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M E M O R A N D U M

TO: Mr. Michael Hurley, CUPE – Ontario Council of Hospital Unions

FROM: Steven M. Barrett (Ext. 6422)

DATE: March 10, 2023 Our File No. 23-365

RE: Bill 60

SUMMARY AND ANALYSIS OF SCHEDULE 1 OF BILL 60: THE PROPOSED *INTEGRATED COMMUNITY HEALTH SERVICES CENTRES ACT*

Goldblatt Partners LLP

A. OVERVIEW

1. On February 21, 2023, the Ontario Ford Government introduced Bill 60, the so-called *Your Health Act, 2023.* On March 1, the Bill passed second reading, and has been referred to the Standing Committee on Social Policy.

2. This summary focuses on Schedule 1 of the Bill, which would enact the *Integrated Community Health Services Centres Act* ("ICHSCA").

3. ISCHA would establish a framework through which private, for-profit corporations (to be known as "integrated community health services centres") are permitted and encouraged to provide non-hospital based medically necessary health services, including surgical services.

4. ICCHA would replace the *Independent Health Facilities Act* ("IHFA"), a much less ambitious legislative framework which has regulated health facilities for almost 35 years.

5. By far, the largest category of services that have been provided outside of public hospitals under the IHFA are diagnostic radiology and ultrasound services.

6. This contrasts with the substantial expansion of non-hospital for-profit surgical and other medical services that the Government intends under ICHSCA.

7. Below, we summarize and critically assess and analyze some of the key features of ICHSCA. Neither our summary nor analysis aims to be exhaustive. Rather, we focus on the implications of the proposed changes for public health care delivery, the diversion of human resources from the public to the private system, the impact on health sector collective bargaining, accountability for quality and safety, and the principles of accessibility and universality.

B. THE CURRENT IHFA REGIME

8. The current IHFA framework provides for the licencing of Independent Health Facilities, which are independently owned and operated clinics. While these facilities provide some limited day surgeries and procedures, they primarily provide various forms of diagnostic services. IHFs are typically for-profit corporations which provide health services insured under OHIP at no charge to patients. They receive funding from the Ministry of Health in the form of facility fees (covering overhead costs) and professional fees (covering physician fees for insured services). While licenced by the Ministry of Health, quality oversight is carried out by the College of Physicians and Surgeons ("CPSO"). For better or for worse, IHFs have become a significant vehicle for the delivery of diagnostic services in Ontario.

C. THE NEW ENHANCED PRIVATIZED HEALTH CARE DELIVERY REGIME CONTEMPLATED BY BILL 60

9. The Government has been clear that ICHSCA is intended to be a vehicle through which the role of non-hospital based private clinics is to be expanded, with the aim of diverting surgical and other hospital services into those clinics.[1]

10. The ICHSCA provides for the licencing of independently or privately owned and operated clinics, to be known as "integrated community health services centre" (ICHSC).

11. An ICHSC is essentially the same entity as an IHF, except that an ICHSC is expressly expanded to include "a community surgical and diagnostic centre" (s.1). No doubt, this explicit definitional expansion to include reference to surgical

[1] https://toronto.ctvnews.ca/ontario-tables-health-care-bill-to-expand-role-of-private-clinics-1.6282893

services is intended to signal a significant policy shift to move more surgery out of public hospitals.

12. At the same time, and as will become more apparently below, there is little in the legislation which explains or supports the notion that these ICHSCs will be operated in a manner which is "integrated" with the public hospital system and other components of our public health care system.

13. As with IHFs, ICHSCs are contemplated as for-profit corporations which provide health services insured under OHIP at no charge to patients. They also may sell non-insured services, devices and products to patients. They receive funding from the Ministry of Health in the form of "facility costs," which are defined to mean the same thing as "facility fees" under the IHFA.

14. Unlike the IHFA, the ISCHA has a lengthy preamble setting out the purported policy justifications for the Bill 60, and which purports to set out themes that are repeated throughout the legislation. These include "connected and convenient care," the provision of OHIP-insured services "at no cost to patients," the integration of community-based health services with "local and regional health system partners," improvement of patient wait times and access to care, and "optimiz[ing] health human resources."

15. Section 5(4) of the Bill requires licensing applicants to provide information to one or more Directors appointed under the Act related to the services to be provided, and mainly reflecting the themes set out in the preamble, including the applicant's capacity to improve patient wait times, its plans to improve patient experience and integrate with the health system, its quality assurance, including policies for infection prevention and control, its business, clinical and professional experience, its staffing model and evidence of the sustainability of the mod, and a description of current linkages with health system partner and of how the applicant would address the health equity needs of the population

16. Under s. 6(1) and 6(2), the Director is to decide whether or not to issue a license based on a consideration of the factors related to the information required on the application, including the nature of the services to be provided in the proposed integrated community health services centre, the extent to which the services are already available and will promote connected and convenient care (including improving patient wait times, patient experiences and access to care and plans to integrate with the health system), the needs of diverse, vulnerable, priority and underserviced populations and linguistic needs, the potential impact on health system planning including the availability of sustainable health human resources, the potential impact on the co-ordination of health services and the projected cost and availability in public money of the proposed license.

17. The Bill also includes some limited restrictions related to the location of ICSCHs: an ICSCH may not be located within or adjacent to a private hospital (s. 6(5)) and an ICSCH may not relocate without prior approval of the Director (s. 10).

18. Significantly, the Bill eliminates the CPSO's quality and safety regulatory role under the previous IHFA. Rather, under the ICHSCA, the CPSO is to be replaced by one or more unnamed "inspecting bodies" appointed under the regulations (s. 43(1)). Inspecting bodies have significant responsibilities, including establishing quality and safety standards, establishing inspection schedules, providing for inspections as it considers advisable or as requested by the Director, appointing inspectors, providing reports, making compliance orders and exercising any power or responsibility provided in the regulations. The Minister or Director may also appoint inspectors (s. 42(1)) and the Director may require an inspector to conduct an investigation (s. 42(4)).

19. There are also provisions respecting safety and quality. Under the IHFA, these standards were established by regulation; under ICHSCA these may additionally established by an inspecting body (s. 43(3)). Under IHFA, an IHF's breach of safety and quality standards can lead to reduced funding or a revocation of a license; under ICHSCA, failure to comply with the applicable quality and safety standards is made a prosecutable offence (s. 63(1)).

20. The ICHSCA also contains new provisions related to accessibility and universality (s. 29(5)), discussed in greater detail in the analysis below.

21. However, as also detailed in the analysis below, ICHSCA leaves fundamental matters to be determined outside of the legislative process, i.e., at the discretion of various parties or through a regulation promulgated by Cabinet.

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D. ANALYSIS OF ISCHSA

22. The Government has sought to quell concerns about increased privatization of healthcare delivery under the ISCHSA by purporting to add safeguards to concerns that have been raised about the adverse impact on the public health care system, including accessibility and quality of care. While ICHSCA contains some limited protections, in our view, the Bill does not address and indeed raises very significant concerns flowing from the Government's policy of increased privatization of hospital services, including the diversion of human resources and the resulting adverse impact on hospital capacity and wait times, the erosion of bargaining rights and protections, concerns relating to safety, quality and accountability, and concerns over accessibility and universality.

23. Moreover, by leaving fundamental matters to be determined at the discretion of various parties or through Cabinet regulations, ICHSCA raises a host of new concerns about roles, accountabilities and the potential that even the limited protections in ICHSCA could be undermined.

(b) Allowing for-profit clinics to proliferate

24. We begin by noting that nothing in the legislation grants preference to the provision of out-of-hospital surgical or diagnostic services on a public or not-for-profit basis, and nothing discourages integrated community health services centre from operating on a for-profit basis. Thus, to the extent that Bill 60 is expected and intended to expand the provision of out of hospital surgical services, it can be expected that this will be accompanied by a shift from not-for-profit public hospital delivery to for-profit corporate health care delivery.

25. Notably, the Bill also proposes to amend the Private Hospitals Act, which currently, under section 3, precludes the establishment of any new private hospitals. Private hospitals have not included independent health facilities under the IHFA. While the Bill maintains the prohibition on new private hospitals, it also provides that a private hospital would not include an "integrated community health services centre" under Bill 60. This means that none of the provisions or restrictions governing private hospitals will apply to integrated community health services centres providing surgical or diagnostic services under Bill 60 outside of hospitals.

(c) Diversion of Human Resources

26. As is well-known, one of the many concerns with non-hospital based for-profit medical clinics is that they divert resources, including human resources, from the public sector to the private, for-profit sector. This concern has become even more acute as a result of staffing shortages that were brought on by and that have persisted since the pandemic, which has been exacerbated by other legislative and policy decisions, such as the public sector wage caps mandated by Bill 124. Indeed, far from seeking to address these dynamics, the Government is persisting in its attempt to cap hospital and other public sector wages by pursuing an appeal to the Bill 124 challenge that it lost.[2]

[2] https://www.cp24.com/news/doug-ford-says-bill-124-doesn-t-exist-as-his-government-appeals-court-decision-striking-it-down-

27. Bill 60 lacks any substantive or explicit safeguards against this problem. Given the Government's clear policy intention to divert more health services from hospitals into these private clinics, it is difficult to imagine that this would not exacerbate a healthcare human resources shortage that is already in crisis, as an exhausted and demoralized healthcare workforce is present with a growing array of job opportunities in the private clinics encouraged by Bill 60, that may in turn come with more predictable day shift hours and higher pay. Thus, there is a serious concern that the expansion of non-hospital based surgical clinics proposed in Bill 60 will threaten the capacity of the public hospital system to maintain even its diminished health human resources capacity and gives private clinics a potential recruitment advantage with respect to a diminishing pool of health care workers.

28. The ICHSCA purports to address this problem by requiring the Director to consider, in deciding whether to issue a licence, "the potential impact on health system planning, including the availability of sustainable health human resources," as well as a number of related considerations, including the extent to which the services are already available in Ontario, the applicant's capacity to improve patient wait times, its plans to integrate with the health system, whether the issuing of the license would improve the availability of the services in the region and the potential impact on the co-ordination of health services (s. 6(2)).

29. However, the obligation on the Director is only to "consider" these factors. For example, there is no requirement that a license be denied if the impact of a proposed ICHSC on hospital human resources is negative, or that a license be revoked if an ICHSC ends up draining needed human resources from nearby hospitals or other publicly funded health facilities. Significantly, the courts have consistently held that the mere obligation to "consider" requires only that the decision maker turn its mind to the factor, but it is otherwise entitled to give the factor some, little or no weight.

30. Both the Ontario Hospital Association[3] and the Ontario Medical Association[4] have emphasized the critical importance of ensuring real and substantial connection, integration and oversight between public hospitals and any proposed expansion of

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[3] See for example https://www.cbc.ca/news/canada/toronto/ont-health-care-1.6718407

[4] See the OMA's proposal for integrated ambulatory centres to provide out of hospital care, which would work in close partnership with (or as part of) public hospitals to ensure credentialling of physicians, quality oversight (including that the right cases are done in the right setting), appropriate funding alignments, and regional planning with hospitals, including HHR capacity alignment, to ensure that staff are not diverted from hospitals: https://www.oma.org/uploadedfiles/oma/media/public/addressing-wait-times-proposal.pdf

non-hospital based surgical facilities. By contrast, Bill 60 contains no such substantive requirements, leaving the extent of connection and integration solely to the discretion of and as a factor to be considered by the licensing body, with little if any ability for persons who may be concerned with the adverse impact of a proposed licence to participate in the licensing or decision-making process.

31. Moreover, to the extent that the Government claims to be addressing the healthcare crisis through Schedule 2 of Bill 60 (which would amend several statutes to allow health care workers registered or licensed in other provinces to immediately start practising in Ontario, without having to wait to complete their registration with the applicable regulatory college in Ontario), it is difficult to see how this is likely to solve the problem, particularly since other provinces are also facing unprecedented human resources shortages.[5]

(d) Erosion of Bargaining Rights and Bargaining Units

32. The ICHSCA does not contain any protections to address the potential erosion of hospital bargaining rights and bargaining units that may flow from the diversion of healthcare human resources from hospitals into private clinics. This has the potential to undermine the hard-fought gains achieved by healthcare unions in terms of wages, benefits, employment security, and job security. Moreover, recent amendments to PSLRTA have made it more difficult for unions to establish successorship rights through transfers of healthcare services and employees. [6] ICHSCA offers nothing to fill this gap.

(e) Safety, Quality and Accountability

33. For their part, public hospitals are subject to rigorous safety and quality standards, which are overseen on a day-to-day basis by independent hospital boards of directors and quality standards committees required to act in the public interest. For example, hospital boards determine hospital privileges, appoint physicians and revoke or suspend appointments for medical staff. As well, under the Public Hospitals Act, hospital Boards are required to make by-laws to establish medical positions and processes for appointments and elections to advisory committees

[5] Notably, for its part, the World Health Organization has estimated a projected shortfall of 10 million health workers by 2030: https://www.who.int/health-topics/health-workforce#tab=tab_1

[6] In 2019, the Government enacted Bill 100, which among other things, significantly narrowed the scope of a "health services integration" within the meaning of PSLRTA.

and positions; to establish committees of the medical staff, including the duties and powers of such committees, to assess credentials, medical records, patient care, infection control, the utilization of hospital facilities and all other aspects of medical care and treatment in the hospital; to establish an occupational health and safety program with specific requirements; to establish a health and communicable disease surveillance program; and to ensure that nurses and nurse managers are included in committees and other decision-making pertaining to the administrative, financial and planning matters of the hospital.

34. None of these safeguards are set out in or required under the ICHSCA. The ICHSCA vests a vast amount of responsibility for establishing quality and safety standards, and for compliance monitoring, in an "inspecting body" whose identity is to be determined by regulation, i.e., by Cabinet, outside of the legislative process (s. 43)). There are no parameters in ICHSCA as to the qualifications of the inspecting body. When it comes to quality and safety standards, the proposed s. 20(2) merely provides that "every licensee shall comply with the applicable quality and safety standards", standards which are left to be determined entirely by the inspecting bodies, or by regulation.

35. As well, as under IHFA, inspections are likely to be reactive rather than proactive, with limited transparency and limited employee/union involvement. While ICHSCA includes a requirement that inspecting bodies make summaries of inspection reports available to the public (43(3)), there are no minimum standards as to what the summaries must contain, leaving open the possibility that the summaries will omit critical information necessary to inform the public, such as the identity of the ICHSC, the nature of the findings, or a description of any enforcement measures taken. Indeed, this model of enforcement is not dissimilar to that in effect in long term care homes in the province which have been found to be entirely inadequate to ensuring quality care.

(f) Accessibility and Universality

36. ISCHA contains provisions ostensibly designed addressed to accessibility and universality by prohibiting ISCHAs from according preference to those able and willing to pay out of pocket for services or discriminating against patients unable or unwilling to pay.

37. In particular, section 29(5) of ICHSCA prohibits "preferences" in the provision of healthcare services. It provides:

No preferences

(5) No person shall,
(a) charge or accept payment for providing an insured person with a preference in obtaining access to an insured service at an integrated community health services centre;
(b) obtain or accept a benefit, direct or indirect, for providing an insured person with a preference in obtaining access to an insured service at an integrated community health services centre; or
(c) offer to do anything referred to in clause (a) or (b).

38. Section 29(6) prohibits discrimination against patients for their "choice" not to pay. It provides:

No refusal for choice not to pay

(6) No person shall refuse to provide or refuse to continue to provide an insured service to an insured person for any reason relating to the insured person's choice not to pay, or not to provide a direct or indirect benefit, for any product, device or service offered at the integrated community health services centre.

39. Section 63 would make it a prosecutable offence to violate these protections.

40. However, when read carefully, these provisions may well fail to prevent some of the abuses they purport to address. Specifically, there does not appear to be anything in section 29 that would prevent an ICHSC from giving preference to its clients willing to pay for extras or upgrades over its patients who do not wish to do so when it comes to accessing services, as long as it doesn't charge or accept a payment or benefit for doing so, and as long as it doesn't refuse services to its non-paying patients altogether. Thus, under the Bill, it may well be that an ICHSC could place its paying clients at the top of a waitlist for a particular service.

41. Also, while section 29(5) restricts the according of preferences to "insured persons" who pay to jump the queue, there is nothing to prevent non-insured persons from paying to jump the queue.

42. In this respect, nothing in the proposed ICHSC would preclude facilities from accepting payments from visitors from other jurisdictions, including healthcare tourists from other provinces or the United States, to jump to the top of a waitlist for a particular service.

43. Furthermore, there does not appear to be any express provision in ICHSCA that prevents 'upselling' – the practice in which a health professional convinces a patient to 'upgrade' their treatment by purchasing uninsured services, products or devices that may not be medically necessary. Upselling is a serious problem in Ontario which is likely to be become more acute with the proliferation of for-profit clinics.

44. In addition, there do not appear to be any protections against patients with easier and less complex cases being referred to for-profit integrated community health service centres, while the public system is burdened with the more complex and difficult cases.

(g) Undermining of Protections through Discretion and Regulation

45. As is apparent from the preceding analysis, many fundamental aspects of ICHSCA are left to be determined in the future, outside of the legislative process, either through exercises of discretion or by regulations promulgated by Cabinet. This raises the possibility that even the limited protections offered by the legislation could be undermined, making the full implications of Bill 60 impossible to assess.

46. To take a few examples:

- As set out above, section 43 of ICHSCA vests a vast amount of responsibility for compliance monitoring in an "inspecting body" whose identity is to be determined by regulation. There are no parameters in ICHSCA as to the qualifications of the inspecting body.
- Section 2 of ICHSCA allows the regulations to exempt a place, service or class of services, health facility, or class of health facilities or person or class of persons from the Act.
- Under IHFA, the Minister was permitted to pay the capital, service and other operating costs of an IHF. However, under section 29 of ICHSCA, the Minister may now also pay "any other prescribed costs" of an ICHSC, potentially expanding the purposes for which public monies may be diverted to a for-profit community health clinic.
- Section 65 of ICHSCA permits regulations to made about a broad range of matters, including prescribing health facilities that are or are not ICHSCs, and prescribing charge, fees or payments that are not "facility fees" under the Act. This could potentially allow a health facility that fails to meet ICHSCA's licencing requirements to nonetheless operate as an ICHSC by regulatory fiat or allow charges to be made directly to patients for certain prescribed services or benefits which are deemed not to be "facility fees".

E. CONCLUSION

47. The ICHSCA raises a number of significant concerns. Given the Government's stated policy of increasing the number and type of for-profit health clinics, it is essential for the governing legislative framework address the concerns arising from this policy shift in terms of diversion of resources, erosion of bargaining units, quality, safety and accountability, and accessibility and universality. ICHSCA fails to address these concerns adequately or in some cases at all. It also leaves critical aspects of the regime – including the identity of the Director(s) and the "inspecting body" and necessary safety and quality standards – to be determined by future appointments and regulations, rendering the full implications of the Bill impossible to predict and assess.

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