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2021 Annual Report, Auditor General:

Ministry of Health

Ontario Health

1st Session
43rd Parliament

Monday 6 March 2023

Chair: Tom Rakocevic
Clerk: Tanzima Khan

Journal des débats (Hansard)

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

Monday 6 March 2023

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Lundi 6 mars 2023

The committee met at 1351 in room 151, following a closed session.

COMMITTEE BUSINESS

The Chair (Mr. Tom Rakocevic): I would like to call this meeting of the Standing Committee on Public Accounts to order.

Mr. Todd J. McCarthy: Point of order, Mr. Chair, if I may?

The Chair (Mr. Tom Rakocevic): Yes, MPP McCarthy.

Mr. Todd J. McCarthy: Mr. Chair, I would like to report back on my notice of my intention to raise a possible breach of parliamentary privilege and contempt of the Legislature that I gave on February 27, 2023, in relation to the member for Toronto Centre with respect to the question of making public certain information regarding in camera discussions.

Having read the draft Hansard, I can confirm that I do not intend and will not pursue the matter further, but I would ask that all members of this committee be reminded of the important duty to maintain confidentiality with respect to matters discussed in camera.

The Chair (Mr. Tom Rakocevic): Thank you. Occasionally, a committee may decide to hold a portion or an entire meeting in closed session, a.k.a. in camera, depending on its needs. The purpose of a closed session meeting is to allow the members to have frank and unfiltered discussions when dealing with administrative matters, to consider a draft report, to receive a briefing, or to deal with documents or matters that require confidentiality, such as personnel or commercially sensitive issues.

The following represents occasions when a committee may decide to meet in closed session: consideration of its agenda; consideration of a draft report to the House; when evidence might involve a sensitive, privileged, confidential or classified matter; concern a matter that is the subject of a pending civil or criminal trial; or where for any reason the committee is of the view that the public interest would be better served by holding the committee in closed session.

As all honourable members of the committee can appreciate, the matters that committees discuss in closed session are privileged, and so it is important that we all do our part in ensuring that the confidence of the committee is kept. Closed session meetings are not transcribed by our Hansard department and only final decisions that the committee comes to are recorded in our meetings.

As such, we should all take care in ensuring discussions from our in camera meetings are not divulged and that confidential documents, such as draft reports, are not distributed outside the committee.

2021 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH

ONTARIO HEALTH

Consideration of value-for-money audit: outpatient surgeries.

The Chair (Mr. Tom Rakocevic): Today we are here to begin consideration of the value-for-money audit on outpatient surgeries from the 2021 Annual Report of the Office of the Auditor General. Joining us today are officials from the Ministry of Health and Ontario Health.

You will have 20 minutes collectively for an opening presentation to the committee. We will then move into the question-and-answer portion of the meeting, where we will rotate back and forth between the government and official opposition caucuses in 20-minute intervals, with three minutes for questioning allocated for the independent member.

Before you begin, the Clerk will administer the oath of witness, or affirmation.

The Clerk of the Committee (Ms. Tanzima Khan): Hi, good afternoon. After I read the affirmation, if you could please individually into your mikes say that you affirm?

Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Matthew Anderson: I affirm.

Dr. Catherine Zahn: I affirm.

Mr. Peter Kaftarian: I affirm.

Dr. Chris Simpson: I affirm.

The Chair (Mr. Tom Rakocevic): Please introduce yourselves for Hansard before you begin speaking.

Please begin when ready.

Dr. Catherine Zahn: Thank you to the member. My name is Dr. Catherine Zahn. I'm the Deputy Minister of Health for Ontario. With your permission, I will make introductory comments.

The Chair (Mr. Tom Rakocevic): Please proceed.

Dr. Catherine Zahn: Thank you, everyone, for this opportunity to address the Standing Committee on Public Accounts regarding the Auditor General of Ontario's 2021 value-for-money audit on outpatient surgeries. Today I'm joined by my colleagues from the Ministry of Health and Ontario Health. Peter Kaftarian, to my left, is the associate deputy minister of clinical care and delivery. Behind me are other members of my team: Melanie Kohn, assistant deputy minister of the hospitals and capital division; Patrick Dicerni, assistant deputy minister of the health programs and delivery division; Michael Hillmer, assistant deputy minister of the digital and analytics strategy division; and Julie Ingo, director of the provider services branch in the physician and provider services division. And then, to my right is Matt Anderson, president and chief executive officer of Ontario Health. Next to him is Dr. Chris Simpson, executive vice-president and chief medical officer at Ontario Health.

On March 17, 2020, just 11 days short of three years ago, the COVID-19 pandemic state of emergency was declared. This demanded prioritization of work to minimize the impact of a new and uncharacterized infectious disease—work to protect the citizens of Ontario and work to secure the health care system, period. Hospitals diverted resources to address the crisis. While emergent and urgent surgery did continue, elective surgery was deferred.

I thank the Auditor General for her recommendations on how, on a go-forward basis, we can improve quality, oversight and funding frameworks for surgery, and for the recognition of the importance of outpatient surgery in enabling positive patient and system outcomes. The Ministry of Health commits to addressing these recommendations as we, to this day, continue our pandemic response and recovery efforts.

Investments already made through our surgical recovery strategy have allowed extended hours, including evenings and weekends. We're very close to achieving our goal of eliminating the pandemic-related surgical backlog by the end of this fiscal year. But at that point, we will still be faced with a backlog that existed prior to the pandemic.

To address this and other challenges the health system faces, the ministry has introduced changes that have the dual goal of increasing throughput for surgeries while simultaneously creating a more connected and convenient experience for patients.

In early February, we announced our latest effort, Your Health: A Plan for Connected and Convenient Care. Your Health is our government's foundation for the future. The plan is built on three pillars: first, providing the right care in the right place—that is, access to the best care closer to home; second, providing faster access to care by improving timelines—specifically, delivering shorter wait times for surgeries and diagnostic procedures; and third, acquiring more health care workers to bolster our workforce and address Ontario's needs in the short, the medium and the longer term.

This is a plan to improve care and build long-term resiliency into the system in order to address current and future challenges. To enable actions under the plan, the government has introduced the Your Health Act, 2023, which, if passed, will leverage publicly funded community surgical and diagnostic centres to reduce wait times while ensuring that there is no financial barrier to receiving these services.

This legislative framework for community surgical and diagnostic centres will ensure connected and convenient patient care through better integration of these centres within the health care system. As the province expands the types of surgeries and procedures being done in the community, it will ensure that all community surgical and diagnostic centres have the oversight to ensure the highest quality of care.

With respect to surgical wait times, we appreciate the auditor's recommendations regarding equitable access to outpatient surgery. Over the past two years, the ministry and the health sector have worked to maximize surgical capacity. The ministry, in collaboration with our health sector partners, has developed a surgical recovery plan that's data-driven, innovative and locally led. The plan has been supported with investments of approximately $880 million. A range of delivery models and settings have been implemented as part of the surgical recovery strategy. These initiatives include:

(1) Supporting low-acuity, publicly funded surgical and diagnostic services in independent health facilities and supporting the licensing of such facilities for existing services;

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(2) Providing active support for hospitals to shift to outpatient care for joint replacement through investments in the Surgical Innovation Fund, an innovation and efficiency initiative and a surgical pathway training fund. The fund supports hospitals in implementing new care pathways, in training staff and in purchasing equipment;

(3) Funding hospitals and the community health sector to perform more surgeries and more pre-operative imaging as well as other investigative procedures.

Thanks to the dedication and hard work of our hospitals, physicians, nurses and health system partners, we've maintained wait time targets for high-priority surgeries, including cancer and cardiac procedures. The result is that nearly 100% of urgent procedures are being completed within target wait times.

Regarding wait time data in public reporting, it goes without saying that data transparency is important. Expansion of real-time surgical efficiency in operating room capacity reporting is a central output of Ontario Health's multi-year centralized wait-list management initiative. Through 2020-21 and 2021-22 investments in centralized wait-list management, the ministry and Ontario Health recommit to ensuring existing wait times data are used by surgeons, hospitals and health system partners to manage resources in the surgical system.

As part of the work on centralized wait-list management, Ontario Health has developed a business intelligence tool known as the health system insights platform. This tool allows hospitals to see wait-lists of individual surgeons within their own hospital, to support load

balancing of surgical cases and reduce wait times. As of February 2023, this tool is live in 80% of eligible hospitals. Ontario Health's target is 90% of eligible hospitals by the end of this fiscal year. The ministry will support implementation of this recommendation, working closely with Ontario Health to engage stakeholders, including the Ontario Medical Association.

Moving on to centralized intake and referral: With respect to the auditor's recommendation to expand the implementation of centralized intake and referral models, an additional pillar of the centralized wait-list management initiative will accelerate uptake of central intake models for surgical care pathways. As part of 2022-23 work on centralized wait-list management, Ontario Health will provide one-time funding for projects that accelerate implementation of intake models for surgical pathways. In parallel, Ontario Health is working with experts from across the health sector to identify best practices and lessons learned from similar initiatives. This work will be leveraged to create a consistent and repeatable framework for launching central intake models across the province. In addition, it will identify the types of procedures that are best suited to central intake.

Going on to the evaluation and oversight of outpatient surgeries: To determine clinical effectiveness and gaps in oversight, the ministry will work on evaluation frameworks for outpatient surgery to include public hospitals, private hospitals and independent health facilities, or IHFs. The ministry will work with Ontario Health to include surgical and procedural IHFs, the Don Mills Surgical Unit and public hospitals that do not report to the wait time information system in the current evaluation construct. The ministry will review oversight structures, considering differences in operations, legislative requirements and existing governance structures for the variety of institutions that we're looking at.

The next topic is prevention of inappropriate billing for outpatient surgeries—

The Chair (Mr. Tom Rakocevic): Deputy Minister, before you begin, you are at 10 minutes, half time. Just letting you know.

Dr. Catherine Zahn: To address the Auditor General's recommendations on inappropriate billing, the ministry has a long-established audit program and uses analytical tools to monitor billings, select claims for review, correct inappropriate billing behaviour and recover overpayments. Recognizing medicare is a valued Canadian institution and ensuring the Commitment to the Future of Medicare Act, we have taken measures to prohibit extra billing and user charges for insured health care services through a dedicated program where the ministry reviews all possible violations of the CFMA. If the ministry finds that an insured person has paid for all or part of an insured service, there's a mechanism that permits full reimbursement.

Lastly, I'll refer to the cost of providing outpatient surgeries. In alignment with the Auditor General's recommendations on funding of outpatient surgeries, the ministry annually reviews funding rates for quality-based procedures, which include many outpatient surgeries. This review takes into account the level of acuity and complexity of patients served through a growth and efficiency model. To encourage efficiency, several procedures are funded through a blended rate that includes both in-patient and outpatient procedures. This encourages providers to shift to more cost-efficient settings where feasible. The ministry continually works with system stakeholders to determine more accurate ways to capture cost data.

In closing, the ministry again commits to implementing the Auditor General's recommendations and continues to review new models of care such as the OMA's recent proposal for integrated ambulatory care. We'll continue diagnostic and surgical recovery work in partnership with Ontario Health to improve the quality of care in all quality dimensions for the citizens of Ontario.

Thank you very much. I'll now turn the floor over to my colleague Matt Anderson, president and CEO of Ontario Health.

The Chair (Mr. Tom Rakocevic): Thank you again for your work and presentation.

Please proceed.

Mr. Matthew Anderson: Thank you, Deputy. Thank you, everyone. I'm Matthew Anderson, president and CEO of Ontario Health. As you heard, joining me today from Ontario Health is Dr. Chris Simpson, our executive vice-president and chief medical officer. Thank you for the opportunity to appear today.

A couple of things I would just start off with, first to say the 2021 outpatient surgery audit conducted by the Office of the Auditor General of Ontario was both timely and an important milestone for our approach to surgeries in Ontario. Ontario Health supports the recommendations, and together with the ministry has made great progress on its implementation. I look forward to today's meeting to provide the opportunity to share progress as well as to discuss areas of our ongoing focus.

By way of background, if you're not that familiar with Ontario Health, we were created by the government of Ontario in 2019, just prior to the pandemic, to connect and coordinate Ontario's health care system. We are a crown corporation. I report to a board of directors. My board chair holds an MOU with the Minister of Health.

We have several accountability structures. We have our MOU. We were also formed under the Connecting Care Act. We have an annual business plan, annual mandate letters and an accountability agreement.

Essentially, the way we work with government, and as outlined in our Connecting Care Act, is we work with the ministry. The ministry will set policy and direction and it's the agency's responsibility to implement that policy. I'm hopeful that today you will see and get a flavour for how well the ministry and Ontario Health are working together to seamlessly provide care for Ontarians.

Ontario Health's role, as I've mentioned, includes health system integration and coordination. We do that through Ontario Health's six regions, which work closely with partners to implement provincial, regional and local

strategies. We oversee the quality and delivery of specific clinical care services, including cancer, renal, cardiac, vascular, stroke, palliative care, mental health and addictions, and transplants.

We also hold funding and accountability agreements within frameworks that are set out by the ministry. We are creating a provincial digital and virtual services infrastructure that will give patients and care providers more complete health information, and we're responsible for setting quality standards and developing evidence-based guidelines to improve clinical care.

We are, in short, very committed to patient-centred care and health equity. We are working to better connect our health care system so Ontarians continue to receive high-quality services when and where they need them. We regularly engage with a broad spectrum of people and groups that have an interest in Ontario health care, listening and learning from the people we serve and those we partner with.

The government's move to integrate 22 agencies into one Ontario Health was timely, providing the necessary foundation to treat Ontario's health system as a single coordinated resource. This coordinated approach was proven central and important in our strategy for both planning and responding to the seven-plus waves of the pandemic. This coordinated approach continues as we plan ongoing improvements to Ontario's health system that include the provision of surgeries for Ontarians.

A couple of quick comments to echo a few things that the deputy minister has already said: One is our focus on actions to manage and coordinate surgeries in Ontario. You've heard about the strengthening of provincial and regional coordination and collaboration. Perhaps we'll get an opportunity to unpack that further in our deliberations today.

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There have been a number of funding strategies that the deputy has spoken to. I won't repeat those, but they have been core, as well, to the rollout of improving access to surgeries.

Finally, there have been a few comments about our centralized wait-list management system. I hope to have an opportunity to discuss that further as we go through our questions. There are many different parts to it, but at the end of the day it's important to note that we do have a centralized wait-list management program in the province of Ontario. Our goal right now is to move that from what is mostly a retrospective system to real-time information for patients and providers on patient wait-lists as we continue to expand our access into community and surgical capacity.

Truly lastly this time, a comment on improving equity and access to surgeries in Ontario: We're very committed to improving equity in its broadest sense, the types of surgery people are waiting for as well as the social determinants of a healthy lifestyle and health as it relates to equity. Ontario's health system is a single integrated resource. This approach and view provides real opportunity for the future of Ontario's health care system and its approach in breaking down pre-existing silos and providing the opportunity to address equity concerns and regional disparities.

Thank you, Mr. Chair. I'll stop my comments there.

The Chair (Mr. Tom Rakocevic): Thank you very much. If you are done with your presentations, we will now proceed to questions. You do have two minutes and 45 seconds left if you wish to proceed and finish your presentation.

Dr. Catherine Zahn: I don't think we've missed anything.

The Chair (Mr. Tom Rakocevic): Okay. Thank you.

Just to remind members: We have rotations where we begin with 20 minutes for the government members and a further 20 minutes to official opposition members, as well as three minutes to the independent members. We will be following this rotation for five rounds.

Just letting everyone know, upon completion of the second round, we will briefly pause for a 10-minute recess to allow those to take a break as needed. As well, the opposition day motion is being debated, and at the time of the vote we will also be recessing for roughly 10 minutes to allow members to participate in the vote.

We'll begin with 20 minutes to the government side. MPP McCarthy.

Mr. Todd J. McCarthy: Thank you, Mr. Chair. Through you to Dr. Zahn and her team: Thank you very much for the opening remarks and the detail associated with them.

Just to be very, very specific: The report that is the subject matter of your opening remarks and the questions today is now a year old, as of tomorrow. It was released March 7, 2022. The issue that does arise still is this question of long and increasing wait times for outpatient surgeries. Can you, through the Chair, tell us what the ministry has been doing and what specifically the ministry will do to address this question of long and increasing wait times for outpatient surgeries in our province?

Dr. Catherine Zahn: Thank you very much for the question, member McCarthy. I will start by recalling the beginning of the declaration of the state of emergency, when Ontario's health sector took action to protect patients' health, protect the health of our health care professionals and protect the security of our structures. That simply meant that we had to ask hospitals to further ramp down elective surgeries, in an attempt to preserve the integrity of the health care system, to address crisis in critical care during the early stages of the pandemic.

As a result, there was a backlog of surgeries, and quite frankly our crisis response demanded attention to those with the most urgent and critical care needs. The result was that non-urgent surgeries or surgeries that addressed people with chronic conditions, generally those that create disability—they're not trivial; chronic pain or difficulty seeing are not trivial things, but they were delayed in favour of continuing care for individuals that had life-threatening conditions, usually cancer or cardiac care.

We're totally committed to continuing to improve access and reducing wait times for surgery, as well as the

prequel to surgeries—that is, diagnostic procedures and a variety of investigations.

For a much more detailed answer to that, I will actually first defer to my partner Mr. Anderson if he wants to add to that, before deferring to Associate DM Kaftarian.

Mr. Matthew Anderson: Great, thank you. It's Matthew Anderson, president and CEO of Ontario Health. There's a number of things—and I'll let Associate Deputy Minister Kaftarian talk about, perhaps, volumes and data. I'd like to speak for a moment about coordination. I made a general comment about this in my opening remarks. One of the things that changed through the pandemic was with our regional structures. We established, both at a regional and sub-regional level, the opportunity for hospitals and other care providers to work together to what we would lovingly refer to as load balancing—this idea of thinking of ourselves no longer as over 100 separate hospital corporations and literally 1,000 or more community agencies and thinking of ourselves as one system.

What we did at that time through the pandemic was look at where we would need to either shift resources—sometimes that was supply, sometimes that was human resources, sometimes it was moving patients; we would move a patient from one facility to another to get better access to care. While the extremeness of the pandemic has passed us by at this time, thankfully, the concepts and the important elements of sharing and looking at things at a regional level or sub-regional level have remained and, in fact, are being reinforced.

Now we can start to address, more systemically, issues of equity. If we think about issues of equity, they come in many forms. Certainly the Auditor General commented on regional variation as a for instance. So now, in the western part of the province, just as an example, we have sub-regional tables out of London and area, Windsor and area, Hamilton and area, Waterloo-Wellington and area, and looking at how do we ensure that we're getting access to all those folks, instead of just, "I happen to be on this particular hospital wait-list or this particular surgeon's wait-list."

So that's given us an opportunity not only to do more—and, again, I'll defer to Associate Deputy Minister Kaftarian to talk about increase, but also to prioritize the long-waiters or those folks who need to go ahead and shouldn't be delayed because they were simply on a different wait-list than what was there before. That level of coordination wasn't there before the pandemic and is there now and is a key part of what we're doing moving forward.

Associate Deputy Minister?

Mr. Peter Kaftarian: Thank you. Peter Kaftarian, associate deputy minister, clinical care and delivery, at the Ministry of Health. Thank you, Deputy Matt, for your first few comments. I'll add a couple of more data points as a matter of reference.

Surgical recovery has obviously been a high priority of the ministry, and there's been over $880 million approved since the start of the pandemic to support hospitals, increase the surgical output, address wait time challenges and improve health outcomes. To support surgical and diagnostic imaging recovery, in 2021, $283 million was invested as part of the fall preparedness plan. We supported hospitals to conduct over 465,000 scheduled surgeries in fully equipped operating rooms and over 110,000 operating hours for MRI and CT machines as the province dealt with the initial pandemic waves.

In 2021-22, the Ministry of Health worked hard to flexibly respond to challenging pandemic conditions and support Ontario hospitals to perform as much surgical and diagnostic imaging activity as possible. In that fiscal year, just over $320 million was invested in a comprehensive surgical recovery plan to allow Ontario hospitals and the community health sector to perform more surgeries, MRIs and CT scan procedures, including evenings and weekends.

Hopefully that answers your question.

Mr. Todd J. McCarthy: Yes. Through you, Mr. Chair: Thank you to the three sets of answers. That is very much appreciated and clarifies my issue.

Other colleagues here in the committee on the government side may have some supplementary or further questions.

The Chair (Mr. Tom Rakocevic): We have 13 minutes. MPP Martin.

Mrs. Robin Martin: Thank you to everybody for coming today and giving us some more information. I was wondering if you could help us with what actions the ministry or Ontario Health is taking to fund innovation and efficiency initiatives at this point, because it's part of what the Auditor General was talking about in the report.

Dr. Catherine Zahn: Thank you very much. It's one of our favourite questions, PA Martin. In my opening remarks, I outlined a number of innovative processes that had been put in place both on the part of the ministry and Ontario Health. We have put them in place on a number of different levels in the hospital setting, in the ambulatory setting and in the creation of a more sophisticated health human resource pool to address some of the shortages that we have.

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With that, I will defer to Matt to give some more details.

Mr. Matthew Anderson: Sure. Great, thank you. Matthew Anderson, president and CEO of Ontario Health. I'm actually going to defer this one to our chief medical officer at Ontario Health, Dr. Chris Simpson.

Dr. Chris Simpson: Thank you. It's Chris Simpson. I'm the chief medical officer at Ontario Health. I'm also a practising cardiologist.

The innovation portion of this has really been quite key, particularly during the pandemic, which posed so many disruptions to the usual flow of things. When we started to see the numbers of people waiting for surgeries start to accumulate as a result of the pandemic pressures, it became necessary to think about new ways of doing things.

The Surgical Innovation Fund, which was a competitive process, led to all sorts of interesting initiatives. Some were very specifically aimed at creating new spaces which

would facilitate transformation to an outpatient surgical experience, so building procedure rooms instead of fully equipped ORs. That, of course, would allow low-acuity outpatient-type procedures to be done in lower-tech rooms while leaving the ORs available to do the things that only the ORs can do, the more complex stuff. So it becomes sort of a win-win.

Surgical pathway training funding has been in place to help health care workers to acquire specific training to be part of the surgical team. That would include providing perioperative care, post-operative care. It can take up to a year to train a new OR nurse, even a very experienced nurse who is working elsewhere in the system. Those funds have been very helpful to reorient the health care workforce toward these strategic goals.

We've also seen some innovations in the broader sense of the word in new partnerships with the College of Nurses, where we've been successful in onboarding more internationally educated nurses and deploying them into the workforce to the tune of something like, I think, 1,400 or so. That, I think, would be classified as innovative activity.

And as Matt has mentioned, I think the broader innovation in the broadest sense of the term has been the Team Ontario approach and working as a system where we have lots of agreements between hospitals, for example, to move some of their volumes to a hospital maybe 45 minutes away that has a little bit of OR time, even sending surgeons to these places and bringing their patients to use the resources collectively.

But the investments specifically with the Surgical Innovation Fund and the surgical pathway training funding have really been very important catalysts to make some of these changes happen.

The Chair (Mr. Tom Rakocevic): MPP Martin.

Mrs. Robin Martin: Thank you. It was mentioned earlier about prioritizing the most urgent and critical cases. I know COVID-19 posed significant challenges for getting some of the cases through. Can you just help us understand how those priorities were made and how you allocated those cases to make sure we were dealing with the most urgent and critical cases during COVID, and subsequently?

Dr. Catherine Zahn: PA Martin, that is a clinical question that I will immediately defer to our clinical expert here. The process for prioritizing individuals based on the urgency of their condition is purely clinical, and the ministry would have had no hand in that.

Dr. Chris Simpson: Thank you, Deputy, and thank you for the question. It's very important, of course, when resources are restricted in extreme circumstances, such as in a pandemic, that we protect, first and foremost, urgent and emergent cases. For example, a patient with acute appendicitis has to have their appendix taken out; they can't go on a wait-list. Somebody in a motor vehicle accident with trauma needs to be dealt with right away. People with very time-sensitive cancer surgeries where not operating means a worse outcome for the patient: Those procedures were all highly protected during the pandemic. We have good evidence that access to urgent and emergent cases like that were protected to the same degree that they were prior to the pandemic, and that perhaps is one of the small success stories in the pandemic.

I think, though, as the deputy said in her opening comments, that just because you can wait for a procedure doesn't mean that that's necessarily the best care. If you think about somebody waiting for a hip replacement, it's perfectly safe to wait a few months; it's not really ideal, because it impairs their quality of life, their mobility. These are important health outcomes.

So we have a comprehensive set of maximum recommended wait time benchmarks that are specific to specific patients and their circumstances, as well as the kind of procedure. We call people who are done inside those benchmark time frames "done appropriately and in a timely way," and those who wait longer we refer to as the "long-waiters." The wait time benchmarks are different for different procedures, but if you wait longer than that benchmark, you are a long-waiter.

As a result of the seven waves of the pandemic, which led us to have to reduce the number of surgeries in order to accommodate the thousands and thousands of patients admitted with COVID, and all of the health human resources redistribution that went along with it, we had to defer some of these deferrable procedures. Over time, we've seen the number of long-waiters actually grow as a proportion of all the people waiting.

So the strategy now is to very purposefully engage in funding and strategic actions to reduce the number of long-waiters. Just in the last few months, as we've escaped the worst of the pandemic, we are seeing reductions in the number of people waiting, and we're seeing reductions in the number of long-waiters as a result of this strategy. We see this as moving to the transformation part of the pandemic, away from the mitigation and more to what we are going to recover to, as opposed to what are we recovering from, and emerging better than we were before.

Specific attention to these long waits and trying to create an environment where every Ontarian can have access to the surgery they need, no matter where they're from, no matter what the surgery, in a clinically reasonable amount of time: That is the goal.

Mrs. Robin Martin: Thank you.

The Chair (Mr. Tom Rakocevic): Any further questions from the government side this round?

Ms. Laura Smith: How much time is there?

The Chair (Mr. Tom Rakocevic): MPP Smith, we have four minutes and 34 seconds.

Ms. Laura Smith: Okay. I want to thank everybody for being here and contributing today.

Mr. Anderson, we talked about a coordinated approach in patient care and wait-list management, and real-time access to surgical capacity. I apologize if we haven't touched on this more, but what is the ministry doing to help enable enhanced transparency by publicly reporting individual surgeons' wait times? And then I'm going to ask a follow-up question, because I have something very specific to that. So if you could speak to that, please.

Ms. Catherine Zahn: There's a great deal of evolution of our ability not only to collect and to look retrospectively at the data, but also to use it for predictive purposes. I have with me here ADM Michael Hillmer, who will able to provide us with more detailed information about the data.

The Chair (Mr. Tom Rakocevic): Before you proceed, I'd ask if you would do an oath or affirmation as a witness of the committee.

Mr. Michael Hillmer: I heard the oath, and I affirm.

The Clerk of the Committee (Ms. Tanzima Khan): I still have to read it.

Mr. Michael Hillmer: Oh, sorry.

The Clerk of the Committee (Ms. Tanzima Khan): Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Michael Hillmer: I affirm.

The Clerk of the Committee (Ms. Tanzima Khan): Thank you.

The Chair (Mr. Tom Rakocevic): Please proceed. Thank you.

Mr. Michael Hillmer: Great. Thanks. My name is Michael Hillmer, assistant deputy minister, digital and analytic strategy. Thank you so much for the question.

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I think with the investments that the government has made in central wait-list management, it sets the stage for being able to understand the real-time wait times of patients for particular procedures and for individual surgeons as well, both regionally and at individual hospitals.

I think the deputy has referenced some of the tools that are now being used regionally and at individual hospitals to be able to understand what the wait times are for individual surgeons, the health systems insights platform. This is a tool that Ontario Health has developed thanks to some of these investments that the government has made. Right now, individual hospitals can see the real-time wait-lists of individual surgeons, and then regional planners at Ontario Health can see what's going on at the region level. I think this all sets the stage for the continuation of some of the innovations that Deputy Zahn and Matthew Anderson and Dr. Simpson have talked about, where we are able to treat regions in the province as one integrated system and do the really important load balancing that has occurred. I think these investments set the stage for transparency and knowledge that you can then use to improve wait times locally and provincially.

Ms. Laura Smith: What is the adoption rate for this tool right now, if it's available?

Mr. Michael Hillmer: Well, it is available. I think I might ask either Matthew Anderson or Dr. Simpson to comment on that one.

The Chair (Mr. Tom Rakocevic): You have just over a minute.

Mr. Matthew Anderson: It's over 90%.

Ms. Laura Smith: Over 90%.

Sorry, time?

The Chair (Mr. Tom Rakocevic): Fifty-nine seconds.

Ms. Laura Smith: Okay.

Are there any future plans to make the surgeon-level wait-list data more broadly available?

Mr. Michael Hillmer: I'll take that one. Thank you for the question. I think at this time, we are considering all the options to both make it available more broadly to system planners—as I said, it's the hospitals who can see the individual surgeon results. The kinds of considerations that I think this policy work would require before it were made public would be to really understand from a couple of levels what the clinicians thought: Were there important nuances such as complexity of procedure or heterogeneity of patient groups that would change the—

Ms. Laura Smith: It's not one size fits all.

Mr. Michael Hillmer: It's definitely not one size fits all. And then you need to understand what the patients need to say, I would have to say, and all of these things would have to then be put into, I think, a risk-benefit and cost-benefit equation to understand if that's something that would benefit the system and the patients and the clinicians.

The Chair (Mr. Tom Rakocevic): Thank you. We're at time.

We're now going to proceed to the official opposition side, beginning with MPP Gélinas.

M^me^ France Gélinas: Thank you, everyone, for coming here today and for your opening comments. This selection was one of my selections back in 2021, and I'm happy that 15 months later all of you were available to come to do deputations in front of public accounts.

I will start with recommendations from the auditor, who says that the "Ministry of Health"—or Ontario Health—should "collect information ... to determine unused capacity"—she's talking about outpatient surgeries; this is her report—"without the need for additional public funding for capital" infrastructure.

This is a recommendation. Your answer to this seems to lead me to believe that we have an understanding as to what is the capacity within our sector, that exists within our hospital sector right now, and that we have plans as to what is the capacity that we need in the future, that that would determine how many private clinics would be allowed to open and in what capacity. I'm interested in learning more about where the capacity is right now within the publicly delivered health care system and what the capacity is that you want in the long term. We all know that the private sector won't invest into procedure rooms or OR rooms unless they have long-term commitment of money coming their way. So where are we at? Where do we need to get to?

Dr. Catherine Zahn: Thank you very much for the question, Madame Gélinas. There are multiple layers to the question, and so I'll do my best, and please let me know if I've skipped over pieces.

I'll start by saying that there are many ways that the ministry ensures that it's utilizing its existing capacity. For example, we've provided additional funding to those structures, those organizations that have been able to increase throughput with their current health human

resources capacity, and that would be both hospitals and independent health facilities. We do collect information on a regular basis to understand the available capacity of the public hospitals as well as the surgical independent health facilities and the one private hospital that does outpatient surgeries.

To more specifically answer that capacity question, I'll preface that by saying that at this moment in time, there is physical capacity in our system; our biggest obstacle to catch up is health human resources. There is a great deal to talk about that at some future point if appropriate. But understanding that, and understanding the geography, so to speak, or the real estate of the health care system, I'll ask ADM Patrick Dicerni to speak more specifically.

The Chair (Mr. Tom Rakocevic): Again, before you proceed, we ask that you swear an oath or affirmation.

The Clerk of the Committee (Ms. Tanzima Khan): Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Patrick Dicerni: I affirm.

The Clerk of the Committee (Ms. Tanzima Khan): Thank you.

The Chair (Mr. Tom Rakocevic): Please proceed.

Mr. Patrick Dicerni: Patrick Dicerni, assistant deputy minister of the health programs delivery division at the Ministry of Health.

Madame Gélinas, thank you very much for your question. I want to address one particular dimension of that question as it relates to how we plan for where additional services will be needed for what we currently know today to be our independent health facilities, or IHFs, which I know you're quite familiar with.

I want to use the example of a recent call for application and how we went about awarding additional cataract volumes across four centres. It goes back about a month and a half ago. We routinely survey our independent health facilities for available capacity, and a similar approach was used as we were determining what the wherewithal of the sector would be to provide additional cataract procedures, so there was a call for application that was issued back in 2021.

To give you a sense, we routinely add one-time funding, and through the pandemic this was an avenue that we used to address not only ophthalmological procedures, but plastics, dialysis service and MRI/CT hours. Over the last three fiscal years, we used a similar approach with our partners at Ontario Health from wait-list and wait time management to put approximately 8,600 additional ophthalmological procedures into our existing IHF partners.

We'd be happy to talk about some volumes across others, but if I could carry on with cataracts for a moment: With the backlog that we were made aware of, most directly through our partners at Ontario Health—and we've heard a little bit about how we define "long-waiters," i.e. those who are outside of clinically acceptable parameters—on the basis of the call for application that was conducted back in 2021, we looked at where we needed that additional capacity within the system. With OH, that was determined to be in the Windsor, Kitchener-Waterloo and Ottawa areas, so there was a determination to add up to 14,000 additional cataract volumes in those geographies to address our long-waiter situation. That 14,000 figure that I just gave you represents up to about 25% of the current cataract wait-list, and largely accounts for the increment that was experienced through the pandemic.

An important point I want to make with respect to how we went about assessing applications: The centres that will perform those additional 14,000 cataract procedures will be doing so within the existing health human resource complement of their facilities, so that was a measure that we took to ensure that we weren't going to be, in an unintended way, facilitating swings in HHR. Not to repeat myself, but those incremental procedures will be done within existing complement.

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If I could, I'd like to speak a little bit about the Your Health Act, 2023, that has been introduced and, if passed, is going to contribute to further wait time reduction as we expand the scope of the procedures that are going to be within the community. That is going to include, as early as the 2023 year, non-urgent, low-risk and minimally invasive cataracts that I mentioned, as well as MRI, CT imaging and colonoscopy-endoscopy procedures, which we would take a similar approach to, vis-à-vis the call for applications.

M^me^ France Gélinas: If you remember, my question was about the capacity that exists right now. I agree with you that the areas that you've identified needed more access to cataract surgery. The number of 14,000—not too sure where it came from, but this is what you dealt with. Why not assign those 14,000 new procedures to the hospitals that already have provided cataract surgeries forever on end in those three areas?

Mr. Patrick Dicerni: With respect to how we assess the existing capacity within the system, possible or otherwise, I'll refer that back to the deputy.

M^me^ France Gélinas: The RFP back in 2021 was only for IHFs. There were hospitals that were interested in having more of those procedures funded in their hospitals so that they could use their underused capacities within their hospital to provide, but the money went to the IHFs. The money did not go to the hospitals, although what I'm talking about—the infrastructure, was there, the staff was there, but only the IHFs could get the extra money.

Dr. Catherine Zahn: Thank you for those comments, Madame Gélinas. The only point I would make, and then I'll turn it over to Dr. Simpson for more specifics about the availability of capacity, is that those were existing independent health facilities. They were not new or incremental, and they too had capacity to take on this work.

I would have to think back about the time frame to understand what the condition of the hospitals was at that time. You'll recall that the hospitals, for some period of time, had been seized with a crisis in critical care and

leaning on independent health facilities or outpatient procedures to facilitate continuing to work on the wait-lists.

But perhaps I will ask Dr. Simpson to speak more specifically about optimizing current capacity.

Dr. Chris Simpson: Sure. Thanks, Deputy. Thank you, member, for the question. I think optimizing capacity really is the way forward, clearly. One of the things that we've observed in the last couple of months is that, for surgeries, the number of people having their surgery done has outnumbered the new people coming on the list by quite a bit, so the absolute number of surgeries being done per unit time is increasing, not surprisingly, since we're, for the first in three years, kind of out of the context of a wave—the recent pediatric wave notwithstanding. From a hospital survey that we did where we had partial responses, it appears that in excess of 90% of hospital OR space is being utilized right now, and that is increasing, I would say, because we're seeing more volumes being done. It would have to be done within this capacity.

We're also seeing a lot of shifting of volumes and funding between centres, so in Kingston, where I am, for example, we've seen Kingston patients going to Brockville, which is 30 minutes away, being done by Kingston surgeons in Brockville space, so using that space more efficiently.

I think in the context of the new surgi-centres, the community surgi-centres, the way to make them successful is to ensure that they are intimately integrated with the whole system. If we want net new capacity, each centre that's offering services must be connected with central decision-making, eyes on the same data and making sure that we're doing the right kind of patients in the right spot. If we're able to gain efficiency by doing more of the same kind of low-acuity-patients-per-unit time in some of these surgi-centres, then the system gets net gain of capacity and so the hospitals will be able to do even more, but I think if we're at 90% or so already, recognizing you can never and probably shouldn't get to 100% because you need to have some space for emergencies and that sort of thing, that kind of wiggle room probably isn't enough to get the results that we want, which is all or nearly all long-waiters done within clinical time.

It's a delicate balance, but I would say the overarching aim is to create net new capacity in a highly integrated system and the magnitude of that net new capacity, I think, is substantial if we want to accomplish our goals of substantially more surgical procedures being done.

M^me^ France Gélinas: When you're using the 90%, are you using 90% of Monday to Friday, 7 till 4?

Dr. Chris Simpson: Yes. This is 90% of current space. So the reciprocal of it is or the reverse of it is 10% is spaces that are just never used, but some of these are, for example, in hospitals that have built extra OR space in a capital project, fully expecting not to use that space right away. It was never funded, but it's sort of built for growth down the road so that you're not having to do construction every three years and that kind of thing. Some of these unused spaces are sort of unfunded, unstaffed physical spaces.

M^me^ France Gélinas: So you're sort of making my point for me, that we have unused, already built, fully operational OR spaces in Ontario right now that sit idle while we are moving forward with investing taxpayers' money for for-profit delivery. Do you see my point? As the auditor recommends we do, why don't we use—well, first of all, collect the information and use the infrastructure that is already there, that the taxpayers have already paid for rather than giving facility fees to for-profit providers to build the same thing in the community when it sits there.

The question I had asked that ADM Dicerni brought forward, as to why it is that it was only the IHFs that were allowed to bid on those new 14,000 cataract surgeries and why weren't the not-for-profit hospitals allowed to have some of those 14,000—because we all know that cataract surgeries get suspended in March, often, because a hospital has no more money to continue to do cataract surgeries till the new money comes in on April 1. Why is it going there rather than to the existing infrastructure that we have when the auditor tells us—and you've agreed to that—to collect that information and to use that capacity?

Dr. Chris Simpson: On that question of policy, I'd defer back to my ministry colleagues, unless Matt—yes, go ahead.

Mr. Matthew Anderson: Hi there. It's Matthew Anderson, president and CEO of Ontario Health. Just a couple of points of clarification: On the 10% capacity that Dr. Simpson was just referring to, just to be clear, there's no equipment in it. That's not built out. So they're not fully functional. They're not built out in many of those instances.

To your point about the IHFs, I definitely would defer to the Ministry of Health on why to the IHFs with that RFP. I do want to point out that for the public hospitals, quite a bit of investment was made. The hospitals were able to operationalize to the fullest extent that they could. Our limitations in the public hospitals right now, by and large, are not due to funding; they're definitely due to staffing, and so we were running up against that as our rate limiter.

Just picking up on a separate point from Dr. Simpson, the ideal of the IHFs—and I'm thrilled that they're being renamed from "independent health facilities" to something else—I can't remember all the letters—but they're much more integrated. I think this is really a critical point for us, and Dr. Simpson's point is making sure that we are trying to tap into, in the context of this particular question, any human resource availability that could be made available, that would be incremental to what we would see in the hospital system.

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What was critical for me—not that long ago, I was a hospital CEO and we had several IHFs in our community. Largely we worked well together, but it was all on a relationship basis. Now what's being proposed is moving away from an independent model to an integrated model. What the goal of that is, among other things, is to tap into additional human resource availability to try and bring our

volumes even further. That would be, in my mind, one of the key things that we're trying to achieve with the government policy.

I'll pause there to see if—

M^me^ France Gélinas: I'll make a little parenthesis that in the not-for-profit system, where Bill 124 applies, they have health human resource issues; in the for-profit system, where Bill 124 doesn't apply, they don't have health human resources issues and are able to take more cases. I'm just putting that out there.

But sure, go ahead. Why was capacity only given to the IHFs, not to our public hospitals?

Dr. Catherine Zahn: Dr. Catherine Zahn speaking. Again, thanks for the follow-up. Member Gélinas, it's important to remember what the scale of things is in the different areas of health care. Overall, the percentage of surgeries that are undertaken in independent health facilities is approximately 3% of all of the surgeries done. There are 200,000 cataracts every year, so only a small percentage of those are undertaken in independent health facilities.

Thus far, we are talking about privately delivered, publicly funded surgeries done in the independent health facilities. These are facilities that have currently been operational for some time. I'll just repeat the comment that I made earlier that one of the minor decision points surrounding this very, very small number of cataracts that were identified to be added to the independent health facility work was an understanding of the work that was going on in the hospitals and an attempt to accelerate the provision of care in a less stressed, more accessible and, possibly in those times, safer environment for patients.

The Chair (Mr. Tom Rakocevic): Just under two minutes remaining.

M^me^ France Gélinas: Okay. Just to wrap up on infrastructure: The Auditor General's report, which you all supported, tells us that the provincial best-practice target rate of operating room use from 7 a.m. to 4 p.m. is 90%. When she did her report, 34% of hospitals did not meet those targets, 72% did not start on time, and it went on and on. Are we doing any better at using the infrastructure capacities that we have now? And why is it that we only collect from 7 a.m. till 4 p.m.? What happens at 4:30?

Dr. Catherine Zahn: I'm not quite sure of the question, but—

M^me^ France Gélinas: The AG, the Auditor General, tells us that 34% of hospitals did not meet the 90% target of using the OR space. The target is 90%, but 34% of hospitals do not meet the 90% target—that is, that they use their OR space from 7 a.m. till 4 p.m., Monday to Friday, 90% of the time. That's the target. Some 34% of hospitals do not meet that target.

Dr. Catherin Zahn: Thank you. I'm going to defer to Mr. Anderson to reply to that specifically, and then I can follow up if necessary.

Mr. Matthew Anderson: Great, thank you. It's Matthew Anderson speaking. We have rolled out the surgical efficiency program—we call it SETP, the Surgical Efficiency Targets Program—

M^me^ France Gélinas: Yes. I'm familiar.

Mr. Matthew Anderson: —to all of our hospitals to move that forward to improve their efficiency. It's certainly difficult to measure over the last two years because of the surgical ramp-up and ramp-down, but our goal is to get to having all hospitals participating in the SETP program to maximize their time frame.

On your question of—

The Chair (Mr. Tom Rakocevic): Sorry, we're out of time, but the question can be re-asked in a subsequent round by the opposition side.

We're now going to the independent member. MPP Collard, you have three minutes.

M^me^ Lucille Collard: I'll try to make the most use of these three minutes and I'll start with a straightforward question. My question is, what is the outpatient surgical backlog as of December 31 and what is it now? Just the numbers—if we've improved.

Dr. Catherine Zahn: Thank you very much for the question. I don't have a figure specifically for the outpatient. I'll ask if we have that. But the high-level numbers to be aware of are that prior to the pandemic there were approximately 200,000 people on wait-lists for surgery; during the pandemic that increased to 250,000 individuals and over the last several months our health care system has been able to eliminate that incremental 50,000 patients—nearly all of those 50,000 patients. So we're back to approximately pre-pandemic levels of about 200,000 individuals on the wait-list. I can't differentiate that from outpatient to inpatient, but it would be a small percentage of those that would be outpatient surgeries.

M^me^ Lucille Collard: Thank you for this. One other recommendation of the Auditor General is to better align funding with the actual costs of providing outpatient surgery in hospitals, private hospitals and IHFs. I noted that the funding that was provided to IHFs turns out to be $792 per surgery, while the private hospitals were funded for an amount that goes to $1,444 per surgery, which doubled the amount of what the IHFs got in terms of funding. Can you explain that discrepancy, if we're talking about funding the actual costs of surgeries?

Dr. Catherine Zahn: Thank you very much for the question. The question that you ask is difficult to answer without understanding the differences in patients. Different facilities are able to accommodate individuals with complex medical conditions, for example, or, in the case of cataracts, high-risk patients, patients with diabetes or one eye blind already. There are a number of patient differences that would have to be taken into consideration to be able to answer that with any accuracy.

M^me^ Lucille Collard: Maybe I could ask the question differently. What is the ministry doing then to align the funding with the actual cost?

Dr. Catherine Zahn: Thank you for the supplementary. Perhaps I can ask ADM Dicerni to address that.

The Chair (Mr. Tom Rakocevic): I'm sorry, we're past time, so if you can get to that question on the subsequent round.

We're returning to the government side. You have 20 minutes to begin the second round. Just a warning, as well:

We're expecting a vote relatively soon, at which point we will recess and, of course, return.

MPP Kanapathi.

Mr. Logan Kanapathi: My question is in regard to centralized intake or transfer of patients. What is the ministry doing to identify the type of outpatient surgery that's supposed to go to central intake and expand implementation of central intake across the province, in alignment with the practices? That was my question.

Dr. Catherine Zahn: Thank you very much for the question, member. The ministry obviously is committed to having the most efficient flow of individuals into a wait system and then out as expediently as possible. I mentioned a number of initiatives in my introductory comments that are undertakings of Ontario Health in that respect.

I will pass over to Mr. Anderson to speak to that.

Mr. Matthew Anderson: Thank you, Deputy.

Thank you for the question. I think what I might do to best answer your question is just take a step back for a moment, because we use a bunch of terms interchangeably and they're all key to what we're trying to do to improve our central wait-list management system.

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In my opening comments I made the comment that we currently have a central wait-list management system in the province of Ontario today. However, as the Auditor General has pointed out, there are many limitations to it, including that it is largely a retrospective system. It's a system that surgeons' offices will input data into. We can run analytics off of it retrospectively, but it's not a real-time system.

What we've been doing—and the deputy highlighted some of this in her opening comments—is there are actually about four parts to this one system that we're describing. The first part is e-referral. This is the ability to actually have, from a primary care office, as an example—very typical—for them to be able to see the wait-lists and be able to make an electronic referral, either to a surgeon's office or into another part of the system called central intake.

The first part was e-referral, and the deputy mentioned a number of investments that have been made there. We have many e-referral systems set up across the province and we're looking to move those to having a set, maybe six or seven across the province, of e-referrals.

That e-referral then goes into a second component called central intake. Central intake—and the Auditor General spoke to this in her report—is a very important element in which it would have algorithms in it that would help us to determine where somebody fits on that priority list. You heard Dr. Simpson speak about the long-waiters and a focus on the long-waiter—this would just be built right into the system to give a weighting to a prioritization. Patient choice would always override, so if you absolutely wanted to see Dr. Zahn even though her wait-list was longer than Dr. Simpson's, you can certainly do that, but the central intake would tell both the patient and their primary care provider that Dr. Simpson's wait is three months and Dr. Zahn's is six months. You may still choose to wait the six months for Dr. Zahn, but you may want to select Dr. Simpson. So that's what the central intake element does.

Again, we've invested in a few projects across the province to see how we can build that component out. This would all plug into our existing component. The existing component is where we collect all of the surgical information, and what that looks like is that once you've gone over to Dr. Simpson, he starts to record that you've been seen, here is the initial assessment, you've now had your surgery and it closes that off. That we capture today, but also, as you've heard right now, that only recently became available to hospitals, so now the hospital can see Dr. Simpson's wait-list. It's created interesting conversations for Dr. Simpson at his hospital, I might add. So now the hospital can see that.

The question which Assistant Deputy Minister Hillmer addressed was we're also investigating where in this process there is visibility for patients: How would that work? How do we respect privacy? Most importantly, how do we ensure privacy through that? And how do we get that last piece in place?

The final piece that you've also heard mentioned today—and I'm sorry; there are so many different pieces to it and we call it all centralized wait-list management when there's actually all these different pieces. The other piece is our health system analytics or insights, which Associate Deputy Minister Kaftarian responded to. That sits on top all of this, where we can pull all of this data up and start to look at all of these different flows. Right now, we have that latter part.

Going back to one of the questions from MPP Gélinas, we have 90% of our hospitals participating in that piece. We will have 100% by end of fiscal. We now also want to get all of our independent health facilities and private hospitals participating in this as well, because right now we don't see their data. If we go back to some of the questions around equity of access, it's critically important that we see all the data. That way, we can be sure that we haven't created—going back to all the complexity of doing new investments and where do we open up new facilities and all that sort of stuff, the real power of the system is that then we can look back to say, "Have we created any inequities? Is it easier to get a surgery in Ottawa than it is in Kingston?" We want to be able to do that deterministically. Right now, we can do that to a good degree for surgeon access at a public hospital, but the first pieces we cannot report on.

We've made these investments. We're bringing these pieces on board. Ultimately, we want to be able to see the whole system so that we can ensure there's equity of access all the way through, right from what we lovingly refer to as wait 1, through to the completion of the surgery and that whole process.

Sorry to take you through all of that. We use one term, but it's actually four or five different pieces.

Mr. Logan Kanapathi: Thank you for that great answer. I have one more follow-up question. Can you

share what other work is required to support the expansion of central intake across Ontario? I will give you more time to elaborate the process.

Mr. Matthew Anderson: Thank you.

May I, Deputy? I'm on a roll. Is that all right?

Dr. Catherine Zahn: Yes, please.

Mr. Matthew Anderson: Okay. I think the only other thing I would add to what I've described is that each of these pieces is going to have important change management elements to it as we start to think about, how are we changing these workflows and making things more efficient for everyone, and in particular, how do we improve equity for our communities and for our patients?

Right now, it's great that we have moved to the place—first, we're collecting all of that information on the surgical part. It's wonderful that we're able to relay that back to the hospitals. I made the comment as well about the regional tables where we're now looking and we have the opportunity. So we don't just look at Kingston General at Kingston General. You heard Dr. Simpson talk about Brockville and the recognition that there was some capacity there and how we could move that forward.

So those are all great pieces. We want to build those out further. The province has been wonderful in making investments and enabling us to do this. It is a bit of a change on the ground for folks. For Dr. Simpson and Dr. Zahn, I think they could both comment from their perspective as specialists on what does it mean as a specialist to be participating in the system. But overall, I think we've got these pieces. It does take time, unfortunately, I would say—longer than I would like. But as you can see, there's a lot of complexity.

We also want to optimize at the referral level how we're going to manage those referrals up in the northwest part of the province. Up in the Thunder Bay and Kenora area will be different than how we're going to manage them in the southeast, and so we may see different systems there. At the end of the day, though, they all have to hook back into one repository where we're able to track and ensure that we understand equity of access.

Mr. Logan Kanapathi: Thank you for all the great work you guys do. I think my colleague MPP Crawford has a question.

The Chair (Mr. Tom Rakocevic): MPP Crawford, you have 11 minutes, 44 seconds.

Mr. Stephen Crawford: I just wanted to touch a little bit on the independent health facilities. There's obviously a lot of discussion on that today. I thought perhaps you could give a little more context to the history of independent health facilities in terms of how and why they were created.

Dr. Catherine Zahn: Thank you very much for the question, MPP Crawford. I'm old enough to remember a long history of independent health facilities. One might be confused by the recency of this, but it's important to remember that the concept of the private delivery of publicly funded health services dates back to the Medical Care Act in, I think, 1967. This was the act that allowed physicians in their private facilities, in their private offices, to bill OHIP. Over the decades, that morphed into physicians' offices that also included small procedures: ultrasound, electrocardiograms and, in my specialty of neurology, electro-diagnostic studies.

So that was occurring at that fairly sporadic level for many years, until the Independent Health Facilities Act, which was, I believe, 1990?

Mr. Patrick Dicerni: Correct.

Dr. Catherine Zahn: It was in 1990 that it codified the concept of larger ambulatory surgery centres to provide this type of, again, primarily privately delivered, publicly funded health care services.

With that preamble, perhaps I'll hand over to ADM Dicerni to give more details.

Mr. Patrick Dicerni: MPP Crawford, thank you very much for the question.

Further to Deputy Zahn's remarks: She's quite right. The IHFA came into being in 1990. It was designed to address a specific set of concerns that were materializing within the system at the time. I'd say those fall into three big categories, one being the proliferation of facilities referring for diagnostic and other insured services. That resulted, in the time, in significant utilization growth of these services—questionable whether that utilization growth was always appropriate utilization growth. That was being done without a regulatory scheme that sat on top of it. The IHFA provided that mechanism to regulate by the concept of issuing of licensure, the type of procedure, the volume of the service for which the facility would be paid an IHF or facility fee.

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The second driver on the IHFA, MPP Crawford, was the need for quality standards and oversight of insured services in these privately operated community-based facilities. With the passage and implementation of the IHFA, at the time, all IHFs became subject to and currently today continue to be subject to a quality assurance program administered by the College of Physicians and Surgeons of Ontario. That uses quality and safety standards developed by that organization and international bodies etc.

The third area would have been patients being charged overhead or facility costs associated with the delivery of insured services. The IHFA prohibits facilities from charging or receiving facility fees from anyone other than the Ministry of Health or Ontario Health, as represented by our colleagues at the end of the table. This ensures that facilities can't be charging patients for insured services to cover overhead costs.

The facility fee is a funding support that allows us to make sure that that delivery of an insured service is occurring but there isn't an additional fee associated with it over and above what the physician would receive for their time and service.

The IHFA also provides a licensing mechanism that includes directors' authority under the act to intervene on behalf of patients to recover inappropriate charges that may have been levied against a patient. There was a standalone piece of legislation in that respect, the CFMA—the

Commitment to the Future of Medicare Act—which also contains protections against that type of behaviour.

I would close by saying we currently have north of 900 IHF facilities receiving that facility fee that we referred to earlier. As a legacy, many of these facilities exist in the southern Ontario area, in and around the GTA. I would point out that since the introduction of the IHFA, approximately 20 additional licences have been granted, other than those that existed prior to.

Mr. Stephen Crawford: Following up on that, you did sort of touch on oversight, but could you give a little more insight into how the ministry has insight into these facilities to ensure that their standards and safety are at the same level as the hospitals?

Mr. Patrick Dicerni: Absolutely. I just want to refer to my notes. As I mentioned in my initial remarks, certainly, currently the oversight, quality and assurance provisions are spelled out, and currently our partner in that respect is the College of Physicians and Surgeons, where they inspect and ensure the facilities that are providing those services are providing them at the highest level of quality etc. that can be expected, not only in our hospital environment but in our community health facilities.

Mr. Stephen Crawford: Are there any instances or variation in outcomes or safety issues versus the publicly funded hospitals?

Mr. Patrick Dicerni: I wouldn't want to comment on public hospitals by way of outcomes and/or variation, but what I can answer for you, MPP, is that there is an established protocol for alerting the ministry and the college to a critical incident as well as a robust complaints process that already exists and certainly would be carried on if the integrated health services facilities act is to be passed. Those complaint processes reside not only on our website but on the IHFA section of the Ministry of Health's website, where we post the complaints process and the outcomes of the CPSO's inspections.

Mr. Stephen Crawford: Thank you.

The Chair (Mr. Tom Rakocevic): MPP Byers, you have four minutes and 35 seconds.

Mr. Rick Byers: Thank you to the presenters. I really appreciate your presentations this afternoon and all the work you've been doing. It's terrific.

Two quick questions from me. Number one is kind of a clarification: In a past life, I worked for the OMERS pension plan and OMERS owned LifeLabs, which was a fantastic blood-testing company. Is that technically an IHF or are they in a different category? They've been in the system, I think, owned independently for almost 20 years or so, but it's curiosity more than anything else. If you don't know where it fits, that's fine; we can follow up later.

Mr. Patrick Dicerni: Thank you for the question, MPP Byers. The laboratory services that I think you're referring to are not IHFs; they are community laboratory and specimen collection centre sites and that is governed by a separate piece of legislation. That is the laboratory specimen collection and services act.

Mr. Rick Byers: Very well known.

Mrs. Robin Martin: Rolls off the tongue.

Mr. Rick Byers: Thank you very much.

Mr. Patrick Dicerni: The LSCCLA, which I know it better by.

Mr. Rick Byers: I hear it on the street all the time.

Just a couple more comments on the Auditor General's report. I really valued your observations and the response to the recommendations she had made. Really, two questions: In my previous life I was an auditor, and when I presented to clients, sometimes they valued my input and other times perhaps not so much, but I wondered if you could emphasize to us the recommendations that you felt were most positively reviewed. We got some of that earlier, but just ones that you found very highly valued and impact the activities of the ministry most, if you will?

Dr. Catherine Zahn: I'll start by saying it's hard to choose. I would say that the health care system has a long history—at least 30 or 40 years, since I've been active—of receiving feedback and taking it with an intentionality to continually improve. When I said over and over that we welcome the comments, it's true, and the health care system, by and large, would agree with me.

With respect to the specifics, I am going to have to defer to one of my colleagues—and it looks like Mr. Anderson is ready to go.

Mr. Matthew Anderson: First off, I would just echo the same. There was nothing in this report that, from an Ontario Health perspective, we felt was off-base or not helpful or anything like that, so we thought that was great. I made a comment to that effect in my introductory comments.

Perhaps it won't surprise you, given the length of the answer I just gave to the previous question, but for me, what was particularly welcome here was the discussion of the central wait-list management program and the idea that everybody should participate. We have a full view of what's going on across the system. Maybe just picking up on a little bit of MPP Crawford's question and Associate Deputy Minister Dicerni's answer, when you build up a system like our health care system over time in different pieces, sometimes you can get to places where pieces just don't quite fit the way you would like them to. Here's an example of where, previously, these were independent health facilities; they collected information separately; they worked directly with the ministry. You've now put in an organization like Ontario Health, charging us to coordinate the whole system. This is an important part of the system that needs to be incorporated and the Auditor General called that out and that's very, very helpful to us as we think about how to move this forward.

Mr. Rick Byers: Okay, thank you.

The Chair (Mr. Tom Rakocevic): That's time.

We are going to be recessing for about 15 minutes to allow members to vote and then return, and for those here, if they need to take a break for any reason. See you very shortly.

The committee recessed from 1518 to 1541.

The Chair (Mr. Tom Rakocevic): Welcome back, everybody. We are going to begin the second round of

questions from the official opposition. Again, I remind members that we have up to five rounds alternating.

We'll begin again with MPP Gélinas.

M^me^ France Gélinas: I will do a memory test for the head of Ontario Health, if you wanted to finish the sentence. But if you have forgotten, you will be forgiven.

Mr. Matthew Anderson: I seek your forgiveness.

M^me^ France Gélinas: No problem.

I will focus on the part of the report where the Auditor General finds that patients have no protections from being misinformed or inappropriately charged for publicly funded, medically necessary surgery. In your response—"your" as in the ministry response—to this particular recommendation from the Auditor General, you say that to protect patients, the 2021 CFA requires applicants "to demonstrate how insured persons will be made aware of what cataract surgeries are available, fees for uninsured optional services and how they intend to obtain consent for any charges for uninsured services," and that these requirements are included in transfer payment agreements for any new licensees. Can you share those with us, and will they be made public?

Dr. Catherine Zahn: Apologies. Again, I can't remember where we were, Madame Gélinas, at the end. Was this a follow-on to the question to Matt, or was this—

M^me^ France Gélinas: No, no. I switched topics altogether. I'm now talking about protections from inappropriately charged fees on publicly funded, medically necessary surgeries, with a focus on cataract surgeries, and the response from the ministry—the updated response that you sent last week to the Auditor General's report—that I read back to you.

Dr. Catherine Zahn: Thank you very much for the question. The intent, I think, is as you see it outlined. The actual application of it is obviously going to require some specific activities on our part to make sure that the oversight is understood, first of all in communications with the sector—what we expect of them—but also amplifying our oversight and providing information on our website, for patients to understand what their rights are and what the specifics about expectations are in these independent health facilities. But perhaps I'll ask ADM Dicerni to speak more specifically about that.

Mr. Patrick Dicerni: Thank you very much for the question. With respect to what I would refer to as "inappropriate charges" or "upselling," particularly related to the current independent health facilities, if I could, I'd like to answer the question in terms of what protections are currently in place, and, if helpful, some of the elements of the proposed legislation that would further that respect.

M^me^ France Gélinas: Go quickly on what's already in place, because I know them inside out. I use them all the time. I'm interested in what's coming.

Mr. Patrick Dicerni: Okay. As per your question, I think there have been some challenges in terms of seeing how to best and most appropriately address instances where there are uninsured services that are being sold or upsold to members of the public. Within the current IHFA framework and the transfer payment agreements that govern those relationships between government and the proponent, there is a requirement to obtain the record that the patient has been informed and consented to the provision of any uninsured service that is connected to a funded, insured service. The transfer payment agreement developed for the new cataract centres that were announced back on January 16 does include a requirement to publicly post information about uninsured service, the uninsured services that are offered and the price of those procedures.

If I could speak a little bit to the proposed legislation, the proposed legislation has a number of elements to enhance patient protection from upselling. First—and it is included in the preamble, but I'll get to the operative sections of the legislation—the government does speak in the preamble of the proposed legislation that the government shares a vision for community-based services that includes protections against patient charges.

If we move into where those protections actually exist within the proposed legislation, no centre can refuse an insured service to a patient who chooses not to purchase an uninsured service in conjunction with that insured service. That can be found in section 29(6) of the proposed legislation: "No refusal for choice not to pay."

No patient can pay and receive an insured service faster than anyone else, and that's, again, in section 29(5), which sets out that people cannot be receiving that any faster by way of paying for said service.

No patient charges for the overhead that the facility incurs: That is, again, in section 29.

Another element is each centre must have a formal patient complaints process in place to respond to patient complaints. Now, currently, that is the practice within the program, but that's a function of the contracts that exist. That has been elevated to the proposed legislation, and that can be found in section 22, the complaints process.

The last element that I would point to is that a new element of the proposed legislation would be leveraging the ECFAA provisions and giving the Patient Ombudsman's office authority to investigate complaints in integrated community health service centres. That can be found in section 70 of the proposed legislation.

M^me^ France Gélinas: Okay. I'll tell you a very short story. I went to a health fair for seniors where I presented on all of the community services available for seniors. I ended my presentation saying, "If you have ever been charged for a service provided by a physician, come and see me." I stayed, and 142 people got in line to come and tell me about—they had no idea why they had to pay. They love their doctor: "He's really, really good; he did a very, very nice job and I really, really like him, but is there a program that would help me pay, because I have $1,000 that I owe to this, and I don't have $1,000." By the end of about 50 or 60, I knew how much physicians charged for the second measuring of the eyes, for the lens—I can line this all up for you. None of them had any idea why they had to pay, but they really, really like their physician and he's very, very good, and they would never, never, never, never put a complaint against him because he's really,

really nice. But they don't have the money to pay for this and they were wondering if the government could help pay.

1550

A complaint-driven mechanism does not work. The people in line, 142 of them—zero of them allowed me to share their complaint, zero of them allowed me to share their names, zero of them will ever make a complaint. They will share their story with me—I'm a safe place—but they would never share with the ministry. None of them wanted to go to the ombudsman, none of them wanted to go to the line where you can complain, none of them wanted to do anything except tell me that they don't understand.

Oh, and I forgot to tell you that if you pay the 400 bucks to have the second measurement, they don't take your licence away, so you can continue to drive. I forgot to throw that in. They send you back to your optometrist and the optometrist gets to decide. But if you don't pay the extra, he takes your licence right there. That was part of the deal, so they talk to one another and say, "Go to this surgeon's residence, or to that surgeon." Because in my neck of the woods, there's no public transportation. You need to drive.

That put aside, what you're telling me is that you can't refuse, you can't jump the queue, they need a formal process to complain, and they can make a complaint to the ombudsman. I can tell you right now that's not enough. What kind of protection can you give people, when it's already happening? I mean, in my neck of the woods, most of them were ophthalmologists and the fees happen in their office. Once they're at the hospital to get the surgery, nothing happens there; you don't have to pay. In the office, they bill, they upsell, they overcharge, and people have no idea what they're paying; they just pay. What can you do about this? Because we're about to open the door to more for-profit providers who will continue that trend.

Dr. Catherine Zahn: Let me start by saying that I'm really sad to hear that, as a physician myself. I think that this is something that we won't have a specific answer to right now, but we'll take it back and discuss what some of the possibilities are for addressing this. Some of them may sit with the ministry or Ontario Health; some of them are with the college, if these are inappropriate behaviours by physicians or by the facilities themselves.

Patrick?

Mr. Patrick Dicerni: Thank you. What I would add to the deputy's remarks, including the comment around the College of Physicians and Surgeons, is to the degree to which any of these services were uninsured services and those individuals were charged an inappropriate rate, the deputy is quite right: That is the domain of the CPSO.

But let me speak a little bit about the occurrence of these types of charges and—I'm paraphrasing—the individuals or the patients who received these charges were sort of unaware as to whether that was going to occur and/or in what amount. Some of the information that I have referred to in the proposed legislation I think will seek to address this.

I would also point out that Health Canada has a role, and an active one, in this space as well. I think we've recently heard the Prime Minister speaking about the nature of ensuring that people aren't charged for insured services. Health Canada does take—if I can describe it so—a mystery-shopper-type approach. I hear you with respect to the lack of willingness, in some cases, for a patient to lodge a complaint against a provider that they have had otherwise good experience with; Health Canada understandably doesn't have the same challenges there. We routinely engage with our Health Canada counterparts on where they are concerned or aware of instances of inappropriate up-charging.

The last point I would make is that the degree to which an Ontarian has been what they feel is inappropriately charged, we are certainly looking at exploring other methods or the feasibility of collecting data on prices and fees that some surgeons are charging patients for uninsured services that are performed in conjunction with the insured service. I'd say that that could take the form of collecting data on patients that have been charged these fees as well.

With respect to—I appreciate, occasionally, there is not an ability to take action if there is not a patient who is lodging a complaint, though we do benefit from, generally speaking, this information to build a body of evidence, if you will, in terms of how these charges are being forwarded. I'd say that connects back to the proposed legislation insofar as, through contract, placing in a conspicuous location within one of these facilities, what are the associated uninsured services that are offered but are in no way contingent to receiving insured service.

M^me^ France Gélinas: I know that you made reference to CPSO. I've had a great discussion with CPSO. They have a website. I took the information from the website; I put it in my monthly bulletin. Nobody knew that it even existed, and they were happy. But that's not enough.

Most of the people who go for cataract surgery are my age or older. Most of them respect their physicians to no end. If he says that you need to give 400 bucks, you don't ask. You just pay because he's really, really good and he's going to give you your vision back so you can drive again. This is it. And if it's $2,000, it's $2,000, and they pay. It's happening all the time. If it happened 142 times in one seniors event that I attended, I'm guessing that it happens more than that. Yet we have a new bill, Bill 60, that talks about oversight, but there's no—when will the regulations for this oversight ever come out?

Mr. Patrick Dicerni: If I could make one additional comment around the experience, the government currently has, the ministry currently has levers at our disposal that go up to and include the revocation of licensure if there are the conditions and the information available for us to take action. I don't want to leave the committee with the impression that we're devoid of levers within our current regime. We aren't, and they are serious powers.

With respect to your comment or question with respect to a regulatory regime that would spell out additional details, there is, assuming passage of the legislation,

regulatory work that the ministry would undertake at the direction of the government. But with respect to the references that I made earlier, there is an elevation of the inappropriate charges as well as a complaints process that has been elevated to the proposed legislation that formerly existed solely within contractual arrangements.

M^me^ France Gélinas: So my original question was that you say in your answer to the auditor on this particular—the auditor says, "Implement additional oversight mechanisms to protect patients again possible misleading sales practices and inconsistent policy." Your answer to that is that you will include this in transfer payment agreements for any new licensee.

My question to you is, will this be public? Will we know what the consequences are? Because right now, the Auditor General tells us that—going by memory—of 326 complaints, half of them were found to be valid, where the people got their money back, and not one physician ever had any consequences. He gave the $400 back and charged the next 500 patients $400, and nothing happened. For the few people who complained, yes, you did a good job; you got their $400 back. But the physician keeps on doing this, every single day, and nothing happens, although you know that he overcharged because he had to pay him back.

Mr. Patrick Dicerni: I want to be careful not to comment on the role of the College of Physicians and Surgeons of Ontario in terms of any discipline that they see as necessary or censure that they see necessary to physicians.

The comment I would make with respect to the chart that you've read from: That chart predates the introduction of the legislation that is front of the House, and the government has made choices to take some of what you've read referencing contractual stipulations and elevate that to the legislation. That's connected to the some of the protections against upselling that I referenced earlier. The ability for ministry and government to spell out additional requirements in the contract absolutely exists at the disposal of ministry and government. The text or details of that are going to be developed in between now and when call for applications and, ultimately, licensure would be granted, assuming passage of the legislation.

1600

M^me^ France Gélinas: Okay, assuming passage of the legislation, my question remains, will we ever see what those accountability mechanisms will be regarding oversight? Or is it because it's going to be private, for-profit that we're not allowed to see what's in the contract?

Mr. Patrick Dicerni: With respect to transparency or visibility of contracts, I would need to defer to somebody who's a little more acquainted with the Freedom of Information and Protection of Privacy Act. The degree to which those contracts are compellable I am unsure.

I suppose the overriding theme of my answer is that many of the conditions that were contemplated initially when that information was brought forward for contractual requirements are now actually embedded in the face of the legislation.

M^me^ France Gélinas: Except that I won't get to see the contract.

The Chair (Mr. Tom Rakocevic): One minute left.

M^me^ France Gélinas: One minute? Oh.

Okay. Just to forewarn you, the next 20 minutes will also be on oversight, but at this point we will be looking at the quality of care oversight, also something the Auditor General refers to.

You will remember that we had physicians do spinal injections for pain, killed one, got three meningitis in a row, did not follow IPAC procedures—all of this. How will we ensure that in those new—whatever you want to call them—independent health facilities, for-profit independent health facilities, we don't continue down this path of having no oversight for IPAC or anything else? Just putting it out there in my last 60 seconds.

The Chair (Mr. Tom Rakocevic): That concludes the second round for the official opposition.

We're now moving to our independent member, MPP Collard. She has three minutes.

M^me^ Lucille Collard: I almost feel like giving you my time. You're so passionate and you know a lot, and I know it's putting the people who have joined us a little bit on notice and on their toes.

I'm just going to ask a simple question. I think you've alluded to it briefly in your presentation. I would like to know about the regional variations. What is the ministry doing to address the significant regional variations in wait times that result in inequitable access to surgery for Ontarians across the province?

Dr. Catherine Zahn: Thank you very much for the question. The inequitable distribution of wait times has a number of factors that contribute to it: health human resources; the remoteness of communities; the, in some cases, lack of primary care—that is, making a first assessment and then passing on.

But to provide some more specifics on that I'm going to hand over to Matt Anderson.

Mr. Matthew Anderson: Thank you for the question. I think on this one I'll just hearken back to a comment from earlier, where we now have regional and sub-regional planning tables across the province. Previous to the existence of Ontario Health, at most there would be some planning perhaps at a LHIN level, which would be 14. Generally, though, hospitals and sub-communities were on their own in terms of working through access to services—also, some limited data, right?

Part of this is—and I won't go through it, because I did a long diatribe on it before. Part one is let's get better information out to people so they can actually see what's going on. You've heard a lot about that already, including hospitals being able to see surgical wait-lists, because previously a hospital wouldn't necessarily see how long somebody was waiting to get access to services.

With our regional programs, we're now bringing all—I'll use the western part of the province as an example. All the hospitals and facilities in a geographic area—we've divided up into a few areas. They will look at and we will show transparency of data of all of the wait times, looking to understand in real time what is the problem—as the deputy mentioned, there are often many different issues

that are going on—and which ones of those can be solved immediately. It may be a technical issue; maybe it's moving some patients somewhere. If it is a funding issue, what we are able to do now, with the support of the ministry, is to take funding and say, "If you are not spending in this community but you are way behind in this community and you have capacity, you have to move some funding from this community over to this community to make sure that you can get caught up on the wait-list." So it's a much broader view of what's happening with these wait times and not doing it on just a hospital-specific level anymore, but doing it across a jurisdiction. We think that the combination of better information, combined with that transparent approach of planning and movement, will get to some of those equity challenges.

The Chair (Mr. Tom Rakocevic): Okay, that's time.

M^me^ Lucille Collard: Thank you.

The Chair (Mr. Tom Rakocevic): We are now beginning our third round with the government side. MPP Martin.

Mrs. Robin Martin: Hey there. Just one quick question, following up on what MPP Gélinas was asking about: My understanding is people that go to have cataract surgery in hospitals, which are publicly funded, are also offered upgraded lenses etc. And so I was just wanting to ask if this is an issue that you think is an outpatient surgery issue or if it's just an issue with patient information and knowledge of availability of recourse?

Dr. Catherine Zahn: Thank you for the question, PA Martin. I'll speak first to the issue of hospitals, and what these fees are and how they're enacted. What you're referring to is the opportunity to have an enhanced or, in some cases, a luxury service provided. I would say with a great deal of confidence that in the hospitals or in the larger independent health facilities, that would never be the price of entry, so to speak. It would never be a condition upon which was based your acceptance to have surgery.

Once surgery is understood to be necessary, the patient would be booked, they would go on a wait-list and then they will have their surgery, and at some point prior to the surgery—actually, I know this process very well, having gone through it recently with my husband—there is a question as to whether or not you want an enhanced lens. So that is the usual process. That is perfectly acceptable, and it's legal.

It's a little less clear what the advantages of, for example, some specific arthroplasty implants are and whether or not there's a great deal of value, but the process as I outlined it legally cannot require that payment to be made as a condition for you having the surgery, and that should extend into independent health facilities. If that's not the case, as I had mentioned before, this is something that we would take away and understand what is possible with respect to investigating it.

Mrs. Robin Martin: Thank you, Deputy Zahn. My question really was if it should extend into public hospitals, as well. We're talking about outpatient surgeries, but the line of questioning was about this happening in independent health facilities and/or integrated community service centres, for which we now have increased oversight. What I'm asking, really, is, should public hospitals also not be informing patients of what is provided under OHIP, what is necessary, and what enhancements might be offered for cataract surgery?

Dr. Catherine Zahn: Yes.

Mrs. Robin Martin: Thank you.

The Vice-Chair (Ms. Donna Skelly): Are there any other questions? We have 16 minutes left. No further questions?

We shall go to the opposition side. MPP Gélinas.

M^me^ France Gélinas: I would continue my line of questioning on oversight. I'm sure you're all aware of the case that is going through the courts in Ontario right now, of physicians doing—

Mr. Todd J. McCarthy: Point of order, Madam Chair. I submit that we are getting into repetition. What we're getting into is a breach of the standing orders, which do not permit questioning or comments on matters before the courts.

M^me^ France Gélinas: I will skip that altogether. If a patient who has surgery gets meningitis in a hospital, it is reported to the health unit. The hospital will review their IPAC right away, and there are layers upon layers of oversight to make sure that a surgery performed in our hospitals is safe. What are the layers upon layers of oversight that exist in independent health facilities? Because the stories we see are that they don't seem to have any, and the Auditor General tells us that they need reinforcement.

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Dr. Catherine Zahn: Thank you again for the question. I think that you're referring to that wide spectrum of concepts that fall into the category of quality of care, period. Those include safety, patient access, outcomes, patient experience, efficiency and equity. Those are all of the things that we think—that I, I should say—those are concepts that need to pertain to the provision of health care outside of a hospital, including in independent health facilities and including, to be honest, in physicians' offices.

With that, I'll hand it over again to ADM Dicerni to speak to some of the specifics, and then probably on to Ontario Health to talk about some of the details of how this would be executed.

Mr. Patrick Dicerni: Thank you very much for the question. If it's okay by you, I'd like to give you a summary of what the current IHFA affords for and allows and mandates by way of quality assurance and inspection, and then some of the additive elements in that domain with respect to the proposed legislation.

Since 1990, when the IHFA came into force, there has always been quality assurance provisions built in, and a couple of those that I would highlight, MPP Gélinas, being the director may request inspections of any IHF by the college under the quality assurance program related to any complaints, any incident or concerns that the director has

reason to have related to the IHFs, in addition to the regular and scheduled inspections of these facilities by the CPSO.

M^me^ France Gélinas: So, just clarify for me that—because when I talk to CPSO, they tell me that they oversee their members, they oversee physicians, but if a physician goes into a private clinic that he doesn't own, they're telling me that they're there to supervise their members. They're not there to supervise private, for-profit companies; they supervise their members. But you seem to tell that even if one of their members goes into a private, for-profit-owned place, that CPSO has a right to inspect.

Mr. Patrick Dicerni: Correct. The CPSO, in their core function, if you will, is responsible for the professional practice of physicians. As per the IHFA, the CPSO is also the government's quality and assurance inspection body. Now, the proposed legislation does avail the government the opportunity to appoint a new or additional quality assurance and inspection partner, but for the regime that exists today, the IHFA, that is a partnership we have with the CPSO that does, yes, absolutely include the professional practice of their members, but also the inspection of the IHF.

M^me^ France Gélinas: So how can we explain that lots of people got meningitis from injections where IPAC procedures were not followed? And this went on for three years.

Mr. Patrick Dicerni: Without wanting to delve into the specifics of those cases—I'm not familiar with what you reference—I'd want to be sure to understand whether those were indeed IHFs. Were those out-of-hospital premises? The CPSO also, through the Medicine Act, has the responsibility to oversee out-of-hospital premises, which is a classification or a categorization of a facility that does procedures using a certain level of anesthesia. So I'm unsure, because the powers and authorities as they relate to what is an IHF versus an out-of-hospital premises differ slightly.

But what I would say to a point the deputy raised earlier: Over the last five years, approximately 5.5 million IHF services have been delivered across all 900 IHFs. There's an average of 45 complaints per year, and that goes back at least over the last 10 years, so I think it's important to keep size and scale in perspective by way of services rendered and complaints received.

With respect to a little deeper on the CPSO's role and what they currently do vis-à-vis IHFs, CPSO publishes inspection program requirements for all of the IHFs, and that's available on their website as well as the inspection requirements for all of the out-of-hospital premises, which differ slightly. The ministry reports inspection results on IHF facilities through our own website as well, and the public complaints process that I referred to earlier is already in place by way of IHFs and some of the enhancements I discussed earlier with the proposed legislation.

M^me^ France Gélinas: Arthroplastic surgery versus a cardiac scan is not exactly in the same risk category. You feel confident that with the complaint mechanism and the inspection by CPSO, that's sufficient to assure people that their surgeries are going to be safe? And we're not talking cataracts anymore; we're talking arthroplasty.

Mr. Patrick Dicerni: To answer your question, yes. I would defer to some of the colleagues down the table, but what I would say is that the quality and assurance program and regime is procedure-dependent and the community quality standard that exists for, say, a cataract would differ demonstrably from what an orthopedic community quality standard is, given that we don't currently fund those orthopedic procedures through our—they're currently known as "independent health facilities." That is a quality standard that's not in place, given those services aren't delivered.

M^me^ France Gélinas: No, but it's about to change, and we haven't seen what those quality services would look like. It's certainly not in the legislation, and when we talk about regulations—well, God knows when that will show up.

Dr. Catherine Zahn: Before passing on to Matt Anderson, I would just remind everyone that the cataract initiative is now; the arthroplasty initiative is 18 months away—

Mr. Patrick Dicerni: Approximately, yes.

Dr. Catherine Zahn: Approximately 18 months, so we have time to explore and understand and to create the care pathways and standards of care before that goes live.

Matt?

Mr. Matthew Anderson: Thank you. I'm not sure I have a lot more to add. As you've heard, right now Ontario Health does not have a quality oversight role. I will perhaps add that I do appreciate the difference with the PHA 4(2), where the hospital is in fact working with the independent facility, because that then does create a quality management oversight path for Ontario Health.

And to your point, MPP Gélinas, it brings in the medical oversight in addition to the CPSO. The CPSO was always there, but this would bring that in. So that's the vehicle that we use now. That isn't used a lot. I'm looking forward to, as the regulations come forward, other areas, perhaps with Ontario Health having a larger role in that, and bringing some of the programs that you read about in the response, the SETP and so on—those could be extended. But of course we would need that responsibility before we could do that.

Mr. Patrick Dicerni: And if I could—the Public Hospitals Act, section 4(2), partnerships that Matt Anderson just referred to were something that the ministry looked at with great interest through the pandemic. Tying it back to an earlier question, what was some of the impetus behind a call for applications for additional cataract procedures? It was looking at the state of the pandemic, bearing in mind that was 2021, understanding how low-acuity procedures could be pushed outside of a hospital environment—I think, Matt, it's fair to say that's where we saw many of the 4(2) partnerships come into being.

Mr. Matthew Anderson: Yes.

Mr. Patrick Dicerni: So we've obviously taken some learnings from that as we are looking at what the new world, if you will, will look like.

The proposed legislation does contemplate new and expanded quality assurance programs for the integrated community health service centres. It's going to retain the assurances that are currently existing within the IHFA for inspections and compliance programs, but it's also working to better align, I would say, and duplicate the quality standards that are used in hospital that Matt Anderson just referenced, which are a function of the Public Hospitals Act, a function of the medical advisory committee within those hospitals. One tangible example would be the proposed legislation's requirement to institute a mandatory continuous improvement process or measures. That's something that wouldn't currently exist—I think it's commonplace in hospitals—so that is an example of something that would be enhanced within the new legislation and mirroring what is experienced in the public hospital system.

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M^me^ France Gélinas: And when do think you will make a decision to bring the oversight and accountability that exists in our hospitals into the new 18-months-down-the-road hip and knee surgery centre that will open for profit?

Mr. Patrick Dicerni: I'll answer the question in the following way: Depending on the pacing and the procedures that are contemplated through a call for applications for the integrated community health services centres, upon passage of the legislation and proclamation of the legislation, the revised quality and assurance standards would become those which IHF licence holders currently—assuming passage, integrated community health facilities—those obligations would immediately become upon them.

As we look at additional procedures outside of a hospital environment, there is the regulatory ability to bring a differing level of requirements, subject to the types of procedures that are going on in that facility. That is a regulatory scheme that is being developed and being worked on, but I can say that that legislation allows for that type of stipulation, depending on types of procedures.

To a point you raised earlier, a diagnostic imaging facility versus an orthopedic ambulatory surgical facility: Those are different degrees of detailed requirements, if I would describe it that way.

M^me^ France Gélinas: I like Mr. Anderson's answers better than yours, because he was committed to having this done and you're telling me that it could be done, but there's nothing that reassured us that it will be done. The law would allow for that to happen, but nothing has happened so far, except for the fact that in 18 months we will have for-profit hip and knee surgery being done, and we don't know what kind of oversight or accountability will be there.

Mr. Patrick Dicerni: As a public servant, I will be bringing forward our best advice to the government of the day with respect to what that regulatory framework looks like, but it wouldn't be for me to describe what is yet-to-be-brought-forward regulatory work.

M^me^ France Gélinas: Okay. Right now, the IHFs are funded by the province. There is a plan to have it switch over to Ontario Health. Is this a commitment or is this something that will happen?

Mr. Patrick Dicerni: The legislation does permit that transfer of responsibility. Ontario Health currently is the accountable or funding entity for PET scans within the province. As well, dialysis was moved over in the past. I wouldn't presuppose the decision-making of the minister or government, but the legislation does enable that transfer of funding and accountability from the ministry currently to Ontario Health in the future.

M^me^ France Gélinas: Okay. I want to use my time wisely, so: Recommendation 10 talks about unreasonable patient activities and billing, and identified inappropriate actions by physicians. She talks about, again, ophthalmologists doing an immense amount of cataract surgeries in one day, billing over $1.1 million just for cataract surgeries. This does not include everything else they bill for to bring to the surgeries.

Your response to this is, "The ministry continues to use extensive analytical tools to monitor billing and select claims for review, and to support correcting inappropriate billing behaviour, and the recovery of overpayments in a timely manner." How much money did you recover in the last—whatever period you want to give me? Let's say the last year.

Dr. Catherine Zahn: So, Madame Gélinas, I'll start by saying the comments by the Auditor General were referable to a small number of physicians—a very small number of physicians.

M^me^ France Gélinas: I agree. Most physicians are honest people.

Dr. Catherine Zahn: Yes, so there's that to be taken into consideration as we're reviewing this.

I wonder if this is something for—

Interjection.

Dr. Catherine Zahn: You don't own the billing.

M^me^ France Gélinas: There's someone at the back who is willing to stand up.

The Chair (Mr. Tom Rakocevic): We have four minutes. And you will have to take the oath or affirmation.

The Clerk of the Committee (Ms. Tanzima Khan): Good afternoon. Thank you. Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Julie Ingo: I affirm.

The Clerk of the Committee (Ms. Tanzima Khan): Thank you.

Ms. Julie Ingo: Thank you for the question. My name is Julie Ingo. I'm the director of the provider services branch within the ministry.

So, actually, in response to an audit that was undertaken in 2016 on physician services billing, as we've noted in the responses that you've probably had a look at, we made some legislative amendments in December 2019 that strengthened the ministry's authority over the recovery of inappropriate payments to OHIP-funded providers. In order to enable a bit of a transition period, we actually had an 18-month period of time following the passage of the legislation before we began to exercise that new legislative

authority in the recovery of, or investigations into and potential recovery of, any inappropriate billing. That took us to May 2021. We are now working through the cases that have been identified under that new legislative framework.

We, on average, would recover about $2 million a year from providers where it's been determined that there has been inappropriate billing. That number varies significantly depending on the nature of the cases, and I would add that our experience with the new legislative framework is still relatively new.

We have a limitation on how far back we can go in reviewing billings. In thinking about the timing on this, with legislative amendments in 2019, following an 18-month adjustment period for everybody to be able to implement those changes, there's a period of time where we're gathering data now to look at cases that we would bring forward for recovery.

M^me^ France Gélinas: When do you share your findings with CPSO?

Ms. Julie Ingo: When we identify areas of concern that are within the CPSO's domain, one of two things can potentially happen. When we're reviewing medical records as a part of an investigation, our medical advisers may identify something that might be a quality or a clinical practice concern. That we would refer certainly to the CPSO for further investigation. The other concern we sometimes identify is along the lines of just general professional misconduct. In cases where we think that the billing behaviour is particularly egregious, we might flag that for the CPSO to consider under the umbrella of professional misconduct.

M^me^ France Gélinas: Okay, but a straight "he charged too much for a procedure, should have used a different code"—none of this gets shared? There has to be misconduct or a quality, something that you see in the patient's record, before you connect with CPSO?

The Chair (Mr. Tom Rakocevic): One minute.

Ms. Julie Ingo: Those would be the primary reasons why we would connect with the CPSO on that. I'm maybe not sure where you're going with this.

M^me^ France Gélinas: I'm going with, okay, you've identified a physician who billed inappropriately, you got money back out from that physician because of the inappropriate billing. It had nothing to do with the patient; it had to do with the billing. When do you share this with CPSO?

Ms. Julie Ingo: It depends on the case. Not all cases of inappropriate billing would be shared with the CPSO. Sometimes, there are legitimate errors on the part of a physician. Something that involves deliberate intent would be something we would consider for referral to the Ontario Provincial Police for fraud investigation.

M^me^ France Gélinas: How many cases would you say you have referred to CPSO since the changes in May 2021?

Ms. Julie Ingo: I'd have to go take that question back and count.

M^me^ France Gélinas: Are we talking one or two, or hundreds?

Ms. Julie Ingo: Certainly not hundreds, but I would have to go back and check on that number.

M^me^ France Gélinas: Okay. I can tell you that none of them have received any sort of mention or anything through CPSO in their files. You can review all of the notes that CPSO puts about physicians and none of them have to do with inappropriate billing.

The Chair (Mr. Tom Rakocevic): We're at time.

Mr. Todd J. McCarthy: Chair, I believe that completes three rounds.

The Chair (Mr. Tom Rakocevic): The independent member has three minutes, and then at that point we will be doing a check-in regarding further rounds.

Mr. Todd J. McCarthy: Thank you. I'd like to address the Chair at that point, sir.

The Chair (Mr. Tom Rakocevic): Okay. MPP Collard.

M^me^ Lucille Collard: Actually, I don't have a question at this point.

The Chair (Mr. Tom Rakocevic): Okay, so this is the point to see if members will be seeking additional rounds. Will the opposition be seeking rounds? Government?

Mr. Todd J. McCarthy: Mr. Chair, I believe, with the initial presentations and then the three rounds of questioning, that we've received very informative and helpful information from Dr. Zahn, Dr. Simpson and CEO Anderson. On that basis, I move for an adjournment.

The Chair (Mr. Tom Rakocevic): The member has moved for adjournment. We are going to be seeking a vote. All those in favour? All those opposed? The vote carries.

We're adjourned.

The committee adjourned at 1631.

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