DRAWING THE LINES

A SUBMISSION

REGARDING THE

COMMUNITY-BASED SPECIALTY CLINICS STRATEGY

OF THE MINISTRY OF HEALTH AND LONG-TERM CARE

Concerning a Proposed Regulation under the *Independent Health Facilities Act* - Prescribed Persons and the Proposed Amendment to O. Reg. 264/07 made under the *Local Health System Integration Act, 2006*

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INTRODUCTION

As Canada's largest private sector union with more than 300,000 members in every major sector of the economy, Unifor is committed to creating a strong and effective union to represent workers' interests – making positive change in communities and workplaces across the country. Unifor is a new kind of labour union organization - one that advocates on behalf of all working people (employed or unemployed) right across the country. Unifor intends to bring a modern approach to unionism: adopting new tools, involving and engaging our members, and always looking for new ways to develop the role and approach of our union to meet the demands of the 21st century.

The health care sector is one of the largest single membership categories in Unifor, with over 26,000 members. This includes over 8,500 workers in public hospitals throughout Ontario in communities as varied as Windsor and Wawa; Geraldton and Kitchener; or Marathon and London. This also includes over 12,000 workers in long term care facilities - some of which are municipally owned and operated, but many of which are controlled by private, for-profit firms. Thousands more Unifor members work in other health care services such as at air or land paramedic services; diagnostic laboratories, medical clinics or retirement homes.

Public Consultation on the Regulatory Initiative

We welcome this opportunity to address the issues that precipitate the posting of draft Regulations relating to the establishment of "community-based specialty clinics". The proposed Regulations, as we understand their intent, aim to amend Regulation 264/07 made under the *Local Health System Integration Act* and create a new Regulation under *the Independent Health Facilities Act*. Apparently, the express intent in proposing such amendments is to allow the Ministry to direct Local Health Integration Networks (LHINs) and Cancer Care Ontario to directly fund "community-based specialty clinics" licenced as independent health facilities and now prescribed as 'health service providers'.

Policies and legislation articulate a government's priorities and intentions. A policy is a statement that a government or organization makes about its intended actions. Legislation is a more formal type of policy; it is a law made by parliament that can help governments align the components of the health system to implement change. Legislation can unify commitments to change and align the visions and goals of the different stakeholders (such as regional health authorities and hospitals). In some cases, legislation provides a mechanism for accountability.

Better health, better care, better value for all: Refocusing health care reform in Canada, Health Council of Canada, September 2013

It is our view that this represents a fundamental shift in public policy that inherently places in jeopardy the ongoing capacity of our community-based, publicly funded and publicly governed hospitals to provide quality, accessible health services in their communities. We are deeply concerned that this regulatory change not only conflicts with prior policy announcements but is also a prelude to the creation or transfer of public services to corporate for-profit entities beyond the statutory reach or ambit of the *Public Hospital Act*. We are deeply concerned that these new specialty clinics will directly compete for operational funding; clinical and support staffing; and patients with

existing community hospitals. Indeed, in the current atmosphere of fiscal restraint, our community public hospitals are challenged as never before to maintain the quality and volume of an essential range of in-patient and out-patient services.

This regulatory change also ignores the substantial innovation and progress within our public hospitals in reconfiguring their clinical services – with ambulatory outpatient clinics providing various surgical, therapeutic and/or diagnostic procedures in settings as varied as free-standing clinics or specialized day programs at hospital sites.

Public Non-Profit Provision of Health Service should be Paramount

Both regulatory proposals notices state explicitly that "*services will not be shifted from hospitals if changes to capacity will impact their stability*"; and furthermore that the "*establishment of community-based specialty clinics will be guided by clinical evidence and stakeholder consultations*."

We appreciate that the obvious potential for adverse impacts on community hospitals is recognized at the outset. We also support strengthening the vital pre-condition that any proposal seeking to shift services from community hospitals through the creation of such specialty clinics is to be determined by robust clinical evidence and consensual expert opinion and be preceded and informed through community and 'stakeholder' consultation. We deplore the absence of any express commitment that the regulatory changes would mandate the assurance that such specialty clinics must be 'public' or 'non-profit' in status.

Ontario's Health Care Action Plan

Better value for health care dollars
…
If we are to continue improving the quality of patient care and access, we will have to shift spending within health care to get better value for our health dollars.

The Action plan includes measures to:

- move more routine procedures into specialized **not-for-profit** clinics when better care and better value can be provided.

Ontario's Health Care Action Plan: Backgrounder, January 30, 2012

Something has seemingly been lost from the prior commitment set out in **Ontario's Action Plan for Health Care**, at page 13, under the heading "Moving Procedures into the Community". The Action Plan stated that "[the government] *will shift more procedures out of hospital and into **non-profit** community-based clinics if it will mean offering patients faster access to high-quality care at less cost*" [our emphasis].

The January 30, 2012 Ministry media Backgrounder release concerning community-based specialty clinics noted that the objective was to:

*Move more routine procedures into specialized **not-for-profit** clinics when better care and better value can be provided.*

Furthermore, the **2013 Ontario Budget** at Chapter 1: A Prosperous and Fair Ontario also indicated in similar terms an express commitment under the heading, 'Better Care, Better Value for Money' that the

Action Plan road map would include a shift of routine clinical procedures currently being performed in community public hospitals to specialized not-for-profit community clinics.

We are deeply concerned that the qualifying term, "not-for-profit" has vanished from this regulatory proposal. We call on the Minister and her Government to unequivocally express their continuing commitment and determination to maintain public, non-profit delivery of health services, including related diagnostic and laboratory services as provided by hospital under the *Public Hospitals Act*. We would encourage Government to expressly seek to repatriate community diagnostic and laboratory services back to the public hospital sector to ensure equitable access as well as critical volume threshold and service capacity in community hospitals and/or publicly owned integrated health delivery organizations.

We note that the **2012 Annual Report of the Office of the Auditor General of Ontario** [Provincial Auditor's report] in reviewing the independent health facilities program identified that less than 3% of the facilities licensed under the *Independent Health Facilities Act* were non-profit organizations. In other words, 97% of the some 800 diagnostic laboratories (x-rays, ultra-sound and sleep studies) and 25 odd surgical clinics (cataract and plastic surgery) were operated by for-profit corporations. And not all are physician or surgeon owned and operated single site operations.

LifeLabs Medical Laboratory Service

To illustrate, one substantial actor in the diagnostic and laboratory service sector operating facilities under the *Independent Health Facilities Act* in Ontario is LifeLabs. Lifelabs Medical Laboratory Services is the country's largest provider of community laboratory services, and indirectly owned by OMERS following the purchase of the MDS Diagnostic Services by the Borealis Infrastructure unit of OMERS. Lifelabs recently completed the acquisition of CML HealthCare and British Columbia-based BC Biomedical and had previously acquired competitors Dynacare and CML laboratories.

In acquiring CML HealthCare, Lifelabs gained an estimated market share of about 67 per cent of non-hospital lab tests in Ontario[1]. A group of smaller community labs gathered under the banner of the Ontario Coalition for Lab Reform suggested the $1.2-billion takeover of CML Healthcare Inc. by LifeLabs Inc. — two of the largest private operators of publicly funded community medical lab services in Ontario — would create a virtual monopoly that would cripple competition and diminish patient care[2].

Equally disturbing is the demise in the same period of two non-profit providers: the Hospital In-Common Laboratories, and the Hamilton Health Service Laboratory Program. The forced closure of these hospital-based services ended some 40 years of quality, cost-effective, accessible health

[1] http://www.theglobeandmail.com/report-on-business/cml-shareholders-approve-merger-with-lifelabs/article14087911/#dashboard/follows/

[2] http://www.winnipegfreepress.com/business/no-plans-to-stop-merger-of-two-large-lab-testing-companies-matthews-222236341.html

care delivery that demonstrated that community and acute care services can be integrated to mutual benefit. Ironically, the end of these services comes at a time when the provincial government is restructuring health care ostensibly to increase integration and control costs[3].

Centric Health

Another example of the corporate presence in health services delivery is Centric Health which operates surgical centres across Canada with a total of 19 operating rooms and 86 beds; including Don Mills Surgical Unit in Toronto, Blue Water operations in Sarnia, Windsor and London; London Scoping Centre as well as the False Creek Health Centre in Vancouver; Canadian Surgical Solutions in Calgary and Maples Surgical Centre in Winnipeg. Centric Health operates in medical assessments, disability and rehabilitation management, physiotherapy and surgical centres, homecare, specialty pharmacy and wellness and prevention.

Type of Service	Hospital Outpatient Services	Independent Health Facility
Radiology	53.8%	46.2%
Ultrasound	33.5%	66.5%
Nuclear Medicine	63.5%	36.5%
Pulmonary	79.6%	20.4%
Sleep	28.9%	71.1%
Total	47.7%	52.3%

We are equally troubled by the Provincial Auditor's report finding that public hospitals are currently providing less than half of selected major diagnostic services performed in this province. It should be a simple matter of sound public policy to optimize service volumes in public hospitals by utilizing their existing capital assets and human resources to provide diagnostic services. It would be only sound policy to encourage public innovation through enhancing access for patients within their communities through non-profit hospital-community partnerships such as satellite, mobile or free-standing clinics where feasible.

Drawing the Lines: Restricting for-profit delivery of clinical health services

The Romanow Report identified the extent to which the private sector should be involved in delivering health care services as one of the most contentious issues facing Canadians. The report specifically noted that large for-profit corporations delivered a range of health services including laboratory services and continuing and long-term care. In his opinion, at a minimum, Romanow believed governments must draw a clear line between direct health services (such as insured services provided by hospitals and physicians) and ancillary services (such as food preparation or maintenance services).

[3] Privatizing Health Care: Laboratory Services – An Early Warning Sign, Relay, Issue 27, Jul-Sep, 2009, Ross Sutherland

Governments must invest sufficiently in the public system to make timely access to diagnostic services for all a reality and reduce the temptation to "game" the system. In order to clarify the situation in regard to diagnostic services, I am therefore recommending that diagnostic services be explicitly included under the definition of "insured health services" under a new Canada Health Act.
Building on Values: The Future of Health Care in Canada, Final Report of the Commission on the Future of Health Care in Canada *(Romanow Report), 2002*

It is the legacy of his report that on this fundamental issue he advocated governments "draw a clear line" and ensuring exclusivity in delivery through a public, not-for-profit system for insured clinical health services, while conceding that 'ancillary' or support services could include private for-profit providers.

The Romanow report did not ultimately accept there to be cogent evidence that more private for-profit service delivery would bring more resources, choice and/or competition into the Canadian health care system and/or improve its efficiency and effectiveness.

In contrast to the Romanow report, the 2012 **Commission on the Reform of Ontario's Public Services**, otherwise known as the Drummond report openly advocated for private, for-profit operators being permitted to bid for a vast array of clinical health services. This claim was advanced earlier by Drummond and others in **Charting a Path to Sustainable Health Care in Ontario**, TD Economics Special Reports, May 27, 2010 report.

The TD Economics report strongly "urge[d] the expansion of private sector involvement in the provision of health care" with the report authors, Don Drummond and Derek Burleton "challeng[ing] the government to open the door more widely for private sector involvement", not merely to improve efficiency or quality of service, but to lay the foundation to capitalize on what they considered to be "huge economic potential" to incent the private sector to build a vibrant economic cluster in Ontario.

Recommendation 5-97: Put a wider array of specialist services to tender based on price and quality, while remaining under the single-payer model.

Build on the success of the Kensington Eye Institute in treating cataracts quickly and efficiently. This model could include private for-profit clinics that operate within the public payer system.

Government should continue to determine what services are offered and set the fees paid by OHIP.
Commission on the Reform of Ontario's Public Services *(Drummond Report), 2012*

It is in this broader content that the Drummond report released on February 15, 2012 chronologically follows the Ontario Health Action Plan, released on January 30, 2010. With an entire chapter dedicated to recommendations affecting the health sector, the most significant difference between the two documents - echoing the contentious issue addressed in the Romanow report – is the debate as to whether community-based specialty clinics could be for-profit entities or should exclusively be non-profit entities[4].

[4] Fasken Martineau Health Law Bulletin: Drummond Report Advocates Shifting Patients Out of Hospital, March 5, 2012, Cathi Mietiewicz and Roy Bornman

To their credit, the Drummond report also recommended a commission-style approach at Recommendation 5-104 to guide the proposed health reforms following the precedent set by the Health Services Restructuring Commission (HSRC). It remains an open debate whether the legacy of the HSRC included any truly significant input from the broad range of affected stakeholder communities, including providers and citizens/patients that Drummond advocated. However, at a minimum he acknowledged that the scale of reform he proposed was vast, dealing with organizational, clinical and business issues and warranted a new commission to engage the public in this continuing debate.

We remain concerned the initial commitment to ensuring ***non-profit*** *community-based clinics* has not been continued, let alone reinforced and strengthened in subsequent regulatory notices or the Ministry's engagement with the predominately private for-profit independent health facilities sector.

In a recent presentation to the Independent Diagnostic Clinics Association Conference on November 16, 2012, Ministry officials suggested that Government can work with the sector to develop models of service delivery that move patients out of hospitals into community settings that offer high quality services at lower cost; and offered to champion the independent health facilities sector as a model for safe, efficient, effective delivery of new services by reinvesting savings[5]. **There was simply no indication that a policy priority or preference existed in favour of non-profit community based clinics**.

We acknowledge that the expressed policy choices and political direction of the Minister may not be wholly embraced by her Ministry. We are aware that the Minister in the last election as well as in the *Action Plan on Health Care* expressly committed to developing health-care delivery in non-profit community settings, rather than expanding the for-profit footprint in health care. The discrepancy must be clarified in very certain and precise terms.

Issue – Shouldice Clinic

Those commitments by the Minister remain consistent with the recent actions and announcements of this Government. The refusal to provide a timely approval for the sale of the family-owned Shouldice private hospital to a publicly traded corporation, Centric Health was indeed a compelling occasion to demonstrate that commitment as a Toronto Star editorial acknowledged[6]. Centric Health, a rapidly growing health services corporation, had announced its intention to purchase the Shouldice Hospital, a private hospital focused on hernia surgical procedures. Centric also has a substantial physiotherapy operation with 105 owned and 36 network physiotherapy clinics across Canada and is controlled by Global Healthcare Investments and Solutions (GHIS), one of the largest private, for-profit healthcare conglomerates in the world.

Issue – Don Mills Surgical

[5] http://www.health.gov.on.ca/en/public/programs/ihf/docs/idca_20121220.pdf

[6] http://www.thestar.com/opinion/editorials/2012/09/18/shouldice_hospital_sale_poses_threat_to_healthcare_system.html

In 2007, the previous Minister George Smitherman vetoed a scheme that would have found the province contracting out OHIP-funded orthopedic operations to the Don Mills Surgical Unit, another grandfathered private hospital operating under the *Private Hospital Act*. The Minister on that occasion explained that such a scheme would contradict Premier Dalton McGuinty's iron-clad commitment to public care. We had understood that the current Government's official position, as outlined by Minister Deb Matthews, had remained unchanged and while receptive to community-based non-profit specialty clinics focused on specific surgeries, the clear policy direction was a non-profit orientation consistent with the Romanow report.

Issue – Copeman Clinic

We also recall the September 11, 2006 speech by Minister Smitherman at the Toronto Economic Club offering a vigorous defense of the public health system against Dr. Brian Day (then newly-elected as president of the Canadian Medical Association and founder of the Cambie Surgery Centre, a for-profit Vancouver private clinic) and other advocates of two-tier private health care and encouraged those involved in health care to declare where they stand in the public-private debate.

Former Health Minister Smitherman also boasted that *The Commitment to the Future of Medicare Act, 2003* legislation, enacted following the Romanow report by his government three years earlier, clearly and expressly prohibited two-tier care, and had kept for-profit health services delivery corporations out of the province. He cited the case of a U.S. company offering mobile ultrasound diagnostic clinics, as well as B.C.-based Copeman Healthcare which intended to open a number of membership-supported private primary care clinics. Both, he said, were stopped "at the border."[7]

There is no new evidence to consider on this issue - Ontarians need an express commitment to non-for-profit health care delivery that:

- does not cut corners to maximize return on shareholders' investment;
- does not have a financial incentive to deny services to "unprofitable" patients;
- does not provide faster access or 'boutique' service for those who can afford membership fees or ancillary charges for non-medically necessary services;
- does not expose Canada to lawsuits under NAFTA and other trade deals if future government regulations affect corporate profitability; and
- does not hide behind commercial or proprietary confidentiality, but is instead publicly accountable and transparently operated within our publicly governed and delivered, not-for-profit system.

We are deeply concerned that neither the *Local Health System Integration Act* nor the *Independent Health Facilities Act* or their accompanying regulations currently stipulate or require such specialty clinics be operated on a not-for-profit basis under the *Public Hospitals Act*. These clinics should only be mandated and/or licensed as either operated by (or in alliance or

[7] http://www.healthedition.com/article.cfm?articleID=5379

partnership with) public hospitals and as not-for-profit corporations dedicated to improving access to and quality of public health services.

These clinics must not be permitted to pursue 'profit'; issue ownership shares or equity stakes; or otherwise distribute any profits or surplus to its members, directors and/or officers and must use any surplus from operations exclusively for its not-for-profit purposes. We strongly recommend against these clinics being established and regulated (such as it exists) under the *Independent Health Facilities Act*, as that rudimentary licensing and quality assurance regime has proven woefully inadequate offering diagnostic services such as x-rays and ultrasound.

Lessons from Recent Public Sector Innovations

We welcome and applaud the many recent public sector initiatives and innovations ensuring "*faster access to high-quality care at less cost".* Timely examples include birth centres being established in Ottawa and Toronto later this year or the expansion of community physiotherapy clinics providing publicly-funded physiotherapy services to ambulatory seniors in clinic-based setting across Ontario. This latter funding and delivery model innovation reforms fee-for-service billing and ensured patients, and especially vulnerable seniors have more equitable access throughout Ontario while strengthening provider accountability.

A Toronto Star article[8] on the reforms quoted the Minister of Health on breaking the stranglehold by for-profit clinics that have controlled the system for decades: "You have to change the model. We have to wind down an archaic system." The Minister noted that the public had been paying physiotherapists' premium rates to companies for group exercise classes rather than individual therapy sessions. The Minister also displayed little surprise by the negative reaction from the for-profit industry, which is controlled by four large corporations such as Centric Health that do two-thirds of the OHIP billings. According to the Star article, physiotherapy was the fastest growing cost in the provincial health system.

The Birth of an Idea - Assisted Reproductive Services

Another example of clinic-based delivery of health services is provided by assisted reproduction services. Such services are provided in 14 specialized clinics and several fertility centres and private physician offices in Ontario; but most of the 14 are private, free-standing clinics located in the Toronto, London and Ottawa corridor[9]. Three clinics receive some funding from the Ministry and all but one clinic is located in a public hospitals and the other is not located in a hospital.[10]

At the current time, IVF clinics and fertility centres are not required to be accredited and can be accredited by Accreditation Canada on a voluntary basis. In the result, not all Ontario clinics are accredited and there are no common provincial standards for clinic operations, services offered or

[8] http://www.thestar.com/news/queenspark/2013/04/18/health_minister_deb_matthews_takes_on_forprofit_physiotherapy_clinics.print.html

[9] Namely, Brampton, London, Markham, Mississauga, Ottawa, Scarborough and Toronto.

[10] http://www.children.gov.on.ca/htdocs/English/infertility/report/caretoproceed.aspx

the prices charged for services. Yet there is a clear public interest in quality services as the financial cost of multiple births is high – during pregnancy, at delivery and later in life.

Not surprisingly, the report by the expert panel **Raising Expectations: Report of the Expert Panel on Infertility and Adoption, 2009**[11] convened by the Minister to provide advice on improving quality in Ontario's adoption system and especially improving access to fertility monitoring and assisted reproduction service noted the critical role of geography in determining access for Ontarians.

Of the nearly 25,000 doctors in Ontario, a little more than half are specialists. Specialists tend to practice in large urban centres and university-affiliated teaching hospitals, where they have access to hospital resources such as diagnostic and laboratory services, operating rooms and inpatient services. This is generally appropriate, as smaller centres lack the volume of patients with specialized needs that larger centres have[12].

There is little comfort for many Ontarians to hear that that the Ministry is contemplating shifting routine, high volume surgeries and procedures out of their community hospitals into specialty clinics. If existing services provided in such clinic setting such as assisted reproductive, physiotherapy or birthing services, are inequitably distributed throughout the province, the proposal to extent further services in clinic setting will only further centralize and consolidate health services at the expense of access in smaller, rural and northern communities.

> Geography – where people live in the province – should not keep Ontarians from getting assisted reproduction services. The relatively small number of fertility clinics across the province makes it difficult for people who live in rural, remote and northern communities to get services.
> **Raising Expectations: Report of the Expert Panel on Infertility and Adoption**, 2009

The conversation should focus instead on the many instances and opportunities, especially in such smaller communities, where centralizing community laboratory work and diagnostic services currently performed under the *Independent Health Facilities Act* could instead be directed to community-based public hospital laboratories. Such a shift of services would increase the hospital's ability to provide care for in-patients, while also increasing access for community patients and reducing overall costs[13].

Improving Access by Reducing Access to Community Hospital Services?

The stated objective of establishing community-based specialty clinics through the transfer or shifting of services from a public hospital to a community-based setting is an oxymoron in terms of 'improving access'. We appreciate that the commitment has been expressed that services will not be shifted from community hospitals if those reductions will impact their stability.

[11] Raising Expectations: Report of the Expert Panel on Infertility and Adoption, 2009
[12] http://healthydebate.ca/2012/05/topic/politics-of-health-care/germany-ontario
[13] https://forprofitmedicallabs.wordpress.com/2013/09/06/private-hospitals-in-specialty-clinic-clothing/

However, public hospitals are obviously and invariably also located in communities. How does relocation of ambulatory services within a community increase, as opposed to simply alter access? Unless the Ministry is committed to ensuring only new volumes are directed to such specialty clinics, we cannot fathom how access is increased in terms of distance or geography. Certainly, access may increase in terms of wait times if wait list times diminish as high volume procedures are consolidated and centralized – but that will limit access for residents in any community with a public hospital that losses service provision.

Many public hospitals operate their own free-standing specialty clinics such as the Stoney Creek campus of St. Joseph's Healthcare, Hamilton while other public hospitals have transitioned in their clinical roles into effectively specialty clinics such Hotel Dieu, Kingston or Holland Orthopaedic and Arthritic Centre, Toronto. These distinct approaches speak to the varied means by which access is impacted – facilitating access through dispersing functions into satellite clinics or limiting access through centralization and consolidation.

> "We can never accept the notion of limited access to health care for the one-third of Canadians who live in rural and remote Canada. **Geography cannot become an excuse for inequity**." (our emphasis)
>
> Honourable Allan Rock, Minister of Health, Canada, speaking at the 132nd Annual General Meeting of the Canadian Medical Association, August 23rd 1999

However, if the specialty clinic is located on the same site as the hospital previously providing the service(s), there is no net impact on access assuming service volumes remain constant. Access tends to be a zero-sum game unless additional sites are opened beyond the 205 communities that presently have a public hospital or such clinics are located in under-serviced areas (relative to the specialty treatment or procedure provided).

Currently, out of the 62 "very small" hospital sites in Ontario, 25 are part of a multi-site corporation, as are 9 of the 31 "small" hospital sites. There is a total of 93 "very small" or "small" hospital sites distributed throughout the province. Typically these small or very small hospitals serve predominantly rural southern Ontario, and relatively isolated locations in northern Ontario. Access to public health services within these communities remains a critical concern in these smaller rural, northern and more isolated communities.

Rural and Northern Health Care Framework/Plan

The proposal for community-based specialty clinics runs completely opposite recent provincial health policy concerning the role of smaller rural and northern public hospitals – as articulated in the work of the Rural and Northern Health Care Panel. The stated Liberal Government commitment to improve access to health care services for the more than 1.9 million Ontarians living in rural, remote and northern areas of the province has generally been expressed in the need to develop a local integrated health service delivery model where most, if not all sectors (such as primary care, or home and/or long-term care) of the health system are formally linked in

order to improve patient access, and a single funding envelope is provided to manage the health of the local population[14].

Certainly patient access to specialized diagnostic services in underserviced areas has also been a perennial issues; with the Provincial Auditor report noting that about 50% of Ontario's municipalities (both rural and urban) have been consistently underserviced; while about 7% have been consistently over-serviced. The Provincial Auditor also noted that more recent analysis across the LHINs revealed incredible variation in practice – service volume ranged from around 1,100 per 1,000 residents in one LHIN to almost 3,400 services per 1,000 residents in another LHIN.

Even then, the analysis did not adjust data for age or gender to better reflect actual health need. The report does acknowledge that community hospitals may be better able to meet local service demands in more rural or northern locations[15]. Ironically, the Auditor's report mentions that the Ministry's response to this funding of inequitable access was to assert that the independent health facility model of service delivery "provides a strong foundation for moving more diagnostic tests and procedures into the community". It certainly hasn't proven to be such a 'foundation' in the past.

Integrating Health Service to Enhance Access

Many small hospitals in Ontario have already developed or are developing health network or 'node' models linking acute care (inpatient and outpatient) with primary care, long-term care and other community-based services such as mental health and addictions[16]. And access is certainly more than geographical proximity with socio-economic status, income, education, cultural and linguistic background and other factors also contributing to determining access.

Certainly northern and/or rural Ontarians face more intense challenges in accessing health care services than do southern rural Ontarians. And access is critically linked to equity issues as well as residents of rural and remote communities typically report lower health status that their urban counterparts:

- life expectancy at birth is generally lower in rural areas compared to urban areas;
- all-cause mortality rates (age-standardized mortality rates) for both genders of all ages increases with increasing remoteness of place of residence;
- higher proportions of rural residents report having a fair/poor health status compared with urban Canadians;

[14] Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come, Ontario Hospital Association

[15] 2012 Annual Report of the Office of the Auditor General of Ontario, page 154

[16] Local Health Hubs for Rural and Northern Communities, Ontario Hospital Association, available at http://www.oha.com/KnowledgeCentre/Library/Documents/Local%20Health%20Hubs%20for%20Rural%20and%20Northern%20Communities.pdf

- greater proportions of rural Canadians aged 20 to 64 years reported being overweight than urban Canadians[17].

In these rural and northern and/or remote communities, existing public health providers should integrate health services across the health continuum through the creation of local hubs, to provide both a physical and virtual coordinated network that improves access to health care services, which expanding to include broader social services where appropriate.

Many small and rural Ontario hospitals are working with their community partners to better integrate and manage primary, acute and long-term care services. They share clinical and administrative resources for acute and post-acute care. This approach has the potential to address long-standing problems of limited access to long-term care services and provide numerous efficiencies for all of the providers.

Diversification into long-term care and other post-acute services such as rehabilitation may provide similar advantages to those associated with expanded secondary care services. The ability to share administration as well as clinical resources across both acute and post-acute care can lead to numerous efficiencies. As a result many small and rural facilities throughout the province have diversified in this direction, collocating or integrating services with Long-Term Care Homes, Seniors' Apartments and Assisted Living and/or through the introduction of complex continuing care and rehabilitation units.

The Core Service Role of Small Hospitals in Ontario, Summary Report, Ontario Joint Policy and Planning Committee (JPPC) Multi-Site/Small Hospitals Advisory Group, December 18, 2006

This approach to integration across the continuum of health services has been a common recipe for health reform. The JPPC Multi-Site/Small Hospitals Advisory Group in 2006 investigated the potential future role of small and rural hospitals and advised the Minister of Health that the Advisory Group had identified five potential strategic directions for small hospitals to consider, in relation to these challenges:

- Enhance and extend primary care
- Expand community networks
- Expand hospital networks
- Integrate and manage primary, acute and long-term care more effectively
- Make greater use of technology

The concept of community-based specialty clinics should also consider that Ontario has 51 cities with a cumulative population of 9,293,031 - and therefore an average urban population of 182,216 per city. Is that sufficient to justify the shifting of services from community hospitals to specialty clinics?

We would acknowledge that only one municipality in Ontario: Toronto - has more than one Group B hospital corporation providing services to its communities - being the 45 general hospitals operating more than 100 in-patient beds. As the much-cited example of the Kensington Eye Institute in Toronto demonstrates, this is simply a considerably unique and different issue for the Greater Toronto Area.

[17] http://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/report_rural_northern_EN.pdf

Some 5.9 million Ontarians live in the seven largest cities in Ontario – Toronto, Ottawa, Mississauga, Brampton, Hamilton, London and Markham. Certainly, for corporate health services providers such as LifeLabs, Centric Health or Extendicare, the GTA is an enviable and attractive 'market' given the volumes of services as is Hamilton, London, Kitchener, Windsor, Kingston or Greater Sudbury. However, the available evidence indicates a pattern of over-servicing in these urban areas by for-profit independent health facilities according to the Auditor General's report.

The Evidence Regarding Cost Effectiveness

With respect to costs there is little evidence that moving ambulatory or elective hospital services to community settings would inherently be cheaper. Indeed, there are grounds to expect a decrease in cost-effectiveness, as a result of a number of factors, including higher compensation (physician-owners) and profit-taking; lower throughput or volumes given the necessity to treat only 'well' patients; and the over-utilization or stimulation of additional activity not otherwise medically necessary.

The McMaster Health Forum Evidence Brief: **Creating Community-Based Specialty Clinics in Ontario**, May 2013 funded by and informing Ministry policy not only assumed that the policy was limiting specialty clinics to not-for-profit entities; it also, and perhaps more importantly, did "not address issues such as effectiveness and cost-effectiveness of particular procedures, tests and assessments"[18].

Certainly whether there could be any reduction in costs for routine services shifted from community hospitals to specialty clinics is an empirical matter once the more profound clinical questions have been addressed affirmatively. Too often the issue of cost reduction is simply an accounting issue of allocating overhead costs to all hospital services – including ambulatory out-patient assessments, treatments and/or surgeries. At best, the answer to the question whether specialty clinics operate at lower costs that out-patient hospital services is : "it depends" and is contingent on ensuring an equivalent comparison – an issue that is especially challenging given the specialty clinics will invariably treat less severe and less complex cases[19].

The issue is further complicated by the general absence of direct quantifiable competition between the public and for-profit sectors. Not only do private clinics "cream-off" the easier and less expensive patients – the public system always serves as the default and back-up for the quality failures of the private for-profit facilities[20] without charging back to the private clinics for the expense of providing remedial services to ensure quality outcomes.

The Romanow report noted that a Devereaux et al. article in 2002 performed a systematic review and meta-analysis of the various studies that compared not-for-profit and for-profit delivery of services concluded that for-profit hospitals had a significant increase in the risk of death and also

[18] McMaster Health Forum Evidence Brief: Creating Community-Based Specialty Clinics in Ontario, May 2013 at page 8
[19] Evidence in brief: Getting out of Hospital – The evidence for shifting acute inpatient and day case services from hospitals into the community, The Health Foundation, June 2011, page 10.
[20] See Romanow report at page 7

tended to employ less highly skilled individuals than did non-profit facilities[21]. That research was followed by a companion systematic review and meta-analysis comparing payments for care at private for-profit and private not-for-profit hospitals[22] which concluded that private for-profit hospitals result in higher payments for care than private not-for-profit hospitals. The analysis concluded that the evidence strongly supported a policy of not-for-profit health care delivery at the hospital level.

> In some cases, regional health authorities have contracted with private for-profit facilities that provide specific surgeries such as cataract and same day surgery. Again, there is no clear evidence that this practice is more efficient or less costly than providing the services in an adequately resourced not-for-profit facility.
>
> The Commission is strongly of the view that a properly funded public system can continue to provide the high quality services to which Canadians have become accustomed. Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible. In addition, as discussed in Chapter 11, any decisions about expanding private for-profit delivery could have implications under international trade agreements that need to be considered in advance.
>
> **Commission on the Future of Health Care in Canada: Final Report**, (Romanow Commission) 2002

There is also evidence amongst existing independent health facilities that over-utilization is a concern. As an example, the Ministry took steps to reduce the use of laboratory tests that did not add value for clinicians and patients after the Ontario Health Technology Advisory Committee (OHTAC) undertook laboratory test utilization reviews for AST and folate tests.

Also, the Auditor General in 2012 reported that about 20% of facility fee tests were likely inappropriate due to unnecessary testing and other questionable practices. The report also noted that the Ministry had commenced a review of IHF billings to identify questionable billing practices after a claims integrity project identified about 25% of operating facilities has some unusual billing patterns.

Quality and Appropriateness of Care

In view of the findings by the Auditor General in relation to diagnostic centres and laboratories licensed under the *Independent Health Facilities Act*, there is an obvious public concern about the adequacy of existing regulation and quality and the eventual impact on public costs.

If specialty clinics are required to meet the same standards of patient care and public accountability as existing public hospitals, can they nonetheless realize reductions in cost for services currently performed in a community hospital setting? We currently have considerable challenges with clinics operated under the *Independent Health Facilities Act* that suggest considerable skepticism is warranted.

[21] Deveraux PJ, et al, A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals, CMAJ 2002 May 28: 166(11): 1399-1406

[22] Devereaux PJ, et al, Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis, CMAJ. 2004 Jun 8; 170(12):1817-24.

1. The Oncology Challenge

The quality of laboratory tests offered in Canada in the area of molecular oncology (the application of genetic knowledge to predict a patient's predisposition to cancer, to diagnose and monitor cancer or predict prognosis, or to improve cancer treatments with personalized therapies) has recently been brought into question.

Recent reports of inaccurate laboratory testing and patients subsequently receiving inappropriate drug therapy have placed a spotlight on this issue. A Molecular Oncology task Force recently found the current regulatory environment for molecular oncology testing 'insufficient' to ensure such problems will be avoided here[23] and noted other countries have far more sophisticated oversight and regulation of molecular oncology testing and clinical cancer genetic services than Ontario does.

In addition to gaps in regulation and quality assurance mentioned above, the Task Force also identified that there is no effective mechanism to evaluate new tests for clinical utility, clinical and analytical validity, and cost-effectiveness, or to manage their introduction into clinical service. Nor is there a standardized process for determining which tests should be offered as part of clinical oncology services in Ontario.

2. The Heart Failure or Cardiac Clinic Challenge

Research frequently indicates that the determining variable is not simply that services are shifted to a community-based specialty clinic, but rather than work practices and work organization affecting referral patterns; inter-professional and disciplinary cooperation; scope of practice or teamwork are the cause of more 'cost-effective' care. It is not surprising that research identifies the availability of allied health professions such as pharmacists, nurses, dieticians, social workers and exercise therapists as likely contributing to the survival benefit associated with Heart Failure clinics, rather than the formal setting of such clinics[24].

Recent evidence that disease management strategies improved functional status resulting in a greater proportion of patients treated at Heart Failure clinics being able to return to work with care provided by physicians and nurses (rather than care by a single practitioner) demonstrates the value of disease management strategies, not of specialty clinics. The quality and appropriateness of care may result in a similar cost-effective treatment whether provided through an out-patient hospital setting or an independent specialty clinic.

The Heart Failure clinics may therefore appear to be a cost effective way of delivering ambulatory care to Heart Failure patients speaks as much to the staffing model embracing multi-disciplinary teams and/or enhancing the scope of practice of nurses rather than relying on a sole physician practitioner. In a similar fashion, other specialty, multi-disciplinary, community–based care has

[23] Ensuring Access to High Quality Molecular Oncology Laboratory Testing and Clinical Cancer Genetic Services in Ontario, Report of the Molecular Oncology Task Force, December 2008

[24] Wijeysundera, H. C., Machado, M., Wang, X., Van Der Velde, G., Sikich, N., Witteman, W., Tu, J. V., Lee, D. S., Goodman, S. G., Petrella, R., O'Flaherty, M., Capewell, S. and Krahn, M. (2010), Cost-Effectiveness of Specialized Multidisciplinary Heart Failure Clinics in Ontario, Canada. Value in Health, 13: 915–921.

been found to be more effective than standard sole physician care[25]. However, that is insufficient evidence that shifting ambulatory service from community hospitals (where such multi-disciplinary teams can more typically be found in smaller communities) to specialty clinics would also be cost effective.

3. The Colonoscopy Challenge

Another recent study found colonoscopies done in private clinic settings in Ontario were not as thorough as those done in academic hospitals. The study, as reported in the Toronto Star[26] revealed 13 per cent of colonoscopies done in Ontario were not completed (the end of the colon not reached) while another study published earlier this year found that private colonoscopy clinics were more likely to screen low-risk patients more frequently than required.

The study published last year in the Canadian Journal of Gastroenterology found that 31.7 per cent of patients in private clinics were being charged a fee in some related manner for ancillary services or goods to access the services. For example, they could be charged to see a dietician for nutrition counselling and many viewed the charge as mandatory.

4. The Diagnostic Imaging Dilemma

There has been phenomenal growth in the utilization of and expenditure for diagnostic imaging services as the proliferation of diagnostic testing over time mirrored advancing imaging technology. There was a 300% increase in the number of computed tomography (CT) scans and a 600% increase in the number of magnetic resonance imaging (MRI) tests performed in Ontario[27] over the period of only a decade.

Such marked increases in utilization raise concerns about inappropriate utilization and the sustainability of such annual increases in spending. The Institute for Clinical Evaluative Science (ICES) Investigative Report **Diagnostic Services in Ontario: Descriptive Analysis and Jurisdictional Review** questioned whether this increasing investment in diagnostic imaging services represented a wise allocation of limited resources and about whether the proliferation was indeed associated with increased medical need.

There is evidence that a rise in entrepreneurial activity among physicians has led to increased diagnostic imaging in ambulatory settings by non-radiologists. Ownership of diagnostic imaging equipment by physicians would allow referral of their own patients to imaging centres in which these physicians have a financial interest—thereby increasing their revenue[28].

The ICES report found that the greatest challenge that lay ahead was to determine and ensure the appropriateness and cost-effectiveness of diagnostic technology. The report recommended the creation of clear guidelines regarding self-referral for diagnostic imaging and noted that simply

[25] http://www.hqontario.ca/english/providers/program/mas/tech/reviews/pdf/rev_smcc_compedium_20091019.pdf
[26] http://www.thestar.com/news/gta/2012/11/29/healthcare_checkup_colonoscopy_clinics_still_falling_short_critics_charge.html
[27] http://www.ices.on.ca/file/diagnostic_services_ontario_oct16.pdf
[28] http://www.ices.on.ca/file/diagnostic_services_ontario_oct16.pdf

increasing the quantity or number of scanners in Ontario, without instituting methods to encourage the appropriate use of imaging technology, would lead to persistent increases in expenditures on diagnostic imaging.

An Open and Transparent Public Quality Assurance Regime

It is simply insufficient for the Ministry to permit the degree of self-regulation of independent health facilities as exists today. The Auditor General reported that the Ministry estimates that about half of Ontario's diagnostic facilities are fully owned and/or controlled by physicians. To grant the College of Physicians and Surgeons of Ontario the authority to set quality standards and perform facility inspections through the Out-of-Hospital Premises Inspection Program (OHPIP) is akin to permitting the Ontario Restaurant Hotel and Motel Association to inspect restaurants, rather than the Public Board of Health.

This represents the devolution of accountability and quality assurance and in view of the risk to patient safety, this function should be returned to the Ministry and integrated into the regulation and inspection of health premises more generally to ensure that patients receiving insured health services and procedures, including cosmetic surgery, colonoscopies, interventional pain procedures and cataract surgeries - in clinical settings outside of hospitals are not placed at risk.

Improving Efficiencies and Reducing Cost

The existing *Independent Health Facilities Act* mechanisms for fee-for-service payment or negotiation of contracts for service volumes have been woefully inadequate. Several previous independent experts' report and provincial auditor reports have urged the Ministry to take appropriate action but to date no such action has been forthcoming.

The 2012 Provincial Auditor's report underscored the Ministry's failure to confirm that negotiated prices were reasonable and expressed concern that technological improvements have resulted in facility fees significantly exceeding the actual cost of performing such services[29]. Existing fee-for-service arrangements for independent health facilities have largely been unaltered from 2005 onward until May, 2012 when the Ministry implemented a 2.5% reduction in facility fees and a 5.0% reduction in professional fees in recognition of improvements in technology and standards of care, according to the Provincial Auditor[30].

Under the fee-for-service model, all independent health facilities are paid a set fee or price. That price is indifferent to the actual measurable costs of providing services in that quantity or location and the funding mechanism does not limit the prospects for over-utilization and/or inappropriate utilization of such services. The specialty clinic proposal is also inconsistent with other elements of the Action Plan for Health Care – not least of which is the effort to enhance primary care through Family Health Teams or to ensure better integration as patients transfer within the health system.

[29] 2012 Provincial Auditor's Report, page 158
[30] 2012 Provincial Auditor's Report, page 156

The 'shift to the community' also masks the inequities and gender divisions within health care as care shifts from the physician-acute hospital male-dominated sector to the chronic health-home care and female dominated sector. The shift to specialty clinics may only further deny opportunities for women to maintain good jobs that allow them to care for their families.

The Action Plan is accurate in suggesting that there is a common cause – an eagerness by the front line providers of care to work collaboratively and collegially to re-tool the system for the challenges of tomorrow. There is a deep and enduring shared commitment amongst public sector health care providers to achieve the goal of a sustainable health care system for the generations that follow IF all parties demonstrate their commitment to our publicly funded single-tier Medicare system.

There is an additional form in which recent health care reform in a climate of public sector retrenchment has increased gender disparities within our society. The burden of providing health care has also been shifting to poorly paid workers in the community and unpaid family care-givers in the home, most of whom are women. Health care reform should not rob communities of "good jobs" and contribute to the development of a low-wage economy. Wage parity with existing institutional jobs recognizes that fair wages and decent working conditions contributes to quality of care. This is particularly the case with the home care sector in many provinces, with substantially lower levels of wages; and greater private involvement than many other sectors.

Women represent not only a disproportionate share of workers in health care; they also provide a disproportionate share of the unpaid labour associated with care-giving in the home and family. The shifting of care from paid labour in health institutions to private households has transferred the social burden of care to women through unpaid caregiving responsibilities within the home. ***CAW Submission to the Romanow Commission****, 2002*

CONCLUSION

It is vital that Ontarians engage in a vigourous public debate relating to the establishment of "community-based specialty clinics", informed by the best available evidence. The regulatory proposal to amend Regulation 264/07 under the *Local Health System Integration Act* and to create a new Regulation under *the Independent Health Facilities Act* should be withdrawn until that debate has reached some form of broad consensus or conclusion and no further evidence is available.

It is our view that moving ambulatory services from public community-based hospitals to potentially for-profit (and especially corporate-owned) specialty clinics represents a fundamental shift in public policy and direction by this Government. Such a shift inherently and fundamentally places in jeopardy the ongoing capacity of our community-based, publicly funded and publicly governed hospitals to provide quality, accessible health services in their communities.

We therefore are deeply concerned with this proposed regulatory change in that it not only conflicts with prior policy announcements but also that it is a prelude to the creation or transfer of public services to corporate for-profit entities beyond the statutory

reach or ambit of the *Public Hospital Act*. We are deeply concerned that these new specialty clinics will directly compete for operational funding; clinical and support staffing; and patients with existing community hospitals. Indeed, in the current atmosphere of fiscal restraint, our community public hospitals are challenged as never before to maintain the quality and volume of an essential range of in-patient and out-patient services.

This regulatory change also ignores the substantial innovation and progress within our public hospitals in reconfiguring their clinical services – with ambulatory outpatient clinics providing various surgical, therapeutic and/or diagnostic procedures in settings as varied as free-standing clinics or specialized day programs at hospital sites. As we reviewed throughout our submission, there is no compelling evidence to suggest that private specialty clinics could perform routine ambulatory procedures at the same high quality standards, without greater risks to patient safety, while enhancing access at less cost and without jeopardizing existing hospital out-patient services.