RESEARCH PAPER

Exploring Privatization in Canadian Primary Care: An Environmental Scan of Primary Care Clinics Accepting Private Payment

Exploration de la privatisation dans les soins primaires au Canada : une analyse de l'environnement des cliniques de soins primaires qui acceptent le paiement privé

AIDAN BODNER, BSc
Research Assistant
Faculty of Health Sciences
Simon Fraser University
Burnaby, BC

SARAH SPENCER, MSc, MPH
Research Coordinator
Faculty of Health Sciences
Simon Fraser University
Burnaby, BC

M. RUTH LAVERGNE, PhD
Associate Professor
Primary Care Research Unit, Department of Family Medicine
Dalhousie University
Halifax, NS

LINDSAY HEDDEN, PhD
Assistant Professor
Faculty of Health Sciences
Simon Fraser University
Burnaby, BC
Assistant Scientific Director
Michael Smith Health Research BC
Vancouver, BC

Abstract

Background: Private payment within primary care has not received extensive scrutiny, despite the emergence of "concierge" primary care services.
Objective: We conducted an environmental scan to explore the nature of private payment for primary care across Canada.
Method: We extracted data from clinic websites on funding models, range of services provided and whether they were independent or part of a chain. We conducted a thematic analysis of service advertisements.
Results: We identified 83 private clinics across six provinces, predominately in urban areas. Private payment-only clinics offered the widest range of services and advertisements emphasised timely, comprehensive care.
Conclusion: The extent to which these clinics and bundling of primary care with privately paid wellness services impact patients' access to care should be the subject of future research.

Résumé

Contexte : Le paiement privé dans le cadre des soins primaires n'a pas fait l'objet d'un examen minutieux, et ce, malgré l'émergence de services de soins primaires « de conciergerie ».
Objectif : Nous avons effectué une analyse environnementale pour explorer la nature du paiement privé des soins primaires au Canada.
Méthode : Nous avons extrait, à partir des sites Web des cliniques, des données sur les modèles de financement, sur la gamme de services fournis et sur le type de cliniques, à savoir si elles étaient indépendantes ou faisaient partie d'une chaîne. Nous avons procédé à une analyse thématique des annonces de services offerts.
Résultats : Nous avons identifié 83 cliniques privées dans six provinces, principalement dans les zones urbaines. Les cliniques privées payantes offraient la plus large gamme de services et leurs annonces mettaient l'accent sur des soins complets et en temps opportun.
Conclusion : La mesure dans laquelle ces cliniques et le regroupement des soins primaires avec des services de bien-être privés ont un impact sur l'accès des patients aux soins devrait faire l'objet de recherches futures.

Background and Objective

Introduction

Concern about privatization within Canadian healthcare is long-standing, and regulations controlling the growth of parallel systems of privately funded healthcare are increasingly being challenged (Hurley 2020). Against the backdrop of Supreme Court rulings in *Chaoulli v. Quebec (Attorney General)* (2005) and *Cambie Surgeries Corporation v. British Columbia (Attorney General)* (2020), private clinics have been increasingly bold in delivering both publicly and privately funded services (Costain 2017; Flood 2005; Ontario Health Coalition 2017). Recent evidence on private clinics in Canada indicates that they have tended to focus

on providing diagnostic and surgical services; however, the number of clinics offering privately funded primary care may also be growing (Graff-McRae 2017; Isabelle and Stabile 2020; Ontario Health Coalition 2017). Clinics can charge membership or à la carte fees for non-insured services, which may have the effect of limiting access to publicly funded services for non-members (Born and Laupacis 2011). Recent reporting has indicated that these practices are widespread across corporate or boutique clinics operating in Alberta and Ontario (Graff-McRae 2017; Ontario Health Coalition 2017). A thriving parallel private primary care system creates a drain on the supply of physicians and other healthcare professionals, catering to a wealthier clientele at the expense of accessibility based on need and exacerbating ongoing primary care shortages. Furthermore, two-tiered primary care is in clear opposition to the *Canada Health Act* (1985) – namely, the Universality Criterion, which establishes access to medically necessary services under uniform terms and conditions, and the Accessibility Criterion, which ensures access is not impeded by additional charges or other means. The current extent of private payment for primary care services has not been formally investigated.

Context

Services provided in primary care settings include health promotion, illness and injury prevention, diagnosis and treatment of common illness and injury and referral to and coordination with specialty services (Flood and Archibald 2001). Primary care in Canada is largely provided through physician-led clinics, with non-physician health professionals integrated through various models of team-based practice (CFPC 2017; Peckham et al. 2018). It is typically publicly funded and privately delivered, with physicians operating independent businesses while receiving remuneration through provincial health insurance plans (Hutchison et al. 2011). Primary care services deemed medically necessary by insurers are free at point of care to insured patients, while exempted services such as cryotherapy for warts and benign skin lesions, excision of benign moles, vaccines for travel and most medical forms and sick notes are commonly paid for by patients privately. This is in accordance with the *Canada Health Act* (1985), which applies only to services deemed medically necessary. Some clinics may choose to request a "block" annual payment to cover these services, but this fee cannot be an obligatory precursor to receiving insured services (Reid 2017). The extent to which this is enforced is unknown. Regardless, "block" annual payments framed as memberships for non-insured services may have the effect of limiting access to publicly funded services for non-members (Born and Laupacis 2011).

Provincial ministries of health regulate private payment for publicly insured services using a variety of mechanisms. Most provinces prohibit physicians who have "opted in" to the public system from direct billing patients for covered services (Flood and Archibald 2001; Marchildon 2020). Extra-billing, where patients are charged an extra fee for services covered in the public plan, is directly prohibited in all but New Brunswick and Prince Edward Island (Flood and Archibald 2001). The elimination of public subsidies, either through price-based

or status-based disincentives, deter physicians from choosing to opt out of the public plan in most provinces; however, there is provincial variability in terms of the specific methods used, including how rapidly physicians can opt out and in (Flood and Archibald 2001). Provincial health legislation is reinforced within practice standards and codes of conduct created by provincial physician licencing bodies. The specific content of these standards, similar to provincial health legislation, varies by province.

This mix of variable provincial policies and regulations has largely discouraged the development of a parallel system of privately funded primary care; however, the emergence of "boutique," "concierge," or "wellness" clinics (henceforth referred to as "private clinics") that deliver primary care while also charging membership fees and/or marketing services that require patients to pay out-of-pocket (beyond the common exempted services mentioned above) may indicate that private payment within primary care clinics warrants attention.

While reports have documented the operation of corporate or boutique clinics in Alberta and Ontario, we do not yet have national information on the extent of these practices (Graff-McRae 2017; Ontario Health Coalition 2017). Online directories of private clinics exist to direct patients to services (https://www.findprivateclinics.ca/), but details offered, funding models used and how clinics describe and advertise their services to patients have not been documented. As long as fees charged by clinics are not obligatory precursors to receiving publicly insured services, operation of these clinics may be legal and in accordance with the *Canada Health Act* (1985). Based on the understanding that private payment affects both accessibility and equity in healthcare (Bambra et al. 2014; Colombo and Tapay 2004; Dahlgren 2014; Gelormino et al. 2011; Hopkins and Cumming 2001; Thomas et al. 2020; Tuohy et al. 2004), private clinics raise concerns about equity in access to primary care and may signal the need for more active surveillance of private payment and possible regulatory reform.

Objective

We conducted an environmental scan to document the extent and nature of primary care clinics offering privately paid services beyond common uninsured services. We documented the services offered and funding models used and explored how these clinics advertise their services to patients.

Method

Search strategy

We sought to identify primary care clinics offering privately paid services beyond those that are commonly excluded from provincial health insurance plans (Appendix 1: Table A1, available online at www.longwoods.com/content/26727). We identified clinics from two existing published lists, supplemented with structured Google searches conducted between November 2019 and June 2020. We also hand-searched websites of identified clinics for

links to additional, potentially relevant clinics. Published lists include FindPrivateClinics.ca and the source list for an existing report on private care in Canada titled *Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients* (Ontario Health Coalition 2017). FindPrivateClinics.ca is an online directory of private clinics and health professionals, sortable by province and specialty (https://www.findprivateclinics.ca/). The Ontario Health Coalition's (OHC's) report summarizes the results of a survey conducted between fall 2016 and spring 2017 in which researchers called all identified private clinics (136 clinics in nine provinces) to assess the extent to which they are charging user fees for medically necessary services (Ontario Health Coalition 2017). Searches on FindPrivateClinics.ca and the list of clinics identified in the OHC report were conducted by screening each clinic listed, province by province.

We supplemented the two above-mentioned sources using a structured Google search. We performed an exploratory background search to develop a suitable list of search terms. Each potential term in the list was concatenated with "Canada" to determine the strongest search string. The strongest strings were those that returned the greatest number of websites matching the inclusion criteria. This resulted in the final search string: "personalized" OR "executive" OR "concierge" AND "general practitioner" OR "family medicine" OR "health clinic" AND "province." Before provincial searches were conducted, we set a custom geolocation code within each province through the "Developer Tools" option on Google Chrome to ensure location searches were performed in their respective provinces (Basques 2018). For each provincial search, we scanned all pages of results until we reached redundancy to locate relevant clinics.

Eligibility criteria

To be included, clinics had to provide and advertise private pay-for-all services or services that would not be reimbursable by provincial health insurance (over and above those in Appendix 1: Table A1) and/or charge patients clinic membership fees. To determine whether clinics marketed services that required private payment by patients, we compared service listings and associated fees on each clinic website to provincial insurance service fee schedules. Included clinics also had to have at least one physical location in a Canadian province or territory and have an English website.

We excluded clinics that had no practising physicians – e.g., those led by a naturopath or nurse practitioner. We also excluded those with no physical location, such as virtual e-health services, and those for which a referral is required for a patient to secure an appointment.

Data extraction

We extracted the following data from the websites of each included clinic: number of primary care physicians and non-MD healthcare professionals employed, geographic location(s), number of locations, provision of e-health services, membership options, cost of membership (if applicable), cost of appointments and services advertised.

We classified clinics as "private payment only," "public insurance plus private payment" or "not stated." Clinics that did not explicitly state their funding model ("not stated") either advertised services outside provincial health insurance plans or explicitly advertised the limited or exclusive nature of services, which was highly suggestive of their private nature, but did not post fee schedules that would allow us to determine their pay structure. We used census metropolitan areas (CMAs), census agglomerations (CAs) and non-CMAs/non-CAs to define the rurality of clinic locations. CMAs are cities with populations of 100,000 or more, while CAs have populations of at least 10,000 and non-CMAs/CAs have populations below 10,000 (Statistics Canada 2016). We labelled clinics as "stand-alone" if they had only a single physical location or as a "chain" if they operated two or more locations.

We grouped individual services into the following categories: general medical services, alternative medical services, medical office services, mental health services, lifestyle services, medical testing, pharmacy, rehabilitation and specialty services (full groupings are included in Appendix 1: Table A2, available online at www.longwoods.com/content/26727). Service categories were defined and added iteratively to ensure comprehensive documentation; once a new category was added, clinics were retrospectively re-assessed to examine whether they offered services within that category. We assumed that clinics that were part of a larger chain operated under the same organizational and payment model unless differences were specified by individual locations. Individual services that were advertised at fewer than five clinics were excluded from the categorization. Finally, we abstracted text from clinic websites promoting any aspect of services offered for thematic analysis.

Analysis

QUANTITATIVE DESCRIPTIVE ANALYSIS

We analyzed differences in service categories offered, comparing stand-alone clinics and chain clinics, as well as payment models using χ^2 tests (or Fisher's exact test when the numbers were small). Some chain clinic locations did not individually report services provided. These clinics were excluded from this analysis. All statistical analyses were performed using RStudio (https://www.rstudio.com/).

THEMATIC ANALYSIS OF SERVICE ADVERTISEMENTS

We analyzed service advertisements thematically, with broad themes drawn from all clinic advertisements (Trotter and Namey 2015). In the development of our coding framework, advertisements were classified per existing deductive themes, with new classifications added inductively if none of the pre-existing options were appropriate (Clarke and Braun 2014; Green and Thorogood 2018). This approach was continued until all service advertisements were categorized. We then defined each theme and selected representative quotes. We also scrutinized existing themes for similarity of concepts and amalgamated and redefined similar themes to better represent the category. To ensure reliability, a second reviewer coded the

TABLE 1. Distribution of private clinics and their key features by province[a] (*n* [%])

Feature	Province[a]						Total (*N*)
	BC	AB	ON	QC	NS	NFLD	
Private clinics	13 (15.7)	14 (16.9)	24 (28.9)	30 (36.1)	1 (1.2)	1 (1.2)	83
Number of physicians	56 (20.5)	71 (26.0)	76 (27.8)	66 (24.2)	4 (1.5)	0 (0.0)	273
Number of physicians per capita (Statistics Canada 2020)[b]	1.09	1.60	0.52	0.77	0.41	0	
CMA	13 (16.0)	12 (14.8)	24 (29.6)	30 (37.0)	1 (1.2)	1 (1.2)	81
CA	0 (0.0)	1 (100)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1
Non-CMA/Non-CA	0 (0.0)	1 (100)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1
Fee schedule present	8 (26.7)	5 (16.7)	5 (16.7)	12 (40.0)	0 (0.0)	0 (0.0)	30
Private payment only	0 (0.0)	0 (0.0)	0 (0.0)	10 (100.0)	0 (0.0)	0 (0.0)	10
Public insurance plus private payment	8 (36.4)	7 (31.8)	5 (22.7)	2 (9.1)	0 (0.0)	0 (0.0)	22
Membership options[c]	10 (23.3)	8 (18.6)	9 (20.9)	14 (32.6)	1 (2.3)	1 (2.3)	43
Membership Costs (C$)[d] (Median[*SD*])	1,950 (1,289.4)	3,150 (1,702.9)		1,199 (1,709.3)			
E-health options	7 (20.0)	4 (11.4)	10 (28.6)	12 (34.3)	1 (2.9)	1 (2.9)	35
Chain locations	4 (8.3)	6 (12.5)	14 (29.2)	23 (47.9)	0 (0.0)	1 (2.1)	48

[a] Provinces and territories with no clinics (Saskatchewan, Manitoba, New Brunswick, Prince Edward Island, Yukon, Northwest Territories and Nunavut) were excluded from the Table.

[b] Per 100,000 population.

[c] Membership options listed for all available packages.

[d] Median membership costs are obtained from all prices listed for full-membership packages (excluding bonus or add-on packages and packages for common uninsured services) (Polyclinic 2020; Doctors of BC 2016; Fédération des médecins omnipraticiens du Québec 2020; New Brunswick Medical Society 2019; Nova Scotia Medical Services Insurance 2014) offered for individual adults. Number of clinics included in median and standard deviation calculations, $n = 14$.

BC = British Columbia; AB = Alberta; ON = Ontario; QC = Quebec; NS = Nova Scotia; NFLD = Newfoundland and Labrador.

advertisements independently with the final coding framework, and any conflicts were reconciled (Joffe and Yardley 2004). We counted the total occurrence of each theme across the clinic websites to determine which themes were most commonly represented.

Ethics approval

As this study involved the collection and analysis of publicly available data and did not involve contacting individuals, consideration and approval by an ethics review board was not required.

Results

We initially identified 119 clinics: six clinics in the OHC report; 52 clinics through FindPrivateClinics.ca; and an additional 61 clinics from our Google search. Two additional clinics were identified through a hand search. We subsequently excluded 38 clinics that did not meet our inclusion criteria, leaving 83 included clinics. Among the clinics we excluded, 29 only accepted private payment for selected services commonly excluded from provincial

health insurance plans, seven clinics had a French-only website, one clinic did not offer a private payment option and one clinic did not offer primary care services.

We identified clinics in British Columbia, Alberta, Ontario, Quebec, Nova Scotia, and Newfoundland and Labrador (Table 1). A total of 273 physicians were listed on clinic websites, ranging from four in Nova Scotia to 76 in Ontario. More than half (57.8%) of all the clinics identified were a part of 13 larger chains operating mostly in Quebec and Ontario. The remaining 35 (42.2%) were standalone. All but two (97.6%) were located in densely populated areas (CMAs).

Payment model

Though many clinics advertised services that would not be reimbursable under provincial health insurance, most websites (61.4%) did not explicitly state their payment model. A quarter (26.5%) included a combination of private payment and public insurance, and 12% of clinics operated on a private-pay-only model (Table 2). All 10 private-pay-only clinics were located in Quebec.

TABLE 2. Payment model distribution among chain and standalone clinics (*n* [%])

	Clinic type			
Payment model	**Chain 48 (57.8)**	**Standalone 35 (42.2)**	**Total**	***p* value**
Private payment only	8 (16.7)	2 (5.7)	10 (12.0)	0.0126
Public insurance plus private payment	7 (14.6)	15 (42.9)	22 (26.5)	
Not stated	33 (68.8)	18 (51.4)	51 (61.4)	

In all, 43 (51.8%) clinics listed costs for memberships. Median (*SD*) costs for full-membership packages ranged between provinces as follows: British Columbia: $1,950.00 ($1,289.4); Alberta: $3,150 ($1,702.9); and Quebec: $1,199 ($1,709.3). Ontario, Nova Scotia and Newfoundland and Labrador did not have clinics that advertised membership fees.

Chain and standalone clinics differed in their funding models. Standalone clinics were more likely to operate using public insurance plus private payment (42.9% vs. 14.6% of chain clinics). Chain clinics were more likely to operate on a solely private payment model (16.7% vs. 5.7%) or not state a funding model (68.8% vs. 51.4%).

Services delivered

Most (91.6%) clinics listed the services they offered. Nine chain locations that did not list services were excluded from this analysis. General medical services such as assessments and diagnostic services were advertised by all 76 clinics. Specialty services were advertised by 64 clinics (84.2%), and lifestyle optimization services by 63 clinics (82.9%). E-health options were offered by 35 clinics.

TABLE 3. Service category distribution by clinic type and funding model (*n* [%])

	Clinic type				Funding model				
Service category[a]	**Chain 41 (53.9)**	**Standalone 35 (46.1)**	**Total**	***p* value***	**Private payment only 10 (13.2)**	**Public insurance plus private payment 22 (28.9)**	**Not stated 44 (57.9)**	**Total**	***p* value****
Alternative medical services	18 (43.9)	26 (74.3)	44 (57.9)	0.0147	10 (100.0)	14 (63.6)	20 (45.5)	44 (44.7)	0.0029
General medical services	16 (39.0)	24 (68.6)	40 (52.6)	0.0192	9 (90.0)	14 (63.6)	17 (38.6)	40 (52.6)	0.0057
Cognitive health services	24 (58.6)	28 (80.0)	52 (68.4)	0.0786	9 (90.0)	15 (68.2)	28 (63.6)	52 (68.4)	0.3019
Medical office services	29 (70.7)	20 (57.1)	49 (64.5)	0.3205	10 (100.0)	14 (63.6)	25 (56.8)	49 (64.5)	0.0242
Lifestyle optimization services	31 (75.6)	32 (91.4)	63 (82.9)	0.1285	9 (90.0)	18 (81.8)	36 (81.8)	63 (82.9)	1
Medical testing services	37 (90.2)	22 (62.9)	59 (77.6)	0.0099	10 (100.0)	15 (68.2)	34 (77.3)	59 (77.6)	0.133
Pharmacy services	2 (4.9)	6 (17.1)	8 (10.5)	0.1333	0 (0.0)	4 (18.2)	4 (9.1)	8 (10.5)	0.3667
Rehabilitation services	5 (12.2)	14 (40.0)	19 (25.0)	0.0116	2 (20.0)	10 (45.5)	7 (15.9)	19 (25.0)	0.0352
Specialty services	32 (78.0)	31 (88.6)	63 (82.9)	0.3635	10 (100.0)	20 (95.5)	33 (75.0)	63 (82.9)	0.0374

[a]For clinic type and funding model analysis, general medical services *p* value = 1.
*Fisher's exact test was used for the analysis of pharmacy services.
**Fisher's exact test was used for the analysis of all funding models.

Chain and standalone clinics differed in terms of the services they offered (Table 3). Stand-alone clinics provided proportionally more alternative medical services and rehabilitation services compared to chain clinics but were less likely to advertise that they provided diagnostic testing.

Comparison by funding model also yielded significant differences (Table 3). Clinics with a private-only payment model provided proportionally more alternative medical services, general medical services and medical office services compared to clinics with a public insurance plus private payment or an unstated payment model.

Service advertisements

Representative quotes from advertisement themes are presented in Table 4, available online at www.longwoods.com/content/26727. Themes included a focus on comprehensive services (49 clinics [59.0% of total clinics identified]), followed by timely service provision

(34 [41.0%]), quality (29 [34.9%]), personalized care (26 [31.3%]) and prevention (26 [31.3%]). Additional themes included an individual's control over their own health outcomes (17 [20.5%]), health optimization (16 [19.3%]), alternative medicine (11 [13.3%]) and cosmetic services (7 [8.4%]). One clinic (Corporate Health Services, ExcelleMD, Calgary, AB) advertised services with a comprehensive focus stating, "We offer a range of à la carte services in one place, letting you make the most of your time by minimizing your travel and wait times."

Discussion

Through a robust search, we sought to describe the scope of private payment for primary care in Canada. We found 83 physician-led clinics across six provinces that explicitly marketed services that required private payment, 48 of which were part of larger chains. More than half charged membership fees. These clinics were clustered within urban areas and offered a broad range of services with advertising that emphasized convenience, comprehensiveness and personalization.

Building off previous research, there is a visible continued presence of private payment for primary care services (Graff-McRae 2017; Isabelle and Stabile 2020; Ontario Health Coalition 2017). This raises concerns about equity in access to care, which is achieved when access is based on need and not one's ability to pay (Whitehead 1991). Parallel private systems can threaten equitable access to healthcare services (Dahlgren 2014; Leatherman and Sutherland 2008; Tuohy et al. 2004), and evidence suggests that even modest user fees or copayments can have a detrimental effect on access, particularly for lower-income households (Kesselheim et al. 2015; Law et al. 2019; Schoen et al. 2010).

The content of service advertisements by clinics suggests a target patient group seeking a broad range of medical services coupled with highly individualized care. Advertisements created strong narratives surrounding what health should look like and the standard at which a patient should expect to receive care. Thematic elements of advertisements include time (both rapid access to services and longer appointments), optimization of health and personalization of services (Bambra et al. 2005). These themes may reflect the fact that despite decades of targeted investment, the public system remains unable to consistently provide whole-person, integrated care; boutique clinics are capitalizing on this gap.

The extent to which the clinics we identified were operating in violation of specific provincial health legislation is beyond the scope of this work; however, the challenges to accessibility and equity remain a concern. For example, in one case, the annual fee charged by a wellness clinic not only provided access to services not covered within provincial health insurance – e.g., physiotherapy, massage therapy – but also provided the opportunity to queue jump for publicly provided colonoscopy screening (Vertes 2013). It is simply "not credible that C$10,000/year was the price of massage and dietary advice and had no bearing on an expectation of expedited access to public resources" (Reid 2017: 158). Provincial ministries of health should undertake more active surveillance or investigations to determine whether,

through membership fees, user fees and extra-billing for publicly covered services, the clinics we have identified are operating in violation of provincial health insurance legislation.

We found a clear clustering of clinics within urban areas. This is consistent with literature on healthcare systems that include a formalized means for parallel private provision, highlighting the profit-driven nature of private providers (Dahlgren 2014; Dickman et al. 2017). Additionally, both greater inequality and the propensity of patients in urban locations to pay a fee for medical services have been associated with the growth of urban-based clinics (Isabelle and Stabile 2020).

The influx of options for private payment also creates potential challenges with respect to physician integrity and conflict of interest. Bundling publicly insured services with alternative wellness services, for example, creates situations where physicians can financially profit from coercing patients into using privately paid services that may be unnecessary and are not evidence based. Furthermore, as larger numbers of physicians are selling products or services, there are risks that publicly funded services become available only to those patients who can afford the expensive "add-ons" (Reid 2017). This may pose a particular challenge in cases where clinics are owned and operated by corporations rather than physicians as physicians in corporate clinics may face pressure to recommend specific privately paid services provided by their clinics.

The observation that all private-pay-only clinics are in Quebec is consistent with factors unique to the Quebec setting, where physicians can more rapidly opt in and out of the public system. These fully opted-out clinics operate in full accordance with the *Canada Health Act* (1985) and are not in a position to coerce patients to pay privately for non-insured services in order to access publicly insured services. However, the potential conflict in this setting is similar to fully opted-out delivery of private specialist services, wherein opting out exacerbates shortages within the public system and creates demand for private services.

Provincial physician colleges have practice standards to address the bundling of insured and uninsured services. Some of these standards point out the need for clear communication with patients about which services are covered and which are associated with a fee (eg., CPSBC 2019) but are otherwise silent on the inherent conflict of interest. Other provincial practice standards do mention the conflict directly (e.g., CPSO 2017), but focus more on the selling of medical devices or products, rather than on delivering uninsured services for a profit. In both cases, practice standards should be strengthened to address the bundling of insured and uninsured services and the inherent conflict therein.

Boutique wellness clinics and executive clinics may pose an additional challenge with respect to primary care physician supply. Corporate-owned clinics, in particular, provide an attractive employment model for family physicians, offering competitive remuneration, regular predictable work hours and little administrative burden while catering to wealthy, worried and well patients. To the extent that these models proliferate, they may compete for the supply of physicians providing comprehensive primary care in urban areas, particularly to lower-income Canadians and individuals with complex, chronic illnesses.

Chain clinics comprised a significant proportion of total clinics discovered in the scan, and these clinics provided more diagnostic services than standalone clinics. This suggests a growing interest in family medicine by big businesses who see potential for profit (Brown 2020; Centre for Primary Care 2019; MacLeod 2020a, 2020b). Concerns have already been raised about challenges with continuity of care and unnecessary testing within corporate virtual care and brick-and-mortar clinics, and there is a clear tension between profits and patient care (Brown 2020; MacLeod 2020b; McCracken et al. 2019).

Limitations

We relied exclusively on data sourced from clinic websites, which results in a number of potential limitations. For example, clinics may not be completely comprehensive in their listing of services or charges. Additionally, for some chain clinic websites, we noted discrepancies in reporting with respect to physician practice locations; often, physician numbers and locations were reported but it was unclear at which locations physicians practised. Thus, caution is warranted in the interpretation of service and physician counts. Furthermore, we have not attempted to fully survey the scope and content of block fees within our search, and some variability by province is expected. It is possible that, within block fee arrangements, clinics may be charging patients inappropriately either by placing surcharges on publicly funded services or by charging an unreasonably large amount for the supplemental services covered. Block fees also raise concerns about informed consent, wherein patients may feel pressured by their physicians to agree to pay (Reid 2017).

The data collected for the scan represent a single cross section and are thus only representative of the collection period. We are unable to comment on broader trends in the availability of private payment over time. Furthermore, information regarding clinics and their services may not be representative past its date of extraction. Variation may also extend to fluidity in what is covered under provincial health insurance plans, such as expansion to include e-health services during the COVID-19 pandemic in Ontario (Ontario Ministry of Health and Ministry of Long-Term Care 2021). Additionally, our search was limited to bricks-and-mortar primary care clinics and, therefore, excluded stand-alone virtual walk-in clinics. There is, however, significant potential for private payment for primary care services within these models, and regulations around these services vary by province (Matthewman et al. 2021).

Our search was conducted in English. While we captured clinics in Quebec whose websites were available in English and French, our search would not have picked up any clinics that offered services in French only. We are underestimating the number of clinics with private payment in Quebec in particular. Furthermore, as the search was limited to physician-led clinics, we did not capture the range of providers increasingly represented in providing primary care services, such as nurse practitioners (DiCenso et al. 2010), and those providers who may also be delivering services privately. The scan only captured private payment for primary care services; thus block fees charged by clinics for uninsured services were

not captured. It may be that clinics offering block fees do not follow provincial billing guidelines for uninsured services (Born and Laupacis 2011; Daw et al. 2020). We did not directly examine clinic ownership. As noted above, large, for-profit corporations may be playing expanded roles in clinic ownership and delivery of both publicly and privately funded care and this requires future-focused research. Finally, while results raise concerns about access to care and potential harms to patients through feeling pressured to pay for supplemental services, more research is needed to explore patient experiences and the impacts of clinics directly.

Conclusion

Parallel private payment for primary care services is occurring in at least 83 clinics across six Canadian provinces as identified through this environmental scan. The extent to which these clinics impact patients' access to care and supply of physicians and other healthcare professionals should be the subject of future research. Similarly, the introduction of membership fees, bundling of public primary care with wellness services and the corporatization of family medicine should all be the subject of both future research and robust investigation by both provincial policy makers and provincial physician regulatory colleges. Findings should also prompt consideration of gaps in public delivery of primary care that private services are addressing, with a view to strengthening equitable and public delivery of high-quality primary healthcare.

Correspondence may be directed to: Lindsay Hedden, Simon Fraser University, Faculty of Health Sciences, 8888 University Drive, Burnaby, BC V5A 1S6. Lindsay can be reached by e-mail at lindsay_hedden@sfu.ca.

References

Bambra, C., D. Fox and A. Scott-Samuel. 2005. Towards a Politics of Health. *Health Promotion International* 20(2): 187–93. doi:10.1093/heapro/dah608.

Bambra, C., K. Garthwaite and D. Hunter. 2014. All Things Being Equal: Does it Matter for Equity How You Organize and Pay for Health Care? A Review of the International Evidence. *International Journal of Health Services* 44(3): 457–77. doi:10.2190/HS.44.3.c.

Basques, K. 2018, December 18. Override Geolocation. Chrome Developers. Retrieved April 15, 2021. <https://developer.chrome.com/docs/devtools/device-mode/geolocation/>.

Born, K. and A. Laupacis. 2011, October 27. Charging Patients for Services: Much Confusion, Little Consensus. *Healthydebate*. Retrieved January 12, 2021. <https://healthydebate.ca/2011/10/topic/cost-of-care/block-fees/>.

Brown, R.H. 2020. Corporatization of Family Medicine in BC. *BCMJ* 62(5): 163–64.

Cambie Surgeries Corporation v. British Columbia (Attorney General), 2020 BCSC 1310. Retrieved January 12, 2021. <https://www.bccourts.ca/jdb-txt/sc/20/13/2020BCSC1310.htm>.

Canada Health Act (R.S.C., 1985, c. C-6). Retrieved January 12, 2021. <https://laws-lois.justice.gc.ca/eng/acts/c-6/FullText.html>.

Centre for Primary Care. 2019, January 14. The Corporatization of Primary Care: Unintended Consequences. Harvard Medical School Primary Care Review. Retrieved April 15, 2021. <http://info.primarycare.hms.harvard.edu/blog/corporatizationofprimarycare>.

Chaoulli v. Quebec (Attorney General), 2005 SCC 35 (CanLII), [2005] 1 SCR 791. Retrieved January 12, 2021. <https://canliiconnects.org/en/cases/2005scc35>.

Clarke, V. and V. Braun. 2014. Thematic Analysis. In A.C. Michalos, ed., *Encyclopedia of Quality of Life and Well-Being Research* (pp. 283–311). Springer.

The College of Family Physicians of Canada (CFPC). 2017, July. *Best Advice Guide: Team-Based Care in the Patient's Medical Home*. Retrieved February 10, 2020. <https://patientsmedicalhome.ca/files/uploads/BAG_TeamBasedCare_ENG-1.pdf>.

College of Physicians and Surgeons of British Columbia (CPSBC). 2019, May 1. *Practice Standard: Charging for Uninsured Services*. Retrieved January 25, 2022. <https://www.cpsbc.ca/files/pdf/PSG-Charging-for-Uninsured-Services.pdf>

College of Physicians and Surgeons of Ontario (CPSO). 2017, November. Uninsured Services: Billing and Block Fees. Retrieved November 4, 2021. <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Uninsured-Services-Billing-and-Block-Fees>.

Colombo, F and N. Tapay. 2004. *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems*. OECD Health Working Papers. Retrieved January 12, 2021. <https://www.oecd.org/els/health-systems/33698043.pdf>.

Costain, K. 2017. Decontextualized Rights: Concerns Regarding the Bedford Section 7 Framework in the Health Care Context of the Cambie Surgery Center Trial. *Appeal: Review of Current Law and Law Reform* 22: 3–24.

Dahlgren, G. 2014. Why Public Health Services? Experiences from Profit-Driven Health Care Reforms in Sweden. *International Journal of Health Services* 44(3): 507–24. doi:10.2190/HS.44.3.e.

Daw, J.R., K.E. Rice and D. Raza. 2020. Fees for Uninsured Services: A Cross-Sectional Survey of Ontario Family Physicians. *CMAJ Open* 8(1): E163–68. doi:10.9778/cmajo.20190189.

DiCenso, A., I. Bourgeault, J. Abelson, R. Martin-Misener, S. Kaasalainen, N. Carter et al. 2010. Utilization of Nurse Practitioners to Increase Patient Access to Primary Healthcare in Canada – Thinking Outside the Box. *Canadian Journal of Nursing Leadership* 23: 239–59. doi:10.12927/cjnl.2010.22281.

Dickman, S.L., D.U. Himmelstein and S. Woolhandler. 2017. Inequality and the Health-Care System in the USA. *Lancet* 389(10077): 1431–441. doi:10.1016/S0140-6736(17)30398-7.

Doctors of BC. 2016. *Revised Fees for Uninsured Services*. Retrieved December 30, 2020. <https://www.doctorsofbc.ca/sites/default/files/public_uninsured_services_2016apr01.pdf>.

Fédération des médecins omnipraticiens du Québec. 2020. *Provincial Fees for Non Insured Services, Previously Insured Services and Incidental Fees Provided by Family Physicians*. Retrieved December 30, 2020. <https://fmoq.s3.amazonaws.com/pratique/facturation/frais-accessoires/Grille-tarifaire-FMOQ-27-02-2020_EN.pdf>.

Flood, C.M. 2005. Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access. *The Journal of Law, Medicine and Ethics* 33(4): 669–80. doi:10.1111/j.1748-720X.2005.tb00535.x.

Flood, C.M. and T. Archibald. 2001. The Illegality of Private Health Care in Canada. *CMAJ* 164(6): 825–30.

Gelormino, E., C. Bambra, T. Spadea, S. Bellini and G. Costa. 2011. The Effects of Health Care Reforms on Health Inequalities: A Review and Analysis of the European Evidence Base. *International Journal of Health Services* 41(2): 209–30. doi:10.2190/HS.41.2.b.

Graff-McRae, R. 2017, November. Blurred Lines: Private Membership Clinics and Public Health Care. Parkland Institute. Retrieved January 12, 2021. <https://www.deslibris.ca/ID/10094162>.

Green, J. and N. Thorogood. 2018. *Qualitative Methods for Health Research* (Fourth Edition). Sage Publications.

Hopkins, S. and J. Cumming. 2001. The Impact of Changes in Private Health Expenditure on New Zealand Households. *Health Policy* 58(3): 215–29. doi:10.1016/S0168-8510(01)00161-0.

Hurley, J. 2020. Borders, Fences, and Crossings: Regulating Parallel Private Finance in Health Care. In C.M. Flood and B. Thomas, eds., *Is Two-Tier Health Care the Future?* University of Ottawa Press.

Hutchison, B., J.-F. Levesque, E. Strumpf and N. Coyle. 2011. Primary Health Care in Canada: Systems in Motion. *The Milbank Quarterly* 89(2): 256–88. doi:10.1111/j.1468-0009.2011.00628.x.

Isabelle, M. and M. Stabile. 2020. Local Inequality and Departures from Publicly Provided Health Care in Canada. *Health Economics* 29(9): 1031–47. doi:10.1002/hec.4117.

Joffe, H. and L. Yardley. 2004. Content Analysis and Thematic Analysis. In D.F. Marks and L. Yardley, eds., *Research Methods for Clinical and Health Psychology* (pp. 56–68). Sage Publications.

Kesselheim, A.S., K.F. Huybrechts, N.K. Choudhry, L.A. Fulchino, D.L. Isaman, M.K. Kowal et al. 2015. Prescription Drug Insurance Coverage and Patient Health Outcomes: A Systematic Review. *American Journal of Public Health* 105(2): e17–30. doi.org/10.2105/AJPH.2014.302240.

Law, M.R., L. Cheng, H. Worthington, S.R. Majumdar, K.M. McGrail, F. Chan et al. 2019. Impact of a Household-Level Deductible on Prescription Drug Use among Lower-Income Adults: A Quasi-Experimental Study. *CMAJ Open* 7(1): E167–73. doi:10.9778/cmajo.20180198.

Leatherman, S. and K. Sutherland. 2008. *The Quest for Quality: Refining the NHS Reforms: A Policy Analysis and Chartbook*. The Nuffield Trust. Retrieved February 10, 2021. <https://www.nuffieldtrust.org.uk/files/2017-01/quest-for-quality-report-web-final.pdf>.

MacLeod, A. 2020a, September 7. Profits before Patients? The Corporate Push into BC's Primary Care System. *The Tyee*. Retrieved April 15, 2021. <https://thetyee.ca/News/2020/09/07/The-Corporate-Push-Into-BC-Primary-Care/>.

MacLeod, A. 2020b, September 11. How BC Can Fix Primary Health Care, With or Without Corporations. *The Tyee*. Retrieved April 15, 2021. <https://thetyee.ca/News/2020/09/11/How-BC-Can-Fix-Primary-Health-Care-Corporations/>.

Marchildon, G.P. 2020. Private Finance and Canadian Medicare: Learning from History. In C. M. Flood and B. Thomas, Eds., *Is Two-Tier Health Care the Future?* (pp. 15–35). University of Ottawa Press.

Matthewman, S., S. Spencer, M.R. Lavergne, R.K. McCracken and L. Hedden. 2021. An Environmental Scan of Virtual "Walk-In" Clinics in Canada: Comparative Study. *Journal of Medical Internet Research* 23(6): e27259. doi:10.2196/27259.

McCracken, R., A. Longhurst, R. Lavergne and D. Contadriopolous. 2019, December 19. Virtual Walk-in Clinics Undermine Primary Care. *Policy Note*. Retrieved April 15, 2021. <https://www.policynote.ca/virtual-primary-care/>.

New Brunswick Medical Society. 2019. *Physicians Guide to Direct Billing*. Retrieved December 30, 2020. <https://www.nbms.nb.ca/wp-content/uploads/2019/11/Direct-Billing-Guide-E-Final.pdf>.

Nova Scotia Medical Services Insurance. 2014. *Physician's Manual 2014*. Retrieved December 30, 2020. <http://www.medavie.bluecross.ca/static/MSI/PhysicianManual.pdf>.

Ontario Health Coalition. 2017, June 10. *Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients*. Retrieved December 30, 2020. <http://www.ontariohealthcoalition.ca/wp-content/uploads/final-report-1.pdf>.

Ontario Ministry of Health and Ministry of Long-Term Care. 2021, April 9. Ontario Health Insurance Plan INFOBulletin: COVID-19 Temporary Virtual Care Services. Retrieved November 4, 2021. <https://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/redux/bul210403.aspx>.

Peckham, A., J. Ho and G. Marchildon. 2018, March. *Policy Innovations in Primary Care across Canada: A Rapid Review Prepared for Canadian Foundation for Healthcare Improvement*. *Rapid Review 1*. North American Observatory on Health Systems and Policies. Retrieved February 10, 2021. <https://ihpme.utoronto.ca/wp-content/uploads/2018/04/NAO-Rapid-Review-1_EN.pdf>.

Polyclinic. 2020. *Charges for Uninsured Services (NOT COVERED BY OHIP): Ontario Medical Association (OMA) Guidelines Jan to Dec 2020*. Retrieved December 30, 2020. <https://polyclinic.ca/2/wp-content/uploads/2020/02/Uninsured-Charges-Feb-2020.pdf>.

Reid, L. 2017. Concierge, Wellness, and Block Fee Models of Primary Care: Ethical and Regulatory Concerns at the Public–Private Boundary. *Health Care Analysis* 25(2): 151–67. doi:10.1007/s10728-016-0324-4.

Schoen, C., R. Osborn, D. Squires, M.M. Doty, R. Pierson and S. Applebaum. 2010. How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries. *Health Affairs* 29(12): 2323–34. doi:10.1377/hlthaff.2010.0862.

Statistics Canada. 2016, November 16. Dictionary, Census of Population, 2016: Census Metropolitan area (CMA) and Census Agglomeration (CA). Retrieved February 10, 2021. <https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/geo009-eng.cfm>.

Statistics Canada. 2020, December 16. Table 17-10-0009-01: Population Estimates, Quarterly. Retrieved January 21, 2021. <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901>.

Thomas, S., S. Barry, B. Johnston, R. Siersbaek and S. Burke. 2020. Embracing and Disentangling from Private Finance: The Irish System. In C.M. Flood and B. Thomas, eds., *Is Two-Tier Health Care the Future?* (pp. 291–314). University of Ottawa Press.

Trotter, R.T. and E.E. Namey. 2015. Qualitative Research Methods. In G. Guest and E. E. Namey, eds., *Public Health Research Methods*. Sage Publications.

Tuohy, C.H., C.M. Flood and M. Stabile. 2004. How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations. *Journal of Health Politics, Policy and Law* 29(3): 359–96. doi:10.1215/03616878-29-3-359.

Vertes, J.Z. 2013, August. *Health Services Preferential Access Inquiry – Alberta. Health Quality Council of Alberta. Volume 1 – Inquiry Report*. Retrieved April 15, 2021. <https://www.hqca.ca/wp-content/uploads/2018/05/HSPAI_Final_Report_Volume_1_Complete.pdf>.

Whitehead, M. 1991. The Concepts and Principles of Equity and Health. *Health Promotion International* 6(3): 217–28. doi:10.1093/HEAPRO/6.3.217.