Canadian Centre for Policy Alternatives
November 2023

At What Cost?

Ontario hospital privatization and the threat to public health care

Andrew Longhurst

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ISBN XXX

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ACKNOWLEDGEMENTS

The author would like to thank Doug Allan, Bob Bell, Sheila Block, Damien Contandriopoulos, Trish Hennessy, Michael Hurley, Natalie Mehra, Danyaal Raza, Randy Robinson, David Urbach, as well as reviewers for their helpful comments on an earlier version of this paper. The author thanks CUPE/OCHU for supporting this research, and the many providers working tirelessly to deliver timely public health care services to Ontarians.

Executive summary

THE ONTARIO GOVERNMENT plans to significantly expand publicly funded surgeries and diagnostic procedures performed in for-profit facilities.

In May 2023, the government passed new legislation (Bill 60) which will encourage the growth of this for-profit sector and expand the types of surgical and diagnostic procedures allowed to be performed outside of hospitals. Drawing on Freedom of Information requests, financial and statistical analysis, and a review of the research literature and policy experience, this report evaluates the government's policy direction.

The government's stated rationale for increasing the use of for-profit care is to increase capacity and reduce wait times. However, expanding the for-profit sector is unlikely to do either: capacity depends on the availability of qualified staff, which is unchanged by the addition of profit.

Further, the current system is working well by Canadian standards. Ontario has already achieved the best wait-time performance for priority procedures among the provinces. The province has consistently performed better than the Canadian average for hip and knee replacements since 2010 and, in recent years, has maintained the shortest wait times for MRI and CT scan wait times. Improving the public system, not undermining it, is the sensible approach.

Since the 1990s, for-profit surgical and diagnostic medical imaging facilities have largely been regulated and funded as independent health facilities (IHFs). Analysis of Freedom of Information requests and Ministry of Health data shows the following:

- Ontario has 902 IHFs, with diagnostic imaging representing 81 per cent of total services provided in IHFs. Ten IHFs provide publicly funded surgical services.
- In addition to the IHFs, Ontario has three publicly funded private hospitals. Only two perform any surgeries at all.
- Between 2012-13 and 2021-22, the share of surgical procedures performed in IHFs increased from one per cent to 1.3 per cent of the total surgeries performed in Ontario. In 2021-22, 98.7 per cent of surgical procedures were performed in public hospitals.
- In 2021-22, public operating room (OR) surgical volumes were below pre-pandemic levels (down 13 per cent from 2017-18), suggesting that provincial underfunding and staffing shortages, not a shortage of for-profit options, remain the biggest obstacles to improvement.
- In 2021-22, for-profit surgical and medical imaging was a half-billion-dollar industry in Ontario (out of a nearly $76 billion health budget).In 2021-22, the Ontario government underreported payments to for-profit facilities by 720 per cent.

A review of the research literature and policy experience with for-profit delivery in Canada shows the following:

- Private delivery worsens public sector staffing shortages and destabilizes public hospitals.
- Increased for-profit delivery risks expanding two-tier health care in Canada through unlawful extra-billing, contrary to Ontario legislation and the *Canada Health Act*.
- Increased outsourcing risks entrenching for-profit hospitals in Canada since Ontario is the largest market with potential interest from domestic and U.S. institutional investors.
- For-profit delivery costs more.
- For-profit facility ownership introduces financial conflict of interest in medical decision-making, which can lead to upselling, self-referrals, and clinically unnecessary procedures.
- For-profit delivery increases risks to patient safety and care quality.

Expanded outsourcing is likely to worsen public hospital staffing shortages that cause longer waits. For-profit surgical and diagnostic delivery comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long

term. However, by focusing on evidence-based policy strategies to increase and improve surgical and diagnostic volumes in hospitals, the Ontario government can reduce wait times.

An evidence-based approach would begin by increasing funding to staff idle operating rooms in public hospitals. Ontario does not lack the physical space and equipment to improve wait times for surgeries and medical imaging; what is missing is the health care workforce necessary to do the work.

In addition to boosting staffing, the province could reduce wait times by pursuing the following strategies:

- Implement single-entry models, teamwork, and standardized wait list management provincewide: Single-entry models include central intake of referrals from primary care providers, a wait list shared by a team of surgeons and other providers, and triage for urgency and appropriateness.
- Maximize and extend hospital operating room capacity: An estimated 34 per cent of hospitals had unused OR capacity in 2019-20, and OR hours can be extended into evenings and weekends.
- Protect patients from extra-billing, prohibit upselling, and require physician disclosure of financial conflicts of interest.
- Increase medical and surgical hospital bed capacity and access to seniors' home and community care, which can reduce hospital bed shortages, cancellations of scheduled surgeries and, ultimately, surgical wait times for all patients.
- Reduce the overuse of clinically inappropriate medical imaging and surgeries.
- Provide accurate accounting of public payments to for-profit facilities and disclose funding agreements.
- Adopt a "vaccines-plus" public health strategy to reduce health system strain and delayed surgical care.

Experience with the privatization of public services shows that such services, once taken over by for-profit providers, are difficult to return to the public sector. Ontario should reconsider its plan to expand for-profit provision of surgeries and diagnostic procedures and instead strengthen public hospitals and implement system improvements.

Introduction

IN AUGUST 2022, the Ontario government announced that it would increase the number of publicly funded surgeries and diagnostic procedures performed in for-profit facilities.[1] Then, in January 2023, the government introduced new legislation to encourage the growth of this for-profit sector through a phased expansion of the volumes and types of surgical and diagnostic procedures allowed to be performed outside of hospitals. The government's stated objective was to increase provincial capacity and reduce wait times.[2]

However, Ontario's for-profit surgical and diagnostic sector—and the government's proposed reforms—have undergone little scrutiny. This research report seeks to address this gap by analyzing the government's policy direction, the existing for-profit surgical and diagnostic industry, and the implications of expanding for-profit involvement in Canada's largest province.

Drawing on Freedom of Information requests, financial and statistical analysis, and a review of the research literature and policy experience, this report finds that the Ontario government's policy direction is unlikely to increase surgical and diagnostic capacity over the long term and risks entrenching a for-profit hospital sector at the expense of the public health care system.

This report recommends that the provincial government rethink its plans for the significant expansion of for-profit surgical and diagnostic delivery and, instead, refocus efforts on public system improvement based on the research evidence and policy experience in Canada and internationally. Effective, evidence-based policy strategies include single-entry and

team-based referral models, improving and maximizing public operating room capacity, increasing access to seniors' home and community care[3] to alleviate hospital overcrowding, and reducing the overuse of diagnostic tests and surgeries. As well, public health interventions to reduce the spread of COVID-19 would help reduce strain on hospitals, and in turn, help prevent cancelled surgeries, backlogs, and longer wait times.

Surgical and diagnostic wait times in Ontario

The Canadian Institute for Health Information (CIHI) reports provincial wait times from surgery booking to completion (called Wait 2, see Table 1), but there are also additional wait times (not reported by CIHI) that account for the patient's full surgical journey.

In 2022, Ontario had the best wait-time performance for hip and knee replacement surgeries in Canada, with 72 per cent and 68 per cent of patients, respectively, receiving surgery within the national benchmark (Table 3). The share of Ontario hip-fracture-repair patients meeting the benchmark was just below the Canadian average, and 59 per cent of patients received their cataract surgery within the benchmark (below the Canadian average of 66 per cent).

TABLE 1: Wait times for surgical patients

Wait 1	Referral from primary care to specialist (surgical) consultation
Wait 2	Surgery booking to completion of surgery
Wait 3	Referral to diagnostics to completion of diagnostic testing (e.g., MRI scan) *May be concurrent to or following Wait 1 depending on care/referral pathway, urgency, and other factors.*
Wait 4	Surgery completion to patient recovery

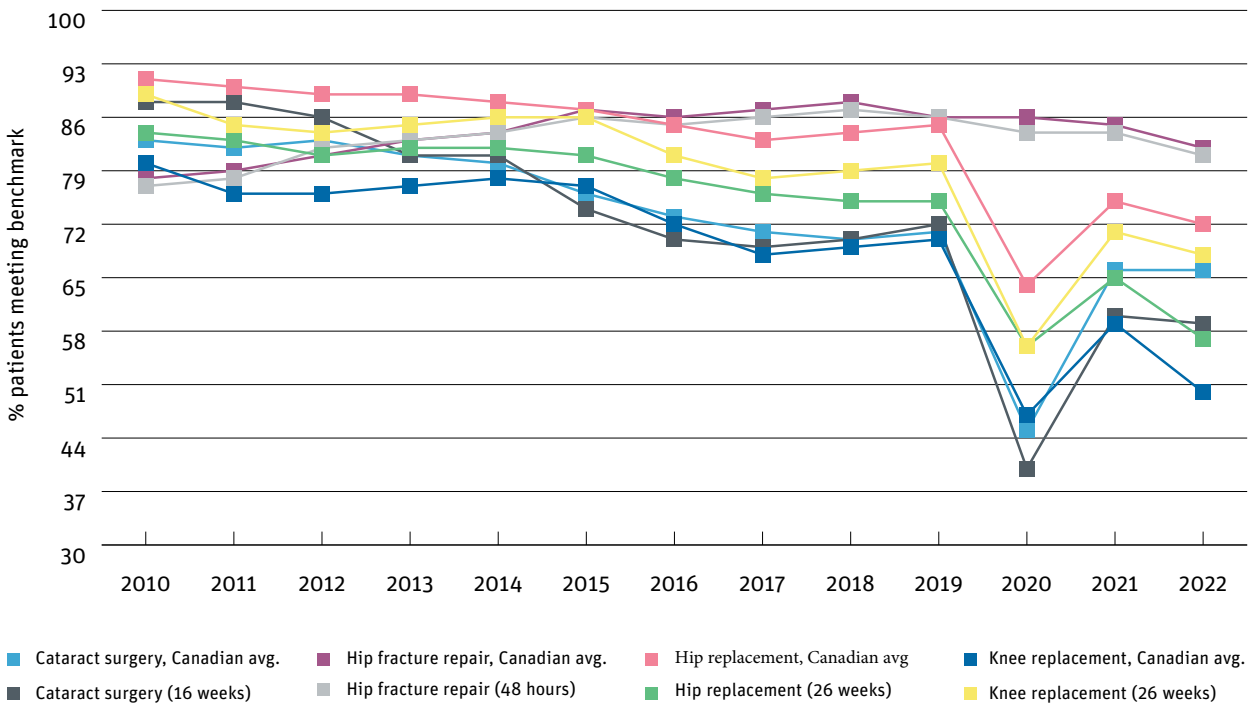
The pandemic created major disruptions to surgical services beginning in 2020. Ontario has made significant progress working down the backlog and reducing wait times, but surgical volumes in 2022 remained slightly below pre-pandemic levels (Table 2). Unlike Prince Edward Island, British Columbia, Nova Scotia, and New Brunswick, Ontario did not increase surgical volumes in 2021 from 2019 levels; on the contrary, volumes in the province fell by 12 per cent.

TABLE 2: Surgical volumes by province (scheduled and unplanned), pre-pandemic and pandemic periods

	Pre-pandemic	Pandemic			% change in surgical volumes		
	Mar-Sep 2019	Mar-Sep 2020	Mar-Sep 2021	Mar-Sep 2022	2019 to 2020	2019 to 2021	2019 to 2022
AB	180,473	138,840	174,315	169,499	-23%	-3%	-6%
BC	249,166	197,924	259,059	217,049	-21%	4%	-13%
MB	58,839	47,916	49,443	49,997	-19%	-16%	-15%
NB	34,592	27,503	34,650	29,362	-20%	0%	-15%
NL	35,768	21,934	32,454	27,541	-39%	-9%	-23%
NS	52,325	36,181	52,964	51,765	-31%	1%	-1%
ON	626,822	399,891	548,499	607,786	-36%	-12%	-3%
PEI	6,490	5,543	6,825	6,630	-15%	5%	2%
QC	305,583	212,103	281,171	N/A	-31%	-8%	N/A
SK	61,387	42,530	57,045	58,580	-31%	-7%	-5%

Source: CIHI, "Surgeries Impacted by COVID-19, March 2020 to September 2022 — Data Tables," March 23, 2023, https://www.cihi.ca/sites/default/files/document/surgeries-impacted-by-covid-19-march-2020-to-sept-2022-data-tables-en.xlsx.
Note: Quebec data are not available for March-September 2022.

FIGURE 1: Percentage of Ontario patients receiving surgery within benchmark for priority procedures, 2009 to 2022



Source: CIHI, "Wait Times for Priority Procedures 2023," data tables, https://www.cihi.ca/sites/default/files/document/wait-times-priority-procedures-in-canada-2023-data-tables-en.xlsx.
Note: These figures constitute Wait 2 (surgery booking to completion) only. To view data in this graph and comparison with Canadian averages, see Appendix B.

Specifically, analysis of wait-time data show:

- In Ontario, the percentage of priority procedure patients meeting the benchmark declined between 2019 and 2022 for all four priority procedures (Figure 1).
- In 2022, 68 per cent of knee replacement patients received their surgery within the benchmark (Table 3).
- In 2022, 72 per cent of hip replacement patients received their surgery within the benchmark (Table 3).
- In 2022, 81 per cent of hip fracture repair patients had their surgery within the benchmark (Table 3).
- In 2022, 59 per cent of cataract surgery patients met the benchmark (Table 3).
- The trend between 2010 and 2022 shows that wait times are increasing in Ontario, but less than the Canadian average (see Appendix B). Ontario has consistently performed above the Canadian average for hip and knee replacements since 2010.

TABLE 3: Percentage of patients receiving surgery within benchmark for priority procedures, 2022

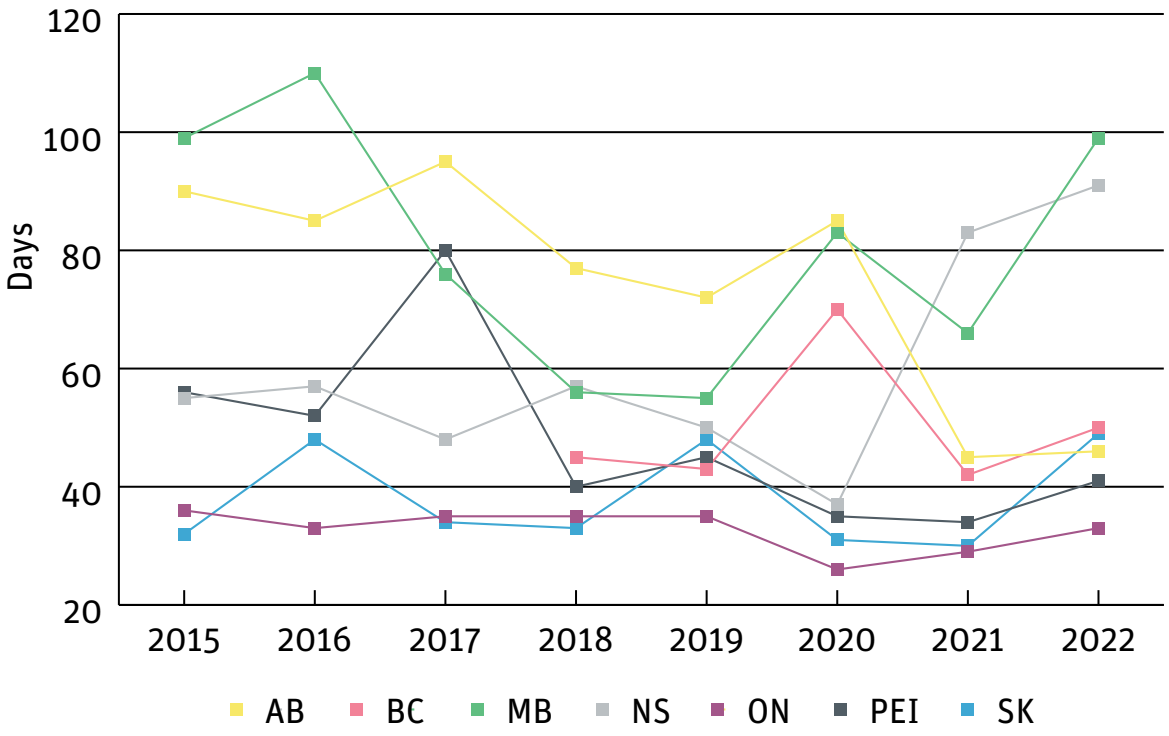
	Hip replacement (26 weeks)	Knee replacement (26 weeks)	Hip fracture repair (48 hours)	Cataract surgery (16 weeks)
Alberta	38%	27%	89%	65%
British Columbia	62%	56%	77%	81%
Manitoba	43%	26%	88%	43%
New Brunswick	38%	28%	82%	62%
Nfld. and Labrador	45%	36%	88%	39%
Nova Scotia	49%	39%	85%	59%
Ontario	72%	68%	81%	59%
Prince Edward Island	53%	36%	91%	40%
Quebec	45%	32%	-	68%
Saskatchewan	34%	23%	81%	63%
Canada	57%	50%	82%	66%

Source: CIHI, "Wait Times for Priority Procedures 2023," data tables, https://www.cihi.ca/sites/default/files/document/wait-times-priority-procedures-in-canada-2023-data-tables-en.xlsx.
Note: These figures constitute Wait 2 (surgery booking to completion) only.

Diagnostic imaging is necessary for many surgical patients and contributes to wait times. In recent years, Ontario has maintained the best performance in the country for MRI and CT waits:

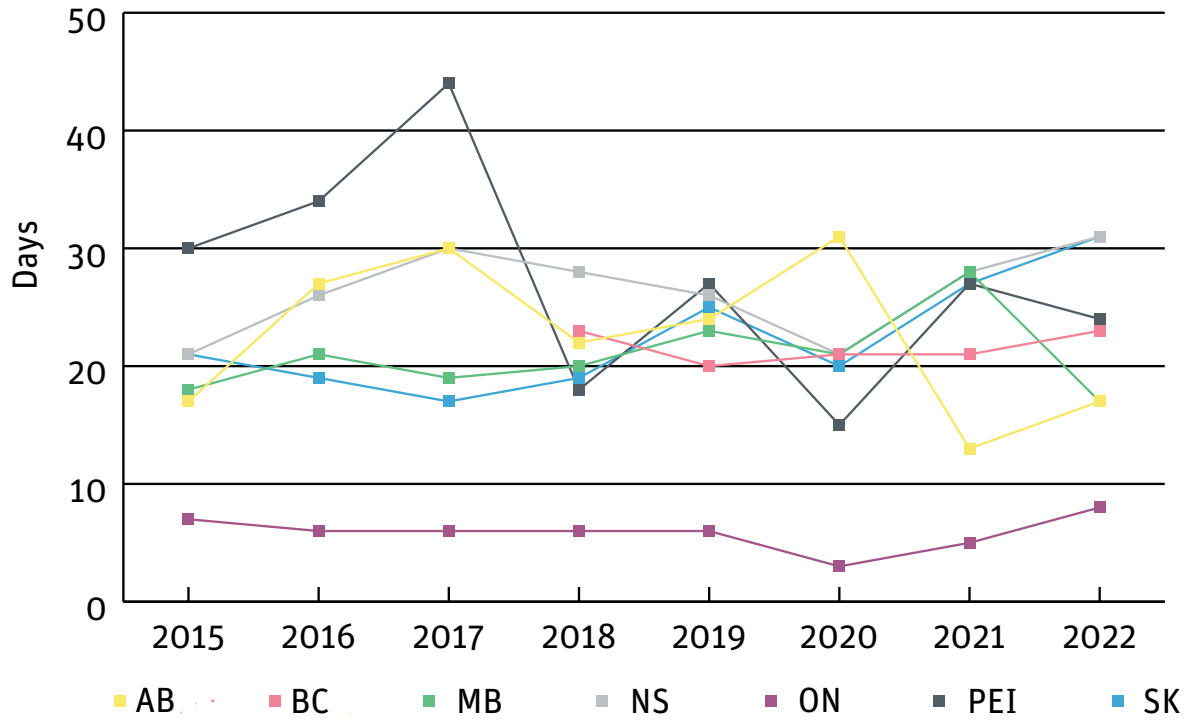
- In 2022, the median wait for an MRI scan was 33 days in Ontario compared to 41 days in P.E.I. (the second-best province) and 99 days in Manitoba, which had the longest median wait (Figure 2). MRI wait times in Ontario have remained stable since 2018, when the median wait was 33 days.
- In 2022, the median wait for a CT scan was eight days in Ontario compared to 17 days in Manitoba and Alberta (tied for second best), and 31 days in Nova Scotia and Saskatchewan, which have the longest median wait (Figure 3). CT wait times in Ontario have remained stable since 2018, when the median wait was six days.

FIGURE 2: MRI scan median wait time in days, 2018 to 2022



Source: CIHI, "Wait Times for Priority Procedures 2023," data tables, https://www.cihi.ca/sites/default/files/document/wait-times-priority-procedures-in-canada-2023-data-tables-en.xlsx.

FIGURE 3: CT scan median wait time in days, 2018 to 2022



Source: CIHI, "Wait Times for Priority Procedures 2023," data tables, https://www.cihi.ca/sites/default/files/document/wait-times-priority-procedures-in-canada-2023-data-tables-en.xlsx.

Ontario has maintained relatively timely and consistent access to these two common types of diagnostic imaging, which are largely delivered in public hospitals, even as other provinces have seen significant increases in median waits. Despite Ontario's superior performance providing timely diagnostic access among the provinces, diagnostic imaging—especially MRI and CT scans—is likely to see the greatest expansion of for-profit delivery under the government's outsourcing plans.

Bill 60 and the expansion of for-profit surgical and diagnostic delivery in Ontario

AS NOTED ABOVE, in August 2022, the Ontario government announced plans to expand the number and types of surgeries and diagnostic tests performed in for-profit facilities. Then, in January 2023, the government announced a three-part, phased approach to increasing for-profit delivery:

- First, the province established new contracts with for-profit facilities in Windsor, Kitchener-Waterloo, and Ottawa to perform 14,000 additional cataract surgeries each year.[4] The government planned to spend an additional $18 million at existing for-profit facilities for "more than 49,000 hours of MRI and CT scans, 4,800 cataract surgeries, 900 other ophthalmic surgeries, 1,000 minimally invasive gynecological surgeries, and 2,845 plastic surgeries such as hand soft tissue repair." When announced in January 2023, the government aimed to have surgical wait lists back to pre-pandemic levels by March 2023.

- Second, the provincial government planned to expand the types of procedures performed in for-profit facilities with a "continued focus on cataracts, as well as MRI and CT imaging and colonoscopy and endoscopy procedures."[5]

- Third, the government introduced new legislation and regulation in February and June 2023 to support an expansion in the types and volume of surgical and diagnostic procedures performed in for-profit facilities, including hip and knee replacements.[6]

On February 21, 2023, the Ontario government introduced Bill 60 (*Your Health Act*), an omnibus bill intended to support the government's policy direction. Bill 60 received Royal Assent on May 18, 2023.[7] Upon review of Bill 60 and analysis by other organizations,[8] the key aspects of the legislation include the following:

- Bill 60 replaces the *Independent Health Facilities Act* (IHFA), which has regulated "independent health facilities" since 1990. The new *Integrated Community Health Services Centres Act* (ICHSCA) provides a new legislative framework that expands the types of procedures performed in independent health facilities (now called "integrated community health services centres") and entrenches these facilities as part of the publicly funded health care delivery system, alongside public hospitals.[9] The government's new term, "integrated community health services centres," is likely to confuse the public with existing "community health centres," which are Ministry-funded, non-profit integrated primary care and social service organizations. For simplicity, this report will refer to "integrated community health services centres" as "for-profit facilities." (The Auditor General of Ontario noted that 98 per cent of independent health facilities are for-profit.[10])

- The ICHSCA director oversees the approval of licences and regulation of for-profit facilities. However, in a change from the IHFA, the ICHSCA director is not required to be an employee of the Ministry of Health, and may be an "individual or other entity."[11]

- The government will continue to use a "call for applications" procurement process whereby proponents submit an application outlining that they seek to obtain a licence to perform the requested services in the identified location(s).[12] The call for applications process requires for-profit facility proponents to submit a description of its staffing model, quality assurance program, existing relationships with other health care providers (i.e., hospitals), and how the facility will integrate with the existing public health system and reduce wait times.[13] The ICHSCA director will then negotiate a transfer payment agreement, with specified terms, volumes, and payment rates, with the provider. If current practice continues, these agreements will not be made public.

- A for-profit facility may offer services, devices, or products that are not insured under the Ontario Health Insurance Plan (OHIP) and, as part of its application, must provide a description of these charges and how patient consent will be obtained.[14]

- "Facility fees" under the IHFA are renamed "facility costs" under the ICHSCA.[15] Only licensed for-profit facilities may charge facility costs to the Minister of Health or a prescribed person, and may not charge patients for facility costs.[16] For-profit facilities must not charge patients fees (extra-bill) for preferential access or withhold insured services because patients are unwilling to pay fees (extra-billing).[17]

- Individuals or corporations convicted of an extra-billing offence (under s. 29) can be fined up to $50,000 for the first offence, and up to $100,000 for the second offence.[18]

- There is no explicit prohibition in the legislation against the practice of upselling patients medical goods or services that are not medically necessary.

- The first new ICHSCA regulation was posted on June 9, 2023, for public comment.[19] It outlines the quality assurance requirements for ICHSCA facilities, recordkeeping and financial accounting requirements, the patient complaint process, and most importantly, identifies the College of Physicians and Surgeons of Ontario (CPSO) as the inspecting body. As it does for existing independent health facilities, the CPSO will assess for-profit facilities for the Ministry of Health. When the government first announced its proposal to expand for-profit surgical delivery in January 2023, the CPSO expressed concerns: "We also shared [with government] that this wasn't the solution to the health-care crisis and would further tax our health human resources shortages and further increase wait times for more urgent hospital-based care."[20]
- Bill 60, in and of itself, does not commit the government to an expansion of for-profit surgical and diagnostic delivery. However, the government has been clear that the legislation will support the government's policy direction of expanding for-profit involvement.

How many publicly funded procedures are performed in for-profit facilities—and at what cost?

SINCE THE 1990S, for-profit surgical and diagnostic medical imaging facilities have largely been regulated and funded as independent health facilities. As of January 2023, there were 902 IHFs offering 2,226 services in Ontario, with diagnostic imaging representing 81 per cent of total services provided in IHFs (Table 4). Ten IHFs provide publicly funded surgical services (seven involving plastic surgery, two ophthalmology, and one obstetrics/gynecology. There are three publicly funded private hospitals; two perform surgeries (Shouldice Hospital and Don Mills Surgical Unit) and one offers substance-use services.[21]

Independent health facilities are either OHIP-funded as "fee-for-service" facilities or through a transfer payment agreement. Fee-for-service facilities submit billings to the Ministry of Health based on the Schedule of Facility Fees for Independent Health Facilities.[22] Diagnostic radiology (x-ray), nuclear medicine, ultrasound, pulmonary function studies, and sleep studies procedures may have facility fees billed fee-for-service. Surgeries,

MRIs, CT scans, PET scans, and other services (e.g., dialysis, midwifery, obstetrics/gynecology) cannot be billed as "fee-for-service" and require a transfer payment agreement, which serves as a contract between the IHF and the ministry, with terms and payment rates negotiated individually. These agreements contain terms, volumes, and payment amounts per procedure that may differ between facilities and are not publicly disclosed. In 2022-23, there were only 18 IHFs with transfer payment agreements for surgical services and medical imaging—all others bill OHIP on a fee-for-service basis.

TABLE 4: Type of service provided as percentage of total services provided in independent health facilities (*n*=2,226), January 2023

Imaging	80.86%
Diagnostic test	18.19%
Surgical	0.63%
Dialysis	0.18%
Midwifery	0.09%
Obstetrics/Gynecology	0.04%

Source: Ministry of Health, "2023 Facility Address with Licensee 06-01-2023,"custom request.

The Ontario government provides very limited public data on publicly funded, independent health facilities and private hospitals. Therefore, multiple Freedom of Information (FOI) requests were made to the Ministry of Health.[23] Analysis of data obtained by FOI request shows the following:

- The volume of publicly funded surgical procedures and medical imaging performed in for-profit facilities has remained relatively stable in recent years. The number of surgeries performed in IHFs increased from 17,473 in 2017-18 to 18,933 in 2021-22 (by eight per cent), while the number of medical imaging services remain unchanged (Table 6). Over the same period, surgical activity declined by 13 per cent in public hospitals, while medical imaging volumes increased by 16 per cent (Table 6). (2020-21 and 2021-22 include pandemic-related service disruptions.)
- Between 2012-13 and 2021-22, the number of surgical procedures performed in IHFs increased from one per cent to 1.3 per cent of the total volume of surgeries performed in Ontario (Table 5). In 2021-22,

98.7 per cent of surgical procedures were performed in public hospitals. (The share of surgeries performed in public hospitals is slightly lower since the above figures do not include surgeries performed in private hospitals.)[24]

- In 2021-22, public Operating Room (OR) surgical volumes were below pre-pandemic levels (down 13 per cent from 2017-18), suggesting that provincial funding and staffing shortages continue to challenge hospitals, despite the government's plans to increase surgical activity in for-profit facilities (Table 6).

- In 2021-22, for-profit surgical and medical imaging was a half-billion-dollar industry in Ontario (out of a nearly $76 billion health budget). Despite relatively stable volumes, public payments to for-profit facilities (both IHFs and private hospitals) increased from $474.6 million in 2017-18 to $513.8 million in 2021-22—or by eight per cent (Table 7). Payments for surgeries increased by 45 per cent from 2017-18 to 2021-22, while payments for medical imaging increased by five per cent. (Public payments to for-profit facilities do not include individual OHIP physician billings called "professional fees." Payments contained in Table 7 only constitute the "facility fee" paid to the facility.)

- By dollar value, for-profit medical imaging facilities receive the largest share of public funding— $458.6 million in 2021-22 (Table 7). Of these, ultrasound and diagnostic radiology (x-ray) received the largest share of public payments.

- Ophthalmologic procedures (mainly cataract surgeries) were the highest-volume surgical procedure performed in IHFs in 2021-22 and attracted the greatest public payment in dollar terms among surgical procedures, followed by procedures performed at two private hospitals that provide publicly funded surgical procedures.

- There are only two private hospitals under contract to perform publicly funded surgical procedures. Shouldice Hospital performs hernia repairs and Don Valley Surgical Unit performs a variety of procedures, which received $8.26 million and $4.97 million, respectively, in 2021-22 (Table 7). Payments to Shouldice Hospital and Don Valley Surgical Unit increased by 19 per cent and 278 per cent, respectively, between 2017-18 and 2021-22. Data on the types

and volumes of surgeries performed were not readily available by FOI request from the Ministry of Health.

- Public payments to for-profit facilities cannot be accurately and completely accounted for in Ontario's Public Accounts. The Treasury Board Secretariat produces detailed annual expenditure reporting, including transfer payments to non-government service providers, which includes IHFs and private hospitals. The Public Accounts significantly underreport public payments to IHFs. In 2021-22, the Public Accounts report $68.5 million transferred to IHFs (facility fees only) while expenditure reporting obtained by FOI puts payments to IHFs (facility fees only) at $474.1 million (Table 8). In 2021-22, the Ontario government underreported payments to for-profit facilities by 720 per cent— and more in previous years. The significant discrepancy is due to a misleading accounting practice whereby the Public Accounts only include payments to IHFs with a transfer payment agreement while excluding the majority of payments to fee-for-service IHFs that do not have such agreements with the Ministry of Health. (Payments to private hospitals can be retrieved by name in the detailed schedule of payments, but are not specifically identified as an expenditure category in the Public Accounts.)

TABLE 5: Publicly funded surgical procedures performed in Ontario public hospitals and independent health facilities, 2012-13 to 2021-22

	Public hospitals		Independent health facilities		Total procedures
	Number	Share of total	Number	Share of total	
2012-13	1,534,167	99.0%	15,229	1.0%	1,549,396
2013-14	1,535,249	98.9%	16,670	1.1%	1,551,919
2014-15	1,555,658	98.9%	16,952	1.1%	1,572,610
2015-16	1,579,548	99.0%	16,485	1.0%	1,596,033
2016-17	1,612,417	98.9%	17,332	1.1%	1,629,749
2017-18	1,619,305	98.9%	17,473	1.1%	1,636,778
2018-19	1,649,506	98.9%	17,906	1.1%	1,667,412
2019-20	1,624,580	99.0%	16,537	1.0%	1,641,117
2020-21	1,286,866	98.8%	16,136	1.2%	1,303,002
2021-22	1,417,622	98.7%	18,933	1.3%	1,436,555

Source: Author's calculations from FOI releases: Ministry of Health, "A-2022-00318," March 8, 2023, and "A-2023-00082," June 21, 2023.
Note: Total procedures excludes procedures performed in Shouldice Hospital and Don Mills Surgical Unit, the only two private hospitals in Ontario performing publicly insured procedures.

TABLE 6: Volumes of publicly funded procedures in independent health facilities and public hospitals, 2017-18 to 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Change (%), 2017-18 to 2021-22
Independent Health Facilities (IHF)						
Ophthalmology	13,948	14,101	13,222	13,222	14,933	7.1%
Plastic surgery	2,925	3,255	2,715	2,987	3,400	16.2%
Obstetrics/gynecology	600	550	600	600	600	0.0%
Total surgical procedures	17,473	17,906	16,537	16,809	18,933	8.4%
% annual change		2.5%	-7.6%	1.6%	12.6%	
Diagnostic radiology	4,299,068	4,387,488	4,265,076	2,881,347	3,898,015	-9.3%
Diagnostic ultrasound	5,404,872	5,622,547	5,565,733	4,701,198	5,689,723	5.3%
Nuclear medicine	462,436	509,188	554,345	488,676	583,362	26.1%
Pulmonary function studies	220,822	221,600	223,654	133,217	210,750	-4.6%
Sleep studies	139,527	143,286	141,497	80,795	109,293	-21.7%
CT	15,940	16,627	20,826	27,541	28,873	81.1%
PET/CT	695	-	-	-	-	-
MRI	39,993	43,644	47,320	46,400	60,882	52.2%
Total medical imaging	10,583,353	10,944,380	10,818,451	8,359,175	10,580,898	0.0%
% annual change		3.4%	-1.2%	-22.7%	26.6%	
Public hospitals						
Total surgical procedures (inpatient & day)	1,619,305	1,649,506	1,624,580	1,286,866	1,417,622	-12.5%
% annual change		1.9%	-1.5%	-20.8%	10.2%	
Total medical imaging (MRI & CT only)	2,653,749	2,785,214	2,851,695	2,699,318	3,087,269	16.3%
% annual change		5.0%	2.4%	-5.3%	14.4%	

Sources: Author's calculations from FOI releases: Ministry of Health, "A-2022-00318," March 8, 2023, and "A-2023-00082," June 21, 2023.
Notes: Payments to IHFs only constitute the facility fee and do not include OHIP payments (professional fees) to physicians.

TABLE 7: Public payments for publicly funded procedures in independent health facilities and private hospitals, 2017-18 to 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Change (%), 2017-18 to 2021-22
Independent Health Facilities (IHF)						
Ophthalmology	$11,004,332	$11,320,196	$10,678,512	$11,147,935	$12,808,542	16.4%
Plastic surgery	$1,882,700	$2,473,000	$1,468,749	$2,225,857	$2,235,332	18.7%
Obstetrics/gynecology	$420,156	$420,156	$420,156	$420,156	$420,156	0.0%
Diagnostic radiology (x-ray)	$118,976,530	$121,107,755	$118,101,669	$81,269,017	$112,713,363	-5.3%
Diagnostic ultrasound	$209,974,445	$216,925,719	$214,166,323	$188,935,003	$225,855,619	7.6%
Nuclear medicine	$41,390,613	$45,220,169	$48,305,847	$43,927,973	$52,822,699	27.6%
Pulmonary function studies	$3,287,224	$3,260,803	$3,332,454	$2,077,731	$3,307,303	0.6%
Sleep studies	$50,919,403	$52,257,373	$51,738,236	$30,598,698	$41,411,617	-18.7%
CT	$2,613,430	$3,361,562	$3,049,803	$4,753,270	$4,757,159	82.0%
PET/CT	$918,500.00	-	$18,354.00	-	-	
MRI	$8,424,333	$8,555,254	$9,034,869	$11,902,161	$17,771,143	111.0%
Total IHF	**$449,811,665**	**$464,901,986**	**$460,314,972**	**$377,257,800**	**$474,102,934**	**5.4%**
Private hospitals						
Don Valley Surgical Unit (multi-surgical)	$1,316,500	$1,316,500	$1,316,500	$3,316,100	$4,979,400	278.2%
Shouldice Hospital (hernia repair)	$6,945,600	$6,945,600	$6,945,600	$7,944,800	$8,266,400	19.0%
Total private hospitals	**$8,262,100**	**$8,262,100**	**$8,262,100**	**$11,260,900**	**$13,245,800**	**60.3%**
IHFs and private hospitals						
Surgical procedures	$38,093,488	$38,999,651	$37,353,716	$47,576,648	$55,201,430	44.9%
% annual change		2.4%	-4.2%	27.4%	16.0%	
Medical imaging	$436,504,477	$450,688,634	$447,747,556	$363,463,852	$458,638,904	5.1%
% annual change		3.2%	-0.7%	-18.8%	26.2%	
Total surgical & medical imaging in IHFs and private hospitals	$474,597,965	$489,688,286	$485,101,272	$411,040,500	$513,840,334	8.3%
% annual change		3.2%	-0.9%	-15.3%	25.0%	

Sources: Author's calculations from FOI releases: Ministry of Health, "A-2022-00318," March 8, 2023, and "A-2023-00082," June 21, 2023. Payments to Don Valley Surgical Unit and Shouldice Hospital are extracted from Treasury Board Secretariat, Public Accounts of Ontario, Ministry Statements and Schedules, Ministry of Health, Ontario Health Insurance Program, Details of Expenses and Assets by Items and Accounts Classification, various years.
Notes: Don Valley Surgical Unit (Clearpoint Health Network) and Shouldice Hospital are the only contracted private hospitals that perform publicly funded surgeries. Payments to IHFs and private hospitals only constitute the facility fee and do not include OHIP payments (professional fees) to physicians.

TABLE 8: Underreporting of public payments to independent health facilities in Ontario, 2017-18 to 2021-22

	Payments to IHFs reported in Public Accounts	Payments to IHFs disclosed by FOI	% Public Accounts underreport payments
2017-18	49,295,978	449,811,665	912%
2018-19	52,222,420	464,901,986	890%
2019-20	51,105,979	460,314,972	901%
2020-21	56,042,326	377,257,800	673%
2021-22	65,801,984	474,102,934	720%

Sources: "Payments to IHFs reported in Public Accounts" are extracted from Treasury Board Secretariat, Public Accounts of Ontario, Ministry Statements and Schedules, Ministry of Health, Ontario Health Insurance Program, Details of Expenses and Assets by Items and Accounts Classification, various years. "Payments to IHFs disclosed by FOI" obtained by Ministry of Health FOI requests A-2022-00318 and A-2023-00082.

Problems with the expansion of for-profit surgical and diagnostic delivery

THE ACADEMIC RESEARCH literature and policy experience with for-profit delivery shows that it worsens public-sector staffing shortages and destabilizes hospitals, and that it is generally more expensive, lower quality, and less safe.[25] By adding an Ontario focus, this report builds on recent reviews of the research literature and policy experience with for-profit delivery in Canada.[26]

For-profit delivery worsens public sector staffing shortages and destabilizes public hospitals

When surgeries and diagnostics are outsourced, the public and for-profit sectors compete for a limited pool of specialized health-care professionals. The private sector may offer incentives to attract health care workers from the public system, such as reduced workloads, less complex patients, and higher pay. The Ontario government's plan to outsource procedures that have greater anesthesia and nursing requirements, including hip and knee

replacements, means that there will be a greater demand on the same limited pool of specialized professionals that are in short supply in public hospitals.[27]

The destabilizing effect of for-profit surgical delivery on public hospitals is borne out by the Alberta experience. In that province, a new study found that as surgical activity in the for-profit sector increased by 48 per cent between 2018-19 and 2021-22, hospital surgical volumes declined by 12 per cent over the same period.[28] At the same time, public hospitals experienced a reduction in the number of staffed medical and surgical beds for patients requiring inpatient surgery.

The Ontario government's plan to expand for-profit surgical and diagnostic delivery comes at a time of widespread hospital staffing shortages, as reported by media, unions, and hospitals. The most recent available data from the Canadian Institute for Health Information signals a worrisome situation. Between 2019-20 and 2020-21, Ontario hospital ORs lost 122 full-time equivalent staff (Table 9)—the only part of Ontario hospitals to experience a decline.[29] Although this includes spring 2020, when ORs paused surgeries (and likely shifted staffing), it stands in contrast to B.C. where OR staffing levels, in fact, increased by 3.6 per cent in 2020-21.[30]

TABLE 9: Ontario hospital operating room (OR) full-time equivalent (FTE), 2011-12 to 2020-21

	FTE	% annual change
2011-12	6,461	
2012-13	6,531	1.1
2013-14	6,556	0.4
2014-15	6,625	1.0
2015-16	6,646	0.3
2016-17	6,767	1.8
2017-18	6,920	2.3
2018-19	7,100	2.6
2019-20	7,131	0.4
2020-21	7,009	-1.7

Source: CIHI, "Trends in Hospital Spending, 2009–2010 to 2020–2021 — Data Tables — Series E: Hospital Calculated Full-Time Equivalents by Service Area," September 2022 release.

A new for-profit delivery model within Ottawa Hospital also suggests that greater parallel, private delivery is exacerbating nursing shortages. An undisclosed contract between the Ottawa Hospital and a private group of orthopedic surgeons to perform publicly funded surgeries on Saturdays has raised concern that for-profit delivery is causing staffing shortages.

The arrangement is unique because rather than outsourcing surgeries to a for-profit facility, the public hospital is contracting with a private surgical group to use the public hospital OR. While neither the Ottawa Hospital nor the Academic Orthopedic Surgical Associates of Ottawa (AOAO) have disclosed the terms of the contract (which began in February 2023), the AOAO reportedly offered OR nurses double their normal wages.[31] One of the two ORs open for urgent and emergency surgeries had to close one Saturday in May 2023 because a staff member called in sick—signalling just how precarious the staffing situation has become.[32] Meanwhile, the hospital's OR, used by the AOAO for contracted orthopedic surgeries, ran as scheduled, raising concerns that the arrangement is contributing to hospital staff shortages. Commenting on the arrangement, David Urbach, head of surgery at Women's College Hospital, stated that "it would be a much better strategy for Ontario to maximize delivery of surgery in our existing public hospitals."[33]

Increased for-profit delivery risks more unlawful extra-billing and two-tier health care

Arguments in favour of for-profit delivery are often based on the claim that contracted facilities will not engage in unlawful extra-billing (also called two-tier health care), which is contrary to Ontario legislation (*Commitment to the Future of Medicare Act* and *Integrated Community Health Services Centres Act*) and the *Canada Health Act*. Extra-billing is an unlawful practice whereby clinics or physicians bill patients privately for medically necessary procedures that are already insured by OHIP. However, the distinction between publicly funded for-profit delivery (at no cost to the patient) and private payment (where patients are charged to "jump the queue") cannot be easily separated. Evidence shows that for-profit clinics and surgical chains are entrenching two-tier health care in Canada through unlawful extra-billing practices.[34]

The B.C. case is instructive, where a well-established for-profit surgical and diagnostic sector has grown from both government outsourcing and unlawful extra-billing in violation of provincial legislation and the *Canada*

Health Act.[35] In 2020, Health Canada reported that six for-profit surgical facilities were audited by the B.C. government in 2016-17 and found to have engaged in an estimated $14.4 million of unlawful extra-billing, including Cambie Surgical Centre ($4.7 million in extra-billing), the longstanding private clinic at the centre of the landmark constitutional challenge.[36] In total, between 2016-17 and 2020-21, B.C. reported $83.3 million of unlawful extra-billing—the most of any province—due to the large for-profit surgical and diagnostic industry in the province (Table 10).

Previous research shows that at least three for-profit surgical providers—False Creek Healthcare Centre, Kamloops Surgical Centre, and Surgical Centres Inc.—were audited by the B.C. government and found to have engaged in unlawful extra-billing at the same time those providers held contracts for insured services with B.C. health authorities (and for Surgical Centres Inc., a contract with Alberta Health Services as well).[37] These cases serve as a cautionary tale for Ontario:

- Toronto-based Clearpoint Health Network owns False Creek Healthcare Centre in Vancouver, which received $12.2 million in B.C. health authority payments between 2015-16 and 2020-21. Under its previous owner, the facility was audited by the B.C. government, found to have engaged in unlawful extra-billing, and had its health authority contract terminated.[38] B.C.'s two largest regional health authorities renewed contracts with the False Creek Healthcare Centre after it was acquired by Clearpoint Health Network, which is wholly owned by Kensington Capital Partners. Kensington Capital acquired Centric Health surgical facilities in 2019, including Don Mills Surgical Unit.[39] In February 2023, CBC revealed that Clearpoint Health Network is exploiting an apparent loophole in provincial legislation and the *Canada Health Act* by charging patients up to $28,000 to have san orthopedic surgery performed in another province.[40]

- Kamloops Surgical Centre received $15,406,530 in public payments between 2015-16 and 2020-21, despite a 2018 B.C. government audit revealing unlawful extra-billing estimated to be $490,414 between 2016-17 to 2017-18.[41] The health authority continued to outsource surgeries to the clinic during and after the period of unlawful extra-billing.

- Calgary-based Surgical Centres Inc. engaged in unlawful extra-billing in B.C. during the same time it held outsourcing contracts with Alberta Health Services and B.C. health authorities. In B.C., three Surgical Centres Inc. facilities were audited by the B.C. government, with extra-billing estimated at $2.1 million between 2015-16 and 2020-21.[42]

Between 2015-16 and 2020-21, Surgical Centres Inc. received the second-largest amount of public funds for surgical outsourcing in B.C.[43] Alberta Health Services held a contract with Surgical Centres Inc. valued at $155 million between 2012-13 to 2021-22.[44] The B.C. government purchased Surgical Centres Inc. facilities in Victoria and Nanaimo, B.C., in 2022, bringing them into the public system, reportedly because their ORs were underutilized. Then, in January 2023, Clearpoint Health Network acquired Calgary-based Surgical Centres Inc.[45]

TABLE 10: Canada Health Transfer deductions for extra-billing (in dollars), 2016-17 to 2020-21

	2016-17	2017-18	2018-19	2019-20	2020-21		Total, 2016-17 to 2020-21
					Deductions under DSP	Total	
BC	16,177,259	16,753,833	13,949,979	13,275,823	17,165,309	23,110,531	83,267,425
QC	8,256,024	unavailable	unavailable	unavailable	41,867,224	41,867,224	50,123,248
AB	0	0	0	0	13,781,152	13,781,152	13,781,152
NB	0	0	0	0	1,277,659	1,342,509	1,342,509
NS	0	0	0	0	1,277,659	1,277,659	1,277,659
SK	0	0	0	0	742,447	742,447	742,447
MB	0	0	0	0	353,827	353,827	353,827
NFLD	1,349	70,819	4,521	1,723	0	0	78,412
ON	0	0	13,905.00	6,560	0	32,800	53,265
PEI	0	0	0	0	0	0	0
Total	**24,434,632**	**16,824,652**	**13,968,405**	**13,284,106**	**76,465,277**	**82,508,148**	**151,019,943**

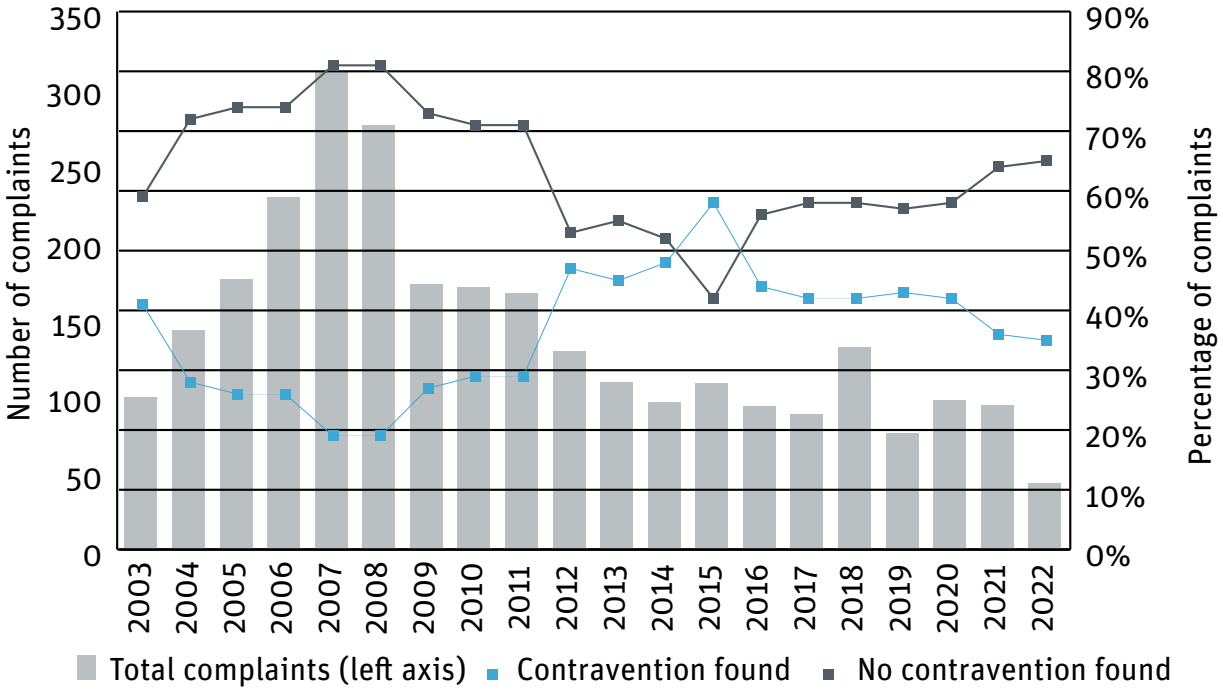
Sources: Health Canada, *Canada Health Act Annual Reports*, various years (2016-17 to 2020-21); Health Canada, "Canada Health Act transfer deductions and reimbursements – March 2023," backgrounder, March 10, 2023.
Notes: Deductions under DSP (Diagnostic Services Policy) refer to deductions for patient charges levied for medically necessary diagnostic imaging. The DSP took effect April 1, 2020 with deductions beginning in March 2023. Under the *Canada Health Act* reimbursement policy, mandatory deductions may be reimbursed provided a province carries out a Reimbursement Action Plan to eliminate the patient charges and the circumstances that led to them. A reimbursement of $15,556,669 to B.C. under the CHA reimbursement policy has been made, which represents a partial reimbursement of its March 2021, March 2022, and March 2023 deductions.

The Ontario government's proposed expansion of the for-profit surgical and diagnostic industry raises concerns about ongoing unlawful extra-billing occuring in these facilities in contravention of the *Commitment to the Future of Medicare Act* and *Integrated Community Health Services Centres Act*. Analysis of data obtained by FOI shows that extra-billing in for-profit facilities remains a problem in Ontario.

Patients can make complaints to the Ministry of Health's Commitment to the Future of Medicare or Independent Health Facility programs if patients believe they have been unlawfully charged. The Ministry of Health does not publicly report complaints or validated contraventions; therefore, data were obtained by FOI request. The ministry withheld facility and provider names, claiming commercial confidentiality that would "prejudice [their] competitive position." Analysis of the FOI results shows the following[46]:

- In 2022, there were 43 complaints related to the *Commitment to the Future of Medicare Act*, of which 35 per cent were verified contraventions (Figure 4). Although the number of total complaints has fallen to historic lows, the share of total complaints found to be contraventions has not fallen below 30 per cent in the last five years.
- From 2003 to 2022, patients have been reimbursed a total of $3,606,518 for unlawful extra-billing under the *Commitment to the Future of Medicare Act*.
- Since 2010, the Independent Health Facilities program has completed 13 extra-billing audits (one audit outstanding) and patients have been reimbursed a total of $14,681 in unlawful extra-billing under the *Independent Health Facilities Act*.
- In total, between 2003 and 2022, patients have been reimbursed $3,621,199 for unlawful extra-billing under Ontario legislation.
- The Ministry of Health maintains a complaint-driven enforcement regime for unlawful extra-billing. This approach likely results in a conservative estimate of the amount of unlawful extra-billing in Ontario. Research by the Ontario Health Coalition that included surveys of for-profit clinics found evidence of unlawful extra-billing in for-profit clinics,[47] which demonstrates the importance of the Ministry of Health moving to a pro-active enforcement regime, with random and unannounced spot audits and stronger public education.

FIGURE 4: Percentage of extra-billing complaints with contraventions found, Ontario, 2003 to 2022



Source: Author's calculations from Ministry of Health FOI request A-2023-00075.
Note: Total complaints include closed audits only (all 2023 complaints remain outstanding). These complaints only include complaints and contraventions under the *Commitment to the Future of Medicare Act*, and exclude 14 completed and outstanding audits for extra-billing contraventions under the *Independent Health Facility Act* since 2010.

Increased for-profit delivery risks entrenching for-profit hospitals in Canada

Now that Ontario—the largest surgical and diagnostic outsourcing market in Canada—is expanding for-profit involvement, there is a much greater risk of entrenching a for-profit, corporate hospital sector in Canada. The market value for surgeries and medical imaging outsourcing is significant in Canada—the Ontario market alone for outsourcing was $513.8 million in 2021-22.

Manitoba, New Brunswick, Nova Scotia, and Quebec use—or plan to expand—for-profit facilities for publicly funded surgeries and medical imaging. As the for-profit surgical and diagnostic sector grows in this country—especially with the creation of a potential $600-million market for hip and knee replacements in Ontario—there is a serious risk that powerful corporate chains will emerge, similar to the experience in Canada's long-term care sector.[48]

An example is the Clearpoint Health Network, a national private equity-owned surgical chain with 14 facilities and 53 ORs that seeks to become a permanent fixture in health care delivery. Clearpoint Health Network's January 2023 acquisition of two regional chains—Calgary-based Surgical Centres Inc. and Quebec-based Chirurgie Dix30—signals growing investor interest and corporate concentration. While Clearpoint contracts with provinces to perform publicly funded surgeries, it also charges patients more than $20,000 per orthopedic surgery by exploiting an apparent loophole in the *Canada Health Act*.[49]

Over the long-term, there is likely to be interest from U.S. investors, and there is already evidence of growing U.S. investor interest. In May 2023, the B.C. Health Coalition, Friends of Medicare (Alberta), and Ontario Health Coalition received emails from the Marwood Group—a large U.S. health care investment advisory firm—asking questions about long-term investment prospects in B.C., Alberta, and Ontario (see Appendix C). The author of this report and B.C. Health Coalition staff took a Zoom call with a representative from the Marwood Group to better understand the information they were seeking. Based on the information the Marwood Group sought, it seems they have U.S. clients with potential health care investment interest in Canada.

As investor-owned corporations, including chains, increase their involve-ment in publicly funded health care delivery in Canada, patient safety and care quality are likely to be compromised. Once entrenched, for-profit corporate chains may form powerful lobby groups—as they have in England, Australia, and the U.S.—that effectively set the prices for government outsourcing as the public system loses its capacity to deliver these services. The chains may oppose the introduction of higher quality and public reporting standards and may use legal and lobbying strategies in an attempt to erode the *Canada Health Act* and pave the way for private health insurance for surgical care, much like Cambie Surgeries Corporation has sought in B.C.[50]

For-profit delivery costs more

The cost-efficiency of public sector delivery compared to for-profit delivery is supported by the peer-reviewed evidence and the experience in other provinces. In April 2023, government data obtained under Freedom of Information revealed that Quebec paid up to 2.5 times more for procedures performed in for-profit clinics compared those performed in public hospitals in 2019-20.[51] As well, in B.C., the workers' compensation system (WorkSafeBC)

often uses private clinics for expedited surgeries. A 2011 study published in *Healthcare Policy* found that WorkSafeBC paid 375 per cent more for an expedited knee meniscectomy in a private clinic ($3,222) than it would have cost for a non-expedited surgery in a public hospital ($859), despite worse return-to-work outcomes for patients receiving private-sector surgery.[52]

The for-profit delivery of publicly funded surgeries is a form of public-private partnership (P3) whereby facility capital costs are negotiated into the per-unit procedure price. This is attractive to provincial governments because costs are only expressed as operating expenditures, rather than capital debt, with the private sector financing the capital asset (at a higher borrowing cost than what is available to government). A review of the Canadian and international evidence on the cost efficiency of P3s found the following disadvantages of P3s in terms of value for money for taxpayers: P3s have higher financing costs and higher private-sector transaction costs and risks; private-sector profit margins are built into contracts and are a cost to the government; and significant (and often unaccounted-for) "transaction costs" are borne by the government to initiate, negotiate, and manage the P3 relationship over the life of the contract.[53]

Unlike other P3 arrangements where the government assumes ownership over the capital asset at the end of the contract term, Ontario's approach to outsourcing surgeries means that the public has helped pay for the for-profit facility and equipment but investors own it. Thus, the benefits of asset ownership are exclusively realized by the private sector. As well, this P3 model means provincial governments have no guarantee that these assets—paid for with public dollars—will remain available to the public system should other revenue streams become more lucrative (e.g., private-pay patients).

Financial conflict of interest in medical decision-making may lead to upselling, self-referrals, and clinically unnecessary procedures

When surgical care or diagnostic testing is provided by a for-profit facility owned by physicians and/or investors, medical decision-making is much more susceptible to conflict of interest, leading to upselling of medical goods and services and clinically unnecessary surgeries and testing. There are at least three concerning practices that result from financial conflicts of interest in health care:

- *Upselling* of medical goods or services that are not medically necessary remains a significant concern with the expansion of profit-motivated facilities in Ontario. In 2021, the Auditor General of Ontario found that there is "no provincial oversight to protect patients against inappropriate charges for publicly funded surgeries."[54] Upselling is common for patients undergoing cataract surgery. Although cataract surgery is fully insured by OHIP, patients may be asked or coerced to pay for a premium eye lens or testing that is not covered by OHIP. In this case, patients are required to pay the difference between the standard OHIP-insured lens and the premium lens as well as any uninsured testing. The auditor general noted that "[s]ome clinics also indicated that specialty lenses are or may be mandatory depending on the surgeon's assessment, which is misleading since all patients have the right to receive publicly funded cataract surgery without paying extra costs for any add-ons."[55] There is an unequal power relationship between patients and physicians, where patients may be reluctantly coerced into paying out-of-pocket. A CBC investigation found that one woman was upsold close to $8,000 for appointments, equipment, and procedures that were not medically necessary. When the patient questioned the ophthalmologist, she was told to leave.[56]

- Self-referral is a practice whereby physicians refer patients to facilities that they own or where they have a financial interest. In a 2014 report, the auditor general noted that about half of independent health facilities were owned or controlled by physicians, and that the Ministry of Health was not actively monitoring whether physicians are referring patients to their own or related facilities:

  > Although the Ministry estimates that about 50% of facilities are owned or controlled by physicians, it has not analyzed the patterns of physicians referring patients to their own or related persons' facilities. In our 2012 report, we noted evidence of overuse of diagnostic imaging tests, particularly when a physician self-refers for such tests. Further, many patients assume they must go to the facility on their physician's referral form, when in fact they can choose a hospital or any facility that offers the required service.[57]

  The auditor general has not since followed up on its 2014 update. However, Bill 60 (the new ICHSCA) does not include language to prevent or restrict the practice of self-referrals when the referring physician has a financial conflict of interest. More recently, in 2021,

the auditor general also raised concerns that there are surgeons with "significantly high or unreasonable billings related to outpatient surgeries" but that there is no provincial oversight.[58]

- Procedures are clinically unnecessary if they provide little or no diagnostic or treatment benefit, are risky, may cause harm, or result in the deterioration in a patient's health status. In Canada, up to 30 per cent of medical and surgical interventions are potentially unnecessary.[59] When outsourcing surgeries and diagnostics, governments may face increased costs because for-profit providers and/or physician owners have a financial incentive to selectively offer and perform more profitable procedures even if they are not clinically necessary.[60] The overuse of surgeries and diagnostic testing also poses risks to patient safety and care quality.

In Ontario, as in other provinces, there is no requirement that physicians publicly disclose their conflicts of interest to patients or regulators. Therefore, the public is at a significant disadvantage in understanding whether physicians have conflicts of interest and how this may influence their medical decision-making.

Risks to patient safety and care quality

Evidence from Canada and internationally shows that private, for-profit health-care delivery is generally less safe and provides lower-quality care.[61] Much of the research comes from the U.S. and England, where for-profit clinics, surgery centres, and hospitals are widespread. When health-care facilities are profit-motivated, they must find ways to reduce costs and return profits to investors. The primary strategy among for-profit hospitals, ambulatory care facilities, and long-term care homes in Canada and U.S. is to maintain lower staffing levels and fewer highly skilled personnel per bed.[62] In turn, hospitals with fewer skilled personnel per hospital bed are associated with higher mortality rates.[63]

Patient safety may be sacrificed in order to generate profits for investors. In a major paper for the *Canadian Medical Association Journal*, P.J. Devereaux and colleagues compared mortality rates for 26,000 for-profit and non-profit hospitals, serving 38 million patients in the U.S., and concluded that "private for-profit ownership of hospitals, in comparison with private not-for-profit ownership, results in a higher risk of death for patients."[64] The researchers

raised concerns about the negative health outcomes if governments open the door to for-profit hospitals in Canada.

Currently, there is no public reporting of complications or serious incidents in for-profit facilities or transfers in Ontario, or private surgical centres anywhere in Canada, but international evidence is sobering. An estimated 82 for-profit hospitals in England were responsible for £250 million in extra costs to the public system over three years, as patients were transferred to public hospitals due to complications in private hospitals.[65]

A growing body of research shows the risks of outsourcing health services to the for-profit sector. In a 2022 study by University of Oxford researchers published in the *Lancet Public Health* journal, researchers concluded that "private sector outsourcing [in England] corresponded with significantly increased rates of treatable mortality, potentially as a result of a decline in the quality of health-care services."[66] England has a well-established for-profit surgical sector where a growing share of surgeries are performed, including 27 per cent of trauma and orthopedic surgeries in 2021-22.[67]

Recommendations

CANADA HAS BEEN called "a country of perpetual pilot projects."[68] In 2006, the federal government's advisor on wait times released a comprehensive report with recommendations on how governments can reduce waits. The report highlighted the need for the federal government to take a much greater role working with provinces to develop, support, and spread promising and successful improvement initiatives across the country.

The report recommended that each province develop administrative and leadership capacity for wait-time coordination across its health regions. It also recommended that provinces adopt the following evidence-based practices: common wait lists and centralized referral to specialties (i.e., single-entry models) with patients assigned to the first available slot for intervention; case management and team-based care; appropriateness; pre-habilitation programs to ensure fitness for surgery; system-wide electronic health records; and a public education campaign to inform Canadians about what is being done to improve wait times.[69]

Moving from pilot projects to system-level change is not easy. International evidence indicates that success depends on frontline providers championing improvement efforts. Don Berwick, former director of the Institute for Healthcare Improvement and one of the founders of the international quality improvement movement, has suggested that instead of trying to improve performance based on a complex set of financial incentives, health systems should focus on "placing more trust in the intrinsic motivation of the healthcare workforce."[70] He recommends focusing efforts on learning

from evidence and less effort into "managing carrots and sticks."[71] Indeed, health systems that have improved quality and timely access have built the operational and clinical capacity needed to spread and scale innovations methodically and systematically—and a culture of data-driven learning.[72]

Ontario has been slow to develop its health care improvement infrastructure in order to support a provincial approach to surgical services redesign and improvement. Over the years, there have been many promising pilot projects, but Ontario has often failed to sustain and spread local initiatives that show promise at reducing wait times and improving the quality of care. The lack of sustained provincial leadership contributes to this problem, and most especially when governments pursue policy directions—such as greater for-profit involvement—that are at odds with the research evidence and policy experience. Instead, the Ontario government should pursue the following recommendations.

Implement single-entry models, teamwork, and standardized wait list management provincewide

The need to develop and implement "single-entry models" (sometimes called centralized intake and referral) as a proven strategy to reduce wait times and provide more comprehensive, team-based care for patients is a prime example where Ontario needs strong provincial leadership. Single-entry models (SEMs) generally include central intake of referrals from primary care providers (or self-referrals, if appropriate), pooled referrals, a wait list shared by a team of surgeons and other providers, and triage for urgency and appropriateness. In 2021, the auditor general of Ontario noted that there were no provincewide single-entry models.[73] However, there have been local and regional attempts.

In 2017, Rapid Access Clinics for hip and knee arthritis and lower back pain were developed and launched in each of the former Local Health Integration Networks (LHINs).[74] These were intended to serve as a single entry for referring potential surgical patients from primary care provider to receive rapid assessment for surgery (or non-operative therapies). The aim of the Rapid Access Clinic was to provide rapid assessment for surgical candidacy by an advanced practice physiotherapist (rather than an orthopedic surgeon) and then facilitate referral to the first available surgeon or preferred surgeon for surgical candidates, thereby freeing surgeons' time to consult with patients who actually need surgery and spend more time in the operating room.

However, this promising initiative has languished as many potential orthopedic surgery patients are referred first to an individual surgeon's wait list rather than the physiotherapist, undermining the efficiencies and cost-savings associated with a single-entry model where providers are working to their full scope of practice and not duplicating clinical work. Similar challenges with physician autonomy under fee-for-service and lack of provincial leadership have emerged with promising models in other provinces, including B.C.[75]

As well, the Waterloo cataract central intake and the Ontario Bariatric Network are promising SEMs that centralize intake of referrals. Along with the orthopedic Rapid Access Clinics, these remain the few examples of SEMs in the province. There is also a distinction between SEMs that include central intake and pooling of referrals among physicians only and those that involve a wider team of physicians and allied health professionals working at the top of their skillset. The dominant way physicians are paid—as fee-for-service independent contractors—creates financial and operational barriers to team-based care models where providers work in the same clinic together.

Making pilot projects and system improvements standard practice across hospitals and regions is the responsibility of the Ontario Ministry of Health and Ontario Health, in collaboration with hospitals, Health Quality Ontario and workforce partners. Health Quality Ontario supports system-level improvement; however, there is a lack of strategic provincial direction from the provincial government. Furthermore, Health Quality Ontario is not empowered by legislation to drive system improvement, which severely limits its independence and ability to lead system-wide improvement efforts. Ontario should build its health system learning and improvement infrastructure based on the internationally recognized Healthcare Improvement Scotland.[76]

The Ministry of Health and Ontario Health should develop an implementation plan for establishing SEMs in a consistent manner across specialty areas provincewide.

Maximize and extend hospital operating room capacity instead of for-profit delivery

Maximizing and extending hospital operating room capacity as well as improving performance can also reduce wait times and costs. Specific strategies include optimizing scheduling and reducing downtime. For example, if two ORs are used with a staggered schedule, surgical teams can

"swing" between rooms as their patients are prepared for surgery by other team members.

Maximizing underused hospital operating room capacity should be prioritized. The province has prioritized for-profit surgical delivery rather than system improvement and fully utilizing the 34 per cent of hospitals that had unused OR capacity in 2019-20. The auditor general noted that "Ontario Health does not formally track reasons for underuse" but found "inadequate planning for OR use and insufficient resources (such as nurse staffing) to keep ORs running for surgeries."[77] Neither the Ministry of Health nor Ontario Health have made firm commitments about how they plan to increase public sector surgical activity in order to reach the provincial target of all hospitals with OR use at 90 per cent. Furthermore, additional capacity can be created by extending OR hours, but a significantly expanded for-profit surgical sector will be competing for the same skilled staff.

Efforts to maximize operating room time may also include moving less-complex procedures out of hospital ORs into specialized outpatient procedure rooms, scheduling more complex cases at the end of the day (which reduces delays and cancellations), and investing in more equipment so surgeons don't lose time waiting for equipment to be cleaned. Standardizing surgical procedures, equipment, and clinical practices can reduce variation and increase productivity with a relatively small investment of money.

Over the longer term, the international research shows that increasing public sector acute care capacity, rather than outsourcing, has the greatest potential to reduce waits in the long run.[78] An OECD study of 13 high-income countries found that a greater number of acute care beds is associated with shorter wait times,[79] and a review of 103 academic articles and policy papers concluded that "cross-national comparisons suggest a consistent link between greater capacity (e.g., acute care beds, physicians, overall spending) and shorter wait times" and that "[p]roactive, targeted investment in public-sector capacity is an effective long-term strategy to control wait times."[80]

Protect patients from extra-billing, prohibit upselling, and require physician disclosure of financial conflicts of interest

Bill 60 does not include provisions to explicitly prohibit the practice of upselling, self-referral, nor physician disclosure of financial conflicts of interests. Considering Ontario is pursuing much greater involvement of

profit-motivated facilities, there should be clear legislative measures to protect patients and address the lack of provincial action to address upselling, as identified by the auditor general. Although there is no high-quality data, recent media reports suggest that medical upselling is likely a pervasive practice, with patients often paying thousands of dollars for medical goods or services that are not necessary.[81]

Furthermore, physician conflict-of-interest disclosure should be a required part of facility licensing under the new legislation and should apply to all physicians, regardless of whether they work in for-profit surgical and diagnostic facilities. This should include any payments they receive outside of their OHIP billings, including payments from for-profit facilities, pharmaceutical companies, medical device companies, and any other third parties. The public and regulators should know if, and what, financial conflicts of interest may influence physicians' medical decision-making.

Finally, the Ministry of Health should adopt a pro-active extra-billing enforcement program that involves spot audits and a public education campaign to encourage patients to report alleged unlawful extra-billing. Evidence released in this report suggests that a high percentage of complaints are found to be unlawful extra-billing, and this unlawful practice likely remains more pervasive due to the province's complaint-driven enforcement approach.

Increase access to seniors' home and community care

Better access to publicly funded home and community care, especially for seniors, can play a role in reducing hospital bed shortages, cancellations of scheduled surgeries and, ultimately, surgical wait times for all patients.[82] Home and community care includes home support (e.g., personal care services, and help with housekeeping, cooking, and taking medications), home nursing, rehabilitation therapy, long-term care and palliative care.

Many patients occupying inpatient hospital beds cannot be discharged due to the lack of community-based alternatives that have the appropriate intensity of clinical care and non-clinical supports. As our population ages, more people will require home care, supportive housing, long-term care, and palliative care. According to the Wait Time Alliance (an organization representing 18 medical-specialty associations), "If we can improve how we care for our seniors, we will go a long way toward creating a high-performing health care system, thereby benefiting

all patients."[83] Investing in seniors' care can reduce hospital overcrowding and wait times.

It is important to note, however, that improving out-of-hospital care for seniors will not solve problems that are rooted in under-capacity within the hospital system. Ontario's per capita funding of health care is the lowest of any province; one consequence of this is that Ontario also has the fewest hospital beds per 1,000 population of any province and the fewest registered nurses per capita.[84] Without substantial new funding for public health care, including complex continuing care in hospital, boosting funding to home and community care will not address the problem of a lack of staffed hospital capacity.

Reduce the overuse of medical imaging and surgeries

Reducing surgical wait times also requires a focus on addressing the overuse of medical imaging and surgeries when they provide little or no diagnostic or treatment benefit. A 2017 report from Choosing Wisely Canada[85] and CIHI concluded that up to 30 per cent of procedures, imaging tests, and pharmaceutical therapies across eight priority areas are potentially unnecessary.[86]

Technological advances have contributed to the growth of medical imaging (e.g., x-ray, MRI, CT), which can be necessary for diagnosis. However, growing evidence suggests that many imaging tests are not necessary and may cause avoidable patient harm. Based on a review of eight Canadian studies, the share of inappropriate MRI exams was estimated to range from two per cent to 28.5 per cent, in large measure because methodologies in these studied varied.[87] A coordinated provincial and national approach to appropriateness, supported with better data reporting and quality improvement programs, would likely reduce inappropriate medical imaging and wait times for those with urgent needs.

There is also growing recognition that surgical interventions may not always be appropriate for patients. Surgical care is appropriate when it is based on available evidence and the patient's health status. Inappropriate surgeries are those that provide no health benefit to the patient, are risky, and may result in deterioration in a patient's health. Inappropriate surgeries can be reduced by ensuring physicians are supported to use the best available

evidence in assessing whether a surgery is appropriate for their patient and by involving and fully informing patients of the potential benefits, risks, and outcomes of surgery. In other words, reducing inappropriate surgeries requires a movement towards shared decision-making between patients and health-care providers, with patients actively involved in the decision to undergo surgery or pursue non-operative therapies.

Routine, low complexity surgical procedures, such as cataract surgery and joint replacements, often have high clinical variation. This means patients with similar diagnoses receive different treatments depending on when, where, and by whom they are treated, despite clinical evidence on the optimal treatment. For example, a 2002 study of B.C. cataract surgery patients found that 26 per cent of patients reported either no change or a deterioration to their eyesight after surgery.[88] The study used patient-reported outcome measures (PROMs) to provide patients' perspectives on their health and the appropriateness of the interventions.

PROMs are standardized and validated surveys completed independently by patients, typically before and after surgery. This data can be used to identify where there are variations resulting in poor outcomes in order to support clinicians to make necessary changes in their clinical practice and to inform health system planners where quality improvement efforts are needed. Growing momentum through the Choosing Wisely campaign and PROM collection—beginning with national standards for hip and knee replacements—is encouraging. Ultimately, PROM collection needs to be systematically and routinely used by clinicians and health system administrators to reduce unnecessary clinical variation and to improve the safety and quality of care.

There are encouraging signs that Ontario is reducing clinically inappropriate medical imaging and surgeries. A 2022 report, published by Choosing Wisely Canada and CIHI, shows Ontario is making improvements across most areas with common overuse of tests and treatments of low clinical value.[89] Ontario needs to remain focused on its Choosing Wisely efforts. In many areas, it can do this by expanding single-entry models with team-based care and a focus on prevention and self-management. For example, the Rapid Access Clinics for Low Back Pain in Ontario should be strengthened so that patients can see a multi-disciplinary team that provides education and supports non-operative self-management.[90] The clinics help reduce the unnecessary referral to a spine surgeon and MRI overuse.

Provide accurate accounting of public payments to for-profit facilities and disclose funding agreements

Current accounting and public reporting of public payments to independent health facilities means that public expenditures flowing to this for-profit industry were underreported by the Ontario government by 720 per cent in 2020-21 and even more in previous years. The Treasury Board Secretariat produces annual detailed expenditure reporting of how the Ontario government spends public dollars, including transfer payments to non-government service providers, but it does not show details of fee-for-service payments to for-profit facilities in the Public Accounts. Ontario should accurately report these payments in the Public Accounts and publicly disclose funding agreements between for-profit facilities and the Ministry of Health.

Adopt a "vaccines-plus" public health strategy to reduce health system strain and delayed surgical care

Finally, the ongoing burden of unmitigated SARS-CoV-2 transmission—along with other viruses disproportionately affecting children, seniors, health care workers, and vulnerable people—is contributing to severe health system strain. In order to manage inpatient volume that remain much higher than pre-pandemic levels, hospitals have, at various points, been forced to postpone scheduled surgeries in order to free up staffing resources, especially nurses, and inpatient beds. As a result, Ontario faces challenges in its efforts to increase surgical volumes above pre-pandemic levels, as this report has shown.

Ontario will be better prepared to prevent delayed surgical care if it adopts a "vaccines-plus" public health strategy.[91] This requires the provincial government and public health officials to manage the ongoing pandemic and the resulting severe pressures on the health system in a manner that is consistent with scientific evidence, with the goal of preventing infection and transmission of this airborne virus. A vaccines-plus strategy includes these six elements:

1. Deliver public education that SARS-CoV-2 is airborne and re-infection comes with risk of acute and long-term complications.
2. Set public indoor air-quality standards.
3. Mandate universal indoor masking in health care settings and in public places when viral transmission is high.
4. Increase access to (and provide guidance on) testing.
5. Require 10-day isolation for positive cases and provide at least 10 paid sick days.
6. Encourage current vaccination that protects against severe disease and death.

Conclusion

THE ONTARIO GOVERNMENT plans to significantly expand surgical and diagnostic activity in the for-profit sector through new legislation and outsourcing contracts, but it has no made firm commitments to fund and staff idle public operating rooms or implement system-wide improvements. Hospital operating rooms sit underused—or shuttered—due to a lack of funding and staffing. Physical space and equipment for surgeries and medical imaging is not the limiting factor in Ontario; what is missing is the health care workforce necessary to increase surgical and diagnostic activity.

Based on the research evidence and experience in Alberta, the Ontario government's plan to expand the volume and types of surgeries and diagnostics that will be delivered in for-profit facilities—including hip and knee replacements—is likely to worsen public hospital staffing shortages that cause longer waits.

A larger for-profit sector invites more unlawful extra-billing and two-tier health care, as the evidence from western Canada shows. The Ontario government risks entrenching a for-profit hospital sector in Canada with a market for surgical and diagnostic outsourcing that is generating investor interest within Canada and the United States. Yet for-profit corporate delivery is more expensive, risks patient safety and care quality, and introduces financial conflicts of interest at odds with objective medical decision-making.

In recent years, Ontario has maintained the shortest wait times for orthopedic surgeries and diagnostic imaging among the provinces. It has done so without the significant for-profit involvement envisioned by the Ontario government. There is a significant opportunity cost to Ontario by pursuing greater for-profit provision at the expense of public system improvement through streamlined referrals, single-

entry models, team-based care models, and fully utilizing existing public operating rooms.

For-profit surgical and diagnostic delivery comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term. However, by focusing on evidence-based policy strategies to increase and improve surgical and diagnostic volumes in hospitals, the Ontario government can reduce wait times. This will require a clear shift away from privatization and for the government to commit to public system improvement by:

- Prioritizing the use of single-entry and team-based referral models.
- Maximizing and extending public operating room capacity.
- Protecting patients from unlawful extra-billing, upselling, and requiring physician disclosure of financial conflicts of interest.
- Increasing access to seniors' home and community care, thereby reducing hospital overcrowding.
- Reducing the overuse of medical imaging and surgeries.
- Providing accurate accounting of public payments for for-profit facilities.
- Adopting a "vaccines-plus" public health strategy to reduce health system strain and delayed surgical care.

Ontario is on the edge of the precipice. Pursuing a policy direction at odds with the evidence and policy experience in Canada risks destabilizing public hospitals, increasing wait times, and entrenching a for-profit hospital industry that seeks to dismantle public health care.

Appendix A: Research methods and data sources

THIS RESEARCH USES Freedom of Information requests, descriptive statistical analysis of publicly available and requested data, and a review of the academic and policy literatures. Specific methods and data sources are described below.

Freedom of Information requests: This report draws on three FOI requests. First, the author requested statistical data from the Ministry of Health, which includes the number of completed surgical procedures performed in public hospitals and independent health facilities (excluding pregnancy terminations), and payments to independent health facilities. Second, the author requested data on the number of completed medical imaging procedures performed in independent health facilities under transfer payment agreements and fee-for-service under OHIP. Third, the author requested extra-billing complaint and audit data.

Data extraction: A dataset containing licensing information for independent health facilities, location, and services offered was obtained from the Ministry of Health through a custom request.

Descriptive statistical analysis: The above FOI requests and extracted licensing data were analyzed in addition to multiple datasets from the Canadian Institute for Health Information (CIHI) referenced throughout the report.

Literature review: With an Ontario focus, the author performed an updated review of the academic and policy literatures about the problems with for-profit surgical delivery and policy strategies to reduce surgical wait times and improve care quality.[92]

Appendix B: Percentage of patients receiving surgery within benchmark for priority procedures in Ontario vs. Canadian average, 2010-2022

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Knee replacement (26 weeks)	89	85	84	85	86	86	81	78	79	80	56	71	68
Knee replacement, Canadian avg.	80	76	76	77	78	77	72	68	69	70	47	59	50
Hip replacement (26 weeks)	91	90	89	89	88	87	85	83	84	85	64	75	72
Hip replacement, Canadian avg.	84	83	81	82	82	81	78	76	75	75	56	65	57
Hip fracture repair (48 hours)	77	78	82	83	84	86	85	86	87	86	84	84	81
Hip fracture repair, Canadian avg.	78	79	81	83	84	87	86	87	88	86	86	85	82
Cataract surgery (16 weeks)	88	88	86	81	81	74	70	69	70	72	40	60	59
Cataract surgery, Canadian avg.	83	82	83	81	80	76	73	71	70	71	45	66	66

Source: CIHI, "Wait Times for Priority Procedures 2023—Data Tables (Updated June 2023)."

Appendix C: U.S. investor interest in for-profit surgical delivery in Canada

MARWOOD GROUP EMAIL to Ontario Health Coalition:

To:Andrew Longhurst <andrew_longhurst@sfu.ca>;

---------- Forwarded message ---------
From: Emily Algert < EAlgert@marwoodgroup.com>
Date: Wed, 10 May 2023 at 11:04
Subject: Research on Canadian Healthcare Market
To: ohc@sympatico.ca <ohc@sympatico.ca>

Hello,

I am reaching out from The Marwood Group, a healthcare research and advisory firm in the United States. We're conducting research on the Canadian healthcare market, specifically looking at access to care, wait times, service availability, and level of public-private partnerships. We are reaching out to stakeholders, such as your organization, to get various perspectives and a better understanding of the overall market. Would someone at your organization have time for a brief discussion about the Canadian healthcare market?

Thank you,

Emily Algert

Associate, Advisory Group

733 Third Avenue, 11th Floor

New York, NY 10017

(845)-480-1555

ealgert@marwoodgroup.com

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We are proud of the difference we make and we hope you are too. This work is only made possible by people who care like you. Please do

MARWOOD GROUP EMAIL to Friends of Medicare (Alberta):

From: Snigdha Udupi <SUdupi@marwoodgroup.com>
Date: May 11, 2023 at 4:05:51 PM EDT
To: Chris Gallaway <fominfo@telus.net>
Subject: Research on the Canadian Healthcare Market

Hi Chris,

I am reaching out from The Marwood Group, a healthcare research and advisory firm in the United States. We're conducting research on the Canadian healthcare market, specifically looking at access to care, wait times, service availability, and level of public-private partnerships. We are reaching out to stakeholders, such as your organization, to get various perspectives and a better understanding of the overall market. Would someone at your organization have time for a brief discussion about the Canadian healthcare market and some specifics insights into Alberta?

Thank you,

Snigdha Udupi

Associate

Marwood Group

733 Third Avenue, 11th Floor

New York, NY 10017

MARWOOD GROUP

Marwood Group email to the B.C. Health Coalition:

From: **Snigdha Udupi** <SUdupi@marwoodgroup.com>
Date: Tue, May 9, 2023 at 3:19 PM
Subject: Questions on public-private healthcare partnerships in BC
To: info@bchealthcoalition.ca <info@bchealthcoalition.ca>

Hi,

I work for a US-based healthcare research and advisory firm, and we are currently conducting research on the Canadian healthcare system, specifically the role of public-private partnerships in British Columbia. I had the following questions for which I was hoping to gain more clarification – would your organization be able to comment on below? Thank you for your help!

1. BC announced a commitment to surgical renewal during COVID-19 (May 2020) – was this a temporary plan? Are there any plans to continue contracting with private clinics to complete publicly funded surgeries?
2. For how long do the current contracts run with private clinics?
3. If contracting with private clinics was a temporary solution, does BC have any plans to address surgical backlog in the future?

Thank you,

Snigdha Udupi

Associate

Marwood Group

733 Third Avenue, 11th Floor

New York, NY 10017

MARWOOD GROUP

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