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Can Ontario offload surgeries to private clinics without undermining public health care?

■ Cite as: *CMAJ* 2023 February 6;195:E199-200. doi: 10.1503/cmaj.1096036

Posted on cmajnews.com on January 18, 2023

Ontario is expanding the number and range of publicly funded health services performed in private community clinics in a bid to reduce wait times and surgical backlogs.

As a first step in the Progressive Conservative government's "three-step plan," the province will invest in "new partnerships with community surgical and diagnostic centres" in Windsor, Kitchener-Waterloo, and Ottawa to perform more publicly funded cataract surgeries using existing staff.

Provincial officials expect these clinics to perform up to 14 000 cataract surgeries per year, reducing wait lists for the procedures to pre-pandemic levels by March 2023, "barring operational issues."

The second step of the government's plan involves an expansion of the private provision of "nonurgent, low-risk and minimally invasive" procedures, such as colonoscopies and endoscopies, as well as MRI and CT imaging. So far, they have provided few details on this step.

Finally, the province will allow private clinics to perform hip and knee replacement surgeries as early as 2024.

Premier Doug Ford and other officials stressed that patients would continue to pay for the outsourced procedures "with their OHIP card, never their credit card." However, they did not answer questions from reporters about whether clinics would be allowed to upsell patients on associated elements of care.

Two-tier fears

Some public health care advocates fear the scheme could see clinics coercing patients to pay for additional or unnecessary services that aren't covered publicly. Others, including the College of Physicians of Surgeons of Ontario and five major health care unions, are concerned the move will divert workers and funding from public facilities while worsening patient outcomes and driving up the cost of care.

"For-profit clinics, long-term care homes and nursing agencies have already cost Ontarians enormously and have seriously worsened the staffing shortage in our public system," according to a joint statement by the Ontario Nurses' Association, Ontario Council of Hospital Unions, and others.

According to the Ontario government, "specific measures will be in place to protect staffing and stability in hospitals" as the role of private community clinics expands — although details on those safeguards are limited.

One unnamed official told the *Toronto Star* that private health clinics will be required to submit staffing plans to show they're not "stealing" human resources from hospitals.

"One of the main problems with private systems is that there is no system," said Leslie Boehm of the University of Toronto's Institute of Health Policy, Management and Evaluation. "What you get is a bunch of independent companies all going their own way. You have very little organization in it."

According to Danielle Martin, chair of the department of family and community medicine at the University of Toronto, upselling is already happening in private clinics providing public services.

For example, Martin said, a colonoscopy clinic might make it difficult for patients to access a publicly funded colonoscopy without paying out-of-pocket for a dietician consult, or a cataract clinic may offer patients only an upgraded lens instead of a publicly covered alternative.

A 2017 survey of 136 private clinics in nine provinces including Ontario found that 88 were charging patients directly for medically necessary services and charging extra user fees.

"When we talk about patients not being charged, that needs to be the case across the whole of the experience if we want this solution not to undermine equity," Martin said.

Does outsourcing work?

An international review published in the *Journal of Hospital Management and Health Policy* last year found "consistent positive evidence" that private provision of publicly funded surgical services reduced wait times.

"Across peer-reviewed studies, it was reported that the provision of publicly funded surgeries through private facilities resulted in a decrease in the number of patients on public waiting lists," according to the authors.

Evidence from other sources — including experts from countries with top-ranking publicly funded systems such as Australia, Denmark and Norway — "also demonstrated increased surgical volumes and reduced wait times."

However, the authors noted some "unintended consequences," including increases in extra billing and an influx of more complex cases to the public system.

Martin said Ontario will need to be "very thoughtful" about how it structures the private provision of publicly funded services to avoid such problems.

"Do I think that we should be moving procedures into the community where it's

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appropriate? Of course. Do I think we need to increase capacity so we can deal with the backlog? Of course," she said. "But we risk making things worse instead of better if we don't design our solutions thoughtfully. The details of how this might take place really matter."

Toward thoughtful partnership

In one example of how public-private collaboration might work, a clinic in Windsor has established a rule where every anesthesiologist and ophthalmologist must also work at the local hospital.

According to Martin, such safeguards should be considered for other staff, too, including nurses, technicians, technologists, and personal support workers.

"The centres should be not-for-profit, and they should be affiliated in meaningful ways with hospitals, so we're not in a situation where hospitals are having to compete with for-profit clinics for staff."

Quality oversight will be key and could be achieved by linking private clinics to hospitals, Martin said. That way, there can be shared oversight, staffing plans and wait lists, "so that there's a single common queue across all the providers of a service."

According to the authors of the international review, the most successful initiatives to reduce surgical wait times combine multiple strategies.

In addition to the private provision of public services, other effective strategies for reducing wait times include same-day surgery and discharge, streamlined preadmission processes, expanded roles for nonphysicians, standardized treatment pathways, and reassessing wait lists regularly.

"Then it starts to look like a health care system, instead of just outsourcing," Martin said. "What we want is to build capacity in an equitable way and a safe way in our health care system, not just outsource to for-profit entities."

Diana Duong, *CMAJ*

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