Bill 160: the latest attack on Ontario's public hospitals

A submission of the Hospital Professionals Division, Ontario Public Service Employees Union, to the Standing Committee on General Government in response to Bill 160

November 15, 2017

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Introduction

The Ontario Public Service Employees Union (OPSEU) represents 130,000 members across Ontario including 25,000 health professionals in 90 hospitals, 8,000 mental health care workers, more than 3,000 paramedics, 4,000 hospital support staff, 3,000 community health care professionals, and more than 3,000 long-term care home workers. We are deeply concerned about changes proposed in Bill 160, the *Strengthening Quality and Accountability for Patients Act.* An omnibus bill with sweeping implications, Bill 160 would repeal, amend or enact more than 40 pieces of legislation. Most of the provisions of Bill 160 have undergone no public consultation. Now, it is being fast-tracked with only four days of public hearings, solely in Toronto. Poor process leads to poor policy and in this case, the poor process has contributed to serious problems in this bill. While we are concerned about the implications of several schedules as proposed under this legislation, this submission will focus on our grave concerns pertaining to Schedule 9 – the creation of the *Oversight of Health Facilities and Devices Act (the act).*

Without any public consultation, Schedule 9 repeals the existing acts covering private hospitals and private clinics including x-ray, ultrasound, MRI, CT, fluoroscopy, nuclear and molecular imaging clinics. It enacts new legislation rolling all of these facilities into one act. The new legislation would govern the licensing and oversight of almost all hospital services provided outside the hospital setting. The new act lifts the ban on private hospitals, falsely renames private clinics as "community health facilities," and contains broad ability for these private clinics to appeal decisions of the Ministry of Health and Long-Term Care (MOHLTC). It does not require new clinics to be non-profit. It does nothing to improve quality of care or protect patients against user fees and extra charges, and almost all significant aspects of the legislation are left to future regulation. It allows the ministry to bring in a proliferation of fully private for-profit hospitals and clinics with the stroke of a pen. For these reasons we are calling for Schedule 9 to be repealed immediately.

Schedule 9: changes for the worse

Schedule 9 of Bill 160 amends 34 pieces of legislation. As previously mentioned, three pieces of legislation would be repealed via Schedule 9, including the *Private Hospitals Act* (PHA), the *Independent Health Facilities Act* (IHFA) and the *Healing Arts Radiation Protection Act* (HARPA). All private clinics and hospitals currently operating under these acts would be rolled into one new act called the *Oversight of Health Facilities and Devices Act*. The new act ominously and dangerously rebrands both private hospitals and private for-profit clinics as "community health facilities."

Why is the *Oversight of Health Facilities and Devices Act* so problematic?

The rebranding of private hospitals and IHFs as "community health facilities" under the OHFDA is not only misleading, but an affront to the notion of the non-profit community health sector. Ninety-eight

per cent of IHFs are for-profit corporations and they differ significantly from the existing community health sector. The *Oversight of Health Facilities and Devices Act* allows these newly branded community health facilities (CHFs) – which unmistakably are private hospitals and clinics – to provide services prescribed in regulations made by the Minister of Health and Long-Term Care. As such, the Minister can now widen the scope of private clinics with few, if any, limits. This is dangerous and we oppose it in the strongest terms.

The new act sets up an Executive Officer (EO) whose powers are not defined in the act but are rather to be defined via future regulations to the act. The new act undermines the minister's previous power to control the transfer and renewal of licences. Contrary to banning private hospitals, the act actually gives the EO the power to request applications at any time for the establishment of any so-called "community health facility." By doing so, the act gives authority to an unelected individual with immense powers to privatize. The legislation will allow any person to apply for a licence to operate a CHF at any time, "whether or not the EO has requested applications."

Additional concerns:

- The form of the licence for so-called community health facilities is open.
- The EO may approve a licence as long as the applicant pays a fee, if applicable, and the application complies with a requirement that the licence is in a form that is acceptable to the EO and contains information that the EO considers necessary or advisable. (all very vague and open-ended).
- In general, if the EO "believes" the applicant to be honest and law abiding, he or she can approve a licence.
- For energy applying and detecting medical devices, the EO has to merely "believe" the applicant is competent and responsible.
- The legislation gives absolute discretionary power to the EO in deciding whether or not to issue a licence; they can amend a licence and/or consent to the transfer of a licence.
- Quality and safety standards are yet-to-be-determined via regulation.
- With the written approval of the EO, the licensee – a private clinic owner – can also be their own quality advisor. This is a major conflict of interest.
- It is unclear whether there will be regulations regarding the monitoring of services. All other safety issues, including reporting of incidents, are yet-to-be-determined by regulation.
- Inspecting bodies will be designated by regulation, and the standards set by those bodies will be as per the regulation.
- Inspectors can enter and inspect without warrant, and the inspector or EO can order a licensee to cease operating or cease providing a service for a time – but penalties for non-compliance are not set. They are yet-to-be-prescribed by regulation.
- The EO can suspend, revoke or refuse to renew a licence under a set of conditions listed, and these decisions can be appealed, first to the Health Services Appeal and Review Board as detailed in the *Ministry of Health and Long-Term Care Appeal and Review Boards Act*, and then

to the courts. It is important to note that the *Private Hospitals Act* allowed the Minister to revoke a licence if he/she deemed it in the public interest to do so, and there was no appeals process.

The *Private Hospitals Act*: limiting private hospitals in Ontario

While it seems counterintuitive to have a *"Private Hospitals Act"* in a province with a public health care system, it is important to note that this is a "limiting" piece of legislation, introduced to grandfather-in private hospitals that existed prior to October 1973. Perhaps most importantly, the *Private Hospitals Act* bans any more licences from being issued. It gives the Minister the power to require annual licence renewals and charge fees for them. Under this act, the Minister can refuse to renew a licence, revoke a licence and decide whether a licence can be transferred in the public interest, and the act sets out the processes for these. It sets out fines and enforcement, and its primary function is to stop the proliferation of private hospitals. By repealing the *Private Hospitals Act*, this Schedule removes the existing ban on the expansion of private hospitals in this province. There is no reason to repeal the *Private Hospitals Act* unless this government intends to introduce new private hospitals. OPSEU sees this as a grave threat to our public hospital and public health care system and we will take strong action to oppose it.

In the new act, the oversight of private hospitals and private clinics – termed "Independent Health Facilities" (IHFs) – is rolled into one act. This is dangerous. Private hospitals admit patients for overnight stays. Private clinics do not. By rolling these into one act, any new definition would have to include the admission of patients for overnight stays. Thus, the permissive regime outlined in the new act will apply to private hospitals. This is unacceptable.

Down this road before: have we learned nothing?

The *Independent Health Facilities Act* has been problematic since its introduction in 1989. The regulation of private clinics has been poor and repeated issues of poor or even dangerous quality of care have arisen. This privatized model of hospital care is a proven failure. It should not be expanded.

In 2013, regulatory changes were implemented to expand the use of the IHF model to cut and privatize public hospital services in Ontario. According to the summary of the amendments and regulation released at that time, "One model being contemplated for establishing community-based specialty clinics is the Independent Health Facility Program." The summary makes clear the government's intention to shift community hospital services to new private clinics established under the IHFA.
As a result of massive public opposition, the MOHLTC halted its plan to systematically contract out public hospital services to private clinics. Perhaps naively, we believed that some inroads had been made, and some clarity provided on the true ramifications of this plan. Sadly, we now see that Bill 160 is just the latest "kick at the privatization can" – an attempt to rebrand IHFs and private hospitals as

community health facilities, and to refocus the government's efforts on expanding these private facilities at the cost of public community hospitals. This is absolutely shameful, and it is so evidently part of the government's relentless plan to dismantle public hospitals – the backbone of the public health care system in this province, and country.

Expanding the scope of regulated devices

Currently, it is the *Healing Arts Radiation Protection Act* which governs the use of x-ray machines in Ontario. The HARPA establishes which regulated health professionals have the authority to operate x-ray machines, and also which ones have the authority to order the procedure. There is a significant body of evidence regarding the risks of patient exposure to ionizing radiation. Those who order such procedures must have the knowledge, skills and expertise to mitigate the risks, by ensuring that a patient does not undergo procedures using ionizing radiation if they are not medically necessary. The same is true for those operating the x-ray machine.

Schedule 9 will repeal the HARPA, which will also be replaced by the *Oversight of Health Facilities and Devices Act* (OHFDA). The new legislation will expand the current scope of regulated devices beyond x-ray machines to incorporate a host of existing and emerging energy applying and detecting medical devices (EADMDs). Like the so-called community health facilities established under the new legislation, the EADMDs would also be overseen by an EO appointed by Cabinet. And just like many of the important aspects regarding so-called community health facilities, much of the oversight framework for EADMDs is yet to be determined through regulations. So much remains unclear.

However, where the HARPA clearly governs which regulated health professionals can order and operate x-rays, the new legislation does not include any restrictions regarding the authority to order x-rays or any other EADMDs. It is worth noting that the over-prescribing of tests and procedures in private clinics is rampant; this is much different than public hospitals. It is in the interest of such clinics to do as many procedures as possible, to ensure the highest volume and maximum payout is reached; they have little to no interest in minimizing the patients' exposure to risk. The weak language used in the OHFDA only serves the purpose of reducing the restrictions that would be placed on so-called community health facilities which utilize EADMDs.

When it comes to operating EADMDs, the legislation merely states that the "Lieutenant Governor in Council may make regulations governing energy applying and detecting medical devices and their licensing and, without restricting the generality of the foregoing, may make regulations…respecting and governing qualifications for the operators of energy applying and detecting medical devices." Therefore, the qualifications for operators of EADMDs *may* be outlined in regulations. This poses a significant risk to patient health, and one must question why the government would not make absolutely clear through legislation that only regulated health professionals have the authority to order or operate an EADMD.

Quality standards not protected by law

Schedule 9 predicates that quality and safety standards are to be outlined in future regulation, like so many other important aspects of the proposed legislation. However, licensees (private clinic owners) can actually be their own quality advisors with written approval of the EO. This is problematic, especially where quality standards are already so different between public hospitals and private facilities. In fact, the act does nothing to improve safety regimes when it comes to private clinics.

The private clinics that exist in Ontario have been plagued with serious quality and safety concerns. A significant body of academic research has shown that fragmenting community hospital services into private clinics has resulted in poorer quality, safety concerns, the proliferation of illegal user fees being charged to patients, and the "cream-skimming" of only the most profitable, low risk, and simplest (and therefore higher volume) procedures. All of this has come at the expense of public hospitals and patients.

Case Study:
Safety fail at private Ottawa clinics threatens public health crisis

In 2011, it was uncovered that a private endoscopy clinic located in Ottawa had not been sterilizing its equipment properly. In an attempt to cuts costs, the Ottawa Hospital had cut thousands of endoscopies and privatized them to private clinics (with much lower quality standards) in the preceding years. As a result of improper sterilization at just one private clinic, 6,800 patients were sent letters warning that they were at risk of having contracted HIV and hepatitis B & C, all from receiving a routine medical procedure!

A study which looked at private colonoscopy clinics showed that 13 per cent of the colonoscopies conducted in Ontario's private clinics were incomplete, leaving patients at higher risk for undetected cancers. These clinics' standard of practice was well below that of public hospitals.

A major part of the problem is that different kinds of private clinics face vastly different types of inspections, and according to the Ontario Health Coalition, "even where long-standing regimes of inspection for serious issues such as radiation exist, they are not followed." In fact, the 2012 audit done by Ontario's Auditor General found serious shortfalls in inspections and quality assurance; 60 per cent of x-ray clinics had not been inspected as frequently as required to protect against radiation; 12 per cent of diagnostic clinics had not been assessed in more than five years, and new private facilities had not been inspected to ensure that equipment emitting radiation had been safely installed in the first place. These are the same facilities that the government would like to expand, and rebrand as "community health facilities."

The *Public Hospitals Act* protects quality standards

In stark contrast to the IHFs described above, public hospitals are required by law to have Quality Committees, Medical and Nursing Advisory Committees, and comprehensive incident reporting systems among a host of other protections. Over decades, the quality regime in public hospitals has expanded to include robust daily oversight. In comparison, the enforcement regime envisioned in this new act is reactive, and almost all meaningful details are left to regulations.

The attack on public hospitals continues: Bill 160 another nail in the coffin

As has been widely reported, Ontario's public hospitals are now experiencing unparalleled rates of overcrowding as a result of years of deep cuts to public hospital beds, services and staff. Patients lay on stretchers in hallways, sometimes for days, waiting for an available bed. Hospitals all across the province are reporting occupancy rates of more than 100 per cent – a far cry from the 85 per cent maximum occupancy rate recommended by the Organization for Economic Co-operation and Development (OECD).

But instead of focusing on fixing the problems our system faces by investing much-needed funds into our public hospitals, which have been starved for nearly a decade, the government has instead chosen, yet again, the privatization route. It is downloading services to lesser-regulated facilities that cut costs by cutting corners, where the workforce is paid less, and treated more poorly, and where patients are increasingly forced to pay for services out-of-pocket.

The new act does not ban the so-called community health facilities from charging membership or other additional fees. While the legislation requires that private clinics not discriminate against patients for refusing to pay them, the weakness of this language amounts to very little protection for patients in reality. Extensive research done by the Ontario Health Coalition has shown that patients are often afraid or completely unaware of their ability to refuse to pay such fees. The stipulation outlined in the legislation does nothing to address the underlying and pervasive issue of private clinics charging patients for medically necessary care.

Furthermore, the government is making changes to the *Ambulance Act*, which will expand the ability for the minister to issue directives to operators of land ambulance services. This could include a directive to convey persons by ambulance to destinations other than hospitals. While we have several concerns about the liability and safety issues this raises, it is particularly troubling that within the broader context of expanding private clinics and hospitals (by way of the OHFDA), this particular amendment could facilitate the use of privatized clinics for patient care, and further cuts to public community hospitals as a result. The amendment addressing directives for alternative destinations must clarify that all

alternative destinations to which paramedics would transport patients must be non-profit, public facilities, and only in clearly defined circumstances.

Conclusion

We are deeply concerned about the proposed changes in Bill 160. The bill makes sweeping changes to Ontario's health care system, many of which are highly problematic, yet most of which have undergone no public consultation. Bill 160, Schedule 9, repeals the *Private Hospitals Act (*a "limiting" piece of legislation that bans private hospital licences from being issued), the *Independent Health Facilities Act*, and the *Healing Arts Radiation Protection Act*, and replaces all three with the *Oversight of Health Facilities and Devices Act.*

The OHFDA serves to rebrand both private hospitals and private clinics as so-called "community health facilities," and gives power to an Executive Officer appointed by Cabinet to establish such facilities at his/her discretion. Any person can apply for a licence to operate a CHF at any time.

In Ontario, we've done the privatization experiment, and it hasn't worked. Since 1989, the *Independent Health Facilities Act* has been problematic, and the regulation of private clinics has been poor. Private clinics that operate in this province have been plagued with serious quality and safety concerns, and they have proliferated illegal patient user fees. Existing private hospitals and facilities already face much different quality standards than public hospitals, yet the OHFDA allows these standards to be weakened even further, to the point where private owners can be their own quality advisors.

The OHFDA also replaces HARPA, which governs the regulated health professionals that can order and operate x-rays. The new legislation does not include any restrictions regarding the authority to order x-rays or other EADMDs. It also fails to stipulate that only regulated health professionals can operate EADMDs. These qualifications requirements *may* be outlined via regulation in the future, but nonetheless, this poses a significant risk to patients.

Our public hospitals have suffered, and continue to do so. Rather than focusing on positive solutions to fix our health care system, the government has introduced Bill 160, the latest attack on public hospitals. If enacted, this legislation would lead to further cuts to public hospitals and the downloading of services to lesser-regulated facilities where costs are cut by cutting corners, where health professionals and other staff are paid less and treated more poorly, and where patients are forced to pay fees and are exposed to greater risks.

It is for these reasons that OPSEU is calling for:

- a complete and immediate moratorium on Independent Health Facilities;
- the return of all services provided by existing IHFs to our public hospitals; and
- repeal of Schedule 9.