Illegal, Unlawful and Unethical:
Case Studies of Patients Charged for Medical Care in Ontario's Private Clinics

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Protecting public healthcare for all.

Introduction & Key Findings

It has taken almost a hundred years to build the public hospital and health insurance systems in our province and our country. A number of local hospitals were built by communities devastated by the Spanish flu pandemic of 1918. The soldiers' memorial and other local "memorial" hospitals date back to the First and Second World Wars. By the end of World War I, hospital medicine modernized with the advent of laboratories, x-ray machines, hospital child birth, and antiseptic surgery. Hospitals began to be used by the middle class. As they found hospital care to be unaffordable for individuals when they were sick, dying and elderly, the need to create a public hospital insurance system grew.[1]

From the beginning, the public/non-profit hospital system and public health insurance systems were developed together, and they remain inextricably linked. Public hospital insurance started in the 1950s across the country, and Public Medicare (public health insurance) was brought in nationally in 1966. Hospital-care insurance and medical-care insurance were combined programmatically under the Ontario Health Insurance Plan (OHIP) in 1972, and OHIP is administered under the terms of the Canada Health Act which combined separate pieces of federal legislation in 1984 and formally banned any form of user fee for medically necessary hospital and physician care.

Today, the *Canada Health Act (1984)* at the national level and Ontario's *Commitment to the Future of Medicare Act (2004)* provide legal protections for Ontario residents to receive needed health care services without financial barriers. The foundational principle of Canadian Public Medicare is that all Canadians have equal access to the medical care we need without being charged user fees or being subjected to extra-billing.

At the same time as OHIP was brought in (1972), private for-profit hospitals were banned in Ontario.[2] A handful of existing for-profit hospitals were grandfathered in while the public hospital system was formalized and modernized. Only three for-profit hospitals remain in operation and of those, only two do surgeries. Thus, throughout Ontario's history of modern medicine, surgeries have been provided mostly in public hospitals that operated on a non-profit basis for the public good. There are some private clinics -- the overwhelming majority of which provide medical imaging – but 98.7 percent of surgeries are provided in public hospitals.[3]

With no mandate, and in fact leading into the 2022 election, having sworn to the public that they would not privatize, in January 2023, the Ford government announced plans to expand for-profit clinics to do surgeries and a range of diagnostics that are currently provided in public hospitals.[4] Concerns were raised about the well-documented history[5] of for-profit clinics violating the core tenets of Public Medicare by extra-billing and charging user fees to patients illegally,[6] among other problems associated with this privatization plan. In response, Premier Doug Ford promised, "No Ontarian will ever

[1] https://en.wikipedia.org/wiki/Ontario_Hospital_Association

[2] The Private Hospitals Act was amended in 1971, and under the amendments which were made effective in 1973, banned all new private hospitals, stopped the existing ones from being expanded and gave the Minister the ability to deny the sale of licenses in the public interest.

[3] https://policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2023/11/AtWhatCost-FINAL-November%202023.pdf page 6.

[4] https://www.ontariohealthcoalition.ca/wp-content/uploads/main-fact-sheet-on-privatization-of-hospitals.pdf

[5] https://www.ontariohealthcoalition.ca/index.php/private-clinics-the-threat-to-public-medicare-in-canada-results-of-surveys-with-private-clinics-and-patients/

[6] https://www.theglobeandmail.com/news/investigations/doctors-extra-billing-private-clinics-investigation/article35260558/

have to pay with a credit card. They will pay with their OHIP card."[7] When the Ford government used their majority to pass enabling legislation, the euphemistically-titled *Your Health Act*, to privatize those services, the government promised "guard rails" to ensure that staff would not be poached from public hospitals and patients would not be turned away if they "choose to pay with their OHIP card".[8] In truth, they actually removed guardrails, enabling an appointed civil servant or even a third party corporation to issue new licenses without going to the Minister of Health, allowing long-term licenses, enabling the renewal of licenses for private clinics that do not comply with the law or have poor inspections records, and expressly enabling "upselling" to patients by the private clinics. The promises of strong protections for patients were performative, not real.

Predictably, and despite the Premier's headline-grabbing rhetoric, user charges for access to needed health care have proliferated. The Ontario Health Coalition has received complaints from hundreds of patients who have been charged for care in private clinics. We have investigated the complaints and have, at the same time, conducted surveys among seniors' and other civil society organizations to document what is happening. In February and March 2024, the Health Coalition received surveys from 120 patients who have experienced one or more incidents of user fees, extra-billing or manipulative upselling and conducted more in-depth case studies of eighteen patients who have been subjected to extra charges at private clinics that are unlawful, unethical and/or illegal. This report includes the evidence from those patients.

Mostly, the currently existing private surgical clinics in Ontario do cataract surgeries and the Ford government has expanded the private for-profit cataract surgery clinics dramatically.[9] (Next, the Ford government plans to expand this into hips and knees, and other surgeries and diagnostics.) Thus, unsurprisingly, the vast majority of the complaints the Coalition receives are about for-profit cataract surgery clinics charging patients.

The Ford government's privatization of our public hospitals' services -- and the concomitant rise of user charges for patients by the for-profit clinics and hospitals – pose an existential threat to the future of this public health care system that has taken our communities a century to build. The Ford government is doing substantially nothing to stop the now-rampant out-of-pocket charges that the private clinics are charging patients. The evidence shows that for-profit cataract surgery clinics are frequent violators of the *Canada Health Act* and the *Commitment to the Future of Medicare Act*, yet the Ford government has increased their funding by a whopping 300 percent[10] and is giving massive expansions to companies that are in breach of our Medicare laws. While claiming to the public that they will never pay with their credit card, only their OHIP card, the Ford government is actually doing the opposite. They are allowing unfettered user fees in the thousands of dollars for often-elderly patients in need of surgeries and tests. Charging patients for access to these health care services re-establishes the two-tier health care system that Medicare was designed to end in 1966. It must be stopped.

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[7] https://www.cbc.ca/news/canada/toronto/ontario-doug-ford-private-clinics-health-care-1.6712444

[8] https://toronto.ctvnews.ca/ontario-passes-health-care-bill-allowing-private-clinics-to-conduct-more-surgeries-1.6389103 Note: this PR wording by the government is incorrect. It is not a "choice". It is actually illegal to charge patients for those services under Ontario law and it is unlawful under the Canada Health Act.

[9] See, for example: https://ottawacitizen.com/news/local-news/ottawa-eye-clinic-says-it-has-a-licence-to-perform-5000-additional-cataract-surgeries-per-year-under-provincial-expansion

[10] https://www.ontariohealthcoalition.ca/index.php/release-report-robbing-the-public-to-build-the-private-the-ford-governments-hospital-privatization-scheme/

Key Findings: Violations of Public Medicare Laws in For-Profit Clinics

18 in-depth case studies of patients

This report includes eighteen case studies of patients who were charged when they went in for cataract surgeries. Out of the eighteen patients' stories are the following trends. Please note that some patients had more than one of these things happen:

- Five patients were threatened with longer wait times if they chose not to pay out of pocket;
    - Patients B, E, L, N, P
- Three patients had vital information about their procedure withheld which didn't allow them to make an informed decision;
    - Patients E, H, P
- Twelve patients were manipulated or coerced into paying out of pocket for unnecessary add-ons, and;
    - Patients A, B, D, F, G, H, J, K, L, M, N, O
- Six patients were told there was no free "option" or were never informed that they could get the surgery without charge.
    - Patients B, C, D, E, F, H

Responses from 231 patient surveys

This report includes 231 responses from a patient survey about extra-billing and user fees. Of the 231 patients, 120 reported one incident or more of extra-billing, user fees and/or manipulative upselling.
Of the 120 where violations of our Public Medicare laws were reported, 82 are about cataract surgeries, 16 are about primary care, 15 are about physician-ordered laboratory tests, and 3 are about diagnostics. The rest of the responses concern endoscopy, colonoscopy, ophthalmology, hernia surgery, vasectomy, and OHIP-eligible fertility treatment. Please note that 3 patients reported violations of our Public Medicare laws in more than one kind of service (e.g., the patient was charged for cataract surgery and primary care). From the patients' responses are the following trends.

Please note, some patients had more than one of these things happen:

- Patients were threatened with longer wait times if they chose not to pay out of pocket;
- Patients had vital information about their procedure withheld which didn't allow them to make an informed decision;
- Patients were manipulated or coerced into paying out of pocket for unnecessary add-ons;
- Patients were told there was no free "option" or were never informed that they could get care without charge;
- Patients were charged for consulting, administrative, membership, and appointment fees;
- Patients were concerned that they would not receive proper care if they did not pay;
- Many patients were forced to cut down on expenses to pay the fees.

Public Medicare: What is Covered

- It is unlawful under the Canada Health Act and illegal under Ontario's Commitment to the Future of Medicare Act to charge patients for medically-needed surgeries or diagnostic tests, including all of the needed elements of the surgery (eye drops, creams etc.)

- It is unlawful under the Canada Health Act and illegal under Ontario's Commitment to the Future of Medicare Act to give preferential access to patients who pay – you cannot have patients pay to jump the queue.

- Patients have the right to informed consent. They must be given full and honest information about their health care treatment choices.

- Manipulating patients into paying for unneeded add-ons is a major problem. In most cases, patients are led to believe they are needed, or that outcomes will be poor or inadequate if they do not pay for them. This is unethical and potentially unlawful, and it is the reason that the Ford government opening the door wide for private clinics to sell all kinds of medically unnecessary add-ons is a significant problem.

Details about what is specifically in the Canada Health Act, the Commitment to the Future of Medicare Act and OHIP Coverage for Cataract Surgeries are in the appendices to this report.

The Most Common Violations of Public Medicare Laws in Ontario's Private Clinics

From our in-depth case studies of eighteen patients who were charged for services in private clinics, the Ontario Health Coalition was able to identify several trends:

- For-profit clinics violated the law outright and told patients that they had to pay for medically-needed surgeries. They did not tell them that there was an option not to pay, which is incorrect in any case, as they are not allowed to charge for an OHIP covered service.
- For-profit clinics flagrantly charged for preferential access to care for those who paid out of pocket. Patients were told that public cataract surgeries have a long waitlist and that they can decrease the waiting time by paying for the surgery. Note: the patient does not know if the length of the public waitlist is true and correct information or not. Often, we find they are being told waitlists are longer than they actually are.
- For-profit clinics withheld vital information necessary to make a voluntary, informed decision about health care services.
- For-profit clinics required patients to pay for add-ons not needed or covered by OHIP, such as upgraded lenses or diagnostic exams in order to get the needed surgery. The patient was told that a surgery, or any other service, cannot be performed unless they pay out of pocket for the add-on.
- Physicians or private clinic staff manipulated patients to pay for add-ons by saying that further tests are needed to get more accurate results for their surgery or that certain lenses provide better results than the OHIP lens. Patients reported that the education they received from the physician or facility feels more akin to a sales pitch rather than being therapeutic.
- The majority of the patients are elderly and vulnerable due to the lack of medical education about how urgent or non-urgent their case is, and what their rights are under public health care legislation in Ontario and Canada.

Case Studies: Violations of the Canada Health Act & the Commitment to the Future of Medicare Act

The following stories are of Ontario residents who are covered by OHIP and have been manipulatively upsold and/or extra-charged in private for-profit clinics.

Patient A
Patient A was referred to an eye clinic in Oakville for cataract surgery by his optometrist on March 1, 2022. He was going to be charged $250 to the clinic for two tests prior to the surgery, which he declined. However, he saw other people pay the amount as he waited for further tests. It was then recommended he get laser eye measurements because they produced better results, he was told. The measurements cost him $500. A further $330 was asked to be paid to the clinic if he wanted to get upgraded lenses that were not covered by OHIP. Despite being told that private clinics work faster than public hospitals, his surgeries were not scheduled until November 14 and 28 of 2023, one and a half years later.

Patient B
Patient B was referred to a private eye clinic in Toronto by her optometrist. Upon arrival, she was charged $130 for a registration fee. She was told that she needed to pay the registration fee to receive an ocular surface test that she was told she needed. She later returned to the clinic for an eye measurement. When the doctor heard that she preferred to have the OHIP-covered lenses, the doctor was quick to note the operation would not take place until the following year. The physician's assistant noticed her displeasure and later advised her that the wait time would only be a few months. Out of curiosity, she asked for the price list of the other lenses and was appalled to hear that the prices ranged from $590 to $4,050 per eye. Prior to the surgery, she was told the eye drops she needed were not covered by OHIP and cost $168.76. She found this strange because her friends had the same surgery, and their eye drops were covered by OHIP. After the procedure, she was informed that the surgery was not as successful as predicted and her distance vision was not as good as it was previously. Overall, she told her family doctor and optometrist that she felt she was given subpar care.

Patient C
Patient C needed cataract surgery and opted to go to an eye clinic in Toronto. He was informed that the surgery would cost $2,440 (laser) or $2,190 (Keratome), plus a COVID-19 charge of $10. The clinic later tried to persuade him to buy eye drops to use after the surgery for $50, but he noted that the same eye drops cost $13.39 at Loblaws. The clinic then told him the first check-up was free, but any following check-ups would cost $75 per visit. The surgeon then advised them to go to Sunnybrook where the surgeon worked and the check-ups would be free. Next, the clinic offered a “free” Enhancement Plan that covered any medical errors during the surgery. Normally, any corrective surgery would cost $1,200, but with the plan, he would pay either $150 for a “free” enhancement (corrective surgery) that covered 1 year, $200 to cover 3 years, or $250 for 5 years. It was essentially an “insurance plan” in case there was an error during the surgery. Patient C was then offered discounts and the new prices were $1,740 (laser) and $1,690 (Keratome). After emailing the surgeon and a lot of heckling, the clinic called to inform him that the laser surgery would now be free, but the eye drops would mysteriously now cost $60. After the surgery, he received an invoice of $1,400 but the patient got it down to $0 after some “mysterious deductions” as the patient describes it.

Patient D
Patient D needed cataract surgery. An eye clinic in the Kitchener area charged them $125 for eye measurements without giving them options about the test and told them it was necessary. Patient D was then informed that any eye drops or ointments needed for the surgery were not covered by OHIP and was not given any option but to pay out of pocket.

Patient E
Patient E had to pay out of pocket for laser cataract surgery on both eyes. The surgeon informed Patient E that if she were to go through the public system, she would face a long wait time of possibly over two years. Patient E was also told that the laser eye surgery was only performed at the private clinic, not the public hospital. This was untrue because her daughter had the laser surgery done in a hospital. Patient E had a successful surgery in the following weeks but feels that she was misled and coerced to pay out of pocket for the surgery. She had to deplete her savings to get this surgery done. Her daughter feels that private clinics blatantly prey on seniors to pay for cataract surgery.

Patient F
Patient F was referred to a hospital in Toronto by her optometrist because she needed surgery for rapidly growing cataracts. However, the hospital informed her there would be a two year wait for the surgery. Feeling that she could not wait for the surgery, she consulted with a private eye clinic in Toronto. Her optometrist had recommended the clinic to her after hearing about the public hospital wait time. At the private clinic, she agreed to pay $1,200 for diagnostic and measurement tests after being told they would guarantee better results. During the consultation, she was not informed about an OHIP-covered option regarding the lenses or surgery. She had to pay $6,350 for the surgeries that occurred in the August and September of 2022. The total cost for her surgery was $7,550. She feels that she had no choice but to pay out of pocket because she needed the surgery to run her business.

Patient G
Patient G was diagnosed with a fast-growing cataract in the right eye and a slow-growing cataract in the left eye. Her optometrist told her that getting cataract surgery through the public system would be a two year wait for the right eye and she wouldn't be able to get onto the waiting list for the left eye. Given this information, she opted to go to a private clinic that her optometrist recommended. At the clinic, she was given options about the lenses, but with the education she was given, she felt that the OHIP lenses were not optimal for her. She states that the consultation felt like a sales pitch; the doctor was slick and the way the lenses were marketed was inappropriate. She was charged $7,000 for both eyes plus eye drops she needed before and after the surgery.

Patient H
Patient H needed cataract surgery. He contacted his optometrist at a local hospital but was told that the doctor no longer worked there and was setting up his own clinic. He contacted the doctor directly and was told to come in for an eye measurement exam. He was told that paying for an upgraded exam would yield better results. He paid $250 for the "upgraded" exam. The doctor later informed him that the surgery was scheduled for the next week. The doctor then asked if he had been informed that the procedure would cost $1,100 per eye. No one had informed him of this charge, and he had no idea that they were now dealing with a private clinic. He was not told about the cost of the surgery until the very last minute. He refused to pay the amount and the $250 was returned to them. He feels that he was misled throughout the process and was kept in the dark until the final minute.

Patient I

Patient I required cataract surgery and went to an eye clinic in Toronto. At her first appointment, she had a brief meeting with the surgeon who gave her information about the surgery. She feels that the information given was inadequate for her to make any decisions, noting she was given a 15-page pre-surgery information booklet that she would have to read. For this interview, she was charged $600. She had many questions after reading the booklet, but the person she was told to contact never answered their phone. Three days prior to the surgery, the surgeon called her and asked which lenses she wanted to be used in the surgery, and she told him she didn't have the information required to make a decision. The surgeon took the time to explain the options to her. On the day of the surgery, she was charged $2,770 and does not know why she was charged this amount, but she paid it nonetheless. After the procedure, she was not given time to ask the surgeon any questions as "he simply vanished". The day after the surgery, she received a call from the clinic and was asked how she was doing. When she asked about speaking with the surgeon, she was told he would call later that day, but he never called. Patient I spoke with a friend who had the same procedure at the same hospital the summer before and the friend paid nothing.

Patient J

Patient J had a cataract surgery done at an eye clinic in Toronto. The surgeon at the clinic recommended a special lens that cost approximately $400 more than the basic lens covered through OHIP. Patient J was told by a technician from the hospital that they would have two options for the measurement test: manual measurements offered through OHIP or an accurate machine measurement, which would cost them $100 per eye. The technicians advised them that they would have to get both eye measurements.

Patient K

For the past twenty-five years, Patient K has been visiting an eye specialist at a Toronto area hospital to take care of his glaucoma. However, in 2023, the eye specialist told Patient K that they needed cataract surgery. Patient K had to get their eye measurement test done at the hospital for $200. Later that month, they had to get their surgery done at an eye clinic in Toronto which cost them $190 per eye. It was recommended to Patient K that they obtain "higher-quality" lenses than the basic ones that OHIP covered.

Patient L

Patient L needed laser cataract surgery in 2018. She was referred to a specialist in a private clinic in Brampton by her optometrist. Patient L was charged $554, presumably for eye measurements as she does not recall receiving a detailed invoice. The clinic told her that if she wanted to get the surgery at a hospital, the wait would be at least three years and quite possibly five years long. When she asked about OHIP coverage, the clinic told her that they did not provide it because she would be receiving surgery faster at the clinic and a hospital would not produce results as good as those in a private clinic. For the surgery, she was sent to a clinic in Vaughan and was charged $1,400 per eye.

The patient was also was pressured into upgrading her lenses, which would cost $900 more per eye. She was informed that the hospital did not carry them and that they were of higher quality than the standard lenses. However, she refused and was told that OHIP would not cover the cost. In total, her cost was $3,354.

Patient M

Patient M, who was eighty years old, was charged $250 per eye measurement for a total of $500. She was going to be charged $2,000 for cataract surgery. However, she was talked out of it by her daughter-in-law. Patient M's daughter-in-law felt that she was being exploited because there was a language barrier between doctors and Patient M.

Patient N
Patient N waited over a year for cataract surgery at a clinic in Kingston to which she was referred by her optometrist. After waiting for a year and not hearing back, she went to a private clinic in Ottawa and was offered cataract surgery within the week. The charges from the private clinic cost her $2,550 per eye. When discussing the lens, Patient N asked if she could get the one offered through OHIP. However, she was advised that waiting for an OHIP-covered lens would take 6-12 months. She was manipulatively upsold to have the more expensive procedure in order to access the service.

Patient O
Patient O was referred to an eye clinic by their family doctor. They were convinced to pay $200 per eye for "advanced measurements" so that the cataract surgery would be "more precise". The clinic gave them three options for lenses: the "basic one" that was covered through OHIP, the "better" option (which Patient O chose) and the "best". The clinic strongly assured Patient O that the results would be better if they opted for the higher cost lenses.

Patient P
Patient P, who is 87-years old, was referred for cataract surgery to an eye clinic. Patient P was told that they would have to pay for the surgery at the private clinic. The doctor offered to refer them somewhere else if they wanted the surgery to be covered under OHIP. However, they were told they would have to wait a year to get surgery. They felt forced to go with private clinic due to their age, and they were charged $1,200 per eye for a total $2,400.

Patient Q
Patient Q was charged $580 per eye for his cataract surgery, $350 per eye for special measurement tests, and $141 for eye drops. Patient Q a is 71 years old is working because he was not able to pay for the surgery.

Patient R
Patient R had cataract surgery done in September 2023. The private clinic charged them $1,800 per eye and extra fees for post operative packages. They are being charged $150 per eye for six sample bottles of eye drops, protective sunglasses, a protective eye shield, and medical tape.

Results of Surveys with 231 Patients

Ontario Patient Survey Results				
User fees charged for medically needed services	No user fees	User fees reported for non-OHIP covered services	Incomplete information provided	Total number of surveys received
120	39	64	8	231

From February 5 to March 8, 2024, the Ontario Health Coalition surveyed 231 people about whether they or their immediate family members had been charged for medically necessary services or manipulatively upsold for medically unnecessary services at private clinics. The Coalition shared electronic and printable surveys online, on social media, and with seniors' and retirees' groups across Ontario.

Patients were asked about:

- What service the extra charge was supposed to cover;
- Whether or not they were given a choice to pay;
- Any reasons they were given for the extra fee;
- What they believed what would happen if they did not pay for the service;
- The amount they were charged;
- The impact of the extra fee on their household budget, and;
- Demographic information.

The largest proportion of patients subjected to extra charges were charged for cataract surgery. After cataract surgery, the most common complaints were about charges for primary care, lab tests, and diagnostic tests. Many patients reported that they were not given a choice of whether or not to pay. Some of them were not informed that the service was OHIP-covered. For some patients, in order to convince them to pay extra charges, they were told – falsely – that OHIP-covered services (such as cataract surgery lens replacement) do not provide for services that were suitable for that patient. Others were led to believe that they would receive lower quality of care from the private clinic if they did not pay. Other patients felt like they had no choice but to pay private clinics because they were told that wait times in hospitals were months or years long, which is often untrue. Private clinics also manipulatively upsold patients medically unnecessary procedures, some of which patients said were later determined by other clinicians to be unneeded. Some patients were not informed about the payment until the procedure was done. If they refused to pay, then the clinic would not provide results.

Many patients were charged for primary care. The vast majority of them were told that they needed to pay an appointment fee, subscription/membership fees, or block fees to be able to see family physicians or nurse practitioners for primary care.

Patients were given no choice to refuse payment in order to receive MRIs or x-rays. One patient believed that if they did not pay, they would die waiting for an MRI that they needed for heart surgery.

The patients were mostly seniors living on fixed incomes. They reported that the extra user fees were unexpected and created significant financial hardships that impacted their lives. Many seniors had to use up their savings or pensions and/or had no choice but to cut back on their household budgets. Some borrowed money to cover the cost, cut on groceries, forewent other plans, or asked their children to pay the fee. Some seniors could afford the cost, but they expressed concern for others who would not be able to do so. Many seniors also reported they never had these fees until recent years.

Cataract Surgery Fees

About one-third of the patients surveyed (82 out of 231) had been charged or manipulatively upsold by private cataract surgery clinics. They reported being charged $500 - $5,000 per eye for the cataract surgery itself. Patients were routinely charged for extra eye measurements/tests and special lenses. They were told that extra measurements/tests that cost $50 - $300[11] per eye were necessary or would provide better outcomes. They were sometimes charged for the tests without a choice or discussion. Patients also reported that private clinics told them that special lenses were safer, would result in better vision, or were more suitable than OHIP-covered lenses. The special

[11] One patient was charged $1,000 per eye for multiple measurements and tests

lenses cost patients anywhere from $85 - $3,000+ per eye. In some cases, patients reported that they were not given a choice about the type of lens they would receive or that the private clinics refused to answer further questions. Thirty-four patients were charged for at least two of the following: cataract surgery, extra eye measurements/tests, special lenses, eye drops, follow-up appointments, or administrative fees.

The following are quotations from patients concerning charges and upselling for cataract surgery at private clinics:

- “We are broke, trying to avoid bankruptcy. [But] At least I can see now.”
- “It did have an impact on the monthly budget. We are retired [and] had to cut back on some expenses or needed items to put off for another month.”
- “It was very hard, there were many other pressing things I could have spent that money on.”
- “[We] have to do what we have done for a long time now and that is [to spend] nothing extra until we recoup.”
- “Huge impact, [I] had to borrow money from my bank and family.”
- “We were told there was a two year wait for cataract surgeries but could get it done right away if we paid.”
- “In order to obtain an "improved" quality of lens, I would have to pay. If I was satisfied with a basic level of vision, I would not have to pay.”
- “It wasn't quite worded as a choice. The other choice was implied rather than mentioned.”
- “Yes, [I was given the choice], but who am I to argue with my professional care giver's recommendations?”

Primary Care Fees

Many patients are charged for primary care fees, including appointment, membership and administrative fees. All of these fees are illegal and unlawful and they were the most commonly described charges for patients who were charged for primary care. For clarity: physicians can charge for uninsured services (such as work physicals or phone-in prescriptions) per service or through a block fee. A block fee is when they charge a fee of $100 or $200 for all such uninsured services a patient might use for 3-12 months. The Health Coalition has always opposed block fees because they open the door to abuses and are used to try to comingle medically needed and unneeded services in order to charge a patient, which is illegal. Also, physicians do not return the unused portion of the fee, which is wrong. However, block fees were not the most common complaint in primary care. From our surveys, we found that patients most often are reporting being charged outright for an appointment with a doctor or nurse practitioner, being charged a membership fee for access to primary care or being charged an “administrative’ fee -- clear violations of our Medicare laws.

The Truth About Wait Times

Many patients are led to believe that the wait times in public hospitals are impossibly long and thus are vulnerable to misinformation from private clinic operators. The Ontario Health Coalition researched the evidence on cataract surgeries – where most of the complaints about extra-billing, queue-jumping and patients being charged for unnecessary add-ons in order to get the surgeries are happening – and we found that Ontario is actually doing quite well on wait times for cataract surgeries. When we are contacted by individual patients who are told of year-long or multi-year long

waits for public cataract surgeries and we look up the actual wait times, almost always the private clinics have misled the patient and overstated the wait times significantly.

Ontario has a wait times website on which anyone can access to look up the real wait times in their area (or across the province). Patients are triaged based on medical need. The level of need is based on a clinical assessment and priorities are assigned from Priority 1 to Priority 4 with target wait times for each.[12] "Priority one" denotes the most urgent level of need, meaning that patient has a high probability of disease progression impacting health or resulting in death. If this category applies to the type of surgery (i.e. the surgery is not elective and the disease or condition can be life- or health-threatening), those patients are seen on an emergency basis. Priority 2 patients have a moderate chance of disease progression but low chance of long-term effects or death. Priority 4 patients have a minimal risk of the same. Wait time targets are set by surgeons, specialists and health care administrators across the province based on clinical evidence of outcomes.

Cataracts can be diagnosed quite early, long before there is any need for surgery to correct them. The most recent reporting period for cataract surgeries in public hospitals is December 2023 and it shows that 78% of patients in Ontario are receiving cataract surgeries within recommended wait time targets and 84% get their appointment with a specialist within wait time targets. The most priority patients for cataract surgeries are not waiting for months and years. For priority two patients, the average wait to see a specialist is within 26 days. The average wait after that assessment for surgery for those (priority two) patients is 56 days (just under two months). The lowest priority patients whose cataracts are not ready for immediate surgery or who do not need it right away are waiting on average 100 days to see a specialist. From specialist appointment to surgery, the wait times for those cases that do not need surgery urgently are 109 days. Thus, even the low priority patients are mostly getting from family physician or primary care practitioner through to the end of their surgery within seven months. For the higher priority patients, the average from start to finish is under three months.

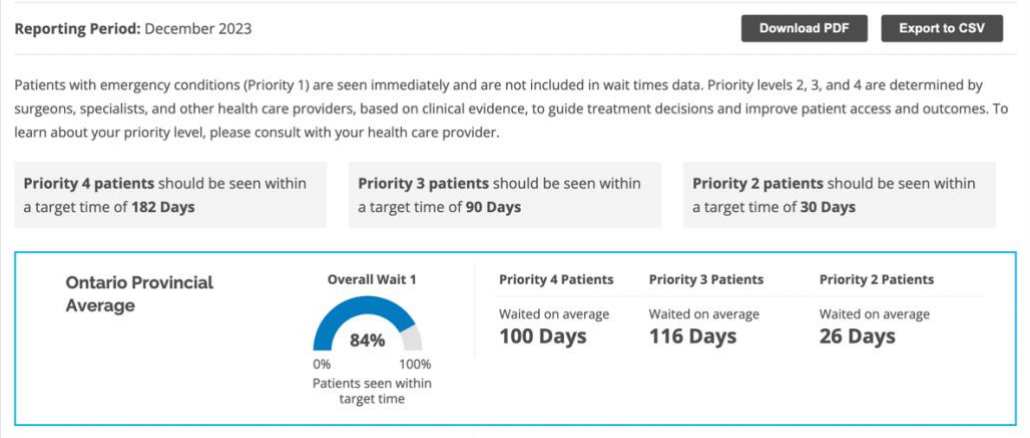
Thus, three quarters or more of patients are getting their surgeries within clinically-recommended targets. To be clear, patients are waiting too long for their surgeries in a number of cases. While the Priority Two and sometimes Priority Three patients are waiting almost a month longer than target for surgeries, Priority Two patients are getting to specialists earlier than target. There can and should be improvement. The point is that the claims of the private clinics and privatization proponents tend to be exaggerated and misleading for patients who generally do not know what their actual level of medical need is nor what the actual wait times are. Patients are vulnerable to being manipulated into paying thousands of dollars illegally and unnecessarily, and such unethical and unlawful behaviour is indeed happening.

The bottom line is that patients are being told at private clinics that wait lists are more than six months and they need surgery more urgently, or patients are being told that wait lists are years long. These claims are most likely false. The patients are not being told the truth either about their need for surgery or the length of actual wait lists.

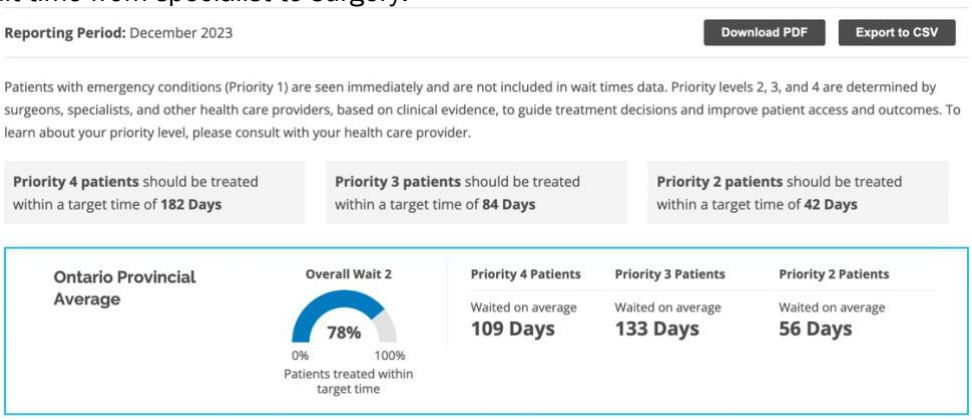
[12] https://www.hqontario.ca/System-Performance/Measuring-System-Performance/Measuring-Wait-Times-for-Eye-Surgeries

These are the results for Ontario cataract surgery wait times up to December 2023:

1. Wait time from primary care to see a specialist:[13]



2. Wait time from specialist to surgery:[14]



Conclusion

Private for-profit clinics are not a "solution" to improve wait times for surgeries and diagnostic tests. Ontario funds its public hospitals at the lowest rate of any province in Canada[15] as a policy choice to foster privatization. We do not need to build private clinics to create operating room capacity. In fact, virtually every local public hospital across Ontario has unused capacity in operating rooms, and many hospitals have operating rooms that lie dormant for weeks or months at a time, or are even closed permanently due to underfunding and understaffing.[16] The majority of the province's public hospitals' operating rooms sit unused in the evening, closing after 3 p.m. or 4 p.m. On weekends, many are closed or only provide emergency surgeries. For example, Carleton Place & District Memorial Hospital's sole operating room is only used in the daytime on weekdays. In North Bay, out

[13] Ontario Health, Wait Times website. https://www.ontariohealth.ca/public-reporting/wait-times-results Accessed March 11, 2024
[14] Ontario Health, Wait Times website. https://www.ontariohealth.ca/public-reporting/wait-times-results Accessed March 11, 2024
[15] https://www.ontariohealthcoalition.ca/wp-content/uploads/Public-Hospital-Expenditure-Per-Capita-2021.pdf
[16] https://www.ontariohealthcoalition.ca/wp-content/uploads/final-report-harm-to-public-hospitals-of-privatization.pdf

of the seven general operating rooms, only five are used on most days and only during daytimes. Only one operating room is open during evenings and on weekends. At the same time, the Ford government has been maintaining downward pressure on public hospitals' global budgets while giving for-profit clinics and hospitals massive funding increases of up to 300%.[17] The promised "guardrails" to stop the exploitation of patients, many of whom are elderly, are performative not real. Unlawfully, illegally, and/or unethically, patients are being charged thousands of dollars for cataract surgeries and are increasingly being charged for primary care. The Ford government's first phase of privatizing our local hospitals has failed to live up to the Premier's headline-grabbing claim that no patient would have to pay with their credit card, only their OHIP card. Given that failure, the government must stop their drive to privatize our public hospitals. They must reopen the existing capacity in our public hospitals, and provide the resources to expand the number of surgeries and hours of diagnostic imaging available in our communities in a way that is in the public interest, uses public hospitals and is in accordance with the Public Medicare laws that our communities have spent a hundred years building.

[17] https://www.ontariohealthcoalition.ca/index.php/release-report-robbing-the-public-to-build-the-private-the-ford-governments-hospital-privatization-scheme/

Appendix I: The Canada Health Act

The Canada Health Act is a federal law in Canada that outlines the principles for universal health care coverage.[18] Its primary function is to ensure that medically necessary health care services are accessible to all Canadian residents regardless of their ability to pay. It bans extra-billing and user charges for patients for medically needed hospital and physician services.

The Act sets out criteria for provincial and territorial health insurance plans. Provinces and territories must fall within the criteria to get full federal funding. In order to qualify for the federal cash funding for health care, provinces must ensure that:

1. Covered services are not subject to extra-billing.
2. Covered services are not subject to user fees.

If violations are found, the province or territory will have their federal funding reduced or withheld and this is reported in the annual Canada Health Act reports.

The five principles of the Canada Health Act are:

- Public administration: Health care insurance plans provided by the province (such as OHIP for Ontario) must be operated on a non-profit basis and be administered and operated by a public authority. The administration of health care services and management of health insurance plans must be carried out by government agencies rather than for-profit organizations.
- Universality: All Canadian residents are covered by Public Medicare regardless of their income, employment, or pre-existing health conditions. It ensures that all residents of Canada have the same entitlement to necessary medical services on uniform terms and conditions. Thus, 100 percent of a province or territory's eligible residents must have public coverage for their needed hospital and physician care on equal terms and conditions.
- Portability: Portability is the ability of Canadian residents to keep their health coverage when they move or travel within the country. When an individual moves from one province or territory to another, they keep their access to medically needed health care services without experiencing a lapse in their ability to do so. It provides a seamless transition when relocating to a new province or territory.
- Comprehensiveness: All medically necessary hospital and physician services – and similar services provided by other designated health professionals -- must be covered by provincial or territorial health insurance plans.
- Accessibility: All insured residents must have reasonable access to health care services without facing financial or other barriers. Examples of financial barriers that are barred are user fees and/or extra charges.

To meet these criteria, medical practitioners cannot extra-bill or charge residents for services covered by the health insurance plans provided by the province (such as OHIP). A resident requiring medically necessary health services, such as surgery or diagnostic tests, cannot have their access limited by premiums or user fees.

[18] https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html

Appendix II: The Commitment to the Future of Medicare Act, Ontario

As we have summarized here, the Canada Health Act ensures that all patients in Canada are protected from extra-billing and user charges. Ontario's Commitment to the Future of Medicare Act (CFMA) is the Ontario legislation that requires adherence to the Canada Health Act.[19] In accordance with the Commitment to the Future of Medicare Act, Ontario residents with valid OHIP coverage are eligible to receive public health care services at no cost and all OHIP-covered services are subject to the protections outlined in the CFMA. It is an offense under the Act to accept payment for a covered service and offending corporations are subject to a fine of up to $50,000 for the first offence and up to $200,000 for subsequent offences. The law also includes fines and a prison term of up to twelve months for individual offenders.[20] The legislation also provides for the Ministry of Health to reimburse patients for unlawful extra-billing and user fees.

The Commitment to the Future of Medicare Act (CFMA) prohibits:

- Extra billing: Physicians or any other designated health care professional are prohibited from charging patients above OHIP and are only allowed to bill for the OHIP fee for publicly insured health services.
- User fees: Charging patients for all or part of an OHIP-covered service, or their private insurer for services covered under OHIP, is not permitted.
- Queue jumping: Under the CFMA, no one can receive payment in exchange for allowing patients to have preferred access to OHIP-covered services. It also does not allow patients to pay extra fees or offer other benefits to secure preferred access to OHIP-covered services.
- Using a block or annual fee to restrict access to insured services: The CFMA does allow charging fees for non-medically necessary things such as sick notes or cosmetic surgery, only for those items that are specified in the regulations. It is important to note that CFMA prohibits physicians and other health care providers or hospitals from denying access to OHIP-covered procedures if patients choose not to pay the block fee for the medically unnecessary items.

[19] https://www.ontario.ca/laws/statute/04c05/v10

[20] https://mcmillan.ca/wp-content/uploads/2004/01/Ambitious_Future_Bill8_0104.pdf

Appendix III: The Truth About What is Covered for Cataracts / Lens Surgery

In Ontario, most of the existing licensed private clinics do medical imaging, and the vast majority of those are x-ray and ultrasound clinics.[21] There are, however, a significant and growing number of private for-profit cataract surgery clinics. As these clinics have expanded, the Ontario Health Coalition has received numerous complaints from patients about extra charges for cataract surgeries.

All kinds of unethical, unlawful and/or illegal things are being done in these clinics to try to get around the prohibition on user fees and extra billing of patients. Patients are being told that laser cataract surgery is not covered. This is false. They are told that the clinic is not covered under OHIP. Again, this is not true. The Canada Health Act and the Commitment to the Future of Medicare Act cover all of Ontario and all medically-needed surgeries and diagnostics. They are told they will have to wait a long time to get surgery if they do not pay. That is illegal. They are told they have to pay $100 for eye drops. Not true. They are told they need an extra eye measurement test. Again, not true.

The Ministry of Health specifies the rules as follows:

Medical practitioners cannot charge for services covered by OHIP. Cataract and intraocular lens exchange surgeries are insured services under OHIP, regardless of how the surgery is performed. Laser surgery is covered. Purchasing extra services cannot be a condition of receiving medically necessary health care services without extra charge. There can be no barriers to accessing medically necessary health care.

Physicians or clinic staff may try to upsell lenses or tests that are not covered by OHIP and are medically unnecessary. The physician or the facility must provide the patient with sufficient information so they can make a voluntary informed decision. They cannot manipulate a patient into believing that if they get the OHIP covered service, they will not have a good outcome. Further, these extra services are not needed and the patient cannot be required to buy them to access medically necessary services.

For example, there is no “standard” lens. All patients must have assessments and tests done by their physician to determine the necessary individualized lens that the patient needs. This individualized lens is covered by OHIP. All assessments done to determine the lens are also covered by OHIP and are tests that are up to date with current and relevant research, no other tests are needed.

If the patient does voluntarily choose to purchase the added services such as lenses that are not needed as part of cataract surgery, then they are entitled to receive credit for the cost of the medically needed service (i.e. the cataract surgery). This credit must appear in the invoice provided to the patient.

All medically necessary surgeries performed in a public hospital or private clinic are covered by OHIP and the clinic cannot extra-bill patients or charge user fees for those services. The equipment used

[21] https://policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2023/11/AtWhatCost-FINAL-November%202023.pdf also see the listing of Independent Health Facilities and Out-of-Hospital Premises here https://www.cpso.on.ca/en/Physicians/Your-Practice/Accreditation-Programs/Independent-Health-Facilities

and the personnel required to perform the surgery or service are covered by OHIP and are not the financial responsibility of the patient.

A consistent complaint the Ontario Health Coalition receives has been that patients are charged exorbitant fees for eye drops or ointments needed before and after cataract surgeries. Of our eighteen case studies here, there are six stories in which the patients are charged for eye drops or ointments. In response to the Health Coalition's inquiry, the OHIP Claims Office stated that these ophthalmic drugs are covered by OHIP since they are medically necessary before and after surgery.[22]

If physicians or facilities are found to violate the Canada Health Act or the Commitment to the Future of Medicare Act, the corporation and the medical personnel charging the patient are subject to being found guilty of an offense under the Commitment to the Future of Medicare Act and fined, and the patient is to be reimbursed. If the Ford government continues to refuse to stop the private clinics from extra-billing patients, they are guilty of violating the Canada Health Act and the federal government must withhold financial transfers for health care in accordance with those violations.

[22] Ontario Health Coalition nursing student intern phone call with OHIP Claim Office on November 22, 2023.