Ontario Health Coalition
Analysis of Bill 60, *Your Health Act*

March 9, 2023

This legislation is ostensibly to facilitate the Ford government's plan to expand private clinics. It replaces the Independent Health Facilities Act. Since the government already had the power to do what it announced publicly (privatize day surgeries and diagnostics from our public hospitals) under existing legislation, this part of our analysis of the legislation focuses on determining what has changed in Bill 60 compared to the existing Independent Health Facilities Act and to understand why they brought in new legislation rather than continuing under the existing Act or amending it.

Included among the key changes are:

- A provision enabling the Ford government to appoint a person or corporation that is not an employee of the Ministry of Health with significant new powers. Currently the Director is a public civil servant in the Ministry of Health. Under Bill 60 the "Director" or Directors have the power to create new private clinics, expand privatization to entire new classes of private clinics and services, expand private clinics, oversee the transfer of licences, plan where and how many services will be provided. This person or corporation will have wide discretion and responsibilities, including those currently in the purview of the Minister and Cabinet. Since they may be a person or corporation -- or multiple people or corporations that are not in the public service -- they are not subject to the conflict of interest, financial disclosure, freedom of information and reporting regulations covering public servants. We could find no provisions to stop corruption.
- A new provision explicitly shielding the new private clinic applicants' information from freedom of information legislation.
- A schedule that deregulates a range of health care staff from physicians, through nurses to health professionals, not only in the private clinics but also in other parts of health care. The implications are significant. For example, the restrictions on who can do surgeries, be Medical Directors in long-term care homes, assess patients and residents, bill OHIP, dispense narcotics, restrain a resident in a long-term care home or operate an x-ray machine which produces radiation have been deregulated and left to new regulations that have not been disclosed to the public.

The Ford government changed the rules of the Legislature to be able to pass legislation much more quickly than was previously the case. Bill 60 was introduced on the first day of the current legislative session. Prior to the introduction of the legislation, there was no White Paper, no democratic discussion about the plan to privatize core public hospital services, and no public consultation. These would be normal processes in a parliamentary democracy for major changes to important legislation. We have not been able to find a single patient advocacy organization that was consulted, not even privately. The bill passed first reading in one day, was introduced for second reading without any amendment despite concerns raised by health advocates and organizations, and passed second reading within two weeks. There has been very little time to compare Bill 60 to existing legislation to see what has changed and assess the implications. In context, Bill 60 amends at least 27 pieces of legislation, repeals two acts and repeals multiple sets of regulations. It is a time-consuming undertaking to cross-reference these pieces of legislation to understand the implications of all the changes. It is not in the public interest for the Ford government to repeatedly push through legislation with unprecedented speed before there is opportunity even to ascertain what is in it.

Note: Under Bill 60, the private clinics are named “Integrated Community Health Service Centres”. However, Ontario already has Community Health Centres which are very different than what is proposed in the new bill. They are non-profit, community based with democratically elected boards of directors, have a deep commitment to equity, and provide team-based primary care in the public interest. The similarity in names is confusing. In any case, “Integrated Community Health Service Centres” is a euphemism for private clinics currently covered by the Independent Health Facilities Act and new ones that the Ford government intends to introduce to privatize our public hospitals’ surgeries and diagnostics. For ease of understanding, we will use the term “private clinics”.

Key Changes under Bill 60:

SCHEDULE I:

Section 3: Enabling the Minister to appoint a Director that is a third party or corporation rather than an employee of the Ministry

The Director in charge of the private clinics is no longer required to be an employee of the Ministry, can be a person not employed by the Ministry, or can be another entity entirely. The Director or Directors is/are appointed by the Minister.

Current provisions under the Independent Health Facilities Act (IHFA) –

- *The Director is an employee of the Ministry appointed by the Minister. (Thus, in the current legislation the Director subject to the requirements of Ontario’s public service regarding conflict of interest, public access to information, financial disclosure etc.) S. 4 (1)*
- *The Director/Directors cannot be a third party.*

Analysis: Under Bill 60, the Director(s) are empowered to create new private clinics and are given wide discretion to do so. Thus, the Ford government has enabled any third party -- including a corporation -- to be given the powers to create new private clinics. There is no provision in Bill 60 that would: prevent conflict of interest in the Director(s) awarding of licences; require financial disclosure; ensure public access to information, nor any additional public interest protections that are required of public servants. This change opens the door to significant corruption.

Section 5: Devolution of the power to expand privatization to the Director

The “Director”, which can be any third party/corporation appointed by the Minister, can make a “call for applications” to establish new private clinics. That call for applications can go to one person or more than one person or corporation, or can be published in any manner determined by the Director.

The Director can issue a licence to the applicant(s). Their decision is discretionary and the Director can prefer any application over others. The Director can set out the limitations or conditions of the licence.

Licences will be five years unless Cabinet passes a regulation to make them longer (which they can do without going back to the Legislature for approval, thus rendering the 5-year limitation in the bill meaningless if they choose to make the licences longer). The Director can make them renewable, at their discretion. The Director is to consider the licensee’s past record with respect to compliance but is not barred from issuing or renewing a licence in the case of poor/non-compliance.

Current provisions under the IHFA –
The Minister is the person who designates private clinics or classes of services that will be under the operation of private clinics and that designation is subject to approval by Cabinet. S. 4 (2) (3) The intention to designate new private clinics has to be published in the Ontario Gazette with 30-days notice and that notice has to set out the services that the private clinic would provide. S. 4 (5) (7)

Sub to these provisions, the Director can issue calls for applications and issue licences.

Licences are five years in duration (no provision for Cabinet to make them longer in regulations). S. 12

Analysis: Under Bill 60, the Director (who can be a third party, a corporation, and not an employee of the Ministry) can issue new licences to create more private clinics with much wider discretion and more powers. That Director may not be an employee of the Ministry and is not subject to the conflict of interest and ethics regulations for public servants. (Note: they can appoint multiple Directors.) There is nothing in Bill 60 to stop corruption among the Director(s).

Under Bill 60, the Director has sole discretion over which persons or corporations they select to receive licences to operate private clinics. In the current legislation the Director could license applicants also, but that provision followed the requirement that the Minister determine which facilities and services would be allowed to be private clinics. In turn, that decision of the Minister was subject to public notice and Cabinet approval. In Bill 60, the Director is given new powers to determine what classes of services would be privatized to private clinics, how many, where, and all the health system planning implications of these. For clarity, all of these health system planning considerations are currently the Minister's responsibilities, not the Director's, and certainly not a third party's.

Regarding the expansion of the number and scope of private clinics: most of the current provisions for public notice and oversight by the elected representatives of the government are taken away. There will be no public notice, no requirement for Cabinet approval, no 30-day notice period. This enables the Ford government to privatize very quickly and will make it very difficult to track the privatization.

The clauses regarding the renewal of licences enable the Director(s) to renew a licence even if the private clinic has a poor track record. The Director(s) have only to "consider" their track record, which has no effective meaning. (Note: the requirement for a *new* licensee is a bit stronger and includes that the Director must be of the opinion that the past conduct of the applicant affords reasonable grounds to believe that they will operate in accordance with the law and in a manner that is not prejudicial to the health, safety and welfare of any person. It is not clear yet how or whether the public could enforce this provision against the government or the Director(s), not in the least because there will be no public notice of issuance of notices for applications, no public access to information about applications and no time for the public to respond. In any case, those provisions are significantly weaker for renewals.)

Overall, the Director/Directors have wide discretion over issuing new licences and renewing licences, can privatize entire new classes of services, will decide where and how many private clinics there are, and will determine who or what will operate them. All of these decisions can happen with no public notice. This legislation devolves the powers of the Minister and Cabinet to a person or entity which could be a third party or multiple parties, including private corporations.

Section 5 – Enabling Upselling:

Under Bill 60 the list of what an application for a licence will include is more detailed than in the current Act. Among these provisions is the "upselling" provision. S. 5 (4)(i). In this section, the private clinic applicant is

required to describe any uninsured services and charges for them (upselling), and their planned method for obtaining patient consent.

Under the IHFA –
There is no such provision.

Analysis: The detail in this section seems positive upon first reading. However, while the applicants have to write up a plan for each item, they are no actual standards. The requirement is only that the applicant submit the information, not that they meet any particular standard regarding the listed items. As such, it is good for PR but meaningless. In reality, there are no standards in the Act and the determination of what corporations get licences to operate private clinics is left almost entirely to the discretion of the Director(s). There may be some standards in regulations, which can be changed by Cabinet at any time without going back to the Legislature, or there may not be. Disturbingly, in the notice of regulation, currently posted on the regulations website, the government is promising to "reduce red tape" in the regulations – which means deregulation, the opposite of stronger standards and actual enforcement.

Further, the practice of upselling to patients is extremely problematic. Inviting private clinics to sell an array of medically unnecessary procedures and tests poses a significant risk to equity and access to care for patients. The (perhaps unintended) consequence of this section is that it actually invites the private clinics to co-mingle medically unnecessary with necessary services, a practice that is common in cataract surgeries currently, but has not been the case in hip and knee surgeries, and is just starting to creep into medical imaging. It is extremely difficult – if possible at all - to police such co-mingling and upselling, and the practice has been widely exploited to manipulate patients into paying for thousands of dollars for medically unnecessary services. The extra charges are often far more than the cataract surgery itself costs under OHIP. Inviting private for-profit corporations to dream up more medically unnecessary procedures and test to sell to patients is reckless. This section is deeply problematic.

Sections 19 – 23: Secrecy, accountability, standards

Section 19 (3) states that all information collected in relation to an application for a licence shall be kept confidential and thus will expressly not be available for public scrutiny under the Freedom of Information and Protection of Privacy Act.

The private clinics will be required to have their own internal processes for dealing with complaints.

The private clinics are supposed to be required to meet safety, quality, inspection, and reporting standards but there are no standards in the legislation. They are left to regulation and will apply only if the government makes regulations for them.

Under IHFA – This secrecy provision does not exist.

Analysis: Much of this section of the legislation remains the same, however in Bill 60 the Ford government has included a specific clause to exempt application for licence information from public access to information, a provision which is not in the current Act. There is virtually no way that the public could challenge a licence applicant based on their history of behaviour. The public will not know who is being asked to apply for a licence, what services they are privatizing and where, who has applied, and what claims they have made about their operating plans and history of compliance. In any case, there is no public consultation and no provision for public input, nor even complaints. Vital information about the applicants for licences to operate private clinics will be excluded from public access to information.

There are no actual standards in this bill.

Section 43: Inspections

Inspections will not be done by the Ministry of Health directly. It is left to regulations, if any, to prescribe what organizations/who is to be the inspecting body. That third party will set all of the standards to which they inspect or assess facilities, including any provisions (or not) for making summaries of inspection reports available to the public, the frequency and all details regarding the inspections, if any.

> *Under IHFA –*
> *The College of Physicians and Surgeons is specified as the inspecting body.*

Analysis: In the existing inspections regime there have been significant problems. The Provincial Auditor reported that the majority of facilities were not inspected for public safety requirements such as shielding patients from radiation. In another recent report, the Auditor found that there is little monitoring and enforcement of questionable billing practices in and that patients were being charged for services in private clinics with inadequate oversight or controls over such practices. Even after significant public outcry and pressure after poor quality issues and harm to patients, the inspection regime remains inadequate and secretive. Inspection reports for private clinics posted online include only one word or one sentence and no other information. A significant number of the clinics have not been inspected in years. Under the new bill there is no improvement in the inspection process, public access to information and public accountability regimes, and it is not clear what entity the Ford government intends to contract as the inspecting body. Note: once it is outside of the Ministry, public access to information legislation does not apply and it is much more difficult– if at all possible – to obtain public disclosure.

SCHEDULE 2:

This schedule deregulates the definitions of key health care staff including:

- *Under the Commitment to the Future of Medicare Act (2004):* the definition of physician is changed to include both a physician lawfully entitled to practise medicine in Ontario "or another prescribed person" which means that they can include others by regulation (passed by Cabinet alone).
- The same change to deregulate who can be defined as a physician is made under the *Fixing Long-Term Care Act (2021).* Currently, under the Act, the Medical Director of the facility must be a physician. With this change, it could be a physician or someone prescribed in new regulations. Currently a physician assesses ALC patients for eligibility for LTC admission, does assessments of residents, determines capacity to attend hearings appealing ineligibility, makes orders regarding the use of restraints. With this change, it could be a physician or someone prescribed in new regulations.
- The definition of nurse in the *Fixing Long-Term Care Act (2021)* is similarly changed to include both a nurse under the *Nursing Act (1991)* or a person prescribed by the regulations. Currently, each LTC home must have at least one RN on duty and present 24/7 and a Director of Care who must be an RN. With this change, they could be a person who is not a nurse as prescribed in the regulations. Currently, only nurses and physicians can approve the use of a PASD, can assess residents for admission, and can assess ALC patients. Again, with this change, it could be a person prescribed in the regulations.
- The definitions of registered nurse in the extended class (nurse practitioner) and registered practical nurse have similarly been changed and left to regulations. As above this impacts who can make orders for the use of restraints (currently a physician or nurse practitioner) and do the specific nursing role provided by an RPN.

- Under the *Fixing Long-Term Care Act (2021)* the Ford government is proposing new powers to make regulations under this Act:
  - prescribing persons who are “physicians”, “registered nurses”, “registered nurses in the extended class” or “registered practical nurses” for the purposes of this Act or for the purposes of specified provisions of this Act;
  - establishing and governing limitations, terms or conditions on the manner in which persons referred to in paragraph 8.1 may carry out their duties and responsibilities under this Act and the duties of licensees with respect to those persons.

- Under the *Gift of Life Act (1990)* the definition of physician is changed, as above, to include not only physicians licensed to practise in Ontario but also anyone prescribed in the regulations. This affects who is able to examine and remove tissues for transplant, who can determine capacity for consent, who can determine the fact of death, who can receive personal health information about donors.

- Under the *Healing Arts Radiation Protection Act (1990*) the definition of who can operate an x-ray machine (which irradiates the patient) is changed to include both a legally qualified medical practitioner and “another person as prescribed” in regulation and both an extended class RN (nurse practitioner) under the *Nursing Act (1991)* or “another person prescribed by the regulations”.

- Under the *Health Insurance Act (1990)* the definition of physician is changed to include both legally qualified medical practitioner lawfully entitled to practise medicine in the place where medical services are rendered by the physician “or another prescribed person”. This primarily impacts who can bill OHIP and be paid for physician services.

- Under the *Medical Laboratory Technology Act (1991*) “No person other than a member shall use the title “medical laboratory technologist”, a variation or abbreviation or an equivalent in another language” and “No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a medical laboratory technologist or in a specialty of medical laboratory technology.” The amendments enable Cabinet to make regulations exempting a person from those sections of the Act. This impacts who can conduct laboratory investigations on human beings or specimens taken from the human body.

- Under the *Medicine Act (1991)* “No person other than a member shall use the titles “osteopath”, “physician” or “surgeon”, a variation or abbreviation or an equivalent in another language,” and, “No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an osteopath, physician or surgeon or in a specialty of medicine.” The amendments would enable Cabinet to make regulations exempting a person from these requirements. This is self-evident. It impacts who can call themselves an osteopath, physician or surgeon.

- Under the *Narcotics Safety and Awareness Act (2010)* currently only designated health professionals as defined in the *Regulated Health Professions Act (1991)* can dispense a monitored drug, collect personal health information, ensure that regulations regarding verification of identity are met, keep appropriate records of the dispensing of monitored drugs. Under the changes, Cabinet can make regulations to designate another person to do these functions. Similarly, the definition of “prescriber” is changed to include a person designated in regulations.

- Under the *Nursing Act (1991)* “No person other than a member shall use the title “nurse”, “nurse practitioner”, “registered nurse” or “registered practical nurse”, a variation or abbreviation or an equivalent in another language,” and “No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a nurse, registered nurse, practical nurse or nurse practitioner or in a specialty of nursing.” Under Bill 60, Cabinet can make regulations exempting a person from these requirements.

- The *Pharmacy Act (1991)* is changed to change the scope of practice for pharmacists to add in “the assessment of conditions for the purposes of providing medication therapies.”

- In the *Public Hospitals Act (1990)* the definition of physician is changed from being “a legally qualified medical practitioner” to “a member of the College of Physicians and Surgeons of Ontario or another prescribed person” and the regulations section of the Act is changed to include powers for Cabinet to make regulations prescribing who can be considered a ‘physician’.

- Under the *Respiratory Therapy Act (1991)* “No person other than a member shall use the title “respiratory therapist”, a variation or abbreviation or an equivalent in another language,” and, “No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a respiratory therapist or in a specialty of respiratory therapy”. This section is amended to enable Cabinet to make regulations exempting a person from these requirements.

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