Legal constraints on Private Sector Involvement in the Delivery of and Payment for Health Care in Ontario

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Introduction

With waiting times one of the biggest issues facing the Canadian health care system and given our limited public resources and aging population, some say an increased ratio of private to public health care providers and payers is inevitable. These pages will identify a number of legal constraints to greater private sector involvement, generally by posing a number of frequently asked questions. Clearly, any significant change in the mix of private-public providers and payers will have to be preceded by legislative change.

1. **Canada Health Act**

- does not “outlaw” for-profit health care
- does not create any offences and no person can be charged with violating it
- governs the relationship between the federal and provincial governments
- makes the payment of a “full cash contribution” from the federal government to each provincial government conditional upon the province establishing a health care insurance plan that meets specified criteria of (a) public administration, (b) comprehensiveness, (c) universality, (d) portability and (e) accessibility in respect of all insured health services
- in itself, a privately paid for service will not contravene any provision of the *Canada Health Act*
- but the service could have attributes such that the province in which it is provided might be in breach of the prescribed provincial obligations
- most relevant are the provisions relating to “user charges” and “extra-billing”

  "extra-billing” means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province.

  "user charge” means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of *insured health services* that have been subject to *extra-billing* by medical practitioners or dentists.

19(1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, *user charges* must not be permitted by
the province for that fiscal year under the health care insurance plan of the province.

- the Canada Health Act does not prevent physicians from “opting out” of the provincial health insurance plan in respect of one or more procedures and receiving payment personally from patients for those procedures at whatever rates the physician may charge but where a physician has received or will receive a payment from the provincial health insurance plan in respect of that procedure, the physician may not receive any additional payment for that procedure as that would constitute extra billing. (See discussion in Section 3 below)

- of interest is the definition of “insured health services”

  “insured health services” means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation

- the definitions of “hospital services” and “physician services” both turn on the services being “medically required” and yet the Canada Health Act does not define what is meant by medically required; this is left to each province to determine

2. Health Insurance Act (Ontario)

- each province has a health insurance act and a health insurance plan; in Ontario, the health insurance plan, known as the Ontario Health Insurance Plan (“OHIP”) is regulated by the Health Insurance Act (Ontario) (“HIA”)¹

- the Health Insurance Act has been modified by two acts:

  - the Health Care Accessibility Act (Ontario) (“HCAA”) (now repealed) and

  - the Commitment to the Future of Medicare Act, 2004 (Ontario) (“CFMA”) (formerly known as “Bill 8”)

3. Can physicians charge their patients more than prescribed fees?

- under the Health Insurance Act prior to the enactment of the Commitment to the Future of Medicare Act, a physician in Ontario could either opt in or opt out with respect to all patients (HIA, Section 15(2))

- if the physician opted out, the physician would render all of his or her accounts for services directly to his or her patients, who in turn, could submit the accounts to OHIP for payment. The physician could then be paid by the patient once the physician was notified

¹ The act applies to “insured persons”. Generally speaking, “insured person” means a person who is ordinarily resident in Ontario. Unless otherwise specified, all references to patients throughout this paper are to patients who are insured persons.
by OHIP that the patient had been “reimbursed” by OHIP (or the physician could be paid earlier if the patient so agreed) (HCAA, Section 2(2))

- even where the physician had “opted out”, the physician was not able to charge more for his or her service than the amount prescribed by the OHIP Schedule of Benefits (HCAA, Section 2(1))

- this changed somewhat with the enactment of the Commitment to the Future of Medicare Act

- now the only physicians able to opt out of OHIP are those who had opted out before the Commitment to the Future of Medicare Act came into effect (CFMA, Section 11(2))

- those who are so grandfathered continue to be limited to charging the amount payable under the OHIP Schedule of Benefits and to receiving payment from their patients after their patients have been reimbursed by OHIP (unless the patients otherwise agree to pay the physician earlier) (CMFA, Section 10(1))

4. What are Insured Services?

- the Health Insurance Act defines “insured services” covered by OHIP as follows:

"insured services" means services that are determined under section 11.2 to be insured services;

…

11.2 (1) The following services are insured services for the purposes of the Act:

1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.

2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.

3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed.

- “prescribed” is defined in section 1 as “prescribed by the regulations” and means as set out on the OHIP Schedule of Benefits to the Health Insurance Act

- while “prescribed services” of hospitals, health care facilities and practitioners are insured services, for physicians to be paid by OHIP, services must be both prescribed and medically necessary

- does this mean that prescribed services which are not medically necessary may be rendered by a physician for payment outside of OHIP? Not necessarily
the Commitment to the Future of Medicare Act prohibits a physician from accepting payment or benefit for an insured service rendered to an insured person except from OHIP (Section 10(3))

an “insured service” for the purposes of the Commitment to the Future of Medicare Act is defined in Section 8 to be a service that is an insured service under the Health Insurance Act (i.e. a service referred to in the OHIP Schedule of Benefits). Whether the service is medically necessary is irrelevant to the determination

therefore, if a service is listed in the OHIP Schedule of Benefits a physician can only be paid by OHIP for rendering it

the only exception to this rule, is for services listed as excluded services in the Regulation to the Health Insurance Act. These services may be rendered to a patient by a physician for payment outside of OHIP

5. What are the “Excluded Services” for which a physician or others can bill patients directly and without a limit on fees?

The General Regulation, Reg. 552 under the Health Insurance Act sets out the “exclusions” from the definition of “insured services”. Some of the exclusions set out under the Regulation include the following:

- most dental care
- routine optometric examinations for persons between 20 and 65
- physiotherapy (except in long-term care facilities) home care - or in patient
- chiropractic services
- some services by osteopaths and podiatrists
- acupuncture
- circumcision
- certain forms of cosmetic surgery (depending on medical necessity)
- sex re-assignment surgery
- treatment related to fertility and conception (depending upon cause of infertility)
- psychological testing
- physical examinations if required for employment, insurance, club membership, legal proceedings , etc.
- vaccinations for meningitis, chicken pox, Hepatitis A&B
- immunizations for travel

6. Can a physician or other person charge additional amounts for rendering ancillary uninsured services (Block Fees)?

block fees are seen by some as a means by which doctors providing insured services can receive compensation under OHIP and also receive supplementary compensation through a direct charge to the patient

this fee has typically covered services of the following nature:
- transfers of medical records
- preparation of documents relating to employment or insurance
- preparation of death certificates
- preparation of documentation for miscellaneous government programs
- prescription renewals
- telephone consultations
- missed appointments
- patient meeting in excess of 20 minutes

- one of the objectives of the *Commitment to the Future of Medicare Act* was to put an end to, or limit, this practice

- Section 18(1) of the *Commitment to the Future of Medicare Act* in its current and final form, reads as follows

  18(1) *If regulations have been made under this section,* a person or entity may charge a block or annual fee only in accordance with those regulations.

  18(3) For the purposes of this section, the Lieutenant Governor in Council may make regulations governing block or annual fees, including the circumstances under which they may be charged and the information that must be provided to the person who is charged, but may not regulate the amount of such fee.

  18(4) In this section, “block or annual fee”,

    (a) means the fee charged in respect of one or more health services that are not insured services as described in section 1 of the *Health Insurance Act*, or a fee for an undertaking not to charge for a service or to be available to provide such service or services if,

      (i) the service or services are or would be rendered by a physician, practitioner or hospital or the service or services are or would be necessary adjuncts to services rendered by a physician, practitioner or hospital, and

      (ii) at the time the fee is paid it is *not possible* for the person paying the fee to know with certainty how many, if any, of the services covered by the block or annual fee the patient will acquire during the period of time covered by the block or annual fee, or

    (b) has any other meaning that may be provided for in the regulations made under subsection (3).

- accordingly, if no regulations are passed under Section 18, there will be no prohibition on charging block fees
- if regulations are passed under Section 18, it will only be possible to charge block fees in accordance with those regulations
- at this time no such regulations have been passed

7. Can anyone operate a private hospital in Ontario?
- the Private Hospitals Act (Ontario) (“PRHA”) prohibits the operation of a hospital by anyone other than an entity designated as a public hospital unless the entity was licensed as a private hospital prior to October 29, 1973
- an owner of a grandfathered private hospital is prohibited from transferring any ownership interests in the hospital without the Minister’s prior approval (PRHA, Section 10(1))
- the Minister may revoke the license if he or she is of the opinion that it is in the public interest to do so (PRHA, Section 15.1(1))
- the Minister may reduce or terminate any grant, loan, financial assistance or amount otherwise payable under this or any other Act if he or she is of the opinion that it is in the public interest to do so (PRHA, Section 15.2)
- in making a decision under Section 15.1 or 15.2, the Minister may “consider any matter he … regards as relevant including … the proper management of the health care system in general and the availability of financial resources for the management of the health care system and for the delivery of health care services” (PRHA, Section 15.3)
- it is forbidden for anyone to construct, add to or enlarge the patient bed capacity of a private hospital or alter or renovate the hospital without prior written approval of the Minister (PRHA, Section 22)
- a private hospital may not be used for any purpose other than the purposes in respect of which the license is issued and “purposes incidental thereto” (PRHA, Section 24(1))
- it is an offence to use a private hospital at any time for the treatment of a greater number of patients than is permitted by the license (PRHA, Section 25)

8. Can a private sector entity use an independent health facility to provide hospital like services in Ontario?
- under the Independent Health Facilities Act (“IHFA”), the Ministry of Health and Long-Term Care licenses and funds independent health facilities (“IHF’s”)
- there are two types of IHFs in Ontario:
  - diagnostic IHFs which are funded on a fee-for-service basis to provide imaging (such as nuclear medicine and diagnostic radiology and ultrasound), sleep studies and pulmonary function tests. IHFs cannot bill more for insured services than the
allowable amounts under the OHIP Schedule of Benefits. They may bill any amount for uninsured services.

- Ambulatory care IHFs are funded on a budget basis, like hospitals, and provide surgical and therapeutic procedures on an out-patient basis, such as cataract surgery, abortions, chronic-care hemodialysis and gynaecologic surgery. They are also prohibited from extra-billing for insured services, but they may bill any amount for uninsured services.

- Licenses to operate IHFs are granted on a discretionary basis based on local need and where the Director appointed under the Independent Health Facilities Act is satisfied that the services will be provided honestly and with integrity in compliance with the regulations or generally accepted quality and standards (IHFA, Section 6(1)). The license may limit the number or types of services which may be provided by the IHF (IHFA, Section 6(3)).

- A license can only be transferred with the consent of the Director appointed under the Independent Health Facilities Act and upon the payment of a transfer fee (currently $100) (Regulation 57/92 to the IHFA, Section 16).

- A licensee that is a private company is prohibited from permitting an issue or transfer of voting shares that may result in a change in control unless its license specifically permits it (IHFA, Section 13(1)). The Independent Health Facilities Act imposes numerous other restrictions and conditions on licensees that are corporations (Section 14).

- An operator of an IHF may not relocate the facility without approval of the Director appointed under the Independent Health Facilities Act (Section 10(1)).

- With the exception of sleep labs, IHFs are not licensed to provide overnight procedures.

9. **Can a private sector entity own and operate a CT Scanner and charge patients directly for CT Scans?**

- The Healing Arts Radiation Protection Act prohibits anyone other than a designated hospital or an IHF from installing or operating a computerized axial tomography scanner (“CT Scanner”). There is an exception for those installed prior to 1984.

- Because CT Scans are listed as insured services under the OHIP Schedule of Benefits where a CT Scan is performed on a patient in Ontario, it may only be paid for through OHIP and only at OHIP rates even if the requirement for the CT Scan is not medically necessary, unless it otherwise constitutes an excluded service (See Section 5 above).

- Some relevant provisions of the Healing Acts Radiation Protection Act are set out below.

  Administration of Act

  (2) The Minister may designate,
(a) a hospital or facility or a class of hospitals or facilities within which it is permitted to install or operate computerized axial tomography scanners; and

(b) the number of computerized axial tomography scanners that may be installed or operated in such hospitals or facilities. 1998, c. 18, Sched. G, s. 51 (8).

Prohibition

(3) No person shall install or operate or cause or permit the installation or operation of a computerized axial tomography scanner unless it is installed and operated in a hospital or facility that is designated under subsection (2) or in a hospital or facility that is part of a class of hospitals or facilities that is designated under subsection (2). 1998, c. 18, Sched. G, s. 51 (8).

Same

(3.1) No person shall install or operate or cause or permit the installation or operation of more computerized axial tomography scanners in a hospital or facility than the number designated under subsection (2). 1998, c. 18, Sched. G, s. 51 (8).

Application

(4) This section does not apply in respect of a computerized tomography scanner that was installed before the 1st day of May, 1984. R.S.O. 1990, c. H.2, s. 23 (4).

10. Can a private sector entity own and operate an MRI and charge patients directly for MRI Scans?

- there is no statutory or regulatory requirement in Ontario that a person must have a licence in order to own or operate a magnetic resonance imager (“MRI”). However, the effect of the legislation regarding the regulation of health professionals is that an MRI must be located either in a public hospital that is listed in schedule N to the regulation under the Public Hospitals Act, or in an independent health facility that is licenced to perform MRIs

- Subsection 27(1) of the Regulated Health Professions Act provides that no person shall perform a “controlled act” set out in subsection (2) in the course of providing health care services to an individual unless the person is a member authorized by a health profession Act to perform the controlled act, or the performance of the controlled act has been delegated to the person by a member who has been so authorized

- Subsection 27(2) of the Regulated Health Professions Act defines the “controlled acts” and includes paragraph 7 “Applying or ordering the application of a form of energy prescribed by the regulations under this Act”
Section 1 of O. Reg. 107/96 under the *Regulated Health Professions Act* prescribes “electromagnetism for magnetic resonance imaging” as one of the prescribed forms of energy.

Under subsection 27(3) of the *Regulated Health Professions Act*, an act is not in contravention of subsection (1) if the person is exempted by the regulations under the Act or if the act is done in the course of an activity exempted by the regulations under the Act.

Pursuant to the *Regulated Health Professions Act*, no one except an authorized health professional (including a member of the College of Medical Radiation Technologists or a member of the College of Physicians and Surgeons of Ontario) may apply or order the application of electromagnetism for magnetic resonance imaging in the course of providing health care services to an individual (Section 27(1) and Section 3.1 of Regulation 107/96 under the *Regulated Health Professions Act*) and even then, only if certain conditions are met. Included within the conditions are the following:

- The electromagnetism is applied for MRI using equipment that is installed in a public hospital whose site is graded under the *Public Hospitals Act* as Group N and the equipment is operated by the public hospital; or

- The electromagnetism is applied for MRI and all of the following conditions are met:
  - it is used to support, assist and be a necessary adjunct, or any of them, to an insured service under the *Health Insurance Act*;
  - it is provided to persons who are insured persons under the *Health Insurance Act*; and
  - it is applied in an independent health facility licenced under the *Independent Health Facilities Act* in respect of MRI; or

- The electromagnetism is applied for MRI and all of the following conditions are met:
  - it is not used to support, assist and be a necessary adjunct, or any of them, to an insured service or is not provided to persons who are insured persons;
  - it is applied in a facility that is operated by a licenced operator under the *Independent Health Facilities Act* in respect of MRI;
  - it is applied in a facility that is operated on the same premises as the independent health facility licenced under the *Independent Health Facilities Act* in respect of MRI;

- it is applied using the same equipment that is used to provide MRI in the licenced independent health facility;
the operator of the facility in which the electromagnetism is applied is a party to a valid and subsisting agreement with the Minister of Health concerning the provision of MRI.