

YOUR OPINION COUNTS...

MAKING YOUR SUBMISSION TO HPRAC:

PLEASE ATTACH THE FOLLOWING INFORMATION SHEET TO YOUR SUBMISSION TO HPRAC. YOUR SUBMISSION SHOULD BE SENT NO LATER THAN APRIL 15, 2008, TO:

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We prefer submissions to be made in Microsoft Word, either on disk (by mail) or by email when possible. Electronic submissions can be made to: HPRACSubmissions@ontario.ca. If fax is more convenient for you, please address your comments to: HPRAC, INTERPROFESSIONAL COLLABORATION PROJECT, at 416-326-1549. Hard copy submissions should be sent to the above address.

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Please note that complete submissions or excerpts may be referenced in HPRAC's report to the Minister of Health and Long-Term Care, and that they will be posted on HPRAC's website. All submissions and correspondence may be the subject of a request under the Freedom of Information and Protection of Privacy Act (FIPPA). If you wish any part of your response, submission or correspondence to be withheld, please indicate that and provide the reason for your request.

This sheet can be downloaded with the full Discussion Guide (PDF format) from the HPRAC website, <http://www.hprac.org>,

Submission of the Vision Council of Canada to the Health Professions Regulatory Advisory Council's
Interprofessional Collaboration Project
May 21, 2008

Defining Interprofessional Collaboration

HPRAC has developed the following statement to convey its interpretation of what the Minister's question portends. Our view is that any initiatives should be directed to finding ways to:

- Assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:
- Improve patient care and facilitate better results for patients;
- Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
- Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

VCC Comment: *The Vision Council believes that HPRAC's report to the Minister must call for a legislated policy mandating collaboration.*

Since 1994 the Ministry has attempted to address the development of conflict of interest regulations for regulatory Colleges at least five times. The importance of this to HPRAC's current review of interprofessional collaboration cannot be over emphasized. At least two regulatory Colleges use or have used their authority to write conflict of interest regulations to restrict association between their members and other health care providers and/or private entities. In spite of the Ministry's policy statements, regulations currently in effect not only do not support collaboration, they actively prohibit it.

Unfortunately, the Ministry of Health and Long Term Care appears unable under the existing framework to challenge anti-collaborative regulations. It is our hope that mandating collaboration in legislation will strengthen the Ministry's resolve.

The Vision Council of Canada represents members of the retail optical industry; they operate in all Canadian provinces and U.S. States and sell well over 9 million pairs of eyeglasses per year. Our members employ opticians and compete against optometrists for the sale of eye care products, relying for those sales on the prescriptions written by optometrists or physicians. Our responses to HPRAC's questions reflect our members' experience with eye care regulation and the roles played primarily by optometrists and opticians in the eye care continuum.

That experience spans the spectrum of possibilities in the provision of eye care: VCC members operate in all Canadian provinces; they operate in the 27 U.S. states where opticians are not regulated and in the remaining states where they are regulated; they operate in Canadian and American jurisdictions where professional regulation permits association and in those jurisdictions where restrictions prohibit it.

Established in Canada in February 1989, the VCC made a submission to the Ministry in July of that year commenting on the recommendations of the Health Professions Legislative Review. Our submission included this comment: "The Vision Council of Canada believes that existing regulations governing members of the optometry profession create artificial barriers between these two groups (opticians and optometrists) in the eye care field that should have a natural synergy and the combined and complementary ability to provide quality, cost effective eye care to the public."

There have been repeated attempts over the past nineteen years to resolve this issue. These include a Ministry-established Primary Eye Care Review and a further Vision Care Stakeholders Consultation, several attempts by the Ministry to establish conflict of interest guidelines (as noted above); and recommendations from government-established bodies such as the Red Tape Review Commission calling for common standards. Despite all of these efforts the College of Optometrists' regulation prohibiting association --- and impeding collaboration -- continues in effect to this day.

The value of collaboration and association has been supported by findings in other jurisdictions, including a 1998 decision by the B.C. Supreme Court in Costco Wholesale Canada Ltd. V. The Board of Examiners in Optometry, which found that the Board's rules (similar to those established by the Ontario College of Optometrists) offended the Canadian Charter's right of freedom of association; a 1989 investigation undertaken by the U.S. Federal Trade Commission (Eyeglasses II) which found that "state-imposed restrictions on the commercial practice of optometry cause significant injury to consumers" and "actually work to deprive consumers of necessary eye care, restrict consumer choice, and impede

innovation in the eye care industry” and, Closer to Home, a 1991 Report of the British Columbia Royal Commission on Health Care and Costs, to name but a few.

Given the history, we repeat our view that HPRAC’s report to the Minister must call for a legislated policy mandating collaboration. For HPRAC's effort to have a positive impact on interprofessional collaboration the Ministry must have the tools and be prepared to deal swiftly and firmly with recalcitrant players whose primary focus is not demonstrably public protection.

Eliminating the Barriers to Collaboration among the Colleges

2. Are there barriers in the RHPA, the health profession acts or their regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how? (For example, do existing scopes of practice restrict or prevent collaboration among health professionals?)

VCC Comment: *As noted above, the College of Optometrists prohibits association between opticians and optometrists (Drug and Pharmacies Regulation Act – R.R.O. 1990, Reg. 550). The regulation goes so far as to prohibit a door between an optometric office and the premises of an optical company or optician (26. (4) (c)) or the employment of an optician by an optometrist (26. (4)(e)).*

We note that the College has proposed a new conflict of interest regulation which is with the Ministry for consideration. The Vision Council believes that the proposed regulation is a significant improvement over the existing regulation, though it is by no means perfect as measured by compliance with MOH Guidelines.

Apart from the anti-collaborative nature of the in-force regulation itself, a significant concern is the selective nature of its enforcement. While it sits on the books, we understand that many optometrists do in fact employ opticians and until recently the College has not enforced this regulation: that they have begun to do so now complicates the relations between the professions considerably.

The Vision Council believes that these restrictions on association are the genesis for the push by opticians to perform independent sight tests, or refractometry. The Vision Council has long held that the consumer is best served by a complete eye health examination, which includes, as only one of its components, refraction.

The Vision Council believes that the best way to enhance relations between eye care providers and to further the public interest is to remove the prohibitions on

association that currently exist. Removal of these barriers will allow those practitioners who choose to do so to work in multi-disciplinary practices providing integrated service. It will not mean the end of how opticians, optometrists and ophthalmologists currently practise, but will allow for innovative and entrepreneurial practices that are currently not possible. By doing this, the consumer will have convenient access to the level of quality eye care that is required, at the most affordable price.

3. Are there barriers in other Acts or regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

4. Are there other policy and/or systems issues that act as barriers to collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

VCC Comment: *As we noted earlier, the Ministry of Health and Long Term Care must have, be seen to have and be willing to use its authority to compel Colleges to adhere to a clear and concise policy on interprofessional collaboration.*

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

VCC Comment: *We don't know that it is so much 'cultural' issues as it is competitive issues that reinforce barriers to collaboration, at least as they exist in eye care. It is clear to the Vision Council that economic issues drive the positions taken by eye care professionals. Opticians want to refract so they can generate prescriptions, sell product and prosper. Optometrists want to prescribe drugs so they can expand their client base, and ophthalmologists want to maintain what has traditionally been their exclusive scope. Members of the Vision Council want to be able to provide access to the convenient, comprehensive and competent service today's consumer demands. Clients are time-challenged and want one-stop shopping: easy and prompt access to a complete eye health examination and the ability to purchase glasses or contact lenses if necessary.*

As we noted above, despite an enormous amount of talking and review in which all players including regulatory bodies, associations and the government were at one time or another participants, not much has changed in almost twenty years. We conclude then that the only way there will be change in this particular field is if it is imposed by the government.

6. Do you have evidence from your experience that liability issues are a barrier to interprofessional care?

VCC Comment: *All opticians and optometrists in Canada are required to have liability insurance. As noted above our members operate in all provinces and U. S. states. We are unaware of any liability issues that have posed a barrier to association.*

7. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?

VCC Comment: *Yes.*

8. If so, what would be the minimum expected terms and conditions for that insurance coverage?

VCC Comment: *While we do not feel qualified to comment on the particular amount we do suggest that the requirement for professionals should reflect the nature of their practice and their employment status. Researchers, academics and inactive practitioners clearly pose a different level of risk, and their premiums and level of insurance should reflect that. Employees who can demonstrate that their employers cover their risk premiums may be entitled to an exemption from the liability portion of the premium, while they may wish to continue to opt into the defense costs portion.*

We believe that, while it may be most convenient for the Colleges to have a single premium for all members, it does not reflect proper insurance principles, and it is not in the public interest to cross subsidize different forms of practice.

Developing Enablers for Collaboration among the Colleges

9. What changes to the RHPA, the health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

VCC Response: *As we noted in our response to question 1, the Vision Council believes that HPRAC's report to the Minister must call for a legislated policy mandating collaboration. One possible precedent can be found in Part 5 (Business Arrangements) Section 97 (1) of the Alberta Health Professions Act which sets in law permission (and prohibitions) on how health care professionals may practice in association with one another and with other persons. While Colleges have the authority to write regulations, codes of ethics and standards of practice with respect to this section, the government's intent to permit association is clear and direct.*

It is clear that the Ministry's policy guidelines have been insufficient; the RHPA requires language similar to that found in the Alberta HPA.

10. What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

VCC Response: *As noted above, the College of Optometrists' Conflict of Interest regulation must be changed to permit association/collaboration.*

11. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?

VCC Response: *HPRAC must take great care in how it approaches the concept of shared services and/or joint colleges. We believe that the economic and status conflicts between related professions generally, though not always, will lead to too many compromises in regulation that are not in the public interest. We are also mindful that such an attempt to combine either administrative or substantive responsibilities of the Colleges would have to overcome the entrenched interests of the Colleges' staff and consultants. As a fundamental shift, it would require significant resources to achieve in the face of a lack of cooperation.*

Most importantly, as it might relate to opticians and optometrists, we would be very concerned about the potential impact of a joint College on our members' ability to operate their businesses and the consequential impact on consumers.

Optometry is, by and large, a much stronger profession with more active and committed members and greater financial resources. Based on our experience in jurisdictions across North America, we believe that optometry would control a joint college and that control would have a detrimental impact on how optometrists are permitted to work with opticians and optical retail companies. Indeed, one need only look at the current regulations imposed on the business aspects of optometric practices and on association and collaboration to justify concern about the possible effects of a joint college controlling both optometrists and opticians.

Most importantly, we do not believe a joint college would serve the public interest and we question whether such an initiative is a priority.

13. Should Ontario introduce a common framework, consisting of common structures and processes, for all regulated health professions to address complaints, investigations or disciplinary matters arising in an interprofessional care setting?

VCC Comment: *The Vision Council believes that a common procedural framework can already be found in the Health Professions Procedural Code. If this is suggesting that if the facts in a particular case involve more than one*

profession that a parallel framework, somehow outside of individual Colleges or composed of an amalgam of them be created we would not be supportive as we believe it would do nothing to enhance the speed or clarity of the resolution.

14. If so, what should and should not be included in the common framework?

15. If not, should the *RHPA*, nonetheless, be amended to give individual Colleges greater flexibility to deal with complaints, investigations and discipline arising in an interprofessional care setting within their own already-established structures?

16. If so, what should and should not be addressed in the amendment? For example, should the *RHPA* be amended to enable Colleges to establish joint committees to deal with complaints, investigations and discipline in respect of issues arising in an interprofessional care setting?

17. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a model be funded?

18. Would the authority to conduct joint investigations following complaints or reports relating to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?

19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?

20. Could such authority contribute to patient safety in interprofessional care?

21. Is legislative change required to accomplish these goals?

VCC Comment: *From our vantage point, that is eye care issues, it is very difficult to respond to questions 14-21. The concept of the College of Optometrists and the College of Opticians working collaboratively on issues of complaints, investigations and/or discipline is a non-starter at this stage.*

22. Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?

VCC Comment: *In the first instance, there must be agreement on the definition of the controlled act. The controlled act of 'dispensing' is not defined in the RHPA; as a result each College with the authority to perform that controlled act defines and enforces it differently. The Vision Council believes until dispensing is defined, and that definition interpreted consistently, any discussion of joint programs is premature.*

We note HPRAC's comment in New Directions that "Evidence shows that the risk of harm in dispensing non-complex eye wear for people aged 19-64 is minimal." To that end, the Vision Council believes that the following definition appropriately

controls those aspects of dispensing that have the potential for harm and leaves in the public domain those that do not. We note that we are proposing age 14 based on the Ontario Medical Association's position on the potential for harm.

Dispensing, for vision or eye problems,

- (i) Subnormal vision devices or contact lenses for any person;*
- (ii) Eyeglasses other than simple magnifiers to any person under the age of fourteen years”*

Alternatively, Alberta's Health Professions Act controls only the objective verification of lenses to the prescription (though we anticipate that the fitting of contact lenses will also be included as a result of an upcoming review of the Reserved Acts). British Columbia, proposes the same control in its Reserved Acts regulation and also controls the fitting of contact lenses, which the Vision Council supports.

With respect to standards of practice, while the VCC acknowledges that theoretically these should be science-based and therefore would seem to be capable of standardization among professions, we believe that a shift even to a consultative model that is somewhat binding on the different professions would be seen as a shift away from the concept of “self” regulation, and therefore would face significant opposition. That said, we believe that standards of practice for the same controlled act should be consistent – and enforced consistently – across professions that share the act.

23. Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar Controlled Acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?

VCC Comment: *Theoretically, yes, but again, not until there is unity on a definition and competitive financial issues are addressed.*

24. Is legislative change required to accomplish these goals?

VCC Comment: *Yes, as noted above.*

25. Should an independent arm's-length organization facilitate and support collaboration among the Colleges, particularly with a view to the development of common standards of practice and professional practice guidelines?

VCC Comment: *The Vision Council believes that this should be the Ministry's responsibility and that, given legislated authority, it should not be onerous. Should that not be possible for whatever reason, we would not support the*

establishment of another organization but would rather see the authority vested in HPRAC.

26. If so, what should its specific mandate include or not include? For example:

- Educate the Colleges, professions and the public on the regulatory model, the health professions and everyone's role within the regulatory system;

VCC Comment: *There is certainly a need for this kind of education, or at least regular reminders to the Colleges about the purpose of the regulatory model, that is to say, public protection, not protection of the profession. Moreover, there is a great need to educate public members appointed to the College as to their role. They need to know that they are not there to accommodate the professional members and to know and understand that the Ministry will support them in their efforts to ensure that Colleges act in the public interest. We do not believe this can be left to the Colleges.*

- Create common resource repositories (e.g., a data warehouse to track regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions and the cost of regulation);
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices;
- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;
- Address issues arising from conflicting legislation, and
- Have an oversight function over regulatory bodies, as in the United Kingdom.

VCC Comment: *The Vision Council believes that the functions of the Council for Healthcare Regulatory Excellence (CHRE) in the United Kingdom are essential to effective self-governance that is rooted in the public interest. We believe this function most appropriately resides with the Ministry of Health and Long Term Care. That said, absent more aggressive and effective involvement by MOHLTC in how Colleges operate and regulate their members, CHRE's responsibilities should be added to HPRAC's role along with the allocation of resources necessary to carry out that role.*

Of particular interest and value is the power to "monitor how regulators carry out their functions" and the "power to give directions requiring a regulator to make rules or change its rules if CHRE feels that it is necessary to protect the public." While the Minister has that authority under the RHPA, there appears to be an unwillingness to exercise that authority.

27. Are there any existing bodies that could take on responsibilities in this area? If so, what are they?

VCC Comment: *As noted above, we believe the Ministry should exercise this authority which it already has under the Act. Absent that, HPRAC should be given it as opposed to the creation of new body.*

28. If not, should a new and independent oversight body be formed? If so, how should it be funded?

VCC Comment: *See responses above.*

29. Should the Minister direct the Colleges, using his existing powers under the *RHPA*, to engage in specific collaborative initiatives (e.g., to develop instruments to support interprofessional care)? Why or why not?

VCC Comment: *We believe the Minister has a moral obligation to use the authority granted him/her in the RHPA to ensure at the least that the Colleges do not use their legislative powers to further professional self-interest. While it may be difficult to direct the Colleges to pursue all initiatives that might perhaps enhance the public interest one must at least ensure that they do not act in a way that interferes with it.*

30. If so, should the Minister provide financial or other incentives to the Colleges to undertake these activities?

VCC Comment: *No. It cannot be said frequently enough: the purpose of the Regulated Health Professions Act is public protection, not professional self-interest. If the government has decided, and experience has shown, that interprofessional care is in the public interest, then it is the Colleges' responsibility to support it. Any cost of doing so is offset by the chosen advantage of being self-regulated.*

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

VCC Comment: *Yes. Colleges must be held accountable for their actions.*

32. Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent across all Colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?

VCC Comment: *The immediate answer would logically be yes. Unfortunately, it doesn't work that way. Some professions, notably from our perspective, opticians, operate in a different milieu than others. Opticians work in the retail*

environment (indeed it is our experience that most consumers have no idea that they are considered regulated health professionals). Consumers are free to choose their preferred provider and they do so as freely as they make other retail choices. Advertising is essential to their successful retail business enterprises and the constraints that are appropriately applied to advertising by physicians (or other publicly funded professionals) seriously interfere with how opticians operate their businesses and consumers make choices among them.

The Vision Council argued successfully against the inclusion of opticians in the Consent to Treatment Act because it makes no sense to include them. When an individual enters an optical store to purchase an eye care product he/she comes with a prescription from a physician or optometrist. It is that provider's responsibility to determine the consumer's ability to provide consent at the eye examination stage, not the optician's at the stage of sale.

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and ophthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

VCC Comment: *Rather than talk about processes and structures in the eye care sector, the most critical current deficiency is the lack of a clear definition of dispensing enshrined in the RHPA, reserving only that which is harmful to registered professions and leaving in the public domain that which is not. While the Colleges of Optometrists and Opticians purport to have agreed on a definition and standards of practice, it is very clear that there is no real agreement and that these Colleges regulate and enforce their regulation of dispensing very differently. This underlying dispute, together with the College of Optometrists' restrictions on association, fuels competitive issues and sabotages the potential for interprofessional collaboration.*

Mandatory prescription release is another essential step (we note that the College of Optometrists is finally calling for this in its proposed conflict of interest regulation; the Vision Council first called for it in 1989.)

These issues must be addressed in the first instance.

As we noted in our response to question 12, we do not believe that a joint College would, at this stage, have any hope of success. And, as noted in our response to questions 25-28, we believe that it is and should be the Ministry's responsibility to facilitate collaboration. Absent the use of that authority, it should rest with HPRAC.

34. Would the development of a *Collaboration Toolkit*, containing some or all of the elements suggested above, serve to facilitate and support collaboration among the Colleges?

35. If so, what should be included in a *Collaboration Toolkit* and who should be responsible for developing it?

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

VCC Comment: *Our experience in Ontario and other Canadian jurisdictions has shown that regulatory Colleges will often use standards of practice, practice guidelines, policies and other tools to avoid oversight scrutiny and therefore impose restrictions that might not otherwise be approved by the government. The Vision Council believes that any tool that can potentially result in a discipline charge against a member must be subject to broad consultation and government oversight and approval before implementation, to ensure both that members are aware of the restrictions on their practice, and that the restrictions promote the public interest.*

37. If so, should the Colleges be given statutory rule-making powers (as in New Brunswick) allowing them to enforce the standards of practice and professional practice guidelines that they adopt? Why or why not?

VCC Comment: *See above.*

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

VCC Comment: *None.*

39. What accountability must accompany any rule-making authority?

VCC Comment: *It should be remembered that Colleges are acting under a statutory authority granted to them by the Legislature to further the public interest. There is nothing inappropriate in being held accountable for the use of a delegated authority.*

Interprofessional Care at the Clinical Level

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?

41. Are any changes to the *RHPA*, the health profession acts or their regulations needed to encourage, require, facilitate and enable interprofessional care at the clinical level? If so, what are they?

42. Should Ontario law have a requirement similar to the one in New Zealand?

43. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?

VCC Comment: *While the Vision Council believes that the word ‘clinical’ is not strictly applicable to much or most of what opticians do or the setting in which they do it, we do agree (as we have consistently stated over the years) that integrated, multi-profession care would provide better, more cost effective and convenient options for eye care consumers.*