SEIU-West submission to the Saskatchewan Government:
Bill 179 – Private MRIs in Saskatchewan Bill 128

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Our Demographics

Based on our current seniority list data, we understand there are eighteen SEIU-West members employed as MRI Techs across the three hospital sites in the Saskatoon Health Region (SHR) and, of these, approximately fourteen are Permanent Full-time employees. At least two of these members may be eligible for retirement at present. There are five others who have been actively employed for over ten years. According to our data, the most recent recruitment (as a new hire) occurred in 2013. Based on information obtained from SAHO (effective March 31, 2012), there were six male employees and twelve female employees in this classification.

In addition, we have two SEIU-West members employed as MRI Tech Working Supervisors; one at each of St. Paul's Hospital and Royal University Hospital. Both are Permanent Full-time employees and both have been working for the Region for more than 25 years.

With the introduction of the MRI unit at the new Five Hills Health Region (FHHR) hospital in Moose Jaw, we have made inquiries about recruitment strategy within this health region. To date, FHHR has not shared any information about their plans to open the unit (timeline), the planned hours of operation or whether efforts to recruit have begun. We have heard from other sources that there may be one or more MRI Techs from SHR applying for a transfer to Moose Jaw.

Staffing Issues

While we did make a request for specific information from SHR, information was not provided prior to the deadline for submissions. Consequently, we are left with 'informed' speculation following consultation with our members.

Presently, we believe the departments are funded based upon a targeted number of MRI scans for the health region set by the Ministry of Health. We also understand that there is a master rotation at each of the hospital units with a baseline staffing level. For example, at Royal University hospital we believe that testing occurs between 8:00 am and midnight and there are five MRI Techs working on a Monday to Friday basis, with only two MRI Techs working on weekends and Earned Days Off. Each facility receives an annual budget based on the amount of staff, supplies and equipment required to deliver the targeted number of tests specific to their facility. We understand there is no additional funding to compensate for additional scans done; whether it is due to a transfer of patients from other health regions or increased demand over and above the targeted number of scans.

According to the Canadian Institute for Health Information (CIHI) data, Saskatchewan's public sector performed 21,814 MRI scans in the year 2006-7. Five years later that number had almost doubled, to 42,069. While this rise was predictable given our province's

growing and aging population, we are fortunate that we have not been billed for every single test performed as occurs in the private for-profit delivery system.

We also understand there are times when baseline staffing cannot be met. There are few, if any, casual employees available to pick up relief shifts. At present, there are a number of lengthy absences due to maternity leaves or illness across the units. As well, we understand that there may be one or more MRI Techs applying for a transfer to Moose Jaw. This illuminates the vulnerability of our public system towards maintaining adequate qualified staffing resources. We certainly do not want to see the private for-profit facility poach these valued resources. Bill 179 and the regulations thereto expose us to this very risk.

Knowledge – Skills – Abilities/Standard of Care Issues

We have reviewed the provincial Joint Job Evaluation job description for MRI Techs and we are aware that SHR public facilities (Royal University hospital, Saskatoon City hospital & St. Paul's hospital) establish and meet the standard of care for an a single MRI Tech to perform the MRI scan including screening and preparing the patient, ensuring their safety and comfort, and producing high quality scans. Such tests are requisitioned by a radiologist or medical specialist for the purpose of proper diagnosis. We also note that such procedures as initiating intravenous contrast media are done based upon the written order of the radiologist and only when the radiologist is in the department (under the supervision of). We promote this best practice model of delivery, and in particular, the administrative control aspect which lends to an equitable, transparent process whereby patients move through the queue based on prioritized acuity levels.

We recognize that the Health Ministry have contracted with the College of Physicians and Surgeons (CPS) to oversee the licensing of private facilities under *The Health Facilities Licensing Act*. To this end, the CPS has established the Advisory Committee on Medical Imaging. The Advisory Committee have adopted the Canadian Association of Radiologists Standards for MRI and are currently involved in a review and revision of Regulatory Bylaw 25.1 on Diagnostic Imaging.

Bylaw 25.1 Operation of Diagnostic Imaging Facilities does not apply to facilities operated by an RHA or the Cancer Agency. This bylaw establishes that a private MRI facility must have a Director to ensure that the imaging facility does not use unqualified personnel. The Director must be approved by the Advisory Committee and must be on-site for 25% of the scans performed each month. They must ensure that a radiologist is on-site for at least 80% of all scans performed each day. As well, they must ensure that a physician is on-site for any injected medication or contrast and to ensure that all technologists are fully accredited.

At present, it remains unclear what revisions are being considered to Bylaw 25.1. In view of Bill 179, this lack of clarity is a troubling feature. We are also concerned by the fact that, as Bylaw 25.1 makes clear, CPS (unlike its counterparts in several other provinces) has no legislative or regulatory mandate to accredit MRI facilities; therefore, when the Ministry's current contract with CPS's Advisory Committee on Medical Imaging expires, the Ministry is free to choose some other accreditation provider. This lack of clarity and certainty is also troubling.

Training

In the absence of disclosure to the contrary, we are doubtful that the Ministry has fully examined the education, training, and labour market implications of Bill 179. A body called CMA Conjoint Accreditation Services, a unit of the Canadian Medical Association, is the accreditor of educational programs (as well as their various practicum sites) in 16 medical technology fields, including the 4 medical radiation disciplines. There are 8 accredited programs for MRI techs, https://www.cma.ca/En/Pages/magnetic-resonance-imaging.aspx. However, none of these programs are offered in Saskatchewan. We are aware that both NAIT and BCIT offer post-diploma programs whose course work component of can be completed entirely on-line, but completing these programs takes at least two years, and include a 4-month practicum component. The programs are not large (annual intake about 45 students).

All of this information supports our contention that our MRI Techs must be viewed as a limited and valuable resource to their profession and to the public system. Training or attracting more of them is neither quick nor easy. We do not want to see the introduction of private for-profit facilities with staffing needs lend to the depletion of the public system and this has been a feature in other jurisdictions.

Waitlist Data – Canadian Institute for Health Information (CIHI)

Generally, we have the understanding that all Level 1 tests are performed in the public system in Saskatchewan within 24 hours of the need being presented. We also believe that the trend, over the last couple of years, has been an increase in the complexity of scans as the number of inpatient scans has been on the rise. This has contributed to a like increase in targets set for the units, as the focus has been to clear beds in SHR acute sites. We suspect that the Saskatoon Health Region, as the tertiary care site for Northern Saskatchewan and the province's main centre of health science training and research has a higher than usual number of complex MRI scans.

In "Wait Times for Priority Procedures in Canada", (2015 CIHI) there is an indication that only five out of ten provinces submit comparable wait time data: Alberta, Saskatchewan, Ontario, Nova Scotia & Prince Edward Island.

Among these provinces, the typical wait (50th percentile) for an MRI scan in 2014 ranged from 29 to 82 days and was 2 to 5 times longer than the typical wait for a CT scan. The 90th percentile ranged from 73 to 214 days for MRI scans. While Saskatchewan wait lists may have increased over the last five years, reports from CIHI illustrate that the volume of scans have increased significantly over this same time period; and our performance in the public system has been remarkably stable. We believe that this moving into a privatized model will drain capacity from the public system.

The Evidence Network article by Dr. Ryan Meili "Look to Alberta today, not twenty years ago, for guidance on private MRIs" confirms that the wait list for an MRI in Alberta has **not** been shortened by access to private imaging clinics; it is actually the longest in the country. Alberta has the second highest number of scanners per capita in the country (26 in hospitals, 13 in free standing clinics). Yet the CIHI wait times in Alberta are listed as 87 days (50th percentile) to 247 days (90th percentile), compared with a 28 to 88 day wait in Saskatchewan.

If increasing the number of MRI tests provided is the Government's objective, there are multiple, unexplored and/or underutilized means within the public system—especially an appropriately-funded public system—to achieve this objective. Based on an extensive review of Canadian and international experiences, the CIHI report "Wait Times for Priority Procedures in Canada" (2014) presents several clear options for improving access to testing

-increase funding to public health providers to clear backlogs;

- -establish wait time guarantees as targets;
- -use of clinical prioritization tools to provide effective wait list management;
- -central intake models; and
- -LEAN strategies.

We would implore the Saskatchewan government to thoroughly explore these strategies prior to passing and implementing Bill 179.

What Have We Learned from the Alberta Experience

Diana Gibson, the Research Director of the Parkland Institute undertook a study in 2012 entitled 'Delivery Matters: The High Costs of For-Profit Health Services in Alberta' which discusses the risks associated with for-profit surgical services. These risks apply equally in the case of for-profit MRI services. The report found that the cost per surgery was higher

than in the public system due to the focus upon corporate profit (return on investment). Variation in the complexity of cases was not adequately factored into the government's initial costing model: the more complex (and therefore more expensive) cases were left to the public sector, while the less complex work was skimmed off by boutique clinics; which do not charge based on complexity but on numbers of scans completed. She also identified other added costs in the case of the Health Resources Centre, such as subsidies from the public sector and the need for the public system to provide further financial support when the Health Resources Centre declared bankruptcy.

Ms. Gibson identified the international evidence confirming that private for-profit operations focus upon corporate tools to maximize profit, including but not limited to minimizing labour costs and overall reduction of costs that might lending to compromising quality.

What was evident in the Health Resources Centre situation is that both parties were dependent on the relationship to provide public care. When one party is failing, the result is poorer quality, duplication costs, and a genuine lack of control; together with a lack of transparency and accountability (access to data is limited when it is held by a private for-profit).

Ms. Gibson also noted that the removal of health professionals from the public system slows it down and results in the public wait list growing even longer

To this end, we would ask whether a cost-benefit analysis has been done by the Health Ministry as this would be a useful accountability and transparency tool. We submit that this work should be done in advance of introducing this legislation.

Facilitating the creation and expansion of private for profit MRI facilities and services can be expected to stimulate inappropriate demand pressures (e.g. from the "worried well"). These pressures will certainly enhance the revenues of the private providers, but will occasion demand, cost, and resource pressures on the publicly-funded health care system. The Alberta experience provides ample proof.

As noted in a recent *Globe and Mail* article ('Alberta can end MRI wait times', January 15, 2015) wait times for non-urgent MRIs are lengthy, in large part because more than half of the MRIs taken each year may be medically unnecessary: 13,000 lower back MRIs and 4,000 knee MRIs (total cost $15 million). This creates a cost burden and comes as a result of such scans routinely being ordered by general practitioners. This does not occur in Saskatchewan; nor do we want to move in this direction.

Regulation Review

Our review of the proposed regulations lends us to conclude that the "one-for-one" mechanism is cumbersome and unworkable, and worst of all, inequitable. It will force an administrative nightmare upon the health regions and the province's clinicians.

It appears that the public sector will maintain the authority to determine who may order MRI services in their health region. However, there is a distinct lack of clarity as to the process of managing the second scan that must be provided to the patient on the public list when the buyer/patient purchases the MRI scan. It is our contention that this process creates a two-tiered system in terms of access. Particularly when you consider that the second scan is to be provided to a 'similar' patient and there is no clarity on the parameters for what would constitute 'similar' needs across patient requirements.

In looking at the management of public wait list (based on the acuity level of the patient), we would refer you to the Manitoba example which provides transparency and accountability for the public. How can it be said that these health services are provided to those on the public wait list on the basis of uniform terms and conditions? When a level 4 scan is accomplished as the like second scan and this is done prior to another patient who needs and waits for a level 2 or 3 scan. We see this as a violation of *The Canada Health Act* and a burden that will interfere with the flow in the current public system.

Conclusion

In July 2010, the Saskatchewan Ministry of Health compiled 'Costing Framework: Third-Party Delivery of Outpatient Specialized Diagnostic Imaging'. This document lists several "principles" which were supposed to govern the Ministry's decisions with respect to private for-profit delivery of MRI services.

1. Third party delivery must support a patient first approach to health care through improving access, quality and choice for patients and their families.
2. Third party delivery must fully comply with the principles and guidelines of the *Canada Health Act*, and all relevant provincial legislation and regulations.
3. Third party delivery must be fully integrated within the publicly funded, publicly administered health system.
4. Third party delivery must meet all necessary health system safety and quality standards.
5. Third party delivery must be implemented through an open, consistent, equitable and fully transparent selection process.
6. Third party delivery must be financially responsible and the cost of the services must be equal to, or less than, what is offered by the publicly delivered health system.

In our view, Bill 179 and its accompanying regulations clearly contradict these principles, particularly principles 2, 5 and 6:

- The main beneficiaries of the bill will not be "patients" (who deserve access to care based on medical need) but wealthy "consumers".
- The third party delivery for pay (by patient) model which the bill enables violates *The Canada Health Act* criteria of universality and accessibility. This violation is not mitigated by the bill's cumbersome and unworkable "one-for-one" mechanism.
- As indicated previously, we see the principle of full integration of third party (for-profit) delivery within the publicly funded and administered health system to pose heightened challenges for our affiliated health regions.
- We do not view the implementation process captured in the Bill and regulations to offer up the much-needed transparency so as to measure the impact upon the public system; nor do we envision that access to information will be extended by a third party.
- In the experience of other jurisdictions, this experiment has led to an increase in the cost of the services and no cost-benefit analysis has been done to provide contrary evidence.

We would submit that access could be improved through the supplement of resources at the provider level, rather than within administration. Finally, we suspect that quality standards might become a moving target in all of this. We know and trust the best practices that exist within the public system.

In our view, this legislation is premature and ill-advised. In a time where the whole province is looking to create efficiencies within the current public health system, but has only embarked on that work in the last two to three years, there has not been enough time or resources dedicated to a systemic change in how we do our current work better. What we have gathered from our informal research is that improvements have been achieved; targets have been met and subsequently heightened, as a result of steps to achieve efficiencies. More work can be done to invest in the public system. Additional resources are being put towards the provision of private MRI's with a cascading effect on surgical waitlists and the question of necessary services; we submit that the dollars anticipated to be paid for private MRI's should be redirected towards the current system and processes we have in place.