the responses of informants in this study, there is anecdotal evidence to suggest that the strategic responses in less populated and rural settings may be structurally different from those reported in the GTA. Although less populated areas of Ontario are also likely to have reduced and eliminated ambulatory services, they may differ in favouring the contracting-out strategy over the subsidiary model. As a result, further research must gauge the short- and long-term effects of these structural changes on the health and mobility of individuals residing in these communities.

## CONCLUSIONS

We have reported here that strategic responses used by hospitals to deliver PT services are related to fiscal constraints imposed on overall operations. Although our data do not allow us to measure clinical or financial outcomes, these strategic responses, based on reports from our respondents, may have achieved cost savings



and cost containment in the short term but may have also created a ripple effect across the continuum of care. Further data need to be evaluated for the period from 2003 to the present in order to determine whether this trend has continued and, if so, the extent to which strategic responses have changed in the face of an emerging and ever-changing national health care environment. Moreover, examples of strategic responses to fiscal constraints in other areas of the province and of the country are needed, including data from more rural and sparsely populated regions, where services may be more vulnerable to restructuring. Health policy and services research must now explore the system-wide health outcomes that result from altering the precarious balance of not-for-profit and for-profit motives in the delivery of PT services, and how changes to the funding mix affect the health and rehabilitation workforce.

## KEY MESSAGES

### What Is Already Known on This Subject

The Canada Health Act (CHA) defines the service-delivery parameters required for provinces and territories to receive federal funding. However, there are ongoing debates and challenges regarding the inclusion of publicly funded physical therapy services within the CHA. Hospitals have consistently ranked as the largest expenditure category within health systems; in the province of Ontario, as the cost of health care has risen, hospitals have implemented strategic restructuring manoeuvres aimed at reducing overall cost while still complying with the terms and conditions of the CHA. The extent to which hospital-based physical therapy services have been strategically restructured in response to fiscal constraints had not previously been explored.

### What This Study Adds

The data collected in this study suggest that all hospital-based physical therapy services located within the Greater Toronto Area were vulnerable to strategic restructuring between 1996 and 2003. The two primary strategic responses used by hospitals were “load shedding” (through the elimination or reduction of services) and “privatization” (through contracting out services or creating internal for-profit subsidiary clinics). Strategic restructuring of physical therapy services, aimed primarily at cost containment, may have yielded short-term financial savings but created a ripple effect across the continuum of care. While contracting-out of service delivery was not widespread, the rise in the number of for-profit subsidiary clinics operating within not-for-profit hospitals has occurred with little research to evaluate its impact on the overall publicly funded health system.

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