Submission on the proposed new regulation under the Independent Health Facilities Act (IHFA), 1990

and

the proposed amendment to regulation 264/07 under the Local Health System Integration Act (LHSIA)2006

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Formal complaint about this process

We have been unable to obtain the actual wording of the proposed regulatory changes. As such, we are providing feedback on the summaries posted on the Service Ontario Regulation Registry. This process is inadequate and does not support sound decision-making.

The Ontario Health Coalition requested a technical briefing on these new regulations in mid-September and repeated that request in writing to the Minister's office on September 20. We noted that we needed the briefing as soon as possible, since the deadline for input was set for October 11. On October 4 we finally received an email back from the Minister's office referring us to a senior policy officer in the Deputy Minister's Office to schedule a technical briefing "at an appropriate time with the most appropriate officials". We immediately contacted this official and requested a technical briefing on the proposed regulation changes. We have not, to date, heard back.

It is our understanding that not all groups are being treated equally in this process. The Independent Health Facilities lobby group was able to get a technical briefing and meeting for their membership with the Ministry in September.

With this submission we are including in the formal record our complaint about the failure of the government to provide information and access to officials to ask questions about the plan to privatize public hospital services to private clinics and the unequal treatment of public interest groups such as the Ontario Health Coalition compared to private profit-seeking interest groups such as the Independent Health Facilities' lobby group. We wish this to be considered a formal complaint.

Recommendation: With this submission, we are formally recommending that full disclosure be made to the public of the specific language of these regulatory changes, and notice given for public input upon the release of the actual wording of the proposed regulations.

Recommendation: Further, and for clarification, if the government intends to remove services from Public Hospitals (and therefore, remove them from the protections afforded to the public under the Public Hospitals Act) then it should make clear what services specifically are proposed. It should make clear how the LHINs will close and cut hospital services and transfer them to the IHFs. It should make clear how the conflicts and differences between the IHF Act and the LHINs regime will be resolved – ie. which process will take precedence. The public should have a robust public input process regarding the specific proposal(s).

Key issues

It appears (though it is unclear because the summaries of the regulations are not clear) that there are three main elements to the proposed regulatory changes:

- The transfer of some or all of the existing IHFs into the LHINs' regimes of funding and oversight.
- The enabling of Cancer Care Ontario to fund private clinics (IHFs) to provide services.
- The expansion of the use of the IHF model to cut and privatize Public Hospital services.

Transferring some or all of the existing IHFs into the LHINs

The LHIN legislation allows the LHINs to transfer services from non-profit providers to for-profit providers. Further, LHINs are required, under the legislation to require integration of service providers perpetually. The LHINs and the Minister of Health are granted extra powers under the LHINs legislation to force the integration of services. The definition of "integration" under the LHIN legislation includes transfers of services from one provider to another, mergers and amalgamations, and closures.

Thus the LHINs legislation sets up a system in which non-profits are subject to endless restructuring in the name of "integration" including:

- shifting and consolidation of non-profit services into fewer and fewer providers
- and/or the transfer of non-profit services out to for-profit providers
- and/or the closure and dissolution of non-profit providers.

For-profits, on the other hand, have many more protections including:

- long-term licenses or agreements, even under the LHINs legislation, that guarantee them public payment for services and therefore stability and continuity of their contracts for care provision for the duration of the licensing term.
- with these longer-term funding arrangements that can be litigated, for-profits effectively cannot have their services transferred out of them to non-profits.

To date, there has been a significant imbalance in the treatment of the non-profit versus for-profit sector under this legislation: an imbalance that leads to a very real risk of the erosion and shrinking of the non-profit ownership and control over vital health care services, and the transfer of this to for-profit ownership and control.

The Ontario Auditor General reports that more than 97% of IHFs are for-profit. He also reports that the current licensing regime allows IHFs to expand the services they offer under their licenses. The entry of such numerous for-profit providers into the LHINs creates a significant danger of further for-profit privatization of vital clinical services.

Any move to transfer some or all IHFs into the LHINs, should be accompanied by changes to the legislation to protect against this.

RECOMMENDATION: The government should make clear which IHFs it intends to transfer into the LHINs and the actual wording of the regulatory change/new regulation required to accomplish this should be subject to public notice and public consultation.

RECOMMENDATION: The LHINs legislation should be amended to prohibit transfers of services from non-profit to for-profit entities.

The current licensing and funding system for IHFs does not align well with the LHINs structure of regional accountability agreements and planning submissions. In the brief summary of the proposed new regulations posted on the Regulations Registry, there was no indication of how the government proposes to deal with this. In the areas in which there are differing or conflicting processes between the LHINs regime and the IHF regime, which would supersede the other? There are a whole range of possibilities, as the two regimes set out very different processes for fiscal oversight, quality and enforcement, planning, licensing and approvals, and other items. As such, it is impossible to give input on the implications.

RECOMMENDATION: The government should make clear whether it is saying that the LHIN regime of accountability agreements, quality and safety inspections and enforcement, funding arrangements and other items would supersede existing funding, licensing etc. arrangements for IHFs; or whether IHFs would be exempt from the LHIN's funding, enforcement and service planning regime; or some combination of the two. Once the government has made clear its actual intention through providing the specific language of the proposed regulation regarding this, the public should receive notice and public consultation should be undertaken.

Expansion of the IHF Model to cut community hospital services

The summary of the proposed amendment and new regulation states that, "One model being contemplated for establishing community-based specialty clinics is the Independent Health Facility Program". The summary outlines the government's intention to shift community hospital services to new private clinics established under the IHFA. The IHF program covers more than 800 IHFs. More than 97% of the IHFs are for-profit corporations, according to the Ontario Auditor General's 2012 Annual Report. The IHF model is not appropriate for the transfer of non-profit community hospital services and should not be used in this way.

Recommendation: The IHF model should not be expanded. To protect public health care and align with the Minister of Health's stated promises about protecting non-profit delivery of health care, the IHFA should be amended to ensure that all future IHFs are non-profit and to prohibit expansion of currently-existing for-profit IHFs.

Recommendation: Any new hospital structures, such as clinics or satellites, should be created under the Public Hospitals Act.

Removal of protections under the Public Hospitals Act

The Public Hospitals Act and its regulations establish a system of public non-profit governance and quality control for hospitals. Public Hospitals are required to have Quality Committees, Medical and Nursing Advisory Committees, a program of continuous quality improvement, reporting of critical incidents and a host of other public interest protections. Public hospitals must report Hospital-Acquired Infections on line to the public, and post-surgical infections and other adverse events are increasingly publicly reported. The same is not true for IHFs.

IHFs have many fewer requirements for quality and safety in the regulations. In fact, over the last two years a flurry of media reports have raised concerns about quality and safety issues in private clinics. In one well-publicized case, an Ottawa area private endoscopy clinic was found to have failed to properly sterilize equipment resulting in 6,800 patients notified that they should be tested for HIV and hepatitis B and C. In a 2007, it was found that 13 % of colonoscopies conducted in private clinics were not completed (the scope failed to reach the colon). Research also found that there are more missed cancers in private clinics that do diagnostic testing than in hospitals. Since then, private clinics proponents claim that enforcement has improved and quality has gone up as a result.

The evidence does not support this contention. In 2011, the College of Physicians and Surgeons completed assessments on 104 out-of-hospital premises. But there are between 800 – 1000 IHFs in Ontario and hundreds have not been assessed. Different types of clinics are subject to different types of inspections, and some appear to still have no inspections or assessments. Even where long-standing regimes of inspection for serious issues such as radiation exist, they are not followed. The 2012 audit by Ontario's Auditor General found serious shortfalls in inspections and quality assurance. Among his findings: 60% of x-ray clinics had not been inspected as frequently as required to ensure proper screening to protect against radiation; 12 % of diagnostic clinics had not been assessed in more than five years to ensure that tests were being correctly read by radiologists; and new facilities had not been inspected to ensure that radiation emitting equipment was safely installed.

Recommendation: The IHF model should not be expanded. To protect public safety and improve quality, the regulatory regime for existing IHFs regarding quality and safety should be improved significantly. In addition, the IHFA regulations should be amended to prohibit IHF licensees (ie. owners) from sitting as the quality advisors for the companies that they own and/or operate. This is an obvious conflict-of-interest.

Recommendation: Any new hospital structures, such as clinics or satellites, should be created under the Public Hospitals Act with all its protections for quality improvement and safety.

Destabilization of community hospitals

With the proposed regulatory changes, the government has made express its intention to expand the contracting of hospital services to private clinics. It has also expressly stated its intention to create a new set of private clinics called "Community-based specialty clinics" and its intention to transfer services (and funding) out of hospitals to these private clinics. This change applies to LHIN-funded hospital services and Cancer Care Ontario-funded hospital services.

The exact scope of services to be cut from community hospitals and transferred to private clinics is not specified. The summary of the new regulations refers to shifting "ambulatory care services" from hospitals to the private clinics.

The Minister has promised that hospitals will be protected from instability as a result of these changes. However, the government's own plan is for 70% of hospital global budgets to be transferred by 2014 to fee-for-service –type funding arrangements (which the government calls payment-by- results or patient-based-funding). This change is already very destabilizing.

The planned removal of the high-volume, easy cases from hospitals as proposed in these regulatory changes, will impact training for physicians, nurses and health professionals; further destabilize

community hospitals' budgets; worsen staffing shortages; and break needed linkages between interdependent hospital services.

In the U.K. and in other jurisdictions, including Canada, multiple reports and many studies report lighter caseloads and evidence of "cream-skimming" by private clinics, leaving the more expensive and heavier caseloads to the public non-profit hospitals. Conversely, we could not find any studies reporting that private clinics take more complex or higher acuity patients. So there appears to be a total consensus of opinion that private clinics like those proposed in the new regulations, result in skimming of the high-volume, easy and relatively healthier caseloads from public hospitals. This has profound implications for destabilizing hospital budgets (these are the procedures that subsidize the more complex and heavy ones), as well as staffing, learning, and clinical interdependencies. Recent studies of the impact of Independent Sector Treatment Centres (private clinics) in the U.K. show decrease in learning opportunities for interns and residents as a result of significant volumes of surgeries shifted to the private clinics. In one recent study, residents performed 19% less surgeries as a result of shifting procedures to private clinics.

In Ontario and across Canada, the emergence of private clinics has worsened staffing shortages in nearby community hospitals. After the private MRI/CT clinics brought in by the Conservative Harris/Eves government were introduced, the University Health Network scaled back the hours of operation of its publicly owned and operated MRI diagnostic tests because it lost between 2 and 4 technologists to one of the new private MRI clinics.[1] Kingston General Hospital lost one of its three MRI technologists to the for-profit clinic.[2] KGH was forced to reduce MRI hours of operation as a result. Windsor Hotel-Dieu Grace Hospital lost one of its MRI technologists to the for-profit clinic in Kitchener. Hotel Dieu was forced to reduce MRI hours of operation as a result.[3]

Recommendation: Any new hospital structures, such as clinics or satellites, should be created under the Public Hospitals Act. The policy of centralization of procedures into high-volume centres should be weighed against the negative impact on local community hospitals and patients who are required to travel from place to place to try to access care.

Recommendation: The benefits of re-integrating care into hospitals that is currently being provided by private clinics should be investigated as an alternative model. Included in the assessment of the benefits of integration of care into Public Hospitals should be: potential improvements in supporting clinical co-dependencies, safety, quality, one-stop access for patients and alignment with municipal transportation systems, staffing, and subsidization of heavier case mix by lighter case mix.

Higher costs and 2-tier health care

Our own research into private clinics across Canada conducted in 2008 found that the cost of procedures varied greatly and was significantly higher in private clinics than in public hospitals. Colleen Fuller, health policy expert in British Columbia reports similar findings in her cost comparisons between hospital funding per procedure and private clinics billings for the same procedures. These findings echo

[1] Mallen, Caroline and Theresa Boyle, Toronto Star "Eves to discuss MRI staff poaching; doesn't say what province will do. Opposition wants to end more clinics" August 12, 2003; A6.

[2] Boyle, Theresa and Robert Benzie, Toronto Star "Second clinic lures MRI worker; Kingston hospital loses technologist Premier to blame, Liberals, NDP say" August 2, 2003; A7.

[3] Ibid; and Boyle, Theresa, Toronto Star "Eves not worried by clinic hiring" August 1, 2003; A19 and Theresa Boyle and Robert Benzie, Toronto Star "Private MRI clinic didn't poach, Eves says, But hospital contradicts Eves' version" July 30; A6

the Ontario Auditor General's conclusions in his special audit of the for-profit cancer treatment centre established by the Conservative government in 2001. The Auditor General found that the clinic had been paid $4 million extra in public funds to set up and was being paid a premium of $500 more per procedure than public Cancer Care Ontario treatment centres.[4]

In addition to billing public health plans, we also found that the majority of for-profit clinics charge user fees and engage in extra-billing of patients, even in violation of the Canada Health Act. This finding was supported by a 2011 study in the Canadian Journal of Gastroenterology that found one-third of the patients receiving colonoscopies in private clinics in Toronto were being charged user fees for this service (in violation of the Canada Health Act). Toronto Star columnist Thomas Walkom found that even the non-profit Kensington Eye Institute surgeons recommend a non-medically necessary "refractive lens implant" to patients (a co-mingling of insured and uninsured services used by the for-profits to extra-bill patients) and the clinic charges a $50 "handling fee" or user fee to patients in addition to the charge for the lens.

In the U.K., multiple British Medical Association Journal studies report that it is generally accepted that private clinics (Independent Sector Treatment Centres) are paid higher prices for surgical procedures. This finding is echoed in pro-privatization think tanks' reports also. Indeed, even the U.K. Department of Health has publicly admitted that higher prices are paid to the private clinics for procedures. In general, actual prices are shielded from public scrutiny under commercial confidentiality provisions but former Health Minister Frank Dobson reports that the private clinics were being paid 11% more than public hospitals for the same procedures.

Recommendation: Any new hospital structures, such as clinics or satellites, should be created under the Public Hospitals Act to protect single-tier universal Medicare. Private clinics that are charging patients user fees, extra-billing and co-mingling services so as to charge user fees are violating the Canada Health Act and should be subject to penalties up to and including closure.

[4] Office of the Provincial Auditor General, Special Audit of Cancer Care Ontario. December 13, 2001