ONTARIO PHYSIOTHERAPY ASSOCIATION
FREEDOM TO FUNCTION

RESPONSE TO HPRAC DISCUSSION GUIDE ON INTERPROFESSIONAL COLLABORATION

PREAMBLE

The Ontario Physiotherapy Association (OPA) very much appreciates having the opportunity to contribute to HPRAC's review on Interprofessional Collaboration Among Health Colleges and Professionals. Physiotherapy is one of the few regulated health professions that has a presence in nearly every delivery stream, including hospital inpatient and outpatient clinics, Community Health Centres, home care, long term care homes and community-based publicly funded and privately funded clinics. Physiotherapists work collaboratively as members of the health care team in all delivery streams.

The HPRAC Discussion Guide asks many important questions that may have a significant impact on health service delivery in the province. Prior to addressing them, the OPA would like to make several points that do not respond directly to the questions, but, we believe, are of critical importance nonetheless.

- We feel that any exercise to facilitate interprofessional collaboration should be guided by several clearly-articulated principles. Those principles would stand as the touchstones to evaluate individual collaboration proposals and initiatives and also to evaluate overall success retrospectively. In our view, the first principle should be that the essential purpose of interprofessional collaboration is to enhance the quality of care delivered to patients, which in turn will increase patient satisfaction and enhance efficiencies within, and the cost effectiveness of, the health care delivery system. This is the standard against which all interprofessional collaboration initiatives should be measured. Some subsidiary principles should include the legal and practical recognition of equality among the RHPA professions plus respect for the independent self-governing framework that is the hallmark of the RHPA.

- The OPA agrees that the Colleges of each health profession play an important role in interprofessional collaboration and is pleased that this referral is a step towards addressing the professional regulators' role in collaboration. It is equally important to note that each profession's voluntary professional association also has a significant contribution to make. As associations, we can promote the benefits of interprofessional collaboration to our membership. We can facilitate collaboration by working with other associations and by acquainting other professions with the competencies possessed by our members and the health care services our members provide. We can influence the design of educational programs to include components that support collaboration. Through our partnerships with other professions, we facilitate system changes that further support collaboration. From practical, day-to-day front-line experience that is fed back from our members, we can identify both opportunities for and barriers to

collaboration. While there is certainly scope for Colleges to support collaboration from the regulators' perspective, there is equal scope for associations to support collaboration from the perspective of the profession.

- Physiotherapists regularly work with unregulated health providers such as physiotherapy assistants, personal support workers and athletic therapists and others who may have some form of self governance, but who are not regulated under the RHPA or under any other statute. The unregulated sector does perform an important role in health care delivery and it is important that regulated and unregulated practitioners work together to provide seamless care and the highest quality of care. We urge HPRAC to consider the potential importance of collaboration with unregulated health care providers and to identify ways in which collaboration can be facilitated to the benefit of patients and the health care system generally.

- To assist all professionals to work collaboratively rather than competitively, to optimize skills and competencies, to improve patient care and outcomes, it will be important to revisit an important principle, namely equality. All discussions of system innovations that have occurred over the last years have demonstrated that success comes when we move past historical hierarchies and proceed with a greater understanding of the skills and competencies that all professions bring to the table. Addressing the system issues beyond and within the RHPA related to collaboration will go a long way to achieving the goals of sustainable change and true interprofessional collaboration.

RESPONSES TO THE DISCUSSION GUIDE QUESTION

In this section, the OPA responds to those questions where our Association has had both relevant experience and comments or recommendations that it wishes to inject into HPRAC's consideration:

Question 1: The OPA supports the principles listed in the statement with one clarification. The inference from the Statement on page 26 ("Assist health regulatory Colleges and their members to work collaboratively, rather than competitively") is that health professions or health practitioners should not compete with one another, that competition and collaboration are mutually exclusive, or that competition is somehow undesirable. As has been documented by studies published by the Canadian Competition Bureau[1], the U.S. Federal Trade Commission[2], the Irish Competition Authority[3] and the European Union[4], competition in health care restrains prices, provides the public with a wider choice of goods and services and improves transparency and quality of care. Although it may appear to be a dichotomy, healthy competition can also lead to collaboration as health care professionals recognize that by joining together in multidisciplinary collaborative practices they can not only provide enhanced patient care, but also become more competitive by being more attractive to

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[1] http://www.competitionbureau.gc.ca/epic/site/cb-bc.nsf/en/02523e.html, May 27, 2008
[2] http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf, May 27, 2008
[3] http://www.tca.ie/templates/index.aspx?pageid=928, May 27, 2008
[4] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2004:0083:FIN:EN:PDF, May 27, 2008

consumers, improving their revenues and capturing economies of scale.

The work of these competition authorities has also shed light on an area that deserves attention in the context of the current referral: enforced collaboration to the detriment of competition. In one of its more recent studies[5 6] the Canadian Competition Bureau concluded that a number of practices of the dental regulators and associations, such as the "order" requirement in Ontario, were designed to, or at least had the effect of, tying dental hygienists and the provision of their services to conventional dental clinics, to the detriment of patient choice and healthy competition.

The OPA respectfully points out that in a quest for interprofessional collaboration, governments, regulators and associations should not engage in enforced collaboration that generates anticompetitive outcomes to the detriment of the public interest.

Interprofessional collaboration should not constrain healthy competition. In fact if we are to address the burgeoning costs of and the hierarchical approach to health care delivery, healthy interprofessional competition should be encouraged.

Question 2: Like many other professions, the education and therefore the competencies of physiotherapy have evolved considerably since the implementation of the RHPA. The venues in which physiotherapists work have also changed dramatically[7], as have Ontario's demographics and the public's expectations of physiotherapists. As a reflection of these changes, there is a need to revisit and update the scope of practice and authorized acts of the profession to ensure that they do not act as a barrier to optimizing the use of physiotherapists. Hospitals and other health care institutions increasingly develop mechanisms to deal with these legislative restrictions and allow the physiotherapists they employ to practise to the full extent of their competencies. The Ministry engages in innovative funding to support those mechanisms. Nevertheless, these are interim solutions at best; the mechanisms vary from institution to institution and they can create complex regulatory problems and system inefficiencies . Those system inefficiencies include institution-specific authority mechanisms, an inflexible workforce and transparency issues in accountability structures. Of particular importance to interprofessional collaboration is an understanding of the competencies, scope and roles of each profession.

A persistent RHPA-related complaint is that regulations under the RHPA take so much time to process. In this regard, the OPA draws HPRAC's attention to a Bill recently tabled in the B.C. Legislature that transfers much of the regulation-making power from the Lieutenant Governor in Council to the Minister of Health as one potential policy instrument to ensure a more timely process.[8]

Question 3: Barriers in other Acts and regulations include:

- Prohibitions in the *(Ontario) Business Corporations Act* and College regulations that prohibit multi-professional shareholders, directors and officers in health professional corporations.

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[5] http://www.competitionbureau.gc.ca/epic/site/cb-bc.nsf/en/02549e.html, May 27, 2008
[6] http://www.competitionbureau.gc.ca/epic/site/cb-bc.nsf/en/02514e.html, May 27, 2008
[7] For example, in 1989 86% of physiotherapists worked in hospitals; in 2003, that figure was less than 50%.
[8] Bill 25 "Health Professions (Regulatory Reform) Amendment Act, 2008."

- The *Public Hospitals Act* and regulations that limit those professions that have admission and release privileges at public hospitals, that can order diagnostic tests and who may serve in supervisory or managerial positions in public hospitals.
- The *Laboratory and Specimen Collection Centres Licensing Act* and Regulation 680 thereunder that limit which professions may order diagnostic tests.
- The (*Ontario) Health Insurance Act* and regulations that inhibit delegation or assignment to other practitioners and require referral practices not supported by the RHPA.
- The policies of some RHPA Colleges that prohibit, or seriously limit, delegation of authorized acts.
- The regulations of two RHPA Colleges that prohibit members of one profession being employed by members of another profession or having any business association with members of another profession. [e.g. The Conflict of Interest regulations of the Royal College of Dental Surgeons of Ontario and the College of Optometrists of Ontario.]

Question 4: Of interest to physiotherapists and other rehabilitation professionals in Ontario is the move towards interprofessional primary care. The Family Health Team initiative was welcomed by all professions and, with the release of the supporting documents to facilitate proposals, we were very happy to see physiotherapy and other rehabilitation professions listed as potential members of the Family Health Team. It has been disappointing that despite many proposals including physiotherapy submitted to the Ministry not one of these has been approved. Whether it is an actual policy that is a barrier to participation or other reasons, where interprofessional collaboration is sought and encouraged it becomes discouraging when those proposals are not funded. The OPA has engaged the Ministry in discussions on this and we hope to see positive results that will achieve the promises of an interprofessional primary care system for Ontario.

Question 5: One major cultural issue that acts as a barrier to interprofessional collaboration is the ongoing hierarchical approach to health care delivery referred to in the Preamble. Another issue is that the RHPA's approach to who can use the doctor title and who can't lacks any criteria, thereby resulting in a range of professions with non-equivalent educational backgrounds having the ability to use the doctor title within a health care setting.

Question 6: In our experience, other professionals are occasionally unaware that physiotherapists are required by our College to have malpractice insurance of a minimum of $ 2 million. Lack of awareness by referral sources of the insurance coverage held by other professions is probably a barrier to collaboration, as is the frequent misapprehension that a referring practitioner remains liable for the treatment provided by other professions throughout the continuum of care.

Question 7: As mentioned above, physiotherapists in Ontario are required to hold a minimum of $2 million of personal liability insurance. The OPA feels strongly that this requirement is both in the public interest and would also potentially enhance interprofessional collaboration.

Question 9: The amendments to the RHPA included in Bill 171 will provide Colleges with additional ability to collaborate on a range of matters including complaints. The

OPA would like to see those changes take effect and be evaluated before recommending another round of amendments.

Question 11: The OPA does support the regulatory grouping of professions whose scopes of practice and authorized acts substantially overlap. It may not be feasible (politically or otherwise) to consolidate regulation within a single College, but the OPA has long-advocated a "constellation" approach to the regulation of such professions. Under our proposed constellation approach, there would be separate Colleges for each profession, but there would be a coordinating (and ultimately a governing) body in the centre comprised of representation from the Councils of each of the separate Colleges. That central body would be a clearinghouse for complaints in the first instance, would work to ensure consistency among regulations, standards of practice, policies and guidelines of each of the Colleges and would arbitrate disputes among the Colleges. One of the principal tasks of the central body would be to forge a common, or at least a consistent, Quality Assurance program among the separate Colleges. As experience and comfort with a central body grew, its role would incrementally evolve from that of an exclusively coordinating body, to a body that had the ability to impose decisions on one or more of the Colleges in the constellation in the interests of regulatory consistency and interprofessional collaboration.

Question 12: The OPA continues to seek considerable scope for the sharing of common administrative services among Colleges, particularly among the Colleges with smaller memberships. This approach would assist the smaller Colleges to be fully effective across the gamut of regulatory activities without imposing punitive registration fees on their registrants.

Question 13: The OPA is open to the idea of a "single window" for the receipt of public complaints; perhaps establishing a pilot project to assess its feasibility. We suspect there are many instances where a member of the public has a valid complaint involving an RHPA practitioner, but does not know to which College to go. Such a "single window" could receive complaints and refer them to the appropriate College – or Colleges in the instance of complaints involving members of more than one profession. This single window might also prompt more attention and generate responses to complaints involving unregulated practitioners.

Questions 15-17: It's our understanding that some Colleges (e.g. CPSO and College of Nurses) are already operating joint processes to deal with complaints, investigations and discipline. If that is so, it would appear that no statutory amendments are necessary, simply the wider adoption of the practice.

Questions 25-28: The OPA does not feel that the creation of another organization is necessary to facilitate and support collaboration among the Colleges. We note that under section 3 of the RHPA one of the duties of the Minister is to "ensure that the health professions are regulated <u>and coordinated</u> in the public interest". There is potentially room for an enhanced role for the Federation of Regulated Health Colleges. The full potential of existing organizations should be examined and realized before we contemplate creating yet another bureaucratic layer in the regulation of health care professions.

Questions 29-31: We see no difficulty with the Minister using his existing powers under the RHPA to direct Colleges to engage in specific collaborative initiatives. What is

important, however, is that the Ministry be effectively engaged in supporting and assisting Colleges to do so once a directive has been issued.

Reimbursing Colleges for developing and implementing Ministerial directives raises complexities. Would the prospect of compensation encourage Colleges to sit back and await ministerial directives? How would the compensation be calculated? Perhaps the solution is to use the existing authority for the Minister to reimburse costs actually incurred (RHPA subsection 5. (5)), but have actual cases decided on a case-by-case basis.

Question 32: There should definitely be minimum guidelines, standards and policies concerning conflict of interest (COI), advertising, record keeping and so on across all Colleges in order to improve transparency and public confidence in the regulatory system, to ensure fairness in competition and to encourage interprofessional collaboration. Currently we have the situation where Colleges are allowed to maintain regulations that are in conflict with the Ministry's COI guidelines. When the Ministry issues such guidelines – and only the Ministry is in the position of being able to do so – the Ministry must support them fully and effectively. Any material variations from the guidelines should have to be fully justified.

Question 36: Standards of practice and professional practice guidelines developed by the Colleges should not be legally enforceable. Only College regulations should be legally enforceable and the regulation-making process should be improved and expedited in order to allow regulations to keep pace with changing circumstances and requirements.

The foregoing concludes our response to HPRAC's Discussion Guide. The OPA would be more than happy to amplify on any of the points made or information provided in this Submission.

ABOUT THE OPA

The Ontario Physiotherapy Association (OPA) is a dynamic health care professional organization representing over 4,400 member physiotherapists, students and assistants across the province. Physiotherapists apply knowledge, skill and judgment to promote health and to assess and break down the barriers that restrict physical function. OPA's resources are dedicated to meeting the needs of its members and to promoting the physiotherapy profession in a leadership role within the health care system in Ontario.