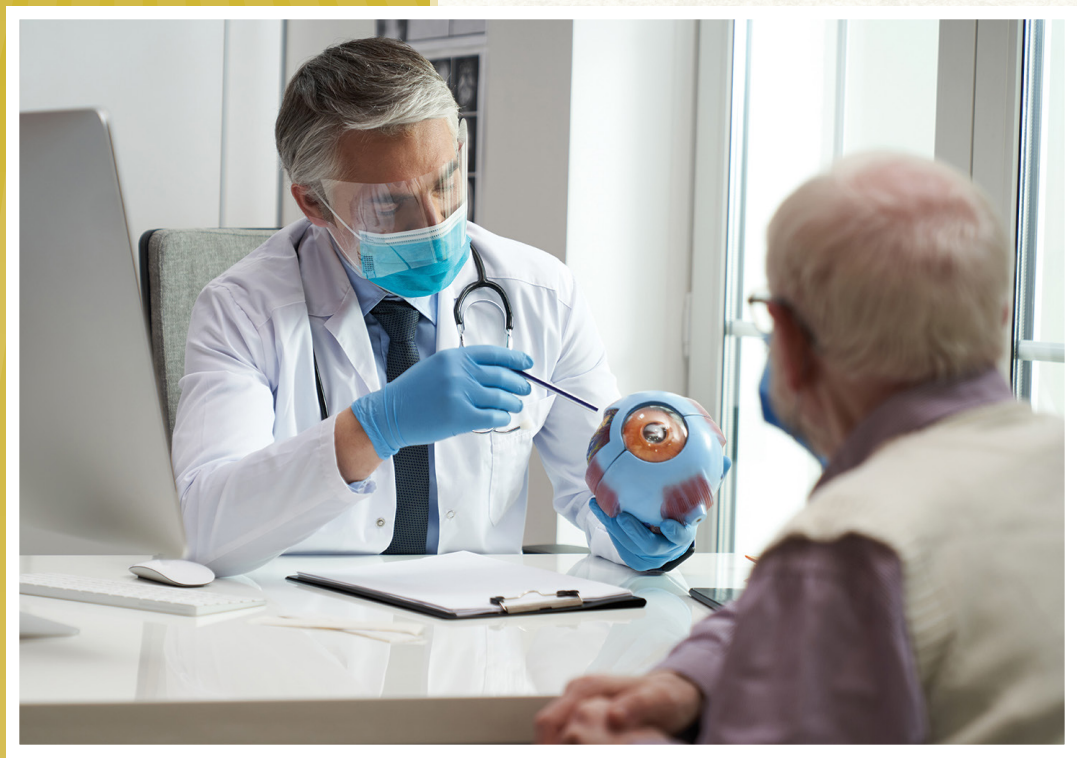
Office of the Auditor General of Ontario

Value-for-Money Audit:
Outpatient Surgeries



December 2021

Ministry of Health

Outpatient Surgeries

1.0 Summary

Outpatient surgery, sometimes referred to as "day surgery" or "ambulatory surgery," is typically a surgery in which a patient spends less than 24 hours in hospital before going home. There are various benefits associated with providing surgeries on an outpatient basis, when it is safe to do so. For example:

- The hospital bed can be used for other patients with urgent and emergent health needs.
- Since fewer hospital resources are required, outpatient surgeries are more cost-effective compared to inpatient surgeries.
- The risk is reduced of patients contracting viruses and infections associated with the hospital setting.
- Since outpatient surgery, when conducted safely and appropriately, can be less stressful than inpatient surgery and allows patients to get back to their normal routine sooner, many patients prefer to recover in their homes rather than in the hospital.

Types of surgeries are not defined as inpatient or outpatient. Many factors, such as patient health and supports available at home, are considered when determining whether a surgery can be safely and appropriately provided on an outpatient basis, or whether the patient must be admitted and remain in the hospital for a longer period of time for post-surgery monitoring and care. While some surgeries could be done on an outpatient basis, other surgeries cannot be done on an outpatient basis given the risk and complexity of the surgery and the need for longer patient monitoring, such as a kidney transplant surgery.

The Ministry of Health (Ministry) provides funding to public hospitals, one private hospital and 10 independent health facilities (IHFs) to provide outpatient surgeries. It also compensates physicians and surgeons performing the surgery through billings made to the Ontario Health Insurance Plan (OHIP). Because surgeries themselves are not defined as inpatient or outpatient, there is no separate funding mechanism for outpatient surgeries.

Public hospitals provide the majority of outpatient surgeries in Ontario. According to data from Ontario Health, in 2020/21, public hospitals provided approximately 330,000 outpatient surgeries, compared to approximately 440,000 to 455,000 outpatient surgeries in the four years prior to the impact of COVID-19, as seen in **Figure 2.** IHFs are able to provide outpatient surgeries only. The Ministry provided approximately $13 million in funding in 2020/21 to the 10 IHFs in Ontario (see **Appendix 1**) for providing about 16,400 outpatient surgeries. One private hospital (Don Mills Surgical Unit) also provides outpatient surgeries and received approximately $2.6 million in funding for providing approximately 1,800 outpatient surgeries in 2020/21.

Based on our review of Ontario's data on surgeries that are commonly performed on an outpatient basis—joint replacement (hip or knee) and cataract surgery—we noted that the percentages of patients treated within benchmark time frames (approximately six months for hip or knee replacement and three months for cataract surgery) have been steadily decreasing. All provinces have shown a similar trend in recent years, with about half of Canadians not receiving these surgeries within recommended time

frames in 2020, compared with around one-third in 2019. Ontario performed slightly above the Canada-wide average in both 2019 and 2020, other than for cataract surgery, where only 40% of Ontarians received cataract surgeries within the benchmark time frame in 2020, as compared to the 45% Canada-wide average.

While outpatient surgeries offer benefits to both patients and the health-care sector as a whole, Ontario's progress on providing timely and accessible outpatient surgeries has been slow due to enduring issues. We confirmed that there is no province-wide centralized intake or referral process (there are centralized processes in some regions or for some types of surgeries) and that some hospital operating rooms are underused. Recently, the Ministry started to address these long-standing issues as part of its work to address the surgical backlogs caused by COVID-19. However, the Ministry and Ontario Health have not done enough to identify effective and cost-efficient practices that can be disseminated across Ontario for delivering outpatient surgeries.

With respect to the provincial oversight on outpatient surgeries, we identified that there are surgeons with significantly high or unreasonable billings related to outpatient surgeries. Further, there has been no provincial oversight of surgery providers to protect patients from being misled about their right to receive the standard publicly funded surgery without having to pay any fees out of pocket. We also noted that providers of outpatient surgeries operate in silos, follow different reporting requirements, and are overseen by different parties. For example, the Ministry and Ontario Health only track wait times for surgeries performed at public hospitals and at one IHF that report into the Wait Time Information System but do not have any insight into wait times at the nine remaining IHFs and the private hospital that provide publicly funded outpatient surgeries. As a result of the COVID-19 pandemic, access to surgeries, including outpatient surgeries, is taking longer, resulting in deterioration and/or complications related to patient health issues and surgery backlogs.

The following are some of our significant findings.

Lengthy and Highly Variable Wait Times for Outpatient Surgery Persist

- **Substantial wait times have not been addressed and have worsened in 2020/21.** Between 2016/17 and 2019/20, though wait times for some surgeries have decreased, wait times for many others have increased. Most surgeries continued to have long wait times; for example, 100 days (for gallbladder surgery) and 259 days (for forefoot surgery) in 2019/20. Wait times increased even further in 2020/21 as a result of the COVID-19 pandemic and related issuance of a directive by the Chief Medical Officer of Health (CMOH). The directive, initially applicable from March 19 to May 26, 2020, required that all non-essential and elective surgeries be stopped or reduced to minimum levels to preserve hospital capacity to care for patients with COVID-19. So, by the end of 2020/21, wait times, for example, were 157 days (for gallbladder surgery) and 356 days (for forefoot surgery), representing increases of 57% and 37% respectively from the previous year.
- **Significant regional variations in wait times make for inequitable access to surgery.** We reviewed wait times across Ontario Health's five regions (West, Central, Toronto, East and North) and noted significant variations in wait times for outpatient surgeries. For example, our review of 2019/20 data noted that patients in the Toronto region who were waiting for forefoot surgery had to wait 354 days, over three times longer than patients in the North region (111 days). As well, patients needing total knee joint replacement surgery in the West region had to wait 322 days, more than three times longer than the 98 days patients in the Toronto region waiting for the same surgery.
- **There is a lack of public reporting of wait times by surgeons.** In Ontario, patients can access wait-time information published per hospital. However, surgeons working in the same hospital can have very different wait times. For example, we found that at one hospital, one ophthalmologist had an average wait time of

155 days while another had an average wait time of 42 days—almost four months less. However, this information is not available to the public, so patients are not able to consider it when deciding which surgeon to work with. In contrast, Alberta publicly reports wait times by surgeon and provides a comparison of surgeon wait times with the provincial average for patient reference. British Columbia also allows the public to go on its provincial surgery wait-times website and search by specific procedure (surgery) or by specialist.

Limited and Slow Progress on Implementing Practices to Improve Wait Times for Outpatient Surgeries

- **The lack of centralized intake or referral can contribute to longer wait times.** Currently there is no province-wide centralized intake or referral process for many surgeries. Co-ordination currently only exists on an ad hoc basis in some regions or for some types of surgery. The purpose would be to ensure patients have timely access to surgeries while continuing to allow for patient choice. For example, centralized intake or referral through Rapid Access Clinics allows orthopaedic patients to be connected with either a surgeon of their choice or the next available surgeon in the region. The lack of a centralized intake or referral process has been a long-standing issue that our Office has raised in past value-for-money audits covering other areas of the health-care system, such as MRI and CT scans as well as cancer care.
- **Hospital operating rooms remain underused.** Ontario Health tracks the use rate of fully equipped hospital operating rooms. Each hospital independently decides how many hours their operating rooms are used (given their funding and staff resources). The provincial best practice target rate of operating room use is 90%. In 2019/20, approximately 34% of hospitals did not meet the 90% target, meaning that some operating room capacity was left unused. While Ontario Health does not formally track reasons for underuse, we noted two possible reasons are inadequate planning for operating room use and insufficient resources (such as nurse staffing) to keep the operating rooms running for surgeries. We noted the issue of underuse of hospital operating rooms in past audits, such as our 2016 value-for-money audit of Large Community Hospital Operations.

Inconsistent Outpatient Surgery Use and Oversight in Ontario

- **Ontario hospitals employ outpatient surgeries in an inconsistent manner.** There are significant differences in the proportion of surgeries being performed on an outpatient basis across hospitals in Ontario. For example, on average, in 2019/20, though hospitals performed outpatient surgeries 95% of the time for a hernia surgery, one hospital was performing it on an outpatient basis only 72% of the time. In another example, gallbladder surgeries were, on average, performed on an outpatient basis in approximately 95% of cases, but one hospital was performing it in only 75% of cases. The Ministry and Ontario Health have not yet reviewed these variations to determine why they are occurring, and whether hospitals face barriers to performing more surgeries on an outpatient basis. However, in 2020/21 (a year impacted by COVID-19), some hospitals increased the proportion of outpatient surgeries performed. For example, one hospital was performing primary total knee replacement surgeries on an outpatient basis in 24% of cases in 2019/20 but they performed such surgery on an outpatient basis in 51% of cases in 2020/21.
- **There is inconsistent oversight and co-ordination of outpatient surgeries delivered by different providers.** Outpatient surgeries can be delivered by a variety of providers in Ontario, namely public hospitals, private hospitals, and independent health facilities (IHFs). However, we noted that there is no overall co-ordination among these delivery organizations. They operate in silos, follow different reporting requirements, and are overseen by different parties. For example,

Ontario Health has accountability agreements with public and private hospitals and IHFs are directly accountable to the Ministry. As well, the provincial Wait Time Information System only tracks wait times for surgeries performed at public hospitals and one IHF. This means that the Ministry and Ontario Health do not have any insight into wait times at the nine remaining IHFs and the one private hospital that provides publicly funded outpatient surgeries. The inconsistency in the way oversight of various service providers is conducted means that neither the Ministry nor Ontario Health has a full picture of outpatient surgeries across the province. A similar concern was also previously raised by Health Quality Ontario (now under Ontario Health) in 2015/16, when it issued a report that noted deficiencies in the way oversight was being conducted of non-hospital medical clinics, including IHFs. However, no significant changes in oversight have been made.

- **Best practices for delivering outpatient surgeries are not being reviewed or disseminated across Ontario.** Hospitals in Ontario are performing outpatient surgeries in a variety of locations. Some provide surgery at their main hospital site, some in areas designated as ambulatory hospitals, and some use surgical areas which are not within the main hospital sites but located in separate buildings. While hospitals make decisions based on their local region and available resources, the Ministry and Ontario Health have not yet conducted any evaluations to try to identify which practices and methods are most effective and cost-efficient and whether they could be adopted across Ontario. For example, we identified one hospital that conducted its own pilot project by purchasing and retrofitting a space in a building across the street from its main hospital. It found that operating room turnover time in the external space was less than nine minutes, as compared to an average of 23 minutes in their main hospital operating room.

Inadequate and Inconsistent Monitoring of Quality of Outpatient Surgeries Across Ontario

- **Quality of outpatient surgeries is not adequately and consistently monitored in Ontario.** Through our discussion with Ontario Health, we noted that the province does not have a centralized method to measure surgical quality and outcomes for all surgeries. For example, outcome data is collected directly from patients receiving primary, elective, unilateral hip and knee replacements (on an inpatient or outpatient basis), including functional status, health-related quality of life, satisfaction with surgery and general health. There are 39 hospitals currently reporting this data. Data collected up to June 30, 2021 indicated that for hip replacement surgery overall satisfaction was 90% at 12 months and for knee replacement surgery was 88% at 12 months. However, since the data only covers hip and knee replacements, there is an opportunity to collect similar data to evaluate the effectiveness and quality of other surgical areas. In addition, hospitals we spoke with also indicated that surgical quality and outcomes are not typically monitored separately for inpatient and outpatient surgeries. However, some hospitals did use different methods, such as using readmission and emergency department visits as well as performing patient satisfaction surveys to compare inpatient and outpatient surgeries, and found positive results. For example, one hospital noted that only 3% of patients were readmitted to hospital within 15 days following their outpatient surgery, and another hospital noted an 85% patient satisfaction rate with their outpatient surgery.

No Regular Review and Monitoring of Funding and Billings for Outpatient Surgeries

- **The Ministry does not adequately oversee and monitor unreasonable outpatient surgery volumes and billings.** Physicians that provide publicly funded outpatient surgeries bill the Ontario Health Insurance Plan

(OHIP). However, the Ministry does not sufficiently review unusual billing patterns or trends to identify possible issues, such as inappropriate billings or inappropriate rendering of services. For example, four ophthalmologists each billed the Ministry from $860,000 to almost $1.1 million in 2019/20. Each of them performed more than 2,000 cataract surgeries that year with a maximum number of cataract surgeries in a single day ranging from 34 to 47. Subsequent to our audit work, the Ministry completed a broad review that included these four ophthalmologists. However, we noted that the review only looked at assessment codes that were being billed on the same day as cataract surgery and resulted in education letters being sent to the ophthalmologists clarifying when this billing is eligible. The issue of unusual physician billings has been raised by our Office in our past value-for-money audits.

No Provincial Oversight to Protect Patients Against Inappropriate Charges

- **The Ministry has no oversight mechanism to prevent patients from being misinformed and being charged inappropriately for publicly funded surgeries.** While medically necessary outpatient surgeries are entirely covered through OHIP, for some surgeries, add-ons are commonly available to patients for an added fee. Cataract surgery is the specialty area with the highest risk of misleading sales practices. Specifically:
  - Our review of patient complaints submitted to the Patient Ombudsman and to the Ministry of Health found that patients often complained about being charged after receiving a publicly funded cataract surgery because they were misinformed of their right to receive standard surgery, free of charge through OHIP, without any add-ons. A 2015 article posted in the *Canadian Medical Association Journal* also highlighted this concern, saying: "Patients who misunderstand the optional nature of noninsured services may make substantial sacrifices to pay for cataract surgery."
  - To gain further insight into and to assess the extent of misleading sales practices, we engaged a professional research firm to carry out "mystery shopping." They collected information by making 80 phone calls to a total of 25 providers of outpatient surgeries, especially cataract surgery. We noted that it is very difficult for the average consumer to obtain complete pricing information. Almost all clinics that the mystery shoppers contacted said that no pricing lists could be shared without undergoing a consultation, but some did share price ranges with cataract surgeries using specialty lenses costing the patient anywhere from $450 to almost $5,000 per eye. Some clinics also indicated that specialty lenses are or may be mandatory depending on the surgeon's assessment, which is misleading since all patients have the right to receive publicly funded cataract surgery without paying extra costs for any add-ons. Furthermore, mystery shoppers were given inconsistent and conflicting information from the same clinics depending on when the call was made.

COVID-19's Impact on Outpatient Surgeries

- **Wait times for outpatient surgeries remained long during COVID-19, resulting in patient conditions deteriorating and/or patients suffering health complications**. The Chief Medical Officer of Health (CMOH) issued a directive twice during COVID-19 limiting non-essential and elective surgeries to ensure sufficient capacity to assist and treat COVID-19 patients. The directive was first put in place from March 19 to May 26, 2020, and then from April 20 to May 19, 2021. This resulted in many outpatient surgeries being further delayed or cancelled again. Though these surgeries have gradually resumed in Ontario, there continue to be long wait times. For example, in the first quarter of 2021/22 patients had to wait over 300 days for a hip or knee total joint replacement surgery and over 200 days for a cataract, forefoot, or

laparoscopic or vaginal hysterectomy surgery. Our observations mirror a recent paper published in *The Lancet* (a peer-reviewed medical journal) in February 2021, which noted that "delaying surgery in patients with the most severe disease can lead to more complicated surgeries, increased use of medications, more difficult recovery, and worse outcomes, including increased rates of revision surgery and reduced quality of life." In addition, since many patients were not seeking care during COVID-19, existing wait times for outpatient surgeries likely understate the needs of Ontarians. While the full impact of COVID-19 to outpatient surgeries has yet to be seen, it will likely increase the burden on Ontario's health-care system in the near future.

- **Available health-care system capacity is not being fully used to help clear surgery backlogs.** Though the Ministry has started taking steps to address the surgical backlog by announcing it will provide $216 million in one-time funding to extend operating room hours at public hospitals to increase the number of inpatient and outpatient surgeries being performed by up to 67,000 surgeries, there continues to be unused or underused capacity across different types of outpatient surgery providers. For example, cataract operations at Kensington Eye Institute (an independent health facility) in 2019 were at approximately 50% capacity due to funding limits. The co-ordination and additional use of available operating room capacity across service providers could help the Ministry address the surgical backlog and shorten the wait times for surgeries.

This report contains 13 recommendations, consisting of 31 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry, in conjunction with Ontario Health, does not have fully effective oversight procedures and systems in place to monitor and confirm the quality of specifically outpatient surgeries. Some aspects of surgical quality and outcomes are being monitored and reported for inpatient and outpatient surgeries combined, and the results show positive performance such as low hospital readmission rates and high patient satisfaction rates. The Ministry does not have a centralized way to measure and report on surgical quality and outcomes for all surgeries being performed in Ontario. As well, hospitals we spoke with confirmed that surgical quality and outcomes are not typically monitored separately for inpatient and outpatient surgeries.

Further, we found that outpatient surgeries are not provided and performed in a cost-effective and timely manner. Patients continue to experience increasing wait times, with wait times worsening due to COVID-19, with some patients waiting over 300 days for an outpatient surgery. Wait times vary considerably depending on the region in which patients live, making for varying access times to outpatient surgeries across the province.

While there are various effective practices for offering outpatient surgeries in Ontario, the Ministry and Ontario Health have been slow to review and implement potential best practices that could improve outpatient surgery access and shorten wait times. Among hospitals, there is an inconsistent approach to the use of outpatient surgeries as a treatment method, with some hospitals using it less often than others. However, the Ministry and Ontario Health have not yet reviewed these inconsistencies to identify and understand the causes and impacts of this.

There also continues to be a lack of adequate oversight and monitoring of unreasonable outpatient surgery volumes and billings to verify that physicians and surgeons are providing quality care in accordance with billing policies. As well, the Ministry has no oversight of what additional fees physicians charge patients, making it impossible to prevent patients from being charged for publicly funded surgeries. We found that some patients could be given misleading information as part of sales practices to make a profit.

Several of our findings, such as the underuse of hospital operating rooms, and the lack of Ministry oversight of billings, have been noted in our past value-for-money audits, including Large Community Hospital Operations (2016), Physician Billing (2016), Cancer Treatment Services (2017), and Virtual Care: Use of Communication Technologies for Patient Care (2020).

OVERALL MINISTRY OF HEALTH RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendations made by the Auditor General and thanks her for conducting this timely audit. The Ministry is committed to the development of innovative solutions that address wait times for both inpatient and outpatient surgeries to ameliorate the impact of the COVID-19 pandemic.

As noted by the Auditor General, the Ministry funds inpatient and outpatient surgeries in public hospitals and also supports some low-risk clinically appropriate outpatient surgeries in community-based settings. Independent health facilities and the private hospital that performs outpatient surgeries represent approximately 3% of the annual surgical output in the province.

The Ministry has made significant investments in various aspects of the surgical system in both 2020/21 and 2021/22 to increase surgical output, address the wait-time challenges, and improve health outcomes for Ontarians. In 2020/21, $283.7 million was allocated to support surgical and diagnostic imaging recovery, which supported hospitals to conduct over 450,000 scheduled surgeries in fully equipped operating rooms as the province dealt with pandemic waves. In 2021/22, the Ministry is investing an additional $324 million to enable Ontario's hospitals and the community health sector to perform more surgeries, MRI and CT scans, and procedures. These investments seek not just to increase surgical output but also to improve the overall efficiency and quality in the way surgeries are delivered in Ontario.

The audit identifies many important areas of consideration and suggestions for improvement in surgery delivery and oversight, and the Ministry is pleased to note the Auditor's recommendations align well with existing work under way or planned by the Ministry and Ontario Health. The Ministry appreciates the Auditor's insights and will continue to work closely with Ontario Health to ensure that Ontarians have access to equitable, quality care, focusing investments and improvement activities in areas where they will have most impact.

OVERALL RESPONSE FROM ONTARIO HEALTH

Ontario Health appreciates the Auditor General's comprehensive audit of outpatient surgery in Ontario. We welcome opportunities to work together with our partners, including the Ministry of Health, clinical and system stakeholders, patients and families, to improve these services in Ontario. The report also provides occasion to further improve the oversight, integration and co-ordination of care for patients receiving outpatient procedures. The integration of Health Regions into Ontario Health has helped to consolidate oversight of services into one organization. However, since the start of the pandemic, Health Regions, facilities and all partners have been co-ordinating in an unprecedented way. This new harmonized approach to services has opened up new opportunities to implement models of care that previously had difficulty gaining traction (for example, centralized intake and wait-list management and more robust partnerships to move procedures out of hospital, where appropriate). The recommendations within this report build upon the work that has been done to date by Ontario Health, the Ministry of Health and many other partners. The report also identifies further opportunities to drive improvements in several areas, many of which echo the goals and objectives

of Ontario Health's strategic plans. Ontario Health welcomes the recommendations from the Auditor General and knows that with the continued and ongoing support from the Ministry of Health and its stakeholders these recommendations can be achieved for a better quality and integrated health-care system for surgical patients.

2.0 Background

2.1 Overview of Outpatient Surgeries

2.1.1 What Is Outpatient Surgery?

Outpatient surgery, sometimes also called "day surgery" or "ambulatory surgery", is typically defined as surgery for which a patient is in a hospital or clinic for less than 24 hours.

Outpatient surgery for the purpose of this audit and agreed upon with the Ministry of Health (Ministry) and Ontario Health is defined as:

- surgery that is funded by the Ministry. As such, outpatient surgeries exclude any surgeries that are not publicly funded (such as private-pay plastic surgeries for aesthetic purposes);
- surgery that treats a known health issue. As such, outpatient surgeries in our audit do not include diagnostic procedures (such as colonoscopies), which are often done in clinics to determine if a health issue exists; and
- surgery that is scheduled, meaning it does not need to be performed on an emergency basis.

Surgeries are not defined as inpatient or outpatient. Whether a surgery is done on an inpatient or outpatient basis depends on patient factors such as health condition and supports available at home as well as surgery factors such as the seriousness of the surgery. That is, even a surgery that is typically done on an outpatient basis could be done on an inpatient basis, which is typically surgery with a hospital stay of more than 24 hours, if a patient has co-morbidities or other health factors that put them at a higher risk of issues following surgery. In these cases, hospitals and/or surgeons may recommend patients remain in the hospital for an extended period of time for post-surgery monitoring.

Due to Ontario's geography, not all regions of the province have the local resources to provide surgeries or post-surgery care. Patients living in rural or remote communities often have to travel (drive or fly) long distances to get to the closest hospital that offers the surgery they require. As a result, these patients may have to receive surgery as an inpatient because it is not safe for them to travel home the same day as their surgery.

Figure 1 describes common examples of outpatient surgeries in Ontario and shows the number of surgeries performed in 2019/20 (prior to the impact of COVID-19) and 2020/21. **Figure 2** shows the total number of outpatient surgeries performed over the last five years according to data from the Ministry and Ontario Health's Wait Time Information System.

2.1.2 How Does a Patient Access Outpatient Surgery?

When a patient is experiencing pain or symptoms that may indicate the need for a surgery, the patient's regular health-care provider (typically a family doctor) will make a referral to a surgeon (specialist) for further assessment. After receiving the referral, the patient has to wait for the surgeon's next available consultation appointment.

After the initial consultation with the surgeon, patients typically undergo further assessments as required, such as a physical assessment, blood test, and/or x-rays. If the surgeon decides that outpatient surgery is a safe and appropriate option for the patient, the surgeon and patient decide on whether to proceed with surgery. If the decision to move forward with surgery is made, the patient is scheduled for the next available appointment for that surgery. As discussed in **Section 4.1.1**, it is at this point that the patient's wait time for a surgery begins.

After undergoing surgery and being cleared by the surgeon to be discharged, the patient is sent home. Patients are typically scheduled for a follow-up

Figure 1: Examples of Outpatient Surgeries

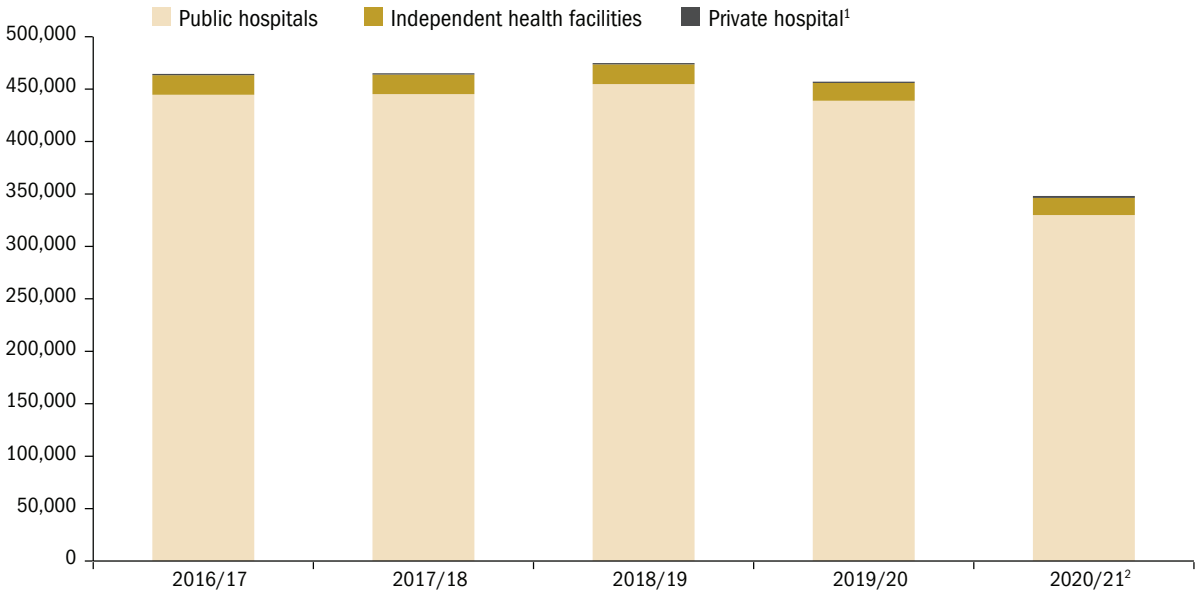
Prepared by the Office of the Auditor General of Ontario

Surgery[1]	Description	Number of Outpatient Surgeries[2] 2019/20	Number of Outpatient Surgeries[2] 2020/21
Cataract	A surgery to remove the natural lens of the eye that has developed a cloudy area (cataract). The lens is generally replaced with an artificial lens.	136,643	104,967
Other Benign Uterine	A common type of surgery would be a procedure to remove uterine fibroids (non-cancerous growths of smooth muscle that develop within and around the uterus) or polyps (non-cancerous focal growths).	20,118	14,217
Knee Arthroscopy	A surgery where two small incisions are made in the knee to repair or remove damaged tissue.	17,385	11,499
Gallbladder	A surgery to remove the gallbladder (a pear-shaped organ that is just below the liver on the upper right side of the abdomen). The most common reason for removing a gallbladder is to treat gallstones and the complications they cause.	17,249	13,800
Hernia Repair (Groin)	A surgery to fix a hernia. A hernia is when part of an internal organ or body part protrudes into an area where it should not be. Hernias most commonly occur in the abdominal area.	14,396	11,772
Shoulder	A common surgery involving the repair of torn tendons in the rotator cuff.	12,358	9,666
Breast (Oncology)	A common type of breast cancer surgery is a lumpectomy, which is the surgical removal of a cancerous tumor.	11,087	9,313
Anorectal	A surgery for conditions affecting the anus and rectum. Conditions which may require surgery include fistulas, warts and hemorrhoids.	6,115	4,494
Forefoot	A common type of foot surgery involves removal of bunions, which are bony lumps that develop on the side of the foot and at the base of the big toe.	5,035	3,724
Sinus Surgery	A surgery that is required for patients with conditions involving the sinuses and nasal cavity. These conditions can arise from trauma, allergies or infections. Sinus surgery can also be required for tumours. Sinus surgery can often be done together with neurosurgery for access to the brain for tumours, infections and brain fluid leak repairs.	3,648	2,474
Benign Ovarian	A common type of benign ovarian surgery would be the removal of an ovarian cyst, which can be a fluid-filled sac or a solid growth that develops on an ovary.	3,559	2,839
Benign Breast	A common type of benign breast surgery is a lumpectomy, which is the surgical removal of a non-cancerous tumor.	3,153	2,546
Prostate (Partial Excision)	A variety of surgical procedures that involve cutting away or vaporizing a section of the prostate (a gland found in the male pelvis area that is part of the urinary tract), which may be causing urinary symptoms or the inability to urinate.	2,935	2,606
Knee (Total Joint Replacement)	A knee replacement is a surgical procedure to replace the weight-bearing surfaces of the knee joint to relieve pain and disability.	2,713	3,025
Hysterectomy (Laparoscopic or Vaginal)	A surgery to remove all or part of the uterus. Common reasons for a hysterectomy that is non-cancer-related include irregular bleeding, uterine fibroids and endometriosis.	2,330	2,504
Hip (Total Joint Replacement)	A surgical procedure to remove the arthritic bone of the hip joint and replace it with synthetic material to relieve pain and stiffness.	2,052	2,901

1. As tracked and reported by Ontario Health through the Wait Time Information System (see **Section 4.1.1**).
2. May include multiple types of surgeries within the surgery area.

Figure 2: Total Number of Outpatient Surgeries Performed, 2016/17–2020/21

Sources of data: Ministry of Health and Ontario Health



Note: The total number of outpatient surgeries performed is based on data reported to the Ministry of Health or to Ontario Health through the Wait Time Information System.

1. Only one private hospital (Don Mills Surgical Unit) in Ontario offers outpatient surgeries.
2. Total number of outpatient surgeries dropped significantly due to the COVID-19 pandemic when all non-essential and elective surgeries were stopped or reduced to minimum levels to preserve hospital capacity to care for patients with COVID-19.

appointment with their surgeon, or in some cases with their regular health-care provider, to ensure the patient's health concern has been addressed.

Figure 3 shows an example of the typical steps in the outpatient surgery journey.

2.1.3 Why Are Outpatient Surgeries Becoming More Common and Why Are They Important?

As discussed in **Section 2.1.1**, while not every surgery can be performed on an outpatient basis, research and studies indicate that outpatient surgeries provide additional benefits when conducted safely and appropriately. For example:

- There are possible financial savings to the health-care system if surgeries are performed on an outpatient basis. A key saving measurement relates to the cost of an inpatient stay, which varies based on the patient's health and required length of stay but according to the Canadian Institute for Health Information, is approximately $5,600 for a seven-night stay.
- By moving surgeries to an outpatient basis, hospitals are able to free up hospital beds, allowing them to maintain capacity to care for patients with health issues that must be addressed on an urgent or emergency basis.
- There is a reduced risk of patients contracting viruses and infections commonly obtained from being in a hospital setting over a long period of time, for example, c. difficile, which can lead to health complications and result in longer recovery time.
- Many patients prefer to recover in the comfort of their homes rather than in the hospital.

Many surgical areas are treating more patients on an outpatient basis because clinical research and studies have found that the quality of patient care is generally consistent with inpatient care, as described further in **Section 4.4.**

Figure 3: Typical Patient Journey of Someone Receiving Surgery as an Outpatient

Prepared by the Office of the Auditor General of Ontario

Patient sees a health-care provider	• Patient sees a health-care provider, often a family doctor, to discuss their health issues.
Patient is referred to a specialist	• Patient is connected with a specialist, who is often also the surgeon that does the surgery and/or provides ongoing care.
Patient undergoes assessments and testing as needed	• This confirms the need for a surgery and collects other important health information to help determine whether surgery can be done on an outpatient basis.
Patient is scheduled for a surgery	• Surgery is scheduled at an organization/facility at which the surgeon has operating room access. • The organization/facility can be a public hospital, private hospital or independent health facility.
Patient undergoes surgery and post-surgery observation on surgery day	• On day of surgery, patient is prepared for surgery on-site and then their surgeon performs the surgery. • Patient is kept for observation and recovery before being discharged to return home. • If patient requires further observation, they may need to be admitted as an inpatient.
Patient receives follow-up care	• Patient works with surgeon, their regular health-care provider, and/or community care organizations for follow-up care as needed.

2.1.4 Where Can Publicly Funded Outpatient Surgery Be Performed?

In Ontario, publicly funded outpatient surgeries are provided in three settings: 104 public hospitals, 10 independent health facilities (IHFs), and one private hospital. Most surgeons delivering surgery in these settings have their own private clinic that they either work for or own to offer assessment, consultation and patient care.

As seen in **Figure 2**, the majority of outpatient surgeries are provided in public hospitals. Public hospitals provided approximately 330,000 outpatient surgeries in 2020/21, while the IHFs provided almost 16,400 and the one private hospital provided approximately 1,800 outpatient surgeries. Public hospitals also typically provide surgeries to patients with more significant health issues or co-morbidities than independent health facilities and private hospitals, which do not have the clinical or capital resources and facilities necessary to care for such patients.

Figure 4 provides a description of the types of organizations offering outpatient surgeries.

Figure 4: Types of Organizations Offering Outpatient Surgeries in Ontario

Prepared by the Office of the Auditor General of Ontario

Type of Organization	Description
Public Hospital	• The majority of outpatient surgeries are performed at a publicly funded hospital. Any hospital with an operating room could be providing outpatient surgeries. • Of over 104 public hospitals in Ontario, 90 (87%) of them have a fully equipped operating room and report their surgery volumes into Ontario Health's Wait Time Information System (see **Section 4.1.1**). However, other hospitals (typically small or rural hospitals) may also offer some outpatient surgeries without reporting into the Wait Time Information System.
Independent Health Facility	• Independent health facilities (IHFs) are independently owned and operated facilities that have licences to receive payment of facility fees in support of the delivery of licensed publicly funded health-care services. There are approximately 900 IHFs in the province, with about 95% providing diagnostic services such as x-rays and ultrasounds. • There are 10 independent health facilities (out of the approximately 900 IHFs in Ontario) that are licensed by the Ministry of Health under the *Independent Health Facilities Act* and receive payment of facility fees to support the delivery of publicly funded outpatient surgeries. **Appendix 1** provides more details about these 10 IHFs. ◦ Seven of these IHFs offer plastic surgery, two offer ophthalmology surgeries, and one offers gynecology surgeries.
Private Hospital	• There are four private hospitals licensed in Ontario under the *Private Hospitals Act,* R.S.O. 1990, one of which provides publicly funded outpatient surgeries: ◦ **Don Mills Surgical Unit**, a part of Clearpoint Health Network, offers multiple publicly funded outpatient surgeries, including cataract and orthopaedic surgeries. Don Mills Surgical Unit received approximately $2.6 million in funding from the Ministry of Health in 2020/21. • The other three licensed private hospitals do not provide publicly funded outpatient surgeries. • The legislation prohibits the creation of new private hospitals in Ontario except under the authority of a licence issued before October 29, 1973.

2.2 Management and Oversight of Outpatient Surgeries in Ontario

2.2.1 Roles and Responsibilities of Key Parties Involved

The Ministry of Health (Ministry) and Ontario Health are key parties involved in managing and overseeing the delivery of outpatient surgeries, in addition to the 104 public hospitals, 10 independent health facilities, and the one private hospital that offer outpatient surgeries, as noted in **Section 2.1.4.**

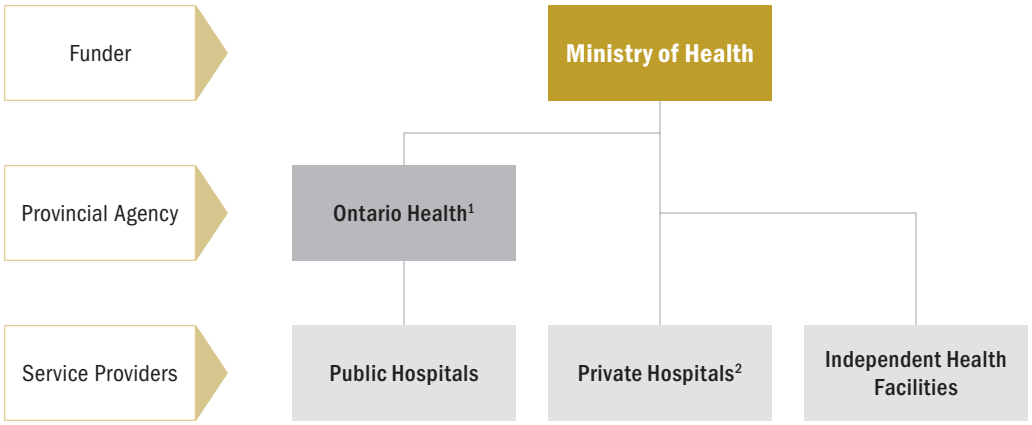
The Ministry is responsible for determining provincial initiatives and priorities related to surgeries. The Ministry also provides funding to service providers offering publicly funded outpatient surgeries as well as compensating surgeons and physicians through Ontario Health Insurance Plan (OHIP) billings, as discussed in **Section 2.2.2.**

Ontario Health, created in 2019 as a result of the integration of multiple provincial agencies, is responsible for co-ordinating the health-care system to provide Ontarians with the best possible care. The Ministry and Ontario Health work together to allocate funding to public hospitals and collect data from public hospitals that are performing outpatient surgeries.

Figure 5 shows the key parties involved in the delivery of outpatient surgeries in Ontario.

Figure 5: Key Parties Involved in the Delivery of Outpatient Surgeries in Ontario

Prepared by the Office of the Auditor General of Ontario



1. As a result of *The People's Health Care Act, 2019*, which enacted the *Connecting Care Act, 2019*, a number of provincial agencies involved in the delivery and reporting of outpatient surgeries (e.g., Cancer Care Ontario, Health Quality Ontario, and Local Health Integration Networks) were integrated into a single agency called Ontario Health.
2. Private hospitals have accountability agreements with Ontario Health (as a result of the accountability agreements they had with Local Health Integration Networks) but the Ministry of Health remains responsible for key oversight of licences and funding.

2.2.2 Funding and Expenditures for Outpatient Surgeries

Surgeons, regardless of the type of surgery they perform, submit claims for payment to the Ontario Health Insurance Plan (OHIP) for any insured surgeries they provide.

For all other costs associated with providing a publicly funded surgery, such as clinical staffing costs, supplies, and overhead, the Ministry provides funding based on the type of service provider and the type of surgery being performed. The Ministry provides funding to public hospitals, the one private hospital, and 10 independent health facilities (IHFs) to offer publicly funded surgeries, and also compensates physicians and surgeons performing the surgery through billings made to the Ontario Health Insurance Plan (OHIP).

Public Hospitals

Surgeries performed in a public hospital can be funded in three ways, depending on the specific surgery. **Figure 6** describes the three ways outpatient surgeries can be funded at a public hospital. However, there is no specific tracking of how much total funding is used for outpatient surgeries versus inpatient surgeries because in most cases the applicable funding method applies regardless of whether the surgery is performed on an inpatient or outpatient basis, since that decision is based on clinical facts.

Independent Health Facilities

The 10 independent health facilities (IHFs) receive funding to perform a volume of surgeries. The Ministry does not always specify the number of each type of surgery that an IHF provides under its scope of licence, other than ophthalmology surgeries. Instead, the Ministry provides overall funding in respect of overhead costs—referred to as facility fees—and specifies overall volumes of surgeries to be performed, and the IHF decides which specific surgeries to offer based on its scope of licence and patient needs. Most IHFs provide surgeries that are less complex and less costly to provide, such as cataract surgery and plastic surgery related to cancers. All publicly funded surgeries completed in IHFs in Ontario are performed on an outpatient basis.

Figure 7 shows Ministry funding to the 10 IHFs that offer outpatient surgeries. **Appendix 1** provides a listing of these 10 IHFs. While the funding has not significantly changed over the past five years—on

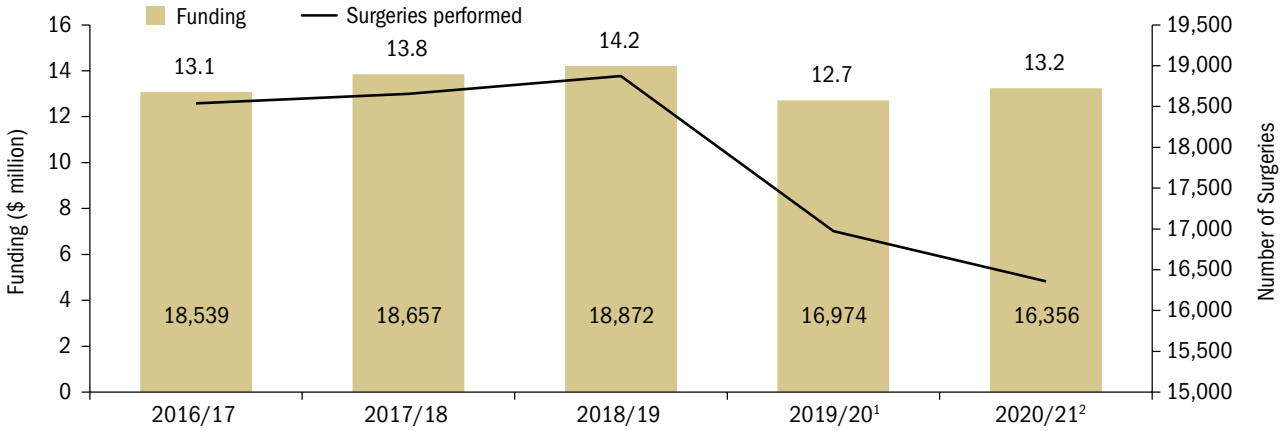
Figure 6: Three Ways Outpatient Surgeries are Funded at Public Hospitals in Ontario

Prepared by the Office of the Auditor General of Ontario

Funding Method	Description	Surgery Examples
1. Volume-Based Funding – Quality-Based Procedure (QBP)	• Surgeries for which the Ministry and clinicians have identified and documented the best way of providing care are funded at a fixed amount per surgery case. • Each hospital is allocated a specific volume of surgeries to be performed and receives funding based on that volume. • The funding may vary slightly, depending on the complexity of the needs of the patient population at that specific hospital.	• Cataract • Shoulder • Knee • Hip
2. Volume-Based Funding – Non-QBP	• Similar to QBP funding, some surgeries are funded at a fixed amount per surgery but do not have specifically identified and documented methods of providing care. • Each hospital is allocated a specific volume of surgeries to be performed and receives funding based on that volume.	• Cholecystectomy (gallbladder removal)
3. Global Funding	• Any surgeries that are not funded through one of the above two methods can be funded through the hospital's global funding, which is funding provided to each hospital without specific direction regarding the healthcare services that are to be paid for out of those funds. • Global funding provides the hospital discretion, allowing them to determine how best to spend the funds to serve the needs of their patient population.	• Urology

Figure 7: Ministry Funding and Number of Surgeries at 10 Independent Health Facilities, 2016/17–2020/21

Source of data: Ministry of Health



1. There was a funding and surgical volume decrease in 2019/20 relating to the ending of a one-time funding initiative in the prior year, as well as a halt of surgeries due to COVID-19 in March 2020.
2. Includes one-time funding of approximately $700,000 as a funding premium to provide surgeries and to address the surgical backlog due to COVID-19. As a result of differing fiscal year ends of each Independent Health Facility, the 2020/21 funding is an approximation based on the most current information available.

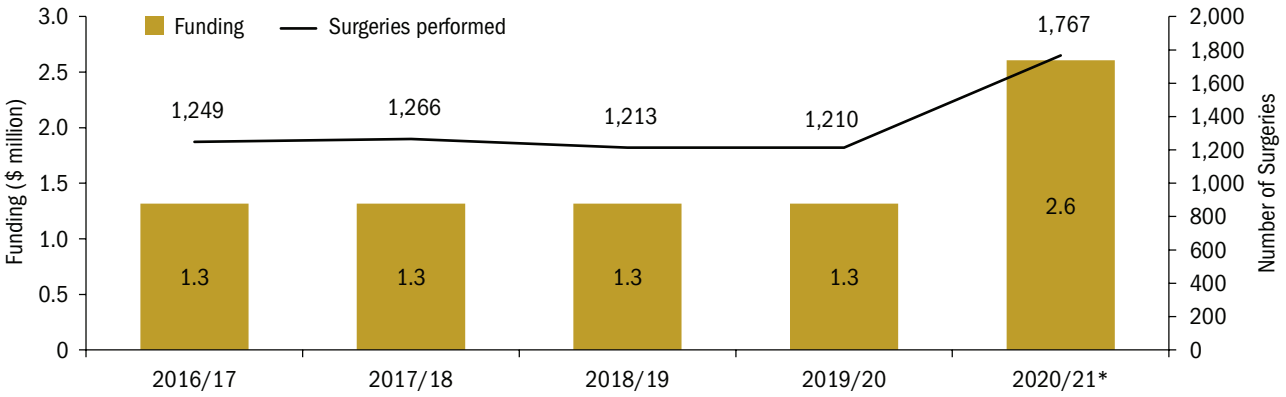
average about $14 million per year—the Ministry provided additional one-time funding of approximately $700,000 to some IHFs in 2020/21 to help address the COVID-19 surgical backlog.

Private Hospitals

Like IHFs, two private hospitals receive overall funding to perform a volume of surgeries. However, private hospitals may provide surgeries that are costlier and/or are more complex to deliver and are not provided by IHFs, such as orthopaedic surgeries. Only

Figure 8: Ministry Funding and Number of Outpatient Surgeries at Private Hospital, 2016/17–2020/21

Source of data: Ministry of Health



* Amount shown for 2020/21 includes a one-time additional payment of approximately $1.3 million to Don Mills Surgical Unit, a private hospital, to help address the COVID-19 surgical backlog by providing additional outpatient surgeries using available capacity.

one of these two private hospitals (Don Mills Surgical Unit) in Ontario provides publicly funded outpatient surgeries.

Figure 8 shows the Ministry funding to the private hospital that offers publicly funded outpatient surgeries. While the funding has remained unchanged from 2016/17 through 2019/20 (about $1.3 million per year), the Ministry provided additional one-time funding of about $1.3 million to the one private hospital, Don Mills Surgical Unit, that provides outpatient surgeries in 2020/21 to help address the COVID-19 surgical backlog.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry), in conjunction with Ontario Health, has effective oversight procedures and systems in place to ensure that:

- the quality of outpatient surgeries is monitored to achieve patient safety in accordance with applicable legislation, policies, standards and guidelines; and
- the results and effectiveness of outpatient surgeries are measured and publicly reported, and corrective action is taken when necessary.

In addition, our audit assessed whether select service providers (public hospitals, private hospital, and independent health facilities or IHFs) of outpatient surgeries, in conjunction with the Ministry and Ontario Health, have effective procedures and systems in place to ensure that:

- outpatient surgeries are provided and performed in an equitable, cost-effective and timely manner to meet Ontarians' needs; and
- resources for outpatient surgeries are used and managed with due regard for economy and efficiency.

In planning for our work, we identified the audit criteria (see **Appendix 2**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry and Ontario Health agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2020 and June 2021. We obtained written representation from Ministry and Ontario Health management that, effective November 19, 2021, it had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

We conducted our work at the Ministry where we:

- interviewed senior management and staff responsible for managing and overseeing the delivery of outpatient surgeries in Ontario;
- reviewed applicable policies, guidelines, legislation, reports and briefing notes related to outpatient surgeries services in Ontario;
- reviewed strategic plans and related performance measure targets and results;
- reviewed funding structures and methodologies;
- obtained and reviewed data being collected, including surgery volumes; and
- obtained and analyzed data related to physician billing for outpatient surgeries.

We also conducted work at Ontario Health where we:

- interviewed senior management and staff responsible for managing and overseeing the funding and delivery of outpatient surgeries in Ontario; and
- obtained and reviewed various data being collected, including surgery volumes and wait-times and operating room usage statistics.

We met with and reviewed information from 15 organizations that provide outpatient surgeries, including public hospitals, private hospitals, and independent health facilities, to understand the delivery of outpatient surgeries in Ontario and identify best practices as well as areas for improvement. **Appendix 3** lists the organizations we contacted.

We engaged a third-party organization to conduct "mystery shopping" to gather information related to the selling practices by private providers on outpatient surgeries.

We also met with the College of Physicians and Surgeons of Ontario to discuss its role as an oversight organization responsible for overseeing the services provided by licensed physicians and surgeons, and its role in conducting assessments of IHFs on behalf of the Ministry of Health.

As well, we contacted stakeholders including the Ontario Health Coalition to discuss the strengths, weaknesses and barriers of the current process of delivering outpatient surgeries in Ontario.

Further, we reviewed relevant research and studies in Ontario and other jurisdictions to identify risk areas, best practices and opportunities in the delivery of outpatient surgeries.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standard on Quality Control and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 Continuously Long Wait Times to Access Outpatient Surgeries

Patients often have to schedule a surgery in advance and then wait weeks, months, or sometimes years before receiving the surgery. Through our discussion with physicians and surgeons, we noted that significantly long wait times can lead to a decline in patient health or complications regarding the patient's health issue, meaning surgery could turn into a more complex—or emergency—surgery if not performed on a timely basis. While some patients may voluntarily choose to wait longer because they want to select a specific surgeon, many other patients

endure significantly long wait times to receive their outpatient surgery.

4.1.1 Increasing Wait Times Have Not Been Addressed and Have Gotten Even Worse in 2020/21

Long wait times for surgeries have been a long-standing issue in Ontario. Though Ontario has been performing slightly above the Canada-wide average, wait times for surgeries in Ontario have been increasing and are still not meeting Canadian benchmark targets.

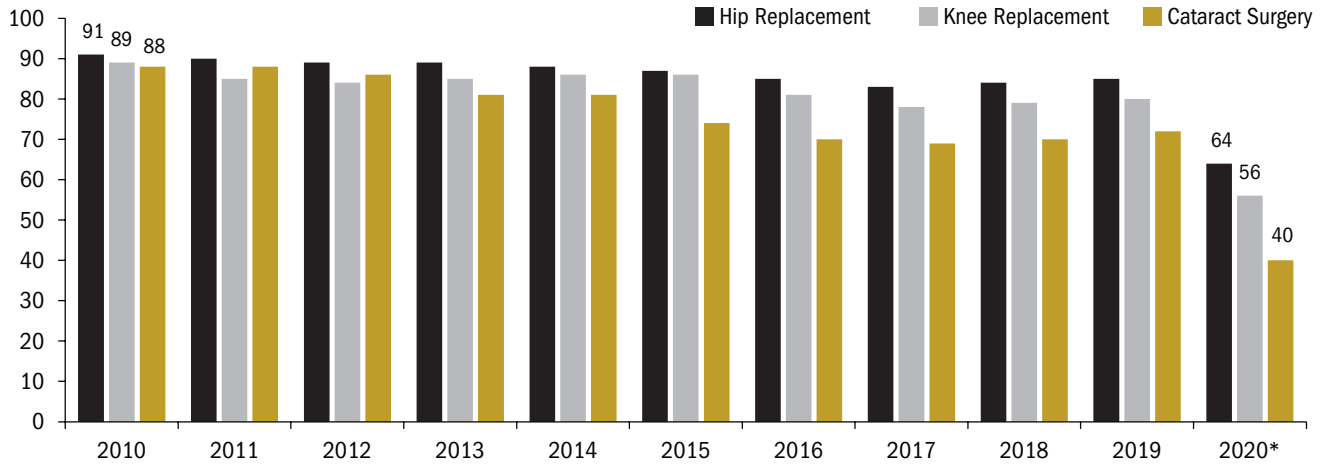
We reviewed Ontario's data from the Canadian Institute for Health Information (CIHI) on three types of surgery that are commonly performed on an outpatient basis: joint replacement (hip or knee) and cataract surgery (as shown in **Figure 1**). We noted that the percentages of patients treated within benchmark time frames (approximately six months for hip or knee replacement and three months for cataract surgery) have been steadily decreasing since 2010 (see **Figure 9**). For example:

- Approximately 88% of cataract surgeries, which are almost always performed on an outpatient basis, met wait-time benchmarks in 2010 but only 72% met the benchmarks in 2019.
- Likewise, approximately 89% of Ontarians received their knee replacement within the benchmark wait time in 2010 but only 80% did in 2019.
- In 2020, cancelled and delayed procedures during the COVID-19 pandemic led to even longer wait times for joint replacements (hip or knee) and cataract surgeries. Around 50% of Ontarians on wait lists did not receive these treatments within recommended time frames, compared with around 20% in 2019.

We also reviewed and compared CIHI data on joint replacements (hip or knee) and cataract surgery across Canada in 2019 (pre-COVID) and 2020 (during COVID) and noted that overall, all provinces showed a similar trend, with about half of Canadians not receiving these surgeries within recommended time frames in 2020, compared with around one-third in 2019. As seen in **Figure 10**, Ontario performed slightly above

Figure 9: Percentage of Patients Treated within Benchmark Time Frames for Joint (Hip or Knee) Replacement and Cataract Surgery in Ontario, 2010–2020

Source of data: Canadian Institute for Health Information



Note: Benchmark time frame for joint (hip or knee) replacement for priority four patients is 182 days. Benchmark time frame for cataract surgery for priority three patients is 112 days.

* Percentage of patients treated within benchmark time frames has dropped since March 2020 due to COVID-19.

Figure 10: Percentage of Patients Treated within Benchmark Time Frames for Joint (Hip or Knee) Replacement and Cataract Surgery in Canada by Province, 2019 and 2020

Source of data: Canadian Institute for Health Information

	% of Patients Treated within Benchmark Time Frames					
	Hip Replacement[1]		Knee Replacement[2]		Cataract Surgery[3]	
Province	2019	2020	2019	2020	2019	2020
AB	64	49	62	39	44	34
BC	76	58	66	50	69	53
MB	55	47	46	37	33	21
NB	48	29	44	25	66	53
NL	76	45	72	21	63	33
NS	59	47	47	31	60	32
ON	85	64	80	56	72	40
PE	66	56	28	32	28	16
QC	76	56	72	43	82	54
SK	47	40	39	28	61	40
Canada	**75**	**56**	**70**	**47**	**71**	**45**

Shaded boxes indicate the province had a higher percentage of patients treated within benchmark time frames than the Canada-wide average.

Note: Canada-wide benchmark time frames for joint (hip or knee) replacement and cataract surgery are as follows:

1. Benchmark average time frame for hip replacements is 182 days.
2. Benchmark average time frame for knee replacements is 182 days.
3. Benchmark average time frame for cataract surgery is 112 days.

the Canada-wide average in both 2019 and 2020, other than for cataract surgery, where only 40% of Ontarians received cataract surgeries within the benchmark time frame in 2020, as compared to the 45% Canada-wide average.

Apart from reviewing data from the CIHI, we also reviewed data from Ontario Health, which tracks surgical wait times on behalf of the Ministry through its Wait Time Information System (WTIS). One type of data the WTIS captures is the wait-time period from when a decision for surgery has been made to when the actual surgery is performed. Hospitals performing surgeries in a fully equipped operating room are required to report surgical data into the WTIS. Of the 104 public hospitals in Ontario, 90 (87%) of them have fully equipped operating rooms and report their data into the WTIS; however, other hospitals (typically small or rural hospitals) may also offer some outpatient surgeries without reporting into the WTIS.

As well, hospitals are required to report cataract surgery data into the WTIS regardless of where they are performed. Data captured through the WTIS is summarized by surgery area and hospital and is available to the public through the Health Quality Ontario website. Wait times vary by patient depending on factors, such as patient health, but typically, patients are divided into four priority levels as seen in **Figure 11**.

As discussed in **Section 2.1.1**, we focused on non-urgent or non-emergency surgeries and reviewed wait times for patients in priority levels two, three and four. These wait times represent the amount of time waited from the date a decision to move forward with surgery was made to the date the surgery took place. As well, the wait times are measured based on the 90th percentile, meaning that 90% of patients received their surgery within that time frame. Though patients within each priority level are typically seen on a first-come, first-serve basis, a surgeon

Figure 11: Priority Level of Surgery

Source: Health Quality Ontario

Priority Level of Surgery	Clinical Description
Priority 1*	The patient could pass away if the surgery is not performed immediately.
Priority 2	The patient experiences severe, difficult to manage symptoms that are likely getting worse.
Priority 3	The patient experiences some pain or other symptoms that do not dramatically impact their quality of life.
Priority 4	The patient may see their condition worsening over time; medical management may be failing to help the patient's condition.

* Not included in wait time data because Priority 1 means the patient requires emergency surgery so they are seen immediately.

may decide to prioritize a patient if there are clinical reasons to do so, such as rapid deterioration in a patient's health or other health issues impacting the patient's condition that may require surgery sooner to prevent the need for an emergency, or urgent, surgery.

We reviewed 10 common types of outpatient surgery wait times from 2016/17 to 2019/20 (before to the impacts of COVID-19) and 2020/21 (during COVID-19) and found that between 2016/17 and 2019/20, wait times for many surgeries increased (anorectal, forefoot, gallbladder, hernia, hysterectomy and prostate), though some decreased (benign ovarian, cataract, shoulder and sinus).

In 2020/21, wait times for outpatient surgeries became even longer due to the COVID-19 pandemic, which impacted Ontario starting in mid-March 2020. On March 15, 2020, the Ministry released a memorandum to hospitals to begin a measured "ramping down of elective surgery and other non-emergent activities" to preserve capacity to care effectively for patients with COVID-19. This was followed by a directive issued by the Chief Medical Officer of Health (CMOH) that required all non-essential and elective surgeries be stopped or reduced to minimum levels. The directive was first applicable from March 19–May 26, 2020, and then again from April 20–May 19, 2021.

Due to the first issuance of the directive, by the end of 2020/21 wait times were even longer than in prior years. For example, wait times were 157 days (for gallbladder surgery) and 356 days (for forefoot surgery) by the end of 2020/21, in comparison with 100 days (for gallbladder surgery) and 259 days (for forefoot surgery) in 2019/20, representing an increase of 57% and 37% respectively (see **Figure 12**).

The second issuance of the directive, which was in effect from April 20 to May 19, 2021 (shortly after the 2020/21 fiscal year end), has continued to impact wait times for outpatient surgeries, as discussed in **Section 4.7.1.**

As a result of the cancellation or delay of most outpatient surgeries during the COVID-19 pandemic, wait times are expected to continue to increase due to significant and growing surgery backlogs. Rising COVID-19 cases in Ontario resulted in the CMOH's second issuance of the directive in April 2021, further impacting outpatient surgeries, as discussed in **Section 4.7.**

4.1.2 Significant Regional Variations in Wait Times Result in Inequitable Access to Outpatient Surgery

Though any hospital with a fully equipped operating room could provide outpatient surgeries, not all hospitals and regions are able to offer outpatient surgeries on a timely basis.

We reviewed regional wait times based on Ontario Health's five regions (West, Central, Toronto, East and North) in 2019/20 and noted significant variations in wait times for outpatient surgeries, as shown in **Figure 13**. For example:

- In the Toronto region, patients receiving forefoot surgery had to wait about 354 days, over three

Figure 12: Outpatient Surgery Wait Times (Days), 2016/17, 2019/20, and 2020/21

Source of data: Ontario Health

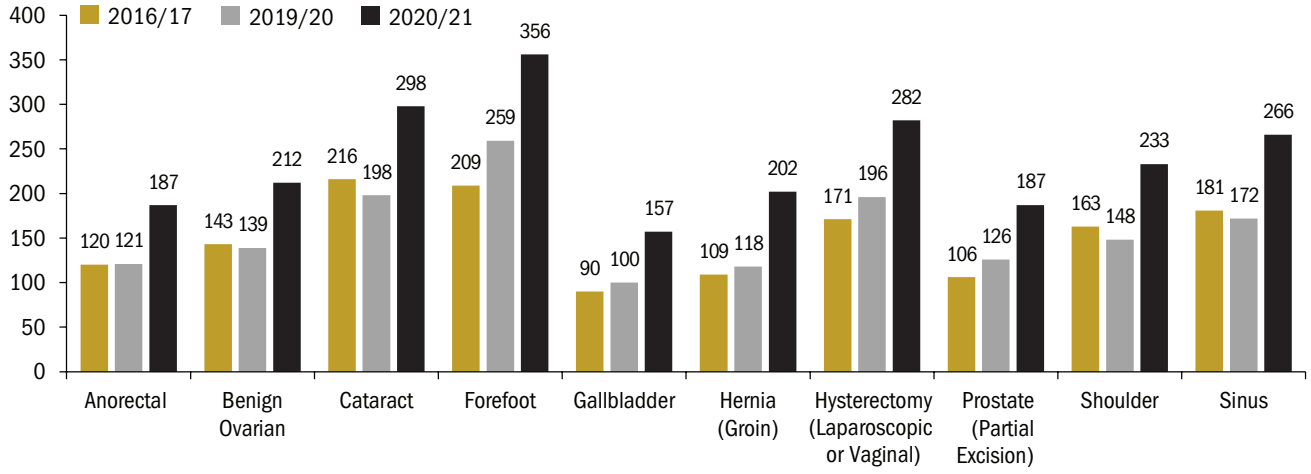
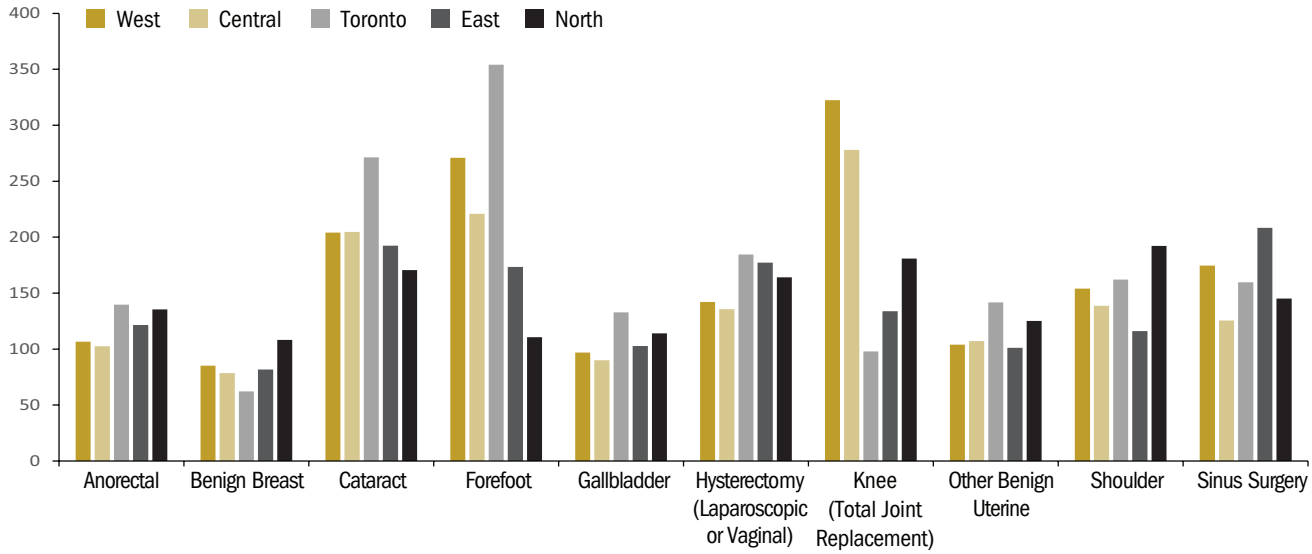


Figure 13: Examples of Outpatient Surgery Wait Times by Ontario Health Region (Days), 2019/20

Source of data: Ontario Health



Note: This analysis includes the average of the 90th percentile wait times of all reporting organizations within each region.

times longer than patients in the North region (111 days).

- In the West region, patients receiving a total knee joint replacement surgery waited almost a year (322 days) while patients in the Toronto region waited about three months (98 days).
- In the Toronto region, patients receiving cataract surgery had to wait 271 days, 100 days more than patients receiving cataract surgery in the North region (171 days).

Through discussion with hospitals, we noted possible reasons for varying wait times across hospitals. For example, some hospitals serve a large geographic region and offer many different types of surgeries within their catchment, often leading to longer wait times for each surgery specialty area

because they have to compete for operating room time, which is limited in supply, an issue discussed further in **Section 4.2.2.** As well, some regions have had significant population growth but there has not always been a related increase in surgical volume allocations or funding.

Due to the significant variations in wait times by region, patients that are living within certain regions are having to wait much longer to receive outpatient surgery resulting in inequitable access to timely outpatient surgeries.

RECOMMENDATION 1

To provide more equitable access to outpatient surgeries across Ontario, we recommend that Ontario Health:

- work with hospitals at a regional level to facilitate regular communications and identify reasons for variations in wait times; and
- through consultation with regions, allocate or reallocate future surgical volumes and funding to reduce wait times and bring them to an equitable level.

RESPONSE FROM ONTARIO HEALTH

Performance management is currently done through a variety of mechanisms by both the Ministry of Health (Ministry) and Ontario Health (for example, cancer program outreach, access to care performance reviews, Ministry-region stocktake processes, etc.). Ontario Health is currently consolidating and improving co-ordination on many of these processes, which historically may have resided within separate agencies that now fall under Ontario Health. Ontario Health looks forward to working with the Ministry and hospitals on conducting an assessment of potential opportunities to align and consolidate these processes at the provincial level by the end of the 2022/23 fiscal year.

The Ministry and Ontario Health are working closely together on volume funding allocation for the 2021/22 fiscal year. The current process involves ongoing collaboration with Ontario Health regions and clinical experts to determine the types of procedures with high wait times, and these areas have been the focus for funding in-year. Ontario Health will begin providing ongoing targeted data reports by March 31, 2022, in order to support regions and the Ministry in monitoring the wait times in these areas.

4.1.3 Lack of Public Reporting of Surgery Wait Times by Surgeon

As described in **Section 2.1.2**, patients requiring surgery are generally referred by their family doctor or health-care provider to a surgeon. If a surgeon determines that surgery is necessary, the patient will be scheduled for an available date for the surgery or added to a wait list until a spot becomes available. Typically, each surgeon maintains their own wait list and surgery schedule, depending on the availability of an operating room.

We found that in Ontario, wait times by surgeon are not publicly available. The former Health Quality Ontario (now Ontario Health) publicly reports wait times by hospital but not by surgeon.

As patients often depend on a referral from their family doctor or health-care provider, they are generally made aware of any potential wait time only once they have met with a surgeon. Patients also may not be aware that wait times could vary from one surgeon to another, even when those surgeons work at the same hospital. Possible reasons for varying wait times could be patient choice, referral patterns where some surgeons receive more referrals than others or some surgeons providing specialized surgeries that others do not offer. For example, we noted the following examples where multiple surgeons working at the same hospital had varying wait times for surgery:

- One ophthalmologist had an average wait time of 155 days, almost four months longer than another one who had an average wait time of 42 days.
- One otolaryngologist (an ear, nose and throat specialist) had an average wait time of

211 days, about three months longer than another one who had an average wait time of 121 days.

- One orthopaedic surgeon had an average wait time of 171 days, over two months longer than another one who had an average wait time of 106 days.

Since patients do not have access to wait-time information by surgeon, they often have no option but to go with whomever their health-care provider refers them to. As a result, patients are making uninformed decisions because they have no way of knowing whether the surgeon they are being referred to has a longer wait time than other surgeons in the region.

We reviewed practices in other provinces and found that wait times by surgeon are publicly available in some provinces. For example:

- In Alberta, the public can access wait times by procedure and surgeon. For example, a patient can go on the Alberta government's wait-times reporting website and select the zone (region) they live in and indicate what surgery they require (such as hernia repair, cataract surgery, gall bladder removal) and search all surgeons who offer that surgery in their region. Furthermore, by clicking on a surgeon's name, patients can access the surgeon's wait times for the most recent reporting period. Alberta goes one step further and shows a side-by-side comparison of the specific surgeon's wait times versus the Alberta-wide wait times for that specific surgery, meaning that patients can compare the surgeon's wait times to the average wait time.
- British Columbia also allows the public to go on its provincial surgery wait-time website and search by specific procedure (surgery) or by specialist. By searching by type of surgery, patients are given a list of all surgeons that perform such surgery, as well as how many patients are on each surgeon's wait list, and how long most patients have had to wait to get such surgery.

The lack of wait-time transparency in Ontario has been raised by our office in the past. For example, in our 2016 value-for-money audit of Large Community Hospital Operations we noted that individual surgeons managed their own surgery wait lists—and some had longer wait lists than others because they were well known or because they got referrals from numerous family physicians. As well, we noted that Ontario did not report wait times by individual surgeon. The lack of wait-time information for each surgeon meant that Ontarians were not aware of this situation and that their physicians did not have the information to be able to refer their patients to another surgeon with a shorter wait list, or to another facility that could offer treatment and/or consultation sooner. We recommended that the Ministry work with hospitals to implement a centralized patient referral and assessment system for all types of elective surgeries within each region. When we performed our follow-up review on the 2016 audit of Large Community Hospital Operations, we found that this recommendation was indicated to us as still in the process of being implemented, an issue that is discussed in **Section 4.2.1.**

RECOMMENDATION 2

To provide greater transparency to patients regarding surgical wait times and to allow patients to make more informed decisions about their surgical care, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- work with public hospitals, private hospitals, independent health facilities and surgeons to track individual surgeon's wait times; and
- publicly report wait times by surgeon similar to the practices in other jurisdictions, such as Alberta and British Columbia.

MINISTRY RESPONSE

The Ministry agrees that transparency of surgical wait times at the surgeon level is important and that this would enable patients to make better-informed decisions about their surgical care. As part of 2020/21 and 2021/22 investments in Centralized Surgical Waitlist Management, the

Ministry and Ontario Health are reinforcing their commitment to ensuring existing wait-times data are used by surgeons, hospitals, and health system planners to better manage resources in the surgical system. The Ministry and Ontario Health will work together to engage relevant stakeholders, including the Ontario Medical Association, to discuss and determine requirements around public reporting of wait times by surgeon.

RESPONSE FROM ONTARIO HEALTH

Ontario Health distributes a quarterly surgeon dashboard, providing surgeons insight into their wait time and comparator wait times for surgeons at their facility, Local Health Integration Network region and province. In addition, a Local Health Integration Network/Regional surgeon report exists to look at performance within hospitals or regions. Ontario Health will investigate the opportunity with the Ministry of Health (Ministry) to expand the distribution of the information available in these tools to additional stakeholders by the end of 2022/23. Ontario Health also looks forward to collaborating with the Ministry to develop a plan to expand public reporting to the surgeon level, which will involve extensive stakeholder consultation and input with relevant parties such as the Ontario Medical Association, patient representatives and clinicians.

4.2 Limited and Slow Progress on Implementing Practices to Improve Wait Times for Outpatient Surgeries

As described in **Section 4.1**, significantly long wait times can lead to a decline in overall patient health and can result in complications and additional health issues. Though the Ministry and Ontario Health are aware of the long wait times, progress on reviewing and implementing strategies and practices that could help reduce wait times for outpatient surgeries has remained limited and slow across the province.

4.2.1 Lack of Centralized Intake or Referrals Limits the Ability to Reduce Wait Times

Although health-care providers and surgeons often build working relationships to provide patients with care on a timely basis, there is an opportunity for the province to implement processes that would allow patients to have more timely access to surgeries. This would still allow them to be involved in choosing a surgeon they prefer.

One possible practice that would foster this is developing a centralized intake or referral process for certain surgical specialties. For example, a family doctor or health-care provider could first refer a patient to a central intake. The patient could then indicate whether they have a specific surgeon preference based on their own knowledge and discussion with their regular health-care provider. If the patient does not have a preference, they can opt to be contacted by the next available surgeon in their region or any other region where more timely treatment is available. As a result, having a centralized intake or referral process in place can help ensure patients are receiving timely access to surgeries while continuing to allow patient choice.

While there is no consistent approach to centralizing referral or intake for all types of surgeries across Ontario, we did note that some regions and surgical service areas took steps on their own to address long patient wait times. For example:

- In April 2021, the Waterloo region adopted a centralized cataract referral program that allows patients to choose the earliest surgery date available, a specific location or a specific surgeon. Of the referrals that were processed by September 2021, 31% of patients chose the first available surgery date; 19% chose the location closest to home; and 50% chose a specific surgeon. As well, an online regional website provides patients with information about the eye surgeons, with access to educational materials on surgery and quarterly wait times. The centralized cataract referral program, together with the online regional website, have provided the opportunity

for shortening wait times without removing patient autonomy.

- As a result of high demand for orthopaedic care and surgery, in 2017 the Ministry and Local Health Integration Networks (now Ontario Health) implemented Rapid Access Clinics for orthopaedic conditions such as hip, knee and lower back pain. Primary care providers, such as family doctors, can refer patients who need an orthopaedic specialist referral, or who require a diagnostic imaging test, to a central intake point in the region that determines whether patients meet the criteria for accessing the Rapid Access Clinic. At the Rapid Access Clinic, a health-care provider completes a patient assessment to determine the right course of care. If surgery is required, the patient will be given an option of the next available surgeon in the region or a surgeon of their choice. Our review of information from the Ministry noted that almost 50% of patients who were seen through Rapid Access Clinics chose the option of seeing the next available surgeon instead of waiting for a specific surgeon.

The Ministry also identified the lack of centralized surgical wait-list management as an issue as part of its plan to address the surgical backlog due to COVID-19. Specifically, the Ministry provided approximately $13 million in 2020/21 for regional projects to support implementation of digital health solutions to address the surgical backlog. We noted that some regions and hospitals in the province have used this funding to start working on centralizing intake for some surgeries. For example:

- Women's College Hospital in the Toronto region has implemented a central intake model for anorectal surgery.
- Halton Healthcare in the Mississauga Halton region expanded services offered through its rapid access clinic to include shoulder assessment.

However, the centralized intake or referral process has not been expanded or widely adopted across the province on a consistent basis. For example, we noted that not all regions and types of surgery were considering the use of this process and for those that were, different surgeries were being considered by different regions. Whatever processes are implemented should be evaluated once in place to determine if they yield any best practices that can be implemented in other regions.

The lack of centralized intake or referral process has been a long-standing issue and our Office has raised this issue and made recommendations in other areas of the health-care system in the past. For example, in our 2017 value-for-money audit of Cancer Treatment Services we noted that some regions in Ontario had implemented a central referral and booking service for some cancer surgeries in an effort to improve wait times and access but this was not consistently available for all cancer surgeries at all Local Health Integration Networks. We recommended that Cancer Care Ontario (now Ontario Health) work with the Ministry and hospitals to assess the benefits of having a centralized referral and booking process for cancer surgeries. We also recommended the Ministry work with Cancer Care Ontario and hospitals to implement centralized referral and booking processes for cancer-related CT scans and MRIs. In our 2021 follow-up, we found that this recommendation was still in the process of being implemented by 2023.

RECOMMENDATION 3

To allow patients access to faster surgeries, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- work with hospitals and clinicians to determine the types of outpatient surgeries that would benefit most from establishment of a centralized intake or referral system to help reduce wait times and improve patient transparency;
- regularly engage hospitals and regions that have implemented centralized intake or referral for surgeries to identify best practices and weaknesses; and
- use best practices identified through this work and other relevant provincial initiatives related to centralized intake or referral to further expand the implementation of these practices

and initiatives across the province within established timelines.

MINISTRY RESPONSE

The Ministry is currently working with Ontario Health and the provincial eServices program to transition oversight of the eServices program from the Ministry to Ontario Health. This transition will allow for better-integrated planning on centralized intake and referral, given that a key focus of the eServices program is on deploying electronic referral systems (eReferral) across the province and the eServices program is currently doing considerable work on implementing eReferral at existing central intakes (for example, Low Back Rapid Access Clinics). The eServices program's activities also include developing eReferral pathways and standardized eReferral forms that incorporate clinical best practices and that can be used to support central intake models.

Accordingly, Ontario Health is currently working with the Ministry and the eServices program to incorporate work on eServices and Centralized Surgical Waitlist Management into a unified strategy going forward. A key workstream under this strategy would involve working to identify which clinical pathways are best suited to central intake, as well as identifying best practices for implementing centralized intake and referral. It is anticipated that the eServices program's learnings to date, along with insights from regional projects that implemented central intake for surgical pathways as part of provincial investments in Centralized Surgical Waitlist Management, will provide key inputs to inform this work.

The province's Rapid Access Clinics (RACs) for moderate-to-severe hip and knee osteoarthritis and low back pain represent an existing example of a centralized intake model that can serve as a blueprint for other elective surgeries. Ontario Health and the Ministry continue to work with their clinical and health system partners to leverage and implement best practices to improve wait times and access to appropriate care.

RESPONSE FROM ONTARIO HEALTH

The Ministry of Health (Ministry) has engaged Ontario Health to establish a multi-year Central Wait List Management strategy. This strategy will outline a plan to incrementally increase visibility to surgical patient flow and promote access improvements including centralized intake models for appropriate procedures on an annual basis. Ontario Health is targeting to complete the strategy by the first quarter of 2022/23 for Ministry funding consideration and will seek to highlight any outpatient-specific opportunities in the plan.

The new provincial Central Wait List Management strategy will be informed through direct consultation with hospitals and regions that have implemented centralized intake or referral. Regular ongoing engagement with hospitals and regions will be completed through consolidated performance management practices highlighted in **Recommendation 1**. Ontario Health is targeting to complete the strategy by the first quarter of 2021/22.

By 2022/23, the Ministry will transfer the Transfer Payment Agreement of the provincial eServices program to Ontario Health. Consolidation of the eServices and Central Wait List Management programs will unify best practices across relevant provincial programs.

4.2.2 Hospital Operating Rooms Remain Underused

The majority of outpatient surgeries take place in operating rooms at public hospitals. However, due to the limited availability of operating-room time, surgeries that are emergency or urgent often take priority over those that are elective and can be done on an outpatient basis.

We reviewed the data tracked by Ontario Health on the rate of use of fully equipped operating rooms in Ontario. We noted differences between hospital operating use rates and on-time surgery rates.

Hospitals Reporting Low Usage Rate of Operating Rooms

Hospital operating room usage rates measure how efficient hospitals are in using their operating rooms to offer surgeries. We noted that hospitals across Ontario had varying usage rates.

The provincial best practice target rate of operating room use is 90%. In 2019/20, for operating rooms running from approximately 7 a.m. to 4 p.m. Monday to Friday, approximately 66% of hospitals met or exceeded the 90%-target operating room use rate. However, we found that 34% did not meet the target, with some hospitals reporting usage rates lower than 70% of their operating room capacity, meaning that operating rooms were available and went unused.

While Ontario Health does not formally track reasons for operating room underuse, we noted that a possible reason for underuse could be a lack of adequate planning for operating room use. For example, a hospital may budget for a higher number of surgeries than the actual demand based on operating room use. Another possible reason could be a lack of resources, for example, nurse staffing, needed to carry out surgeries, which is discussed further below.

Significant Variations in On-Time Surgery Rates Between Hospitals

Hospitals provide operating rooms to surgeons for specific time slots. To maximize use of an operating room, it is important for surgeries to start on time to prevent surgery delays, which can reduce efficiency. Again, we noted differences in the on-time surgery rates across hospitals in Ontario.

The best practice target rate of beginning surgeries each day on time is 85%. In 2019/20, approximately 28% of hospitals met the 85%-target of beginning surgeries each day on time while 72% did not. When surgeries do not start on time, there is a risk that subsequent surgeries later in the day may be delayed or postponed.

While hospitals need the discretion to decide how best to use their operating room based on local patient needs, the Ministry also needs to review different ways of offering outpatient surgeries (as discussed in **Section 4.3**) in order to identify how hospitals can use their operating room time more efficiently.

Some hospitals informed us that they continue to have additional operating-room time available but such time cannot be used without additional financial and human resources. Almost all hospitals we spoke with indicated that the limited availability of qualified operating room staff (such as nurses) has been a barrier to being able to perform more outpatient surgeries. According to data released by the Canadian Institute for Health Information, Ontario had the lowest number of Registered Nurses per capita compared to other provinces in Canada for the last four years. For example, Ontario had approximately 609 registered nurses per 100,000 people in 2020. By comparison, British Columbia had 650 and Alberta had 739 registered nurses per 100,000 people. This barrier has been further impacted during COVID-19 as we were informed by hospitals that there is an expected shortage of nurses going forward in Ontario. Staffing availability could have an impact on hospitals' ability to increase the number of surgeries performed in an effort to clear the backlog of surgeries cancelled or deferred during COVID-19.

To address the future needs of the health-care system, the Ministry announced that it was going to invest $35 million to increase enrolment in nursing education programs beginning in the fall of 2021. However, as of October 31, 2021, it was not known whether this additional funding is adequate and effective in addressing the current issues related to the shortage of nurses.

The issue of underuse of hospital operating rooms was noted by our Office in the past as well. For example, in our 2016 value-for-money audit of Large Community Hospital Operations, we noted that

operating rooms were not fully used. The availability of operating rooms was a factor in the long wait time for some elective surgeries, as was competition for operating-room time between elective and emergency surgeries. We also found that there were frequent operating room closures, as a majority of hospitals typically had planned operating-room closures despite the fact that many patients had been waiting a long time for elective surgery. Many hospitals and surgeons informed us that one or more of their operating rooms were not in use because of funding constraints and the hospitals had no policy to schedule elective surgeries on evenings and weekends due to funding constraints.

RECOMMENDATION 4

To efficiently and effectively offer outpatient surgeries, we recommend that Ontario Health:

- regularly collect information on available capacity and resources, such as staffing, across hospitals with unused or underused operating-room time; and
- using the information collected, reallocate funding based on the availability of resources and unused operating rooms at hospitals to ensure patients have more timely and equitable access to outpatient surgeries across the province.

RESPONSE FROM ONTARIO HEALTH

During the COVID-19 pandemic, Ontario Health and the Ministry of Health (Ministry) identified the need to expand surgical efficiency reporting to include more detailed data capture of evening and weekend surgical activity. This expansion is expected to be completed by the end of 2022/23. Ontario Health regions also have ongoing regular meetings with their health service providers, and Ontario Health also has COVID-19 Recovery Reference Tables that are meeting on a regular basis. Ontario Health looks forward to continuing to work with the Ministry on volume management approaches and reallocation strategies that maximize flexibility to respond to local needs. Ontario Health will reallocate volumes to maximize available capacity based on available data and ongoing discussions with health service providers. Reallocations are conducted within the parameters established by the Ministry's volume management policies.

4.3 Inconsistent Use of Outpatient Surgery and Oversight in Ontario

Various studies have shown that inpatient surgeries are, by their nature, costlier to perform than outpatient surgeries because they involve the use of hospital resources over a longer period of time. In contrast, outpatient surgeries, when appropriate and safe for patients, are less costly to the health-care system and provide similar patient outcomes. For example:

- According to a report released by the Canadian Institute for Health Information in 2021, the estimated cost of a standard hospital stay in Ontario is approximately $5,600 and the average length of stay is approximately seven days. While inpatient stay costs vary based on patient health and the length of hospital stay required, there are possible cost savings when patients are able to safely leave hospital the same day as receiving their outpatient surgery.
- A study released in the *Canadian Journal of Surgery* in 2017 estimated an approximate 30% cost saving can be achieved by performing a total knee replacement as outpatient surgery as opposed to performing it on an inpatient basis.
- Another similar report released by Blue Cross Blue Shield in the United States in 2019 estimated cost savings of 30% to 40% when knee and hip procedures are moved from an inpatient basis to an outpatient setting. While the health-care system in the United States is different than Ontario's, this report shows the possibility of achieving cost savings when moving procedures from an inpatient to outpatient setting.

Despite its cost-efficiency, performing surgery on an outpatient basis has not been adopted widely and consistently across Ontario.

4.3.1 Inconsistent Approaches to Using Outpatient Surgeries across Ontario

Hospitals and physicians decide whether a surgery should be performed on an inpatient or outpatient basis, primarily based on a patient's health condition. However, the decision is also affected by other factors, including:

- The availability of resources in the hospitals (such as an operating room, staff and inpatient beds).
- The availability of resources in the community (such as family supports, home-care services) to assist patients in recovering at home post-surgery.
- The nature of certain surgeries (for example cataract surgeries, which account for the majority of outpatient surgeries in Ontario, are performed on an outpatient basis over 95% of the time across in Ontario).

Apart from cataract surgeries, which are almost always done on an outpatient basis, we noted significant difference among hospitals with respect to other high-volume surgeries, with some hospitals reporting more outpatient surgeries and other hospitals reporting more inpatient surgeries.

We reviewed surgery volumes reported in Ontario Health's Wait Time Information System and compared surgery volumes and rates among various acute, complex, and large community hospitals. We noted significant differences among some hospitals and the average outpatient surgery rate in 2019/20 (before the impacts of COVID-19), as seen in **Figure 14**.

While there may be valid reasons for a hospital to have a lower outpatient surgery rate than its peers, for example, the hospital may provide more complex surgeries or provide care to more complex patients, the Ministry and Ontario Health have not yet looked into the variations in the ratio of inpatient and outpatient surgeries being done across hospitals to determine whether there are certain reasons and/or barriers faced by the hospitals to performing more surgeries on an outpatient basis.

As well, despite the potential benefits of outpatient surgeries (such as reducing cost and improving efficiency), the Ministry and Ontario Health have

Figure 14: Examples of Outpatient Surgery Rates Lower than Provincial Average Rates,* 2019/20

Prepared by the Office of the Auditor General of Ontario

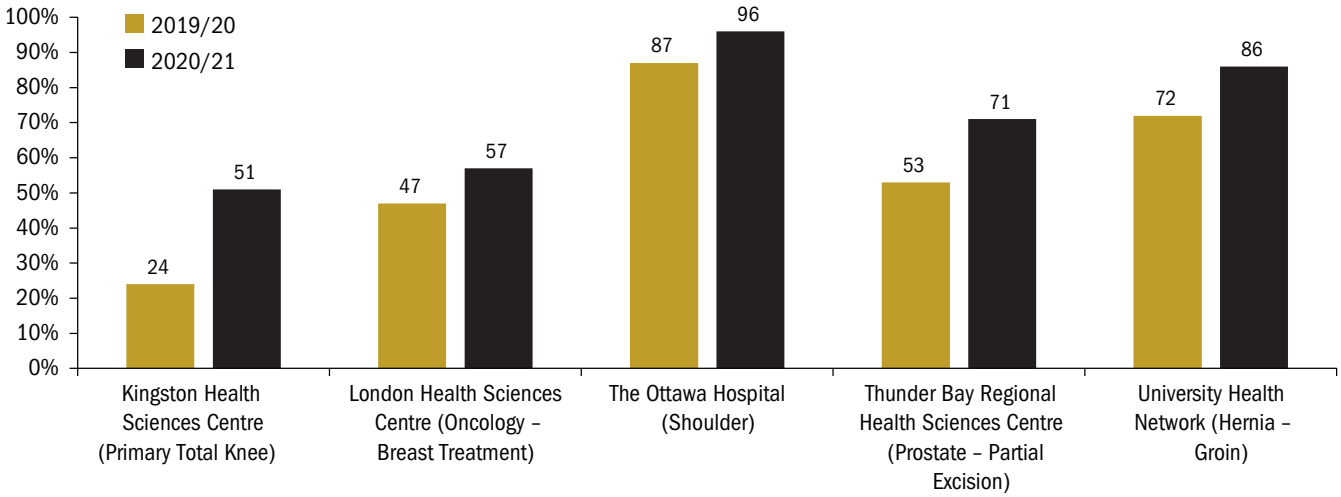
Surgery	Hospital	Ontario Health Region	Outpatient Surgery Rate (%)	Provincial Avg Outpatient Surgery Rate (%)
Anorectal	A	Toronto	83	93
Benign cervical	B	West	83	95
Benign ovarian	C	East	70	85
Forefoot	D	Central	86	97
Gallbladder	E	Toronto	75	95
Hernia – groin	F	East	72	95
Oncology – breast treatment	G	Toronto	63	86
Septoplasty	H	North	78	89
Shoulder	I	East	68	82
Sinus surgery	J	Toronto	82	93

Note: This analysis is based on information from Ontario Health and includes hospitals classified as acute, teaching, complex community, or large community hospitals. Each category of surgery may include multiple types of surgeries within the category.

* Average Outpatient Rate is calculated as the number of surgeries performed on an outpatient basis divided by the total number of surgeries (inpatient and outpatient) performed. The analysis excludes hospitals that do not have any outpatient surgeries in the relevant surgery area.

Figure 15: Examples of Hospitals with Increased Outpatient Surgery Rates for Select Types of Surgery, 2019/20 and 2020/21

Source of data: Ontario Health



* The outpatient surgery rate is calculated as the number of surgeries performed on an outpatient basis divided by the total number of surgeries (inpatient and outpatient) performed at the particular hospital.

provided limited direction to hospitals to consider performing more outpatient surgeries as a treatment method, when they can be performed safely and appropriately as described in **Section 2.1.3.**

As a result of COVID-19, through our review of 2020/21 data and discussion with hospitals, we found that some hospitals moved toward an outpatient approach for surgeries. That is, a higher percentage of surgeries were being done on an outpatient basis in 2020/21. **Figure 15** provides examples of hospitals that increased outpatient surgery rates. While there are other factors that may have impacted these rates, such as some patients who would typically be treated as an inpatient choosing to defer their surgery until after the COVID-19 pandemic, the increase in outpatient surgery rates shows that more surgeries could be performed safely and appropriately on an outpatient basis moving forward. This presents an opportunity for the Ministry and Ontario Health to review practices used by each hospital to determine what has worked well, what barriers still exist across the province, and what actions need to be taken to remove those barriers.

RECOMMENDATION 5

To increase the use of outpatient surgeries in a safe and cost-effective manner, we recommend that Ontario Health:

- work with hospitals on a regular basis to identify challenges and/or barriers to providing more surgeries on an outpatient basis; and
- identify and implement practices and methods within established timelines that enable hospitals to perform more surgeries on an outpatient basis when it is safe and appropriate for the patient.

RESPONSE FROM ONTARIO HEALTH

The Ministry of Health (Ministry) provided funding to Ontario Health to implement the Surgical/Diagnostic Imaging Innovation Funds as an opportunity for hospitals to address rate-limiting factors to increasing the number of surgeries they can provide. A number of projects funded supported the move of volumes to outpatient surgery. Lessons learned and best practices from this work will be shared provincially by the end of

the first quarter of 2022/23 to help better inform future funding and capacity planning.

Ontario Health also looks forward to collaborating with the Ministry to support hospital and independent health facility partnerships (through an extension of the *Public Hospitals Act* subsection 4.2) that would increase outpatient surgery volumes. Ontario Health will create an onboarding plan for facilities not currently reporting to the Wait Time Information System to facilitate more transparency to this work by the end of 2022/23. The data from this reporting can also be used by the Ministry to facilitate more informed decisions on capacity and volume allocation.

4.3.2 Best Practices for Delivering Outpatient Surgeries Not Reviewed and Disseminated across Ontario

Historically, almost all surgeries were performed on an inpatient basis at a hospital. Over time, and with technological and scientific advances, many surgeries shifted to being performed on an outpatient basis. We reviewed the practices of providing outpatient surgeries in Ontario and found numerous methods were being used. While hospitals make decisions based on their local or regional needs and available resources, the Ministry or Ontario Health has not conducted any evaluations to identify effective and cost-efficient practices that can be shared across Ontario and widely adopted by hospitals with low rates of outpatient surgeries as noted in **Section 4.3.1.**

We identified the following examples of outpatient surgery delivery practices used by different hospitals in Ontario.

Hospitals Using Same Operating Room for Both Inpatient and Outpatient Surgeries On-Site

Most hospitals offer outpatient surgeries using the same hospital site and operating rooms for inpatient and outpatient surgery. However, since these hospital operating rooms are generally available to all surgical areas, many disciplines (for example, ophthalmology, orthopaedics, gynecology) may have to share, or compete for, the operating-room time.

Hospitals Designated as Ambulatory Hospitals

Some hospitals in Ontario are specifically designated as ambulatory hospitals to provide surgeries on an outpatient basis and in many cases, these hospitals do not have any inpatient beds for overnight stays. These hospitals typically provide care to less complex (healthier) patients, meaning that the amount of time spent on each surgery is lower. As a result, using these hospitals can help free up resources at other hospitals with the resources necessary to care for more complex patients. For example:

- Hotel Dieu Hospital, a part of Kingston Health Sciences Centre, is designated as an ambulatory hospital and, as such, it specializes in performing surgeries on an outpatient basis but also assists with providing certain inpatient surgeries and addressing surgical backlogs for the surrounding community. We were informed that Hotel Dieu Hospital typically sees healthier patients and that moving outpatient surgeries to Hotel Dieu Hospital also frees up space at another hospital in the region, Kingston General Hospital, to provide care to patients with more complex needs.
- Women's College Hospital in Toronto operates as an ambulatory hospital and does not typically keep patients in hospital overnight after their surgery. Patients who have more complex health issues and cannot be safely sent home after surgery would have their surgery at one of the other hospitals in the Toronto region.

Hospitals with Ambulatory Surgical Areas Off-Site

To free up operating rooms on-site for more complex surgeries or to address growing surgery demand, some hospitals have started using space off-site to provide dedicated operating rooms for specific outpatient surgeries. For example:

- One hospital (London Health Sciences Centre) purchased and retrofitted space in a building across the street from the main hospital site in March 2017, and retrofitted this space to create a dedicated satellite site to perform elective

ambulatory outpatient surgeries with a focus on lower extremity orthopaedic surgeries, such as foot and ankle, shoulder, hip and knee surgeries. Hospital staff and surgeons rotate between the main hospital site and the satellite site. The hospital had previously evaluated the viability of this concept in the main operating room in 2016 and found that operating room turnover time (the time from the completion of one surgery to the time the operating room is ready for the next surgery) decreased by approximately 60% from an average of 23 minutes to less than nine minutes. Costs were also reduced by 60% in a number of the cases completed at the satellite site in comparison to the main operating room, due to standardization and process efficiencies. As a result, more surgeries, on average, per day are completed at a lower price point with higher patient and staff satisfaction at the new satellite site.

- Another hospital (The Ottawa Hospital) signed an agreement with a third-party organization that performs laser eye surgery. Under the agreement, beginning September 2020, the hospital has used the third-party organization's operating rooms to provide cataract surgeries. The hospital retains oversight of the patients and the surgeries are performed by surgeons associated with the hospital. The hospital found that performing cataract surgeries using the operating room at the third-party organization increased efficiency by over 25% compared to providing those surgeries at the main hospital site.

Some jurisdictions, in particular in the United States, have also moved toward performing outpatient surgeries outside of hospital sites. For example, in the United States many outpatient surgeries, such as cataract, orthopaedic and shoulder surgeries, are being performed in ambulatory surgery centres. These centres have the space, layout, staff, supplies and services necessary to perform outpatient surgery. These centres often specialize in specific surgeries rather than attempt to provide a wide range of surgeries. This reduces the risk that certain outpatient surgeries are unprioritized and have to compete with other inpatient surgeries in a general hospital setting, which typically has to prioritize more complicated and urgent or emergent inpatient surgeries.

Studies have shown that outpatient surgeries can be performed more efficiently and cost-effectively when performed in an ambulatory setting. As well, because these ambulatory settings often specialize in a handful of types of surgeries, more can typically be done in a day as compared to the number that are performed in a general hospital setting. For example, a 2014 study released in *Health Affairs* (a peer-reviewed journal on health policy and research) found that procedures done in ambulatory surgery centres took about 31.8 minutes (25%) less time than those in hospitals. Estimated cost savings ranged from approximately $363–$1,000 per outpatient case, depending on the surgery. However, this study did note a risk that providers may recommend unnecessary procedures in physician-owned ambulatory surgery centres to increase profits, which is discussed further in **Section 4.6.**

RECOMMENDATION 6

To modernize the delivery of outpatient surgeries in order to ensure these surgeries can be performed more effectively and cost-efficiently on a timely basis, we recommend that Ontario Health:

- collect information and data on a regular basis from hospitals that have used unique methods of delivering outpatient surgeries, such as using dedicated operating rooms;
- evaluate, with the assistance of clinical evaluation experts, the quality and cost-efficiency of delivering surgeries through these various methods; and
- work with hospitals to develop mechanisms or forums for regular communications and updates so as to facilitate continuous improvements and identify opportunities to innovate the way outpatient surgeries are being delivered across the province.

RESPONSE FROM ONTARIO HEALTH

Ontario Health and the Ministry of Health (Ministry) will leverage the existing clinical advisory group (the Surgery Wait Time and Efficiency Advisory) to provide guidance on identification of best practices. This group meets quarterly and is composed of surgical and administrative experts, Ministry and Ontario Health leadership.

The Ministry provided funding to Ontario Health to support a surgical smoothing project with three facilities (Royal Victoria Regional Health Centre, Sunnybrook Hospital and the Hospital for Sick Children). This work involves clinical expert coaches from the University Health Network and The Ottawa Hospital to support the project facilities. Lessons learned and best practices from this work will be shared provincially by the beginning of 2022/23 to help better inform future funding and capacity planning.

The Ministry and Ontario Health have been collaborating regularly with the Ontario Hospital Association to provide stakeholder webinars as a way to improve information and best practice sharing between all partners (hospitals, Ontario Health regions, Ontario Health and the Ministry). The next webinar is tentatively scheduled for the last quarter of 2021/22. Ontario Health regions also have ongoing regular meetings with their health service providers, and Ontario Health also has Recovery Reference Tables that are meeting on a regular basis.

4.3.3 Inconsistent Oversight and Co-ordination of Outpatient Surgeries Delivered in Different Settings in Ontario

As discussed in **Section 2.1.4**, outpatient surgeries can be delivered in a variety of settings in Ontario, namely public hospitals, private hospitals, and independent health facilities (IHFs). However, we noted that there is no co-ordination between these delivery organizations as they operate in silos, follow different reporting requirements, and are overseen by different parties. We also noted that the Ministry has not evaluated the costs and benefits of delivering outpatient surgeries in different settings to identify opportunities for co-ordination.

While Ontario Health (previously through the former Local Health Integration Networks) has accountability agreements with public and private hospitals, the IHFs offering outpatient surgeries have no formal working relationship with Ontario Health. These IHFs are accountable directly to the Ministry, who determines the funding and surgical volumes.

As well, the Wait Time Information System (see **Section 4.1.1**) managed by Ontario Health only tracks wait times of surgeries performed at public hospitals and one surgical IHF. As a result, the Ministry and Ontario Health do not have insight into wait times for the other surgeries provided by the remaining nine surgical IHFs and the one private hospital that provides publicly funded outpatient surgeries. These organizations provided a combined total of approximately 7,000 publicly funded outpatient surgeries in 2019/20 (before being impacted by COVID-19). We noted that wait times do exist for most surgeries at these providers, but many of them do not formally track surgical wait times for reporting purposes. Having wait-time information from all outpatient surgery providers would help inform planning and decision-making as well as co-ordination between different service providers when attempting to address the surgical backlog created by COVID-19 (see **Section 4.7**).

Ontario Health and the Ministry also have different methods of overseeing service providers. As a result, there is an inconsistency in the way oversight of the various service providers is conducted. This also means that neither the Ministry nor Ontario Health has a full picture of outpatient surgeries across the province. For example, Ontario Health monitors quarterly public hospital performance against surgical volumes and is also able to redistribute funding and volumes based on available capacity and results throughout the year. However, the Ministry funds surgeries based on historical amounts of funding

provided. This means that funding for surgeries cannot be moved between the types of providers, even when there may be capacity available.

Outpatient surgery providers are currently operating in silos and have different oversight mechanisms. This has created a risk of inadequate long-term planning and a risk of not addressing urgent needs on a timely basis, such as the significant surgery wait times resulting from COVID-19. By having all outpatient surgery providers reporting into a single entity and improving co-ordination between providers, there is an opportunity for the Ministry and Ontario Health to better allocate and reallocate funding and plan surgical volumes based on wait times and available capacity in the whole health-care sector.

A similar concern was also raised by Health Quality Ontario (now under Ontario Health) six years ago in its Building an Integrated System for Quality Oversight report in 2015/16. This report noted deficiencies in the way oversight was being conducted of non-hospital medical clinics, including IHFs. The report recommended that new quality oversight legislation be enacted to consolidate the various models, rather than amending the current patchwork of legislation and regulation. However, we found that six years after this report, no significant changes in oversight have been made to align IHFs with other service providers.

We also noted that despite having these various structures of offering outpatient surgeries for over 20 years, the Ministry has not conducted any evaluation of the different types of providers (public hospitals, private hospitals, and IHFs). This means that the Ministry does not know which delivery model is most efficient, which offers the highest quality of care, whether there are certain risks and benefits associated with each type of provider that must be addressed, and whether there are any opportunities for co-ordination between different types of providers.

RECOMMENDATION 7

To offer more cost-effective and timely outpatient surgeries, we recommend that the Ministry of Health, in collaboration with Ontario Health and clinicians:

- conduct an evaluation of all outpatient surgery providers, including public hospitals, private hospitals, and independent health facilities, to determine clinical effectiveness and gaps in oversight;
- require that all service providers (including independent health facilities and private hospitals) report their wait times into the Wait Time Information System; and
- revisit the oversight and reporting structures to confirm that all outpatient surgery providers report relevant data and are overseen consistently, and make changes as needed.

MINISTRY RESPONSE

The Ministry will work on developing options to conduct an evaluation of all outpatient surgery providers, including public hospitals, private hospitals, and independent health facilities, to determine clinical effectiveness and gaps in oversight.

The Ministry will explore opportunities with Ontario Health to have IHFs, the two private surgical hospitals, and any remaining public hospitals that are not yet reporting to be connected to the Wait Time Information System. The Ministry will take into consideration the costs and benefits of these integrations given the time and resources required and the relative surgical output of the facility. Currently, IHFs and private hospitals represent less than 3% of the annual surgical output in the province.

Moving forward, the Ministry will work with Ontario Health to review oversight structures, taking into account that comprehensive acute care hospitals and smaller community-based facilities have significantly different operations, legislated requirements and existing

governance structures, and therefore different oversight mechanisms may be appropriate.

RESPONSE FROM ONTARIO HEALTH

Ontario Health will create an onboarding plan for facilities not currently reporting to the Wait Time Information System to facilitate more transparency to this work by end of 2022/23. The data from this reporting can be used by the Ministry of Health to facilitate more informed decisions on capacity and volume allocation.

4.4 Inadequate and Inconsistent Monitoring of Quality of Outpatient Surgeries across Ontario

As discussed in **Section 2.1.3**, outpatient surgeries provide benefits to both the health-care system and patients. Many surgical areas are treating more patients using an outpatient approach. A number of clinical research and studies have found that these surgeries can be provided safely on an outpatient basis. For example:

- A 2021 study published in the *International Journal of Gynecological Cancer* found that in the United States, as a result of advanced surgical techniques, there was a significant shift from an inpatient to an outpatient setting for hysterectomies performed for endometrial cancer over time and that clinical outcomes were preserved and cost savings were achieved.
- A review published in the *Canadian Medical Association Journal* in 2020 found that same-day discharge for total joint arthroplasty for both hip and knee surgeries has become a safe procedure for qualifying candidates, with outcomes and patient satisfaction equivalent to standard inpatient surgeries.
- A 2018 study published in the *Journal of the American Academy of Orthopaedic Surgeons* noted that outpatient shoulder surgeries, such as rotator cuff repair and shoulder arthroscopy, are commonly performed procedures in the United States and have been shown to be safe with low rates of complications.
- A review published in 2016 by Thieme Medical Publishers (an international medical and science publisher) noted that ambulatory anorectal surgery can be done at a lower cost compared with inpatient procedures while still ensuring patient safety and high levels of patient satisfaction.
- A 2015 study published in the *Journal of the Society of Laparoscopic & Robotic Surgeons* found that total laparoscopic hysterectomy (a surgical procedure for the removal of the uterus) can be safely performed on an outpatient basis with 72-hour readmission rates under 1%.

However, since these studies were mainly based on information from the United States and other countries as well as Canada as a whole, we tried to collect similar information from Ontario Health and hospitals in order to assess the quality of outpatient surgeries in Ontario.

Through discussion with Ontario Health, we noted that the province does not have a centralized way to measure surgical quality and outcomes for all surgeries. Instead, information on aspects of surgical quality and outcomes is being monitored through the following programs:

- Forty-five hospitals in Ontario belong to the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP), which provides a standardized approach and online platform for capturing surgical clinical outcome data. In 2015, the Ontario Surgical Quality Improvement Network was developed to allow hospitals participating in NSQIP to come together in order to identify opportunities for improving surgical care using clinical data collected from each participating hospital. Ontario hospitals participate in NSQIP on a voluntary basis and are periodically benchmarked against over 700 hospitals internationally to assess their performance against 14 key post-surgical outcome indicators. From 2017 to 2021, Ontario hospitals typically performed above the average for 10 of the 14 indicators including hospital

Figure 16: Ontario's Performance on 14 Post-Surgical Outcome Indicators, 2017–2021

Source: American College of Surgeons' National Surgical Quality Improvement

Post-surgical Outcome Indicators	Ontario's Performance against Average*				
	2017	2018	2019	2020	2021
1. Hospital Readmission	✓	✓	✓	✓	✓
2. Mortality	✓	✓	✓	✓	✓
3. Morbidity	×	×	×	×	×
4. Cardiac	×	×	×	×	×
5. Pneumonia	×	✓	✓	✓	✓
6. Unplanned Intubation	✓	✓	✓	✓	✓
7. Ventilator Longer Than 48 Hours	✓	✓	✓	✓	✓
8. VTE (venous thromboembolism)	✓	✓	✓	✓	✓
9. Renal Failure	✓	✓	✓	✓	✓
10. Urinary Tract Infection	×	×	×	×	×
11. SSI (surgical site infection)	×	×	×	×	×
12. Sepsis	✓	✓	✓	✓	✓
13. C. diff (Clostridium difficile) Colitis	✓	✓	✓	✓	✓
14. ROR (return to operating room)	✓	✓	✓	✓	✓

Note: This table includes performance of all cases tracked for the post-surgical outcome indicators, including multiple types of surgeries performed on an inpatient and outpatient basis.

Legend:

✓ = Ontario performed above average

× = Ontario performed below average

* Average of all hospitals participating in the American College of Surgeons' National Surgical Quality Improvement Program.

readmissions, and below the average for four of the indicators including surgical site infections, as seen in **Figure 16**.

- About 55,000 cancer surgeries were performed either on an inpatient or outpatient basis each year in Ontario. Ontario Health prepares a cancer surgical quality indicator report annually to show hospital, regional and provincial performance for a set of indicators, which include 30-day and 90-day post-surgery mortality rates, re-operation rates and unplanned hospital readmissions or emergency room visits. These indicators are only used for cancer surgeries. There is an opportunity to use similar indicators to evaluate the effectiveness and quality of other surgical areas.
- In 2017, the Ministry in collaboration with Ontario Health began implementing a patient-reported outcomes measures program for hip and knee replacement surgeries. Outcome data is collected directly from patients receiving primary, elective, unilateral hip and knee replacements (on an inpatient or outpatient basis), including functional status, health-related quality of life, satisfaction with surgery and general health. This data is collected and reported pre-operatively and post-operatively at three and 12 months in outpatient settings. There are 39 hospitals currently reporting this data and when implementation is complete 57 hospitals will be reporting. Data collected up to June 30, 2021

indicated that for hip replacement surgery overall satisfaction was 90% at 12 months and for knee replacement surgery was 88% at 12 months.

Hospitals we spoke with also indicated that surgical quality and outcomes are not typically monitored separately for inpatient and outpatient surgeries. However, some hospitals did use different ways, such as using readmission and emergency department visits as well as performing patient satisfaction surveys to compare inpatient and outpatient surgeries. For example:

- One hospital indicated of the patients who had outpatient surgeries, 3% of them were readmitted to hospital and 5% were seen in the emergency department within 15 days of their surgery in 2019/20. For inpatient surgery patients, these rates were about 5% and 10% respectively. However, reasons for return visits to hospitals are not necessarily related to surgical outcomes as patients may have other health conditions that require them to visit a hospital.
- Another hospital conducted patient satisfaction surveys separately for inpatient and outpatient surgeries from 2019/20 to 2020/21 and noted an overall satisfaction rate of 66% for inpatient surgeries and 85% for outpatient surgeries.

The College of Physicians and Surgeons of Ontario (College) also has a legislated mandate to ensure quality care is being provided by surgeons practicing in Ontario. While service providers and the College are responsible for monitoring the clinical quality of care, there is an opportunity for the Ministry and Ontario Health to work with these organizations to determine ways to consistently measure and publicly report on the quality of surgical outcomes.

RECOMMENDATION 8

To sufficiently monitor and publicly report on the quality of outpatient surgeries, we recommend that Ontario Health:

- assess whether the number of hospitals currently participating in programs such as the Ontario Surgical Quality Improvement Network is adequate and whether there are benefits to requiring more hospitals to participate; and
- work with service providers to develop and implement metrics to measure surgical quality of care and outcomes consistently and publicly report on those metrics.

RESPONSE FROM ONTARIO HEALTH

Ontario Health will work in collaboration with the Ministry of Health (Ministry) to conduct an assessment of the potential expanded participation of hospitals in the Ontario Surgical Quality Improvement Network by the end of 2022/23. This assessment will need to ensure that additional financial and resource obligations are not placed on already overburdened facilities. In addition, Ontario Health is gathering data on surgical adverse events, which may further inform quality metrics.

Ontario Health has an annual review process in place to review quality metrics across all sectors of care. Currently a number of metrics (for example, surgical site infection, readmissions, etc.) are reported on the Health Quality Ontario website. Ontario Health looks forward to working with the Ministry to develop a plan to expand current surgical quality metrics by the end of 2022/23. Examples of additional reporting from other quality performance processes currently in place can be leveraged to inform this work.

4.5 No Regular Review and Monitoring of Funding and Billings for Outpatient Surgeries

Since most outpatient surgeries are publicly funded in Ontario, it is important to conduct regular reviews of program spending to ensure that taxpayers are receiving value for money. However, we noted the Ministry does not regularly review the costs and funding for outpatient surgeries, which can result in over- or underfunding of certain types of surgeries, which in

turn could impact both the quantity and quality of care being provided to Ontarians.

4.5.1 Funding for Outpatient Surgeries Has Not Been Updated for Years Due to No Regular Tracking of Costing Information

As discussed in **Section 2.2.2**, outpatient surgeries can be funded in various ways depending on the type of surgery and the type of organization providing it (public hospitals, private hospitals or independent health facilities). Based on our review of the different funding methodologies, we noted that the Ministry has not conducted any review recently to ensure that funding aligns with the costs of providing surgeries.

Funding to Public Hospitals

Most public hospitals receive some funding for surgeries through the quality-based procedure (QBP) funding method (see **Figure 6**). This method of funding begins with an overall base rate, which is then multiplied by a factor calculated based on the patient population that a hospital serves to arrive at the per-surgery funding amounts provided to a hospital. Although the patient population factor is updated on an annual basis, we noted that base funding rates for some surgeries funded through QBPs have not been reviewed for approximately five years. For example, funding for knee arthroscopy is currently $5,270 per case. This amount has not been reviewed since 2015/16.

We requested recent funding or costing evaluations related to common outpatient surgeries and found that the Ministry does not adequately track any costing information. The Ministry has implemented the Ontario Case Costing Initiative (OCCI), which consists of a dataset that tracks the costs of care provided by hospitals (including acute inpatient, day surgery, and ambulatory care cases). Hospitals submit their financial data into the OCCI on an annual basis. However, we noted issues that prevent reasonable costing analysis from being done at a provincial level. For example:

- Providing information to OCCI is not currently a mandatory reporting requirement and fewer than half of the hospitals in Ontario report into the OCCI, with many of them being teaching hospitals located in larger urban areas. As a result, the costing information may not be representative of the true costs of providing surgeries across the province, such as at hospitals in rural or remote regions where costs to provide care may be different.
- There is a risk of inconsistency in the way costs are being reported into OCCI, making the data incomparable between organizations. The Ministry also indicated that changes in costing methodology and data quality issues may impact the ability to compare data across years.

There are many reasons why the costs of performing surgeries may change over time. For example, new technologies and methods of providing surgery could result in lower costs per surgery. Further, staffing cost increases and inflation could result in higher costs of providing surgery. Without regularly conducting costing reviews, the Ministry does not know if the funding rates that it provides through the QBP funding method and volume-based allocations (where surgeries are funded on a per-procedure basis) are covering—or exceeding—the actual costs associated with providing the surgery. So, in effect, the Ministry could be under- or overfunding certain surgeries.

The issue of outdated funding, as well as a mismatch between funding and needs, was also noted by our Office in other areas of the health-care system in the past. For example, in our 2019 value-for-money audit of Chronic Kidney Disease Management, we found that the $25,000 funding for a deceased-donor kidney transplant had been unchanged for over 23 years (since 1988) and that kidney transplant centres were reporting an average cost of approximately $40,000. We recommended that the Trillium Gift of Life Network (now under Ontario Health) conduct a review of the funding to confirm what adjustments are needed. However, in our 2021 follow-up we found that while Ontario Health has started working on collecting from hospitals information

on donor intervention and frequencies, it has not reviewed the funding rate yet.

Funding to Independent Health Facilities

We also reviewed surgical funding provided to independent health facilities (IHFs) and noted that the Ministry has not done any costing analysis to determine whether the historical funding aligns to the current costs of offering outpatient surgeries at these facilities.

As part of their annual reconciliation process, IHFs are only required to report the volume of publicly funded surgeries they completed. If the budgeted volume was met, no further action is taken. But, if an IHF reports doing a lower-than-budgeted volume, the Ministry recovers funding on a proportionate basis. Over the past five years there has been no significant recovery, as most IHFs have reported meeting their budgeted volumes.

Unlike public hospitals, IHFs do not receive global funding to help cover general operating expenses and overhead. Instead, Ministry funding to the IHFs—referred to as facility fees—covers related overhead costs for publicly funded surgeries. These facilities often offer private-pay surgeries as well, and those private-pay revenues also help cover costs of running their business.

The Ministry does not obtain costing information from IHFs to use to review their specific costs of providing publicly funded outpatient surgeries. The Ministry receives only their audited financial statements or financial reports, which do not always separate out the costs of providing publicly funded outpatient surgeries from overall costs of running their organization. Without this information, the Ministry does not know whether it is overpaying or underpaying IHFs.

Funding to the Private Hospital That Performs Outpatient Surgeries

While funding to the only Ontario private hospital that offers outpatient surgeries has not changed over the four years before 2020/21 (see **Figure 8**), we noted that the Ministry prepared a costing analysis in 2020 to compare that private hospital's costs to some of the other large hospitals within the same Local Health Integration Network region (Central). The review of the most recent cost year, which was 2018, found that:

- The average costs of performing the two most common surgeries done by the private hospital were almost equal to the costs of providing the same type of surgery at a large hospital in the same region. For example, a cataract surgery was approximately $19 lower per surgery than large hospitals and a knee surgery was only $3 higher per surgery than large hospitals.
- However, the costs for less commonly performed surgeries were slightly higher at the private hospital. For example, a sinus intervention surgery was $83 higher per surgery at the private hospital.

While the 2020 costing analysis did not find any significant variations, the analysis shows that there are variations between private and public hospitals.

Although limited work has been done in Canada to compare the cost of providing outpatient surgeries across different settings, in 2012 Saskatchewan Health compared the costs of providing 34 types of day (outpatient) procedures in private clinics and hospitals. It found that the total cost of performing procedures in the clinics was 26% less than hospitals. Ontario has not done a similar analysis. It will be worthwhile for the Ministry to continuously monitor the costs of providing surgery across service providers in the province to identify where potential efficiencies and savings can be found without impacting surgical outcomes and quality of care.

RECOMMENDATION 9

To better align funding with the actual cost of providing outpatient surgeries, we recommend that the Ministry of Health:

- work with clinical experts to determine accurate ways to capture the costs of providing outpatient surgeries in different settings with regular updates as appropriate in order to avoid over- or underfunding certain types of surgeries; and

- conduct regular reviews (such as every five years) of costing information submitted by different providers of outpatient surgeries to determine the need to adjust funding to identify potential efficiencies and savings.

MINISTRY RESPONSE

The Ministry will work with Ontario Health and other system stakeholders to determine if there are more accurate ways to capture data on outpatient surgery costs. Work will take into account that it is resource intensive for small organizations to participate in Ontario's case costing program, as it involves both technology and staff resource costs to implement costing software. Currently, only a few small hospitals have implemented case costing due to these considerations.

The Ministry currently reviews the funding rates for Quality-Based Procedures (which include many outpatient surgeries) each year based on changes to the Case Mix Index (CMI), which reflects the level of acuity of patients served. The Ministry will also consider processes to conduct regular reviews of the base rate for QBPs (known as the Provincial Cost per Weighted Case Rate). Funding for outpatient non-QBP procedures via the Ministry's Growth and Efficiency Model is also updated annually.

To encourage efficiencies and savings, several procedures are funded using a blended rate that includes both inpatient and outpatient procedures; this encourages providers to shift to more cost efficient outpatient settings where clinically appropriate. The Ministry will continue to monitor the utilization of outpatient surgeries with clinical experts and will update its funding models, as needed, to support effective and cost-efficient care.

4.5.2 Ministry Does Not Adequately Oversee and Monitor Unreasonable Outpatient Surgery Volumes and Billings

Physicians that provide publicly funded outpatient surgeries bill the Ontario Health Insurance Plan (OHIP) directly. As surgeries are not defined as inpatient or outpatient, physician billings for the actual surgery are not dependent on whether the patient has to be admitted as an inpatient or is treated as an outpatient following surgery.

We reviewed OHIP data on common outpatient surgeries and identified physicians with significantly high or unreasonable billings. For example, four ophthalmologists each billed the Ministry for over 2,000 cataract surgeries in 2019/20, each receiving between $860,000 to almost $1.1 million in payments for cataract surgeries only (excluding payments for other insured services such as assessments and testing). We reviewed claim data for these four ophthalmologists and found that the maximum number of cataract surgeries performed in a single day ranged from 34 to 47. While we were informed by some ophthalmologists that it is possible to do a high number of surgeries in a day with the appropriate staffing and operating room resources, we noted that subsequent to our audit work, the Ministry completed a broad review of 307 ophthalmologists, including these four high-billing ophthalmologists. However, we noted that the review only looked at assessment codes that were being billed on the same day as cataract surgery and resulted in education letters being sent out clarifying when this billing is eligible. Two of these four high-billing ophthalmologists received more detailed reviews of their claims in earlier years.

We reviewed other work done by the Ministry on OHIP claims by physicians and found that over the last five years, the Ministry has only reviewed about 47 physicians that had surgical claims.

The following are some of the common issues the Ministry has identified as part of its review of physician claims over the last five years:

- **Inappropriate claims:** Physicians and surgeons were found to have been billing incorrect OHIP

codes for the work performed, typically resulting in payments that are higher than what should have been paid for the service provided.

- **Provision of not medically necessary services:** Physicians and surgeons were providing services that were not medically necessary. For example, they performed tests on patients when the patient did not appear to have any symptoms that indicated the need for those tests.
- **Unusual volume of claims:** Physicians and surgeons were noted as treating an unusually high number of patients.

Some recent examples of issues identified by the Ministry through OHIP claim reviews related to surgeons include:

- An ophthalmologist who provided outpatient cataract surgeries submitted claims to OHIP for treating an average of 70 patients per day, with a high of 227 patients on one day (including not only surgeries but also assessments, testing and consultations). Upon further review, the Ministry found that between 2016/17 and 2019/20 the ophthalmologist's billed services included amounts for work performed by many trained assistants. The Ministry prohibits physicians billing for work performed by others in these circumstances. However, the Ministry did not pursue this matter further and sent a letter to educate and inform this surgeon in 2019/20 that surgeons cannot delegate assessments or procedures to assistants and then submit claims for those services.
- An orthopaedic surgeon was repeatedly submitting claims for specific assessments and services. A review by the Ministry of this surgeon's submitted claims from 2012/13 to 2017/18 found that this surgeon was submitting incorrect claims for several fee codes. The Ministry recovered approximately $258,000 from this surgeon. However, the Ministry has not done any follow-up reviews to confirm that if the surgeon has stopped submitting incorrect claims.
- One ear, nose and throat surgeon (otolaryngologist) was submitting claims for a unique fee code that is not payable when other surgical fee codes are also being claimed. In 2019/20, the Ministry recovered approximately $102,000 from this surgeon in incorrect payments related to claims submitted between 2012/13 and 2016/17.

The examples of high or unreasonable billings we identified and the incorrect billings the Ministry identified as part of its billing reviews on select surgeons indicate that there continues to be a risk that physicians with unusual or high billing patterns are being paid for ineligible services.

Though the Ministry is responsible for overseeing the accuracy and eligibility of physician billings, the College of Physicians and Surgeons of Ontario (College) has the mandate to monitor and maintain standards of practice and to discipline physicians and surgeons who demonstrate professional misconduct or incompetency. However, the College does not have the mandate nor the information to use physician activity or billings as a basis for selecting physicians for a review. The College is often not made aware of these matters until after a physician has already been selected for an assessment or if a complaint or tip is submitted to the College.

While the Ministry sometimes did forward information to the College if it received complaints about possible wrongdoing by physicians, the Ministry did not proactively identify possible wrongdoing using unusual patient visit and billing patterns to share with the College.

The issue of unusual billings and the need to work collaboratively with the College has been raised by our Office before. For example:

- In our 2016 value-for-money audit on Physician Billing, we found that the Ministry did not investigate many anomalous physician billings, including many physicians and surgeons that billed for a high number of days worked or high numbers of services performed as compared to their peers. To strengthen the oversight of payments to physicians to ensure that health-care dollars are spent only on medically necessary procedures and that taxpayer dollars are fully recovered in situations of inappropriate billings, we made a

number of recommendations to the Ministry. For example, we recommended working with medical professionals to establish evidence-based standards and guidelines; monitoring billings to ensure physicians correct their inappropriate billings on a timely basis; establishing an effective mechanism to recover overpayments from physicians when inappropriate billings are confirmed; and streamlining the existing review and education process for physician billing. However, in our 2021 follow-up of our 2016 audit on Physician Billing, we confirmed that most of these recommended actions had not been fully implemented but are now in the process of being implemented by 2022.

- In our 2020 value-for-money audit on Virtual Care: Use of Communication Technologies for Patient Care audit, we noted physicians that reported seeing an unreasonable number of patients in a day and found that the Ministry does not proactively share data with the College to assist them in carrying out their mandate. We recommended that the Ministry collaborate with the College to evaluate the quality of virtual care being provided by physicians with an unreasonable number of virtual-care visits.

RECOMMENDATION 10

To prevent and deter inappropriate billing for outpatient surgeries, we recommend that the Ministry of Health:

- monitor surgical billing data on a regular basis to identify red flags and risks that warrant further reviews;
- conduct timely reviews when unreasonable or unusual trends are noted; and
- collaborate with the College of Physicians and Surgeons of Ontario to evaluate the clinical quality of surgeries and care being provided by surgeons with unreasonable patient activity and billings, and identify and initiate the appropriate actions required.

MINISTRY RESPONSE

Based on the recommendations made in the 2016 Physician Billing audit by the Office of the Auditor General of Ontario, the Ministry recently improved its ability to effectively monitor and ensure timely physician compliance with correcting inappropriate billing.

The Ministry continues to use existing analytical tools to monitor billings and select claims for review, and to support correcting inappropriate billing behavior, and the recovery of overpayments in a timely manner when inappropriate billings have been identified.

As part of its commitment to continuous improvement the Ministry continues to explore new analytical software to streamline monitoring now and in the future.

Most billing concerns are received by the Ministry through tips or complaints from the public, health-care employees, other physicians, government program areas or regulatory bodies, including the College of Physicians and Surgeons of Ontario (College).

When billing concerns are noted, the Ministry conducts timely reviews based on the information provided. If the Ministry suspects issues regarding patient safety or standards of practice, the physician is referred to the College, which has a legislated mandate to ensure quality care is provided by physicians.

4.6 No Provincial Oversight to Protect Patients against Inappropriate Charges for Publicly Funded Surgeries

4.6.1 Surgery Provider Sales Practices Include Providing Misleading Information and Charging Patients for Unnecessary Add-ons

Medically necessary outpatient surgeries are entirely covered through the Ontario Health Insurance Plan (OHIP) and by Ministry funding to service providers. Service providers, including surgeons and/or the clinics they work for, may also offer uninsured add-on

services or products to patients for an added charge in conjunction with some insured surgeries. However, there is no provincial oversight of surgery providers (the surgeons and/or the clinics they work for) who may have provided misleading information to patients who are unfamiliar with their right to publicly funded surgeries and who may be misinformed about these added charges.

Common add-on fees specifically relate to cataract surgeries, which represent the highest volume of outpatient surgeries in Ontario, as shown in **Figure 1.** Patients with a cataract are able to receive cataract surgery that is paid for fully by OHIP. However, patients do have the option to pay—out of pocket or through private health insurance—for a modified eye lens that is not covered through OHIP. When opting for a modified lens, patients are typically requested to pay for the difference between the standard medically necessary OHIP-covered lens and the modified lens, plus any additional uninsured testing fees. The surgeon will still submit a claim to OHIP for the surgery and any publicly funded eye testing performed. Patients receiving the surgery in any setting (public hospital, private hospital or independent health facility) could opt for a modified lens. The decision to have the surgery, as well as the decision on any add-ons such as a modified lens, is made between the patient and their ophthalmologist prior to surgery. Typically, the ophthalmologist's clinic charges the patient for any add-ons, while the public hospital, private hospital, or independent health facility provides the ophthalmologist with the resources, such as an operating room, to offer the surgery.

The add-on charges for a modified lens and additional testing vary by provider but could range from a few hundred to a few thousand dollars. These charges would be paid for directly by a patient or a patient's private health insurance provider.

Patients Not Being Adequately Informed of Their Right to Publicly Funded Surgery

Through discussion with ophthalmologists and a review of medical research, we noted that the standard OHIP-covered cataract surgery is sufficient to address the medical issue of having a cataract in the eye. However, paying for additional testing and a modified lens as part of the cataract surgery could provide non-medical benefits (such as improving vision and/or no longer requiring glasses post-surgery). As such, while patients are entitled to receive the standard surgery in Ontario without having to pay any fees out of pocket, some may choose to pay for a modified lens if they wish, much as some patients opt for laser eye surgery to remove the need for glasses (which is a procedure not covered by OHIP). Ophthalmologists must discuss all uninsured services with cataract surgery patients and must inform these patients of the option of receiving medically necessary tests and lenses without paying any additional charge.

We reviewed Ministry policies and agreements and noted that there is no mandatory documentation that surgeons or organizations must share or keep to document having informed a patient of their right to publicly funded surgery without having to pay any out-of-pocket costs. The Ministry does not require them, for example, to provide patients with documentation about their rights or to obtain patient signatures agreeing to the fact they have been adequately informed of this.

Based on our review of complaints received by Ontario's Patient Ombudsman and the Ministry, we noted instances where patients were not being adequately informed of, or offered, the standard OHIP-covered services; instead, they were often being charged for add-ons. For example, one person who complained was concerned about being charged for cataract surgery when it should have been covered by OHIP regardless of whether it was provided at a public or private clinic. Another person complained about having to pay for cataract surgery because the surgeon did not inform them that they were entitled to receive standard surgery free of charge through OHIP. Therefore, patients may end up paying all cataract surgery costs if they have been misled.

While non-insured services can provide value to patients and patients should have the ability to choose and pay for add-ons, there is a risk to patients

who are not adequately made aware of their rights to publicly funded surgery. A 2015 article published in the *Canadian Medical Association Journal* (a peer-reviewed general medical journal) also highlights this concern by saying, "Patients who misunderstand the optional nature of noninsured services may make substantial sacrifices to pay for cataract surgery. Alternatively, they may decide to postpone or forgo surgery until they can afford the noninsured costs, which will leave them to suffer unnecessarily for longer with correctable impaired vision."

With no provincial oversight and a lack of public awareness about optional add-ons, individuals who are not familiar with their right to publicly funded surgeries may not be aware when they are being misinformed and that they can, or should, submit complaints to the Ministry or the College of Physicians and Surgeons of Ontario. This means that the issue of inappropriate and unusual patient charges could be much more widespread than the complaints being made to the Ontario Patient Ombudsman and the Ministry.

Mystery Shoppers Being Given Misleading and Inconsistent Information

To gain further insight and assess the extent of misleading sales practices and price discrepancies between providers, we engaged a professional research firm to carry out "mystery shopping" by making 80 phone calls to a total of 25 providers and clinics offering outpatient surgeries. The providers and clinics included independent health facilities, a private hospital, and ophthalmologist's or eye clinics (which are private clinics where the ophthalmologists provide care and assessments, such as eye examinations and consultations). The "mystery shopping" involved contacting these clinics, because most ophthalmologists delivering surgery at public hospitals have their own private clinic that they either own or work in to offer consultation and patient care. Ophthalmologists typically provide surgeries in a hospital setting, but most of the consultation and decision-making is done in the clinic.

The "mystery shopping" work involved having actors (the mystery shoppers) call organizations (including independent health facilities, a private hospital and ophthalmologist's or eye clinics) through their general contact phone number multiple times over the span of approximately two months to ask for information about the availability of a publicly funded surgery, especially cataract surgery, which is the specialty area with the highest risk of misleading sale practices. The conclusions, based on calls made by mystery shoppers, include:

- Pricing information is not transparent as it is very difficult for the average consumer to obtain such information, such as pricing for specialty lenses, without undergoing a consultation. Almost all clinics told mystery callers that they could not share pricing lists until the patient was seen in person. Some clinics did share price ranges over the phone, with cataract surgeries using specialty lenses costing the patient anywhere from $450 to almost $5,000 per eye depending on the type of lens used. While there may be certain information that cannot be shared until a consultation has been completed, such as the compatibility of a certain type of eye lens, pricing for add-ons such as specialty lenses should be available to the public prior to consultation so that patients can conduct their own research and make an informed decision to ensure they are not being overcharged or wrongfully charged by a provider.
- Many clinics did indicate that specialty lenses are optional and patients can choose to receive the standard OHIP-covered lens free of charge. However, some clinics indicated that specialty lenses are or may be mandatory depending on the surgeon's assessment. As noted earlier, specialty lenses are considered an add-on and should never be mandatory, meaning these clinics were providing misleading information to the mystery shoppers.
- Mystery shoppers were given inconsistent and conflicting information from the same clinics depending on when the call was made. For example, during some calls, the clinics indicated that the standard cataract surgery is covered through OHIP but during other calls, the same

clinics indicated there will be additional costs that patients will have to pay out of pocket.

- Some clinics indicated that the standard eye testing covered by OHIP is of inferior quality and that add-on tests provide more thorough and accurate results. While there may be benefits to undergoing add-on tests, specifically when opting for a specialty lens, these clinics are misleading patients by indicating that the OHIP-covered testing is inferior.

The issue of inadequately informing patients of their choice to receive a publicly funded cataract surgery has been a long-standing concern in Ontario. For example,

- In 2008, the Ontario Health Coalition, in partnership with Health Coalitions across Canada, performed a study to determine the extent of the problem of privately charging patients extra fees and selling access to care. The study found that private cataract clinics were charging for cataract surgery with special lenses, which they aggressively marketed to patients, despite the fact that the public health-care system already covered all needed care associated with cataract surgery.
- In 2017, the Ontario Health Coalition conducted another study of private surgical and cataract clinics and conducted a survey of patients who received cataract surgeries. Almost a decade after its first study in 2008, the 2017 study found that the extra-billing issue had become more overt and had proliferated, with the majority of private clinics continuing to charge patients extra fees for cataract surgeries and patients not always being made aware of their ability to receive fully covered cataract surgery.

We found that the Ministry does not proactively monitor the practices of surgeons and clinics to confirm that patients are being adequately informed about their right to receive a fully covered surgery without the need to pay out of pocket. Instead, the Ministry typically relies on the patient complaints it receives to identify inappropriate practices by surgical clinics, but as noted above, this method is reactive and ineffective in protecting those patients who may be paying extra fees for these surgeries because they are unaware that they can receive an OHIP-covered surgery without the need for paying any out-of-pocket costs.

RECOMMENDATION 11

To prevent and deter inappropriate patient charges while protecting the province's commitment to funding medically necessary surgeries, we recommend that the Ministry of Health:

- assess and evaluate the feasibility of collecting data on the prices of fees that some surgeons are charging to patients on top of OHIP-covered surgeries as well as on collecting data on patients that are being charged these fees;
- identify tools that can be used to inform Ontarians about cataract surgeries and prevent inappropriate charges to patients; and
- in collaboration with the College of Physicians and Surgeons of Ontario, take disciplinary action against physicians and organizations found to have misinformed, or failed to inform, patients of their right to a fully covered OHIP surgery.

MINISTRY RESPONSE

The Ministry appreciates the first two action items as they support protecting patients against inappropriate patient charges for patients seeking OHIP-insured services. The Ministry will explore the feasibility of collecting data on the prices of fees that some surgeons are charging to patients for uninsured services performed in conjunction with OHIP-insured surgeries, as well as of collecting data on patients that are being charged these fees, as permitted in accordance with any relevant privacy legislation. The Ministry will continue to work to identify tools that may be used to inform Ontarians about cataract surgery and inappropriate charges related to insured cataract surgical services.

The Ministry supports encouraging the College of Physicians and Surgeons of Ontario to consider whether it is appropriate under its mandate to take action against physicians and organizations that have been found to have misinformed, or failed to inform, patients of their right to a fully covered OHIP surgery.

Preventing and deterring inappropriate patient charges is governed between the *Commitment to the Future of Medicare Act* (CFMA) and the College of Physicians and Surgeons of Ontario (College). Under the CFMA, it is a violation for a person or entity to charge OHIP-insured persons for an insured service or a component of an insured service (known as "extra billing"); to pay or receive a fee or benefit from an insured person for providing preferred access to an insured service (known as "queue-jumping"); and/or to make the provision of an insured service conditional upon an insured person paying a block fee for uninsured services. The Ministry reviews all potential violations of the CFMA that come to its attention through specific patient complaints, as well as conducting reviews arising from other sources (anonymous tips from the public, the media, organizations, etc.). The Ministry does not regulate charges by physicians for uninsured services. Instead, the College, the body governing the practice of medicine in Ontario, is responsible for regulating charges by physicians for uninsured services and ensuring that physicians provide health services in accordance with professional guidelines. The College, in accordance with regulations under the *Medicine Act*, has established a policy for physicians and a fact sheet for patients with respect to charging patients for uninsured services. Part of this policy includes requirements for combining insured and uninsured services.

4.6.2 Ministry Expanding Access to Outpatient Surgeries Provided by Private Clinics without Addressing Existing Issues of Inappropriate Billings and Misleading Sales Practices

As discussed in **Section 2.2.2**, in addition to public and private hospitals, outpatient surgeries are provided at 10 clinics that are licensed by the Ministry as independent health facilities (IHFs) (see **Figure 7**). These IHFs, most of which are private, for-profit organizations, have existed for a number of years and have been assisting the health-care system address surgical volumes.

In 2014, the Ministry issued a request for proposal (RFP) to organizations that would like to receive an IHF licence for cataract surgeries, which are almost always performed on an outpatient basis. But, under the terms of the RFP, to qualify, organizations had to be not-for-profits. We reviewed preliminary details of the RFP process and found that, though the Ministry was interested in adding new IHFs, the total service volume for cataract surgeries was not increasing. Ultimately, the RFP did not move forward.

In 2020, we noted that the Ministry issued a call for applications (a term used in 2020 to replace request for proposal) for cataract surgery providers, but this time, the Ministry also planned to increase the volume of cataract surgeries funded. However, unlike the RFP in 2014, the call for applications in 2020 allowed private, for-profit organizations to submit applications. Furthermore, per the terms of the call for applications, these organizations will be expected to provide OHIP-covered surgeries free-of-charge to patients, but they can also offer other services and care that is not covered by OHIP, which patients must then pay for directly.

There are potential benefits to moving surgeries outside of a hospital setting, as noted in **Section 4.3.2.** However, concerns have been expressed about the use of private for-profit facilities to deliver publicly funded health-care services in Ontario.

We reviewed feedback provided to the Ministry by hospitals and ophthalmologists on the recent call for applications and noted multiple concerns were raised. For example:

- Hospitals and ophthalmologists indicated that they were not consulted about the decision to move forward with a call for applications for more private IHFs.
- Some hospitals indicated they were interested in applying for the call for application to provide additional cataract surgeries. However, the Ministry indicated that this initiative was specifically for IHFs and hospitals would have to access other initiatives such as temporary funding to address the COVID-19 surgical backlog.
- Some ophthalmologists raised concerns that having more private IHFs may result in more ophthalmologists choosing to work for an IHF, meaning hospitals may lose the ability to care for patients requiring ophthalmology care.

We spoke with the ophthalmologist-in-chief at a not-for-profit independent health facility and a former Deputy Minister of Health. They indicated that there are benefits to providing more outpatient surgeries in the community (such as through IHFs) rather than in a hospital, but there are also concerns and risks about the use of more for-profit cataract surgery centres. More specifically, there is a higher risk that privately owned organizations may prioritize profits by charging patients for add-ons, and those charges would not be adequately monitored and scrutinized by the Ministry because they do not affect public funding, resulting in no protection of patients' interest. As noted in **Section 4.6.1**, these concerns do exist currently, as the Ministry does not proactively request information about—or review—private-pay add-ons and charges to patients. Therefore, without adequate and appropriate provincial oversight in place, providing more outpatient surgeries through more for-private organizations could further increase the aforementioned concerns.

As noted in **Section 4.6.1**, there also continue to be concerns related to patients being charged for unnecessary services without being adequately informed of their right to receive OHIP-covered surgery and from surgeons being found to bill for unnecessary procedures. While these issues are not specific to IHFs, without adequately addressing these concerns, the Ministry is putting patients at greater financial risk by allowing additional private organizations to provide publicly funded surgeries while also being allowed to charge patients directly for additional uninsured services to make a profit without appropriate oversight mechanisms in place.

We also noted that some of the existing outpatient surgery providers (including IHFs and public hospitals) have excess capacity available to perform cataract surgeries, as discussed in **Section 4.7.2.** This excess capacity could be better used.

RECOMMENDATION 12

If actions continue to be taken to expand the use of for-profit private clinics in the performance of cataract surgeries, we recommend that the Ministry of Health:

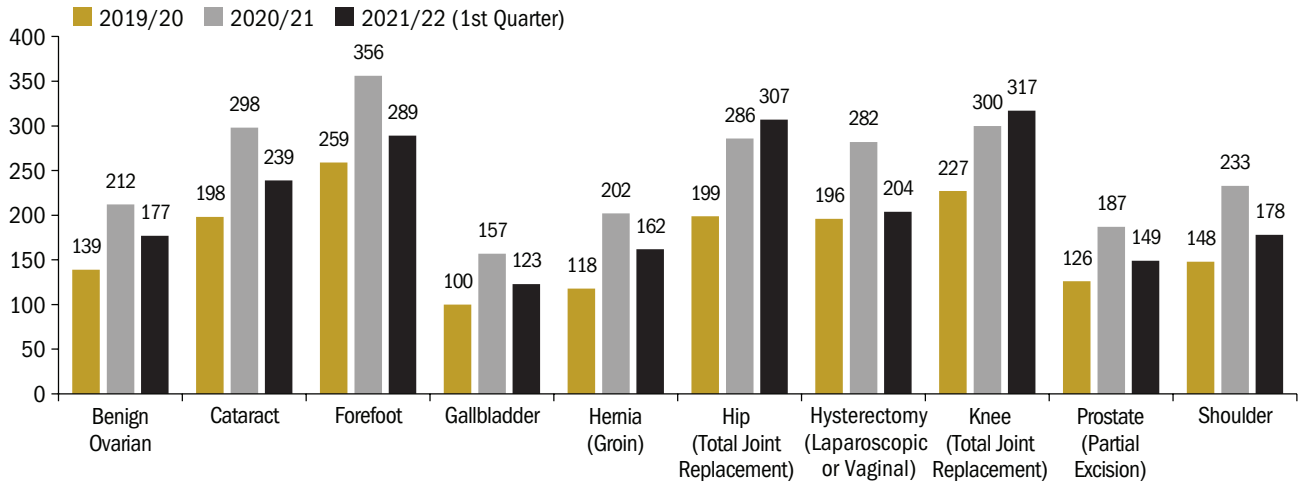
- engage with health-care providers and key stakeholders to determine the risks and benefits of the current call for applications process; and
- implement additional oversight mechanisms to protect patients against possible misleading sales practices and inconsistent policies.

MINISTRY RESPONSE

The Ministry has engaged Ontario Health throughout the current call for applications process, given its role in health system planning, and will engage health-care providers and key stakeholders moving forward. In addition, to protect patients, the call for application forms included a section requiring 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. If any licences are issued, the transfer payment agreement will include related provisions to protect patients.

Figure 17: Outpatient Surgery Wait Times (Days), 2019/20, 2020/21, and First Quarter 2021/22

Source of data: Ontario Health



Licensed IHFs are subject to an existing quality assurance program as required under the *Independent Health Facilities Act*. The quality assurance program is administered by the College of Physicians and Surgeons of Ontario (College), and assessments are conducted at the request of the Director of Independent Health Facilities in accordance with Clinical Practice Parameters and facility standards developed by the College. Furthermore, the College is responsible for governing the practice of medicine and ensuring that physicians provide health services in accordance with professional guidelines. The College has established a policy for physicians with respect to charging patients for uninsured services.

4.7 COVID-19 Continues to Impact Outpatient Surgeries

Outpatient surgeries were significantly impacted starting in mid-March 2020 when the COVID-19 pandemic resulted in cancellations and deferral of non-urgent and elective surgeries, many of which are outpatient surgeries. While there were periods of decreasing COVID-19 cases in August 2020, Ontario faced another wave of increasing cases in the following year (around March and April 2021) that eventually resulted in further cancellations and delays of outpatient surgeries.

4.7.1 Wait Times for Outpatient Surgeries Continue to Be Long During COVID-19, Resulting in Deterioration of Patient Health and Surgery Backlogs

As discussed in **Section 4.1.1**, outpatient surgery patient care was impacted as a result of the COVID-19 pandemic and the directive issued twice by the Chief Medical Officer of Health (CMOH) to all Ontario health-care providers in order to preserve capacity for caring for patients with COVID-19. The directive required that all non-essential and elective surgeries stop or be reduced to minimum levels to ensure that hospitals had sufficient capacity to treat COVID-19 patients. The CMOH directive first applied March 19 to May 26, 2020. In 2021 the CMOH issued the directive a second time, with application from April 20 to May 19, 2021. Many outpatient surgeries were cancelled and/or delayed again as a result of the second issuance of directive.

We reviewed wait times for surgeries that are commonly performed on an outpatient basis and found that many wait times decreased in the first three months of 2021/22. However, wait times for most surgical areas continue to be longer than wait times

as at March 31, 2020. **Figure 17** shows examples of wait times on March 31, 2020, March 31, 2021 and June 30, 2021.

We spoke with service providers about how patients were impacted as a result of long wait times and surgery delays and cancellations as a result of the COVID-19 pandemic. Some of these patient stories are set out in **Appendix 4.** These stories indicate that cancellations and delays of elective surgeries, most of which are outpatient surgeries, during COVID-19 have left many patients struggling with daily activities because of severe pain and limited mobility, as well as suffering from complications associated with their illnesses. Though these surgeries have gradually resumed in Ontario, there continue to be long wait times and surgical backlogs.

Our information is in line with a recent paper published in *The Lancet* (a peer-reviewed medical journal) in February 2021. The paper studied the impact of COVID-19 on elective surgery with a focus on joint replacement, which is one of the common types of elective surgeries that can be done on an outpatient basis. Specifically, the paper indicated that it, "will undoubtedly take many years to grasp the totality of the consequences of delayed joint replacement surgeries, both with regard to long-term health outcomes for patients and costs to health systems and societies." The paper used joint replacement as an example, indicating that patients waiting for joint replacements often suffer from "debilitating pain that disrupts mobility and interferes with daily activities." The paper further noted that "delaying surgery in patients with the most severe disease can lead to more complicated surgeries, increased use of medications, more difficult recovery, and worse outcomes, including increased rates of revision surgery and reduced quality of life. A recent study projected 50% greater odds of worse outcomes when surgery is delayed by more than 6 months—far less time than thousands of patients have already waited."

As discussed in our Office's 2021 value-for-money audit on Cardiac and Stroke Care, since many patients were not seeking care for milder conditions, the volume of these "missing" patients is unknown, meaning that the wait times (as noted in **Figure 17**) likely underrepresent the true growth in the needs of Ontarians during COVID-19. While these "missing" patients' needs for, and impacts to, outpatient surgeries in the upcoming years have yet to be seen, they will likely increase the burden on Ontario's hospitals in the future.

4.7.2 Unused Health-Care System Capacity Available to Help Clear Surgery Backlogs

Though the Ministry has started taking steps to address the surgical backlog, for example, by providing one-time funding to increase the number of surgeries being performed, as discussed in **Section 2.2.2,** there continues to be unused or underused capacity available in the health-care system.

Through discussion with public hospitals, a private hospital, and IHFs that offer outpatient surgeries, we found that though some of these organizations continue to have unused capacity available, currently they are not able to provide additional surgeries. This is often due to funding and resource (that is, staffing) constraints and/or predetermined surgical volumes that limit the number of insured surgeries they can perform.

For example, a research paper released in Longwoods (which publishes academic and scientific reports, commentary, and information about healthcare services) in May 2021 reviewed the pre-COVID-19 costing for cataract surgeries at Kensington Eye Institute, which is one of the independent health facilities offering outpatient surgeries in Ontario. This paper noted that the number of cataract operations at Kensington Eye Institute in 2019 was at approximately 50% capacity because of funding limits.

We also heard that one of the key challenges faced by providers of outpatient surgeries is the lack of clarity around future funding. For example, one provider indicated that it could provide additional capacity but in order to do so, it would have to incur capital costs that would not be reimbursed by the Ministry. Incurring these capital costs without any

guarantee of future funding makes it too risky for them to provide additional capacity.

On July 28, 2021, the Ontario government announced that it would ramp up efforts to reduce surgical wait times by investing into the health-care system in 2021/22 up to $324 million in new funding. Of this amount, $216 million is being dedicated to hospitals to extend operating room hours into evenings and weekends to perform up to 67,000 additional surgeries. As part of the announcement, the government indicated it would work with Ontario Health and hospitals to determine what hospitals could increase their surgical activity based on their local situation. This presents an opportunity for the Ministry and Ontario Health to determine where there is available capacity and demand for outpatient surgeries as well as long wait times. The Ministry and Ontario Health can then use this information to allocate future funding to reduce long-standing wait times that existed before to COVID-19, as discussed in **Section 4.1.1.**

RECOMMENDATION 13

To efficiently and effectively clear the backlog of outpatient surgeries, we recommend that the Ministry of Health:

- collect information on a regular basis from the existing outpatient surgery providers, including public hospitals, independent health facilities, and private hospitals to determine unused capacity without the need for additional public funding for capital costs; and
- allocate any additional surgical volumes and associated funding to providers using a multi-year funding agreement to clear the surgical backlog with established timelines.

MINISTRY RESPONSE

Ontario Health's Surgical Efficiency Targets Program reporting collects data from hospitals on key surgical efficiency metrics, including the degree to which hospitals are leveraging operating room time. Information on available surgical capacity and resources in hospitals is also collected and discussed at Ontario Health's five regional Surgical Recovery Tables. The Ministry will work to also collect information on a regular basis from other outpatient providers (the independent health facilities and the one private hospital that does outpatient surgeries).

The Ministry recognizes the importance of secured multi-year funding to enable health system providers to address key health-care recovery challenges and will pursue this within the considerations and parameters of the government's Multi-Year Planning Process.

Appendix 1: Independent Health Facilities Providing Outpatient Surgeries

Prepared by the Office of the Auditor General of Ontario

Independent Health Facility (IHF)	Specialty Area	Examples of Publicly-Funded Surgeries Performed at the specific IHFs
Kensington Eye Institute	Ophthalmology	Cataract surgeries, glaucoma surgeries, corneal transplants and vitreoretinal surgeries.
Stein Surgical Centre Inc.	Ophthalmology	Cataract surgeries, laser eye surgeries and general eye surgeries.
McLean Clinic	Plastic	Plastic surgery/procedures, such as breast reduction or rhinoplasty for medical purposes and sex reassignment surgery (breast).
The Plastic Surgery Clinic Inc.	Plastic	Plastic surgery/procedures, such as breast reduction or rhinoplasty for medical purposes.
Rosedale Centre for Plastic Surgery	Plastic	Plastic surgery/procedures, such as breast reduction for medical purposes, and removal of skin cancers.
Optimum Medispa	Plastic	Plastic surgery/procedures, such as post-mastectomy breast reconstruction and skin grafts.
Dr. Leonard Harris	Plastic	Plastic surgery/procedures, such as rhinoplasty for medical purposes.
Niagara Plastic Surgery Centre	Plastic	Plastic surgery/procedures, such as breast reduction for medical purposes, and removal of skin cancers.
Cosmetic Surgery Clinic of Waterloo	Plastic	Plastic surgery/procedures, such as post-mastectomy breast reconstruction.
Astra Minimally Invasive Surgery Unit	Gynecology	Gynecology services such as tubal plastic operations (fimbriolysis, salpingostomy), biopsies, myomectomies, and abortions.

Appendix 2: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1. Effective co-ordination between the Ministry of Health, Ontario Health and service providers is in place to ensure patients have equitable and timely access to outpatient surgeries regardless of where they live.
2. Roles and responsibilities of all parties involved in the delivery of outpatient surgeries are clearly defined, and accountability requirements are established, to ensure effective service delivery, co-ordination and oversight.
3. Funding and facilities for outpatient surgeries are allocated based on patient needs, used for the purposes intended, and managed with due regard for economy and efficiency.
4. Sufficient, accurate, and timely operational data is regularly collected and assessed to help guide management decision-making at the Ministry of Health and Ontario Health.
5. Appropriate performance measures and targets are established and continuously monitored against actual results to ensure that intended outcomes are being achieved and that corrective actions are being taken on a timely basis when issues are identified.

Appendix 3: Organizations Contacted

Prepared by the Office of the Auditor General of Ontario

Organization Type	Organization	Region
Public Hospital	Kingston Health Sciences Centre	East
	London Health Sciences Centre	West
	North York General Hospital	Central
	St. Joseph's Health Care London	West
	The Ottawa Hospital	East
	Thunder Bay Regional Health Sciences Centre	North
	University Health Network	Toronto
	William Osler Health System	Central
	Women's College Hospital	Toronto
Independent Health Facility	Astra Minimally Invasive Surgery Unit	Central
	Kensington Eye Institute	Toronto
	McLean Clinic	Central
	Stein Surgical Centre Inc.	Toronto
Private Hospital	Don Mills Surgical Unit	Central

Appendix 4: Patient Stories Related to Long Wait Times and Delays Due to COVID-19

Prepared by the Office of the Auditor General of Ontario

Example	Specialty Area	Patient Story
Patient A	Ophthalmology	Patient A required a trabeculectomy surgery for glaucoma in one eye. She had initially been assessed in January 2020, at which point she was receiving treatment to stabilize her glaucoma until surgery. Her surgery was delayed first due to the COVID-19 pandemic and then as a result of the patient being nervous about visiting a hospital for a reassessment and surgery in the following months. She chose to come to the hospital in October 2020 when her comfort level would allow it, but by then her glaucoma had progressed from moderate to advanced vision loss, meeting the definition for a blind eye. Her surgery was completed three weeks after the reassessment to stabilize her condition but the vision loss was not reversible.
Patient B	Urology	Patient B was informed he needed a urethroplasty in 2020 to address his urethral stricture disease. The surgery, which was classified as elective, was delayed due to COVID-19. This caused the patient to reach the point where his urine was backing up into his kidneys, causing him to be in acute renal failure. In 2021, the urologist had to bring the patient in as an urgent case to relieve the obstruction, but the delay caused permanent damage in his kidneys.
Patient C	Hip	Patient C began experiencing severe hip pain in April 2020. He attempted to self-manage the pain but was unsuccessful. In January 2021, he was diagnosed with bone-on-bone hip osteoarthritis and was informed that the wait time for surgery could be from six to 12 months at best. Patient C became suicidal in February 2021, at which point his spouse advocated for him by pleading for an expedited surgery date and he was eventually taken to the operating room as a priority case in March 2021. Patient C was quoted as saying, "I wonder how many others are in this situation and do not have an advocate. I feel that the system has failed if any patient is made to wait six to 12 months with the level of pain I was experiencing."
Patient D	Breast Cancer (Breast Reconstruction)	Patient D was treated for breast cancer in 2020 and required a breast reconstruction surgery. The surgery was postponed in 2020 due to COVID-19 and rescheduled for May 2021, and then delayed again due to the provincial directive in place during that time. The patient was highly upset that her reconstruction surgery did not fit the eligibility criteria to be performed when the provincial directive to stop elective surgeries was first issued in March 2019 as she explained she was in a great deal of pain and had to remain on medication to control the pain. She received her surgery in June 2021.
Patient E	Ophthalmology	Patient E is a diabetic male with declining cognitive function manifested in his mild dementia. He had cataracts in both eyes and had his first cataract operation in March 2021. His second cataract operation was postponed according to Ontario's directive on non-emergency procedures but was eventually performed at the end of May 2021. During the delay, with only one eye corrected and the other still blurry and disorienting from the cataracts, it was difficult for him to achieve balance in his daily activities.

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