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Public Management and Regulation of Contracted Health Services

A Rapid Review Prepared for the Institute for Health Economics

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Table of Contents

Introduction and Background 1
Methods 2
Scope 2
Analytic Overview 3
Non-Hospital Surgical Facilities (NHSFs) 3
Non-Hospital Advanced Diagnostics Facilities (NHADFs) 7
Conclusion 12
References 14
Appendix A: Accountability in Non-Hospital Surgical Facilities – Detailed Tables by Province 18
Appendix B: Accountability in Non-Hospital Diagnostics Facilities – Detailed Tables by Province 37
Appendix C: Publicly Funded Procedures Performed in NHSFs 58
Appendix D: Literature Search Strategy 59

Introduction and Background

In recent decades, the number of outside of hospital facilities providing advanced diagnostic and surgical services has grown. Most are for-profit with an ownership mix of small business/provider and corporate (Armstrong, 2000; Lett, 2008; Bercovici, 2008; McIntosh & Ducie, 2009; CIHI, 2012; Duckett, 2014; CADTH, 2016; CADTH, 2018). This growth reflects efforts to improve efficiency (Lett, 2008), and a broader shift that governments have taken toward "steering" (managing policy development and providing leadership) rather than "rowing" (directly delivering services) (Deber, 2004).

There is much debate in the literature about the appropriate role of non-hospital facilities in provincial health systems, yet there is limited empirical evidence supporting one side of the debate or the other (Deber, 2004). Much of this debate centres around efficiency. Some argue that shifting care to private-for-profit delivery may increase efficiency if costs can be kept down and quality is maintained or improved (Duckett, 2014). Others argue there is a financial incentive to increase prices, reduce quality and/or overtreat (Deber, 2004), so the challenge faced by government is to hold facilities accountable for costs and quality in order to reap any efficiency gains.

Additionally, provincial governments must ensure these facilities adhere to Canada Health Act (or Medicare) rules of uniform access to medically necessary services. Mechanisms will need to be put in place to ensure that access is based on need and not ability to pay. This is further complicated by the extent that non-hospital facilities receive funding from private individuals (out-of-pocket), or third-party payers (e.g., workers compensation). Given the limited workforce, government must also work to ensure that there is an adequate supply of health professionals to meet rising demands within provincial health insurance programs.

The aim of this rapid review is to compare the mechanisms used across five provinces to ensure accountability between non-hospital facilities and provincial health insurance programs for the delivery of advanced diagnostic and surgical services under Medicare rules, considering three levers of accountability (Deber, 2014):

1. ***Regulation***: governments use regulations (e.g., legislation or bylaws) to require providers to behave in a certain way. They may also delegate this authority to professions (e.g., provincial regulatory colleges).
2. ***Financial Incentives***: governments adjust payment mechanisms to induce providers to behave in a certain way (e.g., pay-for-performance).
3. ***Information***: an indirect approach to accountability whereby governments direct performance information towards users in order to help them make choices about how to get the best care.

Methods

To capture a diversity of regulatory and contracting models, we selected five provinces with evidence of some activity of out-of-hospital surgical and diagnostic services: British Columbia, Alberta, Saskatchewan, Ontario, and Québec. Using the Deber (2014) accountability framework, we developed a template to capture relevant information on regulation, financial incentives, contracts, and performance information in the two sectors (diagnostic and surgical) in each province. To complete these tables, we collected information from publicly available grey literature, as well as from provincial acts and regulations. We supplemented the information found in these sources with academic publications. We then validated this literature review by consulting with experts and, where possible, representatives of ministries of health and delegated health authorities from each province. Complete tables are found in Appendices A and B, and information on the literature search can be found in Appendix D.

A **non-hospital surgical or diagnostics facility** (or clinic) is a facility outside of a hospital where licensed medical professionals provide surgical or diagnostics services to patients. Most of these facilities are for-profit with a mix of small business/provider ownership and corporate ownership. The services they provide may be funded by provincial health insurance programs, by other payers (e.g., workers compensation, private insurance, direct out-of-pocket payments, etc.), or with a mix of funding sources. These facilities may be located on independent sites, or they may be located on the site of an existing health facility (hospital, community health centre, or physician's office[1]). The terminology for these facilities varies across jurisdictions in Canada. In Alberta, British Columbia, and Saskatchewan, they are referred to as non-hospital surgical facilities (NHSF) or non-hospital medical and surgical facilities (NHMSF), in Ontario they are independent health facilities (IHF), and in Québec they are centres medicaux spécialisés (CMS). In this report, we will use the following two terms: 1) non-hospital surgical facility (NHSF); and 2) non-hospital advanced diagnostics facility (NHADF). Note we do not include outpatient treatment facilities that do not provide advanced diagnostic nor surgical services (examples include radiation therapy, and dialysis).

Scope

This review does not provide a description of individual facilities, or an estimation of overall expenditures or funding. While we requested data on NHSF revenue and expenditure from the Canadian Institute for Health Information MIS Database, there were only six identifiable facilities in the dataset which was insufficient to product provincial-level estimates. Also out of scope is a review of the literature evaluating the impact of ownership status on costs, quality, or other outcomes.

[1] For example, *Ophthalmology Associates SHSC* in Toronto, Ontario is located on the same site as Sunnybrook Hospital, and the *Noninvasive Cerebrovascular Laboratory* in Kingston, Ontario is located on the same site as Kingston General Hospital (MOHLTC, 2019).

Analytic Overview

Non-Hospital Surgical Facilities (NHSFs)

The surgical procedures that are performed in NHSFs vary across provinces. Generally, these include ophthalmologic, orthopaedic, dermatologic, plastics and gynecologic surgical procedures (OAG, 2012; Cowling and Léséleuc, 2015). Appendix C contains details on the types of procedures performed outside of hospitals.

Regulation

The approach to regulation in the five provinces can be largely categorized into three models (see Table 1 and the Appendices for details). The western provinces (British Columbia, Alberta, and Saskatchewan) delegate accreditation and regulatory authority to their provincial Colleges of Physicians and Surgeons. The College of Physicians of Saskatchewan (CPSS) adopted the Non-hospital Surgical Facility (NHSF) Standards & Guidelines set out by the College of Physicians and Surgeons of Alberta (CPSA), demonstrating a high level of convergence. All three western provinces introduced legislation[2] at the turn of the 21st century which provided a framework to permit non-hospital facilities to host surgical services and receive funding from the provincial health insurance programs.

In Ontario, the College of Physicians and Surgeons of Ontario (CPSO) plays an active role in setting the standards, while the Ministry of Health and Long-Term Care (MOHLTC) is responsible for accreditation and licensing for the NHSFs. In Québec, the Ministère de la Santé et des Services Sociaux (MSSS) grants licenses and accreditation to NHSFs. This regulatory approach is consistent with the role of regulatory colleges in the western provinces, which perform the same role in standard setting and inspection. However, there are some differences. In the western provinces the NHSFs are contracted with the health authorities, whereas in Ontario the contracts are directly with the Ministry of Health. NHSFs in all provinces almost exclusively provide day surgeries that would only require overnight stays in rare instances (e.g., in the case of complications, or when a patient requires additional recovery time and observation). In Québec, surgical procedures that require more than 24 hours are prohibited by regulation, and Ontario also prohibits overnight stays in NHSFs. In the other provinces, the NHSFs must notify the ministry or health authority whenever a patient stays overnight. Although overnight stays are technically permitted in the western provinces, their models use NHSFs for less complex cases to increase hospitals' capacity to perform more complex surgeries that are more likely to require overnight admission. Overnight stays are rare in Alberta and British Columbia and there exist no NHSFs with the capacity for overnight stays in Saskatchewan.

Québec has a much stricter regulatory environment than the other Canadian provinces examined here. For example, Québec legislation prescribes that NHSFs must be owned and controlled by practicing physicians and that the NHSF board meetings cannot be held without the voting majority of at least one physician with license to practice in the province. These explicit requirements stand apart from the legislation in other provinces in this review, which are silent on the nature of NHSF ownership. In contrast,

[2] British Columbia's Health Professions Act in 1996, Alberta's the Health Care Protection Act in 2000, and Saskatchewan's Health Facilities Licensing Act in 1999.

about half of the non-hospital facilities in Ontario in 2014 were owned by corporations, with the other half by physicians. Québec legislation also forbids publicly funded (RAMQ) services and services funded by other payers (e.g., private insurance, workers compensation, etc.) to be provided in the same facility.[3]

Although there has been some public funding of NHSFs in Québec since 2008, most of the contracts have not been renewed. Instead, a pilot program was launched in 2016 with the stated objective of determining the cost-per-activity for certain day surgeries. Through this pilot, the MSSS contracts with three non-hospital facilities – Rockland MD in Montréal, Opémedic in Laval, and Chirugie DIX30 in Brossard – to provide surgical services within the public health insurance program.

The five provinces have different approaches to regulating the private finance of NHSFs to ensure that access to medically necessary services is based on need and not ability to pay. For instance, in Alberta and Ontario there is an explicit ban on queue jumping in the acts and regulations; though this was not found in the other provinces. Moreover, direct out-of-pocket payments are prohibited in the five provinces in order to meet accessibility conditions of the Canada Health Act.

All the provinces follow the same rule regarding private financing (direct payment): direct payments by patients are *not* permitted for insured services that are provided by a medical professional who is enrolled in the public insurance plan. In all the provinces that permit private financing of NHSFs services (all but Ontario[4]), patients may pay out-of-pocket, using private insurance, or using non-health public insurance (e.g., workers' compensation). In British Columbia and Saskatchewan, there is the added condition that providers of privately financed NHSF services cannot charge a price that is higher than the price set by the provincial insurance plan.

[3] This ban has been challenged as a violation of the Charter of Rights and Freedoms (Section 2d – Freedom of Association) but was dismissed by the Supreme Court of Canada on February 8, 2019.
[4] Ontario does still have two privately financed hospitals (Cedric Health and Shouldice Hospital) that permit direct payments by patients, but these are not classified as NHSFs.

Table 1: Non-hospital surgical facilities – summary of legislation and regulation

	British Columbia	Alberta	Saskatchewan	Ontario	Québec
Legislative framework	In 1999, Lions Gate Hospital contracted an eye centre for insured cataract surgery and the model has persisted until today. The *Health Professions Act* (HPA) requires that the College of Physicians and Surgeons of BC (CPSBC) establish, maintain, and enforce bylaws that regulate non-hospital medical and surgical facilities.	Since 2000, the *Health Care Protection Act* (HCPA) has permitted funding of NHSFs in the provincial health insurance program; however, it explicitly forbids private hospital ownership.	Since 1999, the *Health Facilities Licensing Act* (HFLA) has permitted funding of non-hospital health facilities in the provincial health insurance program, however, there was no activity in this sector until the Saskatchewan Surgical Initiative in 2012.	Since 1990, the Independent Health Facilities Act (IHFA) permits funding of NHSFs in the provincial health insurance program. In 2017, the IHFA was repealed by the *Oversight of Health Facilities and Devices Act* (OFHDA) of the *Strengthening Quality and Accountability for Patients Act* (2017), but that Act has still not been proclaimed.	Since July 1, 2008 the *Loi sur les services de santé et les services sociaux* permits funding of centres médicaux spécialisés (CMS), clinique médicaux associés (CMA), and centres médicaux spécialisé associés (CMSA) within the provincial health insurance program. The bill also requires CMS to support pre- and post-operation rehab (so as to avoid spill over to the public sector from increasing intensity in the private sector).
Accredit. Body	The Non-Hospital Medical and Surgical Facilities Accreditation Program is managed by the CPSBC and is responsible for all accreditation decisions.	The Medical Facility Accreditation Committee of the CPSA.	CPSS has adopted the NHSF Standards & Guidelines set out by the CPSA.	MOHLTC issues the licenses, but the CPSO maintains the standards and performs the inspections.	Either the Conseil Québécois d'agrément (Quebec Council of Accreditation) or Accreditation Canada (Canadian Council on Health Services Accreditation - CCHSA) can authorize accreditation.
Direct payments	Not permitted in NHSFs for insured services provided by a physician who is enrolled in the public insurance plan; privately funded NHSFs must receive all their funding from private sources, and their prices cannot be higher than the prices set by the provincial insurance plan. NHSFs also receive funding from non-health public insurance (e.g., WorkSafe BC or ICBC).	Not permitted in NHSFs for insured services provided by a physician who is enrolled in the public insurance plan, but payments for select enhanced medical goods or services are permissible under strict conditions of written informed consent and the availability of the public option.[5] NHSFs also receive funding from non-health public insurance (e.g., Workers Compensation Board of Alberta).	Not permitted in NHSFs for insured services provided by a physician who is enrolled in the public insurance plan; privately funded NHSFs must receive all their funding from private sources, and their prices cannot be higher than the prices set by the provincial insurance plan. NHSFs also receive funding from non-health public insurance (e.g., WCBSask or SGI).	Not permitted in NHSFs for insured services provided by a physician who is enrolled in the public insurance plan.[6]	Not permitted in NHSFs for insured services provided by a physician who is enrolled in the public insurance plan; accessory fees[7] and additional billing on insured services were explicitly banned Jan 26, 2017. NHSFs can also receive funding from private insurance for selective surgeries[8]; and from non-health public insurance (e.g., CSST or SAAQ).

[5] Enhanced services include upgraded lenses for cataract surgery or a hip replacement more advanced than medically necessary.
[6] Note: Ontario's two remaining private hospitals allow direct billing (out-of-pocket or private insurance).
[7] The Québec Medical Association (QMA) defines accessory fees as costs billed to patients as part of a care, a treatment, or a medical service covered by the RAMQ. Accessory fees have been illegal since January 26, 2017 (QMA, 2017).
[8] Private insurance is permitted for a select number of procedures – notably cataract, hip, and knee surgery (about 50 others by regulation), although there has not been much development of this market.

Financial incentives

Surgical services funded by provincial health insurance programs are divided into two components across the five provinces: the first is the surgeon, who is paid through fee-for-service (FFS) with no differentiation whether the service is provided in a hospital or non-hospital setting. The second is the location, which in the case of non-hospital provision is the basis for contracting with the private, for-profit operators. The contracting agency provides a payment for use of the facility to cover the non-physician costs, such as overhead, surgical supplies, and other staff. Table 2 details the approach to provider payment that each province takes. The general approach of combining FFS with fixed overhead/facility fees has the potential to incentivize increased volume.

This two-pronged approach to payment is found in all five comparator provinces, though it is important to note that this has only been the case in Québec since it launched its pilot program (for three facilities). Prior to the pilot, NHSFs in Québec were funded through block contracts of undisclosed amounts and we were unable to determine the nature of payments. This is in contrast to the volume-based contracts seen in other provinces. Although the exact rate each NHSF is paid per service is not disclosed in the publicly available contracts, Alberta provides the total contracted amount, including a contingency of no more than 30 per cent for overages which can only be accessed with prior approval from Alberta Health Services (AHS). In British Columbia, health authorities report on the total amount paid annually to NHSFs, but like Alberta, the exact rate each NHSF is paid per service is not disclosed. More details on how facilities are paid, and where available, estimates of total spending and volumes, are provided in the Appendices.

Table 2: Non-hospital surgical facilities – financial incentives

	British Columbia	Alberta	Saskatchewan	Ontario	Québec
Provider Payment: Physicians	FFS with the provincial health insurance program (MSP).	FFS with the provincial health insurance program (AHCIP).	FFS with the provincial health insurance program (MSB).	FFS with the provincial health insurance program (OHIP).	Within the pilot program (three facilities): FFS with the provincial health insurance program (RAMQ).
Provider Payment: Facilities	Facility costs: contracts include an undisclosed facility fee to cover overhead or indirect costs of providing insured services in a non-hospital setting, excluding physician costs.	Facility costs: contracts include a facility fee to cover overhead costs and non-physician staffing. This fee varies by procedure.	Facility costs: contracts include an undisclosed facility fee to cover overhead costs and non-physician staffing.	Facility costs: contracts include a facility fee to cover overhead costs and non-physician staffing.	Within the pilot program (3 facilities): retrospective reimbursement of facility costs (overhead, disposables, and non-physician staffing) plus a 10% premium.

Information

There is limited public reporting among all five provinces (see Table 3 for details). Regional health authorities (RHAs) in British Columbia report on payments made to NHSFs for surgical services as part of the financial reporting they do within their annual reports, though few details are provided beyond the

listing of facilities and total paid.[9] Alberta stands out as they make all surgical NHSF contracts publicly available and report on all supplementary surcharges collected for enhanced medical goods or services. The Auditors General of Ontario and Alberta have done some work looking specifically at NHSFs, but most indicators of surgical performance (such as wait-times) do not distinguish between procedures done in-hospital and those done in NHSFs. There are no performance data reported publicly, whether it is on costing, medical errors, critical incidents, transfers to hospitals, or any other metric. Information appears to be the least used accountability lever when it comes to non-hospital surgical services.

Table 3: Non-hospital surgical facilities – information

	British Columbia	Alberta	Saskatchewan	Ontario	Québec
Public Reporting	Information about payments to suppliers for goods and services is included in the Annual Report of the relevant RHA; this information is not detailed enough to provide details on what is included in these payments. Vancouver Island Health, Vancouver Coastal Health, and Fraser Health provide this information, while none could be found for the other two health authorities.	AHS reports the total number of NHSF procedures as well as the total fees collected for enhanced medical goods or services annually (e.g., enhanced lenses for cataract surgery); AHS publishes all contracts with NHSF but does not report facility fee per service.	The SHA annual report includes payments made to the contracted NHSF, as it does with all suppliers.	The Office of the Auditor General of Ontario (OAG) has reviewed Independent Health Facilitates in 1996, 2004, and 2012 with follow-up reports in 1998, 2006, and 2014 respectively.	None found.

Non-Hospital Advanced Diagnostics Facilities (NHADFs)

We consider diagnostics services to include advanced medical imaging or scanning that is performed by a licenced medical professional using an energy applying and detecting medical device (EADMD). These services include Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography - Computed Tomography (PET-CT) (CADTH, 2018), and do *not* include preliminary diagnostic services such as x-rays, ultrasounds, and sleep studies. In 2017, 34 of the 263 (12.9%) facilities that were operating medical imaging machines in the five provinces in our study were non-hospital facilities (CADTH, 2018).[10] All provinces except British Columbia and Québec[11] provide some funding to privately owned NHADFs within their provincial health insurance programs.

[9] For example, for Vancouver Coastal Health the following Schedule of Payments to Suppliers of Goods and Services, which includes some facilities that provide surgical services, is available here: http://www.vch.ca/Documents/VCH-SOFI-2018-Part-G-Schedule-of-Payments-made-to-Suppliers-of-Goods-Services.pdf

[10] In 2017, the provinces were ranked (from most to least) in the following order for the number of MRI scans performed per 1,000 of the population: Ontario, Québec, Alberta, Saskatchewan, and British Columbia (CADTH, 2018). They were ranked in the following order for the number of CT scans performed per 1,000 of the population: Ontario, Québec, British Columbia, Saskatchewan, and Alberta (CADTH, 2018). These rankings are based on total number of exams performed in and out of hospital, but they still give and idea of each province's demand for advanced diagnostics services.

[11] The provincial mammography strategy is an exception to the rule in Quebec whereby privately owned, non-hospital clinics providing mammography screening do receive public funding through the provincial health insurance program.

Regulation

The five provinces are distributed across a spectrum that ranges from indirect to more direct government regulation (see Table 4 for details). Québec has the most restrictive legislative framework since they delisted all advanced diagnostic services not provided in hospitals from the provincial health insurance program. The Québec government oversees the safety and licencing of facilities, but it does not directly contract with NHADFs. Although there is no legislation or regulation directly pertaining to NHADFs, in Alberta, as in Québec, the government delisted advanced diagnostics performed outside of hospital from the provincial insurance program, which means that radiologists cannot bill the ministry of health for these services (only to private payers). While Alberta Health Services (AHS) has contracted with NHADFs to provide scans to publicly insured patients (volume-based contracts covering professional and facility costs at a fixed price per scan), only one of these contracts is still active.

Unlike in Saskatchewan or Ontario, neither Alberta nor British Columbia have provincial legislation that regulates NHADFs. Instead, they both use Health Professions Acts to delegate the responsibility of regulating facilities to their respective colleges of physicians and surgeons (CPSA and CPSBC). There are currently no *privately* owned NHADFs in British Columbia that are delivering publicly funded services. There are two NHADFs in the Fraser Health Authority (FHA) region, but they are publicly owned (they were purchased by the health authority). Therefore, despite these being permitted, British Columbia does not direct public funding to privately owned NHADFs.

Ontario and Saskatchewan rely on regulations as an accountability lever more than the other three provinces. Both have provincial legislation that directly regulates NHADFs (IHFA and PCMIA); however, the Ontario government is more directly involved in regulation because the MOHLTC is responsible for accrediting and contracting with facilities, whereas in Saskatchewan, these responsibilities are delegated to the CPSS and health authority respectively.

In terms of regulating private finance, Ontario is the only province that prohibits charging patients directly for advanced diagnostic services delivered in a non-hospital facility; all of the other provinces allow for the direct billing of patients. We were unable to view contracts that provinces use to set prices with facilities that are providing publicly insured services, but provinces generally use contracts to set service level controls on the volume of service the facilities can provide (e.g., hours of MRI or CT machine operation). Uniquely, the government in Saskatchewan enforces a “one-for-one” (or a “buy two get one”) model that requires NHADFs to provide, at no cost to the provincial insurance program, a second scan of similar complexity to a patient on the provincial waitlist for each privately funded scan it provides.

Table 4: Non-hospital diagnostics facilities – summary of legislation and regulation

	British Columbia	Alberta	Saskatchewan	Ontario	Québec
Legislative framework	The Health Professions Act (HPA) (1996) and Medicare Protection Act (MPA) (1996) permit the funding of NHADFs in the provincial insurance program, but there are currently no privately owned NHADFs providing publicly funded services.	The Health Professions Act (HPA) (2000) permits the funding of non-hospital advanced diagnostics in the provincial insurance program; In 1993, CT and MRI scans were delisted from the public plan if they are provided in a private NHADF.	The Patient Medical Choice Imaging Act (PCMIA) (2016) and the Medical Imaging Facilities Licensing Regulations (2016), permit the funding of advanced diagnostics in the provincial health insurance program.	Since 1990, the Independent Health Facilities Act (IHFA) (1990) and the Medical Radiation Technology Act (1991) permit funding of non-hospital advanced diagnostics in the provincial insurance program.	According to the Health Insurance Act[12], and Regulation respecting the application of the Health Insurance Act (1982), diagnostics in NHADFs were funded by the provincial health insurance program. Advanced diagnostics performed out-of-hospital are delisted. Further detail on which services were delisted and when can be found in the Appendix B: Québec.
Accredit. Body	Professional regulatory body: CPSBC.	Professional regulatory body: CPSA.	Professional regulatory body: CPSS.	MOHLTC; and the professional regulatory body: CPSO.	Professional regulatory body: OTIMROEPMQ[13].
Direct payments	Patients can pay directly for scans in privately owned NHADFs (and then potentially queue-jump in the public system); The MPA prohibits direct billing by physicians who are enrolled in Medicare (MSP) to provide insured services.	Patients can pay directly for scans in NHADFs (and then potentially queue-jump in the public system); Diagnostic imaging services can be purchased privately by patients.	Patients can pay directly for scans in NHADFs (and then potentially queue-jump in the public system); NHADFs cannot charge patients for services that are funded publicly.	Patients cannot pay directly for scans in NHADFs; NHADFs cannot charge patients for all or part of a publicly insured service (however, between 2002 and 2007 direct payment by patients for scans was permitted).	Diagnostic imaging services that have been delisted based on location (administered in a non-hospital setting) can be paid for directly by patients (and then potentially queue-jump in the public system); All NHADFs are privately funded.

Financial incentives

Similar to the funding of surgical facilities, there is little use of financial incentives to hold providers accountable for performance (see Table 5 for details). In three provinces – Alberta, Saskatchewan, and Ontario – there are publicly financed and privately owned NHADFs (all but Québec and British Columbia).[14] In Saskatchewan and Ontario, the contracts cover the costs to the facility, and are volume based, while

[12] RLRQ c A-29

[13] Ordre professionnel des technologies en imagerie médicale, en radio-oncologie et en électrophysiologie médicale du Québec

[14] In Québec, provider payment is structured differently because advanced diagnostic services provided outside of hospital are not publicly insured. Providers of out-of-hospital advanced diagnostic services can be paid out-of-pocket by patients, but primarily they are paid by private insurance plans (e.g., The Commission de la santé et de la sécurité du travail [CSST]). Québec also permits radiologists to practice in both the publicly funded hospital system and the privately funded non-hospital facilities. Therefore, radiologists *can* receive both public and private funding for their services if they choose to work in both delivery settings. In British Columbia, there are currently no *privately* owned non-hospital advanced diagnostic facilities providing *publicly* funded services. The BC government has recently purchased two non-hospital facilities that provide publicly funded advanced diagnostics services, but even though these facilities are "non-hospital," they are still owned by the government.

physicians are paid FFS by the ministry of health. The combination of volume-based contracts and FFS for physicians seems to be a clear incentive for activity/volume with no incentives for performance (e.g., quality or outcomes). However, in Alberta, the one remaining contract with a NHADF is a negotiated fixed price per scan that includes both the physician and facility costs.

On the other hand, the facility fee that providers receive to cover their overhead costs does provide an incentive for efficiency (or at least to be more productive). Facilities receive a fixed fee to cover their non-physician costs (e.g., overhead costs, staff, etc.). The fixed facility fee within a single facility over time means that facilities can profit from keeping costs down. If contracts are not refreshed, the government will not reap these efficiency gains (e.g., in Ontario many active contracts date back to the early 2000s).

Table 5: Non-hospital diagnostics facilities – financial incentives

	British Columbia	Alberta	Saskatchewan	Ontario	Québec
Provider Payment	There are no contracts with privately owned NHADFs in the provincial health insurance program. Publicly owned NHADFs are given stipends to cover both the physician's professional fees and the overhead costs associated with providing the imaging service; privately owned NHADFs are either paid out-of-pocket or by third party insurers (e.g., WorkSafeBC, Insurance Corporation of British Columbia [ICBC]).	In the provincial health insurance program, there is one current contract with a NHADF at a fixed price per scan, which includes all costs, including the physician services and the facility costs. Most NHADFs are paid exclusively by private sources such as out-of-pocket or by third party insurers (e.g., WCB Alberta, private insurers).	Physicians: FFS by Medical Services Branch MSB within the Ministry of Health. Facility costs: contracts include an undisclosed facility fee to cover overhead costs and non-physician staffing; uninsured services are either paid out-of-pocket or by third party insurers (e.g., WCB Sask, Saskatchewan Government Insurance [SGI]).	Physicians: FFS by OHIP Facility costs: contracts include a facility fee to cover overhead costs and non-physician staffing; uninsured services are either paid out-of-pocket or by third party insurers (e.g., WSIB, private insurers).	There are no contracts with NHADFs in the provincial insurance program. Most NHADFs are paid exclusively by private sources, such as out-of-pocket or by third party insurers (e.g., CSST, private insurers); note that radiologists can receive both private and public funding if they provide care in public and private facilities.

Information

As shown in Table 6, beyond reporting patient safety incidents, information (through public reporting) is used very little as an accountability measure by any of the provincial governments. A possible explanation for this is that it is difficult to integrate NHADFs into the provincial picture archiving and communication systems (PACS). In Ontario, participation in PACS is voluntary for NHADFs, and in British Columbia, if the health authorities were to contract with privately owned NHADFs, their images would not be uploaded to the provincial PACS. In contrast, in Alberta, the NHADFs are integrated in the PACS that then allow privately purchased scans to be shared with specialists in hospital (unless patients request their information to remain private). In Saskatchewan and Ontario there has been some public reporting on NHADFs in the form of provincial auditor general reports. Ontario also provides information to patients on wait times. Detailed wait time metrics for every facility (hospital and non-hospital) that provides MRI and CT scans are reported by Health Quality Ontario.

Table 6: Non-hospital diagnostics facilities – information

	British Columbia	Alberta	Saskatchewan	Ontario	Québec
Public Reporting	In contrast with the CPSBC's non-hospital medical and surgical facilities accreditation program (NMSFAP), the CPSBC's Diagnostic Accreditation Program (DAP) does not require disclosure of information about diagnostic facilities considered to be of interest to the public.	Information on diagnostic imaging does not distinguish between scans provided at hospitals and non-hospital facilities.	The 2017, a Provincial Auditor of Saskatchewan report contained a section on the efficient usage of MRI in the (no longer existent) Regina Qu'Appelle Health Authority, including the use of non-hospital facilities. However, there is no agreement between the provincial auditor's numbers and those reported publicly by elected and ministry officials (nor were they consistent between different people reporting them); Current reports on diagnostic imaging do not distinguish nor disaggregate between scans provided at hospital and non-hospital facilities.	The Office of the Auditor General of Ontario (OAG) has reviewed Independent Health Facilitates in 1996, 2004, and 2012 with follow-up reports in 1998, 2006, and 2014 respectively; Health Quality Ontario publishes the wait times of all the advanced diagnostic facilities (non-hospital and hospital) online. The website allows visitors to look up any facility and compare its wait times to the Ontario average.	Non-hospital advanced diagnostics that provide uninsured services are excluded from the RAMQ and are as such outside of any public reporting.

Conclusion

There is considerable variation in the approaches taken by these five provincial governments to regulate and contract with non-hospital facilities that provide surgical and advanced diagnostic services. The challenge facing government is not necessarily one of ownership per se, but about ensuring that the rules of Medicare are applied (i.e., that medically necessary services are accessed based on need and not ability to pay). Among the three broad approaches to accountability, the five provinces rely primarily on of regulatory approaches, with very little use of financial incentives and information.

With regard to surgical services, all provinces contract with NHSFs to provide surgical services within their health insurance programs. Though, in Québec, there are currently only three surgical facilities that are contracted to provide surgical services as part of a pilot program. In British Columbia, many of the restrictions placed on NHSFs that are also found in other provinces, such as on dual practice, private insurance, and extra-billing, are currently being challenged in the courts (*Cambie Surgeries Corporation vs. British Columbia*). Thus, a ruling in favour of *Cambie* could have major implications for the regulation of this sector not only in British Columbia but across the country.

With regard to advanced diagnostics, the regulatory approach taken in British Columbia, Alberta and Québec, is to explicitly limit the use of NHADFs and to primarily provide these services in hospitals. This is achieved by delisting advanced diagnostics provided in community (in Alberta and Québec), thus deeming these as non-medically necessary and leaving these facilities almost exclusively outside of provincial health insurance programs (they are funded directly by patients or, more commonly, by third party payers such as workers compensation). Whereas in Ontario, the NHADFs are not permitted to charge patients directly, and they play a role in the provincial health insurance program.

From our review, we identify some overarching challenges that provincial governments continue to grapple with. These include ensuring the cost effectiveness of the care the facilities provide in the absence of comparable measures across sectors; addressing the limited empirical evidence about the effect facilities have on provincial surgical and diagnostic wait times; and improving measuring and reporting on performance.

Finally, we identify some key questions that may be topics of future research as well as considerations for governments in their effort to optimise the use of non-hospital facilities and ensure the Medicare rules are met:

- **Preferential access and queue jumping**: To what extent do systems that allow out-of-pocket payments for diagnostic services grant preferential access to medically necessary surgical and other specialized services based on income rather than medical needs?
- **Optimizing the use of contracting to ensure value for money:** What is the optimal time period for contracts, how should prices be set, and how might the payments be tied to outcomes?
- **Improving appropriate use of services**: To what extent do profit-maximization goals of corporate-owned facilities lead to inappropriate use services?

- **Ensuring quality-of-care**: What are the best practices for quality assurance/outcome measurement to ensure quality-of-care standards are being met? Who should assume the risk in the event of complications?
- **Strengthen public reporting:** How can information (e.g., public reporting) be used better to hold facilities accountable for cost, quality, and outcomes?

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Appendix A: Accountability in Non-Hospital Surgical Facilities – Detailed Tables by Province

Table A1. British Columbia

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital surgical facilities?	Yes, BC is at the centre of this issue as it is embroiled in a constitutional challenge launched by a private for-profit operator described as "set to reignite [the] debate about private health care [in Canada]".[15] The College of Physicians and Surgeons of British Columbia (CPSBC) classifies British Columbia's non-hospital medical and surgical facilities (NHMSF) as falling into one of the following three categories: Class 1: Provides general anesthesia and major regional anesthesia (epidural, spinal nerve blocks) and may include use of IV sedation and/or analgesia, or local anesthesia only; Class 2: Provides use of IV sedation and/or analgesia where the patient remains responsive and breathes without assistance; and Class 3: Provides local anesthesia only. May provide oral sedation but not IV sedation/analgesia or inhalants.[16]
1.2	Is there public financing of private delivery of non-hospital surgical facilities?	Yes. In 1999 Lions Gate Hospital, part of Vancouver Coastal Health (VCH), entered into a contract with an eye center to perform cataract surgery, which lead to an expression of interest for external clinics to provide a number of procedures, explicitly labeled as "private operators providing public procedures with public dollars".[17]
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Yes. Under Part 4 of the *Health Professions Act*[18] (HPA) and Part 6 of the CPSBC Bylaws,[19] NHMSFs may be for-profit medical corporations. Per section 43 of the HPA, "all voting shares of the corporation are legally and beneficially owned by: (i) registrants of the college, or (ii) companies as defined in the Business Corporations Act…" Thus, a company may own the controlling share of a corporation that operates a health facility.[20] For example, VCH was, until September 2018, contracting with False Creek clinic (owned by publicly traded Centric Health) for a "range of operations".[21]
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital surgical facilities? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	Under *the Health Professions Act* (HPA), the Ministry of Health of BC requires that the CPSBC (the College) establish, maintain, and enforce bylaws that regulate NHMSFs in BC. The HPA is not specifically relevant to the governance of NHMSFs, it is simply the legislation that gives the CPSBC authority to write bylaws,[22] including the bylaws that regulate NHMSFs. In other words, via the HPA, Ministry of Health delegates NHMSF oversight responsibilities to the CPSBC. Part 5 section A of the CPSBC bylaws outlines the CPSBC's Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP).[23] This section of the bylaws provides the most comprehensive description of the accreditation standards for NHMSFs in BC.
2.2	What is the mechanism for enforcing the legislation?	Schedule C of the CPSBC bylaws describes the administrative penalties and costs corresponding to failures of the medical directors of accredited health facilities to comply with the bylaws, as well as

[15] Bailey, I. (2018, May 17). B.C. lawsuit set to reignite debate about private health care. Retrieved from https://www.theglobeandmail.com/news/british-columbia/bc-surgerys-practice-of-billing-challenged-by-health-ministry/article31631721/

[16] CPSBC. (2019). https://www.cpsbc.ca/programs/nhmsfap/facility-accreditation

[17] https://www.longwoods.com/content/20456/healthcare-quarterly/contracting-for-surgery-...-the-vancouver-coastal-approach

[18] HPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#part4

[19] CPSBC Bylaws. (2009). https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf. p 83.

[20] HPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#section43

[21] Fayerman, P. (2018, August 30). Vancouver health authority ends contract with private surgery centre over patient-pay issues. Retrieved from https://vancouversun.com/news/local-news/vancouver-health-authority-ends-contract-with-private-surgery-centre-over-patient-pay-issues

[22] HPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#section19

[23] CPSBC Bylaws. (2009) https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf p. 63.

		any other rules, standards, or policies set by the College.[24] Failures by a facility's medical director to follow the reporting and accreditation standards outlined by the bylaws results in $1,000.00 fine for the first offense, $2,000.00 for the second offence for the same infraction, and $3,000.00 for subsequent offenses for the same infraction.[24]
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Yes, section 14 of the *Medicare Protection Act* (MPA)[25] requires that physicians provide written notice to the Ministry that they elect to be paid for their services directly by patients. If physicians elect to opt-out of the public insurance plan, under section 18 of the MPA, they cannot charge the patient more than the price set by the public insurance plan for a service that is covered by the plan.[26] Once a physician elects to opt-out of the plan, the physician cannot receive any payment from the public plan until they revoke their election to opt-out of the plan.[27]
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital surgical facilities?	The NHMSFAP is managed by the CPSBC and is responsible for all accreditation decisions. The CPSBC bylaws pertaining to the NHMSFAP were recently revised, with new changes coming into effect December 30, 2017.[28] They were drafted by the College in consultation with the health authorities and the Ministry of Health of BC.[29]
3.2	Do accreditation standards differ for public or not-for-profit facilities?	No. The CPSBC accreditation bylaws do not distinguish between facilities that are public and facilities that are not-for profit. Under the bylaws, "*every* [emphasis added] facility must be accredited and maintain accreditation by the committee [the non-hospital medical and surgical facilities accreditation program committee] before it can provide medical, surgical, dental or anesthesia procedures."[30]
3.3	Do accreditation standards differ for facilities receiving public funding?	No. The CPSBC accreditation bylaws do not distinguish between non-hospital surgical facilities based on the nature of their funding. They pertain to the accreditation of *all* non-hospital surgical facilities.
3.4	Are there any additional considerations before licensure/accreditation is granted?	Per section 5-3 of the CPSBC bylaws, the NHMSFAP committee must conduct an on-site assessment of every facility before accreditation is granted. After completion of the on-site assessment, the committee may: (a) grant full accreditation for a period of 5 years or less, (b) grant limited accreditation, or (c) deny accreditation.[30]
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	There does not appear to be a central repository for contracts, they appear to be done with regional health authorities.
4.2	Does any other body have the authority to approve contracts?	CPSBC bylaw 5-8(2) states that no accredited facility may enter into any contract with a health authority or other third party, "until the committee has notified the medical director that the committee is satisfied that the accreditation standards, policies, rules, procedures and guidelines for the NHMSFAP can continue to be met."[30] So, the CPSBC has overarching authority to approve any contracts that any NHMSF may make.
4.3	Are there any mechanisms for appeal?	Uncertain. We were unable to obtain the actual contracts, but pursuant to section 5-6 (1) of the CPSBC bylaws, the NHMSFAP committee, "may revoke, suspend or change the terms of accreditation at any time during the period specified on the certificate of accreditation if, in the opinion of the committee, revocation, suspension or change is warranted by (a) a failure of the facility to comply with the Bylaws and/or, the standards, (b) one or more unacceptable patient outcomes at a facility, or (c) a risk to patient care or safety."[31]

[24] Bylaws. (2009). https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf. p. 99.

[25] MPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96286_01#section14

[26] MPA (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96286_01#section18

[27] Flood, C., & Archibald, T. (2001). The illegality of private health care in Canada. *CMAJ: Canadian Medical Association Journal = Journal De L'association Medicale Canadienne, 164*(6), p. 826.

[28] http://www.bclaws.ca/civix/document/id/mo/mo/2017_m367

[29] CPSBC. (2009). https://www.cpsbc.ca/for-physicians/college-connector/2017-V05-01/01

[30] CPSBC Bylaws. (2009). p 64.

[31] CPSBC Bylaws. (2009). p. 66.

	5. Financial reporting/incentives	
5.1	How are providers paid?	Physicians' professional fees are paid either directly by the patient if they opt-out of the public plan, or by the public plan, if they opt-in. Both opt-in and opt-out physicians are eligible to receive payment from third-party insurers, such as Insurance Corporation of British Columbia (ICBC). The Ministry of Health also provides NHMSFs with funding to cover their overhead or indirect costs of providing insured services in a non-hospital setting.
5.2	Are there price controls?	Yes. Section 18 of the MPA which prohibits opted-out physicians from billing patients more than the price set by the public plan for a service that would be covered by the public plan effectively puts a price cap on the services provided by opted-out physicians.[32] If physicians do not elect to opt-out of the public plan and therefore receive public funding for the services they provide, their professional fees are determined by British Columbia's public insurance plan, the Medical Services Plan (MSP).
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	Not explicitly.
5.4	Are there allowable user contributions for all or part of the service?	MPA section 17 (1) prohibits any payment from a patient, "for or in relation to a benefit, or for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit," by a physician who is *enrolled* in the public healthcare system. But if physicians elect to opt-out of the public insurance plan, under section 18 of the MPA, they *cannot* charge the patient more than the price set by the public insurance plan for a service that is covered by the plan.[32]
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	None found.
5.6	Describe the pricing of contracted surgical services in NHSFs information. What are the expenditures and procedure volumes?	Rather than paying the NHSFs at a specific rate for a specific service, health authorities in BC are purchasing blocks of operating room (OR) time from the facilities and then scheduling surgeries that best suit their current demand and operational flow.[33] Thus, they are directly using NHSFs as additional capacity to the publicly funded hospital-based system. Expenditures and procedure volume estimates to be confirmed.
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	Per section 5-22 of the CPSBC bylaws, "The College may, subject to the provisions of the Act and the *Freedom of Information and Protection of Privacy Act*, in respect of any facility share any information about the facility or any other facility owned by any of the owners, or about the owner or owners of the facility, or about the medical director or members or former members of the medical staff, including any accreditation reports or investigative reports, if the College considers the disclosure to be in the public interest.[34]"
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	Per the CPSBC bylaws, the NHMSF Medical Director must: (a) report to the committee all patient safety incidents of a nature determined by the committee for reporting, (b) report to the committee any death which has occurred during or within 28 days of a procedure in the facility, (c) maintain records of all patient safety incidents, the details of investigations, outcomes and recommendations, and provide a copy of the records to the committee upon request, and (d) provide to the committee annually, and upon request, a written report setting out all procedures performed at the facility in the preceding year or a specific period of time.[35]
6.3	Do agreements/contracts include performance measures?	We were unable to obtain contracts, but the CPSBC bylaws do contain a continuity of care condition that can be considered a performance measure. Section 5-16 of the bylaws requires that: (1) All

[32] MPA (1996).
[33] To the best of our knowledge, the blocks of OR time are priced at $7,500 for 9.5 hours, although this is yet to be validated by BC contacts.
[34] CPSBC Bylaws. (2009). p. 73.
[35] CPSBC Bylaws. (2009). p. 68-9

		medical staff practicing in a facility must ensure continuity of care for their patients including those patients who require admission to a hospital following a procedure performed at the facility, (2) A registrant who is a member of the medical staff of a facility and holds active or admitting privileges at a hospital local to the facility, and whose patient requires hospital admission due to complications arising from a procedure performed at the facility, is expected to admit and manage the patient as appropriate to the patient's condition, (3) A registrant who is a member of the medical staff of a facility but does not hold active or admitting privileges at a hospital local to the facility must have a registrant designate of the same specialty as the registrant who holds active privileges at a hospital local to the facility and who agrees to take the responsibility for the management of any patient requiring hospital admission due to complications arising from a procedure performed at the facility appropriate to the patient's condition, (4) The committee may waive the requirement of section 5-16(3) for dentists, oral maxillofacial surgeons and podiatric surgeons.[36]
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	None found. The British Columbia Auditor General Annual Reports do not refer directly to NHSMFs.
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	Yes. The NHMSFAP publishes a list of all accredited non-hospital medical surgical facilities in British Columbia: https://www.cpsbc.ca/files/pdf/NHMSFAP-Accredited-Facilities.pdf. As of May 7, 2019, there were 53 accredited facilities. Three RHAs (Vancouver Coastal Health[37], Vancouver Island Health[38], and Fraser Health[39]) provide publicly available information about payments made towards suppliers of goods and services in their regions, including NHSFs.

[36] CPSBC Bylaws. (2009). p. 71.
[37] http://www.vch.ca/Documents/VCH-SOFI-2018-Part-G-Schedule-of-Payments-made-to-Suppliers-of-Goods-Services.pdf
[38] https://www.islandhealth.ca/sites/default/files/2018-10/payments-suppliers-services.pdf
[39] https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/About-Us/Accountability/Financial-reporting/2018/20181031_Schedule_of_Vendor_Payments.pdf

Table A2. Alberta

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital surgical facilities?	Yes. Non-Hospital Surgical Facilities (NHSF) are allowed by the Health Care Protection Act (HCPA) since 2000.[40] HCPA Section 1 explicitly bans private hospital ownership. As of January 2019, there were 51 contracts with NHSFs to deliver some publicly funded day surgery services.
1.2	Is there public financing of private delivery of non-hospital surgical facilities?	Yes. Contracts between Alberta Health Services and the NHSF operator provide funding only for facility fees and supplies/implants associated with insured medical services. Professional fees for surgeons are paid by the Alberta Health Care Insurance Plan by Alberta Health.
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	The Act and Regulations are silent on who is permitted to own a NHSF, although all changes in ownership require approval from the Minister to maintain NHSF designation, per HCPA10(2).
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital surgical facilities? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	The Health Care Protection Act and Health Care Protection Regulations.[41] This legislation states that the Alberta government is committed to "a single-tier health-care system that ensures access to necessary medical care based on need and not the ability to pay. It was described as a protection against privatization, particularly against block-billing fees or other payments for insured healthcare services. The HCPA and regulation comply with the Canada Health Act for the delivery of insured surgical services. Uninsured surgical services may be provided at NHSFs. The HCPA and regulation do not regulate the provision of uninsured day stay surgical services in NHSFs (uninsured surgical services include Workers' Compensation Board funded surgeries, privately funded surgeries that are not medically necessary, surgeries provided to non-residents of Canada, etc.). Uninsured extended stay surgical services may only be provided in NHSFs subject to the Minister's designation.
2.2	What is the mechanism for enforcing the legislation?	For insured surgical services, NHSFs are only designated by the Minster per the HCPA upon acceptance and approval of Alberta Health Services' (AHS) business case and proposed contract for the NHSF and subject to being accredited by the College of Physicians and Surgeons of Alberta (CPSA). The legislation contains offences (S.26) for contravention of specified sections in the Act.[42]
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	NHSF operators receive public funding for services provided under contract to AHS. NHSF operators may provide uninsured surgical services that are private pay under the Canada Health Act and Alberta Health Care Insurance Act (individuals not covered by the Canada Health Act; services funded by: a WCB, private insurer, federal government, private pay patient). NHSFs may provide "enhanced goods or services" to patients, with patients funding the enhanced portion of the good/service beyond the basic good/service. To date this has been limited to enhanced lenses in cataract surgeries. S.3 of HCPA prohibits operators and surgeons providing preferential access by providing enhanced goods or services or non-medical goods or services to patients along with insured surgical services.[42] Professional fees for surgeons and anesthesiologists are paid by the Alberta Health Care Insurance Plan by Alberta Health.
	3. Accreditation	

[40] HCPA. (2000). http://www.qp.alberta.ca/documents/Acts/H01.pdf
[41] HCPA Regulations. (2000). http://www.qp.alberta.ca/1266.cfm?page=2000_208.cfm&leg_type=Regs&isbncln=9780779808083
[42] HCPA. (2000).

3.1	What body/bodies are responsible for accreditation of non-hospital surgical facilities?	The Medical Facility Accreditation Committee (MFAC) of the CPSA is responsible for accreditation.[43] The Alberta Dental Association and College is responsible for accrediting NHSFs providing dental surgery. Physicians practicing in NHSFs must follow CPSA's bylaws (dental surgeons must follow ADAC's requirements for dental surgery). The bylaws and accreditation requirements for NHSFs are available on CPSA's website.[44]
3.2	Do accreditation standards differ for public or not-for-profit facilities?	The NHSF Standards & Guidelines are silent on the ownership of NHSF, save for a provision that the College must be notified of any changes in ownership and structure. Currently, all NHSFs in Alberta are privately owned. Surgery in public or not-for-profit facilities occurs in hospital facilities. S. 10 of HCPA also contains provisions for the Minister to be notified of changes in ownership.[45] Public facilities are accredited via Accreditation Canada standards. Medical Device Reprocessing practices and standards are governed by the Canadian Standards Association. NHSFs providing publicly contracted services for AHS are under contractual obligation to follow relevant AHS policies and procedures including infection prevention and control policies and standards.[46]
3.3	Do accreditation standards differ for facilities receiving public funding?	The NHSF Standards & Guidelines are silent on the insurance state of procedures performed
3.4	Are there any additional considerations before licensure/accreditation is granted?	The HCPA 8(3) explicitly requires the Minister to consider whether the proposal is consistent with the Canada Health Act (CHA), the NHSF serves a current and ongoing need, the proposal will have no adverse effect on public service provision, there is expected public benefit (specifically pointing to access, quality, flexibility, efficiency of current capacity, and economic considerations), and sufficient demonstration of commitments to performance and ethical practice (as defined by the Health Professions Act and the College bylaws) The HCPA 8(3)(e) also explicitly requires the Minister consider the viability of the business plan proposed by the health authority (the HCPA predates the establishment of Alberta Health Services (AHS) as the sole, province-wide health authority)
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	Per the HCPA agreements are made with the Health Authority (i.e. Alberta Health Services) but are subject to Ministerial approval.
4.2	Does any other body have the authority to approve contracts?	No, the HCPA is explicit that agreements are made between the operators of NHSF and a health authority, subject to Ministerial approval.
4.3	Are there any mechanisms for appeal?	Ministerial approval is final and binding per the HCPA 8(2).
	5. Financial reporting/incentives	
5.1	How are providers paid?	NHSF are paid a Service Fee, which "represent[s] compensation to the Operator for all resources required to be provided by the Operator to perform the Services at the Facility other than the Physician services compensated for directly by Alberta Health", per 5.1c of the contracts. 3.4 of the contracts state that the Service Fee is implied to cover all operations expenses ("any goods, materials, services, equipment, facilities or personnel (including without limitation all personnel providing professional or administrative services)") for the NHSF to provide services in a timely and acceptable manner, even if not explicit to the contract.

[43] CPSA Standard & Guidelines. (2016). http://cpsa.ca/wp-content/uploads/2015/03/NHSF_Standards.pdf

[44] http://www.cpsa.ca/wp-content/uploads/2017/12/CPSA-Bylaws.pdf; http://www.cpsa.ca/accreditation/non-hospital-surgical-facility/.

[45] HCPA. (2000).

[46] https://open.alberta.ca/dataset/b9dd9349-6d5b-48aa-b83b-d206210a9f97/resource/7ef701ba-1e58-4a5d-b2a4-4f3d5e5de1fa/download/ipc-medical-device-cleaning-2012.pdf

		Surgeons are paid fee-for-service (FFS) by the Alberta Health Care Insurance Plan (AHCIP) identically to how they are compensated for insured procedures. As indicated earlier, NHSFs may provide "enhanced goods or services" to patients, with patients funding the enhanced portion of the good/service beyond the basic good/service. To date this has been limited to enhanced lenses in cataract surgeries. NHSFs may provide uninsured surgical services or non-medical goods or services to patients, and these would be privately funded. But again, S.3 of HCPA prohibits operators and surgeons providing preferential access by providing enhanced goods or services or non-medical goods or services to patients along with insured surgical services.[47]
5.2	Are there price controls?	All contracts with AHS include maximum amounts payable (Schedule B III) which also include a contingency amount, which cannot be accessed without prior written approval by the AHS. The contingency amount varies across the NHSF contracts, but none currently exceed 30%. The NHSF contracts are publicly posted online: https://www.albertahealthservices.ca/about/Page3172.aspx
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	No. There are no explicit incentives, but HCP 8(3)(f) states that a proposal must satisfy the Minister "that the proposed agreement indicates performance expectations and related performance measures for the insured surgical services and facility services to be provided." There are no financial incentives for volume as each surgeon is allocated a maximum number of block-booking allocations per year.
5.4	Are there allowable user contributions for all or part of the service?	HCPA 5(1) explicitly bans charges on enhanced medical goods or services and non-medical goods or services unless the patient was presented a written statement of the nature, purpose, and cost of the charges and consents in writing. HCPA 5(5) permits the patient to rescind at any point before service delivery and 5(6) states charges are not permitted when the alternative is unavailable (for e.g., you cannot be billed for a private/semi-private room because a standard room isn't available) HCPA 6(1) states that any charges in contravention of the Act are to be collected as a debt to the Crown and 6(2) authorizes the Minister to collect on behalf of patients for their reimbursement. Patients or private payers may not contribute payments for insured surgical services. S. 4 of HCPA prohibits patients being charged facility fees for insured surgical services.[47] Patients may be charged for "enhanced goods or services", but this has been limited to date for multi-focal lenses for cataract surgery. NHSFs are to report on enhanced goods and services in accountability reports to AHS.
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	Fees are set in contracts and the Schedule of Medical Benefits for surgeon billings. Complex patients with risk from co-morbidities are considered "major surgery" and should receive surgery in hospital and not a NHSF (see CPSA by-laws and s.2 of the Health Care Protection Regulation). Case costs may be higher with complex cases due to supply usage.
5.6	Describe the pricing of contracted surgical services in NHSFs information. What are the expenditures and procedure volumes?	Alberta Health Services (AHS) manages the contracts regulated by the Health Care Protection Act (HCPA) as well as the contracts outside of the HCPA with NHSFs. Apr 1, 2018-Mar 31, 2019: • Max. value of contracts: ($21,389,884 (incl. contingency: $27,391,494)); • Actual procedure volume: 37,432
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	Total number of procedures done by NHSFs as well as the total amount of fees collected for enhanced medical goods or services by NHSF are reported annually by AHS.[48]
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	None found

[47] HCPA. (2000).

[48] Alberta Health Services. Surgical Contracts. (2019). https://www.albertahealthservices.ca/about/Page3172.aspx

6.3	Do agreements/contracts include performance measures?	Yes. Annual and Quarterly contract compliance and quality performance reports/monitoring are developed and reviewed at the facility/contract level. Quality and performance measures include: accessibility, effectiveness, appropriateness, and safety.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so please provide references and a brief summary.	The Office of the Auditor General of Alberta (OAGA) conducted an initial audit in 2001 with follow-up audit recommendations. In 2014, the OAGA repeated its recommendation that Alberta Health Services strengthen its process to monitor the performance of non-hospital surgical facilities. AHS formed a NHSFs Provincial Working Group in May 2014 to address recommendations from the audit reports from the OAGA and AHS Internal Audit Services. Lead by the Surgery Strategic Clinical Network, the Working Group was comprised of key stakeholders from Alberta Health (AH), the CPSA and AHS. The Working Group issued and implemented the attached report. In 2017 the OAGA concluded that AHS has implemented recommendations to establish an oversight process to monitor the performance of contracted non-hospital surgical facilities and improving its processes to record and analyze performance information for those surgical facilities.

Table A3. Saskatchewan

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital surgical facilities?	The Health Facilities Licensing Act (HFLA) have permitted Health Facilities since 1999.[49] Health Facilities are defined as any place where diagnostic or therapeutic medical procedures are provided. Health Facilities are explicitly privately owned as HFLA 2(1)(i)(i) exempts all facilities "operated by the Minister, the provincial health authority or an affiliate" but the Act is silent on profit status. There was no activity in this sector, however, until the establishment of the Saskatchewan Surgical Initiative (SkSI) in 2012.
1.2	Is there public financing of private delivery of non-hospital surgical facilities?	Although the HFLA does not mention how financing methods or sources of health facilities, the SkSI explicitly directs public funding for non-hospital, private for profit facilities for surgical procedures.[50]
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Again, the HFLA is silent on all matters of ownership for health facilities, but the SkSI specifies the use of Surgical Centres Inc. (SCI) facilities (one in Regina and one in Saskatoon), de facto establishing the inclusion of corporate/commercial for-profit health facilities.
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital surgical facilities? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	The Health Facilities Licensing Regulations[51]. Although these regulations (and the associated HFLA) always permitted private, for-profit ownership and operation, it was not until 2011 that a centre opened. In 2016 separate legislation was enacted, superseding this, for diagnostic imaging.
2.2	What is the mechanism for enforcing the legislation?	HFLA 25(1) provides explicit financial penalties for anyone found in contravention of the Act or Regulations.
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	None found.
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital surgical facilities?	The HFLA 5(1) grants the Minister power to appoint an accreditation program operator. The Health Facility Licensing Regulations 3(2) states that the College of Physicians and Surgeons of the Province of Saskatchewan (the College) is the designated accreditation program operator for the purposes of HFLA section 5. The College bylaw 26.1 governs the "operation of non-hospital treatment facilities in the province of Saskatchewan", but the facilities themselves are explicitly out-of-scope, the bylaws are to establish the standards a health facility must meet in order for a physician to maintain good standing within the college if they are to enter into any form of professional relationship with said facility.[52]
3.2	Do accreditation standards differ for public or not-for-profit facilities?	The College has adopted the NHSF Standards & Guidelines set out by the CPSA "with a few variations"[53], although these variations are never elaborated upon. The NHSF Standards & Guidelines are silent on the ownership of NHSF, save for a provision that the College must be notified of any changes in ownership and structure.

[49] HFLA. (1996). http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/H0-02.pdf
[50] Government of Saskatchewan. *Saskatchewan Surgical Initiative*. http://www.sasksurgery.ca/sksi/thirdparty.html.
[51] HFLA Regulations. (1999). http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/H0-02R1.pdf
[52] CPSS Bylaws. (2018). https://medicine.usask.ca/documents/pgme/policy/RegulatoryBylaws.pdf
[53] CPSS. (2019). *Non-Hospital Treatment Facility Program Overview*. https://cps.sk.ca/imis/CPSS/Programs_and_Services/Non-Hospital_Treatment_Facility_Program.aspx?NonHospitalCCO=1#NonHospitalCCO

3.3	Do accreditation standards differ for facilities receiving public funding?	The NHSF Standards & Guidelines are silent on the insurance state of procedures performed
3.4	Are there any additional considerations before licensure/accreditation is granted?	HFLA 7(2) requires the Minister be satisfied that the Health Facility is in compliance with any relevant acts and regulations in both Saskatchewan and Canada and will continue to be operated as such. HFLA 7(2)(c) explicitly requires consideration that there is need for the diagnostic or therapeutic procedure provided by the Health Facility. HFLA 7(2)(e) & (f) require consideration that the licensure is an efficient use of public resources and not contrary to the public interest.
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	The SkSI provides (now broken) links[54] to third-party surgical providers in the (no longer existent) Regina Qu'Appelle & Saskatoon health regions. The Saskatchewan Health Authority (SHA) has continued the existing contract from RQHR, although they are currently in the process of a new procurement process for future NHSF contracts. In September 2013 the Regina Qu'Appelle Health Region (RQHR) released a Request for Proposals (RFP) for non-hospital insured surgical services[55]. The exact results of this RFP are unknown, although it resulted in no new contracts nor structures carried forward by the SHA.
4.2	Does any other body have the authority to approve contracts?	None found.
4.3	Are there any mechanisms for appeal?	The HFLA 17(1) allows appeal for any ministerial decision relevant to the act.
	5. Financial reporting/incentives	
5.1	How are providers paid?	As part of the SkSI the Saskatchewan Ministry of Health issued costing methodologies and frameworks for both diagnostic and surgical services in June 2010[56]. The goal of this document was to provide a baseline for the cost of delivery in the public system for comparison of third-party providers. No direct reporting of third-party expenditure (in aggregate or by facility) could be found, outside of supplier information in the annual report.
5.2	Are there price controls?	None found.
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	None found.
5.4	Are there allowable user contributions for all or part of the service?	The RFP issued by RQHR included explicit price caps for non-returnable patient goods (e.g., crutches, braces, etc.) which can be charged patients. It is unknown if this schedule is used currently, but it suggests that user contributions are de facto permissible.
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	None found.
5.6	Describe the pricing of contracted surgical services in	Saskatchewan's regional health authorities are responsible for establishing contracts with NHSFs. It is the only province included in this review the provided actual pricing data per service.

[54] The Third Party Delivery page (http://www.sasksurgery.ca/sksi/thirdparty.html) has links for the Saskatoon Health Region (https://www.saskatoonhealthregion.ca/Pages/PageNotFoundError.aspx?requestUrl=http://www.saskatoonhealthregion.ca/about/media-centre/news-releases/Lists/Posts/Post.aspx) and Regina Qu'Appelle Health Region (http://www.rqhealth.ca/inside/district_news/news_communitybased_surgeries.shtml) which direct to pages which cannot be found, even though the domains are still active and used, despite the amalgamation to the SHA.

[55] Regina Qu'Appelle Health Region. (2013). *Request for Proposals Non-Hospital Insured Surgical Services*. http://www.rqhealth.ca/service-lines/master/files/rfp_september2013_surgicalservices.pdf

[56] Saskatchewan Ministry of Health. (2010). *Costing Framework: Third-Party Delivery of Outpatient Surgery*. http://www.sasksurgery.ca/pdf/third-surgerycostframework.pdf

	NHSFs information. What are the expenditures and procedure volumes?	Apr 1, 2018-Mar 31, 2019: • Actual expenditure: $12,290,627 • Procedure volume: Unavailable
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	None found. The College reports the facilities that are seeking accreditation (name, location, medical director(s), inspection date & outcome, and approved procedures list), but no other details.
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	None found.
6.3	Do agreements/contracts include performance measures?	None found.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	None found.
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	None found.

Table A4. Ontario

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital surgical facilities?	Yes. NHSFs have been allowed by the Independent Health Facilities Act (IHFA) since 1990.[57] In 2017, the IHFA was repealed by schedule 9, the *Oversight of Health Facilities and Devices Act (OHFDA), of Bill 160,* the *Strengthening Quality and Accountability for Patients Act (2017).*[58] Bill 160 received Royal Assent on December 12, 2017, but it has still not been proclaimed. Consequently, for the time being, the IHFA remains the legislation that regulates independent health facilities (IHFs).[59] Nevertheless, the OHFDA is still of interest because it provides more recent insight into the intended status of IHFs in Ontario. Thus, this table will provide information from both the IHFA (1990) and OHFDA (2017). Note that OHFDA does not refer directly to IHFs, it refers only to "community health facilities." It defines community health facility as, "a place or a collection of places where one or more services prescribed in regulations made by the Minister are provided, and includes any part of such a place, and a place or collection of places prescribed in regulations made by the Minister."[60] Thus, the term "community health facility" refers to both IHFs and other non-hospital medical clinics. In 2014, the Ontario Auditor General (OAG) estimated that there were 25 IHFs that offered surgical procedures.[61]
1.2	Is there public financing of private delivery of non-hospital surgical facilities?	Yes. IHFs provide services that are covered by the Ontario Health Insurance Plan (OHIP). Additionally, under part IX of the OHFDA, "Funding", the Minister of Health and Long-Term Care may provide funding for community health facilities that may include facility costs and funding for inspecting bodies.[62]
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Yes. Under part IV of the OHFDA, "Corporate Licences", the licensee of an independent health facility (IHF) may be a corporation. Similarly, section 14 of the IHFA also allowed for the licensee of an IHF to be a corporation.[62] In 2014, the Auditor General reported that 98% of Ontario's IHFs were for-profit corporations, and that approximately half of them were owned and operated by physicians.[63]
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital surgical facilities? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	*Independent Health Facilities Act (IHFA), R.S.O. 1990, c. I.3*, and Bill 160: the *Strengthening Quality and Accountability for Patients Act (*schedule 9, the *Oversight of Health Facilities and Devices Act (OHFDA)),* but as previously noted, the OHFDA has received Royal Assent but not Proclamation and as such is dormant legislation. The IHFA provides for the establishment of IHFs in Ontario and outlines their regulations and relationship to the Ontario Ministry of Health and Long-Term Care (MOHLTC). Bill 160 received royal assent on December 12, 2017.[64] Schedule 9 of the bill pertains to oversight of non-hospital surgical facilities in Ontario. The objective of schedule 9 of the bill, the OHFDA, is to strengthen "the safety and oversight of services delivered in community health facilities and with medical radiation devices like X-ray machines, CT scanners, ultrasound machines and MRIs."[65]

[57] IHFA. (1990). https://www.ontario.ca/laws/statute/90i03?search=Independent+Health+Facilities+Act%2C

[58] Bill 160. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2017/2017-12/bill---text-41-2-en-b160ra_e.pdf. This act is to be repealed with Bill 160, Omnibus Health Bill (2019), but the repeal has not been proclaimed by the Lieutenant Governor.

[59] Ontario Ministry of Health and Long-Term Care. (2019). *Independent Health Facilities.* http://www.health.gov.on.ca/en/public/programs/ihf/

[60] Bill 160. (2017).

[61] OAG 2014 Report. (2014) http://www.auditor.on.ca/en/content/annualreports/arreports/en14/406en14.pdf. p. 481.

[62] IHFA. (1990).

[63] OAG 2014 Report. (2014) p. 481.

[64] MOHLTC. (2019. http://www.health.gov.on.ca/en/public/programs/ihf/

[65] Queen's Printer for Ontario. https://news.ontario.ca/mohltc/en/2017/12/strengthening-quality-and-accountability-for-patients-act-2017-1.html. 2017.

2.2	What is the mechanism for enforcing the legislation?	The Lieutenant Governor in Council appoints one or more executive officers. The executive officers may appoint inspectors or classes of inspectors to enforce the provisions of the OHFDA. Under the IHFA, it is also the responsibility of the Lieutenant Governor in Council to enforce the legislation.
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Under the OHFDA: "No person shall obtain, receive or attempt to obtain or receive funding or facility costs or any payment for or in respect of a service that the person is not entitled to obtain pursuant to the conditions, rules and restrictions of funding provided for under this Act or the regulations." These lines come directly from section 3 of the IFHA.[66] Thus, both pieces of legislation prohibit providers from charging fees or facility costs to anyone other than the Ministry.[67]
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital surgical facilities?	Per the IHFA and the OHFDA, the MOHLTC is responsible for issuing licences. The College of Physicians and Surgeons of Ontario (CPSO) also maintains standards and carries out inspections of physician practices that provide out-of-hospital care.[68] However, physicians who provide out-of-hospital surgical services that do not require anesthetic are not necessarily inspected by an accreditation body. In Ontario, no one body is responsible for the accreditation of public hospital and non-hospital surgical facilities. At the national level, the Canadian Association for Accreditation of Ambulatory Surgical Facilities and Accreditation Canada are responsible for the accreditation of facilities performing publicly funded services in a non-hospital setting.[69]
3.2	Do accreditation standards differ for public or not-for-profit facilities?	No. Under part III of the OHFDA, "Licencing and Related Matters," the licencing standards do not distinguish between public or not-for-profit facilities. They outline the licencing process for *any* person applying to operate a community health facility. The IHFA also makes no distinction.
3.3	Do accreditation standards differ for facilities receiving public funding?	No. See 3.2.
3.4	Are there any additional considerations before licensure/accreditation is granted?	In general, the OHFDA states that licences are subject to every condition that may be specified by the executive officer and every condition that is prescribed by the license. More specifically, section 5, (3) requires that the before issuing a license, the executive officer must consider: (a) the nature of the services to be provided in the community health facility; (b) the extent to which the services are already available in Ontario or in any part of Ontario; (c) the need for the services in Ontario or any part of Ontario; (d) the future need for the services in Ontario or any part of Ontario; (e) the projected cost in public money for the establishment and operation of the community health facility; (f) the availability of public money to pay for the establishment and operation of the community health facility; (g) the concentration of ownership, control or management of community health facilities in Ontario or any part of Ontario; and (h) any other matter that the executive officer considers relevant to the management of the healthcare system.[67] These conditions come directly from section 9 (2) of the IHFA.[66]
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	All licences for community health facilities are issued by an executive officer that is appointed by the Lieutenant Governor, and operators of non-hospital surgical facilities have transfer payment agreements with the Ministry. Note that the licensee of a community health facility cannot enter into a contract that results in a change in the beneficial ownership of the facility. The licensee must have the license transferred in accordance with section 10 of the OHFDA.[67] The IHFA includes the same conditions in sections 6, 11, and 16; however, the IHFA refers to a "director" of IHFs who is appointed by the Minister rather than an executive officer.[66]

[66] IHFA. (1990).
[67] Bill 160. (2017).
[68] CPSO. (2013). "Out-of-Hospital Premises Inspection program (OHPIP): Program Standards." https://www.cpso.on.ca/pdf.
[69] Cowling T, de Léséleuc L. Surgical interventions performed outside the hospital operating room. Ottawa: CADTH; 2015. (Environmental Scan; Issue 49). p. 7.

4.2	Does any other body have the authority to approve contracts?	No, the OHFDA explicitly states that all persons applying to operate a community health facility must have a licence from the executive officer. That is, the Ministry is the only authority who can approve licences.[70] Under the IHFA, the Ministry is also the only authority who can approve licences.[71]
4.3	Are there any mechanisms for appeal?	Licences cannot be transferred without the written consent of the executive officer, and given sufficient notice, the executive officer may suspend, revoke, or refuse to renew a licence of an IHF. See part IX, "Funding," section 66 of the OHFDA; or, sections 11, 18 and 19 of the IHFA.[71]
	5. Financial reporting/incentives	
5.1	How are providers paid?	The Ministry pays providers for the services they provide, and the overhead costs associated with providing those services. Per the OHFDA, the Ministry compensates providers for their "facility costs." A facility cost is defined as, "a charge, fee or payment for or in respect of a service or operating cost that supports, assists and is a necessary adjunct, or any of them, to an insured service but is not part of the insured service, and anything else that is prescribed as a facility cost." This is the same as the IHFA, except the IHFA calls them facility *fees.*[71] Physicians are paid a professional fee-for-service by OHIP.
5.2	Are there price controls?	Patients cannot be billed for any insured services provided by a specialty clinic or extra-billed for an insured service.[72] All medically necessary services provided are paid for by OHIP. Section 20 of the OHFDA also prohibits charging patients for preferred access (queue-jumping) to insured services.[73] The Ministry intends to ensure that patients will *not* have to pay any optional fees to access services covered by OHIP.[74] Unlike the OHFDA, the IHFA does not have a clause that explicitly bans charging patients for preferred access, but it still stipulates that professional and facility fees shall only be charged to the Minister.[75]
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	Licensees are paid on a facility fee (as per the schedule of facility fees) × volume basis that provides a direct incentive for volume. There is also a financial incentive for providers to establish IHFs in larger urban communities. As the Auditor General observed in 2014, "each facility is paid the same amount for each type of service available, regardless of the number of services it performs. Consequently, larger facilities in urban areas often benefit from economies of scale, since costs like rent and reception staff salaries do not increase proportionately with the number of services performed."[76] Alternatively, licensees may be paid through a transfer payment agreement which typically set a volume of services and a and a facility fee for the service.
5.4	Are there allowable user contributions for all or part of the service?	No. Under section 20 of the OHFDA, no person shall: "(a) charge or accept payment for providing an insured person with access to an insured service at a community health facility; (b) obtain or accept a benefit, direct or indirect, for providing an insured person with access to an insured service at a community health facility; or (c) offer to do anything referred to in clause (a) or (b)."[77] The IHFA states under section 8 (7) that facility fees shall not be charged to a person other than the Minister.[78] The IHFA was in part introduced to prohibit providers from billing patients for the overhead costs associated with providing insured services. Before the IHFA (1990) was introduced, facilities could charge insured patients a fee to cover their overhead costs, but after the IHFA was passed and IHFs were required to obtain a license from the Ministry, IHFs could bill the Ministry for their facility-fee costs, and they were no longer permitted to bill patients for overhead costs.[79] Ontario's two remaining private hospitals allow direct billing (out-of-pocket or private insurance).

[70] Bill 160. (2017).
[71] IHFA. (1990).
[72] Commitment to the Future of Medicare Act. 2004. https://www.ontario.ca/laws/statute/04c05
[73] https://www.ontario.ca/laws/statute/17o25#BK76. Bill 160.
[74] MOHLTC. A Policy Guide for Creating Community-Based Specialty Clinics. p.4. 2013.
[75] IHFA. (1990).
[76] OAG 2014 Report. http://www.auditor.on.ca/en/content/annualreports/arreports/en14/406en14.pdf. p. 482. 2014.
[77] https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2017/2017-12/bill---text-41-2-en-b160ra_e.pdf.
[78] IHFA. (1990).
[79] OAG 2012 Report. (2012). http://www.auditor.on.ca/en/content/annualreports/arreports/en12/306en12.pdf p.152.

5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	This remains unclear. The services that public hospitals provide are funded by Ontario's Quality Based Procedure (QBP) funding program. QBPs are groups services or procedures for patients who require similar care.[80] A procedure that is designated as a QBP is funded on a price × volume basis. According to the Ministry, this funding that health care providers receive for administering a QBP is "adjusted for the types of patients they serve."[81] However, IHFs do not explicitly follow the QBP funding model as hospitals have their own funding mechanisms that differ substantially from IHFs. According to the Ministry, when setting facility fees for the services provided by IHFs, QBP prices are considered, but not explicitly followed. So, it is unclear if the prices of IHF services can be adjusted for the types of patients they receive, in the way that QBP prices are. Without knowing facility fees set by the Ministry in contracts with IHFs, we are unable to say if there is potential for cream-skimming/selecting good risks.
5.6	Describe the pricing of contracted surgical services in NHSFs information. What are the expenditures and procedure volumes?	MOHLTC is responsible for contracting with NHSFs. Below are estimates of the 2019-20 surgical volumes and the funding provided to NHSFs, by section. Although limited to 12 months for each, these include NHSFs funded both on a calendar and fiscal year basis. In addition to the surgical procedures that they are licensed to provide, Ontario NHSFs may also provide secondary surgeries and services, such as counselling sessions, that are not reported to the government. Physicians bill for these secondary services. 2019-2020: • Estimated expenditure: $20,475,286 • Estimated procedure volume: 32,623
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	The community health facility inspecting bodies established by section 40 of the OHFDA are required to make reports of inspections and cessation orders available to the public. Section 67 of the OHFDA requires that "the executive officer shall make available to the public, (a) every order made by the executive officer under this Act that is in relation to a community health facility; and (b) anything that is prescribed as something that the executive officer must make available to the public."[82] The IHFA does not require that reports of inspections be made available to the public; however, information including assessment status is provided at http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx.[83]
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	Sections 31 and 32 of the OHFDA require that every licenced community health facility have a "quality advisor" and "quality committee." Section 31 requires that every licensee or prospective licensee have a quality advisor who, "(a) must be a member of a regulated health College; (b) must be approved by the executive officer; (c) must not be a licensee or prospective licensee, except with the prior written approval of the executive officer; and (d) must meet any other requirements provided for in the regulations."[84] Section 32 requires that every licensee and prospective licensee has an inter-professional quality committee that shall: "(a) provide advice to the quality advisor on the quality and standards of services provided in the community health facility; and (b) perform any other functions provided for in the regulations."[85] So there is performance reporting at the provider level, but the extent of is depends on what is provided for in the Ministry regulations.
6.3	Do agreements/contracts include performance measures?	Yes, see section 6.2. Bill 160 section 34 requires that every licensed community health facility, "establish and maintain a system to monitor the results of services provided in the community health facility in accordance with the requirements provided for in the regulations."[86] Similarly, section 41 of the IHFA requires that the Lieutenant Governor in Council may make regulations requiring IHFs to monitor the results of the services they provide.[87] Again, the licensing practices established by Bill

[80] MOHLTC. A Policy Guide for Creating Community-Based Specialty Clinics. p.10. 2013.
[81] MOHLTC. http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx. 2018.
[82] Bill 160. (2017).
[83] IHFA. (1990).
[84] Bill 160. (2017).
[85] Bill 160. (2017).
[86] Bill 160. (2017).
[87] IHFA. (1990).

		160 require some performance measures, but the extent of these measures is dependent on the Ministry's regulations.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	The OAG has reviewed Independent Health Facilitates on three occasions: 1996, 2004, and 2012. The OAG also provided follow-up reports to each of these reports in 1998, 2006, and 2014 respectively. In 1996, the OAG recommended that the Ministry better, "ensure the reasonableness of facility fees," "develop specific criteria for determining which technical services and procedures should be licensed," and work with the CPSO to ensure that the CPSO's facility assessments follow a consistent methodology and are clear and timely. The 1998 follow-up report indicated that the Ministry had taken steps to meet every recommendation from the 1996 report; however, the CPSO assessment methodology, and the determination of which service should be funded under the IHFA were both still a work in progress.[88] In 2004, the OAG reported that the Ministry needed to address 7 issues with the IHF program in order to ensure that the program was cost-effective. Similar to the 1996 report, these issues focused on the assessment process of IHFs, and reasonableness of facility fees.[89] In 2006, the OAG reported that the Ministry had established a framework to ensure more consistent assessments of IHFs by the CPSO.[90] The OAG also reported that the Ministry had established a committee for evaluating facility fees, but that this committee would not finalize its report on facility fees until fall/winter 2007.[91] In 2012, the OAG once again recommended that the Ministry improve the how IHFs are assessed, and how facility fees are set/monitored. In particular, the 2012 report notes that as of March 2012, "12% of facilities had not been assessed within the last five years," and that the fixed nature of facility fees means that, "larger facilities in urban areas often benefit from economies of scale," because the costs associated with providing services do not increase proportionally with the number of services the facility provides.[92] However, it should be noted that in 2019, the OAG's 2012 report is note only dated, but potentially a misrepresentation of both the status of IHF assessments in 2012 and today. For example, according to the Ministry, the 12% of facilities that had not been assessed may be explained by the fact that some licences may have been in the process of an ownership transfer or inactive and therefore did not require assessment. In 2014, the OAG reported that the Ministry had begun addressing half of its recommendations from the 2012 report, but that the Ministry still need to identify underserved areas in the province, and review the reasonableness of facility fees.[93] All of the OAG reports highlight the need to better evaluate facility fees. From 1996 to 2014, the OAG recommended that the Ministry improve its system of determining and monitoring facility fees.
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	The OAG's 2012 report lists the total facility fees paid for six surgical services (dialysis, abortion, ophthalmology, plastic, and laser) from 2006/07 to 2010/11.[94] The Ministry has a website (http://www.health.gov.on.ca) that allows visitors to search the IHFs in Ontario by location and services provided. There are estimated to be 14 facilities in Ontario that public payments for the provision of surgical services.

[88] OAG 1998 Report. http://www.auditor.on.ca/en/content/annualreports/arreports/en98/4en98.pdf. p. 286-7.
[89] OAG 2004 Report. http://www.auditor.on.ca/en/content/annualreports/arreports/en04/308en04.pdf. p. 217.
[90] OAG 2006 Report. http://www.auditor.on.ca/en/content/annualreports/arreports/en06/408en06.pdf. p. 305.
[91] Ibid. p. 303.
[92] OAG 2012 Report. http://www.auditor.on.ca/en/content/annualreports/arreports/en12/306en12.pdf. p. 151-2.
[93] OAG 2014 Report. (2014) p. 483.
[94] OAG 2012 Report. (2012). p. 150.

Table A5. Quebec

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital surgical facilities?	Loi sur les services de santé et les services sociaux (LSSSS) allows centres medicaux spécialisés,(CMS) to provide specific surgical procedures (anything requiring >24 hours is explicitly forbidden by the regulations).[95] A clinique médicale associée (CMA) is a CMS, private health facility, or laboratory in an association agreement with a hospital and the relevant regional agency.[96] A CMS which becomes a CMA is a clinique medicale spécialisé associée (CMSA). All physicians in CMAs must be exclusively publicly insured and CMSA physicians must also have privileges at the hospital they are associated with.[97] These facilities must be exclusively staffed by physicians either participating or non-participating in the public health insurance plan, but not both. These are thus private ambulatory centres which acquire a special status and license from the government and must be accredited, which is a unique model in Canada. A CMS with participating physicians must work with public establishments and cannot charge any costs to patients (for publicly insured services). This has taken the form of what some would call subsidized private (similar to Ontario), where these clinics are managed privately but operate in the public environment with access to the public. Thus, there is no standard business model for a non-participating CMS.
1.2	Is there public financing of private delivery of non-hospital surgical facilities?	Services from the publicly insured "basket" of services can be provided by a CMS whether it is operated by a physician who is publicly insured (Régie) or by a physician who is not publicly insured (non-Régie). A non-Régie physician is completely external from insured programs and must operate in exclusively private space (charging patients directly, and patients are not entitled to reimbursements from the public plan). Additionally, a pilot project was introduced in 2016 by the provincial health minister (Barette) with the stated objective of determining the cost per activity for certain day surgeries. Three private clinics are currently involved. These clinics must provide a monthly accounting of services performed and the cost of supplies/human resources/operating costs. The ministry then reimburses the total + a 10% premium.
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	A CMS must be controlled by physician with active membership in the Collège des médecins du Québec (College)[98], so corporate/commercial ownership is prohibited. This was a stipulation in the original 2008 amendment to allow for CMSs. The LSSS also requires CMS to support pre- and post-operation rehab (so as to avoid spill over to the public sector from increasing intensity in the private sector). *Rockland MD* is owned by medical professionals, and *OPMEDIC Laval* is owned by and investment fund, but the operation and control of the facility is done by medical professionals.
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital surgical facilities?	*LSSSS (specifically Section 4.2, r-.25* - Réglement sur les traitements médicaux spécialisés dispensés dans un centre médical spécialisé). Related, Bill 34: *An Act to amend various legislative provisions concerning specialized medical centres and medical imaging laboratories*.[99]
2.2	What is the mechanism for enforcing the legislation?	Licensure of a CMS is through permits issued by the Ministry of Health and Social Services (MSSS) which indicate status (Régie or non-Régie), procedures it is authorized to do, location, and beds (if applicable)[100] Permits are granted by the Ministry for a 5-year period.

[95] MSSS. (2019). *Obtention d'un permis de centre médical spécialisé (CMS)*. http://www.msss.gouv.qc.ca/sujets/organisation/cms/index.php?centre_medical_specialise
[96] Ibid.
[97] Ibid.
[98] Even if the owner is a partnership (or other legal entity) 50% of voting interests (for e.g., board membership) must be physicians with active College membership and must be the majority of quorum at all times (per LSSS 333.2).
[99] National Assembly of Québec. (2009). *Bill 34: An Act to amend various legislative provisions concerning specialized medical centres and medical imaging laboratories*. http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2009C29A.PDF
[100] MSSS. (2019). *Obtention d'un permis CMS.*

		Regarding the pilot project, there is monthly oversight of expenses and activities, and a 4-year period for the permits. The permit also requires accreditation from the Accreditation Canada or le Conseil québécois d'agrément. However, there may be loopholes or lack of enforcement: for instance, a physician owning/working in a cosmetic surgical clinic (uninsured services) can also work in a CMS as a RAMQ-participating surgeon. Some cosmetic non-participating surgery clinics are known to employ participating anesthesiologists. (3-4 clinics in the CMS-P).
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Explicitly banned; a CMS must be either exclusively Régie or exclusively non-Régie as per section 333.3 of the LSSSS.[101] Note that the separation between private and public practicing physicians has been challenged as a violation of the Charter of Rights and Freedoms (Section 2d – Freedom of Association) but was dismissed by the Supreme Court of Canada on February 8, 2019.[102]
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital surgical facilities?	LSSS 333.4 says a CMS must be accredited within three years of the issuance of a permit, they must be accredited by a body recognized by the MSSS. Currently recognized bodies are the Conseil québécois d'agrément (Quebec Council of Accreditation) and Accreditation Canada (Canadian Council on Health Services Accreditation - CCHSA), only one of which is required to accredit the CMS[103]
3.2	Do accreditation standards differ for public or not-for-profit facilities?	All CMS have the same accreditation standards: Through accreditation Canada, as independent medical/surgical facilities
3.3	Do accreditation standards differ for facilities receiving public funding?	As above
3.4	Are there any additional considerations before licensure/accreditation is granted?	CMSA proposals are only considered if the Ministry believes it would improve accessibility and will not impact the capacity of the public system (especially in regards to staffing) and that the proposed CMS has the best quality to cost ratio for the services proposed. A CMSA requires a proposal to be vetted by a regional panel of heads of medical specialties and then be accepted by the Ministry.
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	LSSS 349.3 states CMA/CMSA agreements are between the agency/institution and the CMS owner. This agreement requires prior authorization of the Minister.
4.2	Does any other body have the authority to approve contracts?	No
4.3	Are there any mechanisms for appeal?	LSSS 349.3.7 states there must be a dispute resolution mechanism in the agreement regarding interpretation or application of the agreement. A CMS is still subject to the Loi sur le Protecteur des usagers en matière de santé et de services sociaux (Ombudsman).
	5. Financial reporting/incentives	
5.1	How are providers paid?	Non-Régie physicians can charge as they see fit. We could not find information on if Régie payments are different from standard fee-for-service (FFS) payments. The pilot program's 3 clinics are retrospectively reimbursed facility costs (overhead, disposables, and non-physician staffing) plus a 10% premium.
5.2	Are there price controls?	LSSS 349.3.3 specifies that the unit price must be disclosed in the agreement, but there is no explicit mention of controls, limits or acceptable ranges. The MSSS decides whether the costs are reasonable, and an accounting firm (Raymond Chabot Grant Thornton) oversees and audits for the pilot project agreement with at least one facility (that we spoke to).

[101] Which was upheld by the Court of Appeal of Quebec and application before the Supreme Court of Canada was dismissed (per https://www.lavery.ca/en/publications/our-publications/3069-.html)
[102] Pariseault, C. (2018). *Freedom of association of physicians practising at a specialized medical centre: the Supreme Court of Canada declines to intervene.* https://www.lavery.ca/en/publications/our-publications/3069-.html.
[103] MSSS. (2019). *Obtention d'un permis CMS.*

5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	There is no language about incentives, but LSSS 349.3.2 requires that the minimum and maximum number of services the CMA will provide be specified in the agreement.[104]
5.4	Are there allowable user contributions for all or part of the service?	Only in the case of non-Régie funded services. Since Jan 26, 2017 any accessory costs or additional billing on services covered by public insurance is explicitly banned.[105]
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	No such mechanisms currently exist.
5.6	Describe the pricing of contracted surgical services in NHSFs information. What are the expenditures and procedure volumes?	The MSSS is responsible for contracting with NHSFs. Average price per service is derived based on the number of contracted surgeries performed and the total amount of funding provided to the centres. May 16, 2016-Jan 31, 2018: • Actual expenditure: $21,372,920 (pilot clinics only: $19,745,357) • Actual procedure volume: 26,049 (pilot clinics only: 22,891)
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	For the pilot project: Every month facilities report on the number of interventions performed and canceled, and the amount of equipment used. Before facilities are reimbursed fully, an external audit of their expenses is performed by a third party (Raymond Chabot Grant Thornton).
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	None found
6.3	Do agreements/contracts include performance measures?	No. Contracts provide a fixed fee to incentivise volume.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so please provide references and a brief summary.	For the pilot project: There are monthly and annual audits done by the MSSS that are validated by an external accounting firm, as above.

[104] They must also provide an estimate of quarterly distribution to ensure continuity of service.
[105] Services Québec. (2019). Entrée en vigueur de l'abolition des frais accessoires. http://www.fil-information.gouv.qc.ca/Pages/Article.aspx?aiguillage=ajd&type=1&idArticle=2501263099

Appendix B: Accountability in Non-Hospital Diagnostics Facilities – Detailed Tables by Province

Table B1. British Columbia

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital advanced diagnostic facilities?	Yes. Under section 25.5 (d) of the *Health Professions Act* (HPA), the College of Physicians and Surgeons of British Columbia (CPSBC) is authorised to write bylaws for the accreditation of "diagnostic facilities".[106] According to the CPSBC bylaws, "diagnostic facilities" are defined as a place, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in a: (i) clinical pathology laboratory, (ii) medical imaging facility. Where a medical imaging facility is, "a place where imaging techniques are utilized for diagnostic purposes including but not limited to x rays, ultrasound, computed axial tomography, magnetic resonance imaging, or positron emission tomography."[107]
1.2	Is there public financing of private delivery of non-hospital advanced diagnostic facilities?	Under section 30 (a) of the Medical and Health Care Service Regulations of the *Medicare Protection Act* (MPA), "a practitioner or other person on a practitioner's behalf may charge a beneficiary for the services of diagnostic facilities and practitioners which have not been determined under section 5 (1) (j) of the MPA to be benefits." Thus, if the service provided by the diagnostic facility are a benefit of the public plan then they are covered publicly, if they are not a benefit, the facility can bill the patient directly.[108] However, there are currently no *privately* owned non-hospital advanced diagnostic facilities that provide *publicly* funded services in British Columbia. The government has recently purchased 2 non-hospital facilities that provide publicly funded advanced diagnostics services, but even though these facilities are "non-hospital," they are still owned by the government.
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Yes. Under Part 4 of the HPA[109] and Part 6 of the CPSBC Bylaws,[110] health facilities may be corporations. Per section 43 of the HPA, "all voting shares of the corporation are legally and beneficially owned by: (i) registrants of the college, or (ii) companies as defined in the Business Corporations Act…" Thus, a company may own the controlling share of a corporation that operates a health facility.[111] Again, as 1.2 indicates, even though the law permits it, there are currently no non-hospital surgical facilities delivering publicly funded advanced diagnostic services that are privately owned.
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital advanced diagnostic facilities? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	Under the HPA, the Ministry of Health of B.C. requires that the CPSBC establish, maintain, and enforce bylaws that regulate diagnostic facilities in B.C. The *Health Professions Act* (HPA) is not specifically relevant to the governance of diagnostic facilities, it is simply the legislation that gives the CPSBC authority to write bylaws.[112] Such as the bylaws that regulate diagnostic facilities. In other words, via the HPA, the Ministry of Health delegates diagnostic facility oversight responsibilities to the CPSBC. Part 5 section B of the CPSBC bylaws outlines the CPSBC's Diagnostic Accreditation Program (DAP)[113] This section of the bylaws provides the most comprehensive description of the accreditation standards for *all* diagnostic facilities (including facilities that administer advanced diagnostic services such as CT, MRI, and PET-CT) in B.C.
2.2	What is the mechanism for enforcing the legislation?	Schedule C of the CPSBC bylaws describes the administrative penalties and costs corresponding to failures of the Medical Directors of accredited diagnostic facilities to comply with the bylaws, as well as any other rules, standards, or policies set by the College.[114] Failures by a facility's medical director to follow the reporting and accreditation standards outlined by the bylaws results in $1000.00 fine for

[106] HPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#section1
[107] CPSBC Bylaws. (2009). p. 81. https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf.
[108] Medical and Health Care Service Regulations. (2018). http://www.bclaws.ca/civix/document/id/complete/statreg/426_97#part1
[109] HPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#part4
[110] CPSBC Bylaws. (2009). p 83.
[111] HPA. (1996) http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#section43
[112] HPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01#section19
[113] CPSBC Bylaws. (2009). p 77.
[114] Ibid. p. 99.

		the first offense, $2000.00 for the second offence for the same infraction, and $3000.00 for subsequent offenses for the same infraction.[115]
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Yes, section 14 of the *Medicare Protection Act* (MPA)[116] requires that physicians provide written notice to the Ministry that they elect to be paid for their services directly by patients. If physicians opt-out of the public insurance plan, under section 18 of the MPA, they *cannot* charge the patient more than the price set by the public insurance plan for a service that is covered by the plan.[117] Once a physician elects to opt-out of the plan, the physician cannot receive any payment from the public plan until they revoke their election to opt-out of the plan.[118]
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital advanced diagnostic facilities?	The Diagnostic Accreditation Program (DAP) is managed by the CPSBC and is responsible for all accreditation decisions. The complete details of the diagnostic facilities accreditation standards are available in the CPSBC's Accreditation Standards 2014 – Diagnostic Imaging that became effective in September 2018.
3.2	Do accreditation standards differ for public or not-for-profit facilities?	No. The CPSBC accreditation bylaws do not distinguish between diagnostic facilities that are public and diagnostic facilities that are not-for profit. Under the bylaws, "*every* [emphasis added] diagnostic facility must be accredited by the committee [the diagnostic accreditation program committee] before it can render a diagnostic service."[119]
3.3	Do accreditation standards differ for facilities receiving public funding?	No. The CPSBC accreditation bylaws do not distinguish between diagnostic facilities based on the nature of their funding. They pertain to the accreditation of all diagnostic facilities.
3.4	Are there any additional considerations before licensure/accreditation is granted?	Per section 5-26 (5) of the CPSBC bylaws, an on-site inspection of the diagnostic facility must be conducted by one or more representatives of the DAP committee prior to accreditation. Per sections 5-26 (6) of the CPSBC bylaws, after the on-site inspection has been carried out, the diagnostic facility may be granted *provisional* accreditation for a period as determined by the committee or denied accreditation. Once a facility that has received partial accreditation demonstrates that it "has performed a sufficient number of procedures to permit a full on-site accreditation inspection," and passes the full on-site accreditation, it can be granted full accreditation for 3 years.[120]
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	The government does not currently have any contracts with privately owned non-hospital facilities to provide publicly funded advanced diagnostic services. If the government were to contract with non-hospital privately owned advanced diagnostic facilities to provide publicly funded services, it appears that contracts would be made by the CPSBC.
4.2	Does any other body have the authority to approve contracts?	No. Section 5-31 of the CPSBC bylaws states that no registrant of the College "may utilize or practise in a diagnostic facility in British Columbia unless such facility is accredited under section 5-26 [of the CPSBC bylaws]." In other words, every diagnostic facility has to be approved by the CPSBC or else CPSBC members cannot practice in it.[121]
4.3	Are there any mechanisms for appeal?	Uncertain. We were unable to read the actual contracts, but pursuant to section 5-29 (1) of the CPSBC bylaws, the DAP committee, "may revoke or change the terms of accreditation at any time during the period specified in the certificate of accreditation if, in the opinion of the committee, revocation or change is warranted by a failure to comply with the Bylaws or where there is a risk to patient care or safety."[122]
	5. Financial reporting/incentives	

[115] Ibid. p. 99.
[116] MPA. (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96286_01#section14
[117] MPA (1996). http://www.bclaws.ca/civix/document/id/complete/statreg/96286_01#section18
[118] Flood, C., & Archibald, T. (2001). The illegality of private health care in Canada. *CMAJ: Canadian Medical Association Journal = Journal De L'association Medicale Canadienne, 164*(6), p. 826.
[119] CPSBC Bylaws. (2009). p 77.
[120] Ibid. p. 78.
[121] CPSBC Bylaws. p. 80.
[122] Ibid. p. 79.

5.1	How are providers paid?	Physicians' professional fees are paid directly by the patient if the physician opts-out of the public plan. Non-hospital publicly owned facilities are given stipends to cover both the physician's professional fees and the overhead costs associated with providing the imaging service.
5.2	Are there price controls?	Yes. Section 18 of the MPA which prohibits opted-out physicians from billing patients more than the price set by the public plan for a service that would be covered by the public plan effectively puts a price cap on the services provided by opted-out physicians.[123] If physicians do not elect to opt-out of the public plan and therefore receive public funding for the services they provide, their professional fees are determined by British Columbia's public insurance plan, the Medical Services Plan (MSP).
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	None found.
5.4	Are there allowable user contributions for all or part of the service?	MPA section 17 (1) prohibits any payment from a patient, "for or in relation to a benefit, or for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit," by a physician who is enrolled in the public healthcare system. But if physicians elect to opt-out of the public insurance plan, under section 18 of the MPA, they cannot charge the patient more than the price set by the public insurance plan for a service that is covered by the plan.[124]
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	None found.
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	Unlike the CPSBC's non-hospital medical and surgical facilities accreditation program (NMSFAP), the CPSBC's DAP does not contain a condition that permits the CPSBC to disclose information about diagnostic facilities that it considers to be of interest to the public.[125]
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	Under section 5-25 (6) of the CPSBC bylaws it is the responsibility of the DAP committee to: "(1) establish performance standards to ensure the delivery of high quality and safe diagnostic services and, upon request, to provide a copy of those standards, (2) to evaluate a diagnostic service's level of actual performance in achieving the performance standards, (3) to establish and monitor external proficiency testing programs, (4) to promote high standards in diagnostic medicine, and (5) to keep records of receipts and expenditures in a manner approved by the board."[126] Facilities are also required to report incidents to British Columbia's Patient Safety Learning System.
6.3	Do agreements/contracts include performance measures?	The contracts were not found, but as is outlined above in 6.2, the CPSBC bylaws do require the establishment of provider level performance standards. But the details of these performance standards remain unclear.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	None found. The British Auditor General Annual Reports do not refer directly to NHSMFs.
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	Yes. The DAP publishes a list of all hospital and non-hospital accredited facilities for diagnostic imaging in British Columbia: https://www.cpsbc.ca/files/pdf/DAP-Accredited-Facilities-DI.pdf (this list

[123] MPA (1996).
[124] MPA (1996).
[125] CPSBC Bylaws. (2009). p. 77-82.
[126] Ibid. p. 77.

	was updated May 8, 2019). Three RHAs (Vancouver Coastal Health[127], Vancouver Island Health[128], and Fraser Health[129]) provide publicly available information about payments made towards suppliers of goods and services in their regions.

[127] http://www.vch.ca/Documents/VCH-SOFI-2018-Part-G-Schedule-of-Payments-made-to-Suppliers-of-Goods-Services.pdf
[128] https://www.islandhealth.ca/sites/default/files/2018-10/payments-suppliers-services.pdf
[129] https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/About-Us/Accountability/Financial-reporting/2018/20181031_Schedule_of_Vendor_Payments.pdf

Table B2. Alberta

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital advanced diagnostics?	Yes. Alberta has had privately funded MRI and CT services since 1993.[130] FindPrivateClinics.ca lists 24 centres in Calgary, Edmonton, and Red Deer offering diagnostic imaging.[131] The Accredited Imaging Facility List put out by the College of Physicians and Surgeons of Alberta reveals there are dozens more in many more centres (such as Lethbridge, Medicine Hat, and even a mobile MRI for rural sites).[132]
1.2	Is there public financing of private delivery of non-hospital advanced diagnostics?	Yes. Private clinics provide publicly funded services.[133]
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Yes. Alberta makes use of private for-profit centres that operate interprovincially, such as Mayfair (which operates in Saskatchewan) and Canada Diagnostic Centres (which operates in British Columbia). Corporate chains are predominantly physician owned companies.
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital advanced diagnostics? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	The only relevant legislation appears to the Health Professions Act, which notes the College is responsible for accrediting and setting standards for diagnostic imaging outside of hospitals. Alberta Health's Schedule of Medical Benefits (does not apply to specialists working in hospital) lists all billable insured services. The radiology section delisted MR/CT scans unless they are performed by a NHADF that is contracted with AHS. While Alberta Health Services (AHS) has contracted with NHADFs to provide scans to publicly insured patients (volume-based contracts covering professional and facility costs at a fixed price per scan), only one of these contracts is still active
2.2	What is the mechanism for enforcing the legislation?	As the College provides the licensure as well, facilities are forced to comply with accreditation and standards as a condition of operation. The College also indirectly enforces the legislation through professional (physician) licensure, as the College mandates that a physician must only associate with and practice within sites that meet their standards and comply with their bylaws to remain in good standing. The Health Professions Act 8(4) in Schedule 21 also requires all diagnostic imaging facility staff to cooperate fully with any assessment by the College.[134] Accreditation is required by College – licensed to practice in Alberta, technologists are registered and regulated, and equipment are inspected. No one can practice without meeting these accreditation standards
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	No. Accreditation standards do not speak to any distinction of facilities according to their funding source in any capacity.
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of	As per the Health Professions Act 8(1) in schedule 21, the College is the accreditor for any non-hospital/regional health authority medical facility.[135] This includes facilities providing diagnostic

[130] De Bono, N, Quesnel-Vallée, A, and Carter, R. *The private provision and insurance of diagnostic imaging services in Canada*. https://www.cahspr.ca/en/presentation/52413982f44a7df3179aa9c3
[131] *Find Private Clinics*. (2019). https://www.findprivateclinics.ca/Alberta/Diagnostic_Imaging/lc-1-0-19-0.html
[132] CPSA. (2019). Imaging – Facility Listing. http://www.cpsa.ca/FacilityListing/Accredited%20Facility%20Listing_Imaging.pdf?ad14e2
[133] Mayfair Diagnostics. (2018). *How private MRI fits into public health care.* https://www.radiology.ca/article/how-private-mri-fits-public-health-care
[134] HPA. (2000). http://www.qp.alberta.ca/documents/Acts/h07.pdf

[135] CPSA. (2017). *Diagnostic Imaging: Training Requirement Standards Diagnostic Imaging Modality Approval*. http://www.cpsa.ca/wp-content/uploads/2017/05/Physician-modality-training-standards.pdf

	non-hospital advanced diagnostics?	imaging services. The accreditation program is overseen by the Medical Facility Accreditation Committee, which is internal to the College with members appointed by the governing Council[136].
3.2	Do accreditation standards differ for public or not-for-profit facilities?	No. The College's Diagnostic Imaging Standards & Guidelines differentiate only on the type of diagnostic imaging provided, not according to ownership
3.3	Do accreditation standards differ for facilities receiving public funding?	No. Accreditation standards are indifferent to the funding source.
3.4	Are there any additional considerations before licensure/accreditation is granted?	No. The decision of the College is final and only subject to an internal appeal to the governing council[137].
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	There is only one publicly funded NHADF (in Red Deer), and it is contracted with AHS.
4.2	Does any other body have the authority to approve contracts?	No.
4.3	Are there any mechanisms for appeal?	Uncertain: No contracts could be obtained.
	5. Financial reporting/incentives	
5.1	How are providers paid?	For privately provided services they charge fee-for-service directly to the patient (which may be covered by outside insurance or other corporatist funding, e.g., health spending accounts). Publicly funded scans done in non-hospital facilities are paid a fixed fee per scan that is set by negotiated contracts with AHS.
5.2	Are there price controls?	Prices for publicly funded NHADFs are negotiated with AHS. Privately funded NHADFs can set prices at their discretion.
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	Uncertain: No contracts could be obtained.
5.4	Are there allowable user contributions for all or part of the service?	Yes. Patients can pay out-of-pocket for diagnostic imaging services.
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	Although no contracts (or related information) could be found for pricing for publicly funded services at private facilities, those that are transparent about their private pricing show variation. For example, Mayfair charges uniform pricing for MRI scans, regardless of area scanned[138] (or presumably complexity), but Insight Medical Imaging not only varies the rates by type of scan, but also lists their prices as "starting at", presumably varying with the complexity or other patient factors[139]. Insight's CT scans however are listed at a fixed price, although they vary by area scanned[140].
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance	No such measure could be found, and public wait-time reporting is done by zone not by facility.

[136] CPSA. (2018). Accreditation Program Guide. http://www.cpsa.ca/wp-content/uploads/2017/06/Accred-PG-4y.v1.pdf
[137] CPSA. (2015). *Diagnostic Imaging: Standards & Guidelines*. http://cpsa.ca/wp-content/uploads/2015/03/Standards_Diagnostic_Imaging.pdf
[138] Mayfair Diagnostics. (2019). *Magnetic resonance imaging (MRI)*. https://www.radiology.ca/services/magnetic-resonance-imaging-mri
[139] Although there is not one single price sheet, each scan type lists the 'starting at' pricing on its page. E.g., http://x-ray.ca/services/mri/joints-mri/
[140] As above, prices can be found on the relevant page. For e.g., http://x-ray.ca/services/ct/virtual-colonoscopy/

	(e.g., costs, quality, outcomes) of providers?	
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	None found.
6.3	Do agreements/contracts include performance measures?	None found.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	None found. Although the College may do evaluations of these facilities, no reports, summaries, or other findings were publicly available. Evaluations of diagnostic imaging (such as Choosing Wisely Canada's "Unnecessary Care in Canada"[141]) do not disaggregate between public and private facilities. However, the Auditor General is currently reviewing billing practice for radiologist in hospitals.
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	The College maintains a list of accredited private facilities[142]. All publicly available information that could be found on volumes (e.g., the Government of Alberta Wait Time Information page, which includes information on both CT and MRI services)[143] reports only publicly funded services and does not distinguish between those done at private or public facilities. However, a local health authority expert estimated that of the 200,000 MRIs per year in Alberta, only about 2000 are done out of hospital.

[141] CIHI. (2017). *Unnecessary Care in Canada*. https://www.cihi.ca/en/unnecessary-care-in-canada
[142] CPSA. (2019). Imaging – Facility Listing.
[143] Government of Alberta. (2019). *Alberta Wait Times Reporting Website*. http://waittimes.alberta.ca/

Table B3. Saskatchewan

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital advanced diagnostics?	Yes. In 2016 Saskatchewan introduced *The Patient Choice Medical Imaging Act* which gave residents the option to pay out-of-pocket for a CT or MRI scan,[144] which had been forbidden prior to the change.
1.2	Is there public financing of private delivery of non-hospital advanced diagnostics?	Yes. There are currently two facilities in Regina (the capital and second-largest population centre) offering private MRI services,[145] with one providing CT scans.[146] Saskatoon (the largest population centre) is expected to have a private MRI and CT facility opening in September of 2019.[147] The provincial listing states that there is only one non-hospital MRI facility,[148] and they do not list any non-hospital CT facilities.[149] There are no private PET-CT scans in the province.[150] The current provincial government has been advocating for the expansion of private diagnostic delivery.[151, 152]
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Yes, corporate for-profit chains (Mayfair Diagnostics and Open Skies MRI) are currently being contracted for advanced diagnostics outside of hospitals.
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital advanced diagnostics? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	*The Patient Choice Medical Imaging Act*[153] is the principal legislation, with the Medical Imaging Facilities Licensing Regulations[154] providing the rules and guidelines for opening and operating any medical imaging facility. The intent of the legislation is explicitly to allow for the private, for-profit delivery of MRI and CT services in parallel to the publicly funded system. The act was introduced in June 2016 to add CT services to existing legislation permitting private MRI in February 2016 (the MRI Facilities Licensing Act, which the PCMIA repealed). The PCMIA also superseded the *Health Facilities Licensing Act*.
2.2	What is the mechanism for enforcing the legislation?	Licensure is issued only with compliance to these laws and regulations. PCMIA 26(1) imposes penalties of up to $20.00 per day if a facility upon summary conviction of being in contravention with the act.
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Saskatchewan has introduced the "One-for-One" model, which requires private imaging facilities to provide, at no cost to the public system, a second scan of similar complexity to a patient within the public waitlist for each privately funded scan it provides.[155]

[144] Government of Saskatchewan. (2016). *Patient Choice Medical Imaging Act Introduced to Allow Private Clinics*. https://www.saskatchewan.ca/government/news-and-media/2016/june/08/patient-choice-act
[145] Hill, A. (2018, Nov. 3). *James Smith Cree Nation seeks to open Saskatoon's first private-pay MRI clinic in Market Mall.* https://thestarphoenix.com/news/local-news/james-smith-cree-nation-seeks-to-open-saskatoons-first-private-pay-mri-clinic-in-market-mall
[146] Radiology Associates of Regina. (2019). http://rarsk.com/services/ct
[147] Bosker, B. (2019). *Saskatoon MRI clinic to be a hub for research and education*. https://www.ckom.com/2019/03/21/saskatoon-mri-clinic-to-be-a-hub-for-research-and-education/
[148] Government of Saskatchewan. (2019). *Magnetic Resonance Imaging (MRI)*. https://www.saskatchewan.ca/residents/health/accessing-health-care-services/medical-imaging/procedures/magnetic-resonance-imaging-exam#service-locations
[149] Government of Saskatchewan. (2019). *Computed Tomography (CT) Scans*. https://www.saskatchewan.ca/residents/health/accessing-health-care-services/medical-imaging/procedures/ct-or-cat-scan
[150] Government of Saskatchewan. (2019). *Positron Emission Tomography Computed Tomography (PET CT) Scan*. https://www.saskatchewan.ca/residents/health/accessing-health-care-services/medical-imaging/procedures/pet-ct--scanning
[151] Cowen, P. (2018, Aug. 20) *Health-care facts and figures*. https://leaderpost.com/news/local-news/health-care-facts-and-figures
[152] Stadnichuk, C. (2016, Dec. 9). *Wall expands private pay clinics despite warning from Feds.* http://behindthenumbers.ca/2016/12/09/wall-expands-private-pay-clinics-despite-warning-feds/
[153] PCMIA. (2016) https://publications.saskatchewan.ca/#/products/80929
[154] Ibid.
[155] Provincial Auditor of Saskatchewan. (2017). 2017 Annual Report. https://auditor.sk.ca/pub/publications/public_reports/2017/Volume_1/10_RQRHA%20_MRI.pdf

	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital advanced diagnostics?	PCMIA 5 permits the Minister to appoint anyone to operate the accreditation program. The College has and Advisory Committee on Medical Imaging which developed and manages the Diagnostic Imaging Quality Assurance Program (DIQA). The DIQA has been contracted by Medical Services Branch of the Ministry of Health to ensure all medical diagnostic imaging in the province meets an acceptable quality of patient care.[156] As part of the mandate, they set the standards for any diagnostic imaging facility.
3.2	Do accreditation standards differ for public or not-for-profit facilities?	No. College bylaw 25(1) sets out the conditions for all diagnostic imaging facility and the standards only differentiate by type of imaging provided (e.g., CT, MRI, radiography, etc.) with no distinction made for type of ownership[157].
3.3	Do accreditation standards differ for facilities receiving public funding?	No. Accreditation standards are indifferent to funding source.
3.4	Are there any additional considerations before licensure/accreditation is granted?	PCMIA 6(3) requires that the regional health authority (RHA) of the health region where the imaging facility is to be located to review the application. The RHA is required to report to the Minister if there is a need for such a facility and whether or not it would be an efficient and effective use of public resources if they are seeking to provide publicly funded services. If the facility is seeking to provide privately funded services, the RHA is to report on the anticipated effect of the facility on RHA operations. PCMIA 6(4) requires that the Saskatchewan Cancer Agency (SCA) to likewise review the application and report to the Minister the need and efficacy of the services if they are seeking to provide publicly funded services or the anticipated impact on SCA operations if the imaging facility is applying to provide privately funded services. PCMIA 7(2) also requires that before any license is issued or renewed, the Minister must be assured that the facility will be in compliance with all required laws and statutes, a facility seeking publicly funded services is necessary and an efficient and effective use of resources, and that the imaging facility will not impede on the operations of an RHA nor the SCA.
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	Contracts were originally made with the RHAs and the new province-wide Saskatchewan Health Authority (SHA) has recently put out an request for proposals for continuation and expansion of contracted diagnostic imaging.[158]
4.2	Does any other body have the authority to approve contracts?	PCMIA 20(1) authorizes both the Ministry of Health or an RHA to enter into agreements with a licensed imaging facility.
4.3	Are there any mechanisms for appeal?	PCMIA 18 provides grounds for any applicant to make an appeal to the court on matters of law. No contracts could be found to see if there are provisions for appeal therein.
	5. Financial reporting/incentives	
5.1	How are providers paid?	Providers of publicly financed services are on contract with the SHA and paid by them. Private scans are either paid by outside insurance (typically the Worker's Compensation Board (WCB), but the CFL franchise the Saskatchewan Roughriders are also regular users[159]) or directly out-of-pocket by the patient.
5.2	Are there price controls?	Uncertain: No contracts could be obtained.

[156] CPSS. (2019). *Advisory Committee on Medical Imaging*. https://www.cps.sk.ca/iMIS/CPSS/CouncilAndCommittees/Committees_Tabs_Landing_Pages/Advisory_Committee_on_Medical_Imaging_Tabs_Page.aspx
[157] CPSS. (2019). Regulatory bylaws for medical practice in Saskatchewan http://www.cps.sk.ca/iMIS/Documents/Legislation/Legislation/Regulatory%20Bylaws.pdf
[158] Cowen, P. (2018, Aug. 10) *Community-based MRI service coming to Saskatoon*. https://leaderpost.com/news/local-news/private-pay-mri-service-coming-to-saskatoon
[159] Stadnichuck, C (2016). Wall expands private pay.

5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	Uncertain: No contracts could be obtained.
5.4	Are there allowable user contributions for all or part of the service?	Yes, but only the full amount. Patients are able to pay out-of-pocket for MRI or CT imaging services when they choose to have the scan performed privately. If the scan is paid for publicly, no user contributions are permitted.
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	With no contracts found this information could not reliably be determined, although one private provider does make their private costing available.[160] Private costs are uniform, regardless of the area being scanned or the nature of the patient, although the prices in Saskatchewan do exceed those in Alberta.
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	Although the PCMIA 13(2) does require the facility to notify the Ministry in the case of critical incidents (as defined by the DIQA guidelines), no public information repository could be found. Even the number of scans performed has been inconsistently reported, with the provincial auditor, elected officials, and assistant deputy ministers of Health all providing differing numbers on the number of scans being performed in the private sector. The Ministry of Health has publicly available information on MRI wait times, as well as the number of scans being performed, on their website,[161] but they do not disambiguate between the public and private sectors.
6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	None found.
6.3	Do agreements/contracts include performance measures?	Uncertain: No contracts could be obtained.
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	The 2017 provincial auditor's report of the included a specific section on the efficient usage of MRI in the (no longer existent) Regina Qu'Appelle Health Authority.[162] Although the Provincial Auditor evaluated all MRI services, they did do a specific section on privately owned, non-hospital MRI provision. They found that the one-for-one model did not reduce wait times for the public system (in fact there was an increase over the observed period). Although that was still early on in the program. The provincial auditor also made recommendations for better monitoring of the contracted private operators as well as a more robust and transparent system of tracking and selecting the public patients who are granted the free scans from the one-for-one model.
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	The number of facilities is not well accounted for. Using a Google search, we found that there is no central repository held by the Ministry of Health, the SHA, or the College (neither by the DIQA or generally).

[160] Alberta pricing is here: https://www.radiology.ca/services/magnetic-resonance-imaging-mri, Saskatchewan is here: https://www.radiology.ca/sites/default/files/ckfinder/files/Sask%20PDF%20final%20v2(1).pdf

[161] Government of Saskatchewan. (2019). *Medical Imaging Wait Times*. https://www.saskatchewan.ca/residents/health/accessing-health-care-services/medical-imaging/medical-imaging-wait-times

[162] Provincial Auditor of Saskatchewan. (2017). 2017 Annual Report. https://auditor.sk.ca/pub/publications/annual_reports/2017_aro.pdf

Table B4. Ontario

	1. Screening questions for inclusion:	
1.1	Is there private for-profit delivery of non-hospital advanced diagnostics?	Yes. Non-hospital advanced diagnostics services have been allowed by the Independent Health Facilities Act (IHFA) since 1990.[163] *In 2017,* the IHFA was repealed by schedule 9, the *Oversight of Health Facilities and Devices Act (OFHDA*), of Bill 160, *the Strengthening Quality and Accountability for Patients Act (2017).*[164] Bill 160 received Royal Assent on December 12, 2017, but it has still not been proclaimed. Consequently, for the time being, the IHFA remains the legislation that regulates independent health facilities (IHFs) that provide advanced diagnostic services. Nevertheless, the OHFDA is still of interest because it provides more recent insight into the intended status of IHFs in Ontario. Thus, this table will provide information from both the IHFA (1990) and OHFDA (2017). The OHFDA pertains to all non-hospital "energy applying and detecting medical devices (EADMD). It defines an EADMD as, "a prescribed device that, (a) is an instrument, apparatus, contrivance or other similar article, including a component, part or accessory of any of them, that is manufactured, sold or represented for use in: (i) diagnosing, treating, mitigating or preventing a disease, disorder or abnormal physical state, or any of their symptoms, in human beings, or (ii) restoring, modifying or correcting the body structure of human beings or the functioning of any part of the bodies of human beings, and (b) is used to: (i) apply to the body of a human being acoustic, electromagnetic or particle radiation, or (ii) detect acoustic, electromagnetic, or particle radiation emitted from or applied to the body of a human being pharmaceutically or by other means."[165] In 2018, the Office of the Auditor General of Ontario (OAG) reported that 2017/18, Ontario's IHFs, "with a total of six MRI and two CT machines, performed about 48,000 MRI and 11,320 CT scans outside of hospitals."[166] As of March 2018, there were a total of six MRI machines and four CT machines operated by seven IHFs.[167]
1.2	Is there public financing of private delivery of non-hospital advanced diagnostics?	Yes. The Ontario Health Insurance Plan (OHIP) covers medically necessary advanced diagnostic services that are delivered privately by non-hospital facilities. Additionally, section 65 of the OHFDA, the Minister of Health and Long-Term Care (MOHLTC) may provide funding for community health facilities including facility costs and funding for inspecting bodies. A "facility *cost*" is defined as a charge, fee, or payment for a service or operating cost that supports, assists and is a necessary adjunct to an insured service, but is not part of the insured service. Thus, in addition to the professional fee that physicians (e.g. radiologists) receive for interpreting an advanced diagnostic test, "the Ministry pays facility owners a "facility *fee*"—an amount for each type of service provided and/or a contracted amount—for overhead costs, such as rent, staffing, supplies and equipment."[168] According to the OAG, since 2003, the Ministry has contracted with seven IHFs, "to provide MRI and/or CT scanning services at no charge to patients insured under [OHIP]."[169]
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	Yes. Under section 4 of the OHFDA any person may apply for a license to operate an EADMD in an IHF, and under section 14 of both the OHFDA and the IHFA, the licensee may be a corporation. In 2014, the Auditor General reported that 98% of Ontario's IHFs were for-profit corporations, and that approximately half of them were owned and operated by physicians.[170] Consequently, under the *Medicine Act* (1991), "it is a conflict of interest for a member [of the CPSO] to order a diagnostic… service to be performed by a facility in which the member or a member of his or her family has a proprietary interest unless, (a) the fact of the proprietary interest is disclosed to the patient before a service is performed; or (b) the facility is owned by a corporation the shares of which are publicly traded through a stock exchange and the corporation is not wholly, substantially or actually owned or

[163] IHFA. (1990). https://www.ontario.ca/laws/statute/90i03?search=Independent+Health+Facilities+Act%2C.

[164] Bill 160. (2017). https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2017/2017-12/bill---text-41-2-en-b160ra_e.pdf. This act is to be repealed with Bill 160, Omnibus Health Bill (2019), but the repeal has not been proclaimed by the Lieutenant Governor.

[165] Bill 160. (2017).

[166] OAG 2018 Report. http://www.auditor.on.ca/en/content/annualreports/arreports/en18/2018AR_v1_en_web.pdf. p. 368. 2018.

[167] OAG 2018 Report. p. 412.

[168] OAG 2014 Report. (2014) http://www.auditor.on.ca/en/content/annualreports/arreports/en14/406en14.pdf. p. 481.

[169] OAG 2018 Report. p. 368.

[170] OAG 2014 Report. p. 481.

		controlled by the member, a member of his or her family or a combination of them."[171] The act also requires all CPSO members who or whose family has a proprietary interest in a facility where diagnostic services are performed to notify the College.[172]
	2. Regulation	
2.1	Is there legislation governing private delivery of non-hospital advanced diagnostics? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and any recent changes, e.g., tightening or loosening of restrictions.	*The Independent Health Facilities Act (IHFA), R.S.O. 1990, c. I.3, Medical Radiation Technology Act (MRTA), 1991, S.O. 1991, c. 29,* and Bill 160: *the Strengthening Quality and Accountability for Patients Act, 2017 (schedule 6, Medical Radiation and Imaging Technology Act, and* schedule 9, the *Oversight of Health Facilities and Devices Act (OHFDA)).* The IHFA provides for the establishment of IHFs in Ontario and outlines their regulations and relationship to the MOHLTC. The MRTA regulates, the "use of ionizing radiation, electromagnetism and other prescribed forms of energy for the purposes of diagnostic and therapeutic procedures, the evaluation of images and data relating to the procedures and the assessment of an individual before, during and after the procedures."[173] Schedule 6 of Bill 160 replaces the MRTA. The new legislation was designed to improve the transparency and oversight of the medical radiation and imaging technology professionals, specifically sonographers.[174] Schedule 9, the OHFDA, implemented to strengthen the safety and oversight of services delivered, "with medical radiation devices like X-ray machines, CT scanners, ultrasound machines and MRIs."[175] It is meant to achieve this goal by doing three things: *(1)* "Modernizes and expands the regulation of medical radiation devices in all facilities to ensure safety and quality when using these devices"; (2) "Strengthens accountability in the system for providing high-quality care"; (3) "Ensures patients and their caregivers have access to critical information about the quality of care provided through public reporting."[176] However, Bill 160 has yet to be proclaimed, so neither schedule 6 or schedule 9 of Bill 160 are in force.
2.2	What is the mechanism for enforcing the legislation?	The Lieutenant Governor in Council appoints one or more executive officers. The executive officers may appoint inspectors or classes of inspectors to enforce the provisions of the OHFDA. Under the IHFA, it is also the responsibility of the Lieutenant Governor in Council to enforce the legislation.
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Under section 20 of the OHFDA: "No person shall obtain, receive or attempt to obtain or receive funding or facility costs or any payment for or in respect of a service that the person is not entitled to obtain pursuant to the conditions, rules and restrictions of funding provided for under this Act or the regulations." These lines come directly from section 3 of the IFHA.[177] Thus, both pieces of legislation prohibit providers from charging fees or facility costs to anyone other than the Ministry.[178]
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital advanced diagnostics?	Per the IHFA and the OHFDA, the MOHLTC is responsible for issuing licences. The College of Physicians and Surgeons of Ontario (CPSO) also maintains standards and carries out inspections of physician practices that provide out-of-hospital care.[179] However, physicians who provide out-of-hospital surgical services that do not require anesthetic are not necessarily inspected by an accreditation body. In Ontario, no one body is responsible for the accreditation of public hospital and non-hospital surgical facilities.

[171] Medicine Act. (1991). https://www.ontario.ca/laws/regulation/940114#BK1.
[172] Ibid.
[173] IHFA. (1990).
[174] Ontario Newsroom. (2017). https://news.ontario.ca/mohltc/en/2017/12/strengthening-quality-and-accountability-for-patients-act-2017-1.html.
[175] Ibid.
[176] Ibid.
[177] IHFA. (1990). https://www.ontario.ca/laws/statute/90i03?search=Independent+Health+Facilities+Act%2C.
[178] Bill 160. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2017/2017-12/bill---text-41-2-en-b160ra_e.pdf. 2017.
[179] CPSO. (2013). "Out-of-Hospital Premises Inspection program (OHPIP): Program Standards." https://www.cpso.on.ca/pdf.

		The Ministry will conduct inspections of facilities with x-ray equipment, including IHFs, under the OHFDA.[180] Per section 43 (7) of the OHFDA, Ministry appointed inspectors conducting an inspection of a facility operating an EADMD may: (a) require the licensee to cease the operation of the device and to dismantle the device for the purpose of an examination or test; (b) affix stickers, labels or other things to an energy applying and detecting medical device for purposes of ensuring that the device is not used without the use being detected; (c) make tests and examinations to determine whether or not the energy applying and detecting medical device is installed and used in compliance with this Act and the regulations; and (d) require the production of proof that any person who operates an energy applying and detecting medical device meets the prescribed qualifications and requirements to ensure that this Act and the regulations are complied with.[181]
3.2	Do accreditation standards differ for public or not-for-profit facilities?	No. Under the OHFDA, the licencing standards do not distinguish between public or nor-for-profit facilities. They outline the licencing process for *any* person applying to operate an EADMD.[182] The IHFA does not explicitly refer to EADMD's but it makes no distinction between public or nor-for-profit IHFs.[183]
3.3	Do accreditation standards differ for facilities receiving public funding?	No. See 3.2.
3.4	Are there any additional considerations before licensure/accreditation is granted?	In general, the OHFDA states that licences are subject to every condition that may be specified by the executive officer and every condition that is prescribed by the license. More specifically, section 5 of the OHFDA states that before issuing a licence, the following conditions must be met: (i) the applicant and the device meet all prescribed requirements; (ii) the executive officer is satisfied that the applicant is competent to operate the device and would operate the device in a competent and responsible manner, after considering, as the executive officer may consider appropriate, anything concerning the applicant's history and qualifications that are relevant to the provision of the procedures that will be provided and to the operation of the device; (iii) the applicant and the device have passed any inspection that the executive officer has requested; and (iv) the executive officer is satisfied that a licence should be issued, after having considered: 1. the proposed use of the device, 2. the extent to which the proposed use of the device is already available in Ontario or any part of Ontario, 3. the need for the proposed use of the device in Ontario or any part of Ontario, 4. the future need for the proposed use of the device in Ontario or any part of Ontario, and 5. any other matter that the executive officer considers relevant to the management of the healthcare system.[184] The IHFA does not specifically refer to the operation of EADMDs. Instead, it provides the same conditions as the OHFDA (1-5 above) but refers to *any* service in a an IHF.[185]
	4. Contracts	
4.1	Are contracts with providers made with the provincial government, health region or some other body?	All licences for EADMDs are issued by executive officer that is appointed by the Lieutenant Governor. Thus, the facilities operating EADMDs are exclusively licenced by the provincial government. Unlike IHFs that provide surgical services, the Ministry does not maintain transfer payment agreements (with the exception of MRI and CT) with non-hospital advanced diagnostic facilities, it does maintain a schedule of the diagnostic facilities fees. Per section 10 of the OHFDA, EADMD licences are not transferable.[186] The IHFA does not refer specifically to EADMD licences. Instead, it states that all IHF license are issued by the Ministry and that they are not transferable (see sections 6, 11, and 16 of the IHFA).[187] It should also be noted that

[180] OAG 2012 Report. (2012) http://www.auditor.on.ca/en/content/annualreports/arreports/en18/2018AR_v1_en_web.pdf. p. 149. 2018; Bill 160. (2017).
[181] Bill 160. (2017).
[182] Ibid.
[183] IHFA. (1990).
[184] Bill 160. (2017).
[185] IHFA. (1990).
[186] Bill 160. (2017).
[187] IHFA. (1990).

		preliminary diagnosis (x-ray, sleep study, ultrasound) services are licenced under FFS, but do not require a contract. IHF only require a contract to provide advanced diagnostic imaging services (MRI, CT, PET CT).
4.2	Does any other body have the authority to approve contracts?	No, the OHFDA explicitly states that all persons applying to operate an EADMD must have a licence from the executive officer. That is, the Ministry is the only authority who can approve licences.[188] Under the IHFA, the Ministry is also the only authority who can approve licences.[189]
4.3	Are there any mechanisms for appeal?	The executive officer can issue both cessation and compliance orders to EADMD licensees. According to section 52 of the OHFDA, "if the executive officer or an inspector appointed by the executive officer believes on reasonable grounds that a person is operating an energy applying and detecting medical device without a licence, the executive officer or inspector may serve an order on the person ordering the person to cease operating the energy applying and detecting medical device."[190] Per section 54 of the OHFDA, an inspector or the executive officer may issue a compliance order to a licensee of an EADMD: (a) to do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act; (b) to do anything, or refrain from doing anything, that is necessary or advisable to protect the health or safety of any patient or any other person in or near the premises where the EADMD is operated; or (c) to stop operating the device and to ensure that no one else is operating the device.[191] Under section 18 of the IHFA, the Ministry can revoke the license of an IHF when, among other things, "there is reasonable ground for belief that the independent health facility is being operated or will be operated in a manner that is prejudicial to the health, safety or welfare of any person."[192]
	5. Financial reporting/incentives	
5.1	How are providers paid?	Under the IHFA and the OHFDA, the Ministry is responsible for funding medically necessary advanced diagnostic services that are administered in non-hospital facilities. The Ministry pays facilities both for the services they provide, and the overhead costs associated with providing those services. Per both the OHFDA and the IHFA, the Ministry compensates providers for their facility costs (or fees). Physicians are paid a professional FFS by OHIP. The payment received by physicians working in IHFs, known as the professional fee, is not tracked in detail by the Ministry.[193] According to a key informant in the MOHLTC, it records the quantity of professional fees paid, but it is not able ascribe them to specific NHADFs with 100% certainty. Additionally, in 2018, the OAG reported that the Ministry still pays IHFs operating MRI machines and CT machines at the hourly rate that was agreed upon in 2003 when the Ministry first asked for bids to be submitted by IHFs.[194]In order to receive funding from the Ministry, IHF licensees must submit an annual budget to the Ministry to establish the annual budget. IHFs must also submit monthly service reports to the Ministry detailing the number of hours of services delivered. At the end of the year, once the types of services and hours of operation for each IHF is known, the Ministry recovers any overpayments.[195]
5.2	Are there price controls?	Patients cannot be billed for any insured services provided by a specialty clinic or extra-billed for an insured service.[196] All medically necessary advanced diagnostic services provided by IHFs are paid for by OHIP. Section 20 of the OHFDA also prohibits charging patients for preferred access (queue-jumping) to insured services.[197] The Ministry intends to ensure that patients will not have to pay any optional fees to access services covered by OHIP.[198] That being said, in 2018, the OAG reported that

[188] Bill 160. (2017).
[189] IHFA. (1990).
[190] Bill 160. (2017).
[191] Ibid.
[192] IHFA. (1990).
[193] OAG 2012 Report p. 149.
[194] OAG 2018 Report. p. 399.
[195] Ibid. p. 398.
[196] *Commitment to the Future of Medicare Act*. (2004). https://www.ontario.ca/laws/statute/04c05
[197] Bill 160. (2017)
[198] MOHLTC. (2013). *A Policy Guide for Creating Community-Based Specialty Clinics*. p. 4. http://www.nelhin.on.ca/Page.aspx?id=16034

		the Ministry does not know the actual cost per scan (CT or MRI) performed outside of a hospital.[199] As a result, in 2018, "the [hourly] rate paid for an MRI scan at one IHF can be as high as 175% the rate paid for a similar scan at another IHF," and, "the [hourly] rate paid for a CT scan at one IHF can be as high as 280% the rate paid for similar scan at another IHF."[200] Therefore, controls exist for professional fees paid to physicians (e.g. radiologists) who help operate EADMDs, but the hourly rate paid to IHFs to cover their costs of operating EADMDs can vary greatly between IHFs. In the absence of explicit price controls, the Ministry does enforce service level controls with IHFs providing advanced diagnostic services (e.g. total number of hours of MRI machine operation).
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	The agreements that the Ministry made with IHFs in 2003 that set the hourly rates for CT and MRI scans provide a financial incentive for volume, and as the OAG noted in 2018, they lack an incentive for quality. For instance, since contracts with IHFs do not require IHFs to meet wait-time requirements that Ontario hospitals are required to meet, in 2017/18, none of the IHFs providing MRI scans met the provincial wait-time target of 28 days.[201] IHFs are contracted to provide wait-time information to Cancer Care Ontario.[202]
5.4	Are there allowable user contributions for all or part of the service?	No. Under section 20 of the OHFDA, no person shall: "(a) charge or accept payment for providing an insured person with access to an insured service at a community health facility; (b) obtain or accept a benefit, direct or indirect, for providing an insured person with access to an insured service at a community health facility; or (c) offer to do anything referred to in clause (a) or (b)."[203] The IHFA states under section 8 (7) that facility fees shall not be charged to a person other than the Minister.[204] The IHFA was in part introduced to prohibit providers from billing patients for the overhead costs associated with providing insured services. Before the IHFA (1990) was introduced, facilities could charge insured patients a fee to cover their overhead costs, but after the IHFA was passed and IHFs were required to obtain a license from the Ministry, IHFs could bill the Ministry according to the schedule of facility fees, but they were no longer permitted to bill patients for overhead costs.[205] Thus, it is not permitted to charge users for all or part of an EADMD service, even if it is administered in a non-hospital setting.
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	Uncertain. However, since the hourly funding rates that IHFs receive for administering CT and MRI scans has been fixed since 2003,[206] there has been a long period for IHFs to increase their profits by reducing their costs-per-scan. It is possible that one way for IHFs to keep the cost-per-scan down would be to select good risks. It is also likely since 20003, IHFs have experienced technological advancements and other sources of increased efficiency that allow them to increase their profit margins by reducing the cost-per-scan.
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	The community health facility inspecting bodies established by section 40 of the OHFDA are required to make reports of inspections and cessation orders available to the public. Section 67 of the OHFDA requires that "the executive officer shall make available to the public, (a) every order made by the executive officer under this Act that is in relation to a community health facility; and (b) anything that is prescribed as something that the executive officer must make available to the public."[207] However, the IHFA does not require that reports of inspections be made available to the public.[208] Health Quality Ontario publishes the wait times of all the advanced diagnostic facilities (non-hospital and hospital) online.

[199] OAG 2018 Report. p. 399.
[200] OAG 2018 Report. p. 399.
[201] OAG 2018 Report. p. 399.
[202] Ibid., p. 399.
[203] Bill 160. (2017).
[204] IHFA. (1990).
[205] OAG 2012 Report. p.152.
[206] OAG 2018 Report. p. 399.
[207] Bill 160. (2017).
[208] IHFA. (1990).

6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	Per section 33 of the OHFDA, every EADMD licensee shall ensure that there is a safety officer for the EADMD who is responsible: "(a) for ensuring that the energy applying and detecting medical device is maintained in safe operating condition; and (b) for any other matters related to the safe operation of energy applying and detecting medical devices that are provided for in the regulations."[209] But it is unclear how providers record performance of EADMDs beyond the appointment and work of the safety officer that the OHFDA requires each facility operating an EADMD to have. The IHFA does not refer to EADMDs, but under section 18, it does provide for an emergency suspension of an IHF license, "if the Director is of the opinion upon reasonable grounds that the independent health facility is being operated or will be operated in a manner that poses an immediate threat to the health or safety of any person."[210] This condition provides similar safety oversight to the that provided by section 33 of the OHFDA, but it remains unclear how providers record performance of EADMDs.
6.3	Do agreements/contracts include performance measures?	The contracts between IHFs operating EADMDs and the Ministry are not publicly available, but the OAG recommended in 2018, that the Ministry, "establish performance measures, such as wait-time targets, and incorporate these measures into future contracts with all IHFs."[211] In response to this recommendation, the Ministry said that it would review funding agreements and "consider an analysis and integration of applicable performance measures, including wait-time targets."[212]
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	The OAG has reviewed Independent Health Facilitates on three occasions: 1996, 2004, and 2012. The OAG also provided follow-up reports to each of these reports in 1998, 2006, and 2014 respectively. IHFs were first licenced to operate MRI/CT machines in 2003, so only the 2004, 2006, 2012, 2014 reports include information on the provision of MRI and CT scans by IHFs. In 2004, the OAG recommended that the Ministry "develop and implement a waiting list management system; and monitor and analyze waiting times" for MRIs, including those provided by IHFs.[213] In the 2006 follow-up report, the OAG noted that the Ministry was in the process of implementing a wait-time information system for hospitals, but not for IHFs.[214] In 2012, the OAG observed that according to the Ministry, the, "certain services—such as MRIs, dialysis and colonoscopies—were about 20% to 40% less expensive if delivered in community clinics, including independent health facilities, rather than in hospitals." This observation provides further motive for the Ministry renegotiate agreements with IHFs so that it can assess the hourly rate IHFs receive for providing MRIs and include wait-time performance measures. The 2012 report also recommends that the Ministry, make "information on facility wait times for those services that historically do not have same-day access (such as MRIs and CTs)," publicly available on its website.[215] In the 2014 follow-up, the OAG notes that the Ministry has, "begun collecting wait times from independent health facilities offering MRIs and CTs and was reviewing this information for accuracy, with plans to make it publicly available by March 2015."[216] Detailed wait time metrics for every facility (hospital and non-hospital) that provides MRI and CT scans in Ontario are now available at: https://www.hqontario.ca. Visitors of this site can search for scan providers by location and service and compare facilities to one another based on a series of wait time metrics. Finally, the OAG's 2018 annual report provides an extensive report on the provision of CT and MRI scans in Ontario. It includes two recommendations relating to the provision of MRI and CT scans by IHFs. It recommends that the Ministry "review the existing hourly rate paid for scanning services delivered by each IHF and determine whether the rates are appropriate based on the types of scans, cost per scan and the service volume each IHF performs; and establish performance measures, such as wait-time targets, and incorporate these measures into future contracts with all IHFs."[217]

[209] Ibid.
[210] IHFA. (1990).
[211] OAG 2018 Report. p. 399.
[212] Ibid. p. 399.
[213] OAG 2004 Report. p. 224.
[214] OAG 2006. Report. p. 304.
[215] OAG 2012. Report. p. 152.
[216] OAG 2014. Report. p. 488.
[217] OAG 2018 Report. p. 399.

6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	The OAG 2004 and 2012 reports list the total technical fees paid to facilities for CT/MRI scans. According to the 2004 report, $2,282,000 was paid to facilities in 2003/04.[218] The 2013 report lists the total fees paid from 2005/06 to 2010/11 in millions of dollars: 2006/07: 322.6; 2007/08: 334.7; 2008/09: 352.4; 2009/10: 372.6; 2010/11: 376.8.[219] In chapter 3, "Reports on Value-for-Money Audits," of the 2018 Annual Report of the Office of the Auditor General of Ontario there is an extensive report on the provision of CT and MRI services in Ontario. In its assessment of CT/MRI services, the OAG includes a listing of the seven IHFs that provide MRI and CT scans, and the wait-times for five of these seven IHFs.[220] This report also notes that in 2017/18, the seven IHFs, with a total of six MRI and two CT machines, performed about 48,000 MRI and 11,320 CT scans.[221] However, there is no information on the cost-per-scan that each IHF faces because according to the OAG, "the Ministry does not know the actual cost of a scan performed outside of a hospital, so it cannot assess whether the rates it currently pays the IHFs are reasonable."[222] Finally, in 2016 and 2018, CADTH released very comprehensive reports entitled, "The Canadian Medical Imaging Inventory, 2015" [223] and "The Canadian Medical Imaging Inventory, 2017"[224] respectively. These reports include the number of facilities operating advanced diagnostic tests (CT, MRI, SPECT, PET or PET-CT, PET-MRI, and SPECT-CT), and the volume of tests administered. CADTH provides more recent information on the inventory of medical imaging in Canada at https://www.cadth.ca/imaginginventory.

[218] OAG 2004 Report. p. 216.
[219] OAG 2012. Report. p. 150.
[220] OAG 2018 Report. p. 412.
[221] Ibid. p. 368.
[222] Ibid. p. 368.
[223] CADTH. (2016). *The Canadian Medical Imaging Inventory, 2015*. https://www.cadth.ca/sites/default/files/pdf/canadian_medical_imaging_inventory_2015_e.pdf
[224] CADTH. (2018). *The Canadian Medical Imaging Inventory, 2017*. https://www.cadth.ca/sites/default/files/pdf/canadian_medical_imaging_inventory_2017.pdf

Table B5. Quebec

	1. Screening questions for inclusion	
1.1	Is there private for-profit delivery of non-hospital advanced diagnostics?	Yes. Québec permits privately funded Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) services, but it bans extra-billing, user-fees, and direct-billing by participating physicians who bill the public insurance plan. Québec requires practitioners to opt-out of the public health care system if they are going to bill patients directly for the services that are delisted from the Régie de l'assurance maladie du Québec (RAMQ), Québec's public insurance plan.[225] Advanced diagnostic services administered outside of a hospital are not covered by RAMQ (see 1.2). Consequently, as of 2017, Québec had 9 private for-profit clinics that offered CT scans and 17 that offered MRIs.[226] This is up from 2015, when there were 2 CT scan machines, and 10 MRI machines.[227]
1.2	Is there public financing of private delivery of non-hospital advanced diagnostics?	No. In December 1981, Québec passed Bill 27, *An Act to amend various legislation in the field of health and social service.*[228] This bill allowed the government to delist services from the public insurance plan on the basis of the location of where the service is provided (i.e. in or out of hospital). In December 1982, the government exercised their authority to delist services from the public insurance plan by modifying the *Regulation respecting the application of the Health Insurance Act* (RLRQ, c A-29, r 5)[229] by delisting public coverage of mammography, ultrasonography and thermography when performed out-of-hospital. Then in 1988, Québec delisted CT scans performed out-of-hospital, and in 1995, it delisted MRI scans performed out-of-hospital.[230] As of December 29, 2016, ultrasounds in private clinics were re-listed by RAMQ.[231] Local Québec health policy experts indicate that the plan was to relist MRI and CT scans as well, but to date, that plan has not been implemented. Quebec's breast cancer screening program currently has agreements with some private radiology clinics to provide publicly funded screening mammography as a designated screening clinic.
1.3	Does private delivery include the use of corporate for-profit (e.g., commercial chains) rather than solely medical professional owned for-profit?	As with Québec's centres medicaux spécialisés (CMS), private out-of-hospital clinics that provide advanced diagnostic services are required to be managed by a licenced medical professional.[232]
	2. Regulations	
2.1	Is there legislation governing private delivery of non-hospital advanced diagnostics? Provide a brief summary of the intent of this legislation and how restrictive it intends to be, and	Bill 27, *An Act to amend various legislation in the field of health and social service* (1981); *Health Insurance Act*, RLRQ c A-29 and the adoption of the *Regulation respecting the application of the Health Insurance Act* (RLRQ, c. A-29, r.5) in 1982. The preamble to Bill 27 states that, "it enables the Minister to rationalize the provision of health services and social services by health establishments. The bill provides for a rearrangement of the regulatory powers of the Government and concordance adjustments."[233] Dr. Amélie Quesnel-Vallée

[225] Flood, C., & Thomas, B. (2010). Blurring of the public/private divide: The Canadian chapter. *European Journal of Health Law, 17*(3), p. 266. doi:10.1163/157180910X504081

[226] Ontario Health Coalition. (2017). *Private Clinics and the Threat to Public Medicare in Canada*, p. 51-64.

[227] CADTH. (2016). *The Canadian Medical Imaging Inventory, 2015*, p. 23. https://www.cadth.ca/sites/default/files/pdf/canadian_medical_imaging_inventory_2015_e.pdf.

[228] Bill 27. An Act to amend various legislation in the field of health and social services. https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Ae62a92a3-889e-4578-8d9d-e6f370ed097c. 1981.

[229] RLRQ, c. A-29, r.5. http://legisquebec.gouv.qc.ca/en/ShowDoc/cr/A-29,%20r.%205#se:22

[230] Quesnel-Vallée A. (2013). Delisting medical imaging in private settings from public coverage in Québec. *Health Reform Observer - Observatoire des Réformes de Santé* 1(1), 1-4. DOI: https://doi.org/10.13162/hro-ors.01.01.03.

[231] MSSS. (2016). *Entrée en vigueur aujourd'hui de la gratuité des échographies en clinique médicale*. http://www.msss.gouv.qc.ca/ministere/salle-de-presse/communique-1233/

[232] Règlement d'application de la Loi sur les laboratoires médicaux et sur la conservation des organes et des tissus. (2019). http://legisquebec.gouv.qc.ca/fr/ShowDoc/cr/L-0.2,%20r.%201/; Règlement sur l'exercice de la profession médicale en société. (2019). http://legisquebec.gouv.qc.ca/en/ShowDoc/cr/M-9,%20r.%2021/

[233] Bill 27. An Act to amend various legislation in the field of health and social services (1981). https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Ae62a92a3-889e-4578-8d9d-e6f370ed097c.

	any recent changes, e.g., tightening or loosening of restrictions.	(2013) notes that the use of the term 'rationalize,' "evokes a rational restructuration of practices or organization to achieve greater efficiency. This stated goal suggests that cost-containment of governmental spending on health was an implicit aim of the reform"[234] The motivation of the legislation was to control public spending on diagnostic care by delisting advanced diagnostic services provided out of hospital.
2.2	What is the mechanism for enforcing the legislation?	Per section 24 of RLRQ, c. A-29, r.5, "the Board [Régie de l'assurance maladie du Québec] must publish, each month, in *the Gazette officielle du Québec*, a list, compiled on a regional basis, of the names and business addresses of professionals who intend on practising their profession outside the scope of the plan as professionals withdrawn or as non-participating professionals or who have ceased to practise in this capacity, as well as the date on which their withdrawal or non-participation becomes effective or ceases to become effective."[235] However, radiologists are permitted to participate in the public insurance program and also provide uninsured services in non-hospital settings. Per section 25 of RLRQ, c. A-29, r.5, "any professional who has withdrawn shall, except in the cases of emergency determined by the Act and the regulations, inform an insured person in writing that if the insured person avails himself of the professional's services, he must claim the cost of the services directly from the Board. This notice must be signed by the professional, bear the date of issuance, be drawn up in the manner prescribed hereafter and be delivered by hand in advance by the professional to any insured person who avails himself of the professional's services."[236]
2.3	Are there specific rules or regulations around providers receiving both private and public sources of funding for similar services?	Yes. Québec physicians who opt-in to bill the public plan are explicitly banned from billing patients directly for any publicly insured services that they deliver.[237] However, in the case of advanced diagnostics, the same radiologist can technically work in both the public and private environments (hospital and non-hospital) and receive public and private funding for the same types of services.
	3. Accreditation	
3.1	What body/bodies are responsible for accreditation of non-hospital advanced diagnostics?	Per the *Act Respecting Medical Imaging Technologists, Radiation Oncology Technologists and Medical Electrophysiology Technologists* qualified operators of medical imaging technology must be members of the Ordre professionnel des technologues en imagerie médicale, en radio-oncologie et en électrophysiologie médicale du Québec (OTIMROEPMQ).[238] The OTIMROEPMQ administers permits to providers who wish to operate an energy applying and detecting medical device (EADMD) in Québec.
3.2	Do accreditation standards differ for public or not-for-profit facilities?	Not applicable. Per RLRQ, c. A-29, r.5, advanced diagnostics services administered in an out-of-hospital setting are not covered by Québec's public insurance plan.
3.3	Do accreditation standards differ for facilities receiving public funding?	Not applicable. Per RLRQ, c. A-29, r.5, advanced diagnostics services administered in an out-of-hospital setting are not covered by Québec's public insurance plan.
3.4	Are there any additional considerations before licensure/accreditation is granted?	None found. The fact that advanced diagnostics services administered in an out-of-hospital setting are not covered by Québec's public insurance plan means that there is more autonomy for providers who are licenced to operate EADMDs.
	4. Contracts	
4.1	Are contracts with providers made with the provincial	Private providers of advanced diagnostics services administered in an out-of-hospital setting are not contracted by the provincial or health region since they receive private payment for the services they

[234] Quesnel-Vallée A. p. 2.

[235] RLRQ, c. A-29, r.5. http://legisquebec.gouv.qc.ca/en/showversion/cr/A29,%20r.%205?code=se:24&pointInTime=20190506#20190506.

[236] RLRQ, c. A-29, r.5. http://legisquebec.gouv.qc.ca/en/ShowDoc/cr/A29,%20r.%205?langCont=fr#se:25.

[237] Flood, C., & Archibald, T. (2001). The illegality of private health care in Canada. *CMAJ: Canadian Medical Association Journal = Journal De L'association Medicale Canadienne, 164*(6), p. 826.

[238] http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/T-5

	government, health region or some other body?	provide. However, the persons who operate the equipment that uses "invasive electric energy, according to a prescription" in these facilities are required to be a "medical imaging technologist or radiation oncology technologist" by section 12 of the *Act Respecting Medical Imaging Technologists, Radiation Oncology Technologists and Medical Electrophysiology Technologists*.[239]
4.2	Does any other body have the authority to approve contracts?	Not applicable.
4.3	Are there any mechanisms for appeal?	If operators of equipment that uses "invasive electric energy, according to a prescription" are not a medical imaging technologist or radiation oncology technologist, they are liable under section 188 of the Professional Code which states that, "Every person who contravenes a provision of this Code, of the Act or letters patent constituting an order or of an amalgamation or integration order is guilty of an offence and is liable to a fine of not less than $2,500 nor more than $62,500 in the case of a natural person and of not less than $5,000 nor more than $125,000 in other cases. In the case of a subsequent offence, the minimum and maximum fines are doubled."[240,241]
	5. Financial reporting/incentives	
5.1	How are providers paid?	Providers of out-of-hospital advanced diagnostic services are paid out-of-pocket or by patients' private insurance plans. For example, Sun Life Financial offers Quebec residents coverage for "medically necessary MRI, Ultrasound, CAT and CT scans," in every level of its "Supplemental health care" plan.[242] Regardless of whether or not the physician opts in or out of the public plan, the physician can bill the patient any amount in the private non-hospital facility.
5.2	Are there price controls?	No. The private providers of non-hospital advanced diagnostic services can set the prices of the services they provide. In 2017, fees in Québec for one MRI or CT scan ranged from $600 - $750.[243]
5.3	Do agreements/contracts with providers include financial incentives, e.g., for volume or quality?	Privately funded non-hospital providers of advanced diagnostics services are not contracted with the provincial government. Therefore, the fact that they can set their own fees for advance diagnostic services means that there is a financial incentive for volume.
5.4	Are there allowable user contributions for all or part of the service?	Yes. The advanced diagnostic services included in RLRQ, c. A-29, r.5 that are administered out-of-hospital, and that are therefore not covered by RAMQ, can be paid for in-part or in full by the user.
5.5	Are there pricing differentials for different patient complexity? (or other mechanisms for preventing cream-skimming/selecting good risks?)	Yes. It is up to the discretion of the private provider to price scans depending on the complexity of the service. Therefore, providers can charge a premium to patients who require more complex scans. Note that this is possible because in Québec, opted-out physicians can set their fees at any level. Whereas in Manitoba, Nova Scotia and Ontario, opted-out physicians cannot bill more than they would bill if they were opted-in to the public plan.[244]
	6. Performance information and evaluation	
6.1	What is the nature and extent of public reporting of performance (e.g., costs, quality, outcomes) of providers?	Not applicable. Per RLRQ, c. A-29, r.5, advanced diagnostics services administered in an out-of-hospital setting are not covered by Québec's public insurance plan. Private providers include information on the quality and outcomes of the services they provide on their websites, but only as a means of advertising. For example, *Clarke Radiology* advertises, "top of the line technology and expert diagnosis," on its website,[245] and *Radimed* advertises on its website that their clinics provide, "easy access to a range of services with the best equipment in radiology, screening and diagnostic imaging, in a fully digital environment."[246]

[239] *Act Respecting Medical Imaging Technologists, Radiation Oncology Technologists and Medical Electrophysiology Technologists*. http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/T-5.

[240] Ibid.

[241] Professional Code. http://legisquebec.gouv.qc.ca/en/showDoc/cs/C-26?&digest=.

[242] https://www.sunlife.ca/slfas/Health/Personal+health+insurance/PHI/Plan+comparison?vgnLocale=en_CA

[243] Ontario Health Coalition. (2017). *Private Clinics and the Threat to Public Medicare in Canada*, p. 51-64.

[244] Flood, C., & Archibald, T. p. 826.

[245] http://www.clarkeradiology.com/

[246] https://radimed.ca/en

6.2	What is the nature and extent of performance reporting at provider level (not publicly)?	Unclear. It is likely that private providers track the performance of their services, but the details of providers' performance reporting are not made public.
6.3	Do agreements/contracts include performance measures?	Not applicable. Per RLRQ, c. A-29, r.5, advanced diagnostics services administered in an out-of-hospital setting are not covered by Québec's public insurance plan. Private providers include performance measures of the services they provide on their websites, but only as a means of advertising. For example, clinics advertise how quickly they are able to provide services. A Montréal clinic, *VMMed*, advertises on its website that, "appointments can generally be provided within 24 hours of being requested and final reports are always delivered within 48 hours of the exam."[247]
6.4	Have there been any evaluations, audits or reviews of the services provided through privately owned facilities? If so, please provide references and a brief summary.	No authoritative or comprehensive reviews of the advanced diagnostic services provided by private facilities were found. However, in 2017, the Ontario Health Coalition, a group that aims to "honour and strengthen the principles of the Canada Health Act" conducted a survey of private clinics in Canada.[248] Their survey of 31 private Québec clinics found that private facilities charge $600 - $750 per MRI scan. According to their survey, the average fee per MRI scan in Québec is lower than average fee per scan in Alberta, British Columbia, Nova Scotia, Saskatchewan.[249]
6.5	Is there publicly available information on the number of facilities in operation, volume of procedures, spending, etc.?	Yes. The Ontario Health Coalition's 2017 report, "Private Clinics and the Threat to Public Medicare in Canada," provides information on the number of private facilities administering advanced diagnostic tests in Canada in each province. Additionally, the website www.findprivateclinics.ca. allows users to search for private facilities in Canada by region and the services they provide. Finally, in 2016 and 2018, CADTH released very comprehensive reports entitled, "The Canadian Medical Imaging Inventory, 2015" [250] and "The Canadian Medical Imaging Inventory, 2017"[251] respectively. These reports include the number of facilities operating advanced diagnostic tests (CT, MRI, SPECT, PET or PET-CT, PET-MRI, and SPECT-CT), and the volume of tests administered. CADTH provides more recent information on the inventory of medical imaging in Canada at https://www.cadth.ca/imaginginventory.

[247] https://www.vmmed.com/radiology-mri/about/

[248] https://www.ontariohealthcoalition.ca/index.php/about-us/mission-mandate/

[249] Ontario Health Coalition. (2017). *Private Clinics and the Threat to Public Medicare in Canada*, p. 10.

[250] CADTH. (2016). *The Canadian Medical Imaging Inventory, 2015*.
https://www.cadth.ca/sites/default/files/pdf/canadian_medical_imaging_inventory_2015_e.pdf

[251] CADTH. (2018). *The Canadian Medical Imaging Inventory, 2017*.
https://www.cadth.ca/sites/default/files/pdf/canadian_medical_imaging_inventory_2017.pdf

Appendix C: Publicly Funded Procedures Performed in NHSFs

Table C1.Publicly funded procedures performed in NHSFs

	Alberta	Saskatchewan	Ontario	Québec
Dermatology	√			
ENT/Otolaryngology	√	√		√
Gynecology		√	√	√
Ophthalmology	√		√	√
Oral surgery	√	√		√
Orthopaedics		√		√
Plastic surgery	√		√	√
Pregnancy termination	√		√	
Urology				√
Vascular surgery				√

Note: The types of surgeries performed in NHSFs in British Columbia was not validated by the ministry of health and so we do not include it in this table.

Appendix D: Literature Search Strategy

We searched for sources that describe the different approaches that governments take to regulate and contract with for-profit providers (distinguishing between corporate and medical professional owned for-profit providers) of non-hospital surgical services and advanced diagnostic imaging (e.g., CT, MRI, PET scanning) were included in the rapid literature review. Publicly available documents that describe the use of funding regulations and information (e.g., performance reporting) for the private for-profit providers were also included.

Information sources

We searched selected academic databases (Ovid MEDLINE, Embase Classic+Embase, CINAHL Plus with Full Text, Scopus, and EconLit) and Google Scholar. Reference lists of relevant articles were reviewed for additional sources.

Search strategy

We used the following search term when searching for studies that examine the government regulation and contracting of non-hospital *surgical* facilities: (surg* AND (privat* OR non-hospital OR "non hospital" OR out-of-hospital OR contract OR private clinic OR private facilit*) AND (Canada OR "British Columbia" OR Alberta OR Saskatchewan OR Ontario OR Qu*bec)). For non-hospital *diagnostic facilities*, we used the following search term: (medical imaging OR medical technology OR scanning OR "MRI" OR "CT" OR "PET") AND (privat* OR non-hospital OR "non hospital" OR out-of-hospital OR contract OR private clinic OR private facilit*) AND (Canada OR "British Columbia" OR Alberta OR Saskatchewan OR Ontario OR Qu*bec). All database searches were restricted to 2000 to present. All database searches were also limited to "human" results, and publications written in English or French.

Grey literature was used to inform the tables describing the management and regulation of contracted health facilities in each of the five provinces. Grey literature was found using broad terms related to non-hospital surgery AND the province name accompanied by targeted searches of the following websites: provincial quality councils, provincial auditor general, CADTH, CIHI, and Health Canada, as per the recommendation of the Grey Literature Search Guide provided by the Gerstein Science Information Centre at the University of Toronto Libraries website. All results were exported into a reference management software (Zotero) and reviewed by a research assistant.

The articles retrieved by our search strategy were screened using the following criteria to determine if they warranted inclusion in our bibliography:

Inclusion Criteria:

- Published since 2000 (or publication date of D & C i.e., 2000)
- Focused on non-hospital surgical care
- Jurisdiction is Canada or one of our 5 provinces

Exclusion Criteria:

- Duplicate articles

- Non-English and non-French
- Full text not available
- Focused on in-hospital surgery (or out-of-hospital outpatient care with no diagnostics or surgery)

As a final step, we created a Google Custom Search Engine (CSE) to verify that we did not overlook any relevant grey literature when researching the tables for each province. The Google CSE searched the following websites for relevant grey literature (note that the *English* version of all Québec and Canadian websites was searched):

- Health Canada (https://www.canada.ca/en/health-canada.html
- CADTH (https://www.cadth.ca/)
- CIHI (https://www.cihi.ca/en)
- Alberta Auditor General (https://www.oag.ab.ca/)
- British Columbia Auditor General (https://www.bcauditor.com/)
- Ontario Auditor General (http://www.auditor.on.ca/)
- Québec Auditor General (https://www.vgq.qc.ca/default-EN.aspx)
- Saskatchewan Auditor General (https://auditor.sk.ca/)
- Health Quality Council of Alberta (HQCA) (https://www.hqca.ca/)
- British Columbia Patient Safety and Quality Council (BCPSQC) (https://bcpsqc.ca/)
- Health Quality Ontario (HQO) (https://www.hqontario.ca/Home)
- Québec Health and Welfare Commissioner (http://www.csbe.gouv.qc.ca/en.html)
- Saskatchewan Health Quality Council (HQC) (https://www.hqc.sk.ca/)

The Google CSE was searched twice, once using our surgical search term, and once using our advanced diagnostics search term:

1. *Surgical Google CSE Search (3840 references)*
2. *Advanced Diagnostics Google CSE Search (869 references)*

The above two searches of the Google CSE provided an efficient tool for verifying that we did not overlook any relevant grey literature when researching the tables for each province.

NORTH AMERICAN
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The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, health organizations, and governments promoting evidence-informed health system policy decision-making. Due to the high degree of health system decentralization in the United States and Canada, the NAO is committed to focusing attention on comparing health systems and policies at the provincial and state level in federations.