In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the "OMA")

- AND -

MINISTRY OF HEALTH

(the "MOH")

(together, "the PARTIES")

REPLY BOOK OF DOCUMENTS OF THE ONTARIO MEDICAL ASSOCIATION VOLUME 1 OF 2

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37. **Appendix A**: Modeling Assumptions

TAB 1

Ontario (https://www.ontario.ca/page/government-ontario)

Quality-Based Procedures

Learn more about how Ontario is supporting high-quality care for surgical and medical procedures.

This information is intended for health care providers. Learn more about health programs and services available in Ontario. (https://www.ontario.ca/page/your-health#section-8)

Overview

The Quality-Based Procedure (QBP) program provides volume-based funding for health care services where evidence-based best practices have been defined for patients with clinically related diagnoses or treatments.

The program is intended to:

- improve quality of care
- obtain better value for money in the delivery of health care services

QBPs offer opportunities to:

- reduce variation in costs and quality of care
- improve processes and clinical design
- enhance patient experience and improve patient outcomes
- drive system efficiencies

For each QBP, a clinical handbook is developed by a multi-disciplinary clinical expert advisory panel that outlines:

- evidence-based care pathways
- recommended practices
- performance indicators to monitor for ongoing quality improvement

In this patient-based funding model, health care providers receive funding for health care services based on:

- an established price (adjusted for the level of acuity of the patients they serve)
- an initial volume target based on historical activity, population growth and recommendations from clinical advisory bodies (hospitals can also adjust volumes as needed)

QBP clinical handbooks

Elective QBPs

The following handbooks are for elective QBPs that are Ontario Health region-managed (including Bundled QBPs)

- Cataract Day Surgery (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-cataract-day-surgery-en-2023-12-11.pdf) (May 2021 - version 2)
- Primary Hip and Knee Replacement (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-primary-hip-and-knee-replacement-en-2023-12-11.pdf) (November 2013)
- Non-Cardiac Vascular - Aortic Aneurysm (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-non-cardiac-vascular-aortic-aneurysm-en-2023-12-11.pdf) (March 2022)
- Non-Cardiac Vascular - Lower Extremity Occlusive Disease (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-non-cardiac-vascular-lower-extremity-occlusive-disease-en-2023-12-11.pdf) (March 2022)
- Paediatric Tonsillectomy and Adenoidectomy (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-paediatric-tonsillectomy-and-adenoidectomy-en-2023-12-11.pdf) (November 2016)
- Knee Arthroscopy (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-knee-arthroscopy-en-2023-12-11.pdf) (May 2019)
- Integrated Corneal Transplant Care (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-integrated-corneal-transplant-en-2023-12-11.pdf) (March 2018)
- Non-Emergent Integrated Spine Care (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-non-emergent-integrated-spine-care-en-2023-12-11.pdf) (January 2022)
- Degenerative Disorders of the Shoulder (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-

handbook-degenerative-disorders-shoulder-en-2023-12-11.pdf) (July 2015 - version 2)

- Hysterectomy (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-hysterectomy-en-2023-12-11.pdf) (August 2016)

Non-elective QBPs

The following handbooks are for non-elective QBPs that are Ontario Health region-managed

- Stroke - Acute and Postacute (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-stroke-en-2023-12-11.pdf) (December 2016)
    - Stroke Appendices (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-stroke-appendices-en-2023-12-11.pdf)
- Heart Failure - Acute and Postacute (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-heart-failure-en-2023-12-11.pdf) (February 2015)
- Chronic Obstructive Pulmonary Disease - Acute and Postacute (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-copd-en-2023-12-11.pdf) (February 2015)
- Hip Fracture (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-hip-fracture-en-2023-12-11.pdf) (May 2013)
    - Hip Fracture Clinical Handbook Rapid Review Appendices (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-hip-fracture-appendices-en-2023-12-11.pdf) (April 2013)
    - Indicator Handbook for Hip Fracture (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-hip-fracture-indicator-en-2023-12-11.pdf) (July 2013)
- Community-Acquired Pneumonia (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-pnemonia-en-2023-12-11.pdf) (February 2014)

QBP's that are Ontario Health – Cancer Care Ontario managed

For a copy of the most recent clinical handbook, please reach out to the following email addresses:

- Chronic Kidney Disease: ORNFundingPolicy@ontariohealth.ca (mailto:ORNFundingPolicy@ontariohealth.ca)
- Cancer Surgery QBP: SOPInfo@ontariohealth.ca (mailto:SOPInfo@ontariohealth.ca)

- Systemic Treatment: OH-CCO_ST-QBP@ontariohealth.ca (mailto:OH-CCO_ST-QBP@ontariohealth.ca)
- GI Endoscopy: cancerscreening@ontariohealth.ca (mailto:cancerscreening@ontariohealth.ca)

Non-funded procedure clinical handbooks

The following clinical handbooks have also been developed for procedures that are not funded as QBPs. Health care providers are encouraged to implement the best practices in these clinical handbooks.

- Aortic Valve Disease (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-aortic-valve-disease-en-2023-12-11.pdf) (March 2016)
- Coronary Artery Disease (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-coronary-artery-disease-en-2023-12-11.pdf) (March 2016)
- Hyperbilirubinemia (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-hyperbilirubinemia-en-2023-12-11.pdf) (December 2017)
- Integrated Retinal Care (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-retinal-en-2023-12-11.pdf) (March 2018)
- Low Risk Birth (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-low-risk-birth-en-2023-12-11.pdf) (July 2017)
- Paediatric Asthma (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-paediatric-asthma-en-2023-12-11.pdf) (November 2021)
- Sickle Cell Disease (https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-sickle-cell-disease-en-2023-12-11.pdf) (December 2017)

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TAB 2

Professional Staff Credentialing Toolkit

SECOND EDITION
SEPTEMBER 2021

Ontario Hospital Association

Acknowledgements

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The OHA would also like to acknowledge the contributions of health system stakeholders, including staff at the Ontario Medical Association (OMA), in providing helpful feedback on this resource.

This edition is an updated version of a Toolkit originally published in 2012. We wish to recognize the significant contributions of OHA member hospitals, OHA staff, health system stakeholders, and lawyers at DDO Health Law in developing the original content.

About the Author

Kate Dewhirst is the founder of the health law firm Kate Dewhirst Health Law. She focuses on credentialing, privacy and access to information, and difficult clinical scenarios. Kate advises hospitals on all aspects of their relationships with physicians and other Professional Staff (dentists, midwives, extended class nurses) from recruitment to difficult disciplinary matters. She trains Chiefs of Department, Chiefs of Staff, Medical Advisory Committees, and hospital boards on their credentialing obligations and assists hospitals to implement practical systems to manage their Professional Staff. Kate was in-house legal counsel at the Centre for Addiction and Mental Health in Toronto from 2003 – 2008. She is a frequent speaker for the OHA on credentialing, risk management, privacy, and freedom of information issues.

Disclaimer

This resource document was prepared as a general guide to assist hospitals in understanding the legislation and processes around credentialing professional staff members. The material in this resource document is for general information only and may need to be adapted by hospitals and health care providers to accommodate their unique circumstances. This document reflects the interpretations and recommendations regarded as valid at the time of publication based on available information. It is not intended as, nor should it be construed as, legal or professional advice or opinion. Hospitals concerned about the applicability of specific credentialing practices and issues relating to privileges within their organization are advised to seek legal and/or professional advice based on their particular circumstances. Neither the OHA nor the Toolkit author, jointly or severally, will be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this resource guide.

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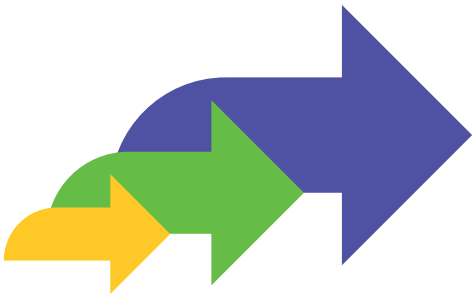


Introduction to the Toolkit

The Ontario Hospital Association (OHA) has a mandate to promote and foster excellence in health care governance, promote a culture of shared accountability, and assist hospitals in their efforts to enhance the governance of their organizations. In support of this mandate, the OHA is pleased to provide this updated edition of the Professional Staff Credentialing Toolkit to Ontario hospitals.

The Toolkit provides practical guidance to assist hospitals in managing one of their most critical resources: Board-Appointed Professional Staff (physicians, dentists, midwives, and extended class nurses). It explores the relationship between hospitals and the Board-Appointed Professional Staff who are granted "privileges" to practice at a specific hospital.

Although the Toolkit contains a list of Resources and References, it does not provide a synthesis of credentialing literature. For those interested in a review of the literature, a list of references is provided in Appendix III.

Guide to the Toolkit

What is the *Professional Staff Credentialing Toolkit*?

The Toolkit is a resource for Ontario hospitals. It is specifically designed for hospital board members, CEOs, Chiefs of Staff/Chairs of the Medical Advisory Committee (MAC), Chiefs of Departments (and other clinical leaders), and Heads of Divisions, as well as the many administrative personnel who manage the hospital's credentialing process. The Toolkit begins with background information, then guides readers through the credentialing process chronologically (i.e., from recruitment through retirement). It provides several resources including, frequently asked questions (FAQs), templates, checklists and sample documents.

Why is the *Professional Staff Credentialing Toolkit* needed?

The relationship between Ontario hospitals and their Professional Staff is tremendously important to the patient care experience. The relationship is also complicated and can be difficult to explain to patients, board members, Professional Staff members and hospital leaders. This Toolkit was drafted to provide a comprehensive education on the roles and responsibilities, history and current issues that arise between hospitals and their Professional Staff.

The credentialing process involves many stakeholders within the hospital playing different and crucial roles. Mistakes can be costly: gaps have the potential to compromise quality of care, disrupt staff and lead to legal proceedings. The legal context of credentialing is unique to hospitals and has a rich history. The Toolkit is intended to provide concrete, practical information that demystifies the process and reflects both legal requirements and best practice.

What's New in the Update

This second edition updates the 2012 Professional Staff Credentialing Toolkit to:

1. Reflect updates made to the OHA/OMA Prototype By-law;
2. Reflect changes made to the *Public Hospitals Act*, section 33 mandatory reporting of physicians to the College of Physicians and Surgeons of Ontario (see pages 43, 84, 95) and section 44 ceasing to operate or provide services (with amendments relating to the *Connecting Care Act*, 2019) (see page 109);
3. Acknowledge the Auditor General of Ontario's comments in 2016 and 2018 recognizing the financial implications of the *Public Hospitals Act* scheme on a publicly funded health care system (see pages 17-18);

4. Acknowledge the introduction of the *Connecting Care Act*, 2019 and the new Ontario Health Teams (see pages 9, 11);

5. Include the Health Insurance Reciprocal of Canada's recommendations for credentialing (see pages 15-17);

6. Address the impact of new technology on credentialing including for remote consultations such as telehealth and medical assistance in dying (see pages 11-12);

7. Include updates in case law (that is, decisions that have gone before the Ontario Health Professions Appeal and Review Board and courts across Canada) (see pages 18, 22, 23, 28-29, 46, 49, 60-61, 98, 114, 119, 142-145); and

8. Reference advances made in joint credentialing efforts (see pages 65-67, 71-72)

Mandatory Requirements versus Best Practice and Innovative Ideas

In **Chapter 2, Legal Context,** readers will learn that the *Public Hospitals Act* and its regulations set out a comprehensive code for managing the privileges hospitals grant to physicians. The process mandated by the *Public Hospitals Act* is a legal requirement. When an obligation flows from the *Public Hospitals Act*, its regulations, other legislation, or case law that has developed over years, the Toolkit identifies the source of the requirement.

In other instances, the Toolkit identifies best practice or makes recommendations about practical ways to address privileges issues. For example, dentists, midwives and extended class nurses are not subject to the detailed processes set out in the *Public Hospitals Act*; therefore, there is significant flexibility for hospitals to design their own processes for credentialing Professional Staff other than physicians and dealing with their privileges issues. Often, hospital by-laws treat all Professional Staff the same, but the Toolkit identifies when this need not be the case.

It is important to note that this Toolkit builds upon the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2021* (OHA/OMA Prototype By-law) , which we recommend for our hospital members. If a hospital has not adopted the by-law or has customized it to suit their unique situation, the hospital's own by-laws need to be considered in the context of all privileging matters. It is important to adapt any of the sample documents offered in this Toolkit to your own context.

Chapter Summaries

Chapter 1, Overview, provides answers to two fundamental questions: (1) What are privileges? and (2) Who needs them? This Chapter provides a basic overview of credentialing.

Chapter 2 sets out the **Legal Context** associated with the credentialing process. Hospitals will become familiar with key Ontario statutes such as the *Public Hospitals Act*. In addition, readers will learn about the significant consequences faced by hospitals when credentialing requirements are not carried out properly.

Chapter 3, Roles and Responsibilities, describes key players in the credentialing process and the responsibilities of various stakeholders, including members of the hospital board, MAC, Professional Staff, health regulatory colleges and others. The chapter contains itemized lists detailing responsibilities for various hospital staff, to help them better understand their role in the credentialing process.

Chapter 4, Planning and Recruitment, guides readers through the steps for recruiting Professional Staff. Readers will learn about Professional Staff Human Resources Plans and impact analyses.

Chapter 5 addresses **Initial Appointments**, including receipt of applications, credentialing and checking references, consideration by the Credentials Committee and MAC, and appointment decisions made by the board. Readers will learn about an individual's right to apply for privileges, what a hospital privileges application should include, and how to manage common issues associated with initial applications.

Chapter 6 deals with **Professional Staff Re-appointment**. This chapter explores changes to privileges, re-application rights, re-application content and criteria, and how to manage Professional Staff members who fail to re-apply for privileges.

Chapter 7 addresses **Everyday Management** issues once privileges are in place, including orientation and training of Professional Staff, key policies, leaves of absence, and occupational health and safety.

Chapter 8 examines **Performance Evaluations and "Progressive Management"** issues. This chapter explains how to establish good communication with Professional Staff, complete performance evaluations, implement a system of progressive management, and discipline Professional Staff as necessary.

Chapter 9 – in rare circumstances, hospitals must consider **Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges**. This chapter looks at how these situations arise, as well as various types of suspensions and the notification process. It provides practical information to assist the board and MAC in discharging their duties when these difficult situations occur.

Chapter 10, Resignation and Retirement, can present challenges to hospitals in terms of transfer of care, succession planning and notifying the proper parties. This chapter highlights a number of important considerations, including the creation of resignation/retirement policies and ensuring that Professional Staff take certain steps prior to departing.

Chapter 11, Maintaining Credentialing Files, highlights key documentation issues and the content of the hospital credentialing file. This chapter discusses the need for confidentiality, issues that may arise with freedom of information requests and recommendations relating to retention periods.

Chapter 12, Academic Issues, identifies credentialing issues specific to academic health centres. This chapter defines key players in teaching hospitals; explores the relationships between the Professional Staff, the university and the hospital; and describes different academic disputes that may affect privileges.

At the end of this Toolkit, there are various appendices that provide helpful reference materials:

Appendix I: Glossary
Appendix II: Excerpts from *Public Hospitals Act* (and Regulation 965), *Regulated Health Professions Act, 1991*, and the OHA/OMA Prototype By-law
Appendix III: Resources and References

Chapter 1: Overview

Chapter Summary

- One of the most important governance roles undertaken by hospital boards is credentialing of Professional Staff (including physicians, dentists, midwives and extended class nurses).
- "Credentialing" is an umbrella term used by many hospitals, which includes a range of activities and processes, such as: applications for initial appointments, verification of qualifications, identification of the scope and nature of privileges, granting of privileges, periodic review and annual re-appointment.
- Hospital "privileges" create unique relationships between hospitals and their Professional Staff and those relationships exist in a complicated legal context. Rights are triggered when someone applies for and receives privileges at a hospital.
- Professional Staff are key members of every hospital's clinical team, without whom, hospitals cannot provide clinical services.
- Privileges are important to practitioners and have a professional, financial, and reputational impact on Professional Staff.
- Hospital by-laws set out categories of Professional Staff (such as Active Staff and Courtesy Staff) and the rights attached to each category.
- Not everyone who provides clinical care at a hospital requires privileges.

Board-Appointed Professional Staff

This Toolkit covers the relationship between hospitals and their Board-Appointed Professional Staff (physicians, dentists, midwives and extended class nurses). "Medical Staff", "Dental Staff", "Midwifery Staff", and "Extended Class Nursing Staff" are all defined terms under the *Public Hospitals Act*, Regulation 965. By definition, membership in those groups requires privileges granted by the hospital board.[1]

PROFESSIONAL STAFF CATEGORY	GRANTED PRIVILEGES TO:
Medical Staff	Diagnose, prescribe for, and treat patients
Dental Staff	**Oral and Maxillofacial Surgeons:** diagnose, prescribe for and treat patients **Dentists:** attend to patients in cooperation with a member of the Medical Staff
Midwifery Staff	Assess, monitor, prescribe for and treat patients
Extended Class Nursing Staff	Diagnose, prescribe for and treat patients

1 See, R.R.O. 1990, Reg. 965, s. 1(1). Please note that, under Regulation 965, the definition of Extended Class Nursing Staff also includes extended class nurses who are employed by the hospital. However, the Regulation states in section 7(2.1), that the sections on appointments and re-appointments and dismissal, suspension or restrictions of privileges apply only to extended class nurses to whom the board has granted privileges. Hospitals may employ nurse practitioners and if they are employed, those nurse practitioners are not permitted to be members of the Board-Appointed Professional Staff according to the *Public Hospitals Act*.

This Toolkit characterizes these four groups collectively as "Professional Staff. For the most part,[2] Professional Staff are independent contractors and not hospital employees.[3] Regardless of the relationship (whether employee or independent contractor), membership in the Professional Staff always requires privileges.

The Toolkit does not apply to other types of hospital employees who also provide clinical services (e.g., nurses, pharmacists, laboratory technicians, dieticians, psychologists, social workers, occupational therapists, physiotherapists, medical radiation technologists and others). It specifically does not apply to extended class nurses who are hospital employees because the *Public Hospitals Act* regime does not apply to employed nurses in the extended class.

What are Privileges?

The term "privileges" is used because Professional Staff are given the privilege of using hospital resources in return for providing care to hospital patients. There is no definition of "privileges" in the *Public Hospitals Act* or its regulations. As stated in the case of *Kadiri,* "[p]rivileges define the scope of a physician's ability to use the hospital's resources to care for his or her patients."[4]

Generally speaking, the concept of privileges is understood to include:

- Membership in a category of Professional Staff (such as Active, Associate, Courtesy, *Locum Tenens*).
- Types of clinical procedures or services the member is entitled to perform for hospital patients (such as the right to admit in-patients, register out-patients and perform certain kinds of clinical procedures).
- Access to certain hospital staff, facilities, equipment, systems and supports (such as working with other health care professionals, use of the Operating Room, certain machinery and tools, or information systems).
- Affiliation with a particular Department or Division, in larger organizations.

Hospitals can choose to define "privileges" in their Professional Staff by-laws. Having a definition of privileges is not legally required, but it is a good practice as it explains when changes to a Professional Staff member's title, environment, relationships, compensation, resources or duties may give rise to a *Public Hospitals Act* dispute process and when such changes may not. Hospitals without a clear definition of privileges may find themselves in a formal dispute process before the Medical Advisory Committee, Board and beyond under the *Public Hospitals Act*, for changes made to a Professional Staff member's resources and supports at the hospital that the hospital thought it had the unilateral discretion to amend at any time. Such changes might include changes to office space, access to specific levels of nursing or other clinical staff, scheduling, or upgrades to hospital equipment. Formal dispute resolution processes under the *Public Hospitals Act* can be extremely costly and time consuming, as discussed further in this Toolkit.

The concept of physician privileges was examined in detail in the Ontario Hospital Appeal Board case of Dr. Dittmer and Parkwood Hospital.[5] In this case, a physiatrist's access to an electromyography laboratory was terminated. Conducting EMGs comprised approximately 95% of his practice at Parkwood and his Parkwood practice provided approximately 20% of his income. Parkwood Hospital asserted that laboratory access was a courtesy, and therefore terminating such access did not substantially alter Dr. Dittmer's privileges. The Appeal Board, however, interpreted privileges broadly and found that termination of Dr. Dittmer's laboratory access constituted

2 There are notable exceptions, for example, radiologists and pathologists may be employees of hospitals. Some hospitals choose to employ some or all of their Professional Staff.

3 There has been some discussion around the changing status of physician employment. See the 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, the Auditor General's Recommendation 14: "To ensure that hospitals are able to make the best decision in response to the changing needs of patients, the Ministry of Health and Long-Term Care should assess the long-term value of hospitals employing, in some cases, physicians as hospital staff." and the Ministry response "The Ministry accepts this recommendation and will develop, in consultation with stakeholders, a proposal for a review" at p. 467.

4 Kadiri v. Southlake Regional Health Centre, 2015 ONCA 847 at para 11.

5 *Dittmer v. The Board of Directors of Parkwood Hospital* (1998), unreported file No. H 99/97 (Ontario Hospital Appeal Board). This case is also reviewed in detail in Chapter 12, Academic Issues.

a "substantial alteration" of his privileges within the meaning of section 41(1)(b) of the *Public Hospitals Act*.[6] The Appeal Board also stated the following with respect to privileges:

> "Privileges" is not a defined term in the Act. In broad terms, hospital privileges comprise a bundle of rights of a physician to carry out professional practice in the hospital. Those rights include some degree of access to the material and human resources of the hospital including hospital beds for the physician's patients (if the privileges include the right to admit patients), operating rooms (if the physician is a surgeon), diagnostic equipment, examining rooms, interns, residents, lab technicians and nursing staff. To the extent that the hospital's by-laws or the document setting out a physician's privileges do not specify the resources attaching to the grant of privileges, a particular physician's privileges must be taken to include access to those resources which are typically employed in the type of practice in which that physician is engaged. Further, and again to the extent to which access to resources is not, and has not previously been specified in the by-laws or the documents setting out the particular physician's privileges, the resources to which the physician has historically had access in his or her practice in the hospital must be considered in determining what access to resources attached to the privileges in question.[7]

The case of Drs. Kutzner and Blackwell in Saskatchewan also examined the issue of hospitals making changes to physician privileges and concluded that not every change to a physician's access to facilities and services constitutes a change in privileges giving rise to a right to a hearing.[8]

That said, extra caution should be exercised where a hospital proposes to temporarily or permanently restrict or change a member's resources or supports so as not to substantially alter privileges or otherwise inadvertently suspend, restrict or revoke a member's privileges – thereby triggering a right to a *Public Hospitals Act* hearing. *See Chapters 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges and 10, Resignation and Retirement.*

Hospital privileges are valuable to those who hold them; to be appointed to a hospital can have significant professional, financial and reputational benefits. Some health care practitioners aspire to belong to a particular hospital's Professional Staff in order to have access to certain kinds of patients or equipment, for the research or educational opportunities, or for the collegial environment.

Privileges cannot be delegated or shared. Privileges are granted to an individual after they apply to the hospital and are credentialed and approved by the board. An individual with privileges cannot delegate or assign their hospital privileges to any other person.

Categories of Professional Staff

Hospitals establish their own categories of Professional Staff as these are not prescribed by the *Public Hospitals Act.*

As an example, the OHA/OMA Prototype By-law identifies six standard categories of Professional Staff with the following details respecting the rights and responsibilities attached to each category (among others[9]). *See table on next page.*

To change a member's category of Professional Staff membership constitutes a change in privileges, giving rise to the application of the *Public Hospitals Act.* If the recommended change of Professional Staff category is not made at the request of the member, the member may request a hearing before the hospital board.

6 *Dittmer* at 10 , the Appeal Board states "[s]ubstantial" is to be measured against the physician's practice in that hospital, not against his overall practice." The EMG laboratory services constituted only 20% of his overall medical practice, but 95% of his practice at Parkwood Hospital.

7 *Dittmer* at 8. See also *Abramson v Medical Advisory Committee (North York General Hospital),* 2011 CanLII 93929 (ON HPARB).

8 *Prairie North Regional Health Authority v. Kutzner,* 325 D.L.R. (4th) 401, 2010 SKCA 132. See also *Bhargava v. Lakeridge Health Corporation,* 2011 CanLII 22743 (ON HPARB), *Davidson v Sunnybrook Health Sciences Centre*, 2012 CanLII 35969 (ON HPARB) and *Dr. Steven Bryniak v. Regional Health Authority B*, 2013 NBQB 395 (CanLII).

9 Not every hospital has adopted the OHA/OMA Prototype By-law and may have different categories of Professional Staff or may define the scope of privileges differently.

CATEGORY OF PROFESSIONAL STAFF	PURPOSE	ADMITTING PRIVILEGES	INDEPENDENT PRACTICE	VOTE AT PROFESSIONAL STAFF MEETING	OTHER
Active	The main group of members of the Professional Staff Must have at least one year of completed satisfactory service	Yes	Yes	Yes*	If an academic institution, active staff members are usually required to hold and maintain a university appointment
Associate	Mandatory transitional (or probationary) category for all new appointments to the hospital seeking active staff privileges (for at least one year but not longer than two years)	Yes**	Depends – some hospitals require associate staff to work under the supervision of an Active Staff member ***	Maybe*	At six-month intervals, supervisor to complete a performance evaluation
Courtesy	To meet a specific need of the hospital or where the board deems it advisable	Not usually	Depends – some hospitals allow independent practice while some require certain courtesy staff to work under the supervision of Active Staff members	No	As an extension of courtesy privileges or as another category called "Regional Ordering", some hospitals give authority for remote specialists to order laboratory tests and treatments without being part of the Active Staff.
Locum Tenens	Planned replacements for a physician, dentist or midwife or to provide episodic or limited surgical or consulting services	Yes**	Depends – some hospitals require *Locum Tenens* staff to work under the supervision of an Active Staff	Not usually	
Extended Class Nursing	Extended class nurses who are not employees	Yes ****	Not during initial probationary period	No*	New applicants have a probationary period of six months to include a performance evaluation

CATEGORY OF PROFESSIONAL STAFF	PURPOSE	ADMITTING PRIVILEGES	INDEPENDENT PRACTICE	VOTE AT PROFESSIONAL STAFF MEETING	OTHER
Honorary	To honour a former member who has retired and/or contributed to the hospital and has an outstanding reputation or made an extraordinary accomplishment	No	No – no regular clinical, academic or other duties	No	Note – this is not a "category" of professional staff but rather a policy or practice that hospitals may choose to maintain. The OHA/OMA Prototype By-law does not include this category
Temporary					The OHA/OMA Prototype describes temporary appointment as a process (see section 3.6 of the Prototype Bylaw). For further information, see the discussion in Chapter 5: Initial Appointment

* Only physicians are entitled under the *Public Hospitals Act* to vote at meetings of the Medical Staff and to be eligible to be elected or appointed an Officer of the Professional Staff. The OHA/OMA Prototype By-law extend the name of The Medical Staff to the "Professional Staff" and allows dentists, midwives and extended class nurses to attend meetings of the Professional Staff. However, only Active Staff and Associate Staff physicians may vote under the OHA/OMA Prototype By-law at meetings of the Professional Staff.

** There can be some exceptions within the categories (for example, some Associate Staff members may not have admitting privileges).

*** The *Public Hospitals Act* does not require specific Professional Staff categories and does not require that certain categories of Professional Staff be supervised. The OHA/OMA Prototype By-law recommends that Associate and *Locum Tenens* categories "work under the supervision of a member of the Active Staff." This may be achieved in a variety of ways in practice (on a continuum of conducting periodic reviews and mentoring, to direct oversight of all clinical work). Hospitals should be able to explain the supervising expectations to those involved. Guidance may come from regulatory colleges on the role of supervisors. In any case, the scope of the supervision should be clear to both the supervisor and supervisee at the outset of the relationship.

**** Since 2012, registered nurses in the extended class have had the authority to admit patients to hospitals under Regulation 965 of the *Public Hospitals Act.*

Upon initial appointment and with any subsequent change to a member's category of privileges, a hospital should communicate in writing to which category the Professional Staff member belongs. This is most important if there will be an initial appointment to one category of privileges with the intention for the individual to transition to a different category after a set period of time, after achieving further training or experience, when someone else retires, or another triggering future event.

Note - there are also specific categories of professional staff that may be particular to academic hospitals. Please review Chapter 12: Academic Issues for further information.

Core Privileges – Types of Procedures

Upon appointment to the Professional Staff, the hospital should advise the member of the types of procedures that they are permitted to perform.[10] Few hospitals have gone so far as to produce lists of core privileges that attach based on a Department or Division. However, doing so can greatly clarify the scope and range of the privileges assigned to a member on appointment or re-appointment. Providing a list of core privileges may also avoid unnecessary hospital limitations to a professional's scope of practice. Having a list of the types of procedures that attach to the appointment or re-appointment serves as a role description and assists the hospital when determining whether the applicant is qualified. It also tells the applicant what to expect. The kinds of elements that may be set out in the role description include:

- List of procedures to be performed (noting any exclusions);
- Departments to be served;
- Description of types of patients to be seen (such as: diseases, risk categories, body parts, or anatomical regions);
- Technology or equipment to be used;
- In-patient/out-patient services; and
- Knowledge or training expectations.

It is important to clarify whether an appointment in a particular Department or service requires or entitles all Professional Staff in that Department or service to perform all clinical procedures or whether certain procedures are restricted based on training, experience, or seniority.

10 Note that the midwifery scope of practice is the same for each midwife across the province regardless of hospital.

Who Needs Privileges?

A physician, dentist,[11] midwife, or extended class nurse[12] who wants to provide services at a hospital requires privileges. Without privileges, physicians, dentists, midwives or extended class nurses from the community are treated as external practitioners who cannot admit, diagnose, prescribe for, treat, or order tests for patients of the hospital. They cannot use hospital equipment or other hospital resources. They are not allowed to participate in rounds (on-site clinical consultations and discussions about patients) nor view patients' health records.[13] They are generally not permitted in areas of the hospital restricted to staff and would be subject to visiting hour restrictions. They would be allowed to attend continuing education rounds or other sessions where professionals or the general public are invited.

Midwives practicing in Ontario require privileges at a hospital as part of their registration requirements, although midwives can be registered with the College of Midwives of Ontario without privileges. Since midwives offer choice of birthplace to their clients, midwives are required by the College of Midwives of Ontario to meet competency requirements for both hospital and home births. Obtaining hospital privileges is therefore critical to the practice of midwifery in the province.

Sometimes, the lines are blurry as to whether activity at or for the hospital requires privileges. Hospitals may need to develop policies for managing relationships with practitioners who do not require privileges, to establish the boundaries. Hospitals may require legal advice to set up policies to clarify the relationships for the following kinds of situations:

11 For purposes of this Toolkit, we include oral and maxillofacial surgeons in the meaning of dentists.

12 However, as mentioned above, there is another category of extended class nurse who is employed by the hospital and does not hold privileges.

13 Of course, under the *Personal Health Information Protection Act*, 2004, personal health information can be disclosed to external practitioners with the consent of the patient, as required by law, or by relying on implied consent if the external practitioner is a member of what is commonly known as the patient's "circle of care". As Ontario Health Teams are implemented, external health care providers will not necessarily need hospital privileges to view hospital records using shared electronic health information systems.

	GENERALLY DO NOT NEED PRIVILEGES IF...	WILL USUALLY NEED PRIVILEGES IF...
Clinical observers	They are truly only observing (in accordance with the hospital's clinical observer policy, having signed a confidentiality agreement and having been registered with someone at the hospital to attend with them). These arrangements should be short-term in nature (i.e., measured in weeks or a few months, and not years).	Asked for clinical consult on a case or assist in the provision of treatment, e.g., "hands in the surgical field". Writing in or reviewing the clinical chart. A long-term relationship is contemplated.
Researchers	They are strictly doing research with no clinical interaction with patients.	Providing clinical care. Engaged in a clinical trial as the treating physician/researcher. Writing in the clinical chart. Some hospitals have created a special category of privileges for researchers; where such a category exists, the researcher should seek privileges.
Complementary and alternative therapy practitioners	Therapies are performed by practitioners (who are not regulated health professionals) who have been retained by patients directly. Some hospitals have introduced complementary and alternative therapy policies to address patient requests to have their personal non-regulated providers visit them in hospital. The policies can include disclaimers and releases to be signed by the patient; the hospital does not take responsibility for the care provided. The practitioner does not have access to the patient's hospital chart without patient consent; the practitioner may not document on the patient hospital chart.	Physicians, dentists, midwives or extended class nurses who are performing complementary and alternative therapies – will still need privileges in order to be part of the Professional Staff. The board must have approved their provision of alternative and complementary therapies as within their scope of privileges.
Students (not yet licensed physicians, dentists, midwives or extended class nurses) *See Chapter 12, Academic Issues.*	Generally do not need privileges but are subject to the terms of an affiliation agreement between the hospital and a university or college (which includes terms such as professional liability protection coverage (insurance), indemnity and accountability	n/a
Residents *See Chapter 12, Academic Issues.*	It depends. Some hospitals rely on the robust application process at a university and do not require residents to hold hospital privileges.	It depends. Some hospitals have a category of privileges for Residents (or House Staff) requiring them to hold privileges if they are providing patient care within the hospital.

	GENERALLY DO NOT NEED PRIVILEGES IF...	WILL USUALLY NEED PRIVILEGES IF...
Fellows *See Chapter 12, Academic Issues.*	It depends. Some hospitals rely on the robust application process at a university and do not require Fellows to hold hospital privileges. Some hospitals have Research Fellows or other types of Fellows who do not have patient care duties and do not require those groups to hold privileges.	It depends. Some hospitals have a category of privileges for Fellows (or House Staff) requiring them to hold privileges.
Retired Senior Staff Members	Mentoring and acting as a general source of information and knowledge exchange to Professional Staff members. Attending and speaking at educational events. This arrangement usually requires a contract or written terms to explain that the individual is no longer a member of the Professional Staff and expectations around privacy. Some hospitals use different coloured name badges for retired staff.	Providing clinical care. Consulting on specific cases. Writing in the clinical chart. Meeting patients.
Medical Assistance in Dying (MAiD)	It depends. Some hospitals may permit external clinicians to do remote (telehealth or through other technology) consultations at the initiation of an inpatient without privileges. The practitioner does not have access to the patient hospital chart without patient consent; the practitioner may not document directly on the patient hospital chart.	Performing or assisting with a medically assisted death within a hospital. It depends. Some hospitals require external clinicians who do remote (telehealth or through other technology) consultations at the initiation of an inpatient to have privileges before consulting or reviewing the health record to evaluate an inpatient's eligibility for MAiD. Writing in the clinical chart.
Ontario Health Team or collaborative shared care arrangements	Not providing services on behalf of a hospital Only providing services at other service sites such as long-term care home, community health centre, primary care team, home care agency etc. and not at the hospital. Seeing patients onsite at a hospital where there is an obvious and official notice that the service is being provided by a separate individual or organization that is not the hospital (such as: a pharmacy, a co-located primary care clinic, or a supportive housing service etc.) Given read-only access to a shared electronic record for the region or shared patient group.	Providing services on behalf of a hospital Seeing patients onsite at a hospital where it is the hospital's program or service Seeing patients offsite or in any other environment where the service is being provided by the hospital (such as: mobile teams, assessment clinics, telehealth services etc.) Wanting to integrate services so that external clinicians have authority to admit, discharge or treat individuals in hospital or related to hospital programs Writing in the hospital's clinical chart as part of the hospital.
Telehealth/telemedicine	It depends. Usually where patient is at your hospital, but practitioner is somewhere else (Host Hospital)	It depends. Usually where practitioner is at your hospital, but patient is somewhere else (Home Hospital)

Medical Assistance in Dying (MAiD)

With the introduction of medical assistance in dying (MAiD), hospitals have faced a new challenge of dealing with external physicians and nurse practitioners attending at hospitals to complete eligibility evaluations or perform an assisted death for an inpatient. Some hospitals have discovered that patients have engaged their own first or second consultations to determine eligibility for MAiD with external clinicians without the prior knowledge of the hospital. This may be more common in hospitals that do not provide MAiD. Some of those consultations are taking place via telephone calls and remote video meetings while others happen where the external clinician attends onsite at the hospital without notifying the hospital of their presence. Hospitals are advised to have policies to address when external physicians or nurse practitioners are required to hold hospital privileges before being permitted to perform assessments or examinations on hospital premises. Hospitals should also have educational materials to explain the process to patients and their families inquiring about MAiD. Hospitals should ensure anyone who is performing a clinical intervention or delivering MAiD on their premises has the appropriate privileges to do so.

Telemedicine/telehealth Consultants

The College of Physicians and Surgeons of Ontario defines "telemedicine" as:

> [b]oth the practice of medicine and a way to provide or assist in the provision of patient care (which includes consulting with and referring patients to other health-care providers, and practising telemedicine across borders) at a distance using information and communication technologies such as telephone, email, audio and video conferencing, remote monitoring, and telerobotics," noting that "[p]atients, patient information and/or physicians may be separated by space (e.g. not in same physical location) and/or time (e.g. not in real time).[14]

The Canadian Nurses Association uses the World Health Organization's definition of "telehealth" as:

> the delivery of health care services, where patients and providers are separated by distance. Telehealth uses ICT [information and communications technology] for the exchange of information for the diagnosis and treatment of diseases and injuries, research and evaluation, and for the continuing education of health professionals.[15]

For purposes of this Toolkit, a "telemedicine/telehealth appointment" is a clinical consultation provided by a clinician at one location (the "Home Hospital") to a patient at another location (the "Host Hospital") through the use of video and telecommunications technology.

Although telemedicine/telehealth have been utilized for decades, the law with respect to credentialing telemedicine/telehealth consultants remains unclear. Hospitals have adopted a number of differing practices regarding telemedicine/telehealth appointments. Hospitals should seek legal advice to determine how best to manage Professional Staff who are engaged in telemedicine/telehealth appointments (as a Home Hospital) and the best arrangements to make with external consultants performing telemedicine/telehealth appointments with patients at their hospitals (as a Host Hospital).

In our view, a Home Hospital is best situated to evaluate the credentials of telemedicine/telehealth consultants in the manner set out in the *Public Hospitals Act* and in the OHA/OMA Prototype By-law, and to continually monitor the care provided by the telemedicine/telehealth consultant. It would be extremely difficult for a Host Hospital to adequately discharge any duty to credential telemedicine consultants since it has no way to observe the consultant first-hand, or conduct monitoring as necessary on an ongoing basis. However, both Home and Host Hospitals require legal and insurance advice to explain the risks and risk management strategies they should employ in order to facilitate these appointments and meet their obligations under the *Public Hospitals Act* and their Professional Staff by-law.

14 College of Physicians and Surgeons of Ontario, "Telemedicine" (April 2007, reviewed and updated December 2014), online: CPSO, <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Telemedicine>.

15 Canadian Nurses Association, "Fact Sheet: Telehealth", (March 2018), online: CNA, <https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/telehealth-fact-sheet.pdf>.

How are Physicians Treated Differently than Dentists, Midwives and Nurse Practitioners with Respect to Hospital Privileges?

As you will read in Chapter 2, Legal Context, the *Public Hospitals Act* applies to physicians only, and not to dentists, midwives or extended class nurses. However, the regulations under the *Public Hospitals Act* allow hospital boards to pass by-laws for other Professional Staff members and, to the extent that hospitals exercise that discretion, the Professional Staff by-law typically applies the same procedural rights to all groups.[16] All hospitals that engage the services of dentists, midwives and extended class nurses should have clear credentialing rules that apply to those groups. However, it should be noted that only physicians have the right to appeal a decision of a hospital board that affects their privileges to the Health Professions Appeal and Review Board (HPARB) and then on to the Divisional Court. The *Public Hospitals Act* does not extend this right of appeal to any other members of the Professional Staff. Where there is a question about the particular procedural protections to be afforded to an individual in a specific case, the board should consult its legal counsel.

Overview of the Credentialing Process

"Credentialing" is commonly used as an umbrella term to capture a full range of activities and processes including: applications for initial appointments, verification of qualifications, identification of the scope and nature of privileges, granting of privileges, periodic review and annual re-appointment.

However, there are actually four aspects included under the umbrella term of credentialing:

1. **Planning:** The process of strategic planning regarding necessary Professional Staff resources.
2. **Recruitment:** The process of identifying and interviewing candidates for available positions.
3. **Credentialing:** The process of obtaining, verifying and assessing the qualifications of practitioner to provide care or services in or for a health care organization.[17]
4. **Privileging:** The process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance.[18]

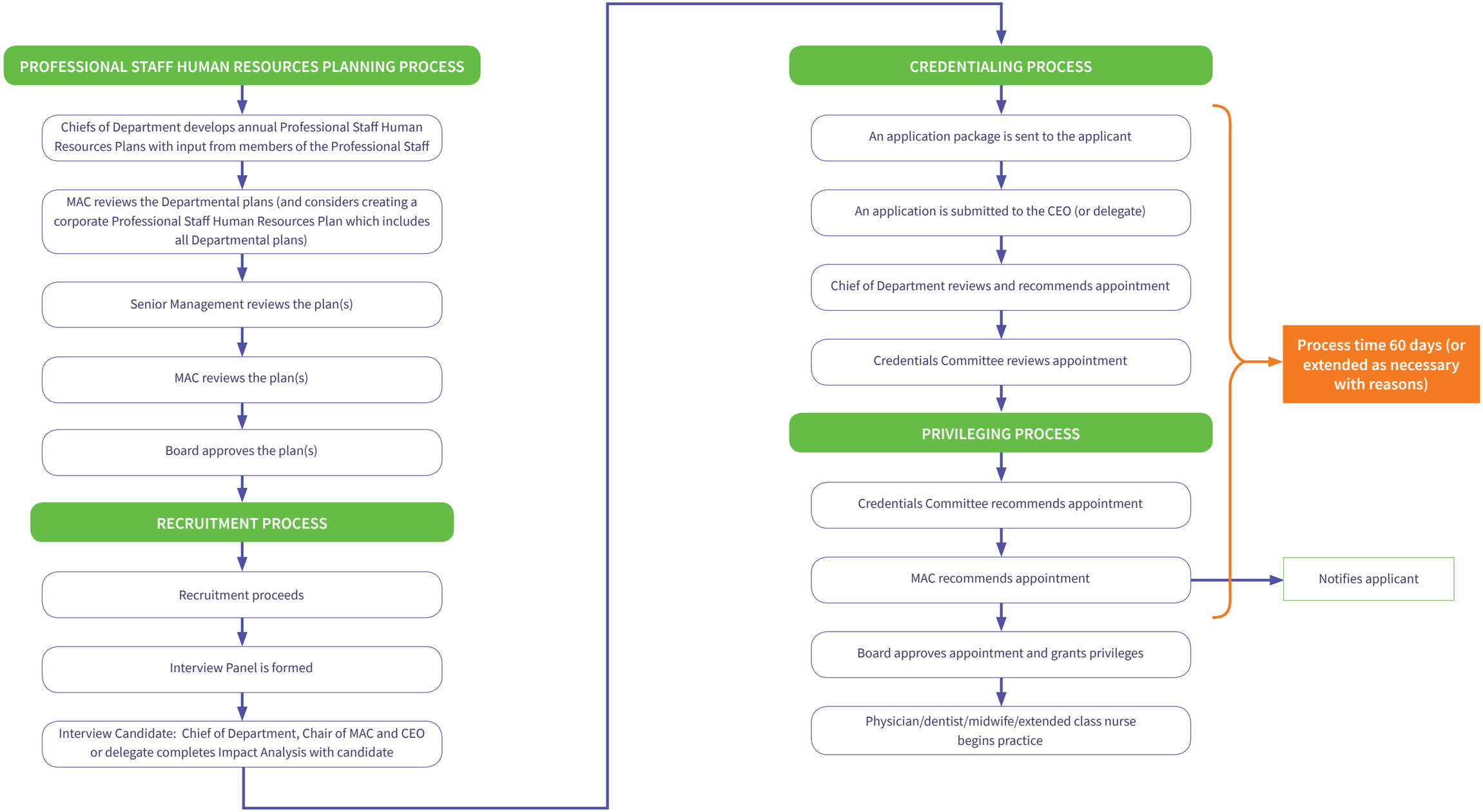
To become a member of the Professional Staff, an individual must apply to the board for an appointment. If, and when an individual is appointed to the Professional Staff, the board grants a category of privileges (see above). These privileges must be renewed annually through the hospital's re-appointment process should the professional choose to re-apply for privileges.

16 For example, the OHA/OMA Prototype By-law extends the procedural rights afforded to physicians under the *Public Hospitals Act* to all categories of the Professional Staff.

17 This definition comes from an American source, but conveys the Canadian use of the term. See the Medical Staff Essentials: Your Go To Guide, The Joint Commission, 2017, p. 255.

18 See the Hospital Accreditation Standards (HAS), Joint Commission 2010, Joint Commission Resources, Inc. Oakbrook Terrace, IL, at GL-26.

Credentialing Process



Reasons to Credential

The hospital, through its board, must exercise due diligence in all aspects of the credentialing process (from recruitment through application, appointment and re-appointment, performance evaluation, and as necessary, suspension, restriction and revocation).

Hospital Professional Staff have a direct impact on the quality of care provided in a hospital, and for that reason, there must be an effective method to ensure the hospital recruits and maintains an appropriate complement of skilled health practitioners.

A hospital's failure to properly evaluate applicants at the outset – and, once granted privileges, assess current members of the Professional Staff with some regularity – could result in harm to patients and potentially expose the hospital to liability.

Patients and their families assume that Professional Staff have been appropriately vetted by the hospitals in which they practice, and put their trust in such a process even where they are not intimately familiar with the specifics of the process. A robust credentialing program also:

- Ensures every candidate has the knowledge, skill and judgment to deliver care.
- Screens for issues that could compromise quality of care and safety.
- Ensures accuracy of documentation.
- Finds candidates who meet strategic directions and needs of the hospital.
- Ensures a general willingness to be part of a team environment and be governed by the Rules and Regulations of the hospital.
- Contributes to a positive working environment.

A sound credentialing program makes good sense for hospitals. It clarifies the hospital's expectations and processes, and creates transparency. It is also required by law. In the case of *Thannikkotu*, the Ontario Health Professions Appeal and Review Board stated:

> ...the [*Public Hospitals Act*] requires the Board of the Hospital to fulfill a fiduciary duty to ensure it effectively credentials physicians in accordance with the terms of the Act, any hospital governing by-laws and patient safety. Underlying this duty is the notion that patient safety must be of paramount concern to the Board of the Hospital when making a decision regarding physician applications for appointment.[19]

As evidenced in case law (see *Chapter 2, Legal Context*), a court may find a hospital negligent for failing to appropriately credential its Professional Staff. The Health Insurance Reciprocal of Canada (HIROC) issued a Risk Reference Sheet acknowledging there has been increased litigation resulting from lapses in credentialing processes:

> As evidenced by HIROC claims and related Canadian inquests, credentialing, privileging and performance management processes are closely linked to the provision of safe and high quality patient care and more than an administrative duty of healthcare organizations. Decisions made should be based on standardized criteria and processes that are transparent, freely available, fair, balanced and equally applied to all. Consequently, inconsistent and questionable credentialing and privileging practices directly impact patient safety and the culture of an organization.[20]

In that Risk Reference Sheet, HIROC explains the following themes in litigation claims by patients against hospitals for:

- Perceived/actual 'rubber stamping' of recommendations for appointment/ reappointment by healthcare organizations

19 Thannikkotu v. Trillium Health Centre, 2011 HPARB at p. 19.

20 Health Insurance Reciprocal of Canada, Risk Reference Sheet: Inappropriate Credentialing, Re-Appointment and Performance Management, 2020 at p. 1 https://www.hiroc.com/system/files/resource/files/2020-11/Inappropriate_Credentialing.pdf

- Perceived over reliance on information from provincial/ territorial professional regulatory authorities to inform appointment and privileging decisions
- Alleged multi-patient harm incidents involving the same practitioner resulting in class actions
- Allegations that re-appointment processes did not include quality and utilization data and performance reviews
- Lack of performance evaluation processes for Professional Staff and chiefs/heads
- Alleged failure to have a robust process that asks for all pertinent malpractice claim settlements (versus those with a legal judgment) and complaints resulting in a regulatory body hearing (versus those with negative finding/undertaking)
- Perceived lack of independent verification of information provided by applicants

HIROC also noted the following themes in litigation against hospitals by their Professional Staff members for:

- Allegations that appointment, re-appointment, privileging and disciplinary decisions were unreasonable, arbitrary and/or made in bad faith
- Out-of-date professional staff by-laws
- Allegations that there was a breakdown in process for revoking privileges:
  - Not previously defined and/ or not related to quality of care issues (e.g. to resolve interdisciplinary/ conflicts among practitioners)
  - Without following due process (e.g. progressive disciplinary and natural justice)
- Perceived/actual systemic tolerance of unprofessional/ disruptive behaviour, in particular in surgical and obstetrical settings
- Lack of documentation of:
  - Discussions with credentialed staff regarding their unprofessional/disruptive behavior resulting in ongoing conflicts and denial of the conversations and the behaviour
  - The rationale to support appointment, reappointment, privileging and disciplinary decisions
- Perceived lack of independent verification of information provided by applicants

THE CASE OF DR. MICHAEL SWANGO

Dr. Michael Swango is a physician convicted in the United States of murdering four patients and is suspected of involvement in dozens of fatal poisonings of patients and colleagues over a 15-year period in the 1980s and 90s. He moved frequently and held a number of positions in different professions within health care (including as a paramedic). At a few workplaces, his colleagues raised suspicions, but there were no in-depth investigations; his colleagues either were unable to prove their concerns or he would disappear before suspicions were confirmed. He is alleged to have used an alias, forged documents, and falsified his criminal record to secure positions in a number of hospitals in different American states. Unfortunately, it is said these facilities did not rigorously review or confirm the documents he presented on initial appointment and therefore did not uncover his criminal record for poisoning or his trail of poor evaluations and disappearances under suspicious circumstances. While an extreme case, it does underscore the need for a rigorous credentialing process with checks and balances to uncover fraudulent applications.[21]

21 See J. Stewart, *Blind Eye: How the medical establishment let a doctor get away with murder*. New York: Simon & Schuster, 1999.

THE CASE OF DR. DENNIS ROARK

Dr. Dennis Roark was able to work as a physician for more than a decade in the United States and London, Ontario without having completed medical school.[22] He plead guilty in the United States to using false documents to obtain a medical license. Although he had not completed medical school, he held medical residency positions and was hired at different hospitals. His case was uncovered when he applied for a cardiac surgery position in the United States and the hospital contacted the American Medical Association for independent verification of the information in his application form about his medical school. He was not on the list. With further probing, it was discovered that he falsified his records. In response to this case, the College of Physicians and Surgeons of Ontario contacted hundreds of medical schools throughout the world to verify the educational background of all the doctors practising in Ontario. The search uncovered another person operating as a physician without proper training, Stephen Chung, who had been working as a physician in Hamilton from 1983 to 1998 without graduating from medical school. In 2002, he was given an 18-month conditional sentence after defrauding the Ontario health care system of $4.5 million.

Tips for Appropriate Credentialing

Boards and hospital management should consider the following credentialing practices:

- Boards should become familiar with their roles in credentialing and rigorously review recommendations from the MAC for appointment and re-appointment.
- Hospitals should integrate quality and utilization data with appointments and re-appointments.
- Hospitals should develop performance evaluation processes for their Professional Staff.
- Hospitals should make transparent their credentialing processes for all members of the Professional Staff and apply the same rules regardless of the Professional Staff group.
- Chiefs, Heads, or other management should allocate beds and resources exclusively based on clinical priorities.
- Hospitals should ensure new Professional Staff members do not commence provision of services until they are granted hospital privileges.
- Hospitals should streamline the credentialing process to avoid delays, minimize administrative burdens (especially for important recruits) and improve patient access to care.
- Chiefs should become familiar with progressive management and always afford members of the Professional Staff with the basic elements of natural justice to which they are entitled. *See Chapter 2, Legal Context.*
- Hospitals should ensure all applications for privileges are processed in a timely way for all Professional Staff.

Is this the Right Model?

Our current model of the relationship between Professional Staff and hospitals has come under fire recently for the costs associated with disputes. The Auditor General of Ontario commented on the complexity of the appeal process for hospitals and physicians under the *Public Hospitals Act* and has even called for a review of the physician appointment and appeal processes for hospitals and physicians under the *Public Hospitals Act*.[23] In the 2016 report, the Auditor General stated:

22 B. Sibbald, "Phoney-physician furore leads to massive credentials check" CMAJ 1998; 159 (5):557.

23 Recommendation 13 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, at p. 467: "To ensure that hospitals, in conjunction with physicians, focus on making the best decisions for the evolving needs of patients, the Ministry of Health and Long-Term Care should review the physician appointment and appeal processes for hospitals and physicians under the *Public Hospitals Act*.

A hospital's professional staff include the physicians, dentists, midwives and Nurse Practitioners who work in the hospital. Professional staff are appointed directly by the hospital's board – they are typically not salaried employees. Instead, they are reimbursed by the Ontario Health Insurance Plan for services they provide to patients at hospitals and wherever else they practice.

Physicians who work as medical staff are given hospital privileges, meaning they have the right to practice medicine in the hospital and use the hospital's facilities and equipment to treat patients without being employees of the hospital. These hospital privileges were originally intended to allow physicians to base their decisions primarily on what is best for the patient and not what is best for the hospital. The *Public Hospitals Act* (Act) of 1990 governs important elements of the physician-hospital relationship.

We have noted some instances where hospitals were not able to resolve human resources issues with physicians quickly because of the comprehensive legal process that the hospitals are required to follow under the Act. In some cases, longstanding disputes over physicians' hospital privileges have consumed considerable hospital administrative and board time that could be better spent on patient care issues. …

…while hospitals can manage their own employees, such as nurses, pharmacists, dieticians and lab technicians, they do not have the same authority to manage physicians without going through the legal process specified by the Act. This legal process is lengthy, cumbersome and costly, and does not put the patients' interests first …[24]

The Auditor General provided two case examples:

Case 1: One hospital told the Auditor General that it feels stuck when it needs to make service changes or wants to transition resources between programs (for example, to shift operating room time from one type of surgery to another). If Professional Staff are affected, there is no simple mechanism to give notice to those Professional Staff and move on. If the hospital wishes to recommend that a physician move either within the hospital or to another hospital, or to sever its relationship with a physician, the hospital may not be able to do so without triggering appeal rights under the *Public Hospitals Act*. The hospital explained its relationships with physicians is more time consuming and costly than its relationships with its employees. The hospital said the *Public Hospitals Act* leaves the hospital without the flexibility to adjust physician and other staffing resources to meet changing local needs.

Case 2: A hospital reported it spent five years in administrative and legal disputes with one physician. The hospital's internal and external independent reviews found the physician hindered the functioning of the department in which he worked. The College of Physicians and Surgeons of Ontario's investigation confirmed that the physician failed to follow hospital policies. However, the hospital board was not able to refuse the physician's reappointment because the physician appealed the board's decision to the Health Professions Appeal and Review Board. The physician continued to work at the hospital for four years while the case was heard. HPARB reinstated the physician without any conditions at the conclusion of the hearing. The hospital spent $800,000 in legal fees. The hospital was eventually able to repair the hostile work environment with the physician over time.[25]

Also in the 2016 report, the Auditor General stated that the Canadian Medical Protective Association, who provides legal advice and defence to physicians, reported a 87% over 10 years of legal cases involving disputes between hospitals and their physicians from 285 such cases in 2006 to 533 cases in 2015.

24 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, at pp. 465-466.

25 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, at p. 466.

FAQs

1. If a physician does not have privileges, what can that physician do in the hospital?

Similar to any member of the public, the physician can visit the hospital (i.e., visit patients who are receiving visitors, and attend public lectures or other hospital events). The physician cannot access the patient's health record, sit in on clinical rounds, admit, treat, diagnose, consult or order tests, or use hospital equipment. The physician would not be permitted in areas restricted to hospital staff, and would be subject to visiting hour restrictions.

2. Can privileges be delegated or assigned?

No. Privileges attach to an individual and cannot be delegated or assigned to another person.

3. Does a physician who is employed by the hospital require privileges?

Yes. Regardless of the relationship (whether employee or independent contractor), membership in the Professional Staff always requires privileges.

Chapter 2: Legal Context

Chapter Summary

- The *Public Hospitals Act*, and Regulation 965 made under that Act, create a comprehensive framework that governs the relationship between hospitals and Medical Staff.
- In order to be a member of a hospital's Medical Staff, physicians must be given privileges by the hospital board, regardless of whether they are independent contractors or employees.
- A robust body of case law (judge-made law, also known as common law) exists in Ontario and throughout Canada that clarifies the duties owed by hospitals to their community and to their physicians.
- Regulation 965 requires hospitals with Dental Staff, Midwifery Staff or Extended Class Nursing Staff, to articulate in their by-laws the duties of these Professional Staff and the criteria with respect to their appointment and re-appointment. Hospitals may choose to extend the same credentialing and privileging rules applied to the Medical Staff to all Professional Staff and can do so through their by-laws. However, since the *Public Hospitals Act* scheme does not apply to them, Dental Staff, Midwifery Staff and Extended Class Nursing Staff do not have the same rights of appeal to the Health Professions Appeal and Review Board (HPARB) and Divisional Court accorded to physicians.
- The key legal principles that must inform all encounters with physicians – and other Professional Staff members by extension – relate to "procedural fairness" and "natural justice":
  - The member is entitled to adequate notice about the proceedings and any allegations and evidence against them.
  - The member must be given a reasonable opportunity to defend themselves and to provide their own version of events, to bring evidence, to make arguments and to cross-examine witnesses.
  - The decision-making body has a duty to act fairly and in an unbiased manner.
- Hospitals should seek legal advice when privilege disputes arise with Professional Staff to ensure that all legal processes set out in the *Public Hospitals Act* and the hospital by-laws are followed, and that procedural fairness is extended to the Professional Staff member at all stages.
- Credentialing in the context of academic health centres attracts additional legal rules. *See Chapter 12, Academic Issues.*

Understanding the Legal Context

All hospital management and board members need to be familiar with the legal context of hospital privileges.

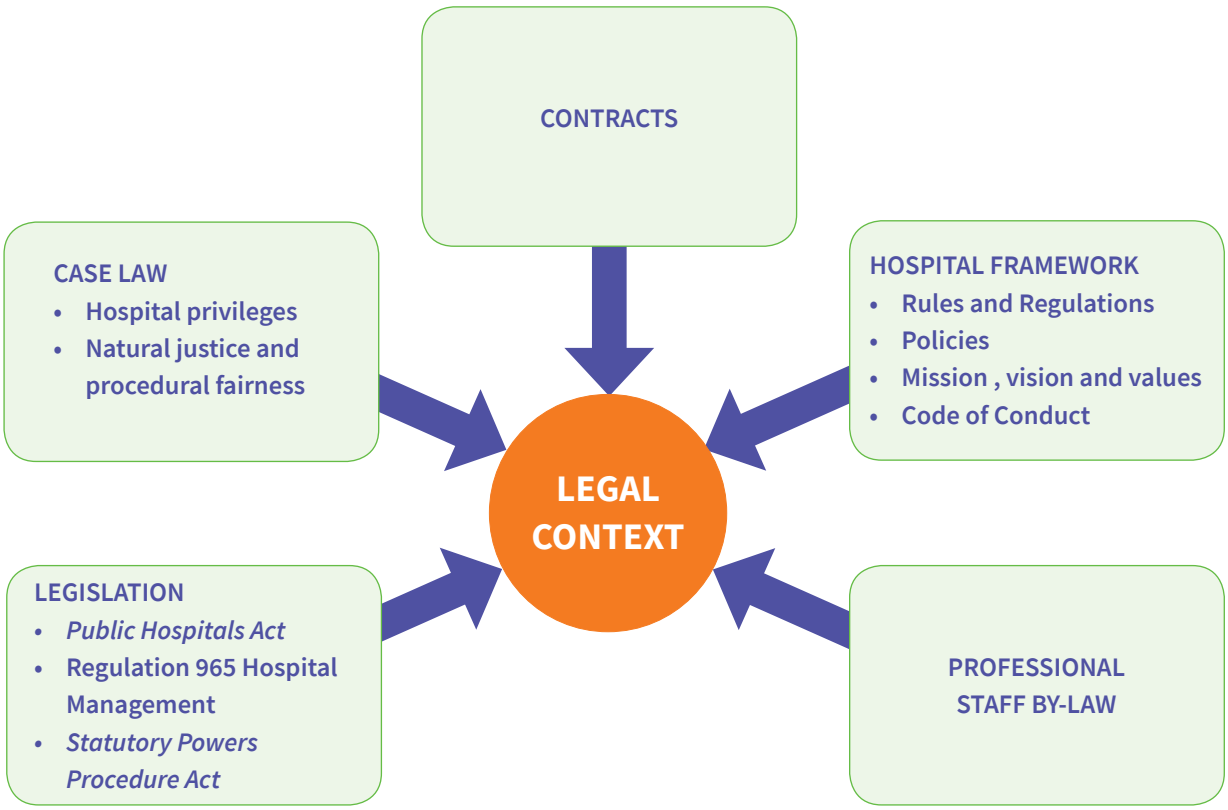
There can be serious costs and consequences for hospitals involved in privileges disputes. There are a variety of ways to manage these relationships and avoid most privileges disputes. A basic understanding of the legal context will assist hospitals in avoiding common mistakes.

Hospitals are primarily governed by provincial (and not municipal or federal) law. When addressing hospital privileges issues, a hospital in Ontario is bound by:

- *Public Hospitals Act* (see specifically the Definitions and sections 33-44) https://www.ontario.ca/laws/statute/90p40
- Regulation 965 under the *Public Hospitals Act* (see specifically the definitions and sections 2-4, 6-7.1, 18) https://www.ontario.ca/laws/regulation/900965
- *Statutory Powers Procedure Act* https://www.ontario.ca/laws/statute/90s22

- The hospital's Professional Staff by-law (so-called, if extended to Dental Staff, Midwifery Staff and/or Extended Class Nursing Staff) or Medical Staff by-law (if only relating to physicians). See the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law).
- Canadian case law on hospital privileges and administrative law principles of procedural fairness and natural justice.
- Contracts between the hospital and the Professional Staff member setting out respective obligations.
- The hospital's mission, vision and values, Rules and Regulations, policies, and Codes of Conduct.

See Chapter 12, Academic Issues, for additional legal considerations for credentialing in the context of academic health centres.



Public Hospitals Act

From a legal perspective, the relationship between hospitals and members of their Medical Staff[1] is a statutory relationship of privileges. There is a comprehensive scheme in the *Public Hospitals Act* explaining that a hospital board may appoint physicians to the Medical Staff, how members of the Medical Staff are to be appointed and re-appointed, and how to resolve disputes between hospitals and members of the Medical Staff about restrictions, suspensions and revocations of privileges through board hearings.

The case of Beiko[2] dealt with a group of ophthalmologists who went to court to sue for breach of contract and negligent misrepresentation when the hospital reduced their operating room time. The physicians initiated a court process for damages prior to having their appeal before HPARB finalized. The court held it did not have jurisdiction to hear a dispute about privileges without the parties having followed the statutory route in the *Public Hospitals Act* first. The court's decision nicely summarizes the *Public Hospitals Act* scheme, as articulated by Mr. Justice Morawetz:[3]

> "In my view, the Act establishes a comprehensive code under which the hospital determines privileges for a member of staff.
>
> Section 36 establishes the basis upon which the board (defined in the Act) may determine hospital privileges. Having undertaken that responsibility, it follows that issues relating to privilege are determined in accordance with the provisions of ss. 36-43. Although the board has not specifically been granted the power to award monetary damages, it does have the power to establish a MAC, which has the authority to consider and make recommendations to the board respecting any matter referred to it under s. 37 and perform such other duties as assigned to it by or under this or any other Act or by the board.
>
> Every application in respect of privileges is to be submitted to the administrator who immediately refers such application to the MAC.
>
> The MAC in turn makes recommendations in respect of each application in writing to the board. The MAC also gives written notice to the applicant and to the board of its recommendation. Thus, an applicant can then require a hearing by the board in accordance with subsection 37(7). At a hearing by the board, the person requiring the hearing is afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced at the hearing.
>
> Any member of the medical staff of a hospital who considers himself or herself aggrieved by any decision which substantially alters his/her privileges is entitled to written [reasons] of the decision and a hearing before the Appeal Board [HPARB].
>
> The procedures in respect of a hearing before the board also apply to a hearing before the Appeal Board. The Appeal Board has the authority to substitute its own opinion for that of the board, person or body making the decision appealed from.
>
> There is a further procedure available to any party to appeal from the decision of the Appeal Board to the Divisional Court, which appeal may be made on a question of law or fact or both and the Court may substitute its opinion for that of the Appeal Board."

The *Public Hospitals Act* scheme has a provision that addresses scenarios where a Medical Staff member disagrees with a privileges decision taken by the hospital or hospital board. Physicians must first seek recourse using their rights and remedies under the *Public Hospitals Act*. They will usually be turned away by courts if they try instead to circumvent the *Public Hospitals Act* process and go directly to the civil legal system to seek redress (such

1 The *Public Hospitals Act* does not refer to other members of the Professional Staff such as Dental Staff, Midwifery Staff or Extended Class Nursing Staff. However, the *Public Hospitals Act* Regulation 965 acknowledges these clinicians and requires that hospitals with these Professional Staff groups outline their relationship with their hospital through their by-laws.

2 *Beiko* v. Hotel Dieu Hospital St. Catharines, [2007] O.J. No. 331 (Sup. Ct. Jus.).

3 *Beiko* at paras. 45-52, pp. 9-10.

as breach of contract legal claims, as in Beiko).[4] Both the physician and the hospital may appeal board decisions to HPARB,[5] and further, to the Divisional Court.[6] Aggrieved members of the Medical Staff can also take HPARB decisions in their favour to court, to seek damages from a hospital.

The key provisions of the *Public Hospitals Act* relating to the credentialing process are identified below:

- The hospital board must establish the Medical Advisory Committee (MAC) with members of the Medical Staff.[7]
- Only the hospital board may appoint physicians to the Medical Staff, determine the scope and type of privileges granted, and revoke, suspend or refuse to appoint a physician.[8]
- Every physician is entitled to apply for appointment or re-appointment to the hospital's Medical Staff, and the CEO must supply an application form to a physician on written request.[9]
- Every appointment to the Medical Staff is limited to not more than one year. [10]
- Every application for appointment to the Medical Staff must be immediately referred to the MAC and considered within 60 days (the 60-day period can be extended by the MAC on written notice to the applicant and the board, with reasons).[11]
- The MAC must give written notice of its recommendation to the applicant and the board.[12]
- The applicant is entitled to a hearing before the board. [13] However, if an applicant does not request a hearing, no hearing is held and the recommendation of the MAC may be accepted by the board. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*
- Section 39 sets out the rules that apply to a board hearing.
- When a physician has applied for re-appointment within the prescribed time, their appointment continues until re-appointment is granted or, if the board refuses to grant the re-appointment, until the HPARB appeal process is completed if it proceeds to HPARB.[14]
- The board has the power to close the hospital or close a service with no right of an affected physician to a board hearing.[15]

The *Public Hospitals Act* scheme is explained throughout this Toolkit. *See also Chapter 3, Roles and Responsibilities, for a detailed listing of the role of each stakeholder in the privileges process.*

4 Note though the decision of the Ontario Court of Appeal in *Kadiri v. Southlake Regional Health Centre, 2015* ONCA 847 (CanLII) where the Court said whether a physician has followed through with the statutory privileges dispute-resolution process under a hospital's bylaws and the *Public Hospitals Act* will turn on the specific facts of each case. Depending on the specific circumstances of a case, proceeding to a hearing before the HPARB may or may not be required of the physician. In the *Kadiri* case, the physician was not required to go to HPARB before bringing his action in court because (i) Dr. Kadiri and the Hospital had worked out an arrangement to deal with their dispute and (ii) at the time Dr. Kadiri commenced his lawsuit, he had returned to a full practice at the Hospital with full privileges.

5 Section 41.

6 Section 43.

7 Section 35.

8 Section 36.

9 Section 37(1).

10 Section 37(2).

11 Section 37(3) - (5). See Waddell v. Weeneebayko, 2018 CanLII 39843 (ON HPARB) at para 86 where HPARB reviewed a situation where a hospital did not consider a physician's application within 60 days from the date of the application but concluded that was primarily due to the physician's actions and confusion over whether the physician was re-applying for privileges or not.

12 Section 37(6).

13 Section 39(1).

14 Section 39(3). Note that this right to maintain an appointment does not apply where privileges are revoked or suspended.

15 Section 44. This section removes the usual *Public Hospitals Act* procedural entitlements with respect to privileges decisions where a board (or the Minister of Health) determines the hospital will cease to operate as a public hospital or cease to provide a service.

It is important to remember that the *Public Hospitals Act* privileges scheme applies even when physicians are employees of the hospital. Some hospitals for historical or strategic reasons, employ all their Medical Staff or specific types of physicians (e.g., pathologists). When a physician has privileges and is an employee, the employment relationship can be terminated for just cause or with appropriate notice, per employment law.[16] But the physician retains their privileges, and those privileges can only be terminated through the process set out in the *Public Hospitals Act.*

Where an employment relationship has been terminated, it may be contemplated that the individual continue as an independent contractor and maintain their privileges.

The relevant excerpts from the *Public Hospitals Act* are included in AppendixII.

Hospital Management Regulation 965

Regulation 965 under the *Public Hospitals Act* provides further details about the roles and responsibilities of the MAC and references that a hospital may have privileged Dental Staff, Midwifery Staff, and Extended Class Nursing Staff.

Regulation 965 sets out that the board must establish the criteria for appointment and re-appointment of Medical Staff in the by-laws; and when the hospital has Dental Staff, Midwifery Staff or Extended Class Nursing Staff, their criteria for appointment and re-appointment must be identified.[17]

The Regulation also identifies which physicians must be on the MAC (only physicians may vote at the MAC):

- President of the Medical Staff;
- Vice-President of the Medical Staff;
- Secretary of the Medical Staff;
- Chief of Staff (or a physician on the MAC who is appointed as Chair of the MAC);
- If the hospital is a Group A hospital,[18] the Chief of Dental Staff, if any; and
- Other physicians appointed in accordance with the by-laws.[19]

The MAC has an obligation to make recommendations to the board on various privileges matters, including:

- Every application for appointment or re-appointment of Dental Staff, Midwifery Staff or Extended Class Nursing Staff;
- What privileges to grant to Dental Staff, Midwifery Staff or Extended Class Nursing Staff; and
- Dismissal, suspension or restriction of privileges of all Professional Staff members.[20]

The MAC is also responsible under Regulation 965 for making the following recommendations to the board:

- By-laws respecting all Professional Staff;
- Clinical and general rules relating to all Professional Staff;
- Quality of care provided by all Professional Staff;
- The supervision of the practice of medicine, dentistry, midwifery and extended class nursing by the Professional Staff members;[21] and
- Where the MAC identifies systemic or recurring quality of care issues in making its recommendations to the board under sub-clause (2)(a)(v), it shall also make recommendations about those issues to the board's Quality Committee.[22]

16 *Ready v Saskatoon Regional Health Authority*, 2017 SKCA 20.

17 Section 4(1)(b).

18 Public hospitals are classified into different groups according to size and function; see *Public Hospitals Act*, R.R.O. 1990, Reg. 964, "Classification of Hospitals".

19 Section 7(1).

20 Section 7(2) - Note that these MAC obligations apply only with respect to Extended Class Nursing Staff who are not employees.

21 Section 7(2) - Note that these MAC obligations apply with respect to Extended Class Nursing Staff, both employees and independent contractors.

22 *Public Hospitals Act*, R.R.O. 1990, Reg. 965, s. 7(7).

Regulation 965 also creates a process for transferring patient care when a member of the Professional Staff is unable to perform their professional duties. In such a case, the Professional Staff member must arrange for another member of the Professional Staff to take over care of the patient, and that transfer of care must be duly noted in the patient's health record.[23] If the hospital's administrator (CEO) believes that a member of the Professional Staff is unable to perform their duties with respect to a patient, the CEO has a duty to notify:

- The Chief of Staff/Chair of the MAC
- In the case of a physician, the President or Secretary of the Medical Staff
- In the case of a member of the Extended Class Nursing Staff, the Chief Nursing Executive[24]

Board Membership

Regulation 965 prohibits any employees or members of the Medical Staff, Dental Staff, Extended Class Nursing Staff or Midwifery Staff from being voting directors on the board; as such, these individuals can only be non-voting members. This regulation requires the CEO, Chief of Staff, Chief Nursing Executive and the President of the hospital's Medical Staff to sit as members of the board.

The relevant excerpts from Regulation 965 are included in Appendix II.

Statutory Powers Procedure Act

The *Statutory Powers Procedure Act* [25] is an Ontario statute that prescribes procedural rules for tribunal proceedings; this includes hospital board hearings where privileges decisions are under review.

Some procedural rules under the Act are mandatory. For example, the Act requires that a Professional Staff member be provided with reasonable information of any allegations, prior to a hearing, where their good character, propriety of conduct or competence is an issue in the proceeding.[26]

The Act also creates discretionary powers that the hospital board may choose to utilize. For example, a hospital board may admit oral testimony and "any document or other thing, relevant to the subject-matter of the proceeding."[27] A hospital board may also "take notice" of certain facts, meaning it can consider facts that have not been proven by the parties through evidence. Examples of such facts include generally recognized scientific or technical facts.[28]

Procedural requirements under the Act may be waived with the consent of the parties and the board;[29] this includes foregoing a hearing altogether.[30] Further flexibility can also be attained if the board creates its own rules. Such rules may address procedures such as pre-hearing conferences, electronic hearings and alternative dispute resolution. [31]

Hospitals should seek legal advice to establish the procedural rights for their privileges hearings.

By-laws

This Toolkit references and relies on the OHA/OMA Prototype By-law. If a hospital has not adopted the by-law or has customized it to suit their unique situation, the hospital's own by-laws need to be considered in the context of all privileges matters. It is important to adapt any of the sample documents offered in this Toolkit to individual organizational contexts.

The *Public Hospitals Act* requires that hospital by-laws include provisions for the organization of the Medical Staff in the hospital. Regulation 965 under the *Public Hospitals Act* also requires that, if a hospital has a Dental Staff,

23 Section 18(1) and (2).

24 Section 18(3). Although not mentioned in the *Public Hospitals Act*, for dentists, the CEO might contact the Head of the Dentistry Division/Department, and for midwives, the CEO might contact the Head of the Midwifery Division/Department.

25 *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22

26 Section 8.

27 Section 15(1).

28 Section 16(b).

29 Section. 4(1).

30 Section 4.1.

31 Sections 4.7 and 5.2.

Midwifery Staff or Extended Class Nursing Staff, the by-laws must set out the duties of the staff and the criteria with respect to their appointment and re-appointment.

Hospitals must keep in mind that the rights to a board hearing[32] and to appeal board decisions to HPARB and Divisional Court apply only to members of the Medical Staff. Those rights do not extend to the other Professional Staff members. The OHA/OMA Prototype By-law applies much of the *Public Hospitals Act* scheme for Medical Staff to other Professional Staff members, e.g., one-year appointments to the Professional Staff and the right to a hearing before the board if the applicant requests, after receiving the MAC's recommendation with respect to privileges. This is a decision each hospital must make. Of course, a hospital cannot extend to the other Professional Staff members the right to appeal board decisions to HPARB and then to Divisional Court – only legislation can do that.

This Toolkit generally assumes that the right to a board hearing has been extended to Dental Staff, Midwifery Staff, and Extended Class Nursing Staff, as we would consider that best practice.

While each hospital's Professional Staff by-law will be different, in general terms, the by-law will cover such things as:

- The hospital's criteria for appointment and re-appointment to the Professional Staff. For example, licence to practice, professional liability protection (insurance), appropriate references, and appropriate specialist qualifications where applicable.
- The different categories of Professional Staff (e.g., active staff, associate, courtesy staff, etc.) and the rights and responsibilities that attach to those categories (e.g., right to admit patients, responsibility to attend Departmental meetings).
- Where the hospital is organized into Departments, the different Departments (e.g., surgery, emergency, pediatrics, etc.) and the clinical leaders within those Departments.
- The process to be followed to fulfill each of the requirements of the *Public Hospitals Act*:
  - Handling of initial applications
  - Process for granting initial appointments
  - Process for granting annual re-appointments
  - Process for approving changes in privileges
  - Steps to be taken when it is considered necessary to restrict, suspend or revoke an appointment (including urgent mid-term action)
- Administrative matters, such as granting leaves of absence, monitoring practice and transferring care from one Professional Staff member to another.

Hospital Rules and Regulations

Hospital Rules and Regulations, policies, mission, vision and values, Codes of Conduct and medical directives also contribute to the legal context within which Professional Staff members work.

While not every hospital has written Professional Staff Rules and Regulations, hospitals should consider addressing the following topics in written form:

- Board privileges hearings
- Chief of Staff/Chair of the MAC selection process
- Code of Conduct
- College reporting obligations
- Continuing professional education expectations
- Delegation of controlled acts
- Dispute resolution
- Effective referrals
- Health records content and completion
- Job descriptions for clinical leaders (Chiefs of Department, Chief Nursing Executive)

32 For clarity, "board" refers to the hospital board, and "HPARB" refers to the Health Professions Appeal and Review Board, a provincial tribunal that hears appeals concerning physicians' hospital privileges under the *Public Hospitals Act*.

- Leave of absence
- *Locum Tenens* appointments
- Maintaining Professional Staff files
- Medical directives
- Most Responsible Clinician/Transfer of Care
- Occupational health and safety policies regarding immunizations, screenings and tests
- On-call guidelines
- Participation on committees
- Requests to reduce on-call coverage
- Supervision of students and trainees
- Suspension/restrictions/revocation of privileges policy
- Telehealth and remote consultations and procedures
- Utilization expectations
- Vacations/sick days
- Whistleblower protection

As with by-laws, Rules and Regulations should be reviewed on a routine basis (e.g., every three years) to ensure they reflect or are consistent with:

- Any updates to the hospital's by-laws
- Any changes to the *Public Hospitals Act* that could impact operationally on the Professional Staff
- Actual practice within the hospital
- Restructuring within the hospital and its clinical leadership
- New legislative requirements, such as critical incident reporting under Regulation 965
- Best practices within the industry

To be effective, these Rules and Regulations, policies, Codes of Conduct and medical directives must be easily accessible to members of the Professional Staff. They should be mentioned during any orientation for new Professional Staff Members and available online, if possible, through a hospital intranet or portal.

If problems arise with a member of the Professional Staff, they should be directed to the relevant Rules and Regulations to assist them in understanding the expectations of the hospital.

Contracts

As stated above, most Professional Staff members are independent contractors, not hospital employees. While not mandatory, the parties may choose to document their understanding of their relationship in a formal written contract.

In some cases, hospitals and Professional Staff recruits will enter into formal written contracts that document each party's roles and responsibilities and reflect any promises or negotiations made as part of the recruitment process. This contract supplements the contract created by the privileges process.

Many contracts are in writing, but it is important to realize that verbal contracts can also be legally binding. Written contracts are preferred as they stand as concrete evidence, clearly detailing terms and conditions that will be enforceable should disputes arise, and often setting out consequences and damages to be assessed if the contract is broken.

No contract should be signed until the board has granted privileges.

Written contracts with recruits may address the following matters:

- Nature and scope of privileges granted
- Category of staff (associate staff, active staff, courtesy, *Locum Tenens*)
- Probationary periods (if any)
- Accountability (e.g., to Chief of Department)
- Whether the Professional Staff member will be supervised
- Whether the Professional Staff member will have leadership responsibilities
- On-call commitments
- Participation in existing alternate payment plans
- Recruitment incentives, such as office space, administrative support, moving expenses, and signing bonuses (*see Chapter 4, Planning and Recruitment*)
- Termination clause

See also Chapter 5, Initial Appointment, for letters of offer for initial appointments.

Contracts may also be entered into under the following circumstances:

- Many hospitals enter into agreements with those holding Professional Staff leadership positions (e.g., Chief of Staff/Chair of the MAC or Chief of Department). Such agreements should document certain elements of the arrangement, such as the compensation/stipend paid by the hospital for the position, term and termination provisions, and the scope of duties. In particular, any additional duties and the reporting relationship for those duties should be included as part of such an agreement.
- Where a physician, dentist, or midwife is an employee of the hospital, a written employment agreement is recommended. A common provision in these agreements is that if the individual's privileges are revoked, the employment relationship ends (unless the employee has other non-clinical duties that could continue). However, hospitals should remember that privileges cannot be terminated using notice provisions in an employment contract. The only way privileges can be revoked is using the legal process under the *Public Hospitals Act*. As a reminder, Regulation 965 under the *Public Hospitals Act* differentiates between extended class nurses who are employees and extended class nurses who have privileges and are not employees.

Affiliation Agreements

Academic health sciences centres are formally affiliated with universities that have medical schools, through a written affiliation agreement. Affiliation agreements typically include elements that require:

- Certain members of Professional Staff to hold an appointment at the university, and if they lose that appointment they cannot be on the hospital's Professional Staff (or if they lose their hospital appointment they cannot be on the university faculty).
- Hospitals and Professional Staff must abide by certain university policies when issues arise within the hospital environment that involve cross-appointed faculty and/or students (such as harassment policies).
- Disclosure of information about any actions taken by either the hospital or the university that may affect the appointment of the Professional Staff member.
- Other affiliation agreements may be entered into with universities or colleges that do not have a medical school (e.g., where the agreement is between the college and the hospital to place the college's students in a clinical setting).

See Chapter 12, Academic Issues, for more information about the academic context.

Case Law

While the *Public Hospitals Act*, Regulation 965, and the hospital by-laws set out the comprehensive code to follow with respect to hospital privileges, case law from HPARB, Ontario courts and other Canadian courts interpret the rules through actual events. There are hundreds of cases that interpret rules about hospital privileges and that clarify the rights and responsibilities of the Professional Staff members, hospitals, administrators and boards.

The case law focuses on physicians, as opposed to other members of the Professional Staff. As previously mentioned, Dental Staff, Midwifery Staff and Extended Class Nursing Staff have no statutory right to appeal hospital board decisions; as such, they are not the focus of case law (but the principles of the case law would nonetheless apply).

There are a wide range of procedural rights and issues that can arise in the context of hospital privileges disputes. It is not possible to canvass all those issues here.

The main themes that emerge from privileges case law are:

1. Hospitals owe a duty of care to their patients (and staff).

Hospitals have an obligation to under the *Public Hospitals Act* and its regulations to provide competent medical personnel and appropriate facilities to their patients.[33] A hospital is not responsible for negligence of the physicians

33 *Yepremian et al v. Scarborough General Hospital*, (1980) 110 D.L.R. (3d) 513 (Ont. C.A.).

who practice in the hospital, but it is responsible to ensure that physicians or staff are reasonably qualified to do the work they might be expected to perform.[34]

CASE OF YEPREMIAN V. SCARBOROUGH GENERAL HOSPITAL
(Ontario Court of Appeal, 1980)

In *Yepremian*, the plaintiff had a cardiac arrest and suffered brain damage. The plaintiff claimed damages against a doctor and the hospital where he had received care. The plaintiff claimed that the hospital should be liable for the negligent medical care of its physician. The Court of Appeal held that the hospital was not vicariously liable for the actions of its physician, but that a hospital would be responsible if it does not appropriately select its medical staff. The Court of Appeal wrote:

> "I think,a member of the public who knows the facts is entitled to expect that the hospital has picked its medical staff with great care, has checked out the credentials of every applicant, has caused the existing staff to make a recommendation in every individual case, makes no appointment for longer than one year at a time, and reviews the performance of its staff at regular intervals. Putting it in layman's language, a prospective patient or his family who knew none of the facts, would think: 'If I go to Scarborough General, I'll get a good doctor.'"

Hospitals also have an obligation to provide safe and effective care to their patients and create safe working environments for their staff – these are the primary obligations of hospitals and supersede any professional's right to practice.

Not all hospitals are held to the same standard of care. There is case law recognizing that some smaller community hospitals and their physicians are not held to the same standard of care as larger teaching centres:

> The evidence is that these criteria and the professional staff to meet them were at a higher level in large teaching hospitals in other parts of Canada, but in my view the Defendant Moncton hospital must be judged by the standards reasonably expected by the community it serves, not communities served by large teaching facilities.[35]

It is best to err on the side of caution and make credentialing decisions with the utmost care, fairness and thoughtfulness, not only for the protection of the patients, but also to protect the hospital and its board from liability.

2. Hospitals owe procedural fairness and natural justice to members of their Professional Staff (and individuals applying for membership).

While no one has a right to be granted hospital privileges,[36] hospitals are responsible for following the *Public Hospitals Act*, Regulation 965, and their own by-laws when dealing with issues of appointment, re-appointment, and changes to privileges and when managing suspensions, restrictions or revocation of privileges.

Administrative law governs agencies that have the legal authority to make decisions that can affect others – such as hospital boards. Directors who sit on hospital boards have been vested with important power and must uphold certain principles in order to use this power responsibly. Two of these principles are **natural justice** and **procedural fairness**.

Natural justice means justice that is defined in a moral sense – what is fair – as opposed to legal justice grounded in the law. Natural justice encompasses the ideas that an individual has the right to adequate notice about proceedings and to be heard by an impartial decision-maker.

34 Ibid.

35 *Bateman v. Doiron* [1991] N.B.J. No. 714, aff'd (1993), 141 N.B.R. (2d) 321 (N.B.C.A.).

36 In the 2010 Rosenhek decision, Justice Greer stated, "No physician has a right to hospital privileges. Patient safety and quality of care are the paramount concerns when making a decision with respect to physician privileges." *Rosenhek v. Windsor Regional Hospital* [2010] O.J. No. 2893 (Sup. Ct. Jus.) at 33.

Procedural fairness, or due process, is a twin concept to natural justice. It is a duty of decision-makers to ensure procedural fairness in the circumstances, including:

- The nature of the decision being made and process followed in making it.
- The nature of the statutory scheme and the terms of the statute pursuant to which the body operates.
- The importance of the decision to the individual or individuals affected.
- The legitimate expectations of the person challenging the decision.
- The choices of procedure made by the agency itself.[37]

Specifically, within the credentialing process, procedural fairness is owed by the hospital to the Professional Staff member:

- The Professional Staff member has a right to receive notice of the allegations against them.
- The Professional Staff member has a right to present their case before the board, to present witnesses, to review documentation in advance, and to cross-examine witnesses.
- The Professional Staff member has a right to have a fair, impartial, open decision-making process.

Procedural fairness is a major reason why a board cannot act as a "rubber stamp" of the MAC's recommendation. It must instead "bring an independent responsible and committed approach to the review process."[38] Members of the MAC and the Credentialing Committees must bring this same commitment to the process.

Through the *Public Hospitals Act*, physicians who feel aggrieved by an appointment or re-appointment decision or with respect to the suspension, restriction or revocation of their privileges are given the right to a hearing before the hospital board. They can raise procedural fairness and natural justice issues at that time. They may also raise fairness issues before HPARB and after that to the courts, if necessary.

To illustrate the importance of natural justice and procedural fairness, consider the case of *Rosenhek v. Windsor Regional Hospital*.[39] In 1989, the hospital board revoked Dr. Rosenhek's privileges without providing him with an opportunity to respond. In 2007, the Ontario Superior Court of Justice found that there was bad faith and a denial of natural justice on the part of the hospital board. The court also found that Dr. Rosenhek experienced economic loss as a result of the manner in which his privileges were revoked. The Court awarded the physician three million dollars in damages.

Natural justice and procedural fairness simply reflect common sense. As the Ontario court has described:

"The requirements of natural justice could be easily satisfied. The doctor could be provided with the nature of the complaint, in advance. The doctor could then have the report and opportunity to question the complainant regarding the allegations. The doctor could appear before the Medical Advisory Committee and state his or her position. The Medical Advisory Committee could make their recommendation based upon the evidence before them. As long as the committee members are not biased or have a conflict then they should be able to make reasoned recommendations to the Hospital board. Due to the nature of the composition of hospital boards they would probably follow the recommendations of their Medical Advisory Committee, unless there is good reason not to follow the recommendation."[40]

37 *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817.

38 *Cimolai v. Children's and Women's Health Centre of British Columbia*, [2006] B.C.J. No. 2199 (S.C.), at 60.

39 *Rosenhek v. Windsor Regional Hospital* [2007] O.J. No. 4486 (Sup. Ct. Jus.).

40 *Zahab v. Salvation Army Grace General Hospital – Ottawa* [1991] O.J. No. 763 (Ct. J. (Gen. Div.)).

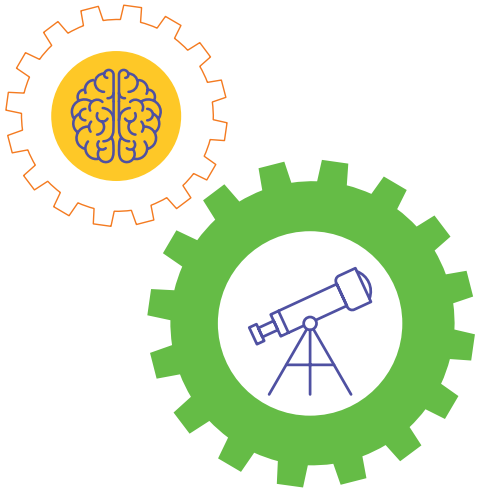
3. The *Public Hospitals Act* sets out a comprehensive code for addressing privileges issues.

Occasionally, physician plaintiffs will initiate legal actions outside the *Public Hospitals Act* scheme, such as wrongful dismissal, constructive dismissal or breach of contract lawsuits against hospitals. Unless there is a clear and entirely separate matter to be resolved, the courts generally discourage physician plaintiffs from initiating legal actions outside the *Public Hospitals Act* scheme.

In the cases of Drs. Fornazzari and Bagheri in Ontario,[41] two physicians claimed damages for breach of contract against the same hospital, alleging constructive dismissal because the hospital introduced a new physician compensation model. In almost identical decisions, the Superior Court of Justice held:

> "Section 41 of the [*Public Hospitals Act*] sets out a comprehensive code to deal with disputes arising from decisions not to appoint or re-appoint or decisions which change or substantially alter an individual's hospital privileges. It states that the person is entitled to written reasons from the board, a hearing before the Appeal Board and ultimately, the [*Public Hospitals Act]* provides a right to appeal the [Health Professions Appeal and Review Board] decision to the Divisional Court. In my view, given that the Plaintiff's argument with CAMH concerns the alteration of her compensation, which arises from her application for re-appointment, the proper process for her to follow is that set out in the legislation, specifically s. 41 of the [*Public Hospitals Act*]. It seems to me that whether the proposed change to the compensation model constitutes a substantial alteration to the privileges of the doctors would be exactly the sort of question the specialized board ought to be determining."[42]

Justice Morawetz (who also presided in the *Beiko* case that introduced this Chapter) concluded that the court did not have jurisdiction to usurp the statutory regime of the *Public Hospitals Act* on issues relating to privileges. He concluded that, following the statutory process, it is open to applicants to bring an action for damages. He also stated that strictly employment or contractual issues between hospitals and physicians could be dealt with by the courts.



41 *Bagheri v. Centre for Addiction and Mental Health*, 2010 ONSC 2886, [2010] O.J. No. 2050, (Sup. Ct. Jus.) and *Fornazzari v. Centre for Addiction and Mental Health*, 2010 ONSC 2884, [2010] O.J. No. 2056 (Sup. Ct. Jus.).

42 *Fornazzari v. Centre for Addiction and Mental Health*, 2010 ONSC 2884, [2010] O.J. No. 2056 (Sup. Ct. Jus.) at 7; *Bagheri v. Centre for Addiction and Mental Health*, 2010 ONSC 2886, [2010] O.J. No. 2050, (Sup. Ct. Jus.) at 7.

Chapter 3: Roles and Responsibilities

Chapter Summary

- While other chapters in this Toolkit organize credentialing responsibilities by task, this chapter summarizes those responsibilities by role (for example, a board member or Chief of Department can turn to their "role" in this chapter and see a summary of all the responsibilities commonly assigned to that role).
- This chapter identifies common roles and key players. It is acknowledged that each hospital may identify different positions to fulfill the listed responsibilities and will adapt the roles and listed responsibilities to its specific situation.
- Under each of the "roles", we have summarized the possible "responsibilities" that can be assigned to that role. Only where we have indicated by the acronym PHA for *Public Hospitals Act* or its Regulation 965, or RHPA for *Regulated Health Professions Act*, 1991, is the responsibility mandatory. Otherwise, hospitals may wish to assign the list of responsibilities to reflect their own by-laws and practices.
- The lists of responsibilities align with the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law) and common practices of hospitals.
- Hospital by-laws may assign additional responsibilities that go beyond the legislation.
- Hospitals can exercise discretion in assigning many of the tasks in the credentialing process so long as the board makes the final decisions.

Overall Responsibility

The following Table lists credentialing tasks covered in this Toolkit and provides examples of the role(s) commonly assigned to complete each task.

TASK	COMMONLY ASSIGNED TO:
Recruitment (Chapter 4)	Chiefs/Heads
Impact Analysis (Chapter 4)	Chiefs/Heads
Applications (Chapter 5 & 6)	CEO receives application
Credentialing (Chapters 5 & 6)	Credentials Committee
Initial appointment (Chapter 5)	• Chiefs/Heads recommend appointments • Medical Advisory Committee (MAC) recommends appointments • Board decides appointments
Re-appointment (Chapter 6)	• CEO receives re-appointment applications • Chiefs/Heads recommend re-appointments • MAC recommends re-appointments • Board decides re-appointments
Performance Reviews (Chapter 8)	Chiefs/Heads

TASK	COMMONLY ASSIGNED TO:
Progressive Management/Discipline (Chapter 8) - Warning - Reprimand - Supervision - Required additional training	Chiefs/Heads (in consultation with Chief of Staff/Chair of MAC)
Administrative Suspensions (Chapter 9)[1]	• Chief of Staff/Chair of the MAC recommends suspensions • MAC reviews suspensions • Board decides suspensions
Immediate Mid-Term Suspensions (Chapter 9)	• Chief of Department or CEO or Chief of Staff/Chair of the MAC • MAC reviews mid-term suspensions on an urgent basis • Board decides on mid-term suspensions on an urgent basis
Non-Immediate Mid-Term Suspensions (Chapter 9)	• CEO or Chief of Staff/Chair of the MAC or Chief of Department (or their delegates) recommends non-immediate mid-term suspensions • MAC reviews non-immediate mid-term suspensions • Board decides non-immediate mid-term suspensions
Decision to Restrict, Suspend or Revoke Privileges (Chapter 9)	• Chiefs/Heads recommend decisions (internal or external investigation) • MAC reviews and recommends decisions • Board makes final decision
Resignation and Retirement (Chapter 10)	Chiefs/Heads

Chapters 4 to 10 of this Toolkit explore these tasks in more detail. They identify the source of the legal requirements and offer recommendations for best and innovative practices in these areas.

1 Some hospitals have policies that contemplate "administrative suspensions", which are suspensions for acts such as failing to pay regulatory College dues and having a lapse in licensure, failing to maintain professional insurance, failing to meet occupational health and safety obligations (e.g., mask fit testing, cardio-pulmonary resuscitation, tuberculosis testing), or failing to rectify health records deficiencies after being notified. There is no legal requirement to include administrative suspensions.

Board

The **board** is commonly responsible for:

1) Appointing and re-appointing the Medical Staff, as well as revoking or suspending appointments and cancelling or suspending any member of the Medical Staff who no longer meets the hospital's qualifications or who contravenes any applicable by-laws, rules, regulations or statutes (PHA).

2) Appointing and re-appointing other members of the Professional Staff (i.e., dentists, midwives and extended class nurses), where the by-laws provide for these types of Board-Appointed Professional Staff members.

3) Determining the scope of any privileges granted to a member of the Professional Staff (PHA).

4) Reviewing temporary appointments made by the CEO and recommended by the MAC to continue (PHA).

5) Holding hearings on Medical Staff privileges issues (and on privileges issues relating to other members of the Professional Staff, where the by-laws provide for these types of Board-Appointed Professional Staff members) (PHA).

6) Complying with the rules for privileges hearings established by the *Public Hospitals Act* (PHA).

7) Representing the hospital at appeals to the Health Professions Appeal and Review Board (HPARB) in Medical Staff privileges matters (PHA).

8) Approving Rules and Regulations for the Professional Staff.

9) Approving policies and procedures that are applicable to the Professional Staff.

10) Making decisions about the granting of a leave of absence for Professional Staff where there will be a suspension or restriction of privileges (or, alternatively, approving a leave of absence policy to be administered by the Chief of Staff/Chair of the MAC).

11) Monitoring activities in the hospital and taking such measures as it considers necessary to ensure compliance with the *Public Hospitals Act*, its regulations and the hospital by-laws (PHA).

12) Passing by-laws to set standards for appointing and re-appointing members of the Professional Staff (PHA).

13) Appointing the Chief of Staff (if there is one) who chairs the MAC (or appointing a member of the MAC to act as Chair of the MAC) (PHA).

14) Establishing the MAC to assess credentials, health records, patient care, infection control, the utilization of hospital facilities and all other aspects of health care and treatment at the hospital (PHA).

15) Determining through the by-laws whether the MAC will include non-Medical Staff members (without a vote), in addition to the voting Medical Staff members on the MAC.

16) Establishing sub-committees of the MAC, and appointing non-Medical Staff members of those sub-committees as appropriate (PHA).

17) Receiving reports from the MAC through its Chair respecting the work of the MAC.

18) Determining departmental and divisional structures, if any (PHA).

19) Appointing the Chiefs of Department, if any (PHA).

Key messages for **boards:**

- Professional Staff credentialing is one of the most important duties the board fulfills in a hospital.
- The board ultimately makes any decisions about Professional Staff privileges: categories and scope of privileges; appointment; re-appointment; changes to privileges; and suspension, restriction or revocation of privileges.
- While the preparation and coordination of materials may be done by hospital staff or board sub-committees, the final decisions must be made by the board alone, and cannot be delegated.
- All privileges decisions must be made on a case-by-case basis after a thorough, careful and independent review by the board.
- The board is responsible for ensuring an effective and fair credentialing process. While it does not need to receive all the details for every applicant or each member of the Professional Staff – it must be assured that the processes meet legal requirements. This responsibility can be discharged by:
  - Ensuring the Professional Staff By-law is reviewed by legal counsel (usually every three years or more frequently if there is new legislation or new guidelines such as the OHA/OMA Prototype By-law).
  - Asking the Chief of Staff/Chair of the MAC to summarize the hospital's credentialing process and confirm it has been followed.
  - Asking whether there are any differences in how dental, midwifery and extended class nursing applications are processed as compared with physician applications.
  - Ensuring the MAC recommendations are consistent with the hospital by-laws, Rules and Regulations, hospital policies and Professional Staff Human Resources Plans.
  - Asking a board sub-committee, such as an Audit Committee, to do an annual audit of the hospital's credentialing process by reviewing a random sample of applications for appointment, re-appointment and changes to privileges.
- While the board should give significant weight to the MAC's clinical expertise when reviewing its recommendations on appointment and re-appointment, there are additional issues that the board must consider when making privileging decisions such as: quality of patient care; patient, staff and public safety; the hospital's legal obligations; fairness to the Professional Staff member; the role of the hospital in the community; and the effective and efficient operation of the hospital.
- Hospital privileges disputes can be extremely expensive and can have negative consequences for the reputation of the hospital – board members must take this role seriously.
- Privileges hearings are unique to hospitals and the board members should understand their role in a quasi-judicial process.
- HPARB can overturn a hospital's decision. If it does so, a member of the Professional Staff may have the right to return to the hospital or have access to resources that were previously restricted.

FAQs

1. How often should the board receive credentialing training?

The *Public Hospitals Act* does not require board training, but governance best practice generally recommends that board members receive credentialing training during their orientation and at least every three years thereafter (and more frequently if there are new developments, such as new legislation, new guidelines, or significant new case law).

2. When do Professional Staff appointments and re-appointments come to the board's attention?

Appointments may come to the board's attention throughout the year, as new Professional Staff members apply for privileges or are actively recruited to become part of the hospital's Professional Staff.

All appointments are for a maximum term of one year under the *Public Hospitals Act*. Re-appointments to the Professional Staff tend to come to the board's attention all at once, as most hospitals define a "credentialing year" for all Professional Staff members, with applications for re-appointment due at the same time each year (e.g., a credentialing year may be July 1st – June 30th, with re-application forms due by April 30th). Note that there is no requirement for all Professional Staff members to follow the same credentialing year, and there may be benefits to staggering the timing of re-appointment applications (such as by Department so that different Departments submit applications at different times throughout the year) to make the workload more evenly distributed throughout the year for administrative staff, the MAC and board.

There may also be temporary, mid-term, or consultant staff appointments that come before the board for approval throughout the course of the year.

If there is an urgent need to suspend, restrict or revoke a member's privileges, the board should be alerted as soon as possible.

If for any reason the MAC is not recommending someone for appointment or re-appointment, the MAC must notify the board, along with the applicant, as required by the *Public Hospitals Act* (this applies to a physician in all cases, and also to other Professional Staff where the by-laws specifically require this). The applicant may choose to request a hearing before the board concerning their privileges.

Medical Advisory Committee

The **MAC** is commonly responsible for:

1) Making recommendations to the board, including recommendations concerning the:

   a. Applications for appointment or re-appointment to the Professional Staff and any requests for changes in privileges. This applies to every application from every member of the Professional Staff (PHA).

   b. Privileges to be granted to each member of the Professional Staff (PHA).

   c. Revocation, suspension or restrictions of privileges of any member of the Professional Staff (PHA).

   d. Quality of care provided in the hospital by the Professional Staff (PHA and the *Excellent Care for All Act*).

   e. Professional Staff by-laws (PHA).

   f. Rules and Regulations respecting the Professional Staff (PHA).

   g. Policies and practices that affect the Professional Staff (PHA).

   h. Creation of MAC sub-committees (PHA).

2) Making recommendations to the Quality Committee of the board where the MAC identifies systemic or recurring quality of care issues.[2]

2 *Public Hospitals Act*, R.R.O. 1990, Reg.965, s.7(7).

3) Reviewing applications for appointment or re-appointment to the Medical Staff within the 60-day window set out by the *Public Hospitals Act* (or extending the 60-day period on written notice to the applicant and the board, with reasons)[3] (PHA).

4) Notifying the board and the applicant of its decision, in writing, of its recommendation regarding any application for appointment or re-appointment (PHA).

5) Supervising the clinical practice of medicine, dentistry, midwifery and extended class nursing at the hospital (PHA).

6) Appointing Medical Staff members to certain committees (PHA).

7) Receiving reports of MAC sub-committees (PHA).

8) Advising the board on any matter referred to the MAC by the board (PHA).

9) Receiving recommendations for appointment and re-appointments from the Credentials Committee (where one exists).

10) Reviewing applications with reference to Professional Staff Human Resources Plans and impact analyses.

11) Reviewing temporary appointments made by the CEO that are proposed to be continued.

12) Investigating quality of care issues with respect to specific members of the Professional Staff as requested.

Key messages for **MAC**s:

- The MAC is the primary committee responsible for supervising the Professional Staff in the hospital.
- The MAC is accountable to the board in accordance with the *Public Hospitals Act* and its regulations.
- The *Public Hospitals Act* and its regulations, as well as the hospital by-laws, set out the duties of the MAC.
- The MAC is responsible for making recommendations to the board concerning the appointment, re-appointment, revocation, suspension or restriction of – or any changes to – the hospital privileges of all Professional Staff members. The MAC does not make final decisions with respect to hospital privileges – the board does.
- The board relies on the MAC's recommendations due to the MAC's clinical expertise – however, the board is not bound to follow their recommendations. It is possible that a hospital board will not agree with the MAC or will challenge the process the MAC followed to come to its recommendation.

"The most cogent source of medical expertise relevant to the practice of medicine within a hospital is to be found in its Medical Advisory Committee and Chief of Staff. A board has every justification to give great weight to their advice. **However, a Board of Governors must not permit itself to become the rubber stamp of approval for proposals made by its Medical Advisory Committee**. No member of a Board of Governors ought to feel uneasy or embarrassed to question the basis of a proposal of the medical staff. Every Board member owes a duty to his community to require that the advisors of his board demonstrate that they have given full and fair consideration to the issues, and that their recommendations support the established policies and objectives of that hospital. A board is in breach of its trust to the public if, for selfish motives, it permits any individual or group involved with the operation of its hospital to deviate from those objectives or distort those policies."

Re Sheriton and North York General Hospital **(Hospital Appeal Board, 1973) referred to in** ***Pratt v. Fraser Health Authority*** **(BCSC, 2007)**

3 It would be considered best practice to review all Professional Staff applications for appointment or re-appointment within 60 days (or extended as necessary with reasons).

- The MAC should ensure the information provided to the board is accurate and complete. Taking into account the *Public Hospitals Act* and the privileges case law, the MAC should endeavour to demonstrate to the board that its recommendation is:
  - Consistent with the *Public Hospitals Act* and its regulations and the hospital by-laws.
  - Objective (i.e., any conflicts of interest have been identified and managed).
  - Fair to the Professional Staff member.
  - Aligned with the hospital's mission, vision and values.
  - Balanced and complete – The MAC has considered the issues of quality of care; patient, staff and public safety; the community's needs; and the effective and efficient operation of the hospital.
- In most hospitals, the MAC does not get involved in the detailed review of every candidate for appointment or re-appointment. It faces the same challenges as the board; it must exercise thoughtful, independent judgment and not act as a mere rubber stamp for the work of the Credentials Committee (or person assigned to perform the credentialing function).
- In order to be assured it has the right information upon which to base its decisions, the MAC should:
  - Support the development of departmental Professional Staff Human Resources Plans (and as appropriate, a corporate plan) so that there is an objective assessment of the hospital's needs and interests.
  - Understand the hospital's mission, vision and values.
  - Review the terms of reference for the Credentials Committee (or person assigned to perform the credentialing function) and its procedures every three years (or more frequently if there have been significant changes in the legal landscape).
  - Ask the Credentials Committee for an annual report identifying challenges and emerging issues.
  - Provide training to or written policies for Chiefs/Heads responsible for making recommendations to the MAC so that there is a consistent approach with respect to appointment, re-appointment and disciplinary decisions and so that they understand the scope of their authority for changing activities, resources and duties of members of the Professional Staff.
  - Where the MAC anticipates it will not recommend an appointment or re-appointment, offer to meet with the member of the Professional Staff in order to hear their side and to ensure it has complete information from both sides (i.e., the Chief of Department/Head and the Professional Staff member) before making a recommendation to the board. Note that there is no statutory obligation for the MAC to offer a member of the Professional Staff a meeting or a hearing before the MAC in these circumstances.
- The MAC should ensure:
  - Consistency across Departments and Divisions.
  - Alignment with the hospital's mission, vision and values.
  - Removal of subjectivity and personality-based decision-making and recommendations.
- The MAC structure offers an opportunity for the dissemination of information throughout the hospital. The MAC typically consists of the Chief of each Department; as such, it is a vehicle to convey updates on key hospital initiatives to the Chiefs, who can then pass information to the Professional Staff members at departmental meetings.

FAQs

1. Given that the MAC is made up of clinical experts, why doesn't the board delegate privileges decisions to the MAC?

The *Public Hospitals Act* does not allow the board to delegate its decision-making authority to the MAC. While the MAC must make recommendations to the board, the board retains the ultimate accountability for privileges decisions.

2. If there are non-physician members on the MAC, can those members vote on Professional Staff appointments or re-appointments?

No. The *Public Hospitals Act*, Regulation 965 permits only physicians (and the Chief of the Dental Staff if there is one in certain hospitals) to sit as members on the MAC. Some hospitals have broadened their MAC membership to include other disciplines, but those other disciplines may not vote on official MAC business such as privileges matters. For example, the OHA/OMA Prototype By-law allows for the CEO, Head of the Midwifery Division/Department, Head of the Dental Division/Department, Chief Nursing Executive and any Vice President of the hospital to attend MAC meetings, but without a vote. Even if hospital by-laws extend privileges to dentists, midwives and extended class nurses, only physician members (and Chief of the Dental Staff if there is one) of the MAC can vote on their appointment, re-appointment, and mid-term action affecting Professional Staff member privileges. However, the MAC may wish to solicit input from practice leaders for midwives, dentists and Nurse Practitioners.

3. Is the MAC required to hold a meeting or hearing if there is a privileges dispute?

No. The *Public Hospitals Act* requires that there be a board hearing, if the applicant so requests, but does not require a hearing or meeting at the MAC before that board hearing. The OHA/OMA Prototype By-law also does not contemplate a MAC meeting or hearing. Although there is no statutory obligation to offer a member of the Professional Staff a meeting or a hearing before the MAC, if a dispute arises, the MAC may choose to offer to meet with the member of the Professional Staff in order to hear their side and to ensure it has complete information – from both the Chief of Department/Head and the Professional Staff member – before making a recommendation to the board.

See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges, for more information on how to run these hearings.

Chief of Staff/Chair of the MAC

Hospitals are required under the *Public Hospitals Act* to have either a Chief of Staff or a Chair of the MAC. Where the hospital does not have a Chief of Staff, the board must appoint a Chair of the MAC from among the members of the MAC. Where a hospital decides to have a Chief of Staff, the Chief of Staff is appointed by the board and must fulfill the function of the Chair of the MAC. Sometimes this position is called the Physician-in-Chief (or Psychiatrist-in-Chief, at mental health facilities).

The Chief of Staff/Chair of the MAC has specific roles set out in the *Public Hospitals Act* and its regulations, as well as in section 9.3 of the OHA/OMA Prototype By-law. Some of the duties set out below may be performed by a Vice-President Medical or Medical Director.

The **Chief of Staff/Chair of the MAC** may be responsible for:

1) Acting as the Chair of the MAC (PHA).

2) Acting as an *ex-officio* member of the board.

3) Acting as an *ex-officio* member of all MAC sub-committees.

4) Reporting regularly to the board on the work and recommendations of the MAC:

   a. Supervising the clinical, academic and administrative activities of the Professional Staff.

   b. Considering applications for Professional Staff privileges.

   c. Consulting with Chiefs of Department and Heads regarding proposals to change Professional Staff members' privileges.

   d. Making recommendations to the board (and in some hospitals, making decisions) with respect to leaves of absence, and if appropriate, imposing conditions on privileges for members returning from a leave of absence.

5) Participating in all MAC discussions, including recommendations made by the MAC regarding the granting, renewal, suspension, restriction or revocation of privileges.

6) Apprising members of the Professional Staff of their rights to a hearing or appeal in privileges matters.

7) Representing the MAC at board hearings on privileges matters.

8) Ensuring the credentialing process complies with the *Public Hospitals Act* and its regulations, the hospital by-laws, Rules and Regulations and hospital policies and practices.

9) Receiving application forms from the CEO (keeping a copy) and sending them to the Credentials Committee and applicable Chief of Department.

10) Meeting with potential applicants to the Professional Staff.

11) Reviewing patient care with respect to specific Professional Staff members as necessary (PHA).

12) Filing reports with the MAC if it becomes necessary to take over the care of a patient, as required by the *Public Hospitals Act* (PHA).

13) Temporarily restricting or suspending the privileges of any member of the Professional Staff and reporting to the MAC.

14) Ensuring the development of:

    a. Departmental Professional Staff Human Resources Plans and a corporate plan, as appropriate

    b. Recruitment strategies

    c. Orientation program

    d. Quality improvement programs

    e. Continuing education and professional development for the Professional Staff

    f. Resource utilization reviews

    g. Rules and Regulations

    h. Policies and practices

    i. Performance evaluation process tied to re-appointment

15) Participating as a member of the hospital's Senior Management Team in decisions with respect to strategic planning and resource allocation.

16) Receiving and considering complaints about behaviour, impairment/incapacity or competence involving Professional Staff members and ensuring the complaints are acted upon by the MAC where appropriate.

17) Notifying the Professional Staff member's regulatory college if there are reasonable grounds to believe a member has sexually abused a patient.

Key messages for **Chief of Staff/Chair of the MAC**:

The Chief of Staff/Chair of the MAC oversees all the responsibilities of the MAC with respect to hospital privileges.

- As a non-voting member of the board, the Chief of Staff/Chair of the MAC serves as a liaison between the MAC and the board, reporting to the board on quality of care issues and recommendations on privileges appointments. The Chief of Staff/Chair of the MAC acts as the voice of the clinical leadership and answers the board's questions with respect to vision, direction and process issues of Professional Staff credentialing.
- The Chief of Staff/Chair of the MAC should be prepared to assure the board that: the credentialing process is reasonable, prudent and meets public hospital standards; and the credentialing process contemplated in the by-laws is consistently followed. Some boards may require an annual certification to this effect, signed by the Chief of Staff/Chair of the MAC.
- The Chief of Staff/Chair of the MAC has the responsibility to introduce members of the Professional Staff to the board through the appointment process.

- A major challenge faced by the Chief of Staff/Chair of the MAC is managing conflicts of interest. The Chief of Staff/Chair of the MAC receives complaints about members of the Professional Staff and participates in or is accountable for investigations into allegations about impairment/incapacity, behaviour or incompetence. As a result, the Chief of Staff/Chair of the MAC should not participate in decision-making at the MAC if they have participated in any way in an investigation.
- The Chief of Staff/Chair of the MAC is responsible for ensuring that concerns about Professional Staff members are appropriately managed and escalated.
- The Chief of Staff/Chair of the MAC may be privy to highly confidential information (especially with respect to health, personal, legal or professional issues) relating to members of the Professional Staff. It is critical that the Chief of Staff/Chair of the MAC maintain strict confidentiality and not share more information than is necessary for any particular purpose.
- The Chief of Staff/Chair of the MAC is often tasked with managing informal disputes between Professional Staff members and between Professional Staff members and their Chiefs/Heads.

Credentials Committee

A Credentials Committee is typically a sub-committee of the MAC. However, hospitals are not required to have a Credentials Committee. If the hospital does not have a Credentials Committee, the functions of the Credentials Committee may be performed by the MAC itself.

In some hospitals, these functions may be performed by the administrative assistant to the CEO or a Manager/ Director of Medical/Professional Affairs. For purposes of the Toolkit, we refer to the one or more individuals as the "Credentials Committee", acknowledging that there may be an administrator who completes the steps prior to the Credentials Committee or MAC reviewing the packages.

The **Credentials Committee** may be responsible for:

1) Reviewing the materials submitted in applications for appointment, re-appointment and changes to privileges.
2) Receiving recommendations of Department Chiefs for re-appointment applications.
3) Ensuring the hospital has received all necessary information from applicants to make a decision.
4) Ensuring an impact analysis has been performed for new applicants.
5) Investigating each applicant's professional competence.
6) Obtaining proof of license and professional liability protection coverage (insurance).
7) Reviewing letters of reference or otherwise contacting referees.
8) Verifying each applicant's qualifications.
9) Reviewing regulatory college public register information for applicants.
10) Confirming occupational health and safety and administrative requirements have been met (such as mask fit testing, CPR, immunization, and infection control requirements).
11) Considering whether an application meets the qualifications and criteria of the hospital by-laws.
12) Ensuring all paperwork is organized and signed.
13) Identifying problems or defects with an application.
14) Reminding applicants of pending deadlines.
15) Submitting a report and recommendations to the MAC.

Key messages for **Credentials Committees**:

- The Credentials Committee may be charged with the data collection and quality control functions of the credentialing process. If the Credentials Committee does not perform its function (and the responsibilities are not performed by another person or group), the MAC and board will not have reliable data upon which to base their decisions.
- The principles of "natural justice" and "procedural fairness" apply to the application process for appointments and re-appointments to the Professional Staff. This means:
  - The criteria for appointment and re-appointment must be transparent:
    a. All qualifications and criteria must be set out in the by-laws.
    b. No other criteria may be used.
  - Applicants must be alerted to and given an opportunity to correct mistakes or omissions in their forms.
  - All applicants must be judged fairly and objectively according to the transparent criteria (for an example of the types of criteria used to qualify Professional Staff members for appointment and re-appointment – see the *OHA/OMA Prototype By-law*).
- The application forms for appointment and re-appointment must be aligned with the by-laws. Every time the by-laws are amended, the application forms need to be reviewed and updated as necessary. This includes in joint credentialing relationships with other hospitals.
- The applicant, Chief of Staff/Chair of the MAC and Chiefs of Department should be alerted to problems with applications as soon as possible so that issues may be resolved well in advance of appointment and re-appointment deadlines.
- The Credentials Committee should inform the MAC on an annual basis of any themes, emerging issues or challenges it identifies with respect to the appointment and re-appointment process.

While the credentialing function is usually tied to applications, there is an ongoing role for an administrative person to monitor the licensure and professional liability protection coverage (insurance) of all Professional Staff members. Hospitals must ensure that someone in the organization reviews reports from the regulatory colleges (i.e., the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Midwives of Ontario and the College of Nurses of Ontario) for reports of suspended, restricted or revoked licenses.

CEO

There are a number of credentialing responsibilities assigned to the CEO under the *Public Hospitals Act*. The OHA/OMA Prototype By-law identifies additional opportunities for the CEO to be involved in the credentialing process.

The **CEO** may be responsible for:

1) Supplying application forms to any physician, upon written request, as mandated by the *Public Hospitals Act* (PHA).[4]
2) Supplying application forms to dentists, midwives and extended class nurses upon request.
3) Making available to new applicants, along with the application forms, important information about the hospital, including the mission, vision, values and strategic plan; the Health Ethics Guide (as applicable in certain faith-based organizations); by-laws, Rules and Regulations and appropriate policies to applicants for appointment to the Professional Staff.
4) Receiving applications for appointment and re-appointment and applications for changes to privileges, and referring these immediately to the MAC (PHA).
5) Meeting with potential applicants to the Professional Staff.

4 It would be considered best practice to do the same for other professions who ask for an application.

6) Granting temporary privileges to physicians, dentists, midwives and extended class nurses, and continuing those privileges on the recommendation of the MAC until the next board meeting.

7) Temporarily restricting or suspending the privileges of any member of the Professional Staff where appropriate under the by-laws and then reporting the details of the action taken to the MAC.

8) Notifying a Professional Staff member's regulatory body if there are reasonable grounds to believe that the member is incompetent, incapacitated or has sexually abused a patient, as required by the *Regulated Health Professions Act* (RHPA).

9) Notifying the College of Physicians and Surgeons of Ontario if:

   a. A physician has been denied appointment or re-appointment by reason of incompetence, negligence or misconduct;

   b. A physician has had their privileges restricted or cancelled by reason of incompetence, negligence or misconduct;

   c. A physician voluntarily or involuntarily resigns from the Medical Staff or restricts their practice by reason of incompetence, negligence or misconduct; or

   d. A physician voluntarily or involuntarily resigns from the Medical Staff or restricts their practice as a result of or during the course of an investigation into their competence, negligence or conduct (PHA).[5]

10) Notifying the Chief of Staff/Chair of the MAC if they believe that a physician is unable to perform the person's professional duties with respect to a patient in the hospital (PHA).

Key messages for **CEO**s:

- Busy CEOs may need to delegate some of the responsibilities assigned to them in the by-laws. CEOs should review their obligations as set out in the by-laws and determine which of their responsibilities they will delegate and to whom. It is important to note that the CEO remains responsible for those functions they delegate to others.

- One of the recommendations of the Dupont/Daniel inquest[6] in Windsor, Ontario was for CEOs to have more responsibility to temporarily suspend a member of the Professional Staff if there are concerns about the member's practice. This reflects a long-standing concern that, unless there is a legal obligation to report, clinicians may not be willing to report their fellow clinicians to authorities. The OHA/OMA Prototype By-law empowers CEOs to temporarily restrict or suspend privileges in specific circumstances, such as where the Professional Staff member's conduct is reasonably likely to expose a patient or co-worker to harm or injury.

- The mandatory reporting requirements under the *Public Hospitals Act* and the *Regulated Health Professions Act* with respect to incompetence, negligence, misconduct and sexual abuse usually fall to the CEO.

- Hospital privileges disputes can be extremely expensive and have negative consequences for the reputation of the hospital. The CEO should never be taken by surprise when a privileges issue is being brought before the board for consideration. The CEO should be informed of all Professional Staff disputes.

- CEOs should not participate in internal investigations with respect to Professional Staff privileges in order to avoid conflicts of interest. However, CEOs do not have voting rights as board members under the *Public Hospitals Act* regulations, and as such, are unable to participate in decisions made at board hearings.

5 See also the *Regulated Health Professions Act, 199*1, Schedule 2 the Health Professions Procedural Code, s. 85 for mandatory duties of reporting any regulated health professional including physicians, midwives, dentists, and nurse practitioners to their regulatory colleges in the cases of incompetence, incapacity or sexual abuse of patients.

6 Verdict and Recommendations of the Coroner's Jury in the Daniel/Dupont Inquest (2007) https://www.oha.com/Documents/Dupont-Daniel%20Inquest%20-%20Jury%20Recommendations%20-%20Dupont-Daniel%20Inquest%20December%202007%20--Homicide.pdf

- CEOs should be aware that the *Public Hospitals Act* requires the CEO to provide an application form to any physician who requests one; this is not discretionary. Some hospital by-laws have been amended to extend this right to any Professional Staff.

Chiefs of Department/Heads of Division

Academic health sciences centres and larger tertiary centres are complex organizations often divided into Departments and Divisions, to organize the delivery of care and the Professional Staff members. In this type of organization, Chiefs of Department and Heads of Division often take over a sizeable portion of the duties assigned to the Chief of Staff/Chair of the MAC.

Not all hospitals have Departments or Divisions; in smaller hospitals, the duties of Chiefs of Department may be undertaken by other supervisory leadership positions such as clinical directors and senior physicians/clinicians or may remain under the jurisdiction of the Chief of Staff/Chair of the MAC. Throughout the Toolkit, we often refer to the "most appropriate clinical leader" in order to acknowledge the different roles in hospitals.

Descriptions of the duties of Chiefs, Deputy Chiefs and Heads have been significantly streamlined in the OHA/OMA Prototype By-law. This means that hospitals should develop position descriptions for Chiefs of Department and Heads of Division (either as stand-alone policies or part of the Rules and Regulations), to be approved by the board.

Chiefs of Department may be responsible within their own Department for:

1) Preparing and implementing a Department-specific Professional Staff Human Resources Plan in accordance with the hospital's strategic plan after receiving and considering input from the members of the Professional Staff. Participating in the development and implementation of the hospital's overall Professional Staff Human Resources Plan, where applicable.

2) Ensuring that new Professional Staff members participate in Departmental orientation programs.

3) Making recommendations to the MAC regarding appointment, re-appointment, change in privileges and any disciplinary action to which Professional Staff members of the Department would be subject.

4) Advising the MAC with respect to the quality of care provided by the Professional Staff members of the Department.

5) Developing, in consultation with members of the Department and the MAC, standards for quality, patient safety and patient care for the Department that are consistent with hospital quality standards that shall serve as the basis for individual Professional Staff members' annual evaluations.

6) Speaking to Professional Staff members about their behaviour, interpersonal skills or competency, if required, and documenting more formal disciplinary type conversations.

7) Conducting a written performance evaluation of all Professional Staff members of the Department on an annual basis as part of the re-appointment process and conduct an enhanced performance evaluation on a periodic basis.

8) Supervising the professional care provided by all members of the Professional Staff in the Department.

9) Disciplining Department members in regard to matters of patient care, cooperation with hospital employees, compliance with hospital by-laws, Rules and Regulations, and policies, including on-call requirements and documentation of care.

10) Examining the condition and scrutinizing the treatment of any patient within the Department if concerns about quality of patient care arise; notifying the attending Professional Staff member and speaking to the Professional Staff member if concerned about a serious problem in the diagnosis, care or treatment of a patient. This includes assuming the duty of investigating, diagnosing, prescribing for and treating the patient if the Professional Staff member is not able to do so (PHA).

11) Notifying a Professional Staff member's regulatory college if there are reasonable grounds to believe that a member has sexually abused a patient (PHA).

12) If the hospital by-laws allow, temporarily restricting or suspending privileges of a member of the Professional Staff in consultation with other members of the senior team.

Heads of Division may have similar responsibilities within their Division.

Key messages for **Chiefs/Heads**:

- The clinical leaders, such as Chiefs of Department, who directly supervise members of the Professional Staff have the biggest impact on the credentialing process, they:
  - Recruit.
  - Determine the needs of the hospital.
  - Determine whom to recommend for appointment, re-appointment, and changes to scope and categories of privileges.
  - Perform performance reviews.
  - Identify problems.
  - Manage team dynamics.
  - Manage problems with competence, behaviour, capacity/impairment.
  - conduct internal investigations.
  - Take disciplinary action, in consultation with the Chief of Staff/Chair of the MAC as appropriate.
  - Recommend taking action to restrict, suspend or revoke privileges.
  - Under some hospitals' by-laws, have the power to temporarily suspend privileges (after consulting with other senior members).
  - Assume responsibility for care if urgent needs arise.
- It is therefore critical for the Chiefs to clearly understand:
  - Their role in the credentialing process (and the scope and limits of their authority to make oversee their Professional Staff members).
  - The hospital's mission, vision and values (and the strategic directions of the hospital).
  - How to set clear goals and standards of practice for their Professional Staff.
  - How to performance manage their Professional Staff and in particular, how to address competence or capacity/impairment issues and behavioural issues and how to have difficult conversations about complaints and performance expectations.
  - The fundamentals of managing and leading a team.
- Chiefs will also want to ensure that they follow the rules and processes set out in the by-laws and that they:
  - Avoid recruiting new members of the Professional Staff without informing anyone.
  - Take disciplinary action where required, consistent with the processes contemplated in the by-laws and in consultation with the necessary people to avoid overstepping into a unilateral change in privileges.
  - Consult with the Chief of Staff/Chair of the MAC or CEO on serious cases.
  - Develop clinical programs that are aligned with the hospital's strategic plan.
  - Understand that Professional Staff members have additional rights under the *Public Hospitals Act* and by-laws beyond what other independent contractors or employees would have and that there is a legal process that must be followed in order to change, restrict or revoke a Professional Staff member's privileges.

- Unfortunately, some of the highest profile and most costly decisions involving privileges disputes with Professional Staff members relate to disputes between Chiefs/Heads and the Professional Staff in their Departments or teams.[7] It is essential that before a Chief/Head makes any change to a Professional Staff member's duties, activities, compensation, or resources, they consult with the Chief of Staff/Chair of the MAC or the CEO. *See Chapters 8, Performance Evaluations and Progressive Management and Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*
- The annual performance review and evaluation process is also critical. It is an opportunity to recognize positive performance, to point out problematic performance, and to identify ways to improve or remedy performance issues.

FAQs

1. What types of matters should be reviewed as part of the annual performance review of a Professional Staff member?

- Skills, attitude and judgment of the applicant.
- Participation in continuing education.
- Ability of the applicant to communicate with patients, families, and staff.
- Ability of the applicant to cooperate with the board, CEO, Chief of Staff/Chair of the MAC and Chief of Department.
- Ability to supervise staff.
- Appropriate and efficient use of hospital resources.

The jury recommendations from the Dupont/Daniel inquest[8] also commented on what should be included in an annual evaluation of physicians:

> "Professional Staff by-laws should ensure annual evaluation of physicians' quality of medical care, utilization of resources, completion of required programmes, and professional behaviours including interactions with patients and staff. Such evaluations should include feedback/assessments from multiple members of the healthcare team (i.e., 360 degrees evaluation)."
>
> ***Jury recommendation from the Dupont/Daniel Coroner's Inquest***

2. What if concerns are raised about performance during a *Quality of Care Information Protection Act, 2016* review?

If concerns are raised during a *Quality of Care Information Protection Act*, *2016* review regarding the skill or competence of a Professional Staff member that do not require immediate action or discipline, the Quality of Care Committee (as it is known under that Act) should conclude the review process and include a recommendation to review the individual's actions. However, any follow-up disciplinary review is likely to be linked, at least in perception, to the process and the hospital will have to consider how to manage or alleviate staff concerns in this regard.

7 See for example, *Saskatoon Regional Health Authority and Johnson, 2014 SKQB 266 (CanLII)*, <http://canlii.ca/t/gdr5n>, *Horne v Queen Elizabeth II Health Sciences Centre*, 2018 NSCA 20 (CanLII) and *Tenn-Lyn v Medical Advisory Committee*, 2016 CanLII 80391 (ON HPARB).

8 Verdict and Recommendations of the Coroner's Jury in the Daniel/Dupont Inquest (2007) https://www.oha.com/Documents/Dupont-Daniel%20Inquest%20-%20Jury%20Recommendations%20-%20Dupont-Daniel%20Inquest%20December%202007%20--Homicide.pdf

Professional Staff

Examples of duties of Professional Staff are set out in the OHA/OMA Prototype By-law in section 6.7.

Members of the **Professional Staff** may be responsible for:

1) Attending and treating patients within the limits of the privileges granted unless the privileges are otherwise restricted.

2) Recognizing the authority of and being accountable to the Chief of Staff/Chair of the MAC, Chief of the Department, Head of Division, the MAC, CEO and the board.

3) Participating in annual and any enhanced periodic performance evaluations, and providing such releases and consents as will enable such evaluations to be conducted.

4) Being candid, honest, thorough and accurate in their applications for appointment, re-appointment and changes to privileges.

5) Completing and submitting re-application or change of privileges forms on a timely basis, with complete and accurate information.

6) Complying with applicable legislation and the hospital's by-laws, Rules and Regulations and policies.

7) Ensuring they meet the criteria for re-appointment to the Professional Staff set out in the by-laws, including meeting the occupational health and safety requirements of the hospital and maintaining professional practice liability coverage (insurance).

8) Taking recommended steps to improve or remedy performance issues.

9) Advising the Chief of Staff/Chair of the MAC about the commencement of any regulatory disciplinary proceeding, proceeding to restrict or suspend privileges at other hospitals, or malpractice action.

10) Ensuring they are skilled and able to perform all procedures assigned to them.

11) Ensuring that any concerns relating to the operations of the hospital are raised and considered through the proper channels of communication within the hospital such as the Chief of Staff/Chair of the MAC, Chiefs of Department, MAC, CEO and/or the board.

10) Providing the Chief of Staff/Chair of the MAC (or the member's Chief of Department) with at least two-three months' notice of the members' intention to resign.

11) Providing input, if interested, to the development of departmental Professional Staff Human Resources Plans.

Other Key Roles

President of the Medical Staff

The **President of the Medical** Staff has a limited role in the credentialing process. As a member of the MAC, the President of the Medical Staff will be involved in reviewing applications and re-appointment applications and making recommendations to the board. The President of the Medical Staff is not a voting member of the board and hence is not able to participate in board privileges hearings.

The *Public Hospitals Act* includes a process for addressing serious problems in the diagnosis, care or treatment of a patient by the attending physician. The Chief of Staff/Chair of the MAC and Chief of Department are primarily responsible for discussing serious problems with the attending physician and relieving the physician of responsibility for that patient if the serious problems are not addressed to their satisfaction. In this case, the Chief of Staff/Chair of the MAC or Chief of Department, as applicable:

- Assumes care of the patient;
- Notifies the attending physician, CEO and patient that the physician has been relieved of their responsibility for the patient;
- Advises two members of the MAC of actions taken within 24 hours; and,

- Provides a written report to the Secretary of the MAC within 48 hours.

The *Public Hospitals Act* states that, where a hospital does not have a Chief of Staff, the responsibilities above apply to the President of the Medical Staff.

Secretary of the Medical Staff

Similar to the President of the Medical Staff, the **Secretary of the Medical Staff** is a member of the MAC and as such, will be involved in reviewing applications and re-appointment applications for privileges and making recommendations to the board.

The *Public Hospitals Act* also gives the Secretary of the Medical Staff a specific duty relating to action taken by the Chief of Staff/Chair of the MAC, Chief of Department or President of the Medical Staff where one of them relieves an attending physician of responsibility with respect to a particular patient because of a serious problem in diagnosis, care or treatment. If the MAC concurs with the action taken, the Secretary of the Medical Staff must make a detailed report of the problem and the action taken to both the CEO and the board.

Students, Residents and Fellows

It is very common for **students** to be working in a hospital as part of their formal education. Much like Professional Staff members with privileges, students will often be provided with an identification badge, e-mail address, locker, and other amenities. However, these amenities do not amount to "privileges".

The relationship between hospitals and medical students (or dental, midwifery, extended class nursing students) is usually set out in academic affiliation agreements, which are written agreements between a hospital and the university or college with which it is affiliated.

Residents and fellows are treated differently from medical and/or dental students. They sometimes receive privileges because they have a degree. A separate category of privileges often exists for residents and fellows, setting limits on their privileges and any required supervision.

Observers

Many hospitals have in place policies with respect to observers. **Observers** may not diagnose, care for or treat patients, and as such, they do not need to apply for or receive privileges. In the event that an observer is called on to provide clinical care, privileges must first be obtained.

Regulatory Colleges

Health regulatory colleges are bodies that regulate the practice of a particular health profession to protect and serve the public interest.

The duties of the health regulatory colleges may be found in the *Regulated Health Professions Act,* the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*), and the legislation governing the specific profession (i.e., the *Medicine Act*, the *Dentistry Act,* the *Midwifery Act* and the *Nursing Act*).

Colleges are responsible for:

1) Serving and protecting the public interest.
2) Regulating the practice of the profession.
3) Governing college members in accordance with the relevant legislation and by-laws.
4) Giving out certificates of registration to those entitled to practice.
5) Developing standards of qualification for persons to be issued certificates of registration.
6) Developing and enforcing standards of practice.
7) Developing and enforcing professional ethics standards.
8) Developing and maintaining programs that assist members with exercising their rights under the Regulated Health Professions Act, and the Health Professions Procedural Code.
9) Responding to patients' concerns and investigating complaints from members of the public, hospitals and other colleges.

10) Disciplining members, including conducting discipline hearings, where appropriate.

11) Working in consultation with the Minister of Health and Long-Term Care to ensure that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals.

12) Fostering positive relationships between the college and its members, other health profession colleges, key stakeholders, and the public.

13) Promoting inter-professional collaboration with other health regulatory colleges.

14) Having a website with a public register of its members and their standing.

Colleges also require their members to undergo quality reviews (such as peer assessments or other reviews) and may restrict a member's practice by imposing terms and conditions on the member's licence. In the case of the College of Physicians and Surgeons of Ontario, college inspectors may inspect or observe a physician's private practice.

FAQs

1. Why does a hospital have to get involved in credentialing at all? Isn't credentialing the responsibility of a regulatory College?

A health regulatory College screens its members to ensure they have the requisite training and experience to hold licensure or registration in the College and grants permission for its members to use restricted titles such as "physician", "surgeon", "dentist", "dental surgeon", "nurse practitioner" or "midwife". A hospital is entitled to and expected to rely in part on documentation from a regulatory College of a candidate's licensure status (such as through a Certificate of Professional Conduct and information included on the public register). However, a hospital's process of credentialing goes well beyond what a regulatory College completes and takes into account screening criteria set out in the hospital's by-laws. The functions are complementary but are not a substitution for each other.

Health Professions Appeal and Review Board (HPARB)

HPARB hears all privileges appeals under the *Public Hospitals Act*. Under the *Public Hospitals Act*, only members of the Medical Staff are entitled to appeal a decision of the hospital board with respect to their privileges to HPARB.[9] (HPARB was previously known as the Hospital Appeal Board.)

Any applicant for appointment or re-appointment to the Medical Staff of a hospital who was a party to a proceeding before the hospital board, and who considers themselves aggrieved by that board's decision not to appoint or re-appoint them to the Medical Staff, is entitled to a hearing before HPARB. Any member of a hospital's Medical Staff who considers themselves aggrieved by any decision revoking, suspending, or substantially altering their privileges is also entitled to an HPARB hearing.

HPARB grants a hearing "*de novo*", which means HPARB hears and decides upon all the evidence and does not simply review the decision of the hospital board. The parties may call new witnesses and supply new documentation and evidence that had not been considered at MAC meetings or hospital board hearings. Even if there had been procedural missteps by a hospital in following the *Public Hospitals Act* requirements in credentialing or privileging, the HPARB process starts a new process.[10]

At the conclusion of a hearing, HPARB may confirm the decision of the hospital board, substitute its decision for that of the hospital board, or direct the board or any other person to take such action as it considers appropriate, in accordance with the *Public Hospitals Act*. Any party (the physician or the hospital) can appeal the decision of HPARB to Ontario's Divisional Court.

9 The *Public Hospitals Act* is silent on the availability of an appeal to HPARB for dentists, midwives or extended class nurses. HPARB has not yet published a case from those professional groups under the *Public Hospitals Act* privileges regime.

10 See Waddell v. Weeneebayko, 2018 CanLII 39843 (ON HPARB) at para 86 where HPARB reviewed a situation where a hospital did not consider a physician's application within 60 days from the date of the application but concluded that was primarily due to the physician's actions and confusion over whether the physician was re-applying for privileges or not. However, even if there had been procedural issues by the hospital board, the HPARB hearing was a hearing de novo and the merits of the application were to be considered.

Chapter 4: Planning and Recruitment

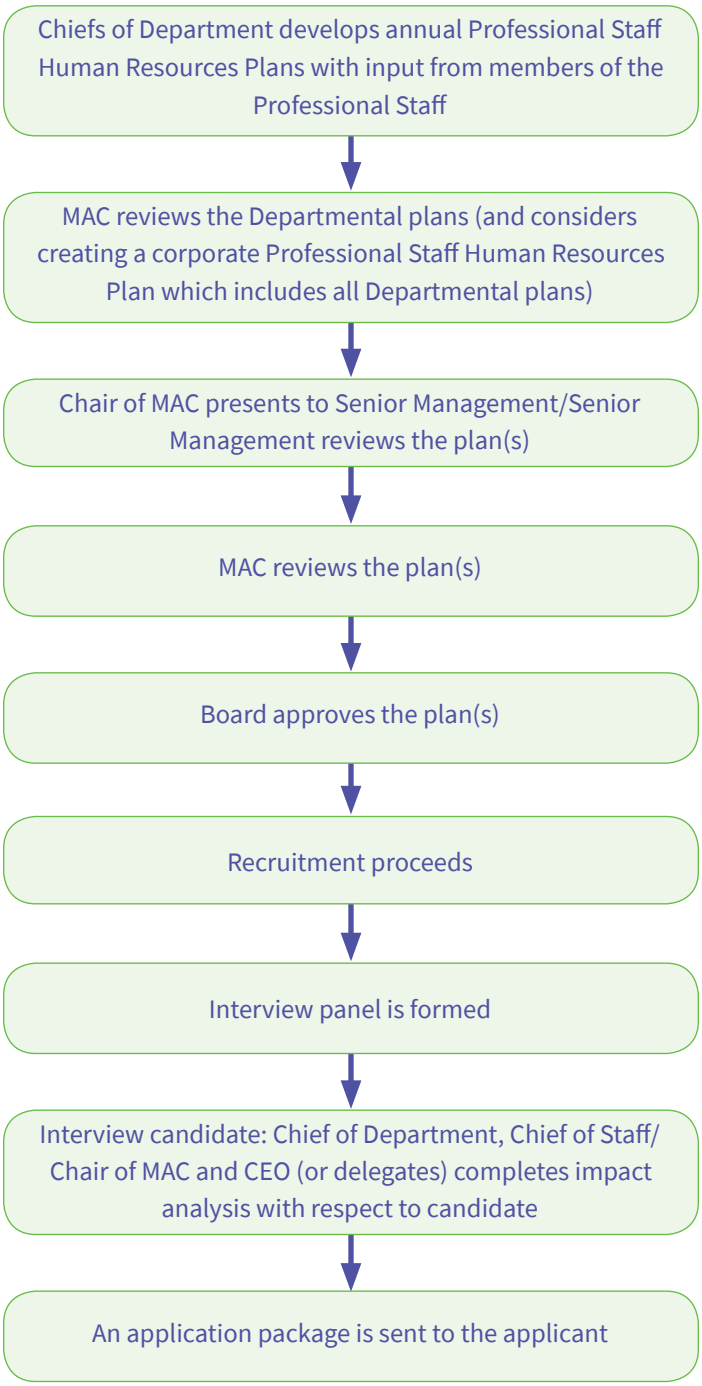
Reference Key:

Public Hospitals Act:	None
OHA/OMA Prototype By-law:	Sections 3.3, 3.4, 3.5

Chapter Summary

- A formal Professional Staff Human Resources Plan helps hospitals determine the appropriate number and type of Professional Staff members they require in both its current state and future state, in order to meet strategic goals for clinical care – these may be done on corporate and Departmental levels.
- A Professional Staff Human Resources Plan is also an excellent succession planning tool.
- While the *Public Hospitals Act* does not mandate planning initiatives, the OHA/OMA Prototype By-law references both Professional Staff Human Resources Plans and impact analyses as required tools which need to be completed before initial appointments are granted.
- Professional Staff Human Resources Plans that involve broad consultation throughout the hospital can assist with providing an objective analysis for the recruitment needs of a hospital and its community.
- Performing an impact analysis for each new applicant helps hospitals operate within their financial restrictions and ensure efficient utilization within their organizations.
- From time to time, hospitals may refuse initial appointments to the Professional Staff based on insufficient resources or misalignment with the strategic directions of the hospital. To successfully defend that position, hospital boards can rely on objective data included in the Professional Staff Human Resources Plans and individual impact analyses.
- Recruitment efforts need to be consistent with the Professional Staff Human Resources Plans.
- Systemic recruitment issues have made recruitment of physicians, in particular, challenging. Government programs (such as *Locum Tenens* programs) have been created to assist smaller, rural or northern hospitals with their recruitment efforts.
- Recruitment initiatives should be well-communicated internally to avoid disputes with existing Department staff who may be adversely impacted (e.g., less operating room (OR) time).

Planning and Recruitment Process



Professional Staff Human Resources Plans

Hospitals are becoming even more strategic about their planning, recruitment and succession planning efforts for Professional Staff.

Professional Staff Human Resources Plans and individual impact analyses (for initial appointment) are tools that can assist hospitals to collect the information they need to operate efficiently and effectively.

There are no legislative requirements that prescribe how a hospital should carry out its planning efforts.

The OHA/OMA Prototype By-law references both Professional Staff Human Resources Plans and impact analyses as required tools which should be completed before initial appointments are granted.

A Professional Staff Human Resources Plan provides information and future projections with respect to the management and appointment of the Professional Staff based on the mission, vision and strategic plan of the hospital.

The Chief of Staff/Chair of the Medical Advisory Committee (MAC) (or most appropriate clinical leader) should be tasked with the responsibility to ensure that the hospital has a Professional Staff Human Resources Plan(s). The Plan(s) should be informed by the Chiefs of Department after receiving and considering the input of members of the Professional Staff in the Department.

Each Department's input could consider:

- The required number and expertise of Professional Staff.
- Reasonable on-call requirements for members of the Professional Staff of the Department.
- A process for equitably distributing resource changes to members of the Professional Staff within the Department.

- A process for making decisions with respect to changes in Department resources and a related dispute resolution process.[1]
- Chiefs of Department (or most appropriate clinical leaders) should also consider identifying:
  - Current number and type of Professional Staff members (part-time and full-time) within Department.
  - Professional Staff members who are expected to resign or retire within next two years.
  - Number and type of Professional Staff members needed to provide the current level of services.
  - Anticipated change in service levels over the next two years (due to change in population, hospital's strategic plan, etc.).
  - Anticipated increase or decrease in number and type of Professional Staff members needed to provide services over next two years.
  - Number and type of Professional Staff members to be recruited.

The Plans may also identify any changes in resources (space, equipment, budget, and support staff) that may be required to accommodate additional Professional Staff members within the Department. These Plans also create an opportunity to approach and engage senior Professional Staff members in a strategic constructive discussion about the hospital's needs and their anticipated retirement plans.

Professional Staff Human Resources Plans may be reviewed by the Chief of Staff/Chair of the MAC (or most appropriate clinical leader), the CEO (or delegate), and the MAC before they are sent to the board for approval. The Plans should be updated on a regular basis, as the hospital updates and fine-tunes its own strategic plan. Hospitals should consider distributing the Plan(s) to Professional Staff members and applicants for appointment as appropriate.

Board Reliance on the Plans

Professional Staff Human Resources Plans are important resources for the board. The OHA/OMA Prototype By-law expressly contemplates that a board may refuse to appoint an applicant to the Professional Staff when:

> "...the Professional Staff Human Resources Plan and/or Impact Analysis of the Corporation and/or Department does not demonstrate sufficient resources to accommodate the applicant."[2]

Case law supports the board's right to refuse appointment in such cases. The British Columbia Medical Appeal Board (now the Hospital Appeal Board) confirmed that a hospital is entitled to determine the services it will plan and provide, and it can refuse to appoint physicians who seek privileges that are inconsistent with the services it provides:

> "There is no hospital in this province which can serve all the needs of the population which it serves. It is the responsibility of its Board of Management to determine which services are to be delivered to best answer the needs of the community and can be supplied by the hospital. The demands for any new service come from two sources: the community and the physicians practising in that community.
>
> In this case, no evidence has been submitted to suggest that the community itself felt the need for a plastic surgery service at the Hospital. Patients requiring this service have been looked after in nearby hospitals and in the referral centres in Vancouver. As well, the physicians practising in the Hospital gave no evidence that they felt that their patients were suffering from a lack of this service being immediately available in Langley. Although evidence was presented by the Hospital which revealed that the community was reaching a size where a plastic surgeon could be supported, the Manpower Committee of the Hospital has not yet recommended that the service be developed further than that which is currently available. Long range plans obviously include this as an expansion

1 Section 8.4.

2 Section 3.3(5)(b)

service along with others, but no evidence was presented to suggest that plans have been developed to allow such an expansion in the near future."[3]

In considering a new application, the board of a hospital may take into account the ratio of physicians to available beds and whether a particular Department is adequately staffed or a specialty is filled.[4] A board of a hospital is entitled to determine the appropriate complement of doctors for its Medical Staff.[5]

An applicant may try to prove that a hospital requires another physician or other type of Professional Staff member in order to provide sufficient and safe care to a community.[6] Hospitals do not have to grant privileges to every individual who applies. However, if a hospital proposes to refuse an initial appointment to the Professional Staff based on insufficient resources or misalignment with the needs or strategic directions of the hospital, the hospital will need to provide evidence or statistics to support that position in a timely manner (such as through a Professional Staff Human Resource Plan or impact analysis).

Systemic Recruitment Challenges

Physician shortages are uniquely felt in smaller rural and northern communities. Hospitals may wish to avail themselves of the following services that address the impact of physician shortages:

- The *Underserviced Area Program* of the Ministry of Health, which addresses some of these issues by offering health care professionals both practice and financial incentives, and supports for health service providers.
- HealthForceOntario,[7] a Government of Ontario initiative that assists communities and hospitals to address recruitment challenges, including immigration and supervision issues:
  - Provides information about licensure, certification requirements[8] and career counseling and support for internationally educated health professionals.
  - Administers the Locum Credentialing Application Program, whereby family physicians interested in doing *Locum Tenens* to work in small and rural hospitals can complete an application form which is provided to interested hospitals.[9]
  - Provides urgent emergency department locum coverage as an interim measure of last resort to designated hospitals that are facing significant challenges covering emergency department shifts, by making physicians from other emergency departments in Ontario available for shifts (known as the Emergency Department Coverage Demonstration Project).[10]
- Touchstone Institute[11] (formerly the Centre for the Evaluation of Health Professionals Educated Abroad) provides professional competency assessment, ongoing evaluation and orientation programs for internationally educated health professionals.

The Agreement on Internal Trade (AIT) is another factor that may impact recruitment. The AIT is a signed treaty amongst Canada's provinces and territories that entitles physicians and other health care professionals

3 Varkony v. Langley Memorial Hospital (1992), (BC Medical Appeal Board) at 18-19.

4 *Re Macdonald and North York General Hospital*, [1975] O.J. No. 2372 (Ont. Div. Ct.).

5 *Chin v. Salvation Army Scarborough Grace General Hospital*, [1988] O.J. No. 517 (Ont. Div. Ct.).

6 *Dr. Borenstein and Humber River Regional Hospital* (2003), (ON Health Professions Appeal and Review Board).

7 See HealthForceOntario <http://www.healthforceontario.ca/> for all programs, including HealthForceOntario Northern Specialist Locum Programs (NSLP), Rural Family Medicine Locum Program (RFMLP), Emergency Department Locum Program (EDLP) and HealthForceOntario Postgraduate Return of Service (ROS) Program.

8 HealthForceOntario, Licensing and Certification (2019), http://www.healthforceontario.ca/UserFiles/file/PRG/Module01-PRG-Licensing-EN.pdf

9 http://www.healthforceontario.ca/UserFiles/file/PRC/recruitment-essentials-locum-en.pdf

10 http://www.healthforceontario.ca/UserFiles/file/EDLP/ed-toolkit-2013-en.pdf

11 https://touchstoneinstitute.ca/

with a practice licence in any Canadian province to an equivalent licence in any other province. The College of Physicians and Surgeons of Ontario (CPSO) has expressed concerns that some provinces may have lowered their entry standards in order to recruit physicians.[12] With the Ontario *Labour Mobility Act,* 2009, physicians from another province who may not meet CPSO standards are entitled to a CPSO licence. This increases the need for a thorough credentialing process on the part of Ontario's hospitals. *See Chapter 5, Initial Appointment.*

Recruitment Process

Most applications for initial appointment to a hospital will be received because of planning and recruitment efforts. Hospitals tend to identify needs through the preparation and updating of a Professional Staff Human Resources Plan. They then undertake a search (post a job description and seek applicants) either directly or through a search firm. Some recruit through the academic and clinical placements of learners and fellows.

In order to avoid a deluge of applications, postings for Professional Staff positions should invite expressions of interest (not applications). These applicants can then be pre-screened before they receive applications. *See discussion of receiving unsolicited applications for appointment in Chapter 5, Initial Appointment.*

The recruitment process will involve a face-to-face interview, typically involving the CEO (or delegate), Chief of Staff/Chair of the MAC and applicable Chief of Department (or most appropriate clinical leaders). This interview allows the hospital to canvass any questions or issues raised by the application form or supplemental materials submitted by the applicant. The applicant can also familiarize themselves with the hospital premises and resources.

It is also a useful practice to debrief any applicant who chooses not to accept privileges at the hospital after showing an initial expression of interest. This can help the hospital identify areas where it needs to improve its recruitment efforts.

12 J. Hefley, J. Mandel and R. Gerace, Internationally Educated Healthcare Workers: Focus on Physicians in Ontario (HealthcarePapers 10(2) 2010:41-45.

Recruitment Incentives

Rural and northern hospitals have also been proactive in coming up with their own creative strategies to address shortages. For one, common credentialing policies and processes allow hospitals to pool their Professional Staff resources more easily. *See Chapter 5, Initial Appointment, for a discussion of Joint Credentialing Initiatives.*

Foundations have raised funds to support hospitals in their Professional Staff recruitment efforts.

Return of service arrangements are another form of recruitment incentive, whereby a hospital or the Ministry of Health pays for postgraduate education of physicians. This payment is made in the form of a loan, which is forgiven over time when the physician returns to the community to work at the hospital. Hospitals should seek legal advice on how best to protect themselves when structuring such arrangements.

Impact Analysis

The OHA/OMA Prototype By-law defines an impact analysis as:

> a study conducted by the Chief Executive Officer in consultation with the Chief of Staff and the affected Chief(s) of Department to determine the impact upon the resources of the Corporation, including the impact upon the resources of a Department, of a proposed appointment of an applicant to the Professional Staff or an application by a Professional Staff member for additional privileges or a change in membership category.[13]

The impact analysis should be a standard form that can be easily completed for each applicant for appointment, and should canvas the following areas:

- Will the Professional Staff member be using inpatient resources?
- Will the Professional Staff member be paid a stipend, recruitment bonus, etc.?

13 Section 1.1(v)

- Will the Professional Staff member require an in-hospital office or other clerical support or office equipment?
- Will the Professional Staff member require OR time?
- Will the Professional Staff member require clinic time? specialized unit time? laboratory support? diagnostic imaging support?

For the planning and recruitment of midwives, the Ministry of Health's needs assessment process should be consulted as it is an independent process to the one hospitals perform.[14] *See the OHA Resource Manual for Sustaining Quality Midwifery Services in Hospitals for more information.*

The impact analysis should be reviewed by the Chief of Department, Chief of Staff/Chair of the MAC (or most appropriate clinical leaders) and CEO (or delegate).

It is also critical that the impact analysis focus on the impact of a new recruit on the existing Professional Staff. In the case of *Beiko*, four ophthalmologists practising at Hotel Dieu Hospital in St. Catharines brought a breach of contract lawsuit against the hospital and its CEO.[15] The hospital recruited a new ophthalmologist with the objective of increasing the number of ophthalmologic cases performed at the hospital. However, the new recruit would impact the OR time available to the existing four. The four attempted to claim $500,000 in damages from the hospital through a breach of contract lawsuit, alleging that their OR block was effectively a contract between them and the hospital. The ophthalmologists complained about their reduced OR time as a change in privileges, which reduction was supported by the MAC and ultimately the hospital board at a privileges hearing. The court found that the physicians could not sue the hospital for breach of contract until they pursued their appeal rights to the Health Professions Appeal and Review Board (HPARB) under the *Public Hospitals Act*. Nevertheless, the case underscores the importance of communicating clearly and transparently with existing Professional Staff about recruitment plans and inviting them to make proposals as to how to achieve the hospital's objectives.

For example, when a hospital wishes to recruit a full-time physician to take the place of several part-time physicians, it would be prudent for the hospital to meet with the existing physicians to identify the hospital's concerns about the part-time service, any gaps in hospital needs, and how a full-time physician would better serve the hospital and community. The Chief of Department (or most appropriate clinical leader) may also invite the existing part-time physicians to make proposals to the hospital about how they can better service the Department's needs, in order to have a clear and open process prior to recruiting.[16]

Best Practices in Recruitment

- Recruiting Professional Staff in accordance with the Professional Staff Human Resources Plans.
- Completing essential steps in the recruitment process.
- Communicating clearly the category/status of appointment for which you are recruiting.
- Approving an application from a candidate only with objective data to support recruitment in the form of a Professional Staff Human Resources Plan and individual impact analysis for the applicant.

FAQs

1. If a dentist, midwife or extended class nurse makes an application for appointment, does the hospital have to process the application?

Under the *Public Hospitals Act*, a bundle of rights attaches to a physician candidate as soon as they request and submit an application to the hospital. While no one is entitled to an appointment to the Medical Staff at a hospital, an applicant is entitled to have their application reviewed by the MAC and board and to receive a decision

14 See the OHA "Resource Manual for Sustaining Quality Midwifery Services in Hospitals", p. 35.

15 *Beiko v. Hotel Dieu Hospital St. Catherines*, 2007 CanLII 1912 (Ont. S.C.).

16 If the existing part-time Professional Staff members disagree with the recruitment strategy a privileges dispute may arise. Such situations can be difficult for all parties involved. Legal advice should be sought.

about appointment in a timely manner. These rights under the *Public Hospitals Act* apply only to physicians, but it would be considered best practice to extend these rights to dentists, midwives and extended class nurses through the hospital's by-laws. If these rights are not extended, it is important for the hospital to have written by-laws or processes that explain the hospital's approach to initial applications from dental, midwifery, and extended class nursing applicants. There should be a fair and transparent process for all applicants to the Professional Staff.

2. How do we avoid having candidates recruited outside the formal credentialing and appointment process?

Hospitals can implement office opening protocols so that someone (such as the Chair of MAC, Manager of the Medical Affairs Office, or assistant to the CEO) performs a check and balance to ensure that no member of the Professional Staff starts working within the hospital without having privileges. This is usually achieved by ensuring that physicians, dentists, midwives and extended class nurses cannot obtain the following until they have been approved by a central office:

Email address
Phone number
Keys
Access to health records

Hospitals should also ensure their Chiefs/Heads understand and adhere to a formal recruitment process.

3. How should conflicts of interest be managed when dealing with recruitment efforts? Don't existing Professional Staff members have an inherent conflict of interest in determining whether there is enough work for a new or different kind of health practitioner to join a Department or hospital?

Conflicts of interest can and do arise with recruitment efforts. The introduction of new members and disciplines to a Professional Staff team can have potentially negative implications for the financial opportunities and access to hospital resources available to existing members of the team. It is important to acknowledge and declare these conflicts. Professional Staff Human Resources Plans that involve broad consultation throughout the hospital can assist with providing an objective analysis of the recruitment needs of a hospital and its community. Boards should ask if there are any conflicts of interest with respect to the recommendations to grant (or refuse to grant) privileges.

Chapter 5: Initial Appointment

Reference Key:

Public Hospitals Act:	Sections 36-38
OHA/OMA Prototype By-law:	Sections 3.1 – 3.6

Chapter Summary

- As a result of planning and recruitment efforts, hospitals will receive applications for initial appointment to the Professional Staff.
- A hospital may also receive uninvited applications for appointment.

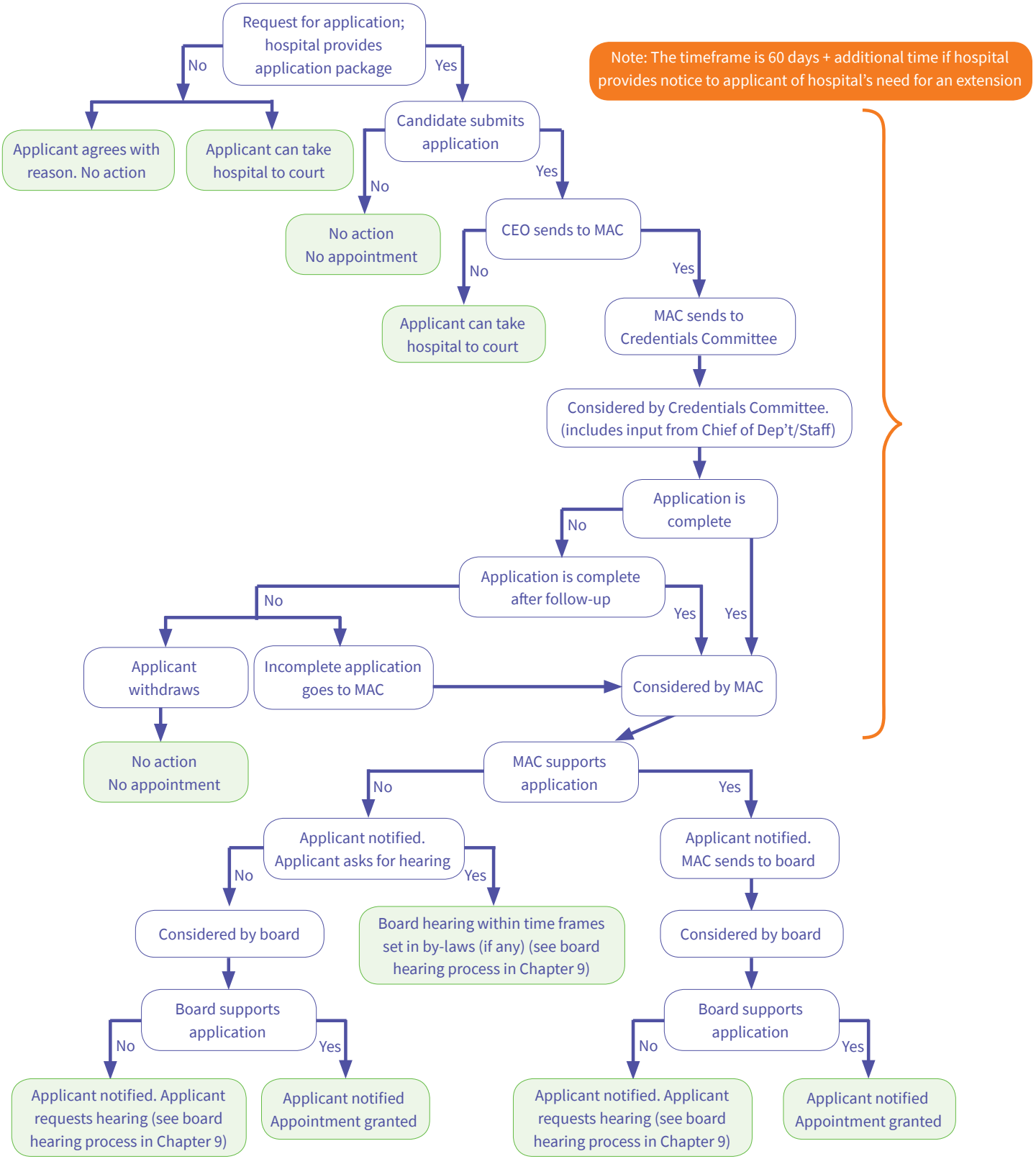
There are six steps to the initial appointment process:

1. Receipt of application form
2. Collection of supplemental information
3. Verification of credentials (including independent confirmation of information)
4. Assessment of credentials (including alignment with hospital goals and resources)
5. Recommendation of the Medical Advisory Committee (MAC)
6. Decision by the board

- Any physician who applies for privileges at a hospital is entitled to have their application considered by the board (this right is found in the *Public Hospitals Act* and can also be extended to apply to dentists, midwives or extended class nurses if included in the hospital's by-laws). A hospital cannot merely refuse to review a physician's application.
- Extra care should be taken with initial appointments to the Professional Staff, because these applicants may be unknown to the hospital. This requires greater reliance on third-party information (including from academic institutions, regulatory bodies and references).
- An initial probationary period may be appropriate to allow hospital leadership to assess a new Professional Staff member's skills. However, it is inappropriate to leave individuals in a permanent state of "probation".
- Credentialing is the process by which a hospital reassures itself that applicants for initial appointment to the Professional Staff have all the necessary qualifications in order to be granted privileges.
- While there is a significant role for Chiefs of Department (or most appropriate clinical leader), administrative staff, the Credentials Committee and the MAC, it is the board which makes the ultimate decision whether or not to grant privileges.
- The concept of temporary appointments can be included in the hospital by-laws to allow a CEO or Chief of Staff/Chair of the MAC the authority to grant time-limited appointments in urgent situations (e.g., in a pandemic or otherwise as part of emergency preparedness). [1]
- Chiefs and Heads must realize that a formal credentialing process is required for each new applicant to the Professional Staff (regardless of the applicant's seniority). Hospitals should have processes to ensure privileges are in place before work commences.

1 See section 3.6 of the OHA/OMA Prototype Bylaws

Appointment Process



Initial Appointment Process by Role

Right to Apply for Privileges

Most applications for initial appointment to a hospital will be received because of planning and recruitment efforts (*see Chapter 4, Planning and Recruitment*). Interested candidates will be considered in the context of a position opening, and the successful candidate will submit an application.

However, section 37(1) of the *Public Hospitals Act* provides that any physician is entitled to apply to be appointed at any hospital. The CEO must give an application form to any physician who asks for one. Once submitted, the CEO (as the administrator under the *Public Hospitals Act*) is required to forward the application to the MAC immediately. The physician is entitled to have their application ultimately considered by the board in a timely manner. A hospital cannot refuse to review an application. If a hospital refuses the initial appointment, for whatever reason, the candidate is entitled to request a hearing before the board. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

On a practical note, although not required, some hospitals will ask physicians to meet with the hospital before providing an application form. This allows the hospital to explain its Professional Staff needs to the physician, so that the physician can better understand whether there is a need for their services and whether the application for appointment will be favourably received.

In summary, a bundle of rights attaches to a physician candidate as soon as they request and submit an application to the hospital. While no one is guaranteed an appointment to the Medical Staff at a hospital, an applicant is entitled to have their application reviewed by the MAC and board and to receive a decision about appointment in a timely manner.

These rights under the *Public Hospitals Act* apply only to physicians, but they can be, and are usually extended to dentists, midwives and extended class nurses through the hospital's by-laws. If these rights are not extended, it is important for the hospital to have written by-laws or processes that explain the hospital's approach to initial applications from dental, midwifery, and extended class nursing applicants. There should be a fair and transparent process for all applicants to the Professional Staff.

Content of an Application Package

The hospital by-laws should set out the content of the application package to be sent to candidates interested in an appointment to the hospital's Medical Staff (or Professional Staff, as applicable). The application package typically includes (or provides a link to online resources):

- Application form for initial appointment
- Mission, vision, values and overview of the hospital's strategic plan
- *Public Hospitals Act* and Regulation 965
- By-laws
- Professional Staff Rules and Regulations
- Listing of policies applicable to the Professional Staff
- Applicable codes of ethics, such as the Health Ethics Guide of the Catholic Health Association of Canada

The *Public Hospitals Act* does not prescribe what must be included in an application form or package; this is reserved for the hospital's by-laws. Section 3.4 of the OHA/OMA Prototype By-law sets out recommended content for Professional Staff applications for initial appointment, including "signed consents to enable the hospital to inquire with the applicable regulatory college and other hospitals, institutions and facilities where the applicant has previously provided professional services or received professional training to allow the hospital to fully investigate the qualifications and suitability of the applicant." This Toolkit includes sample content for an application for appointment and a sample application form.

There is more publicly available information about candidates for privileges than ever before. Regulatory Colleges now post additional information on their public registers about licensed members' criminal charges, cautions-in-person, mandatory continuing education, and disciplinary findings from other jurisdictions. This information is vital to review at the initial appointment phase. However, if a hospital's by-laws do not contemplate such information as relevant to the initial application, the hospital could be criticized for collecting and considering irrelevant content.

Receipt of an Application and Timelines for Processing

Under section 37(3) of the *Public Hospitals Act*, applications are to be submitted to the CEO (as the administrator under the Act) who shall immediately refer the application to the MAC. In many hospitals, applications are sent directly to the Professional Staff Office or credentialing office. It should be clear on the application form to which position or office within the hospital the application is to be submitted. In some hospitals, application forms are completed online. *See Chapter 11, Maintaining Professional Staff Files.*

The *Public Hospitals Act* sets timelines for the processing of applications. It requires that the MAC render its recommendation to the board in writing within 60 days of the date of the application.[2] An extension beyond the 60 days is permitted on notice to both the board and the applicant (but the notice must include reasons for the delay).[3] The Credentials Committee and the MAC must be mindful of the timelines and seek to process applications in a timely manner.

There have been a few physician privileges cases that address the issue of the timing of the processing of an application. For example, in the case of Waddell v. Weeneebayko, 2018 CanLII 39843 (ON HPARB), the Health Professions Appeal and Review Board reviewed a situation where a hospital did not consider a physician's application within 60 days from the date of the application. HPARB

2 *Public Hospitals Act* s. 37(4).

3 *Public Hospitals Act* s. 37(5).

concluded that delay was primarily due to the physician's actions and confusion over whether the physician was re-applying for privileges or not.

While the *Public Hospitals Act* only strictly applies to physician applications, the hospital by-laws should consider extending the same timelines to the processing of applications of other members of the Professional Staff, or clearly identify alternate timelines. Whatever the decision, hospitals should ensure their practice is fair and transparent and that applications are processed in a timely manner.

No Professional Staff member should have to experience unreasonable waits in processing their applications. Delays in processing hospital applications for all Professional Staff can have a serious negative impact on clinical care.

Chief of Department's (or Most Appropriate Clinical Leader) Recommendation of an Applicant

If the hospital has Departments and/or Divisions, the Chief of Department and/or Head of Division should be asked to comment on any application for initial appointment to their staff.

If the hospital does not have Departments or Divisions, the by-laws should set out an explanation of who will be asked to comment on the application (i.e., the most appropriate clinical leader).

The Credentials Committee will need to know the background for recruiting the applicant (if any) and whether there were any negotiations relating to the type or scope of privileges. The Chief of Department and/or Head of Division should be clear about whether they support the application and the reasons why or why not.

Credentials Committee's Collection, Verification and Assessment of Qualifications

Credentialing is the process by which a hospital collects, verifies and assesses the information included in the application and reassures itself (often through independent third-party confirmation) that applicants for initial appointment have all the necessary qualifications for the position. This is the stage where hospitals demonstrate their due diligence in the appropriate vetting of prospective Professional Staff members. Extra care and review should be taken for initial appointments to the Professional Staff because in general, these applicants are not known to the hospital.

In the United States, credentialing is a highly regulated activity.[4] In Ontario (and Canada generally), the act of credentialing is not prescribed in the *Public Hospitals Act* or its regulations, and there are no accreditation standards specifically related to hospital credentialing. As a result, credentialing practices differ from hospital to hospital and should be set out explicitly in the hospital by-laws and hospital policy. The hospital by-laws ought to describe the tasks to be completed before an application is brought to the hospital board for consideration for appointment. These tasks are usually completed in sequence by an administrative person, the Credentials Committee and the MAC.

The *Public Hospitals Act* requires that the MAC review all applications before the hospital board makes a decision about appointment. In practice, most hospitals include one or more steps prior to the MAC review. Specifically, by-laws typically require an administrative person and then the Credentials Committee to do the first review of all applications.

4 *See Verify and Comply, A Quick Reference Guide To Credentialing Standards, Seventh Edition* Stephanie Russell, Kathy Matzka, and Carol S. Cairns 2017, *The Handbook for Credentialing Healthcare Providers*, Ellis Knight, 2016, and *Health Care Credentialing, A Guide to Innovative Practices*, Fay A. Rozovksy et al, Walters Kluwer, Aspen Publishers, 2010.

Since there is no legal requirement to have a Credentials Committee, committee tasks may be performed by an individual or another group or committee. In some hospitals, these tasks are completed by the assistant to the CEO or a Manager/Director of Medical Affairs. For purposes of the Toolkit, we'll refer to the one or more individuals as the "Credentials Committee", acknowledging that there may be an administrative person who completes the steps prior to the Credentials Committee reviewing the packages.

For a summary of the roles and responsibilities of the Credentials Committee, see Chapter 3, Roles and Responsibilities.

In summary, the Credentials Committee performs the following tasks with respect to applications for initial appointment:

- Reviews each application and any supplemental material (e.g., written letters of reference, certificate of professional liability protection coverage or insurance, copy of certificate of registration, curriculum vitae, Certificate of Professional Conduct (CPC), and content posted on the public register available through the applicant's regulatory college).
- Reviews the recommendation of the Chief of Department/Head of Division specific to each application.
- Contacts primary sources of information, as well as independently verifies the information provided by the applicants.
- Ensures all required information has been provided and follows up with candidates if their applications are incomplete.
- Investigates each applicant's professional competence.
- Verifies the applicant's qualifications.

The hospital by-laws set out the criteria against which every applicant for appointment is to be evaluated. Hospitals may only consider the criteria listed in the by-laws when determining an applicant's qualifications. In order to be fair, the evaluation and appointment process criteria must be transparent to the applicant.

In making a determination to support an application for appointment, a Credentials Committee should be able to answer "yes" to all the following statements:

- ☑ The application is complete.
- ☑ The application meets the criteria in the by-laws.
- ☑ The application is appropriate for the privileges requested (that is, contains the relevant information and qualifications for the category and types of privileges requested).
- ☑ The Chief of Department/Head of Division supports the application.
- ☑ All three letters of reference support the application.
- ☑ The applicant is in good standing with their regulatory body.
- ☑ The applicant has appropriate professional liability protection coverage or insurance in place.

Reminder: Information collected by the hospital is confidential and should be protected. *See section on Confidentiality, Access and Disclosure in Chapter 11, Maintaining Credentialing Files.*

Letters of Reference

Most hospitals require candidates for initial appointment to provide letters of reference. These letters of reference come from individuals with whom the candidate has worked in the past. Given that the hospital is unlikely to have first-hand experience with most candidates, letters of reference are an important part of the credentialing process for initial applications.

As a practice tip, it is a good idea to:

- Construct a questionnaire that sets out specific questions for the referee to answer.
- Scan a picture of the applicant and send it to the professional references with the questionnaire to confirm the identity of the individual.

Hospitals rely on referees to provide an objective and honest description of the candidate and their conduct, experience and competence. Hospitals should require that the letters of reference be sent directly to the hospital and that the letters be kept confidential (i.e., not shared with the candidates). Practically speaking, the letters should be kept confidential and should not be subject to access or review if a candidate or Professional Staff member asks for access to their file. *See Chapter 11, Maintaining Professional Staff Files.*

In *Straka v. Humber River Regional Hospital et al.*,[5] a physician was offered a position at the Humber River Regional Hospital contingent upon Humber's receiving letters of reference from his colleagues at St. Michael's Hospital. The letters were provided to Humber in strict confidence. Dr. Straka did not receive an appointment, but was permitted to practice on a Locum Tenens basis. Dr. Straka brought a court application to compel the hospital to give him a copy of the letters of reference. His application was defeated because the court found the letters to be "privileged". The court held that the shield of confidentiality was essential to the effective maintenance of the relationship between referees and hospital boards. Giving references is effectively a peer review process, and a critical element to the credentialing process. As such, the court found that it was important to keep the reference letters confidential from the applicant. The court also concluded that Dr. Straka should have pursued a review of his case under the *Public Hospitals Act* (i.e., his appropriate remedy for the refusal of his application was to appeal to HPARB, not apply to the court).

Given the importance of reference letters to the peer review process and credentialing, it is recommended that the hospital receiving the letters take measures to ensure their source is legitimate. Hospitals may choose to contact referees by phone, confirm the name of the referee with the Canadian Medical Directory or other similar listing, or use the Internet to cross-reference referees and their professional backgrounds.

Certificate of Professional Conduct

In the OHA/OMA Prototype By-law, applicants for appointment to the Medical Staff, Dental Staff, and Midwifery Staff must have a current Certificate of Professional Conduct (CPC)[6] from their most recent licensing bodies. Extended Class Nursing Staff must have a letter of good standing.

A CPC verifies that a Professional Staff member is registered, and confirms membership in good standing with their respective college. Hospital personnel involved in credentialing can request CPCs to assist them in reviewing applications for hospital privileges.

A CPC will likely contain the applicant's qualifications (including date, place and specialties), history of previous disciplinary findings, and other information that the Registrar believes is relevant to an application for hospital privileges. It may not be up-to-date on current matters before the College.

To obtain a CPC, a member must request it from their regulatory college, along with a fee and consent to the release of information.

MAC's Recommendation for Appointment

If the hospital does not have a Credentials Committee, the MAC is responsible for all the elements listed above as tasks assigned to the Credentials Committee. The MAC should have a thorough review of any applications that are identified as problematic.

The additional tasks that the MAC will perform are:

- Reviewing the Credentials Committee's report.
- Considering the Departmental Professional Staff Human Resources Plans.
- Considering the impact analysis data.

5 51 O.R. (3d) 1, [2000] O.J. No. 4212 (C.A.).

6 The name of the CPC varies according to the regulatory body and may be called a letter of professional conduct, a letter of standing, or another name similar in nature.

- Making a recommendation to the board as to whether to grant privileges to the applicant.
- If the recommendation is positive, considering and determining the list of procedures and privileges to give the applicant.

Regulation 965 of the *Public Hospitals Act* allows only physicians to be voting members of the MAC. While many hospitals have created a more multi-disciplinary MAC to reflect the reality of the Professional Staff mix within the hospital, any Professional Staff member on the MAC who is not a physician cannot have voting rights with respect to decisions about initial appointments (or any other privileges matters).

When the MAC makes its decision (to either recommend or not recommend the applicant), it must notify both the applicant and the hospital board in writing.

Sections 37(6) and (7) of the *Public Hospitals Act* require that a physician applicant be notified that they are entitled to:

- Written reasons for the recommendation if a request is received by the MAC within seven days of the receipt by the applicant of notice of the recommendation.
- A hearing before the hospital board if a written request is received by the board and the MAC within seven days of the receipt by the applicant of the written reasons. If a hearing is requested, see Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges, for a discussion about board hearings.

This notification can also apply to other members of the Professional Staff if the same process is extended to them in the hospital by-laws.

For the vast majority of applicants, there will be no need for a hearing because the MAC will recommend the applicant for appointment and the MAC will prepare a list of initial appointments for the board to consider. However, when there are problems with the application, the MAC should seek legal advice. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

Board's Role: Deciding to Appoint to the Professional Staff

Once the administrative staff person has collected the information, the Credentials Committee has reviewed the applications and made recommendations to the MAC, and the MAC has reviewed the applications and made recommendations to the board, the next step is appointment, which is the responsibility of the board.

Section 38 of the *Public Hospitals Act* states that if an applicant does not require a hearing after receiving the MAC's written recommendation with respect to appointment, the board may implement the recommendation of the MAC.

Section 39 of the *Public Hospitals Act* states that where an applicant requires a hearing, the board shall appoint a time for the hearing and at that point will decide on the appointment. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

To make its decisions about appointments and the privileges to be assigned, the board primarily relies on the recommendations of the Credentials Committee and the MAC. The board is entitled to give "great weight" to the recommendations of the MAC, due to its medical expertise.[7] However, the board must make its own independent decision. The board is responsible for ensuring an effective and fair credentialing process.

While it does not need to receive all the details for every candidate, it must be reassured that the processes meet legal requirements. This responsibility can be discharged by:

- Ensuring the Board-Appointed Professional Staff By-law is reviewed by legal counsel (usually every three years or more frequently if there is new legislation or new guidelines such as the OHA/OMA Prototype By-law).

7 *Re Sheriton and North York General Hospital* (ON Hospital Appeal Board, 1973), referred to in Pratt v. Fraser Health Authority (BCSC, 2007)

- Asking the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) questions about:
  - The length of time it takes to process applications.
  - The trends in applications.
  - Whether the hospital is successful or faces challenges with respect to recruitment.
  - The steps the Credentials Committee takes to:
    a. Protect against fraudulent applications.
    b. Verify information in applications from primary sources and independent third parties.
    c. Review letters of reference and whether and how they follow up on issues of concern.
    d. Follow up on applications that raise concerns.
    e. Review trends in credentialing best practices.
  - How the applications relate to the Professional Staff Human Resources Plans and the hospital's strategic plan.
  - Whether the candidates are qualified, and not just the only applicants who applied.
- Considering whether the MAC's recommendations are consistent with the hospital by-laws, Rules and Regulations, hospital policies and the Professional Staff Human Resources Plans.
- Asking a board sub-committee (like the Audit Committee) to complete an annual audit of the hospital's credentialing process by reviewing a random sample of applications for appointment, re-appointment and changes to privileges.

Further, if any board member has independent knowledge of a candidate, that knowledge should be disclosed. It would be prudent to seek legal advice if the board independently raises concerns about a candidate who has been recommended for appointment by the MAC.

Regional/Joint Credentialing Initiatives

A variety of circumstances arise when regional or "joint" credentialing between hospitals makes sense, including:

- When two or more hospitals share Professional Staff.
- When Hospital A needs Professional Staff to perform a service and Hospital B provides the Professional Staff to perform that service (e.g., Hospital B provides anesthesiologists to Hospital A).
- When the hospitals intend to share Professional Staff in an under-resourced area and want to allow for streamlined credentialing.
- To reduce the burden on Professional Staff who work in multiple locations.

A hospital board cannot delegate its responsibility for decisions about appointment or re-appointment to the Professional Staff. Each hospital board retains ultimate responsibility for the credentialing process and cannot fetter (meaning confine or restrain) its decision-making power by virtue of being part of a joint credentialing initiative. Any joint credentialing initiatives must be satisfactory to each hospital's board.

There may be many ways to conduct joint credentialing. It is important for participating hospitals to seek legal advice early in the process to ensure the proposal for joint credentialing meets legal requirements.

To initiate a joint credentialing initiative, all participating hospitals should consider:

- Recording how the joint credentialing initiative will be conducted (such as through a Joint Credentialing Policy that is approved by each hospital board) to:
  - Identify the purposes for the initiative.
  - Determine the scope of the initiative:
    a. Will it only apply to certain categories of Professional Staff?
    b. Will all participating hospitals share a Professional Staff?

- Clarify how accountability for each hospital in the partnership is retained under the *Public Hospitals Act* and Professional Staff by-law.
- Address all aspects of the joint credentialing initiative including processes of appointment, re-appointment, change in privileges and suspension, revocation or restriction of privileges.
- Identify the common criteria for appointment and re-appointment in the joint process.
- Determine how information (and how much information) will be exchanged among the participating hospitals with the consent of the individual and for what purposes (and what happens if an individual withdraws consent for the sharing of information).
- Determine how complaints, problems and disciplinary matters will be managed and communicated between the participating hospitals.
- Identify which hospital(s) will conduct performance reviews.
- Determine how liability, indemnities and insurance will be affected (this may be easier where there is a joint insurer for all participating hospitals).

- Amending their Professional Staff by-law to contemplate the joint credentialing process and making any necessary changes to hospital by-laws in order to harmonize with the common criteria for appointment and re-appointment.
- Creating a new Joint Credentialing Application Form that addresses the new process and its terms and conditions.
- Discussing the initiative with their Professional Staff to explain how the process will work and who is entitled to participate.

As one example of joint credentialing initiatives, some hospitals have streamlined application processes for candidates who have gone through the usual credentialing process at another participating hospital. Applicants may qualify for a streamlined application process provided they hold and agree to maintain a primary appointment at another participating hospital. Streamlined applications may include content such as:

- A Joint Credentialing Application Form requesting privileges (that is, the category, type and scope of privileges requested);
- A shared CPC;
- A consent permitting all participating hospitals where the applicant has applied to review all credentialing information held by other hospitals for purposes of joint credentialing;
- Relevant undertakings that would be required on appointment or re-appointment; and
- Consents and releases that would be required on appointment or re-appointment.

The hospital where the applicant holds the primary appointment typically shares the applicant's privileges file with the other hospitals to allow their Credentials Committee (or equivalent) to carry out their investigations and due diligence, and the primary hospital typically provides written assurance that it has complied with the agreed-upon credentialing processes in its by-laws. This cuts down on the need to collect the original documentation and independently verify references, saving significant time.

No applicant information should be shared amongst hospitals participating in a joint credentialing scheme without the prior written consent of that applicant. This consent should form part of the application process.

Hospitals should highlight that the following information could be exchanged among participating hospitals:

- Information relating to the application for appointment or re-appointment and any supporting documentation.
- Information from the applicant's regulatory college.
- Information from the applicant's professional liability protection provider (insurer).

- Any changes to privileges including actions or proposals to restrict, suspend or revoke privileges for any reason.
- Performance reviews.
- Requests and grants of leave of absence.
- Complaints or compliments with respect to the applicant's practice.
- Information relating to internal investigations involving the applicant.
- Information with respect to external investigations involving the applicant such as by OHIP, a coroner, or the police.

All information exchanged should be treated as confidential by the receiving hospital.

Examples of joint credentialing systems in Ontario include: the cMARS reappointment system

Probationary Period

The OHA/OMA Prototype By-law includes the concept of a probationary period for new recruits to the Associate category of Professional Staff (before becoming Active Staff) and for Extended Class Nursing. While not required by law, probationary periods have been recognized in case law as providing hospital leaders "the opportunity to assess, in a supervised setting, an associate's abilities"[8] in the case of new recruits and existing Professional Staff who wish to change categories of privileges. This assessment may be foundational to the hospital establishing a safe environment for its patients.

However, there has also been a misuse of probationary periods. In the case of *Saskatoon Regional Health Authority and Johnson*, *2014 SKQB 266* (CanLII), <*http://canlii.ca/t/gdr5n*>, a department head was described as a"rogue elephant stampeding through the Bylaws" (para. 119) who used temporary appointments to create a longer probationary period for his department and did not explain to candidates that appointments were temporary only.

Temporary Appointments

A temporary appointment refers to limited clinical privileges that have been granted for a specific period of time. Details of such appointments may be outlined in a hospital's by-laws or policies.

It may be necessary at times for the hospital to accommodate temporary appointments to the Professional Staff to deal with time-sensitive issues or to meet specific hospital needs. For example, in the case of a telehealth consultation or appointment for the purposes of assisting with a medically-assisted death. *See Chapter 1.*

Although not contemplated in the *Public Hospitals Act*, hospital by-laws typically include a provision to allow for temporary appointments. In the OHA/OMA Prototype By-law, the authority is granted to the CEO (or delegate), after consultation with the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) to:

- Grant a temporary appointment and temporary privileges to a physician, dentist, midwife or registered nurse in the extended class; and
- Continue a temporary appointment and temporary privileges on the recommendation of the MAC, only until the next board meeting.[9]

However, temporary appointments are always subject to MAC and board approval and must be brought forward for such approval at the earliest opportunity.

From time to time (for example, in the summer months when hospital boards may not meet), it may happen that a temporary appointment starts and finishes before board approval can be sought. In such cases, the board should be notified of the appointment.

8 Thannikkotu v. Trillium Health Centre, 2011 HPARB at p. 20.

9 See OHA/OMA Prototype By-law, s. 3.6.

Situations that give rise to the need for temporary privileges require increased due diligence. Often, these appointments are to accommodate visiting professionals or involve urgent care situations. It is always available for the hospital to grant modified or restricted temporary privileges (for example, a hospital might grant a new Professional Staff member temporary privileges and require an existing Active Staff member to co-sign health records entries). An urgent situation does not relieve the hospital from exercising due diligence. Temporary appointments should not be granted until the applicant's licensure and professional liability protection coverage (insurance), at a minimum, have been confirmed. If time permits, hospitals should collect as much information as possible as would have been collected in the usual course for an initial application, including a CPC.

It is strongly advised that each hospital have clear policies in place to ensure all temporary appointments are granted to competent and qualified persons only.

Temporary appointments are not recommended on a regular basis and should be reserved for exceptional circumstances. For example, as a measure of emergency preparedness:

- Emergency preparedness documentation must include how appointments will be determined in case of a disaster or pandemic.
- Look first to existing members of Professional Staff (who have already gone through the credentialing process) and broaden their appointments to a wider range of privileges as appropriate.
- If hospitals in a region intend to share their Professional Staff members for a short duration of time in an emergency, participating hospitals could send each other a list of their approved Professional Staff members (with their approved privileges) so that temporary privileges can be granted.

Hospitals should avoid leaving Professional Staff members in a temporary appointment category. It is important to communicate with an appointed staff member the nature of their status (i.e. clear communication to avoid future potential conflicts over the nature of their appointment). Hospitals should have a mechanism for following up at the end of a period of appointment so that there is no confusion over whether temporary becomes something more because the staff member continues to provide services after a fixed term.

Lessons Learned in New Brunswick

As a backdrop to why a robust credentialing process is so critical, hospitals are encouraged to read the New Brunswick Commission of Inquiry into Pathology Services at Miramichi Regional Health Authority, a report of Mr. Justice Paul S. Creaghan.[10]

The report deals with the activities of one pathologist and the system that failed to properly credential him. Dr. Menon came to the Miramichi Regional Health Authority in 1993 as the sole applicant for a staff position in surgical pathology at the Miramichi Regional Hospital. When his application was referred to the Credentials Committee, no one was available to act as a pathology peer to assist in the evaluation of Dr. Menon's competency.

The Credentials Committee approved probationary privileges for one year, characterized as the usual practice for any new member of the medical staff. In spite of this fact, the hospital CEO offered Dr. Menon a position without any restriction as to term. The application for initial privileges did not go to either the MAC or the board for approval.

Over many years, there were problems with Dr. Menon's turnaround times and his absenteeism. He was resistant to quality improvement initiatives, and there were minor and major errors in his diagnoses and his reports. During his time on staff he was not peer reviewed. Attempts to discipline and terminate him were never followed through. Finally, a complaint to the College of Physicians and Surgeons of New Brunswick resulted in an executive suspension of Dr. Menon's license to practice in 2007.

10 Commissioner's Report, Vol. 1: Commission of Inquiry into Pathology Services at the Miramichi Regional Health Authority (December 8, 2008), available online at: http://leg-horizon.gnb.ca/e-repository/monographs/30000000048259/30000000048259.pdf . Or to obtain a copy of this report please contact the New Brunswick Department of Health.

The College action terminated Dr. Menon's conduct of surgical pathology at Miramichi Regional Health Authority after he had been on staff for 12 years.

In his report, Mr. Justice Paul S. Creaghan wrote:

> "I am satisfied that Mr. Tucker and the hospital's Credentials Committee did not get adequate information or satisfactory reference on Dr. Menon's qualifications and capabilities before hiring him. It is self-evident that the first rule in providing quality assurance in any hospital department is to take reasonable steps to ensure that the health professionals who are employed are fully capable of doing the job required of them. Why was Dr. Menon terminated in Fredericton? What was his employment record in Holland? Why was the Chief of Anatomical Pathology in Saint John unwilling to hire him?
>
> These were all red flags that did not get waved very vigorously or were not looked for hard enough. The fact that a pathologist was much needed in Miramichi was no excuse. The chance for a poor doctor rather than risk having no doctor simply is an unacceptable principle to apply in our health delivery system."[11]

And at Recommendation No. 6, he further stated:

> "The requirements for granting hospital privileges at the Miramichi Regional Hospital were perfunctory. If a physician had a license to practice medicine in New Brunswick and passed a collegiality test administered by the physicians' Credentials Committee, they would be a suitable candidate for hospital privileges. Initially the Committee would recommend a one-year probationary period. Subsequently, the normal course would see an annual renewal of those privileges by the board of directors on the recommendation of the Committee as a matter of routine. The Commission found that the process of granting hospital privileges was very informal and lacked serious assessment of competency. However, from a realistic and practical standpoint, the process is what can be expected in a small regional hospital facility."[12]

FAQs

1. Must we process unsolicited applications?

In the case of physicians — yes. Any physician is entitled by law to apply for privileges at a hospital. The by-laws may or may not extend this right to dentists, midwives and extended class nurses (and if not, there should be written rules to communicate to dental, midwifery and extended class nursing applicants that their unsolicited applications will not be processed).

Once received, the hospital must ensure the MAC reviews an application and makes a recommendation to the board, and that the board considers it.

A hospital does not have to grant privileges to everyone who applies. Practically speaking, it is reasonable for hospitals to have clear recruitment processes so that interested parties have an opportunity to access application forms and be apprised of any available positions. Interested applicants may also be redirected to Chiefs of Department and/or Chiefs of Staff for further information.

2. Can we refuse to process an application that is incomplete?

No. It must be processed and considered by the board, but appointment may be refused because the candidate does not meet the required qualifications set out in the by-laws. In the case of *Re Watts and Clinton Public Hospital,*[13] the hospital refused to process an application (for re-appointment) because the Credentials Committee identified that it was incomplete. The court found that whether an application is complete is "immaterial". The *Public Hospitals Act* sets up a scheme by which the MAC reviews the application, makes its recommendation, and presents that recommendation to the board. There is no scope to refuse to process the application.

11 Creaghan Report, p. 23.

12 Creaghan Report, p. 108.

13 Ontario Superior Court of Justice, 2005.

The Credentials Committee (or other hospital representative) should advise the applicant in writing that the application is not complete and ask for the missing information. If the applicant refuses to provide the information, the applicant should be given the options of (a) submitting the remaining information by a set date; (b) requesting the application be put on hold; or (c) withdrawing the application. Applicants should also be reminded that if their applications are refused because they are incomplete (which will happen if the missing information is material), they may have to report the refusal in future applications for privileges (although not included in the OHA/OMA Prototype By-law, some hospital by-laws include such reporting obligations).

3. Can we ask for information not listed in our by-laws?

No. If a hospital wishes to amend the qualifications for appointment, the hospital must amend its by-laws.

4. Should hospitals conduct criminal record checks on Professional Staff applying for appointment?

The OHA/OMA Prototype By-law does not explicitly refer to criminal record checks as a required part of the appointment process. However, some hospitals have introduced criminal record checks for all clinical staff (including board-appointed Professional Staff) given their access to potentially vulnerable patients.

The OHA generally recommends that hospitals conduct criminal record checks at the time of an applicant's initial appointment to the Professional Staff. Hospitals are further encouraged to align their criminal record check policies for Professional Staff with those for employees, board members, volunteers, etc.

A criminal record check lists unpardoned offences, convictions and criminal activity under the Criminal Code (Canada). A vulnerable sector check lists pardoned offences and dropped charges, and can be conducted in addition to a criminal record check where the hospital deems it appropriate. Criminal record checks and vulnerable sector checks may only be initiated with the consent of the individual.

5. What should hospitals do if an applicant has a criminal record?

Hospitals may wish to seek legal advice. Hospitals should consider the following factors when determining whether an individual's criminal record makes the individual unsuitable as a candidate to join the Professional Staff:

- The nature of the criminal activity.
- When it happened.
- The patient population the hospital serves.
- The proposed scope of privileges and activities the individual would perform.

Criminal record history should be treated as confidential.

6. What should we do if we discover someone has been providing clinical care at our hospital without being credentialed/appointed?

Seek legal advice immediately. The individual should be notified immediately and be told to cease all clinical work. The Chief of Staff/Chair of the MAC, Chief of Department (or most appropriate clinical leader), CEO and hospital insurers should be notified. The MAC and board will also need to be notified.

If someone does not hold privileges at the hospital, they cannot see the chart, sit in on rounds, admit, treat, diagnose, consult or order tests, or use hospital equipment. While a full review will need to be done, someone should immediately confirm the nature of the individual's license and determine whether they hold professional liability protection coverage (insurance). It will also be important to collect information with respect to any complaints or concerns raised about the person's practice within the relevant timeframe. The person may be given temporary privileges through the normal course, if they meet the qualifications.

It will be important to review how it came to be that the person started working without being properly appointed.

7. How much information does the board usually receive about the Professional Staff it appoints?

The board will usually receive a written report from the MAC supplemented by a verbal report from the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) on behalf of the MAC. The board will usually receive a list of names of candidates for appointment and each candidate will have a category of privileges requested. These reports are typically brief. For initial appointments, the Chief of Staff/ Chair of the MAC (or most appropriate clinical leader) may provide some background about recruitment efforts and how candidates for appointment will fulfill elements of the Professional Staff Human Resources Plans. The board needs sufficient information to be satisfied with the process followed by the Credentials Committee and the MAC in arriving at the recommendation. If it is not satisfied, it should seek more information. A board could have a sub-committee (such as the Audit Committee) complete an annual audit of the hospital's credentialing process by reviewing a random sample of applications for appointment, re-appointment and changes to privileges. However, a board will need much more information (and possibly, independent legal advice) than a mere list of candidates and list of privileges if the MAC is recommending the board:

- NOT appoint a candidate to the Professional Staff
- NOT re-appoint a member of the Professional Staff
- Suspend a Professional Staff member's privileges
- Restrict a Professional Staff member's privileges
- Revoke a Professional Staff member's privileges

See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.

8. Can the board disagree with the MAC? What happens if the board is considering not implementing a recommendation of the MAC?

Yes. Although the board receives recommendations from the MAC (as required by the *Public Hospitals Act*), the board must ultimately make its own decision with respect to initial appointment (and re-appointment). In fact, it is a duty of the board to question the information and to satisfy itself, independently from the MAC, that a particular individual should be granted privileges.

However, if the board receives a recommendation from the MAC that, for some reason, it is considering not implementing, it is recommended that the board receive independent legal advice before making its decision. The issue should be deferred to the next board meeting and legal counsel consulted by the Board Chair in the interim.

9. Should the appointment of physicians and other Professional Staff members be dealt with in an in camera session of the board?

Yes. These decisions deal with personal matters relating to Professional Staff members. For that reason, it is appropriate to hold the meeting in camera and report the outcome of the debate/discussions to the open session, as determined by the board.

10. Can the board appoint physicians for more than one year?

No. The *Public Hospitals Act* specifically states that appointments can be "for a period of not more than one year".

Often, new appointments come to the attention of the board at a time different from an annual re-appointment date. If the hospital has adopted a set date for all re-appointments, the board can decide how it wishes to manage the appointment term (as long as it is not for more than one year to align the new member to the annual re-appointment calendar).

11. Must a hospital have a Credentials Committee?

No. The *Public Hospitals Act* does not require that there be a Credentials Committee. In such a case, the MAC would ultimately be responsible for the duties of the Credentials Committee set out in this chapter.

12. We are a small hospital. Can we grant privileges to a physician on the basis that the closest tertiary centre has already done its investigations and granted the physician privileges?

You may want to consider initiating a joint credentialing process, including a joint Credentials Committee. As a reminder, regardless of the credentialing process, each hospital's MAC must review every application for

privileges, and the board must make final decisions about appointment. However, there may be streamlined or expedited processes as discussed in this Chapter.

13. Why do we need to ask members of our Professional Staff for evidence of insurance? Doesn't their college already do this?

Every hospital has a duty to satisfy itself that every member of its Professional Staff has appropriate professional liability protection coverage or insurance (e.g., most physicians are members of the Canadian Medical Protective Association). Even where a joint credentialing process has been established, each hospital should have a process in place to check that the applicant has appropriate professional liability protection coverage or insurance.

14. Are dentists, midwives and extended class nurses entitled to the same procedural protection as physicians under the *Public Hospitals Act*?

The provisions of the *Public Hospitals Act* apply to members of the Medical Staff only. The *Public Hospitals Act* itself does not refer to other Professional Staff members. However, the regulations under the *Public Hospitals Act* allow hospital boards to pass by-laws for other Professional Staff groups (dentists, midwives, and extended class nurses). And when hospital boards do so, the by-laws typically apply the same processes to all groups. For the purposes of consistency, the OHA recommends that the same or similar processes are used for the appointment of Professional Staff.

In any particular case, where there is a question about what particular procedural protection should be afforded to an individual applicant or group of applicants, the board should consult its own legal counsel.

15. Are courtesy medical staff, locum tenens, and temporary medical staff entitled to the same procedural protection as active and associate medical staff under the *Public Hospitals Act*?

The general rights to procedural fairness and natural justice established by the *Public Hospitals Act* apply to all medical staff, regardless of the category of appointment. However, members of the Active Staff usually have entitlements to longer notice, more consultation and involvement in decision-making given their highly integrated role within hospitals. A hospital's by-laws set out categories of Professional Staff (such as Active Staff and Courtesy Staff) and the rights attached to each category. Those rights might be slightly different.

16. Should we send a letter of offer before the application has been approved by the board?

It is important for hospitals to be clear with applicants about the stage of their application and the contingencies for full appointment. Hospitals should avoid enticing applicants to make significant changes in their professional, personal and family lives (such as resigning from a current post and/or planning a major geographical move) until, and unless it is clear that the application will be approved. Clear and transparent communication is essential.

Chapter 6: Re-appointments and Changes to Privileges

Reference Key:

Public Hospitals Act:	Sections 36-38
OHA/OMA Prototype By-law:	Sections 3.7, 3.8

Chapter Summary

- Any Medical Staff member who applies to a hospital for re-appointment or a change of privileges is entitled to have their application considered by the board. A hospital cannot merely refuse to review a Medical Staff member application (this right can be extended to also apply to other members of the Professional Staff through the hospital by-laws).

There are six steps to the re-appointment process:

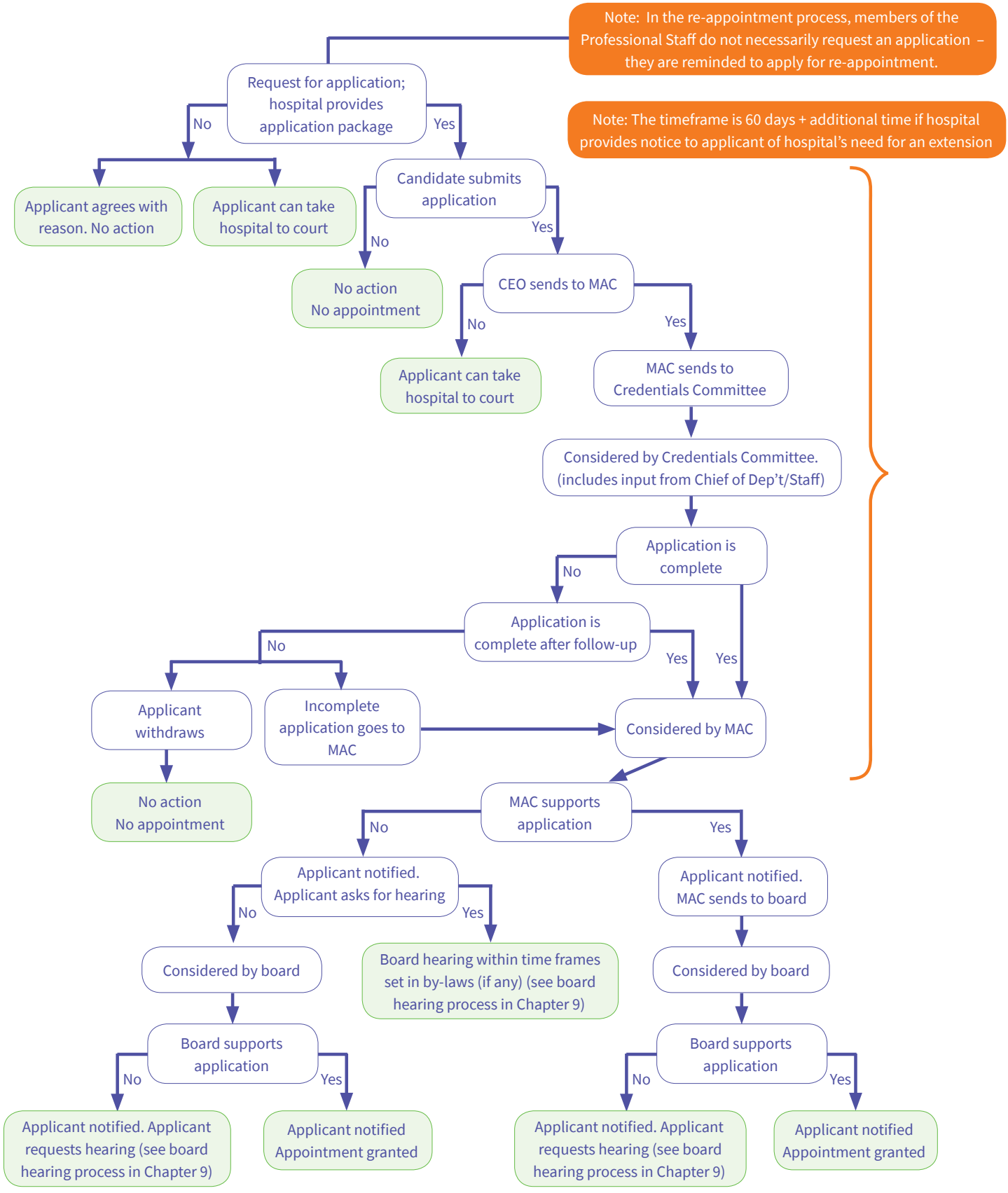
1. Planning for re-appointments.
2. Collection of information through an application form and supplemental information.
3. Verification of credentials (including independent confirmation of information).
4. Assessment of credentials.
5. Recommendation of the Medical Advisory Committee (MAC).
6. Decision by the board.

- While the initial appointment application may be more detailed, hospitals have an ongoing responsibility to collect information, and verify and assess the credentials of members of the Professional Staff for re-appointment. It is insufficient to rely on the absence of negative information (i.e., no complaints) as the sole basis for re-appointment.

- Professional Staff members can also request to have their category of privileges or range of privileges changed, and this change of privileges request may trigger the need for the Professional Staff member to submit additional information.

- It is still the board that makes re-appointment and change of privileges decisions. This responsibility cannot be delegated to the MAC.

Re-appointment Process



Re-appointment Process by Role

Differences from the Initial Appointment Process

Much of Chapter 5, Initial Appointment, will be relevant to this Chapter on re-appointments. However, the re-appointment process is generally not as cumbersome as the initial appointment process, because the hospital is familiar with the applicant and the historical and static information would have been gathered during the initial appointment process.

Right to Apply for Re-appointment or Change of Privileges

Section 37 of the *Public Hospitals Act* provides that any physician is entitled to apply to be re-appointed at any hospital or to apply for a change in hospital privileges.

A re-appointment application must be provided to a physician on written request. Once submitted, the physician is entitled to have that application forwarded to the MAC and ultimately considered by the board. If a hospital refuses an application for re-appointment or change of privileges for whatever reason, the candidate is entitled to request a hearing before the board. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

In summary, a bundle of rights attaches to a candidate as soon as they request and submit an application for re-appointment to the hospital. While no one is guaranteed to be re-appointed or to have their privileges changed, an applicant is entitled to have their application reviewed by the MAC and board and receive a decision about re-appointment or change of privileges.

These rights under the *Public Hospitals Act* apply only to physicians, but can be and usually are extended to dentists, midwives and extended class nurses through the hospital's by-laws. If these rights are not extended, it is important for the hospital to have written by-laws or processes that explain the hospital's approach to re-appointment for

Dental Staff, Midwifery Staff and Extended Class Nursing Staff. There should be a fair and transparent process for re-appointment to the Professional Staff.

Timing

The hospital by-laws should include a placeholder that allows the MAC to annually set a date(s) for re-appointment applications to be submitted. While many hospitals schedule all re-appointments to the Professional Staff at the same time every year, hospitals can stagger their re-appointments. Large hospitals may choose to stagger their re-appointment process (for example, by Department or Division) so as not to overwhelm the board with hundreds of re-appointment applications at the same time. The board may also be asked to consider re-appointments at other times, (e.g., as initial appointments expire).

Content of an Application

The hospital by-laws should set out the content to be included in an application for re-appointment. The application package usually includes (or provides a link to online resources):

- Application form for re-appointment.
- *Public Hospitals Act* and Regulation 965.
- By-laws (if they changed within the last year, or confirmation that they have not changed).
- Rules and Regulations (if they changed within the last year, or confirmation that they have not changed).
- Listing of new policies applicable to the Professional Staff.
- Listing of new initiatives pursued by the hospital.

The *Public Hospitals Act* does not prescribe what must be included in an application form for re-appointment. This is reserved for the hospital's by-laws. Section 3.7 of the OHA/OMA OHA/OMA Prototype By-law includes recommendations for what should be included in an application for re-appointment.

As explained in Chapter 5: Initial Appointment, hospitals should make sure to include in the criteria for re-appointment all information necessary to identify strengths and problems with candidates. There is more publicly available information about candidates for privileges than ever before. Regulatory Colleges now post additional information on their public registers about licensed members' criminal charges, cautions-in-person, mandatory continuing education, and disciplinary findings from other jurisdictions. This information continues to be relevant at the re-appointment stage. However, if a hospital's by-laws do not contemplate such information as relevant to the application for re-appointment, the hospital could be criticized for collecting and considering irrelevant content.

Receipt of an Application and Timelines for Processing

Under section 37(3) of the *Public Hospitals Act*, applications for re-appointment are to be submitted to the CEO (as the administrator under the Act) who shall immediately refer the application to the MAC. In many hospitals, re-appointment applications are sent directly to the Professional Staff Office or credentialing office. It should be clear on the application form to which position/office within the hospital the application must be submitted. In some hospitals, the application forms are completed online. *See Chapter 11, Maintaining Professional Staff Files.*

For timelines that apply to processing applications for initial appointment, see Chapter 5, Initial Appointment. These same timelines apply to processing of re-appointment applications.

Chief of Department's (or Most Appropriate Clinical Leader) Recommendation of an Applicant

In an initial appointment, the hospital relies on letters of reference to confirm an applicant's qualifications. For re-appointments requests to changes to privilege, hospitals rely on the Chief of Department's recommendation. In smaller hospitals not divided into Departments/Divisions, the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) may fulfill the role of reviewer.

The Chief of Department or Head of Division (or whoever is commenting on the application) should be clear whether they support the application and the reasons why or why not. Merely stating that there have not been any problems with a member of the Professional Staff is insufficient. Each member of the Professional Staff should have some kind of annual performance review. *See Chapter 8, Performance Evaluations, Monitoring, Progressive Management and Discipline, for a sample list of matters to be included in a re-appointment performance review.* For efficiency, Active Staff member performance reviews may be more in-depth than reviews of other categories of Professional Staff.

Factoring the results of the annual performance review into the credentialing process is one of the key ways that re-appointment differs from the initial appointment process.

Credentials Committee's Collection, Verification and Assessment of Qualifications

In addition to the initial appointment duties it performs, the Credentials Committee plays an ongoing role in collecting, verifying and assessing information for applications for re-appointment and for changes to privileges.

In summary, the Credentials Committee performs the following tasks with respect to applications for re-appointment:

- Reviews each application and supplemental material (e.g., evidence of professional liability protection coverage or insurance and may also include information from the regulatory college public register).
- Reviews the recommendation of the Chief of Department specific to each application (or Chief of Staff/Chair of the MAC in hospitals without Departments).
- Contacts primary sources of information and collects information to independently verify the information provided by the applicants (for example, the public register of the regulatory college).
- Ensures all the required information has been provided and follows up with candidates if their applications are incomplete.
- Investigates each applicant's professional competence.
- Verifies the applicant's qualifications.

The hospital by-laws set out the criteria by which every applicant for re-appointment is to be evaluated. Hospitals may only consider the criteria listed in the by-laws when determining an applicant's qualifications. These ideas are also useful for any independent confirmation required for re-appointment.

In making a determination to support an application for re-appointment, the Credentials Committee should be able to answer "yes" to all the following statements:

- ☑ The application is complete.
- ☑ The application meets the criteria in the by-laws.
- ☑ The application is appropriate for the privileges requested (that is, contains the relevant information and qualifications for the category and types of privileges requested).
- ☑ The Chief of Department (or most appropriate clinical leader) supports the application.
- ☑ The applicant is in good standing with their regulatory body.
- ☑ The applicant has appropriate professional liability protection coverage (insurance) in place.

Reminder: Information collected by the hospital is confidential and should be protected. *See section Confidentiality, Access and Disclosure in Chapter 11, Maintaining Credentialing Files.*

MAC's Recommendation for Re-appointment

The MAC performs the same analysis for re-appointment as it does for initial appointment, but based on the information provided on re-appointment.

As a reminder, the *Public Hospitals Act*, Regulation 965, allows only physicians to be voting members of the MAC. While many hospitals have created a more multi-disciplinary MAC to reflect the reality of the Professional Staff mix within the hospital, any Professional Staff member on the MAC who is not a physician cannot have voting rights with respect to decisions about re-appointments.

Sections 37(6) and (7) of the *Public Hospitals Act* require that a physician applicant be notified that they are entitled to:

- Written reasons for the recommendation, if a request is received by the MAC within seven days of the receipt by the applicant of a notice of the recommendation.
- A hearing before the board if a written request is received by the board and the MAC within seven days of the receipt by the applicant of the written reasons. *If a hearing is requested, see Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

This notification can also apply to other members of the Professional Staff if the same process is extended to them in the hospital by-laws.

Just as with initial appointments, for the vast majority of applicants for re-appointment, there will be no need for a hearing because the MAC will recommend the applicant for re-appointment and the MAC will prepare a list of re-appointments for the board to consider. However, when there are problems with the application, the MAC should seek legal advice.

Board's Re-appointment to the Professional Staff

The board's role in re-appointment is exactly the same as with initial appointment. The board needs sufficient information to be satisfied with the process followed by the Credentials Committee and the MAC in arriving at the recommendation. The board has a duty to question the information received and satisfy itself that the recommendation is appropriate. *See Chapter 5, Initial Appointment.*

Changes to Privileges

Professional Staff members are also permitted to request changes to their Professional Staff category or type of privileges. Requests for changes may arise in situations such as where a Professional Staff member:

- has undertaken new training and would like to expand services and procedures offered to the hospital
- was told they would be considered for a change of category of privileges after a probationary period
- has been in a particular role and wants to change roles for which they are qualified (such as a surgical assistant who wishes to provide full surgical services)[1]
- wishes to reduce services, such as on-call coverage or no longer provide a particular type of procedure
- wishes to become more involved with the hospital (such as moving from courtesy staff to associate or active staff)

Professional Staff who wish to change their privileges must do so by making similar applications (just like a re-appointment application). Such applications are

1 See for example, *Thannikkotu v Trillium Health Centre*, 2012 CanLII 16327 (ON HPARB), <http://canlii.ca/t/fqrwf>. In that case, Dr. Thannikkotu appealed to HPARB when his application for a change of privileges from courtesy staff to active staff was rejected by the hospital. While HPARB concluded the hospital was not fully fair or transparent in handling the application, it was not persuaded that Dr. Thannikkotu's scope of practice fits the criteria of active staff category under the hospital's by-law. He had never acted as most responsible physician and had not completed a two year period as an associate staff member.

considered in the same way as applications for re-appointment unless additional information is required to expand the scope of practice for an applicant at the hospital. If a broader range of privileges will be extended, it may be necessary to collect information in the same manner as through initial appointments. It is also appropriate in requests for changes to privileges to conduct an impact analysis and consider the impact of the request on other members of the Professional Staff.

Chiefs/Heads or other leaders must explain the process for applying for a change of privileges to Professional Staff members who raise issues of concern about their current status. This is especially important where a Professional Staff member has been in a temporary role and has a reasonable expectation of an eventual category change or if a Professional Staff member decides they want to increase or decrease their services. While such conversations may start out as informal discussions, Professional Staff members should be told there is a formal process they are entitled to engage if they wish to be considered for changes to the category of their privileges or types of procedures they provide at the hospital.

Chiefs/Heads cannot unilaterally decide to change the category of privileges held by members of their Department or Division or at the hospital in general.[2]

FAQs

1. Do all re-appointments need to take place at the same time?

No. In most hospitals, for administrative convenience, all appointments or re-appointments for particular Departments/Divisions are considered together, but they do not have to be. Each hospital can decide on the process that works best for its circumstances.

2. What happens if someone fails/refuses to re-apply?

It is usual practice to send a general reminder of deadlines for applications for re-appointment to all members of the Professional Staff. If this general reminder fails to elicit an application form, it is also common practice to send at least one specific reminder directed to the individual (and to investigate whether the contact information for the member has changed).

The *Public Hospitals Act* provides that, when a physician has applied for re-appointment *within the time prescribed*,[3] their appointment continues until re-appointment is granted or, if the board refuses to grant the re-appointment, until the Health Professions Appeal and Review Board (HPARB) appeal process is completed (if any). Hospitals can, therefore, prescribe a window of time during which re-appointment applications will be accepted. If someone fails or refuses to re-apply within that window, they are not considered to have submitted an application. Generally speaking, they have no right to a board hearing and no right to appeal the decision to HPARB. They would be considered to be resigning their appointment and privileges. *See Chapter 10, Resignation and Retirement*, *for how to follow up to ensure appropriate transfer of care at resignation.*

If the window is missed through Professional Staff member error or inadvertence, or failure of the hospital to send out reminders about the application deadlines, leniency on late submissions may be appropriate.

3. What steps should be taken when a member of the Professional Staff refuses, on principle, to provide certain information on their re-application form?

Legal advice should be sought. Generally speaking, the Credentials Committee and MAC may treat this as an incomplete application. As discussed in Chapter 5, Initial Appointment, an incomplete application must be processed and considered by the board, but re-appointment may be refused if the candidate does not meet the required qualifications set out in the by-laws. As a courtesy to the Professional Staff member, the Credentials Committee should advise the applicant in writing that the application is not complete and ask for the missing information. If the applicant refuses to provide the information, the applicant should be given the options of (a) submitting the remaining information by a set date; (b) requesting the application be put on hold; or (c) withdrawing the application. Applicants should also be reminded that if their applications are refused because

2 See for example, Tenn-Lyn v Medical Advisory Committee, 2016 CanLII 80391 (ON HPARB), <http://canlii.ca/t/gvrcr>

3 Section 39(3).

they are incomplete (which will happen if the missing information is material), they may have to report the refusal in any future applications for privileges, as some hospital by-laws require such reporting.

When the MAC recommends that the board refuse to re-appoint due to a materially incomplete application form, the Professional Staff member is entitled to ask – and will most likely ask – for a hearing before the board. The board will then hear why the individual refuses and will determine whether to allow the application or not.

4. If a Professional Staff member wishes to expand or contract/reduce their services, how is that negotiated?

It depends on what the individual wishes to do and whether that vision aligns with what the hospital needs. Requests for changes to privileges require active communication. Where a Professional Staff member desires a change (whether it is to take on new procedures, use different equipment, change categories of membership, take fewer consultations, or reduce on-call services), such changes may be agreeable to the hospital. Where there is an alignment of interests, a Professional Staff member would make an application for a change of privileges and that application would follow the same process for re-appointment. However, there will be situations where a Professional Staff member's requests are not acceptable to the hospital. In those cases, it is important for the most appropriate hospital leader to listen to the request, explain why the request is not aligned with the hospital's interests (including for example the impact on patient care, other Professional Staff members and other hospital staff), and discuss possible alternative options or timing. If after receiving the hospital's concerns a Professional Staff member still chooses to make the application for a change in privileges, that application must be considered by the hospital. Unsupported applications for changes to privileges are usually denied. *See Chapter 9 Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

Chapter 7: Everyday Management

Reference Key:

Public Hospitals Act:	Section 33
OHA/OMA Prototype By-law:	Section 3.10

Chapter Summary

- Although Professional Staff members are generally not hospital employees, issues arise in their everyday management that are similar to those occurring with employees, such as: orientation, training, occupational health and safety and leaves of absence.
- Open communication is critical, as it helps to maintain healthy relationships and enhances early identification of any issues related to members of the Professional Staff.
- Hospital Professional Staff "compacts" or statements of mutual expectations may be useful to capture common commitments to patient care.
- Hospitals should consider developing leave of absence policies to manage Professional Staff member absences that fall outside normal vacation and sick days.
- Policies, medical directives and other general information relating to the Professional Staff should be maintained.

Orientation

Similar to employees, Professional Staff require orientation to the hospital upon their initial appointment (or when they return from an extended leave). While they may not receive as comprehensive an orientation program as hospital employees, a basic orientation is important.

As part of the application process, members of the Professional Staff should receive copies of:

- Mission, vision, values and strategic plan of the hospital;
- By-laws;
- Rules and Regulations;
- Listing of policies applicable to the Professional Staff; and
- Health Ethics Guide (where applicable).

New members to the Professional Staff should also receive a copy of (or be provided with instructions for electronic access to) the following (not an exhaustive list):

- Codes of Conduct;
- Computer access, software policies and telecommunications policies;
- Departmental rules and policies;
- Effective referrals;
- Emergency code policies;
- Health records policy;
- Infection control procedures;
- Leave of absence policy;
- Medical directives;
- Occupational health and safety policies;
- Organizational charts;
- Patient rights policies;
- Privacy policy;
- Reductions in on-call coverage
- Resignation and retirement policy;
- Smoke-free policy;
- Workplace harassment and discrimination policy;
- Workplace violence prevention policy; and
- Accessibility policies.[1]

1 The *Accessibility for Ontarians with Disabilities Act* requires public and private sectors to develop standards in the areas of customer service, built environment (buildings and other structures), employment, information and communications, and transportation. Each hospital as a "designated public sector organization" is required to comply with the requirements of the ***Integrated Accessibility Standards Regulation*** which establishes the accessibility standards for information and communications, employment, transportation, the design of public spaces and customer service.

Hospital-Professional Staff Compacts

Hospital-Professional Staff "compacts" (or statements of mutual expectations) are becoming more popular as vehicles to engage Professional Staff members in strategic planning and facilitate on-going communication between hospital management and Professional Staff.[2] These compacts generally communicate mutually agreed upon values, commitments, responsibilities and shared goals between hospitals and their Professional Staff. They may exist outside the hospital's by-laws, Rules and Regulations, Codes of Conduct and policies and procedures, but should be consistent with those documents. Compacts are not intended to be formal legal agreements and so they may or may not be communicated in writing. They are intended to be "living" documents or commitments that develop over time to reflect the changing dynamic of providing care.

Mandatory Training

Each hospital will determine any mandatory training expectations for its Professional Staff. The list of training requirements may or may not mirror the requirements for other clinical staff. The following kinds of training may be appropriate for members of the Professional Staff:

- Privacy
- Computer training
- Charting expectations
- Emergency codes
- Fire training
- Occupational health and safety (including workplace violence and harassment prevention)
- Any policies that relate to training or requirements that will be placed on Professional Staff as a condition of being granted privileges

2 S. Shukla et al. "Physician compact: a tool for enhancing physician satisfaction and improving communication" *Physician Executive Journal of Medical Management*. 2009, 35(1): 46-49.

Infection Control and Screening

Every hospital should clearly state its expectations relating to site-specific infection control, testing and screening requirements for all personnel (regardless of whether they are employees or independent contractors). Such requirements shall include compliance with provincial communicable disease surveillance protocols as mandated through Regulation 965 of the *Public Hospitals Act*.[3]

Regulation 965, section 4(e) of the *Public Hospitals Act* requires that hospitals pass by-laws that "establish and provide for the operation of a health surveillance program including a communicable disease surveillance program in respect of all persons carrying on activities in the hospital."

The Regulation further notes that, "[these by-laws] shall, with respect to a particular communicable disease, include the tests and examinations set out in any applicable communicable disease surveillance protocol published jointly by the Ontario Hospital Association and the Ontario Medical Association for that disease and approved by the Minister.[4] Further information on the Communicable Diseases Surveillance Protocol is available online.[5]

Hospital personnel will also be expected to use Routine Practices[6] at all times, and Personal Protective Equipment when required.

Occupational Health and Safety

Members of the Professional Staff have responsibilities to assist hospitals in meeting their occupational health and safety obligations. These responsibilities should be reinforced in the by-laws, letters of offer and re-appointment, and hospital policies.

3 *Public Hospitals Act,* R.R.O. 1990, Reg. 965, s. 4(e) https://www.ontario.ca/laws/regulation/900965#BK4

4 *Public Hospitals Act,* R.R.O. 1990, Reg. 965, s. 4(2)

5 https://www.oha.com/labour-relations-and-human-resources/health-and-safety/communicable-diseases-surveillance-protocols

6 For further information on Routine Practices, please refer to "Routine Practice and Additional Precautions in Health Care Settings", Provincial Infectious Disease Advisory Committee, Public Health Ontario (Third Revision, 2012): https://www.publichealthontario.ca/-/media/documents/bp-rpap-healthcare-settings.pdf?la=en

Workplace violence and harassment laws apply to all employers in Ontario, including hospitals. Violence and harassment are issues that must be addressed as part of every hospital's overall occupational health and safety program. Hospitals must:

- Have written policies about workplace violence and harassment prevention.
- Have violence and harassment programs that deal with reporting, investigating and dealing with incidents of violence and harassment.
- Conduct risk assessments about workplace violence prevention.
- Inform their Joint Health and Safety Committee or Health and Safety Representative (or where neither exists, the workers) of the results of risk assessments.
- Implement control measures to address the risks identified in risk assessments. The control measures must cover summoning immediate assistance in the event of a violent episode.
- Inform and instruct workers on the violence and harassment policy and program (including the control measures).

Changes to the *Occupational Health and Safety Act* were introduced in part in response to the tragic death in 2005 of an Ontario nurse, Lori Dupont, at the hands of Dr. Marc Daniel, a member of the hospital's Professional Staff. Ms. Dupont had ended a romantic relationship with Dr. Daniel months earlier, but they continued to work in the same hospital. Dr. Daniel had a history of abusive and harassing behaviour, in both his professional and personal life. He received psychiatric and psychological treatment at the hospital during a medical leave. He murdered Ms. Dupont in the operating theatre recovery room of the hospital on a day they were scheduled to work together.

The jury commented that, despite significant documented complaints of serious disruptive behaviour, the hospital was indecisive about how to manage the physician. The inquest jury recommended amendments to the *Public Hospitals Act* and called on hospitals to develop processes to allow for the early identification of and response to disruptive physician behaviour. The jury also underscored that a clinician's right to practice must never be interpreted to supersede patient or staff safety, nor quality of care.[7]

Incapacitated and Incompetent Professional Staff

Under the *Regulated Health Professions Act*, "incapacity" occurs when a regulated health professional "is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practice". "Incompetence" occurs when a regulated health professional's care of a patient displays "a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted."

Managing incapacitated and incompetent Professional Staff raises a host of challenges. Clinical leaders should be familiar with their obligations under the *Regulated Health Professions Act* and *Occupational Health and Safety Act* with respect to managing these issues.

There are important discussions to facilitate among the staff in order to foster a culture that balances patient safety and support for the Professional Staff member.

Hospitals must file a report with the applicable regulatory college if there are reasonable grounds to believe that a Professional Staff member is incompetent or incapacitated.[8] A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a Professional Staff member for reasons of professional misconduct, incompetence or incapacity must file a report

7 See Verdict of Coroner's Jury, Lori Dupont Inquest: https://www.oha.com/Documents/Dupont-Daniel%20Inquest%20-%20Jury%20Recommendations%20-%20Dupont-Daniel%20Inquest%20December%202007%20--Homicide.pdf

8 *Regulated Health Professions Act,* 1991, S.O. 1991, c.18, Schedule 2 Health Professions Procedural Code s. 85.2.

with the Registrar of the individual's college.[9] A report is required even where the Professional Staff offers to resign.

There are additional but similar rules under section 33 of the *Public Hospitals Act* for reporting physicians:

> Where,
>
> (a) the application of a physician for appointment or reappointment to a medical staff of a hospital is rejected by reason of his or her incompetence, negligence or misconduct;
>
> (b) the privileges of a member of a medical staff of a hospital are restricted or cancelled by reason of his or her incompetence, negligence or misconduct;
>
> (c) a physician resigns from a medical staff of a hospital or restricts his or her practice within a hospital and the administrator of the hospital has reasonable grounds to believe that the resignation or restriction, as the case may be, is related to the competence, negligence or conduct of the physician; or
>
> (d) a physician resigns from a medical staff of a hospital or restricts his or her practice within a hospital during the course of, or as a result of, an investigation into his or her competence, negligence or conduct,
>
> the administrator of such hospital shall prepare and forward a detailed report to The College of Physicians and Surgeons of Ontario.

When making a report to a regulatory college, a hospital may balance a number of factors in addressing such issues, including:

- Statutory obligations;
- The desire to have a productive and efficient workforce;
- The desire to have positive work environment;
- Privacy rights Professional Staff members might have;
- Establishing "reasonable grounds" to believe the member is incapacitated or incompetent;
- The member's explanation for their conduct; and
- Addressing any medical problems of the Professional Staff member.

Hospital leadership should be familiar with resources for Professional Staff who have impairment or capacity issues, including the Ontario Medical Association Physician Health Program.[10] Hospitals should also consider the CPSO/OHA Guide to the Management of Disruptive Physician Behaviour (2008), the Health Quality Council of Alberta "Resource Toolkit: Managing Disruptive Behaviour in the Workplace" (2013) and the Canadian Medical Protective Association Discussion Paper, "The role of physician leaders in addressing physician disruptive behaviour in healthcare institutions" (2013) .

Leaves

Since members of the Professional Staff are often independent contractors and not employees, Professional Staff members independently arrange for their colleagues to cover routine absences such as vacation and sick days. However, every hospital should have a policy or protocol to provide guidance for situations beyond those routine absences, including where:

- A member of the Professional Staff desires or requires a leave of absence from duties at the hospital; and
- The hospital will be affected by the leave and is therefore involved in the plans to arrange for suitable clinical and administrative coverage for the member's services.

9 *Regulated Health Professions Act* Code, s. 85.5 and additional obligations to report in such cases to the College of Physicians and Surgeons of Ontario for physicians exist under the *Public Hospitals Act*, s. 33.

10 For the Physician Health Program, call 1-800-851-6606 or visit http://php.oma.org/. For nursing practice support, visit http://www.cno.org/en/learn-about-standards-guidelines/Practice-Support/practice-support-faqs/. For LifeWorks, the midwifery support program, call 1-877-207-8833 or visit www.lifeworks.com. For the Members' Assistance Program for dentists, call 1-800-268-5211 or visit or www.workhealthlife.com.

As a note, in some hospitals, *Locum Tenens* arrangements are used to cover planned vacations so that a leave of absence is not required.

The OHA/OMA Prototype By-law includes a provision for leaves of absence:

3.10 Leave of Absence

(1) Upon request of a Professional Staff member to the relevant Chief of Department, the Chief of Staff may grant a leave of absence of up to 12 months, after receiving the recommendation of the Medical Advisory Committee:

(a) in the event of extended illness or disability of the member, or

(b) in other circumstances acceptable to the Board, upon recommendation of the Chief of Staff.

(2) After returning from a leave of absence granted in accordance with section 3.10(1), the Professional Staff member may be required to produce a medical certificate of fitness from a physician acceptable to the Chief of Staff. The Chief of Staff may impose such conditions on the privileges granted to the member as appropriate.

(3) Following a leave of absence of longer than 12 months, a Professional Staff member shall be required to make a new application for appointment to the Professional Staff in the manner and subject to the criteria set out in this By-law.

It will also be necessary to involve the board if the leave of absence will be accompanied by a restriction or suspension of privileges.

Each hospital may consider having a leave of absence policy for Professional Staff, to include:

- How the member should make a request for leave of absence;
- Who makes decisions about leaves of absence and under what circumstances;
- The criteria to be considered for approving a leave of absence;
- How the decision about the leave of absence will be made and communicated;
- Duties of the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) during a member's leave;
- What will happen if there needs to be an extension or termination of leave;
- How the member can request an extension;
- How the member requests reinstatement;
- The criteria to be considered for reinstatement;
- Who makes decisions about reinstatement;
- How the decision about reinstatement will be made and communicated; and
- What happens if the member does not request reinstatement or an extension of leave, and the leave lapses.

Factors to consider when granting a leave of absence:

- The reason for the request;
- The length of leave requested;
- Whether leaves of absence have been granted in the past to other members in similar circumstances;
- Whether granting the current request for leave will set a precedent, and what this implies;
- Whether the hospital will reasonably be able to arrange for coverage during the leave and whether patient care will be compromised;
- Other information provided by the member and the Chief of Staff/Chair of the MAC (or most appropriate clinical leader); and
- Any other factors deemed appropriate.

Factors to consider at the time of reinstatement after a leave of absence:

- Whether the timing of the reinstatement coincides with what had been planned (e.g., early return may not be possible if contracts have been secured with other clinicians to provide coverage).
- Whether it is safe for the member to return and whether patient care could be compromised.
- Whether the member meets all criteria for re-appointment to the Professional Staff.
- Whether the hospital is able to accommodate any supports, restrictions, or requirements for supervision or monitoring of the member.
- Other information provided by the member and the Chief of Staff/Chair of the MAC (or most appropriate clinical leader).
- Any other factors deemed appropriate.

Documentation

Someone, such as an administrative person who supports the Credentials Committee (administrative assistant to the CEO or a Manager/Director of Professional Affairs, for example), should keep track of certain documentation relating to the Professional Staff in order to be able to chronicle changes over the years. Such information can be important for defending litigation and to demonstrate communication with members of the Professional Staff if they claim they were not advised about new initiatives or policies. Examples include:

- Medical directives (date stamped, indicating when replaced, and by what, and when revoked).
- Announcements of new initiatives, hospital plans, etc.
- Policies relating to the Professional Staff (date stamped, indicating when replaced, and by what, or when revoked).
- Professional Staff By-law.
- Mandatory training lists to confirm who completed training.
- Annual lists of appointments to the Professional Staff.
- Annual Chief of Staff/Chair of the MAC certification of the credentialing process.

For further detail about what should be kept in individual Professional Staff member files, see Chapter 11, Maintaining Credentialing Files.

FAQs

1. What key policies do we need to manage successfully our Professional Staff?

It is up to each hospital to determine its list of priority policies for Professional Staff. Hospitals can look to the following list for guidance:

- Codes of Conduct
- Computer access, software policies and telecommunications policies
- Departmental rules and policies
- Effective referral
- Emergency code policies
- Health records policies
- Infection control procedures
- Leave of absence policies
- Medical directives
- Occupational health and safety policies
- Organizational charts
- Patient rights policies
- Privacy policies
- Reduction in on-call coverage
- Resignation and retirement
- Smoke-free policies
- Workplace harassment and discrimination policies
- Workplace violence prevention policies
- Accessibility policies

2. Must Professional Staff complete mandatory training exercises employees take part in?

A hospital should determine which of its mandatory training requirements apply to its Professional Staff. Anything directly relating to the Professional Staff member's primary obligations (such as with respect to personal devices) or impacting the provision of services on-site, and safety or quality of care issues, should involve the Professional Staff.

3. How do we manage Professional Staff who refuse to comply with provisions under the *Occupational Health and Safety Act* on the basis that they are not employees? (e.g., refusal to wear proper footwear in the operating room)

Hospital occupational health and safety policies should be mandatory for all members of the Professional Staff. Members of the Professional Staff are obliged to comply with the hospital's legal duty to maintain safe premises. Failure to abide by such provisions can result in disciplinary action. *See Chapter 8, Performance Evaluations and Progressive Management.*

4. Do all leaves of absence require a process of approval by the hospital board?

No. Many leaves are managed through *locum* coverage, vacation or other informal arrangements that are not brought to the attention of the board. However, if a hospital proposes to suspend or restrict a Professional Staff member's privileges during the leave of absence, the board must be involved in those decisions.

4. How long can we grant Professional Staff members a leave of absence?

For members of the Medical Staff, because an appointment cannot exceed 12 months, it is generally understood that a leave of absence cannot extend beyond the privileging year (i.e., up to 12 months). Hospitals typically have annual appointment processes for dentists, midwives and extended class nurses also. If this is the case, the same time limitation applies to their leaves of absence where there will be a restriction or suspension of practice.

5. How do we align requests for parental leave for 18 months with a 12-month privileging year?

In late 2017, the provincial and federal governments introduced changes to parental leave entitlements for employees to extend job protection and employment insurance benefits. If a Professional Staff member is an employee, those employment entitlements are automatically available. If a Professional Staff member is an independent contractor, the issue of position protection should be considered as part of practice plans and hospital policies. Hospitals should seek legal advice.

6. Do we have to take a Professional Staff member back after a leave of absence?

Upon return from a leave of absence, the Professional Staff member may be required to produce a certificate of fitness. Legal advice should be sought if the hospital is considering not permitting a Professional Staff member to return from a leave of absence.

In the case of *Re Powell River General Hospital and Dr. Hobson*,[11] a physician took a leave of absence from the staff of the hospital for several months. Upon application for re-appointment, he was refused by the hospital. On appeal to the B.C. Medical Appeal Board, Dr. Hobson was ordered re-appointed with limited privileges (including treating patients for conditions resulting from diseases for which he previously treated them). While it was clear in that case that the community could not support three general surgeons, and there was no demonstrated need or benefit to the hospital in a grant of full privileges, the Medical Appeal Board determined that the community would benefit to the extent he was able to treat his prior patients who required his further services.

11 December 9, 1990, at pp. 4-5.

Chapter 8: Performance Evaluations and Progressive Management

Reference Key:

Public Hospitals Act:	Sections 33-34
OHA/OMA Prototype By-law:	Section 3.7(2)(c), 4.1, 4.2

Chapter Summary

In order to satisfy the hospital's obligations to its patients, the public, and its employees, hospitals have an ongoing responsibility to oversee the work performed by Professional Staff and manage any issues that arise.

- The management of Professional Staff performance includes effective communication, performance evaluations and progressive management. These tasks generally fall to the Chief of Staff/Chair of the Medical Advisory Committee (MAC) or the most appropriate clinical leader, such as the Chief of Department or Head of Division.
- Successful management of the Professional Staff starts with setting clear goals and expectations and is realized through consistent follow-up. Hospital leaders cannot over-communicate with the Professional Staff about the duties, obligations and standard of performance expected of them.
- Performance evaluation is an opportunity to recognize successful practice and to be proactive and to avoid or moderate certain performance issues.
- Progressive management is the process that should evolve from the performance evaluation. It is a systematic process designed to achieve optimal performance in a respectful and professional manner.
- Hospitals can and should take a progressive management approach when responding to issues of a Professional Staff member's competency, conduct or capacity. All management action including disciplinary action should be fair, clear, consistent and progressive (when reasonable).
- Disciplinary action can include verbal and written warnings, apologies, reprimands, suspensions, and restriction or revocation of privileges (or can lead to a decision not to re-appoint a member) as long as appropriate processes are followed. If there have been long-standing legacy issues with a member of the Professional Staff that have not been addressed or managed, it may take longer to realign the member with the hospital's culture and requirements or to sever the relationship.
- With the exception of temporary suspensions in urgent situations, only the board can suspend, restrict or revoke hospital privileges. Chiefs of Department and Heads of Division (or most appropriate clinical leaders) should be careful not to overstep their jurisdiction when disciplining members of the Professional Staff. Depending on the severity and impact of the decision, it could constitute a "change in privileges" giving rise to the member's having a right to a hearing before the board.

Communication

All good management starts with setting and communicating clear goals and expectations.

It is essential that hospitals communicate with their Professional Staff on an ongoing basis about the expected duties, obligations and standards of performance. While initial communication is important, follow-up communication is often what makes the difference in managing difficult situations. Consistency and clarity are essential for effective communication.

Communications to, and expectations from, Professional Staff should be reasonable, as well as equally and consistently applied to all members of the Professional Staff (and as necessary, to members of smaller groups similar to departments and divisions).

Goals and expectations that are specific to a member of the Professional Staff should be documented in the member's first letter of offer, annual performance evaluation, or letter of re-appointment. It helps if there are written role descriptions, lists of core privileges and Codes of Conduct that can be referenced to set and manage expectations.

If there are general rules and expectations for the entire Professional Staff of the hospital/department/division (such as policies, Rules and Regulations, mission, vision and value statements or clinical guidelines), it is helpful for those to be set out in writing and distributed (or made available through a hospital intranet) to all Professional Staff (and shared with all new Professional Staff in orientation packages).

Performance Evaluation

A performance evaluation is an effective, systematic method of communication between a hospital and its Professional Staff. The OHA/OMA Prototype By-law contemplates an annual performance evaluation process for members of the Professional Staff that is tied to the re-appointment process.[1]

In addition to its recommended use in the re-appointment process, the performance evaluation should be used by hospitals for the following purposes:

- Clarifying role requirements and standards.
- Providing feedback to the Professional Staff member regarding their progress toward meeting these standards (including both positive and constructive feedback).
- Guiding future performance by formulating an action-plan.

Those charged with responsibility for conducting the performance evaluation process should be provided with formal training on the proper methods for conducting such evaluations.

In addition to formal performance evaluation processes, members of the Professional Staff need regular and timely feedback about their performance, including reinforcement for positive actions and redirection for negative actions. Much of this feedback will be provided verbally, and should be provided on an ongoing basis, not just annually once the re-appointment processes have been invoked.

As a cautionary note, *pro forma* performance evaluation template letters should not be utilized if there have been problems with a member's conduct, competency or capacity. Such template letters could be used against a hospital in privileges disputes and civil litigation to demonstrate the Professional Staff member's behaviour could not have been problematic because their annual performance evaluations were positive. Annual performance evaluation letters should be customized to address any problematic issues.

Identifying Performance Issues

In addition to the issues identified in the performance appraisal, everyday management of Professional Staff may lead to the identification of matters that require attention on a timely basis, that is, they cannot wait until the annual performance evaluation or re-appointment process.

Every hospital should have a policy about processing complaints and concerns about members of staff (including members of the Professional Staff). There should be a variety of ways in which issues can be detected early and reported to hospital authorities.

Generally speaking, Chiefs of Department (or the most appropriate clinical leaders) (and ultimately the Chief of Staff/Chair of the MAC) have the responsibility to investigate and respond to concerns.

1 See OHA/OMA Prototype By-law s. 3.7. Some hospitals engage in detailed performance evaluations every three years and simple evaluations annually.

Performance issues may come to the hospital's attention through:

- Administrative alerts (such as Health Records alerts when Professional Staff members have not completed their charts)
- Complaints from patients or families or the public
- Complaints from staff, volunteers, or other health care institutions
- Complaints from students or affiliated academic institutions
- Criminal charges or convictions
- Incident reports (including death and critical incidents)
- Internal investigations
- Media/social reports or online reviews
- Peer reports
- Performance measures
- Performance reviews/observations by supervisor
- Reports from regulatory colleges
- Self-reports
- Utilization reports

Examples of some categories and situations giving rise to the need for progressive management include (this is not an exhaustive list):

- **Assault/Harassment/Sexual Harassment:** abusing patients, staff or others verbally, physically or sexually; harassment; engaging in inappropriate relationships.
- **Attendance** – failing to:
  - attend to patient care needs because of absence;
  - provide on-call coverage;
  - attend mandatory meetings;
  - secure coverage for absences;
  - meet with the Chief of Department or Head or other clinical leaders on reasonable request; or,
  - arrive on time for patient care appointments or administrative meetings.
- **Behaviour:** engaging in rude, disruptive or insubordinate behaviour.
- **Fitness to Practice:** practicing while impaired.
- **Health Records:** failing to keep appropriate records, offensive content, insufficient documentation, incorrect content, making illegible records, falsifying records, and/or failing to sign off on charts.
- **Misrepresentations:** misrepresenting information in the course of patient care or administrative or other duties, including on applications for appointment or re-appointment.
- **Patient Safety and Patient Rights:** action or inaction giving rise to concern for the safety or well-being of a patient; failing to respect patient rights.
- **Privacy:** breach of privacy including, for example, inappropriate collection, use or disclosure of information or loss or destruction of records, failing to assist the hospital with privacy complaints, inappropriate storage of records, use of unauthorized technology, inappropriate activity in shared electronic information systems with other health care organizations or national/provincial/regional databases.
- **Professional Practice:** providing sub-standard practice, refusing to perform necessary services, providing inappropriate care or advice, failing to register patients, influencing patients to take certain action or inaction for personal gain.
- **Public Safety:** action or inaction giving rise to concerns for the safety of the public or specific persons.
- **Research, Academic or Teaching Misconduct:** failing to abide by accepted research and academic practices, or to provide appropriate teaching or support to medical residents and students.
- **Rules:** failing to abide by the policies and procedures of the hospital or department or division specific rules.

Investigations

Regardless of how an issue of concern comes to the hospital's attention, it may be necessary to conduct an investigation in order to verify the allegations. There may be statutory obligations to investigate (for example, in the case of allegations of violence, harassment or safety). The exact nature and scope of the investigation will depend on the type or character of the alleged concerns. An investigation might take minutes to complete and involve asking a few questions and identifying solutions. However, there may be complicated situations that take weeks to complete and require external investigators, interviews, document review, research and formal reports.

A meeting or interview with the Professional Staff member is almost always warranted in an investigation. Even when there is overwhelming evidence against someone, it is still essential to interview them so they have an opportunity to provide an explanation.

When conducting an investigation into a member's conduct, competency or capacity, a hospital should:

- Decide the purpose for and goals of the investigation.
- Scale the investigation to the nature and severity of the situation.
- Determine who will receive the report and whether it will be confidential.
- Determine whether the report will be directed to legal counsel to establish privilege.
- Select the investigator(s) (who should be impartial).
- Determine the scope of the investigation including timelines, methodology, and clear and specific terms of reference for the investigator(s), with input from the Professional Staff member.
- Ensure the Professional Staff member has an opportunity to respond to the allegations or concerns raised.

A Progressive Management Approach

With the exception of egregious situations, incidents, or behaviour, problems involving Professional Staff should be dealt with using a "progressive management" approach. The essential elements of that approach are:

1. **Clear Goals and Expectations:** Professional Staff should be given a clear set of goals and expectations.
2. **Regular and Timely Feedback:** Professional Staff need regular and timely feedback about their performance. If an incident occurs, feedback should be provided to the member of the Professional Staff as soon as possible after the incident.
3. **Formal Feedback and Documentation:** While it may be appropriate in the initial stage of dealing with a minor issue to have an informal discussion, "chat over coffee" or "hallway conversation" with the member of the Professional Staff to clarify the expectations, the formality of the feedback and documentation should increase depending on the severity of the situation and over time. Consider the following continuum of progressive formality:

Continuum of Progressive Disciplinary Actions

Informal verbal conversation only.	Informal verbal conversation with a note to file.	Official meeting with Chief of Department (or most appropriate clinical leader) with a confirmation letter to member and letter to file.	Official meeting involving the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) with a confirmation letter to member and copy of letter to central Professional Staff file.	Investigation by Chief of Staff/Chair of the MAC (or most appropriate clinical leader) with written record in the central Professional Staff file (or, in smaller hospitals, involving an external peer review to conduct an investigation).	Meeting with the MAC and/or hearing before the board.

Hospitals are reminded that all notes, emails, texts, letters and other documents can become a matter of public record in Professional Staff privileging cases, coroners' investigations, privacy investigations and other legal proceedings.

If the hospital leadership does not document its concerns, as well as document that the Professional Staff member was informed of the issues and given an opportunity and the means to improve, many internal and external adjudicators will consider that the incident or issues did not happen or that there was a procedural defect in the management of the situation. This can often lead to the dismissal of the allegations. It is very difficult to respond to allegations that a member of the Professional Staff "has had issues for years", if there is no written evidence to support such allegations. If there is no documentation, hospital leadership may have to start afresh and respond to the allegations occurring within the last year of appointment. Any form of documentation can be helpful, including email messages and hand-written notes to file. It is good practice to date notes to file and confirmation letters to the member, and to record the dates of conversations.

4. **Opportunities to Succeed (not set up to fail):** If there is an issue with a member of the Professional Staff, the member should be given the opportunity and means to improve. That might include clarifying short- and long-term goals and expectations in writing, coaching or mentoring the member, providing an encouraging work environment, assisting the member to re-integrate into a team environment, or suggesting extra training, remedial training or supervision. Rules should be applied equally throughout a Department; leaders should avoid targeting only certain Professional Staff for compliance. Chiefs of Department (or most appropriate clinical leaders) may themselves become the subject of scrutiny if it can be shown that they did nothing to assist a struggling member of the Professional Staff to improve, or if they in fact set up an environment where the member would certainly fail. Similarly, not sufficiently supporting a struggling member may also jeopardize the acceptability of the progressive management action.

5. **Progressive and Proportional Response:** Depending on the situation, Chiefs of Department (or most appropriate clinical leaders) may eventually, or urgently, need to take disciplinary action. The response should be proportional to the issues and the history with the Professional Staff member. Consider the following continuum of progressive disciplinary action options (not an exhaustive list – and these options may be considered alone or in combination):

    - Verbal recommendation
    - Verbal warning (with deadlines for improvement with note to Department file
    - Written warning (with deadlines for improvement)
    - Written warning (with deadlines for improvement) with copy to Chief of Staff/Chair of the MAC (or most appropriate clinical leader) and copy to central Professional Staff file
    - Verbal apology
    - Written apology
    - Reprimand
    - External peer review
    - Mandatory training/education
    - Increased supervision
    - Recommendation to the Chief of Staff/Chair of the MAC (or most appropriate clinical leader)/CEO for temporary suspension*
    - Recommendation to the Chief of Staff/Chair of the MAC (or most appropriate clinical leader)/MAC for permanent or temporary reduction or change in duties or assignments*
    - Recommendation to the Chief of Staff/Chair of the MAC (or most appropriate clinical leader)/MAC for revocation of privileges or change in category of privileges*

**Note: A Chief of a Department (or other clinical leader) may not unilaterally exercise these options as they give rise to the member of the Professional Staff's right to a hearing before the board.*

6. **Professional Staff Member Given Due Process:** Demonstrating that the process by which a member of the Professional Staff is disciplined may be just as important as being able to demonstrate that an issue occurred. As a general rule the more serious the issue or the more serious the proposed disciplinary action, the more procedural rights should be given to the member of the Professional Staff. Chiefs of Department (or most appropriate clinical leaders) should seek advice from the Chief of Staff/Chair of the MAC (or other senior clinical leader) or legal counsel if unsure as to the process that must be followed in a particular disciplinary case. The following is a short list of the progressive bundle of rights that Professional Staff may be entitled to exercise depending on the severity of the situation and the proposed disciplinary response:[2]

   - Right to know what rules apply to them.
   - Right to know the case and allegations against them.
   - Right to know the identity of the person making allegations, and the content of those allegations.
   - Right to try to remediate or improve their actions.
   - Right to know (and sometimes choose, or at least comment on) the process by which they will be judged (or the rules that apply to the review of the situation before a decision is made).
   - Right to make a response (verbally or in writing).
   - Right to have a lawyer represent them.
   - Right to a hearing before an "impartial" decision-maker.
   - Right to have input in the selection of investigator or decision-maker.
   - Right to a decision.
   - Right to have written reasons for the decision.

2 As a reminder, the Public Hospitals Act sets out specific rights of members of the Medical Staff in the context of a refusal to re-appoint or a suspension, restriction or revocation of privileges. The hospital by-laws and the Professional Staff Rules and Regulations may also set out specific rights.

A similar model that has received a great deal of attention in the medical community is the "Disruptive Behaviour Pyramid" by Gerald Hickson and his colleagues.[3] Their "staged approach" to managing behaviour begins with informal feedback and providing various opportunities for improvement prior to disciplinary action. The "cup of coffee" approach (advising the individual about issues in a casual setting, such as over a cup of coffee) is intended to manage behavioural issues before they become risk management and legal issues. The model focuses on creating awareness, as some individuals are simply unaware that their behaviour is not the norm, or that certain behaviours detract from a culture of safety. The approach also allows for human error, as it is only when a pattern persists that authoritative intervention is required. The model serves as a reminder that the majority of Professional Staff do not pose any behavioural issues.

Helpful guidance material has been developed in response to the growing body of literature that raised concerns about the behaviour of health care professionals and the impact of behaviour on patient outcomes. For example, recent guidance material has been released from the Health Quality Council of Alberta, "Resource Toolkit: Managing Disruptive Behaviour in the Workplace" (2013)[4] and the Canadian Medical Protective Association Discussion Paper, "The role of physician leaders in addressing the physician disruptive behaviour in healthcare institutions" (2013)[5]

Immediate, Mid-Term Action

If there is an egregious incident (usually having to do with safety or significant risk management issues), immediate disciplinary action may be warranted.

Section 34 of the *Public Hospitals Act* sets out requirements for a Chief of Department, or Chief of Staff/Chair of the MAC or President of the Medical Staff (depending on the structure of the hospital) to intervene in situations where

3 G. Hickson et al, "Disruptive Behaviour Pyramid" Acad Med, Nov. 2007

4 March 2013 https://hqca.ca/health-care-provider-resources/frameworks/managing-disruptive-behavior-in-the-healthcare-workplace-provincial-framework/

5 2013 https://www.cmpa-acpm.ca/static-assets/pdf/about/annual-meeting/13_Disruptive_Behaviour_booklet-e.pdf

there are serious concerns about the diagnosis, care or treatment of a patient. That officer of the Medical Staff (or delegate) is required to:

- Discuss the issue with the attending physician.
- If changes in diagnosis, care or treatment satisfactory to the officer are not made, they are required to:
  - Assume the patient care responsibilities for that patient (investigating, diagnosing, prescribing for and treating the patient).
  - Notify the attending physician and the patient (if possible) that the attending physician is no longer providing care.
  - Inform two members of the MAC within 24 hours of the assumption of patient care and file a written report to the MAC within 48 hours.
  - If the MAC agrees with the opinion of the officer that the action was necessary, the MAC is required to file a detailed written report to the CEO and the board.

Sections 4.1 to 4.5 of the OHA/OMA Prototype By-law provides an example of how hospitals can implement the section 34 requirements (and extend the requirements to apply to the members of the Dental, Midwifery and Extended Class Nursing Staff). Those sections of the OHA/OMA Prototype By-law also provide an example of how a hospital can require all members of the Professional Staff to be on alert for and report situations of serious patient safety issues (for example, belief that another member is incompetent or attempting to exceed their privileges, or acting in a manner that could cause harm or injury).

All serious concerns about incompetence, misconduct, or negligence should be reported to the CEO and the Chief of Staff/Chair of the MAC (or most appropriate clinical leader as indicated in the by-laws) immediately with any evidence to support such claims as such concerns may require a report to a regulatory college and may warrant temporary suspension or restriction of the member's privileges.

See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.

FAQs

1. Can we selectively enforce a policy against only certain Professional Staff members?

No. One of the key principles in managing Professional Staff in hospitals is the consistent application of rules and policies. Hospital MACs and boards may be criticized (and actions taken against the Professional Staff member overturned) if it becomes clear that certain members of the Professional Staff were singled out.

2. At what stage of disciplinary action do we have to report a member of our Professional Staff to their regulatory college?

Legal advice should be sought when considering making a mandatory report to a regulatory college. However, the following is clear, the administrator of the hospital should create a report as soon as possible:

- where an application for appointment or reappointment is rejected by reason of incompetence, negligence or misconduct;
- after a board has suspended, restricted or revoked a member's privileges;
- after a CEO, Chief of Staff/Chair of the MAC or Chief of Department has temporarily suspended a member's privileges;
- if the MAC has issued a finding against the member of incompetence, negligence, incapacity or misconduct;
- if the member resigns or retires related to their competence, negligence or conduct;
- if the member voluntarily resigns or restricts their practice during an investigation into their practice or behaviour;
- if there are allegations of sexual abuse (unless there is reason to believe the allegations are frivolous or vexatious).

For a description of reports to regulatory colleges, see Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.

3. How should the hospital respond if a complaint is about the CEO, or Chief of Staff/Chair of the MAC in their capacity as a member or Professional Staff?

Such reports should be directed to the CEO or Chair of the board, as appropriate, who will determine the course of action. Legal advice should be sought when considering what steps to take. Hospitals should consider engaging an external consultant to conduct an investigation to ensure objectivity.

4. This chapter and Chapter 9 explain that privileges can be restricted, suspended and revoked. What is the difference?

"Restriction" means any negative modification, reduction, reassignment, or change to a Professional Staff member's privileges.

"Suspension" means the temporary revocation of some or all of one's privileges. A suspension may be immediate or non-immediate.

"Revocation" means the withdrawal or cancellation of some or all of one's privileges after they have been granted. A revocation of privileges is the most serious of these actions.

Chapter 9: Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges

Reference Key:

Public Hospitals Act:	Sections 33, 36, 39, 41-44; Regulation 965 Section 18(3)
OHA/OMA Prototype By-law:	Sections 3.1(3), 4.1, 4.2

Chapter Summary

- Hospitals have an obligation to provide safe and effective care to their patients and create safe working environments for their staff. These are the primary obligations of hospitals and supersede any Professional Staff member's right to practice. A hospital's failure to take action to suspend, restrict or revoke privileges in cases of incompetence, incapacity or misconduct can leave hospitals exposed to civil litigation.
- When the Medical Advisory Committee (MAC) recommends that a physician not be appointed or re-appointed to the Medical Staff, or that a physician's privileges be suspended, restricted, revoked or otherwise changed, the *Public Hospitals Act* and the hospital by-laws set out a process whereby the physician is entitled to a formal hearing at their request before the hospital board (it would be considered best practice to extend these rights to apply to Dentists, Midwives or Extended Class Nursing Staff through inclusion in the hospital's by-laws).
- Only the board can decide not to appoint, re-appoint, suspend, restrict or revoke the privileges (except when the hospital by-laws allow the CEO or Chief of Staff/ Chair of the MAC to instigate initially urgent, time-limited suspensions).
- Chiefs of Department (or most appropriate clinical leaders) cannot simply "terminate" a member from the Professional Staff with notice or pay in lieu of notice. A much more complex process must be followed.
- These decisions have significant financial, reputational and emotional impact on Professional Staff members. If clinicians are refused appointment or re-appointment or have their privileges suspended, restricted or revoked, there is an immediate impact on their practice. They may also be obliged to alert all future hospitals, because some hospital by-laws require disclosure in the application form of any loss of privileges or failure to obtain privileges at other hospitals.
- In most situations, there will be a duty for a hospital to report to a regulatory college if the hospital refuses, suspends, restricts or revokes privileges (under either the *Public Hospitals Act* or the *Regulated Health Professions Act*).

Legal Context

As described in Chapter 2, Legal Context, the *Public Hospitals Act* sets out a comprehensive scheme to allow physicians to challenge hospital decisions that negatively impact their practices. However, it is best practice to extend these procedural rights to dentists, midwives and extended class nurses through the hospital by-laws.

While no one has a right to be granted or keep hospital privileges[1], hospitals are responsible for following the *Public Hospitals Act*, Regulation 965, and their own by-laws when processing applications for appointment, re-appointment and changes to privileges or when considering suspensions, restrictions or revocation of privileges.

These decisions can be organized into two categories:

- **Applications for Appointment/Re-appointment:** Refusals of initial appointments, re-appointments or changes to privileges (a board decision is made after the appropriate application is received).
- **Mid-term Action:** Suspensions, restrictions or revocations of privileges between annual re-appointments (this typically occurs when an urgent response is necessary such as for reasons of safety).

1 In the 2010 Rosenhek decision, Justice Greer stated, "No physician has a right to hospital privileges. Patient safety and quality of care are the paramount concerns when making a decision with respect to physician privileges." *Rosenhek v. Windsor Regional Hospital,* 2010 ONSC 3583, [2010], O.J. 2893 (Sup. Ct) at 33.

These decisions have a direct impact on a clinician's current and future livelihood. Therefore, they are sensitive to manage and require hospital management to have at least a basic understanding of the legal context and rights afforded to the clinician. Hospitals require legal advice in these circumstances.

For additional information, see Chapter 2, Legal Context.

Impact on the Individual

Decisions impacting privileges have significant financial, reputational and emotional impact on clinicians. Refusal of an appointment or re-appointment or the suspension, restriction or revocation of privileges would have an immediate, personal impact on a clinician. They may also be required to notify the regulatory college under the *Public Hospitals Act* or *Regulated Health Professions Act*. And, as some hospital by-laws require any loss of privileges or failure to obtain privileges at other hospitals to be disclosed on application or re-application, the clinician may also have to alert future hospitals about the privileges decision.[2]

The timing of board decisions can also have a significant impact on the clinician. When a Professional Staff member has applied for re-appointment, the *Public Hospitals Act* requires that the Professional Staff member's privileges continue intact:

a. Until the re-appointment is granted, or

b. Where they are served with notice that the board refuses to grant the re-appointment, until the time for giving notice requiring a hearing before Health Professions Appeals and Review Board (HPARB) has expired; and, where a hearing is required, until the decision of HPARB has become final.[3]

However, a physician who appeals a mid-term suspension or revocation to HPARB may not be permitted to practice while awaiting the outcome of the HPARB hearing or of any subsequent appeals. Mid-term suspensions should not be entered into lightly given the significant impact on the Professional Staff member. For example, midwives are required to provide continuity of care for their patients (that is, prenatal, intrapartum and postpartum care) over several months and a mid-term suspension may significantly interrupt that care model.

ROSENHEK DAMAGES AWARD

Hospitals must understand that there can be serious consequences to bad faith action by hospital leadership and boards. The leading case is *Rosenhek v. Windsor Regional Hospital*[4], where Mr. Justice Joseph G. Quinn stated the following:

> "I find there was bad faith on the part of the Board of Governors in terminating the privileges of Dr. Rosenhek for a very minor problem and for which Dr. Rosenhek may have been only partially responsible ... The lack of good faith is based on the manner in which [the board] hearing was conducted and the reason for revocation of privileges.
>
> "I find [the hospital's] predominant purpose in revoking [Dr. Rosenhek] privileges was to resolve a perceived problem among the specialists ... It is also clear that [the hospital's] decision to revoke [Dr. Rosenhek's] privileges was not in accordance with the *Public Hospitals Act*. The recommendations of the Medical Advisory Board were never given to [Dr. Rosenhek] as required by s. 37(6). [Dr. Rosenhek] was never given notice of the hearing as required by s. 37(7). I find that [the hospital's] act, in revoking [Dr. Rosenhek's] privileges, was unlawful ... [Dr. Rosenhek], I find, has suffered an economic loss as a result of the revocation ... I find that [Dr. Rosenhek's] is entitled to damages from [the hospital] on the basis of the tort of intentional interference with economic relations ...
>
> "In conclusion, I would allow [Dr. Rosenhek's] claim in the amount of $3,000,000 plus prejudgment interest."

2 Please note, such a report about being refused privileges is not a requirement under the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law).

3 *Public Hospitals Act*, s. 39(3) as it applies to physician privileges.

4 Ibid. (Note that this hospital board's subsequent decision in 2009 to revoke Dr. Rosenhek's privileges was upheld by HPARB (HPARB October 2009).)

Does a Hospital Have the Authority to Make Changes to Privileges without Giving Rise to a Suspension, Restriction or Revocation of Privileges?

To ensure effective management and operations, a hospital – through its Chief of Staff/Chair of the MAC, Chiefs of Department, Heads of Division and other clinical leadership – has reasonable latitude to assign or re-assign Professional Staff duties, resources, and supports without triggering a change in privileges and the legal rights to a board hearing.[5] However, a hospital must be mindful that at some point – depending on the nature and magnitude – changes made by the hospital could be seen by the member (and just as importantly by HPARB or a court) to result in a substantial alteration of privileges (or suspension, restriction or revocation of the Professional Staff member's privileges), even if there is no change in the category of privileges the member enjoys.

Hospitals should exercise extra caution, if they propose to temporarily or permanently restrict or change a member's duties, resources or supports substantially, thereby negatively altering the member's:

- Income;
- Ability to engage in the type of practice they have enjoyed at the hospital (for example, a surgeon may require access to the operating room (OR) to conduct surgery);
- Access to the use of residents or students;
- Access to research subjects;
- Opportunities for referrals; or
- Reputation.

This is an especially important message to convey to Chiefs of Department and Heads of Division and other clinical leadership so that they do not unilaterally change or revoke a member's duties, resources and supports in ways that substantially alter their privileges and inadvertently trigger the *Public Hospitals Act* legal process.

Chiefs of Department should also remember that any comprehensive changes within a Department need to be fair and reasonably allocated amongst the Professional Staff members (e.g., if a new surgeon requires a block of OR time, the OR time of the other Department members should be impacted proportionately).

Reasons to Refuse an Application or to Suspend, Restrict or Revoke Privileges

The following are examples of situations that could result in refusals of applications for appointment or re-appointment, or mid-term suspensions, restrictions or revocations of privileges:

- The individual does not have or fails to maintain the qualifications for appointment, re-appointment or change in privileges as set out in the hospital's by-laws.[6]
- The appointment is not (or re-appointment is no longer) consistent with the need for service.
- The Professional Staff Human Resources Plans or impact analyses do not demonstrate sufficient resources to accommodate the applicant.
- The appointment is not consistent with the strategic plan and mission of the hospital.
- There are concerns about the individual's competence, capacity or conduct.
- Issues have been identified relating to safety, quality of care, legal compliance or effective operations of the hospital, as evidenced by letters of reference,

5 See for example, *Prairie North Regional Health Authority v. Kutzner*, 325 D.L.R. (4th) 401, 2010 SKCA 132 where the Saskatchewan Court of Appeal concluded that the hospital had the authority to change operating room schedules without giving an affected physician a right to appeal. See also *Davidson v Sunnybrook Health Sciences Centre*, 2012 CanLII 35969 (ON HPARB) and *Abramson v Medical Advisory Committee (North York General Hospital)*, 2011 CanLII 93929 (ON HPARB).

6 See OHA/OMA Prototype By-law, ss. 4.3(8) and 4.8(1). See *Waddell v Weeneebayko Area Health Authority*, 2018 CanLII 39843 (ON HPARB), aff'd 2019 ONSC 7375 (Div Ct).

performance reviews, complaints, incident reports, self-reports, administrative alerts, regulatory college reports, etc.

- There are concerns about the individual's malpractice history or civil/criminal/regulatory claims history.

The reason for refusing appointments and reappointments may differ from the reasons to suspend, restrict or revoke privileges. These reasons are often set out in the hospital by-laws,[7] Rules and Regulations, Code of Conduct policies, or perhaps in written contracts with the Professional Staff.

A hospital should always maintain a transparent process for reaching its decisions, clearly outlining the reasons for its decisions (e.g., changes in privileges), whether these are budgetary, changes in clinical service direction, or issues with individual Professional Staff members.

REASONS TO REFUSE APPOINTMENT OR RE-APPOINTMENT OR TO SUSPEND, RESTRICT OR REVOKE PRIVILEGES

- No position available
- Not qualified
- Concerns raised in letters of reference (for initial appointment)
- Concerns about malpractice history or civil actions/criminal record/regulatory claims
- Concerns about competence, capacity or conduct
- Incomplete application
- Lack of resources
- Performance review concerns
- Suspended/revoked license to practice
- Suspended or terminated professional liability protection coverage (insurance)
- Change in strategic direction
- Closing service or hospital[8]
- Failure to follow hospital policy
- Failure to complete occupational health and safety requirements or mandatory training

Teamwork, Culture and Dissenting Voices

A culture of patient safety requires that everyone who works in a hospital be free and willing to raise their issues of concern. Professional Staff members should be encouraged to advocate for patients and to speak up about quality, collegiality, safety, excessive workloads, and poor equipment. The Canadian Medical Protective Association has stated its concerns about efforts by hospitals to restrict healthcare providers from responsibly fulfilling the role of advocate:

> In addition to posing a significant risk to patient safety, such restrictions are contrary to the lessons learned and the improvements adopted in safety-driven industries (such as the nuclear or airline sectors) where employees are encouraged to speak out to identify and correct unsafe practices. In the interests of patient care, … hospitals should be encouraging – not discouraging – reasonably voiced perspectives, even if these views are contrary to their own. For their part, physicians have a responsibility to provide an informed perspective, in a professional and reasonable manner that offers constructive recommendations for improvement. In those instances when … hospitals believe the advocacy efforts are not appropriate, a process based on procedural fairness and the fundamentals of natural justice should be employed to deal with such concerns. The requirement for such a process is universal and should be equally applicable regardless of a physician's practice relationship with the institution (e.g. privileges, employment, contract, etc.).[9]

These conversations can be uncomfortable but are vital to safety.

There are limits to appropriate advocacy specifically where a Professional Staff member crosses over the line of responsible or respectful engagement. Privileges disputes case law is clear that where a Professional Staff member contributes to a toxic work environment, that activity negatively impacts on patient safety and care

7 See OHA/OMA Prototype By-law ss. 4.3(8) for refusing privileges, and s. 5.2, for suspending, restricting or revoking privileges.

8 *Public Hospitals Act*, s. 44.

9 CMPA, Changing Physician-Hospital Relationships, p. 6 https://www.cmpa-acpm.ca/static-assets/pdf/research-and-policy/public-policy/com_2011_changing_physician-e.pdf

and may justify denial of re-appointment or suspensions, restrictions or revocation of privileges. For example, in the *Pierro v. The Hospital for Sick Children*[10] , where the Court stated that disruption and conflict amongst a hospital's employees can only adversely affect the care of patients, and that a hospital is "obliged to ensure that its employees can work together in the most harmonious environment possible."

Where there are serious disruptions to a team environment, such behaviour may justify serious action. In *Gupta v. William Osler Health System*[11], the court stated that a hospital board has a variety of factors to consider when revoking hospital privileges:

> It is clear that the Court in Rosenhek was not suggesting that the only public-interest factor to be considered related to the quality of care provided by the hospital. I appreciate, as stated by this Court in Soremekun at para. 16, that ensuring patient safety in the provision of hospital services is a main purpose of the Act and it was the one factor singled out in the Rosenhek case. However, the Court there referred to "various public-interest factors" (emphasis added). As the Appeal Board held, there must be a balance of several disparate interests, including the Respondent's right to expect that its professional staff will follow its policies and their responsibilities. As the Respondent argues, public interest must include maintaining public confidence in public institutions, and egregious misconduct by people working in those institutions, particularly physicians, attacks this public confidence. Furthermore, as the Appeal Board noted, [the nurse] has a right to a safe working environment, free from harassment and threats of violence. This is not a matter of punishing the Appellant, or applying private law concepts, as the Appellant suggests, but rather furthering the various public objectives of the Act.

10 *Pierro v. The Hospital for Sick Children*, [2016] ONSC 2987

11 *Gupta v William Osler Health System*, 2017 ONSC 1294 (Div Ct).

Chief of Department Makes Initial Recommendations

As a reminder, except if the hospital by-laws permit, when there is a need for immediate action, a Chief of Department cannot unilaterally suspend or revoke someone's privileges. The term Chief of Department will be used in this section, but it is acknowledged this role may be played by another clinical leader.

If there are issues with a candidate for initial appointment or with a member of the Professional Staff, the Chief of Department will likely be the first person to address those issues. *See Chapter 5, Initial Appointment; Chapter 6, Re-appointments and Changes to Privileges; and Chapter 8, Performance Evaluations and Progressive Management.*

If the Chief of Department wishes to initiate proceedings to refuse, suspend, restrict, or revoke privileges for any reason, **prior** to taking any steps to reduce or limit the clinician's practice, they should:

1. Advise the Chief of Staff/Chair of the MAC of all the relevant information as soon as possible, including:
   - A summary of the actual or potential issues.
   - A copy of any documentation of how the issues have been raised and addressed with the Professional Staff member (including copies of any annual performance reviews or letters of reference, if applicable).
   - A summary of the action the Chief proposes the hospital take (whether the Chief recommends refusal, suspension, restriction or revocation of privileges).
2. Notify the Chief of Staff/Chair of the MAC if there are extenuating circumstances that must be considered or addressed (such as health issues affecting the Professional Staff member's performance, keeping in mind that such information must be carefully protected).
3. Consider and advise the Chief of Staff/Chair of the MAC whether the concerns are serious enough to propose immediate suspension (if so, see Mid-Term Action Process below).

Informal Resolutions and Collection of Information

Informal resolutions can often be achieved before initiating formal proceedings. Often, the Chief of Staff/Chair of the MAC (or the CEO, VP Medical or some other senior leader) can become involved as an objective third-party before the matter goes to the Credentials Committee (for applications for appointment, re-appointment or changes to privileges) or to the MAC (for possible mid-term suspensions, restrictions or revocations of privileges). The Chief of Staff/Chair of the MAC may assist in discussing options and resolutions and potentially mediate between the Chief of Department and the applicant/member of the Professional Staff. There may be external resources that can be utilized to find solutions (such as the Ontario Medical Association's Physician Health Program). The Chief of Staff/Chair of the MAC may decide to initiate an investigation or gather further information. *See Chapter 8, Performance Evaluations, and Progressive Management.* The Chief of Staff/Chair of the MAC should also consult with legal counsel.

Formal MAC Process

If informal efforts do not resolve the issues, then the formal MAC and board processes must be engaged if the hospital proposes to refuse an application for appointment, re-appointment or changes to privileges or proposes to suspend, restrict or revoke privileges. There are slightly different processes depending on whether the issue relates to the processing of an application for initial appointment, re-appointment, or changes to privileges, or involves mid-term action for suspension, restriction or revocation of privileges.

Initial Appointment, Re-appointment and Changes of Privileges

Chapters 5 and 6 dealt with initial appointments and re-appointments to the Professional Staff. In those chapters, it was explained how applications are reviewed by the Credentials Committee and then forwarded to the MAC.

If there are problems with one or more applications, the MAC may choose to have a separate meeting to investigate thoroughly the concerns. In some cases, it may be appropriate for the MAC to invite the applicant to the MAC meeting to provide their side of the story. While a meeting before the MAC is not required by the *Public Hospitals Act*, some by-laws contemplate giving the member an opportunity to respond to the issues or allegations against their application.[12] This can be a useful part of this process that can lead to early resolution of issues and avoid the time, cost and emotional upheaval resulting from a privileges hearing before the board. Depending on the circumstances, a separate MAC meeting can be very informal (with short questions and answers) or more like a legal proceeding.

When the MAC makes its decision (to either recommend or not recommend the applicant to the board for appointment or re-appointment or a change to privileges), it must notify both the applicant and the hospital board in writing of its decision. Sections 37(6) and (7) of the *Public Hospitals Act* require that a physician applicant be notified that they are entitled to:

- Written reasons for the recommendation if a request is received by the MAC within seven days of the receipt by the applicant of a notice of the recommendation.
- A hearing before the board if a written request is received by the board and the MAC within seven days of the applicant receiving the written reasons.

This notification can also apply to other members of the Professional Staff if the same process is extended to them in the hospital by-laws.

When informal processes have not resolved outstanding issues with an application, especially when the MAC does not support the application, applicants are likely to request a board hearing.

12 The OHA/OMA Prototype By-law does not contemplate a MAC meeting where an application for appointment, re-appointment or change to privileges is not being recommended for the MAC's approval, given that such a meeting is not a legal requirement. Such processes can also be set out in hospital policy.

Mid-Term Action

In Chapter 8, performance reviews and progressive management were discussed. If the informal resolutions above are exhausted, and the hospital wishes to pursue a suspension, restriction or revocation, someone who has been involved in the matter (either the Chief of Department, Chief of Staff/Chair of the MAC, CEO or VP Medical) should formally notify the MAC in writing of their concerns and supply the MAC with all relevant documentation.

The grounds for immediate mid-term action and non-immediate mid-term action are different. In an instance of immediate mid-term action, the member of the Professional Staff ceases to practice at the hospital *immediately* (cannot treat patients or earn an income). The grounds for immediate action are often limited to the most emergent situations, where the conduct, performance or competence of a member "exposes or is reasonably likely to expose any patient, health care provider, employee or any other person at the Hospital to harm or injury," or "is or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the hospital."[13] Whereas in an instance of non-immediate action, the member of the Professional Staff continues to practice in the hospital while the matter is referred to the MAC for recommendations. *Also, see the section on Temporary Suspension later in this chapter.*

For any serious allegations against a member of the Professional Staff, the MAC may choose to have a separate meeting to investigate thoroughly the concerns. In those cases, it is likely appropriate for the MAC to invite the member of the Professional Staff to the MAC meeting. While a meeting before the MAC is not required by the *Public Hospitals Act*, some by-laws[14] contemplate giving the member an opportunity to respond to the allegations (especially if there are allegations of professional misconduct, negligence or incompetence that can give rise to a duty to report to the member's regulatory college). Again, this can be a useful part of the process that can lead to early resolution of issues and avoid the time, cost and emotional upheaval resulting from a privileges hearing before the board. Depending on the circumstances, a separate MAC meeting can be very informal (with short questions and answers) or more like a legal proceeding.

MAC Privileges Meetings

In either case (whether for refusal of an application or for mid-term action), if a separate MAC meeting is held, the MAC may meet as a whole committee or strike a panel of the Executive Committee of the MAC (if one exists) to preside over the meeting.[15] Only MAC members with the right to vote on issues related to appointments, credentialing, re-appointments and disciplining shall preside at such a meeting of the MAC. Specifically, the *Public Hospitals Act*, Regulation 965, allows only physicians to be voting members of the MAC. While many hospitals have created a more multi-disciplinary MAC to reflect the reality of the Professional Staff mix within the hospital, any Professional Staff member on the MAC who is not a physician cannot have voting rights. This is particularly critical during privileges disputes, where every decision and action taken throughout the process may be subject to the later scrutiny of HPARB or the courts. If there is a MAC panel, the membership must be acceptable to the applicant/Professional Staff member, although the applicant/Professional Staff member must have valid reasons for objecting to any particular member (i.e., an actual or perceived conflict of interest).

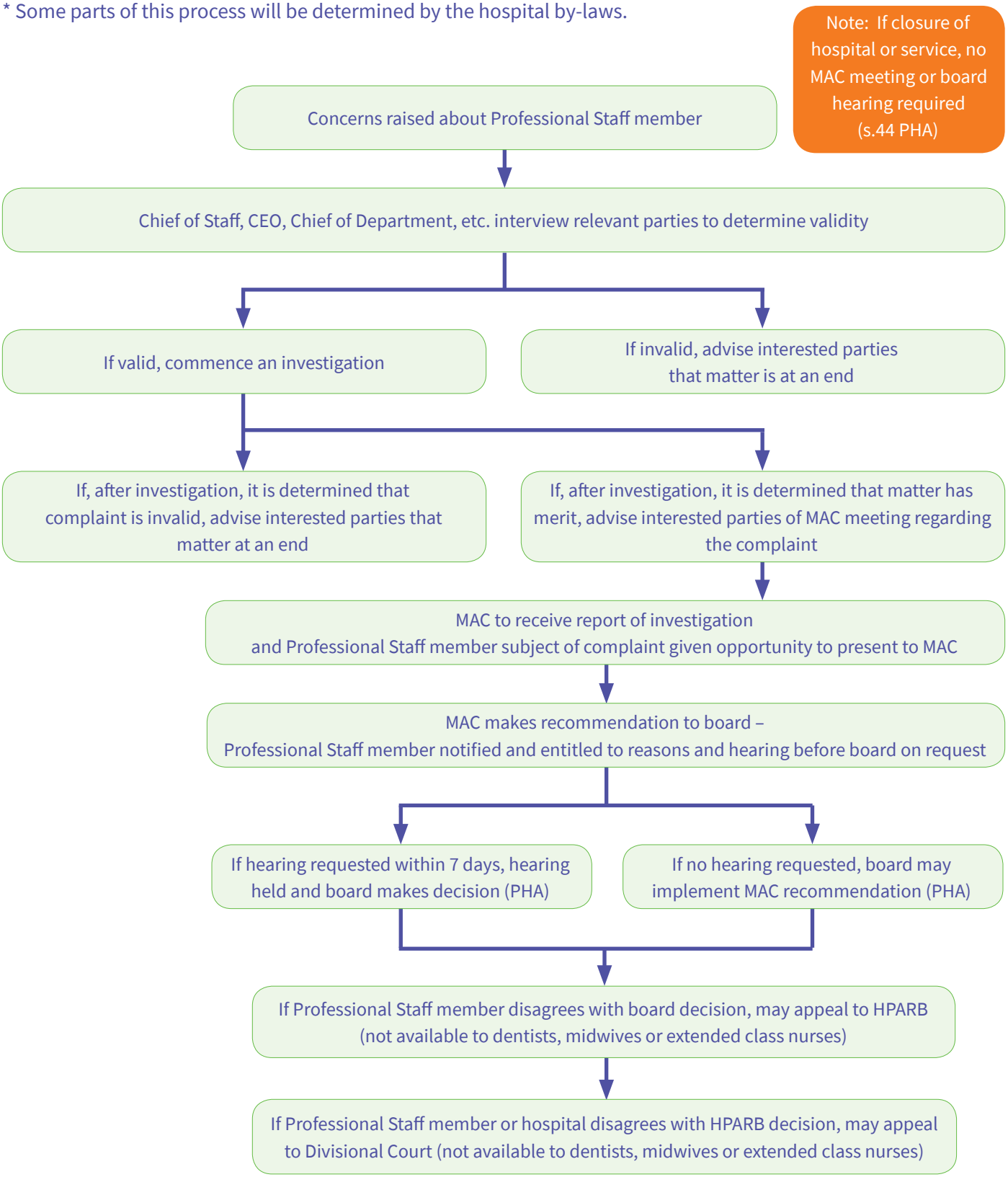
13 OHA/OMA Prototype By-law, s.5. See also *Abouhamra v Prairie North Regional Health Authority,* 2016 SKQB 293 (CanLII) at para. 131: "the immediate suspension of a professional person (or even of other privileges) is a drastic step that should be taken only as a last resort and even then only after careful consideration of whether other measures might suffice," and at para. 132: 'the weight of judicial authority is that the harsh remedy of interim suspension is to be used sparingly and carefully, and must rest upon a proper factual foundation."

14 For example, the OHA/OMA Prototype By-law contemplates a meeting before the MAC in situations where a temporary restriction or suspension of privileges was applied or where there is a recommendation to the MAC for the restriction or suspension, or revocation of privileges. See section 5.5.

15 While neither the *Public Hospitals Act* nor the OHA/OMA Prototype By-law contemplate an Executive Committee of the MAC, there may be benefits – depending on the size of the MAC – of including a MAC Executive Committee in the by-laws in order to handle issues like this and help avoid scheduling problems.

Mid-Term Suspension, Restriction, Revocation

* Some parts of this process will be determined by the hospital by-laws.



The hospital can establish the rules and format for a MAC privileges meeting. The MAC and the applicant/Professional Staff member should agree on a date and time for the meeting. The by-laws or policy typically provide a timeframe within which the meeting must happen, in order to ensure that the process moves along without undue delay. Caution should be exercised in creating timelines that are too rigid in the by-laws or policy, as the parties to the meeting may not be able to schedule and prepare within a few days or weeks, particularly when the facts and legal issues are complicated.

If the MAC and the Professional Staff member can negotiate a satisfactory resolution to the matter at the MAC level (e.g., remedial training, attendance at the Ontario Medical Association's Physician Health Program, etc.), this resolution must be sanctioned by the board if it involves any restriction on the Professional Staff member's privileges. Otherwise, if the clinician is dissatisfied with the MAC's proposed recommendation to the board and asks for a board hearing, they are entitled to one.[16]

Ultimately, the board decides about all privileges decisions. Accordingly, other than immediate interim suspensions by the CEO or Chief of Staff/Chair of the MAC or Chief of Department, which are discussed later in this Chapter, no substantial alteration in privileges can be implemented until a decision is made by the board.

Board Hearings

When the MAC recommends that a physician not be appointed or re-appointed to the Medical Staff or that a physician's privileges be suspended, restricted, revoked or otherwise changed, the *Public Hospitals Act* and the hospital by-laws set out a process whereby the physician is entitled to a formal hearing before the hospital board. It is best practice to extend these rights to dentists, midwives or extended class nurses through inclusion in the hospital's by-laws.

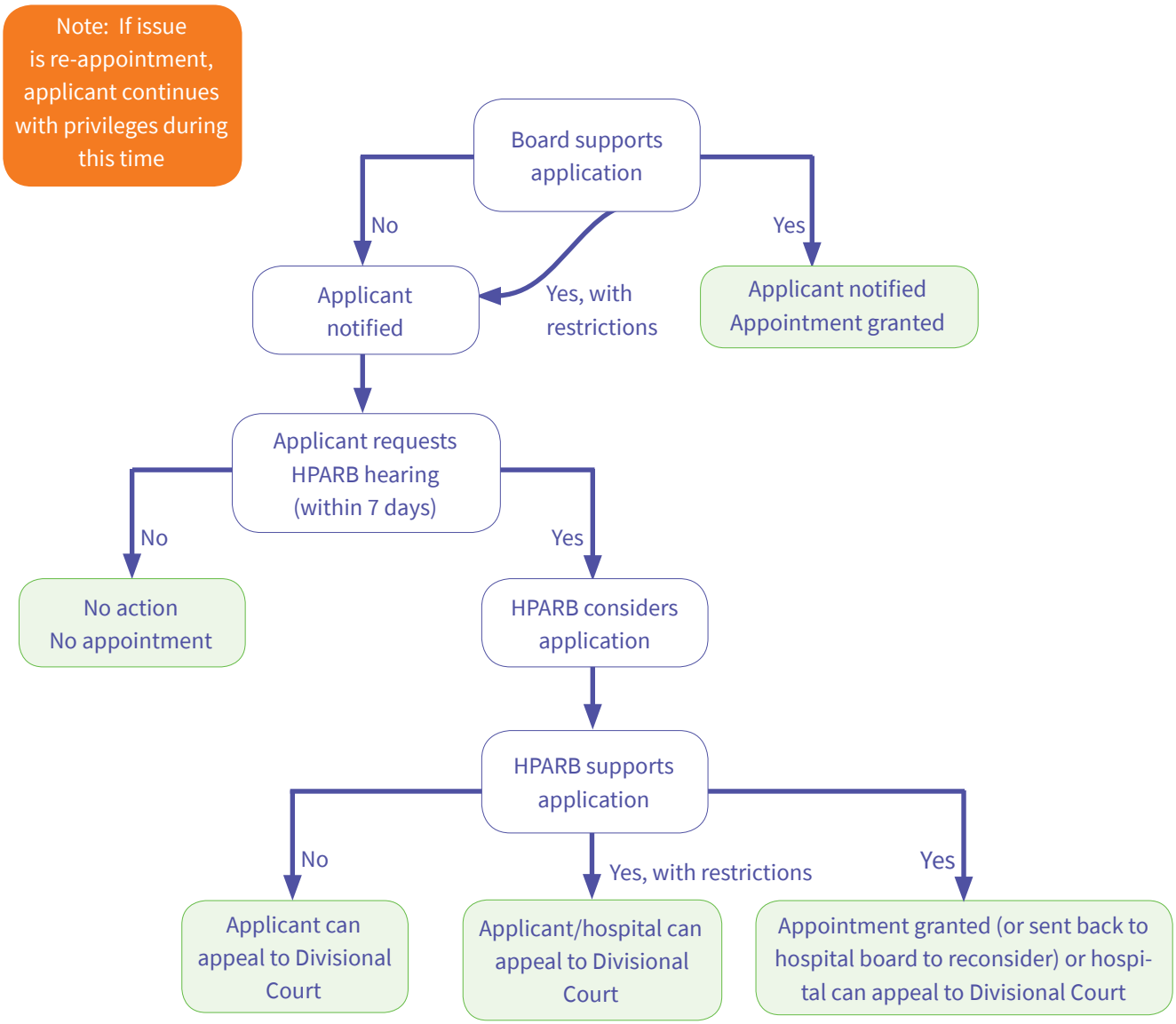
MAC RECOMMENDATION	IMPACT ON MEMBER	RIGHT TO A BOARD HEARING?	SOURCE
Refusing a request for initial application for any reason (other than due to closure of hospital or service). This includes: no position is available, not qualified, concerns about references, incomplete application, or concerns about competence, capacity or conduct	Clinician is not invited to join the Professional Staff	Yes	PHA, ss. 36, 37
Refusing a request for re-appointment for any reason (other than due to closure of hospital or service) including: no longer meets qualifications; concerns of competence, capacity or conduct	Member of the Professional Staff is not renewed and is no longer able to practice at the hospital	Yes	PHA, s. 36
Refusing a request for a change in privileges	Member's privileges and appointment level do not change	Yes	PHA, s. 37

16 This is a right of physicians under the *Public Hospitals Act*, and may be a right extended to other members of the Professional Staff through the hospital by-laws.

MAC RECOMMENDATION	IMPACT ON MEMBER	RIGHT TO A BOARD HEARING?	SOURCE
Suspending privileges because of administrative issue (e.g., incomplete health records)	Temporary suspension of privileges; member cannot provide all or portion of services	Yes	PHA, ss. 36, 37
Suspending privileges because no longer holds qualifications	Member cannot provide all or portion of services	Yes	PHA, ss. 36, 37
Restricting privileges because of concerns of competence, capacity or conduct	Member cannot provide a portion of services	Yes	PHA, ss. 33, 36, 37
Revoking privileges because of concerns of competence, capacity or conduct	Member's appointment is terminated and cannot provide any services	Yes	PHA, ss. 33, 36, 37
Refusing a request for appointment or re-appointment because closing a service or hospital	Applicant or member of the Professional Staff is not appointed or renewed and is not able to practice at the hospital	No	PHA, s. 44
Refusing a request for a change in privileges because closing a service	Member's privileges and appointment level do not change	No	PHA, s. 44
Restricting privileges because closing a service or hospital	Member cannot provide a portion of services	No	PHA, s. 44
Revoking privileges because of closing a service or hospital	Member's appointment is terminated and cannot provide any services	No	PHA, s. 44
Changing duties, resources or supports	Member's duties, resources or supports within the hospital are increased or decreased or otherwise changed in some way	It depends. If substantial alteration of privileges, yes. If not substantial alteration of privileges, no (case law).*(See analysis under section "Does a Hospital Have the Authority to Make Changes without Giving Rise to a Suspension, Restriction or Revocation of Privileges?" in this Chapter)*	

Board Hearing Process

* Continued from Appointment Process (Chapter 5) and Re-appointment Process (Chapter 6).



When a hospital board makes a decision about privileges, it is considered to be a "quasi-judicial decision-maker"; therefore, it must act fairly and in accordance with the principles of natural justice. *See Chapter 2, Legal Context.*

If an initial applicant/Professional Staff member desires a hearing before the board, they must make a request in writing to the Board Chair within seven days of receiving reasons for the MAC's recommendation.[17] Practically speaking, the notice is often delivered to the Board Chair through either the CEO, the Chief of Staff/Chair of the MAC or the most appropriate clinical leader, as the applicant/Professional Staff member will have had no contact with the Board Chair up to this point.

The Professional Staff member (or the initial applicant) and the MAC (and any others specified by the board) are parties at a board hearing.[18] The Chief of Staff/Chair of the MAC or a designate represents the MAC at the hearing. There are generally three lawyers involved:

- legal counsel to the MAC;
- legal counsel to the Professional Staff member; and
- legal counsel to the board (as decision-maker).[19]

The board has two choices:

- For the hearing to be before the full board, which can often lead to scheduling challenges;[20] or,
- The board can delegate to the Executive Committee the authority to hear the privileges dispute on behalf of the full board.[21]

If the board wishes to explore other options, it should consult legal counsel.

17 *Public Hospitals Act*, s. 37(7) applies to physicians only. These procedural rules may be extended to other members of the Professional Staff through the hospital by-laws.

18 *Public Hospitals Act*, s. 39(2).

19 *Dignan v. Board of Directors of South Muskoka Memorial Hospital* (1998), (ON Health Professions Appeal and Review Board).

20 Board hearings can last from hours to days.

21 As long as the hospital's administrative by-laws contemplate a Board Executive Committee to which the board may delegate decision-making on matters such as privileges hearings, and the Executive Committee reports back its findings to the full board at its next meeting.

Only board members with the right to vote shall preside at board hearings. The board may not include anyone who has taken part in any investigation or consideration of the subject matter of the hearing.[22]

This rule most often impacts the CEO and Chief of Staff/Chair of the MAC, or other members of the MAC who sit on the board and who may have been involved in earlier efforts to investigate or resolve the privileges dispute. Any member of the MAC who participated in the MAC meeting is also precluded from participating in the board hearing. (Note, however that employees of the hospital and members of the Professional Staff do not have voting rights as board members under the *Public Hospitals Act* regulations, and are therefore unable to vote at board hearings in any event.) Further, the Professional Staff member may object to the presence of a particular board member on the board hearing panel, but must have valid reasons for the objection (i.e., a perceived or actual conflict of interest).

While the board is entitled to unilaterally set a date and time for the hearing,[23] practically speaking, the scheduling is often a matter of some negotiation. The board, MAC and the applicant/Professional Staff member should agree on a date and time for the hearing. The by-laws or policy typically provide a timeframe within which the hearing must happen in order to ensure that the process moves along without undue delay. Caution should be exercised in creating timelines in the by-laws or policy that are too rigid, as the parties to the meeting may not be able to schedule and prepare within a few days or weeks, particularly when the facts and legal issues are complicated. The applicant/Professional Staff member should be advised in writing of the context for the board hearing and the procedural rights that are applicable. After the hearing, the board notifies the parties of its decision. The applicant/Professional Staff member is entitled to receive written reasons for the decision.[24]

It is important to note that within the legal context, rights of appeal from a decision of the board only apply

22 *Public Hospitals Act,* s. 39(4).

23 *Public Hospitals Act,* s. 39(1).

24 For physicians, this right is set out in the *Public Hospitals Act*, s. 41(1).

to physicians. That is, if a member of the Medical Staff (or physician applicant for initial appointment) feels aggrieved by the board's decision, they have the right to request a hearing before HPARB.[25] This right is not available to members of the Dental, Midwifery or Extended Class Nursing Staff because the right comes from the *Public Hospitals Act* and cannot be extended to apply to other disciplines in the by-laws. A request for an HPARB hearing must be made within seven days of receiving the board's written reasons for its decision. Decisions of HPARB may be appealed to Divisional Court.[26]

No Hearing if Closing the Hospital or Closing a Service

While most situations in which a clinician's privileges are negatively affected give rise to the right for a hearing before the hospital board, there are two notable exceptions. When a hospital is closing and will cease to operate as a hospital, all members of the Professional Staff will be negatively affected. Sections 44(1) and (1.1) of the *Public Hospitals Act* state that in these circumstances a board may:

- Refuse the application of any physician for appointment or re-appointment to the Medical Staff or for a change in hospital privileges;
- Revoke the appointment of any physician; and
- Cancel or substantially alter the privileges of any physician.

Similarly, under sections 44(1.2) and (2), if a hospital will no longer be providing a particular service, a board may:

- Refuse the application of any physician for appointment or re-appointment to the Medical Staff of the hospital if the only hospital privileges to be attached to the appointment or re-appointment relate to the provision of that service.
- Refuse the application of any physician for a change in hospital privileges if the only privileges to be changed relate to the provision of that service.
- Revoke the appointment of any physician if the only hospital privileges attached to the physician's appointment relate to the provision of that service.
- Cancel or substantially alter the hospital privileges of any physician which relate to the provision of that service.

Section 44(3) states that the board may make a decision without holding a hearing. Section 44(4) revokes the normal procedural rights of physicians to have their applications considered by the MAC, to receive the MAC's recommendation, to require a hearing before the board and to appeal to HPARB.

Since section 44 applies only to physicians, it is important to remember to include these exceptions in the by-laws so they apply to dentists, midwives and extended class nurses within the hospital.

Section 44(5) protects corporations which own or operate hospitals from liability "for any act done in good faith in the execution or intended execution by a board of its authority under subsection (1) or (2) or for any alleged neglect or default in the execution in good faith by a board of such authority." In *Beattie v. Women's College Hospital*,[27] two physicians who practiced for many years in the hospital's urgent care centre brought an action for wrongful dismissal after the hospital closed its urgent care centre and, as a consequence, terminated their privileges. The Ontario Court of Appeal upheld the trial judge's dismissal of the action on the ground that it was barred by s. 44(5).

Temporary Suspensions

In order to manage urgent situations, by-laws should contemplate a procedure for temporary suspensions of privileges.

For example, the OHA/OMA Prototype By-law includes authority for the CEO, the Chief of Staff/Chair of the MAC, Chief of a Department, or their delegates, to temporarily restrict or suspend hospital privileges. In the case of immediate action, section 4.3 reads as follows:

25 *Public Hospitals Act*, s. 41.

26 *Public Hospitals Act*, s. 43(1).

27 2018 ONCA 872.

(1) The Chief Executive Officer, Chief of Staff, or Chief of Department may temporarily restrict or suspend the privileges of any Professional Staff member, in circumstances where in their opinion the member's conduct, performance, or competence:

(a) exposes or is reasonably likely to expose any Patient, healthcare provider, employee, or any other individual at the Corporation to harm or injury; or

(b) is or is reasonably likely to be detrimental to Patient safety or to the delivery of quality Patient care within the Corporation,

and immediate action must be taken to protect Patients, healthcare providers, employees, and any other individuals at the Corporation from harm or injury.

(2) Before the Chief Executive Officer, Chief of Staff, or Chief of Department takes action authorized in section 4.3(1), they shall first consult with one of the other of them. If prior consultation is not possible or practicable under the circumstances, the individual who takes the action shall immediately provide notice to the others. The individual who takes the action shall forthwith submit a written report on the action taken with all relevant materials and information to the Medical Advisory Committee.

In the case of non-immediate action, section 4.4 of the OHA/OMA Prototype By-law states that:

(1) The Chief Executive Officer, Chief of Staff, or Chief of Department may recommend to the Medical Advisory Committee that the appointment of any Professional Staff member be revoked or that their privileges be restricted or suspended in any circumstances where in their opinion the Professional Staff member's conduct, performance, or competence:

(a) fails to meet or comply with the criteria for annual reappointment;

(b) exposes or is reasonably likely to expose any Patient, healthcare provider, employee, or any other individual at the Corporation to harm or injury;

(c) is or is reasonably likely to be detrimental to Patient safety or to the delivery of quality Patient care within the Corporation or impact negatively on the operations of the Corporation; or

(d) fails to comply with the Corporation's by-laws, Rules, or Policies, the *Public Hospitals Act*, or any other relevant law.

(2) Before making a recommendation under section 4.4(1), an investigation may be conducted. Where an investigation is conducted, it may be assigned to an individual or committee within the Corporation other than the Medical Advisory Committee or an external consultant.

While the *Public Hospitals Act* provides that only the board may revoke or suspend Medical Staff privileges, HPARB has recognized that there needs to be a process in the by-laws, such as that in the OHA/OMA Prototype By-law, "which permits [the hospital] to immediately suspend privileges pending a formal hearing in which the elements of natural justice are preserved, while at the same time protecting the public interest."[28]

Even in an emergency, there is a duty of fairness owed to the Professional Staff member involved. If a situation involving a Professional Staff member of the hospital gives rise to the need immediately to suspend the member's privileges, the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) must immediately notify the Professional Staff member in writing. The notice should specify the incident or incidents that gave rise to the suspension of privileges (on an interim basis) and explain the member's procedural rights to a board hearing (and to appear before the MAC if that process is available under

28 *Nikore v. Brantford General Hospital* (ON Hospital Appeal Board, 1990). See *Kaila v Bluewater Health*, 2014 CanLII 19532 (ON HPARB) for an example of a case involving an immediate, temporary suspension of privileges without a hearing. Following the suspension, the Hospital Board re-instated privileges with conditions and restrictions, which the physician then appealed to HPARB. HPARB's decision was to reinstate with conditions (such as advising security when he entered or exited the hospital), which it found did not substantially alter the physician's privileges. The facts in *Gupta v William Osler Health System*, 2017 ONSC 1294 (Div Ct) also involve an immediate temporary suspension that was confirmed by the MAC and the hospital board, followed by a meeting of the MAC to consider whether the physician could return to work or would have his privileges revoked.

the by-laws). In these emergency situations, timing can be extremely sensitive: the Professional Staff member has been stripped of their livelihood and their professional reputation is at risk. All parties should make efforts to coordinate schedules to deal with matters expeditiously, without compromising the quality of the investigation.

Administrative Suspensions

Some hospitals have policies that contemplate "administrative suspensions", which are suspensions for acts such as failing to pay regulatory college dues and having a lapse in licensure; failing to maintain professional liability protection (insurance); failing to meet occupational health and safety obligations (e.g., mask fit testing, cardio-pulmonary resuscitation, tuberculosis testing); or failing to rectify health records deficiencies after being notified. These suspensions may be recommended by the Chief of Department, Chief of Staff/Chair of the MAC or most appropriate clinical leader, but are implemented only upon a board decision. They are intended to be time-limited, as they suspend privileges only as long as the issue remains unremedied. Once remedied to the satisfaction of the Chief of Staff/Chair of the MAC, Chief of Department (or most appropriate clinical leader) (e.g., the mask fit testing has been completed or the health records have been brought up-to-date), the suspension is over and the Professional Staff member may return to full service at the hospital.

Such suspensions still trigger the rights and procedural fairness requirements of the *Public Hospitals Act* and the by-laws. Someone whose privileges have been suspended would be entitled to a board hearing, if requested.

Communication is the key to the successful management of these issues. It is important for hospitals to consider:

- Dissemination of policies and standards that highlight the administrative suspension consequences.
- Sending reminders to all Professional Staff well in advance of deadlines to comply.
- Providing warning notice(s) in advance of deadlines to members who have not complied (with documentation of the efforts made by the hospital to contact the member).

If a member of the Professional Staff receives a suspension, they may have to alert future hospitals of the suspension (because some hospital by-laws require such disclosure in their applications). Some hospitals provide a document that accompanies the suspension that explains the reason for the suspension, so that the member can include the document in future application packages.

Tips

Boards should consider the following:

- It may not be acceptable for a board to revoke or not renew a Professional Staff member's privileges where there has been no previous history of documented complaints or attempts at effecting remediation or other more moderate forms of disciplinary action.
- To the extent that a hospital has policies and Rules and Regulations, they must be consistently enforced or it may be difficult to rely on a breach of them as grounds for taking disciplinary action.
- It is crucial to keep the MAC and board members separate during privileges disputes so that board members will be free to participate in the board hearing.
- Before revoking a Professional Staff member's privileges, the MAC (and the board) should consider what steps, if any, have been taken or could be taken to remediate the hospital's concerns with the Professional Staff member's practice.
- Revoking a Professional Staff member's privileges due to a lack of collegiality is possible; however:
  - The Professional Staff member's behaviour must be significant enough that it may impact on quality of care.
  - The Professional Staff member must have been given an opportunity to correct their behaviour and failed to do so (unless the behaviour was egregious).[29]

29 See CPSO/OHA Guidebook for Managing Disruptive Physician Behaviour, online: OHA <http://www.oha.com/CurrentIssues/Issues/eHealth/Documents/Guidebook%20For%20Managing%20Disruptive%20Physician%20Behaviour.pdf>.

- The process contemplated by the *Public Hospitals Act* treats all Medical Staff members equally and does not distinguish between active staff and other categories of staff such as (probationary, associate, courtesy or temporary staff). It can be just as difficult to revoke the privileges of an associate Professional Staff member as a long-standing member of the Professional Staff. However, active staff and Professional Staff members who provide full-time equivalent services at a hospital may deserve longer notice periods for change and greater involvement in discussions and input into change initiatives than do other categories of Professional Staff.
- HPARB or a court can overturn a hospital board's privileges decision and can order that an individual be reinstated to the Professional Staff.
- When HPARB or a court finds that a hospital board's decision is unwarranted or is deficient with respect to procedural fairness, a member of the Professional Staff may have legal remedies to compensate for any financial loss they experienced.[30] Even if a Professional Staff member is eventually reinstated, there may still be a claim for lost income and legal costs incurred during the period in which their privileges were restricted or suspended.[31]

Reporting Obligations

When a hospital has taken action against any Professional Staff member (that is to suspend, restrict, or revoke privileges) for reasons of professional misconduct, incompetence or incapacity, there are reporting obligations to a regulatory college and perhaps within the hospital organization itself. There are two sources for these obligations: the *Public Hospitals Act* and Health Professions Procedural Code under the *Regulated Health Professions Act.*

Public Hospitals Act

The reporting obligations that arise under the *Public Hospitals Act* relate only to physicians (not dentists, midwives, extended class nurses) in the following circumstances:

- The CEO of a hospital (the administrator of the hospital) must notify the College of Physicians and Surgeons of Ontario (CPSO) if:
  - A physician has been denied appointment or re-appointment by reason of incompetence, negligence or misconduct.
  - A physician has had their privileges restricted or cancelled by reason of incompetence, negligence or misconduct.
  - A physician resigns from the Medical Staff or restricts their practice within a hospital and the CEO has reasonable grounds to believe that the resignation or restriction is related to the competence, negligence or conduct of the physician.
  - A physician voluntarily or involuntarily resigns or restricts their practice from the Medical Staff during the course of, or as a result of, an investigation into their competence, negligence or conduct.[32]
- The CEO of a hospital (the administrator of the hospital) must notify the Chief of Staff /Chair of the MAC (and Chief Nursing Executive if it involves an extended class nurse and the President or Secretary of the Medical Staff if it involves a physician) if they believe that a member of the Professional Staff is unable to perform the person's professional duties with respect to a patient in the hospital.[33]

30 *Horne v Queen Elizabeth II Health Sciences Centre*, 2018 NSCA 20 (CanLII).

31 *Rosenhek v. Windsor Regional Hospital*, [2007] O.J. No. 4486 (Sup. Ct.). See also *Kadiri v. Southlake Regional Health Centre*, 2015 ONCA 847, which confirms that in cases of reinstatement, depending on the circumstances, a physician may be able to bring a claim in court without first seeking relief from the HPARB.

32 *Public Hospitals Act,* s. 33.

33 *Public Hospitals Act,* R.R.O. 1990, Reg. 965, s. 18(3). Note that midwives and dentists are now mentioned in this section (since a 2017 regulatory amendment).

- An officer of the hospital's Medical Staff must notify the attending physician if they are aware that a serious problem exists in the diagnosis, care or treatment of a patient.[34]

Regulated Health Professions Act, Schedule 2: Health Professions Procedural Code

Reporting obligations arise under the *Regulated Health Professions Act* in the following circumstances:

- Where a CEO of a hospital (person responsible for the operation of the hospital) has reasonable grounds to believe that a member (including dentists, midwives, extended class nurses) and who practices at the facility is incompetent or incapacitated.[35]
- Where a board of a hospital revokes, suspends or imposes conditions on a member's privileges for reasons of professional misconduct, incompetence or incapacity, or where a member resigns or relinquishes their privileges before the hospital had the opportunity to take such actions.[36]
- Where a hospital or another member of the Professional Staff comes into possession of information that would alert them to concerns regarding sexual abuse of a patient.[37]

Legal advice should be sought when considering making a report to a regulatory college. Following legal advice, it is advisable to report as soon as possible in the following circumstances: (1) privileges have been suspended, restricted or revoked; (2) the MAC has issued a finding against the member of incompetence, negligence, incapacity or misconduct; (3) the member resigns or retires or voluntarily restricts their practice during an investigation into their practice or, behaviour; or, (4) there are allegations of sexual abuse.

34 *Public Hospitals Act*, s. 34(3). Note, dentists, midwives and extended class nurses are not mentioned in this section.

35 *Regulated Health Professions Act,* Health Professions Procedural Code, s. 85.2.

36 Ibid. S.85.5.

37 Ibid. S.85.1 and 85.2.

FAQs

1. Are dentists, midwives, extended class nurses entitled to the same procedural protection as physicians under the *Public Hospitals Act*?

Strictly speaking, no. The provisions of the *Public Hospitals Act* apply to members of the Medical Staff only. The *Public Hospitals Act* itself does not refer to other Professional Staff members. However, the regulations under the *Public Hospitals Act* do allow hospital boards to pass by-laws for other Professional Staff groups (dentists, midwives, extended class nurses). And when hospital boards do so, the by-laws typically apply the same processes to all groups. For purposes of consistency and fairness, the OHA recommends as best practice that the same or similar processes are used for the appointment of Professional Staff.

In any particular case, where there is a question about what particular procedural protection should be afforded to an individual applicant or group of applicants, the board should consult its own legal counsel.

2. Why can we not just dismiss a member of the Professional Staff? Can't we just give the person "notice"?

As discussed above and in Chapter 2, Legal Context, the *Public Hospitals Act* sets out a comprehensive code for managing the relationship between a hospital and a physician. This entitles any physician on the Medical Staff the right to a hearing before the board before their privileges are impacted. Even in the rare circumstance where a physician has privileges and is also an employee at a hospital, the physician's privileges cannot be terminated without making available the legal process under the *Public Hospitals Act*. The cornerstone of the privileges framework is procedural fairness, which must be provided at every step.

It is possible that the hospital's by-laws may not extend the same concepts of natural justice and procedural fairness to other members of the Professional Staff (dentists, midwives, extended class nurses). This would be unusual.

3. Are there any circumstances in which we can suspend Professional Staff privileges immediately? Who has the right to do this?

A hospital's by-laws should provide a mechanism that allows specific hospital leaders (e.g., the CEO and Chief of Staff/Chair of the MAC or the Chief of Department) to suspend a Professional Staff member's privileges pending a formal hearing in cases where public protection demands immediate action. Even in this circumstance, the hospital owes a duty of natural justice and procedural fairness to the Professional Staff member. Timelines for board hearings in these circumstances are typically expedited, taking into account that the Professional Staff member's livelihood and reputation are at risk.

4. Must the hospital first try to help a member of the Professional Staff remediate their behaviour before revoking privileges?

Where the behaviour or performance issues can be remediated, this is typically a prudent course of action. The concept of procedural fairness includes ensuring that the discipline matches the problem. If the discipline is too severe too early in the process, the hospital board risks being overturned at HPARB.

There may also be lessons the hospital and its leadership can learn to improve the relationship, behaviour or performance of the Professional Staff member.

5. Can we suspend a Professional Staff member who doesn't do their share of on-call?

Yes. If it is part of their responsibilities and the Professional Staff member refuses to participate (and does not have a legitimate reason why they cannot participate), this may be cause to suspend privileges. This may warrant a temporary suspension (i.e., effective until the problem is remedied) or may lead to the revocation of privileges or recommendation not to re-appoint.

The issue of reducing on-call obligations may also arise in the context of an individual's intention to retire. Some hospitals have an agreed upon staged reduction in privileges including on-call obligations for senior Professional Staff who intend to retire. *See Chapter 10, Resignation and Retirement.*

In the case of *Bhargava v Lakeridge Health Corporation* [38] the Health Professions Appeal and Review Board considered whether a hospital's "Physician On-Call Policy" to tie a reduction in on-call coverage to a proportionate reduction in elective resources amounted to a substantial alteration of the Appellant's privileges. HPARB concluded that Dr. Bhargava's privileges were substantially altered when the hospital reduced his cardiology services commensurate with his choice to reduce his on-call coverage. However, HPARB also concluded that the hospital had the authority to implement the policy and apply it to Dr. Bhargava in accordance with the *Public Hospitals Act*.

6. Can we suspend a Professional Staff who doesn't complete their charts on a timely basis?

Yes. However, the hospital must have a policy that sets out its expectations regarding chart completion.

7. Can we ask a member of the Professional Staff to undertake not to exercise their privileges during an investigation? And if so, must we report that to the regulatory college?

It is possible to negotiate with a Professional Staff member that they will not exercise their privileges during an investigation into their competence, capacity or conduct. Under the *Public Hospitals Act*, an administrator must report a physician to the CPSO if the physician restricts their practice within the hospital during the course of or as a result of an investigation in their competence, negligence or conduct. For other disciplines, the hospital should seek legal advice as to whether a report to the regulatory college is required.

8. Why does the board need to revoke privileges? Isn't this the role of the college?

No. Health regulatory colleges have the jurisdiction to suspend or revoke, or add restrictions to, a licence to practice. The decision to revoke Professional Staff privileges is solely the jurisdiction of the hospital board.

38 2011 CanLII 33743 (ON HPARB), <http://canlii.ca/t/flskv>.

9. Once we revoke privileges, can HPARB reinstate those privileges?

Yes. A decision of a hospital board can be appealed to HPARB, and HPARB may reinstate those privileges.

10. Can a Professional Staff member initiate a wrongful dismissal/constructive dismissal case against the hospital?

The concepts of wrongful dismissal/constructive dismissal only apply to Professional Staff members when they are employees of the hospital. Courts have held that when Professional Staff members are individual contractors rather than employees, the *Public Hospitals Act* scheme must be utilized; however, when Professional Staff members are employees, they may also have the right to wrongful dismissal claims in addition to their rights under the *Public Hospitals Act*.

11. Who can/should we tell when we revoke, suspend or restrict privileges?

The hospital should seek legal advice as to what mandatory reports are required to the regulatory college. Generally, if the revocation, suspension or restriction results from a determination of incompetence or incapacity, a report will be required.

Legal advice may be required to determine how to announce appropriately internally and externally revocations, suspensions and restrictions of privileges. If related to incapacity or issues about the member's health, extra care should be taken to protect the person's personal health information. A hospital should keep a list of internal people to notify when a Professional Staff member has privileges revoked, suspended or restricted. The list could include:

- CEO
- Chief of Department, Head of Division (or other clinical leaders)
- Chief of Staff/Chair of the MAC
- Health records
- Hospital committees (if the Professional Staff member sat on internal committees)
- Paging/information/front desk (so that they can remove or suspend the member from their lists)
- Pharmacy
- Security
- Senior management team

Subject to terms of common credentialing processes that contemplate such reports, hospitals should not advise other hospitals where the Professional Staff member has privileges without seeking legal advice.

Additional legal advice should be sought with respect to communicating with the member's patients.

12. Do we need a Professional Staff member on the board panel that hears a privileges dispute under the *Public Hospitals Act*?

No. Any Professional Staff who sit on the board cannot vote. The board can, however, engage clinical experts to provide objective advice to the board if complicated competency issues arise. This process may provide even better, objective advice to the board.

13. Does the board have the authority to settle a privileges matter?

Yes. If the MAC and Professional Staff member reach a settlement (such as an agreed-upon plan of remedial training) that is acceptable to the board, the parties can agree not to proceed with the formal board hearing.

14. Can the board disagree with the MAC's recommendation?

Yes. The board should give great weight to the MAC's recommendations, but it cannot rubber stamp those recommendations. It is possible for the board to accept the MAC's recommendations about appointments, re-appointments, changes in privileges, revocation/suspension/restriction of privileges, to reject the MAC's recommendations, or to substitute its own opinion.

Chapter 10: Resignation and Retirement

Reference Key:

Public Hospitals Act:	Section 33
OHA/OMA Prototype By-law:	Section 3.11

Chapter Summary

- Hospitals and members of the Professional Staff have joint responsibility for managing the transfer of care issues that arise when a member of the Professional Staff resigns or retires.
- The standard period of notice for a resignation/retirement is two to three months. Hospitals should use discretion during unique circumstances.
- Hospitals should clarify in writing their transfer of care standards and applicable policies and follow up with Professional Staff individually, as warranted.
- Notices of resignations/retirements must be in writing (if not, the hospital should provide written follow-up).
- Professional Staff Human Resources Plans should include succession planning.
- Some resignations/retirements require reporting to regulatory Colleges.

Obligations and Timing

The transfer of patient care following notice of impending resignation or retirement is a mutual obligation of the hospital and the member of the Professional Staff.

In many hospitals, two to three months' notice is required to ensure the safe and organized transfer of care. Hospitals are advised to use discretion during unique circumstances of resignation or retirement.

Hospitals should specifically prepare for circumstances under which an urgent transition of care and duties must occur (such as in the case of an unanticipated illness or early maternity/parental leave). Under these circumstances, the hospital will inevitably assume a greater degree of responsibility for managing the transition. In such cases, it will be important for the affected Department's other clinical staff to work closely with the most appropriate clinical leader.

The College of Physicians and Surgeons of Ontario (CPSO) has written guidelines for termination of the relationship between physicians and their patients, with which physicians are expected to comply.[1] These guidelines pertain most directly to private practice settings. Nevertheless, most of the principles in the CPSO statement translate readily to a hospital setting. A hospital could choose to adopt the CPSO's guidelines and extend them to apply to all Professional Staff members (physicians, dentists, midwives and extended class nurses).

Succession Planning

To the extent that such departures can be anticipated, hospitals should include retirement and resignation planning in their Professional Staff Human Resources Plans. *See Chapter 4, Planning and Recruitment.*

Documentation

Hospitals should consider implementing a Professional Staff Resignation/Retirement Policy so that their expectations for transfer of care are clearly outlined prior to a member's decision to resign or retire.

1 College of Physicians and Surgeons of Ontario, "Ending the Physician-Patient Relationship" (May 2017), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ending-the-Physician-Patient-Relationship >; College of Physicians and Surgeons of Ontario, "Closing a Medical Practice" (September 2019), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Closing-a-Medical-Practice >.

All resignations and retirements should be provided by the Professional Staff member in writing. Hospitals should ensure the Professional Staff member clarifies:

- Their proposed last date of service.
- Whether the resignation/retirement relates to all services they provide at the hospital (or only a subset).
- Whether the member wishes to maintain any relationship with the hospital (such as courtesy staff or *locum tenens* appointment, which would constitute a request for a change in privileges). *See Chapter 6, Re-appointments and Changes to Privileges.*
- Their plan for transfer of care.

It may also be necessary for the hospital to clarify with the Professional Staff member:

- The hospital's expectations for transfer of care and transfer of administrative responsibilities.
- Whether the resignation triggers a resignation of other affiliations (such as university appointments or joint appointments with community agencies).
- The hospital's administrative requirements arising out of the resignation/retirement and key contact individuals on specific issues (e.g., leaving office space, return of hospital badge, security passes and keys).
- The restrictions on holding hospital email addresses after resignation.
- How the Professional Staff member should identify themselves post-resignation (i.e., is there an "honorary" staff category of privileges that recognizes the former affiliation?).

FAQs

1. When a member of the Professional Staff resigns during an investigation into competency or behaviour, is the hospital required to advise the College? Is the hospital required to advise other hospitals where it knows the member has privileges?

The hospital must notify the CPSO if a physician voluntarily or involuntarily resigns (including retires) from the Medical Staff or restricts their practice within a hospital during the course of, or as a result of, an investigation into their competence, negligence or conduct.[2]

Further, if a hospital intended to revoke the privileges of any Professional Staff member for reasons of professional misconduct, incompetence or incapacity, but did not revoke the privileges because the Professional Staff member resigned, retired or relinquished their privileges, the hospital must notify the health regulatory college.[3] This obligation typically falls to the CEO (but may be delegated).

Unless previously agreed upon with the member (such as in joint credentialing arrangements), there is no obligation to inform other hospitals of the resignation, and hospitals should seek legal advice before doing so. Significant negative consequences can occur when a hospital engages in discussions with third parties regarding a physician's competence, capacity or conduct.

2. How should we confirm a resignation?

To avoid confusion, a notice of resignation/retirement should always be submitted in writing. If it is tendered verbally, the hospital should ask for it in writing. If the member refuses to put it in writing, the Chief of Staff/ Chair of the Medical Advisory Committee (MAC) or delegate should confirm it in writing.[4]

2 *Public Hospitals Act,* s. 33.

3 *Regulated Health Professions Act,* 1991 Health Professions Procedural Code, s. 85.5.

4 See *Waddell v Weeneebayko Area Health Authority,* 2018 CanLII 39843 (ON HPARB), aff'd 2019 ONSC 7375 (Div Ct) where significant confusion arose after a physician resigned in writing but intended to continue an affiliation on his own terms with the hospital.

3. What should we do if someone resigns or retires unexpectedly, with little or no notice?

You may wish to impress upon the Professional Staff member that they have professional obligations to their patients. It may be necessary to send a letter to remind them of the hospital's expectations with respect to transfer of care.

You may also wish to seek legal advice.

4. Can we include a "resignation" or "retirement" notice period in our letters of offer/letters of re-appointment and in the by-laws?

Yes. You can disseminate a Professional Staff Resignation/Retirement Policy, but you can also notify the members of the expectation of "notice" in the hospital's by-laws and in letters of initial appointment and re-appointment such as the following:

> *If you wish to terminate your privileges with this hospital, you will provide the hospital with at least three months' notice in writing. This period of notice may be waived in whole or in part by the Hospital, at its discretion.*

5. Who can we (and should we) notify if a Professional Staff member resigns or leaves?

The hospitals should keep a list of internal people to notify when a Professional Staff member gives notice of their resignation or retirement. The list could include:

- Board
- CEO
- Chief of Department, Head of Division (or other clinical leaders)
- Chief of Staff/Chair of the MAC
- Hospital committees (if the Professional Staff member sat on internal committees)
- Secretary of the MAC
- Paging/information/front desk (so that they can remove the member from their lists
- Pharmacy
- Security
- Senior management team

Depending on the circumstances, it may be appropriate for the hospital and the Professional Staff member to issue a joint communiqué to notify patients and referring community agencies. The hospital should work with the resigning/retiring member to notify community partners served by the Professional Staff member. Under an academic affiliation agreement, there may also be obligations to inform a university of the member's departure. *For additional information, see Chapter 12, Academic Issues.*

If the member resigns or retires in the context of a dispute with the hospital, a hospital concerned about facing a claim for defamation should seek legal advice about disclosure of the pending resignation/retirement.

6. We think that a Professional Staff member who joined us just a few years ago should no longer be practising. Can we suggest they retire? Should we not have given them privileges in the first place?

The initial appointment to the Professional Staff must be done in the same way for all applicants through a robust credentialing process. Once appointed, the provision of care by Professional Staff should be guided by the rigour of the annual re-appointment process, and in response to any concerns about patient care as they are raised. Issues of age and ability to safely practice are sensitive matters, and you may wish to seek legal advice. *See Chapter 5, Initial Appointment; Chapter 6, Re-appointment and Changes to Privileges; and Chapter 8, Performance Evaluations and Progressive Management.*

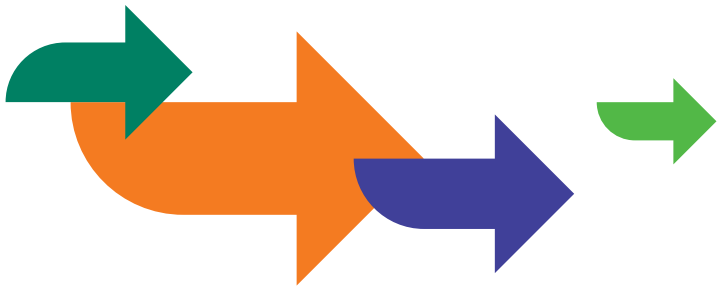
Note that hospitals may not have mandatory retirement policies for Professional Staff members who are age 65 or older, given changes in 2006 to the Human Rights Code. In the case of *Shaver v. Queensway Carleton Hospital*[5] a physician alleged discrimination when he was required

5 2017 HRTO 685 (CanLII), <http://canlii.ca/t/h4df8>

to resign his privileges in accordance with the hospital's on-call "sunset" policy, which he argued was tantamount to mandatory retirement. The human rights tribunal concluded there was no discrimination because the decision was not related to Dr. Shaver's age or disability, but instead related to his decision to cease his on-call duties.

7. How should we manage on-call requirements for Professional Staff who may be approaching retirement?

The issue of reducing on-call obligations often arises in hospitals in the context of a Professional Staff member's intention to retire. Some hospitals have an agreed upon staged reduction in privileges including on-call obligations for senior Professional Staff who intend to retire. If hospitals offer these arrangements, they should have a written policy to clarify the terms and process for consideration. Prior to implementation, such policies should be distributed to the Professional Staff for consultation.



In the case of *Bhargava v Lakeridge Health Corporation*[6] the Health Professions Appeal and Review Board considered whether a hospital's "Physician On-Call Policy" to tie a reduction in on-call coverage to a proportionate reduction in elective resources amounted to a substantial alteration of the Appellant's privileges. HPARB concluded that Dr. Bhargava's privileges were substantially altered when the hospital reduced his cardiology services commensurate with his choice to reduce his on-call coverage. However, HPARB also concluded that the hospital had the authority to implement the policy and apply it to Dr. Bhargava in accordance with the *Public Hospitals Act*.

6 2011 CanLII 33743 (ON HPARB), <http://canlii.ca/t/flskv>.

Chapter 11: Maintaining Credentialing Files

Reference Key:

Public Hospitals Act:	None
OHA/OMA Prototype By-law:	None

Chapter Summary

- Maintaining a centralized documentation system for Professional Staff credentialing files helps to identify, in a timely way, issues relating to Professional Staff performance.
- Some hospitals have adopted an online system to assist in the process, including reminders of key deadlines.
- Hospitals must take measures to protect the confidentiality of the credentialing file.
- Freedom of information legislation applies to hospitals, although there are specific exclusions that relate to credentialing files.
- Hospitals should have a formal policy with respect to how long they retain the documentation within a credentialing file.

Content of Credentialing Files

Although not a legal requirement, it is recommended that hospitals maintain a central credentialing file for every member of the Professional Staff. Professional Staff members' files should be centrally stored so that all relevant information is available for credentialing, performance reviews, privileges hearings and providing references. Centralizing Professional Staff files in a single location within the hospital leads to easier identification of emerging patterns regarding a member's professional development or performance issues, especially as positive or negative feedback is received.

The credentialing process has become more involved and rigorous over the years. As a result, more documentation is required to chronicle the relationship between hospitals and their Professional Staff members. While a credentialing file may once have been made up of a single letter from the applicant requesting privileges to provide services at the hospital, today's credentialing file is likely to include:

- Photograph (confirmation of identification);
- Contact information (work information/home information/emergency contact information);
- Initial application form and supporting documentation (including notes from third-party confirmation of credentials. *See Chapter 5, Initial Appointment)*
  - Evidence of schooling (certificate or diploma)
  - Evidence of post-graduate training (internships, residencies, fellowships)
  - Evidence of training and experience
  - Confirmation of license to practice
  - Confirmation of professional liability protection (insurance) coverage
  - Chronological work history in health care
  - Curriculum vitae
  - Criminal record check results
  - Release and authorization forms
  - Certificate of professional conduct from regulatory college
  - Letters of reference (these should be kept separately, marked "Strictly Confidential", and the member should not have access to this information if the letters were provided in confidence). *See Chapter 5, Initial Appointment.*
  - Copies of infection control test results and screenings, and certificates of completion for mandatory occupational health and safety training and screening
  - Follow-up correspondence asking for further information or confirmation of completion;

- Application forms for annual re-appointment and changes to privileges (including notes from third-party confirmation of credentials) *See Chapter 6, Re-appointment and Changes in Privileges.*
  - Updates to initial application
  - Updated curriculum vitae
  - Letters of recommendation from Department Chiefs and others
  - Certificates of professional conduct from college
  - Copies of infection control test results and screenings and certificates of completion for mandatory occupational health and safety training and screening
  - Release and authorization forms
  - Follow-up correspondence asking for further information or confirmation of completion;
- Correspondence between the hospital and the Professional Staff member
  - Letters of offer (or employment contracts if employees)
  - Notification of recommendations made by the Chief of Department (or most appropriate clinical leader) and the Medical Advisory Committee (MAC) and decisions made by the board with respect to appointment, re-appointment, change of privileges or suspension, restriction or revocation of privileges;
- List of privileges held (as amended from time to time);
- List of administrative duties;
- Correspondence relating to physical or mental impairments (this information should be marked "strictly confidential protected from unauthorized access");
- Correspondence relating to leaves of absence;
- Performance reviews and peer reviews;
- Written compliments from patients, colleagues, staff, the public;
- Written complaints from patients, colleagues, staff, the public;
- Investigation reports involving the Professional Staff member's practice or conduct;
- Disciplinary correspondence, letters of warning, reprimands, notices of suspension;
- Reasons from board hearings;
- University appointments and related correspondence;
- Cross-appointment information and related correspondence;
- Legal advice received by the hospital with respect to the member (this should be kept separately, marked "Strictly Confidential", and the member should not have access to the information); and
- Consents by the member for release of information from the file.

These documents are usually stored in reverse chronological order (most recent documentation at the top of the file).

Some hospitals require that documents from third-parties (such as graduate school diplomas) be notarized so that the receiving hospital has greater assurance (or has reassurance) that they are "true copies" of the originals and have not been altered.

Online Tracking Systems

A few hospitals have initiated electronic, online applications for initial appointment and re-appointment to assist in expediting the collection and storage of Professional Staff member information. Some of these programs are sophisticated and include a variety of features that help streamline the application process, reduce duplication, and organize information quickly and logically. By using an online application tool, some or all of the information can be produced by Professional Staff members (or administrative staff) using simple forms and drop-down menus. For example, a member may be able to answer whether mask fit testing has been completed, whether a change in privilege status is requested, and whether privileges have been obtained at another hospital.

Once an application form is complete, it can be accessed online by the Chief of Department (or most appropriate clinical leader), Credentials Committee, and MAC for review. As well, some of these programs can track statistics, which provide MACs with a much more detailed picture of current privileges and any changes throughout the hospital.

Online tools can also be excellent methods for facilitating communication. For example, some hospitals use online tools to notify Chiefs of Departments (or most appropriate clinical leaders) about such matters as when there are new applications or when they need to approve applications. This can save a great deal of time for those who would otherwise have to send out this information manually.

As well, select departmental access to limited information allows a timely determination of whether someone who presents on a unit or in the operating room (OR) actually has privileges. Some hospitals find that their online databases are used by OR staff to verify newly appointed members of the Professional Staff or physicians who have been granted temporary privileges. It would also allow new staff on a unit to verify the privileges of a long-standing Professional Staff member.

There are many benefits to the electronic programs, and the uses are limited only by a hospital's creativity (and budget).

Retention Periods

The OHA Record Retention Guidelines (2018)[1] recommend the following retention periods:

RECORD	PHYSICIAN APPLICATIONS
Legal retention period:	n/a
Recommended retention period:	Two years
Rationale:	*Limitations Act*, s.4
Comments:	If the application results in an appointment, the application constitutes part of the appointment record.
RECORD	**PHYSICIAN APPOINTMENT RECORDS**
Legal retention period:	n/a
Recommended retention period:	End of appointment year plus six years
Rationale:	Reasonable practice/*Limitations Act*, s.4 and s.15
Comments:	Physicians' appointments are generally made from year to year. Except for incidents involving patient care or disciplinary consideration or action, the issues most likely to arise with respect to an appointment are the terms of the appointment, which involve primarily contractual issues, for which two years would be an appropriate retention period. Incidents or disciplinary considerations that could have some relevance to a legal proceeding, inquiry or investigation (especially relating to patient care) should be retained longer, given the ultimate limitation period of 15 years under the *Limitations Act*. The seven-year recommendation is a balance between these considerations. Hospitals may wish to use it as the basis for a single retention period for appointment records.

Note: Hospitals should apply the same rules to all Professional Staff credentialing files.

1 Page 21.

Confidentiality, Access and Disclosure

The Professional Staff member's credentialing file should be considered confidential and stored in a secure location (whether in hard paper copy or electronically). Generally speaking, access to the information should be restricted to hospital staff members who have a need to know and use the information (such as the Chief of Department (or other clinical leader), Chief of Staff/Chair of the MAC, CEO, Credentials Committee, and administrative staff performing credentialing-related functions).

Hospitals should develop policies or practices to anticipate requests for access to Professional Staff credentialing files and should identify on what authority information will be shared under the following kinds of circumstances (e.g., with written consent from the member, or as permitted or required by law):

- Professional Staff members access to their own files (need to keep third-party information that was provided to the hospital in confidence, such as letters of reference);
- Legal requests (for example, relating to regulatory college proceedings, litigation, and criminal investigations);
- Requests from a university if the member is cross-appointed;
- Requests from other hospitals if the member is cross-appointed or for their own credentialing processes;
- Requests from patients and their families;
- Requests from the public;
- Requests from the Ministry of Health;
- Requests from Occupational Health and Safety;
- Requests for letters of reference;
- Media requests; and
- Disaster or emergency management – sharing information with other hospitals, or the province or region to establish options for emergency staffing of the health care system.

Hospitals may need to seek legal advice when responding to requests for access to these files.

Freedom of Information Requests

Hospitals are subject to the *Freedom of Information and Protection of Privacy Act*.[2]

The Act has two purposes:

(a) To **provide a right of access to information** under the control of institutions in accordance with the principles that,

  i. Information should be available to the public,

  ii. Necessary exemptions from the right of access should be limited and specific, and

  iii. Decisions on the disclosure of information should be reviewed independently of the hospital controlling the information; and

(b) To **protect the privacy of individuals** with respect to personal information about themselves held by institutions and to provide individuals with a right of access to that information.

The Act establishes that every person potentially has the right of access to **any record or part of a record** in the custody or under the control of the hospital. While the right of access is quite broad, the hospital's obligation to provide access to records is affected by the following limitations:

- Only records that came into the custody or under the control of the hospital on or after January 1, 2007 are subject to the Act;
- The hospital may refuse access to records if the request is deemed to be frivolous or vexatious;

2 R.S.O. 1990, c. F-31.

- Certain records are excluded from the Act, meaning that the Act does not apply to them; and
- The Head of an institution (the Board Chair or their delegate) must not (in the case of mandatory exemptions) or may not (in the case of discretionary exemptions) disclose certain records.

Section 65 of the Act excludes credentialing files from the requirements of the Act. Clause 65(6)5 provides that the Act does not apply to records collected, prepared, maintained or used by (or on behalf) of the hospital that relates to meetings, consultations, discussions or communications about applications for hospital appointments, appointment of hospital privileges and anything that forms part of the personnel file. Generally speaking, records in a credentialing file will not be subject to a right of access under the Act and are excluded from the privacy provisions of the Act.

However, the credentialing file exclusion is not absolute, and section 65(7) outlines its exceptions. These exceptions refer to the types of records subject to the Act, which, if a hospital received a request for access, would require the hospital to process the record and determine if any other exclusions or exemptions apply. These exceptions are:

- An **agreement** between a hospital and a union;
- An **agreement** between a hospital and one or more hospital employees which ends in a proceeding before a court, tribunal, or other entity relating to labour relations or to employment-related matters;
- An **agreement** between a hospital and one or more employees resulting from negotiations about employment-related matters; or
- An **expense account** submitted by an **employee** of a hospital for the purpose of seeking reimbursement for expenses incurred by the employee in their employment.

There are other exclusions and exemptions under the Act and exclusions in other legislation (such as the *Quality of Care Information Protection Act*) that would restrict the release of credentialing file records to the public (such as labour and employment, quality of care information, research, teaching, personal practice, third-party and personal information records). Hospitals should review the *OHA Guidance Document # 11: FIPPA and Implications for Credentialing and Personal Practice Records* for further recommendations for how to deal with Freedom of Information requests for credentialing file records under the Act.

The Information and Privacy Commissioner of Ontario (IPC) has considered section 65(6)5 in three cases involving access requests for documents relating to complaints made about physicians with hospital privileges. The IPC determined that in order for section 65(6)5 to apply, the hospital seeking to rely on the exemption must establish that:

1. the records were collected, prepared, maintained or used by an institution or on its behalf;
2. this collection, preparation, maintenance or usage was in relation to meetings, consultations, discussions or communications; and
3. these meetings, consultations, discussions or communications are about applications for hospital privileges, the appointments or privileges of persons who have hospital privileges or anything that forms part of the personnel file of those persons.

In two cases where physicians with hospital privileges were seeking access to documents relating to complaints made about themselves, the IPC upheld the hospitals' exclusion of the documents from the purview of the Act (Order PO-3526 (2015) and Order PO-3336 (2014)).

In Order PO-3526[3], the document sought was an investigation report prepared by an investigator retained by the hospital to investigate complaints made by a number of hospital staff against the physician who sought the report. The IPC found that "the subject matter of the investigation report – complaints made about the appellant and investigated for the benefit of [the hospital's] consideration of them in the context of its relationship with the appellant – has some connection to the appellant's hospital appointment and privileges." In reaching its conclusion to uphold the exclusion of the report, the IPC confirmed that:

3 https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/134779/index.do

- There is no requirement that some action be taken in respect of the physician's appointment or privileges in order for the exclusion to apply.
- An outstanding application for privileges or an amendment, alteration or revocation of privileges is not necessary to engage the exclusion.
- Such action (i.e. an outstanding application or amendment, alteration or revocation of privileges) is not a prerequisite for establishing that a record prepared for a hospital was used by it in communications about the appointment or privileges of a physician.
- There is no requirement that the individual with privileges is a hospital employee in order for the exclusion to apply.

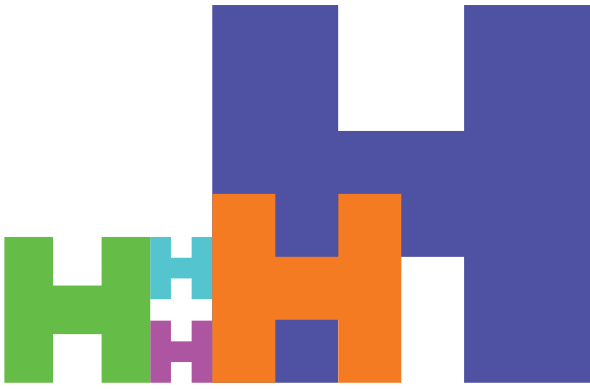
In Order PO-3336[4], the documents at issue were 36 emails sent to and from hospital employees and privileged staff on hospital-issued email accounts over the course of resolving six complaints brought against the physician. Some of the records summarized meetings, which were shared with staff who were unable to attend, as well as the actual communications between those who initiated the complaints and the hospital. With respect to the third branch of the test, the IPC held that "the examination of the complaints that are reflected in the records, including a determination respecting his privileges at the hospital, demonstrates a sufficiently strong and significant connection between the contents of the records and the continuation of the appellant's hospital privileges." The IPC found that all three branches of the test were met and that section 65(6)5 operated to exclude the records from the operation of the Act.

In contrast to these two decisions, in Order PO-3861 (2018)[5], the IPC found that section 65(6)5 did not apply to exclude the records sought from the application of the Act. In this case, the documents sought related to complaints that the requester had made to the hospital, the University of Ottawa, the College of Physicians and Surgeons of Ontario and the hospital's Board of Governors regarding a number of physicians with privileges at the hospital. The records consisted of emails discussing the complaints, consulting about the complaints, discussing what materials to review in order to respond to the complaints, and providing responses to the complaints, both in draft and final form. The IPC held that the third branch of the test was not met, and distinguished Orders PO-2526 and PO-3336, finding that the records for which the exclusion was claimed did not have "some connection" to applications for hospital appointments, the appointments or privileges of persons who have hospital privileges or anything that forms part of the personnel file. Instead, the IPC found that the discussions related to how to respond to the appellant's complaints.

Other Documents

For use in litigation or privileges hearings, hospitals should also keep corporate records that relate to Professional Staff rules and decisions such as historic versions of:

- Professional Staff by-laws (and explanations for changes)
- Rules and Regulations
- Professional Staff policies (or other policies passed by the MAC)



4 https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/134339/index.do

5 https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/315903/index.do

Chapter 12: Academic Issues

Reference Key:

Public Hospitals Act:	Regulation 964
OHA/OMA Prototype By-law:	None

Chapter Summary

- Credentialing in the context of academic health centres is subject to additional legal rules and management considerations.
- In an academic hospital, a triangular relationship exists among Professional Staff, the university and the hospital. Many clinicians are both "faculty" at the university and "Professional Staff" at the hospital.
- Managing the relationship with residents, fellows and post-doctoral fellows raises slightly different issues than credentialing Professional Staff. Recruitment and verification of credentials may be predominantly dealt with through a Post-graduate Medical Education Office at a university (although some hospitals retain a credentialing role).
- A number of additional academic disputes may affect privileges, including academic freedom and intellectual property issues, which may be managed by utilizing dispute resolution processes determined by the university (and not the hospital exclusively depending on the affiliation agreement and applicable policies).
- Affiliation agreements, Professional Staff by-laws, and contracts between hospitals and Professional Staff may be examined by the Health Professions Appeal and Review Board (HPARB) and courts in privileges disputes to determine whether there is sufficient evidence of an academic commitment on the part of the hospital, and to determine the scope of decision-making between the hospital and university. These documents have a dramatic impact on whether an individual has a right to a hospital board hearing and whether a hospital is justified to alter duties or resources, terminate a contract, revoke privileges, or revoke access to services. Great care must be taken to appropriately detail the academic mission and expectations in these documents.

Academic Hospitals

An academic or teaching hospital is one affiliated with a university that provides formal clinical training placements for health professionals. As well, academic hospitals generally provide the most complex and urgent care services in the province and are the sites of basic and clinical research programs.

The *Public Hospitals Act*, Regulation 964,[1] categorizes hospitals in Ontario. There are three categories of academic hospitals:

- Group A hospitals, being general hospitals providing facilities for giving instruction to medical students of any university, as evidenced by a written agreement between the hospital and the university with which it is affiliated, and hospitals approved in writing by the Royal College of Physicians and Surgeons for providing post-graduate education leading to certification or a fellowship in one or more of the specialties recognized by the Royal College of Physicians and Surgeons.
- Group H hospitals, being psychiatric hospitals providing facilities for giving instruction to medical students of any university.

1 *Public Hospitals Act*, R.R.O. 1990, Reg. 964, Classification of Hospitals.

- Group L hospitals, being hospitals for the treatment of patients suffering from alcoholism and drug addiction and providing facilities for giving instruction to medical students of any university as evidenced by a written agreement between the hospital and the university with which it is affiliated.

There are 24 hospitals in Ontario that have teaching or research affiliations with one of the six university medical (or health sciences) schools. These are in London (University of Western Ontario), Hamilton (McMaster University), Toronto (University of Toronto), Kingston (Queen's University), Ottawa (University of Ottawa) and Northern Ontario (Northern Ontario School of Medicine).

Key Players

In this chapter, we will introduce key players in the legal framework for credentialing in an academic context. A few of these players were introduced in Chapter 3, Roles and Responsibilities, and will receive more thorough review here.

CAHO – The Council of Academic Hospitals of Ontario (CAHO) is the non-profit association of Ontario's 24 academic hospitals and their research institutes. CAHO provides a focal point for strategic initiatives on behalf of these academic hospitals.

CaRMS – The Canadian Resident Matching Service provides an electronic application service and a computer match for entry into post-graduate medical training throughout Canada. To date, CaRMS administers the matching process for: post-graduate Year 1 entry residency positions; Year 3 Family Medicine - Emergency Medicine residency positions; Internal Medicine subspecialty residency positions; and Pediatric subspecialty residency positions.

Clinical faculty members are licensed clinicians who hold joint appointments between a hospital and a clinical department at an affiliated university and are responsible for supervision (including teaching and evaluation) of undergraduate and post-graduate trainees enrolled with the university. The terms of appointment at a university may differ and are determined through university policies, affiliation agreements and other contracts. These terms of appointment may include financial requirements such as conforming to practice plan membership. Some appointments, such as "Geographic Full-Time", may involve a salary, an office and other supports and an income ceiling for redistribution of funds for teaching and research purposes within the Faculty/Department.

Clinical fellows are clinicians or dentists who are doing additional subspecialty training that usually begins after completion of a standard resident program. They must be registered as clinical fellows at an affiliated university and must be engaged in academic activities. Depending on the subspecialty, a fellowship can last from one to three years beyond residency. They may or may not require privileges at a hospital (depending on the hospital's by-laws). Their practice in a hospital is generally supervised by a member of the Professional Staff.

House staff may be a term used in hospital by-laws to refer to a category of privileges for post-graduate trainees who are enrolled in an academic program at an affiliated university, and who hold a professional license of registration with the relevant regulatory college.

Observer is a person who informally observes patient care at the hospital, unrelated to a formal supervisory or training program.

PARO is the Professional Association of Residents of Ontario (PARO), which represents medical residents in Ontario.

Post-doctoral fellows or **PDFs** are individuals who hold a Ph.D. degree and are appointed to an academic hospital to do research under supervision.

Post-graduate Medical Education Office at a university is usually the liaison between academic hospitals and universities for residency and fellowship placements.

Post-graduate trainees is a term sometimes used to include residents, clinical fellows, research fellows and PDFs.

Research fellows are trainees who perform research duties. They may be licensed as post-graduate trainees by a regulatory college, and sometimes have patient contact.

Residents are clinicians who complete specialty training in a two to five year program that starts after completion of their clinical degree. They must be registered in a Residency Program with an affiliated university and must be engaged in academic activities. They may or may not require privileges at a hospital (depending on the hospital's by-laws). Their practice in a hospital is supervised by a member of the clinical faculty.

Supervisors are clinical faculty who are delegated by their respective training programs to educate, observe, assess, and supervise the educational activities of students. They may also be the most responsible clinicians for the patients receiving care in the hospital.

Undergraduate students are university students enrolled in an undergraduate education program. They do not hold any special status or membership with a regulatory body.

Additional Legal Context

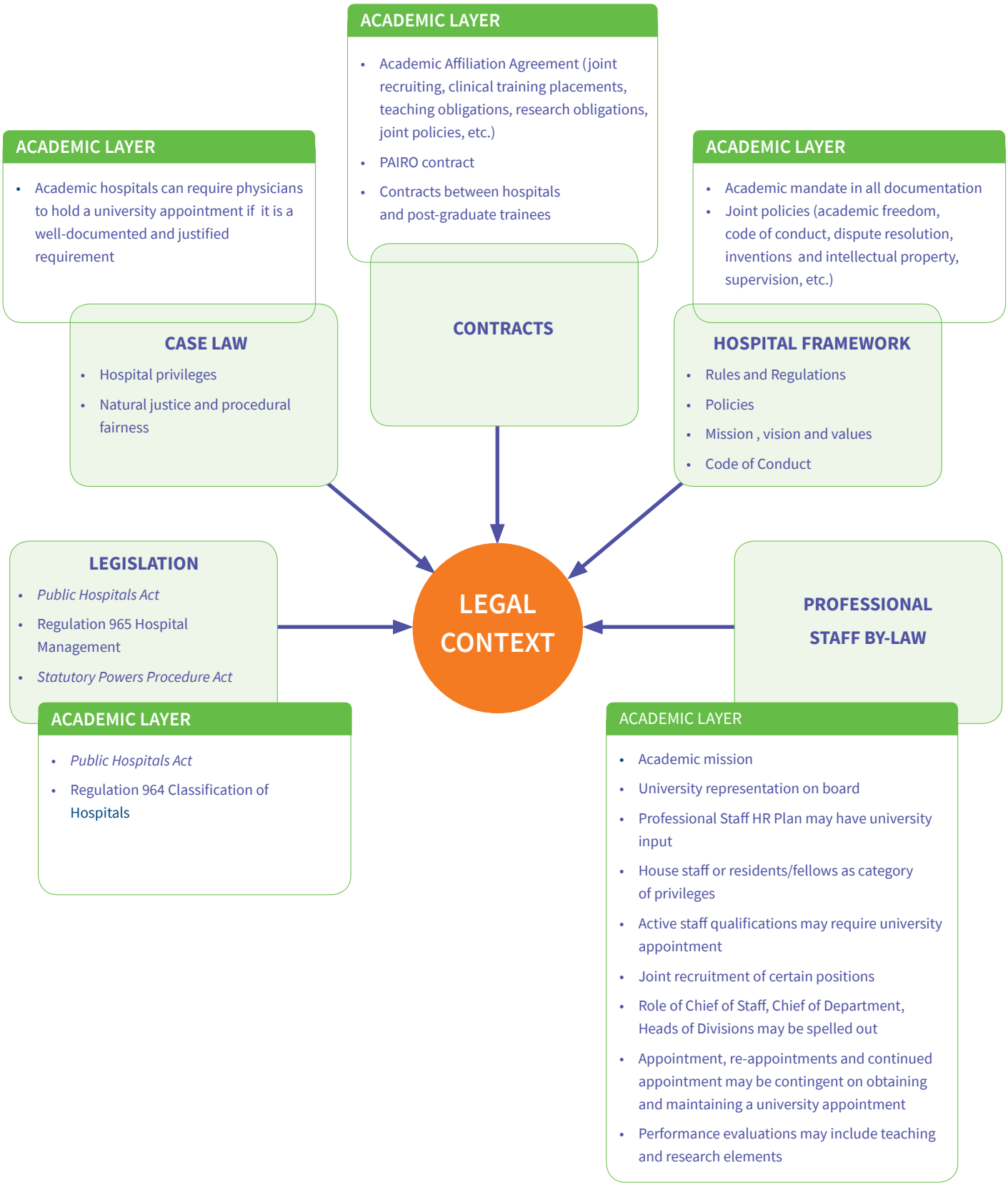
In Chapter 2, Legal Context, we highlighted the legal context in which hospitals perform their credentialing functions. When dealing with credentialing issues in an academic hospital, there are additional issues to consider:

- **LEGISLATION:** The *Public Hospitals Act*, Regulation 964, defines three categories of academic hospitals and the Ministry of Health maintains an online list of those hospitals.[2]
- **PROFESSIONAL STAFF BY-LAW:** The Professional Staff by-law of an academic hospital will have an additional layer of academic content, such as:
  - Acknowledgement of the mission of the hospital as an academic hospital (such as a tripartite mission of teaching, research and clinical service)
  - University representation on the board
  - Professional Staff Human Resources Plans may require university input
  - Special qualification requirements for appointment or re-appointment to the active staff such as:
    a. Holding a university appointment
    b. Academic or research achievements
    c. Meeting requirements set forth in an affiliation agreement
  - Processing of applications may need to be done in accordance with an affiliation agreement and there may be joint recruitment efforts with the university
  - Acknowledgement that the hospital board may refuse to appoint or re-appoint a candidate for failure of the applicant to obtain an academic appointment where such academic appointment was a condition of the appointment
  - Acknowledgement that the hospital board may suspend, restrict, or revoke privileges for failure to maintain an academic appointment if it was a requirement for appointment
  - Additional categories of Professional Staff may include "house staff" or "residents/fellows" and specific qualification, appointment and re-appointment criteria for that new category
  - Joint recruitment and appointment of Chiefs of Departments or Heads of Divisions with the University
  - Additional roles and responsibilities for Chief of Staff/Chair of the Medical Advisory Commitee (MAC), Chief of Department, Head of Division with respect to teaching and research in addition to clinical service
  - Performance evaluations of Professional Staff may include teaching and research elements

Community hospital by-laws may also need to acknowledge academic pursuits and university affiliations. The Dittmer case described later in this chapter underscores that if a hospital wishes to give preferential access to hospital resources for Professional Staff who hold an appointment at a university, denying or removing

2 See the Ministry of Health website at: http://www.health.gov.on.ca/en/common/system/services/hosp/hospcode.aspx#groups

Academic Hospital Legal Context



access to those resources for Professional Staff who do not hold an appointment at a university, the close relationship between the hospital and the university must be clearly set out in the Professional Staff by-law of the hospital.

- **HOSPITAL FRAMEWORK:** There is an additional layer of hospital documentation and policies when dealing with academic issues, such as:
  - In an academic hospital, the "academic" mandate is often woven through the foundational documents (mission, vision, values, and policies).
  - Through the affiliation agreement, there may be joint or university policies that will also apply to the hospital, clinical faculty, and students, residents and fellows, such as:
    a. Academic freedom
    b. Code of Conduct
    c. Dispute resolution
    d. Inventions and intellectual property
    e. Moonlighting
    f. Research
    g. Sexual harassment
    h. Supervision of trainees
- **CONTRACTS:** Academic affiliation agreements include binding requirements on hospitals for matters such as:
  - Joint recruitment and appointment of Chiefs of Department/Heads of Divisions, active staff/clinical faculty, and scientists
  - Clinical training opportunities for students, residents and fellows
  - Teaching obligations
  - Research obligations
  - Joint policies

These contracts may be signed by fully-affiliated "teaching" hospitals as well as community hospitals that have specific academic mandates. Again, the Dittmer case described below demonstrates that if a hospital gives Professional Staff who hold an appointment at a university preferential access to hospital resources, and denies or removes this access for Professional Staff who do not hold an appointment at a university, the affiliation between the hospital and the university must be clearly documented (in addition to having the access rules set out in the Professional Staff By-law of the hospital).

The contract between PARO and CAHO is also relevant with respect to resident compensation.

There may also be contracts between hospitals and post-graduate trainees that set out certain conditions to be met.

- **CASE LAW:** As described later in this chapter, there are cases specific to the academic hospital context.
- **COLLEGE POLICIES:** As an additional layer, there are specific College of Physicians and Surgeons of Ontario policies with respect to:
  - Professional Responsibilities in Undergraduate Medical Education.[3]
  - Professional Responsibilities in Post-graduate Medical Education.[4]

Planning and Recruitment

Chapter 4, Planning and Recruitment, underscored the importance of the Professional Staff Human Resources Plans as credentialing tools. The Professional Staff Human Resources Plans can play a significant role in documenting the academic goals of a hospital and can be used as joint planning tools between a hospital and its affiliated university. They can also be used to explain refusals to

3 College of Physicians and Surgeons of Ontario, "Professional Responsibilities in Undergraduate Medical Education" (May 2012), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Undergraduate-Med >.

4 College of Physicians and Surgeons of Ontario, "Professional Responsibilities in Postgraduate Medical Education", (May 2011), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Postgraduate-Medi >.

appoint to the Professional Staff applicants who do not meet the academic (i.e., teaching or research) aspects of the position.

Credentialing of Residents, Fellows, and Post-Doctoral Fellows

Residents may be hospital employees who are hired through an agreement negotiated between CAHO and PARO.

Practices differ between hospitals as to whether they credential residents and fellows. In many cases, residents and fellows are simply registered with the affiliated university and overseen by clinical faculty at the hospital without undertaking a separate credentialing process by the hospital. In other cases, hospitals perform additional credentialing practices for post-graduate trainees (such as checking to see that the applicant has proof of immunization and evidence of professional liability protection coverage (insurance), and require signed contracts).

If a hospital has residents or fellows, it may choose to include in its Professional Staff By-law a separate category of Professional Staff such as:

House Staff

Residents and fellows as members of the House Staff:

(a) may undertake such academic, clinical, research and administrative duties and responsibilities as assigned;

(b) shall be appointed annually or for any shorter period to the House Staff by the board upon the recommendation of the MAC;

(c) shall participate in the care of patients under, and subject to the supervision and direction of the Professional Staff, and in concurrence with the guidelines provided by their respective regulatory college;

(d) shall be registered in a post-graduate program of the university for the purpose of fulfilling the requirements for a regulatory College Certificate of Registration, including International Medical Graduate residency programs or pre-residency clerkships, and/or fulfilling the specialty or sub-specialty requirements to obtain a regulatory certificate; and

(e) shall be on the educational registry or fully licensed by the respective regulatory college.

Please note, the *OHA/OMA Prototype Board-Appointed Professional Staff By-law*, *2011* (OHA/OMA Prototype By-law) does not include a category of House Staff.

Resident allocation to different universities and programs of study is often done through CaRMS, through its matching process. Once a resident is assigned to a university program, it is the university program that makes arrangements for placement at various different hospitals or community teaching sites. All residents are registered through the Post-graduate Medical Education Office of their university. With respect to fellows, they too are registered through the university Post-graduate Medical Education Office. If they are not so registered, they are not considered by the Ministry of Health as a fellow. International medical graduates may also pursue placements through HealthForce Ontario's Access Centre and Ontario's Repatriation Program.

Until a post-graduate trainee is registered with an affiliated university, they may not be entitled to apply directly to an academic hospital for a placement. Separate or slightly different application expectations for post-graduate trainees may exist in the Professional Staff By-law, in contrast to other categories of Professional Staff, to acknowledge the coordinating role of the Post-graduate Medical Education Office.

Hospitals and affiliated universities have a vested interest to share responsibility for ensuring that applicants to post-graduate trainee programs are legitimate graduates of their referring programs. Given the international opportunities for students, there may be additional immigration issues for universities and hospitals to manage. Just as with applicants to the general Professional Staff, it is important for hospitals and universities to ensure they verify an applicant's credentials.

Academic Disputes and Dispute Resolution

There are a number of additional academic disputes that can affect privileges, including: academic qualifications, academic performance evaluations, academic freedom, and intellectual property issues. Depending on the terms of the affiliation agreement, those disputes may be managed utilizing dispute resolution processes determined by the university alone or a joint hospital/university dispute resolution process (that is, the affiliation agreement may not permit the hospital to manage certain disputes without consulting with the university or following university policies).

Regardless of the reason for the dispute or the dispute resolution process articulated in an affiliation agreement, a hospital board always retains the exclusive authority under the *Public Hospitals Act* to make decisions about appointments or re-appointments to the Medical Staff or about suspending, restricting or revoking Medical Staff privileges (and this authority may be extended to apply to all members of the Professional Staff through the by-laws).[5] Even if a university makes a decision to terminate a relationship with an individual who is jointly appointed to a hospital, the hospital must give the individual the procedural process owed under the Public Hospitals Act and the hospital by-laws before taking any action with respect to the individual's hospital privileges.

However, if through a contract, a university has the sole discretion to make decisions (for example, about academic performance or the rotation of residents to hospital programs), changes in those decisions do not grant entitlement to a hospital privileges hearing or a cause of action against the hospital.

In the case of *Dr. Phillips v. Foothills Provincial General Hospital*,[6] Dr. Phillips entered into a contract for a residency training position in neurosurgery with Foothills Provincial General Hospital in accordance with the terms of an affiliation agreement between the hospital and the University of Calgary. Continuation of Dr. Phillips' contract with the hospital was subject to the receipt of, and the maintenance of, a satisfactory evaluation by the university. The hospital terminated Dr. Phillips' residency upon receiving from the University of Calgary a six-month evaluation of Dr. Phillips' performance indicating that Dr. Phillips was not academically qualified to continue in the university's post-graduate clinical program in neurosurgery. Dr. Phillips argued that the procedures set out in the university's Terms of Reference had not been followed and that the rules of natural justice were not observed. The hospital argued that the evaluation of Dr. Phillips' qualifications in neurosurgery and the conduct of the appeals were academic matters within the exclusive jurisdiction of the university. Once the university made a determination that Dr. Phillips was not qualified, the hospital was authorized by contract with Dr. Phillips to terminate his residency. The court concluded that the offer of a position as a resident in neurosurgery at the hospital was based on the selection, interview and acceptance process which lay solely and exclusively within the purview of the university. The court also concluded that there were no procedural defects by the university. The court found that Dr. Phillips did not have a cause of action against the hospital for the academic appeals offered through the university. His claims against the hospital were dismissed.

Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges

A body of case law exists with respect to refusing appointments and re-appointments and suspending, restricting or revoking privileges specific to the academic context. The following are the key messages from that case law:

- Under certain circumstances determined by the documentation of the academic affiliation, it may be justifiable for an academic hospital to revoke a member of the active staff's privileges if they fail to maintain an appointment with the affiliated university (*Matangi*[7]).

5 See below the discussion of *Dr. Matangi v. Kingston General Hospital,* [1998] 40 0.R. (3d) 41 (Gen. Div.) for clarification that a hospital cannot abdicate to a university its responsibilities with respect to privileges.

6 *Phillips v. Foothills Provincial General Hospital* [1989] A.J. No. 349, 95 A.R. 268 (AB. Q.B.)

7 *Dr. Matangi v. Kingston General Hospital,* [1998] 40 0.R. (3d) 41 (Gen. Div.).

- If a hospital is going to give Professional Staff who hold an appointment at a university preferential access to hospital resources, and if a hospital proposes to deny or remove access to those resources for Professional Staff who do not hold an appointment at a university, the affiliation between the hospital and the university must be clearly documented and the rules should be set out in the Professional Staff by-laws of the hospital (*Dittmer*[8]).
- If a hospital revokes a physician's access to interns or residents (material and human resources of the hospital), such revocation may constitute a substantial alteration in privileges even if the physician continues to enjoy the same category of privileges – and the physician may have a right to a hearing under the *Public Hospitals Act* (*Dittmer*[9], *Peterson*[10] and *Rabin, Posen and Jindal*[11]).

CASE OF *HORNE V. QUEEN ELIZABETH II HEALTH SCIENCES CENTRE AND CAPITAL DISTRICT HEALTH AUTHORITY* (Nova Scotia Court of Appeal, 2018)

Dr. Horne was a cardiologist and researcher at the Queen Elizabeth II Heath Sciences Centre. Her appointment began in 1998 when she was offered a joint position as an assistant professor of cardiology at Dalhousie's Department of Medicine and as a staff physician in the Hospital's Division of Cardiology. Upon appointment, the allocation of her time was 30% clinical, 10% teaching and 60% research.

Dr. Horne enrolled study participants for her research at the hospital's heart function clinic, where she was on medical staff. Dr. Horne and the director of the clinic, Dr. Howlett, had a difficult relationship. Following escalating tension, Dr. Horne's hospital privileges were summarily varied to restrict her enrollment of the clinic's patients and she was unable to continue her research.

Four years after the variation of Dr. Horne's privileges, the Health Authority's board of directors, which had ultimate authority over privileges, decided that the summary variation had not been justified, and reinstated Dr. Horne's privileges.

Dr. Horne then sued the Capital District Health Authority, claiming that her privileges had been summarily varied in bad faith and in breach of her contract, causing compensable harm to her research career. A jury awarded Dr. Horne damages of $1.4 million for administrative bad faith. Dr. Horne appealed and the Health Authority cross-appealed to the Nova Scotia Court of Appeal, where the damages award was reduced to $800,000.

The Court of Appeal confirmed that the wrongfulness of the summary variation of Dr. Horne's privileges was to be assessed administratively, not contractually and that the trial judge correctly concluded that the only appropriate cause of action was administrative bad faith.

The Court of Appeal set aside the damages award of $1.4 million though because of a confusing and deficient jury charge. In determining the quantum of damages, the Court of Appeal stated that it was assessing "as general damages, a non-pecuniary lump sum to compensate Dr. Horne for her suffering from Capital Health's actionable conduct," and clarified that the damages award was "not an arithmetically calculated pecuniary loss," nor was it lost income, nor was "it to punish Capital Health for its bad faith." The Court of Appeal assessed Dr. Horne's general damages for loss of reputation and loss to her research career at $800,000.

8 *Dr. Dittmer v. The Board of Directors of Parkwood Hospital,* August 6, 1998, Ontario Hospital Appeal Board.

9 Ibid.

10 *Dr. Peterson v. Board of Trustees of Ottawa Civic Hospital* #2 November 1, 1984 (Ontario Hospital Appeal Board).

11 *Drs. Rabin, Posen & Jindal v. Board of Trustees of Ottawa Civic Hospital,* September 16, 1992 (Ontario Hospital Appeal Board).

Observers

Hospitals receive many requests to observe clinical encounters as part of educational sessions (and for other reasons). Privacy issues arise with the introduction of observers to a clinical interaction. Because of this, many hospitals have in places policies with respect to observers. Such policies usually explain how observers are to be registered within the hospital and supervised, and the confidentiality expectations for the observer.

From a credentialing perspective, it should be clear that observers may not diagnose, care for or treat patients. If not engaged in clinical care, they do not need to apply for or receive privileges. However, in the event that an observer is called on to provide clinical care, privileges must first be obtained.

FAQs

1. What is the agreement between PARO and CAHO?

At the time of writing, the 2016-2020 version of the agreement between the PARO and CAHO is available online.[12] It sets out the employment relationship between residents and academic hospitals in Ontario.

2. Under what conditions can residents or students be removed from the supervision of an academic instructor?

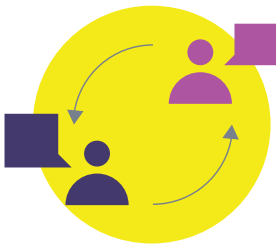
Just as with any professional relationship, problems can arise between residents/students and their academic instructors. A variety of strategies may be employed depending on the nature of the concerns or dispute (the issues could range from personality conflicts, academic misconduct, loss of academic appointment, incompetency, harassment, or incapacity among others). The terms of the academic relationship are set out in academic affiliation agreements and policies of participating universities and hospitals. It is important to identify and follow applicable rules with respect to investigations, dispute resolution, hearings and appeals.

3. If a physician does not meet productivity expectations of their division and that negatively impacts their appointment at the hospital, what appeal processes are available?

Productivity expectations of academic clinicians may be set out in affiliation agreements, contracts for services, appointment letters, policies, or performance reviews by either the participating university or hospital or both. Dispute resolution clauses will guide the appeal processes available to individuals. If a Professional Staff member's privileges are suspended, restricted, or revoked, they are entitled to a hearing before the hospital board.

4. Should resident trainees who are "moonlighting" be credentialed at institutions that are not their base hospital?

The Royal College of Physicians and Surgeons of Canada defines "moonlighting" as extracurricular (i.e. outside of a residency training program) provision of clinical services for remuneration, by residents registered in a postgraduate medical education program leading to certification with the College of Family Physicians of Canada (CFPC) or with the Royal College of Physicians and Surgeons of Canada (RCPSC).[13] Hospitals should review their affiliation agreements, by-laws and policies to determine whether external resident trainees should provide clinical services and should follow any credentialing requirements they would otherwise apply to their own residents.



12 See http://www.myparo.ca/your-contract/.

13 Royal College of Physicians and Surgeons of Canada, "CBD Policy: Moonlighting" (2016), online: RCPSC < http://www.royalcollege.ca/rcsite/documents/cbd/cbd-policy-comm-moon-e.pdf >.

Appendix I: Glossary of Terms

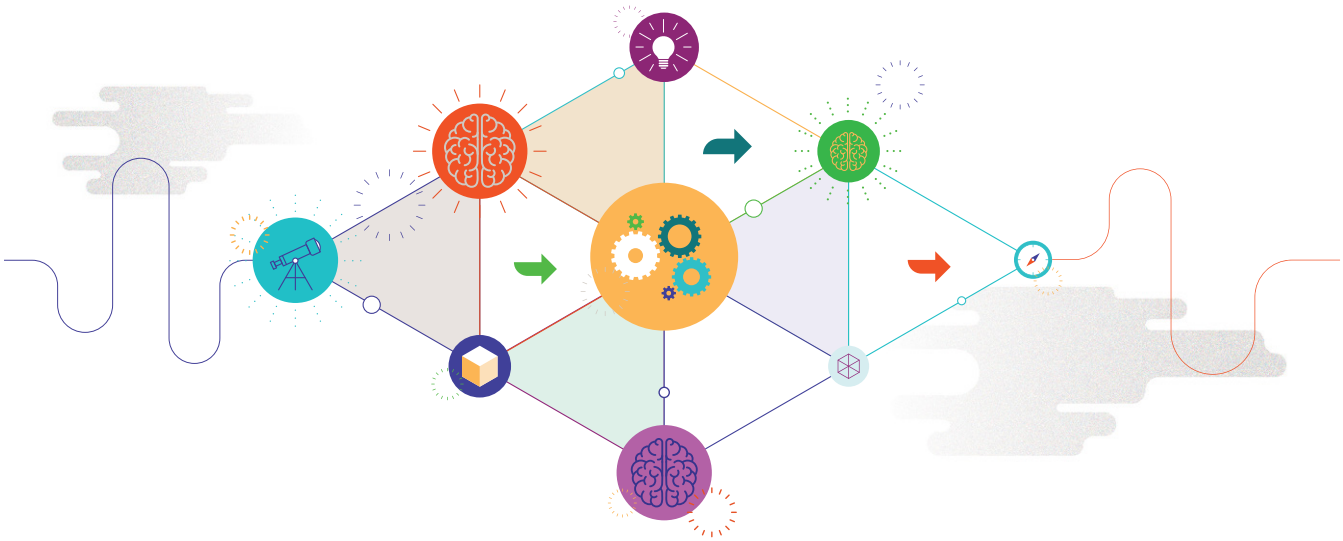
This Toolkit generally relies on the same definitions set out in the *OHA/OMA Hospital Prototype Board-Appointed Professional Staff By-law,* 2011(OHA/OMA Prototype By-law). The following words and phrases have the following meanings:

WORDS AND PHRASES	MEANINGS
Board	Board of Directors of the Hospital.
Chair of the Medical Advisory Committee (Chair of the MAC) or Chief of Staff	The member of the Professional Staff appointed to serve as Chair of the MAC. Must be a member of the MAC.
Chief Executive Officer (CEO)	In addition to "administrator," as defined in the *Public Hospitals Act*, the President and Chief Executive Office of the Corporation.
Chief Nursing Executive	The senior nurse employed by a hospital who reports directly to the Chief Executive Officer and is responsible for nursing services provided in the hospital.
Chief of Department	A member of the Professional Staff appointed by the board to be responsible for the professional standards and quality of care rendered by the members of that department at the Hospital.
Chief of Staff	See Chair of the MAC.
Credentials	A license, certificate or other documented qualification that establishes that a person has achieved a particular form of competency.
Credentialing	The process by which a hospital reviews a prospective Professional Staff member's qualifications, experiences, licenses, etc., to determine whether the individual meets the requirements of the hospital for privileges.
Credentials Committee	The committee established by the MAC to review applications for appointment and re-appointment to the Professional Staff and to make recommendations to the MAC; if no such committee is established it shall mean the MAC itself.
Dental Staff	Those dentists appointed by the board to attend or perform dental services for patients in the Hospital.
Department	An organizational unit of the Professional Staff to which members with a similar field of practice have been assigned.
Division	An organizational unit of a Department.

WORDS AND PHRASES	MEANINGS
Extended Class Nursing Staff	Those Registered Nurses in the Extended Class who are: 1. Nurses who are employed by a hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital. 2. Nurses who are not employed by a hospital and to whom the board has granted Privileges to diagnose, prescribe for or treat out patients in the hospital. (Note that this Toolkit applies only to Extended Class Nursing Staff who fall under paragraph 2 above.)
Head of a Division	The member of the Professional Staff appointed to be in charge of one of the organized Divisions of a Department.
HPARB or Appeal Board	The Health Professions Appeal and Review Board, which has the statutory authority to reconsider any decision made by a hospital board relating to a physician's privileges.
Impact Analysis	A study to determine the impact upon the resources of the hospital corporation of the proposed appointment of an applicant for appointment to the Professional Staff.
In Camera	A closed proceeding of the board.
Medical Advisory Committee (MAC)	The committee established pursuant to the OHA/OMA Prototype By-law that is required by the *Public Hospitals Act* to advise the board on credentialing of Professional Staff and other quality of care issues.
Medical Staff	Those physicians who are appointed by the board and who are granted privileges to practice medicine in a hospital.
Midwifery Staff	Those Midwives who are appointed by the board and granted Privileges to practice Midwifery in a hospital.
Natural Justice	Explained in Chapter 2, Legal Overview.
Patient	Unless otherwise specified or the context otherwise requires, any in-patient or out-patient of a hospital.
Policies	The administrative, human resources, clinical and professional policies of a hospital and includes policies and procedures adopted by the board.
Professional Staff	The Medical Staff, Dental Staff, Midwifery Staff and members of Extended Class Nursing Staff who are not employees of a hospital.
Professional Staff Human Resources Plan(s)	A hospital's plan from time to time which provides information and future projections with respect to the management and appointment of the Professional Staff based on the mission and strategic plan of the hospital corporation.

Public Hospitals Act	The *Public Hospitals Act* (Ontario), and, where the context requires, includes the regulations made thereunder.
Registered Nurse in the Extended Class	A member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act*, 1991.
PUBLIC HOSPITALS ACT DEFINITIONS:	
administrator	The person who has for the time being the direct and actual superintendence and charge of a hospital.
Appeal Board	The Health Professions Appeal and Review Board under the Ministry of *Health and Long-Term Care Appeal and Review Boards Act*, 1998.
board	The board of directors, governors, trustees, commission or other governing body or authority of a hospital.
hospital	Any institution, building or other premises or place that is established for the purposes of the treatment of patients and that is approved under this Act as a public hospital.
medical advisory committee	A committee established under Section 35 of the *Public Hospitals Act.*
physician	A legally qualified medical practitioner.
treatment	The maintenance, observation, medical care and supervision and skilled nursing care of a patient and, if dental service is made available in a hospital by its board, includes the dental care and supervision of the patient.
HOSPITAL MANAGEMENT REGULATION 965 DEFINITIONS:	
admitted	Received and lodged in a hospital but does not include registered as an out-patient.
attending dentist	A member of the Dental Staff who attends a patient in the hospital.
attending midwife	A member of the Midwifery staff who attends a patient in the hospital.
attending physician	A member of the Medical Staff who attends a patient in the hospital.
attending registered nurse in the extended class	A registered nurse in the extended class who attends an out-patient in the hospital.
dental staff	1. The oral and maxillofacial surgeons to whom the board has granted the privilege of diagnosing, prescribing for or treating patients in the hospital, and 2. The dentists to whom the board has granted the privilege of attending patients in the hospital in co-operation with a member of the medical staff.
dentist	A member of the Royal College of Dental Surgeons of Ontario.
extended class nursing staff	Those registered nurses in the extended class in a hospital, 1. Who are employed by the hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital, and 2. Who are not employed by the hospital and to whomthe board has granted privileges to diagnose, prescribe for or treat out-patients in the hospital.

medical staff	Those physicians to whom the board has granted privileges of diagnosing, prescribing for or treating patients in the hospital.
midwife	A member of the College of Midwives of Ontario.
midwifery staff	Those midwives to whom the Board has granted privileges of assessing, monitoring, prescribing for or treating patients in the hospital.
nurse	A member of the College of Nurses of Ontario who is a registered nurse.
registered nurse in the extended class	A member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act,* 1991. For the purposes of this Regulation, a reference to a patient includes an out-patient, except where the context otherwise requires.



Appendix II: *Public Hospitals Act (and Regulation 965), Regulated Health Professions Act, 1991, and OHA/OMA Hospital Prototype Board-Appointed Professional Staff By-law, 2011*

Public Hospitals Act Public Hospitals Act, R.S.O. 1990, c. P.40 (ontario.ca)

Public Hospitals Act Regulation 965 R.R.O. 1990, Reg. 965: HOSPITAL MANAGEMENT (ontario.ca)

Regulated Health Professions Act, 1991 Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (ontario.ca)

OHA/OMA Hospital Prototype Board-Appointed Professional Staff By-law, 2021 Ontario Hospital Association Board Appointed Professional Staff (oha.com)

Appendix III: Resources and References

Primary and Secondary Non-Legal Sources

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TAB 3

Ontario Cancer Screening Performance Report 2023

Special Focus: Equity in Cancer Screening

ONTARIO HEALTH | JANUARY 2024

Ontario Health
Cancer Care Ontario

Parts of this material are based on data and information compiled and provided by the Canadian Institute for Health Information, Ministry of Public and Business Service Delivery, or Ministry of Health. Any conclusions, opinions, results, or statements contained in this report are those of the authors and do not necessarily represent those of the aforementioned nor should their endorsement be inferred.

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Foreword

Cancer is the leading cause of death in Ontario. Approximately one in two people in Ontario can expect to be diagnosed with cancer in their lifetime, and approximately 1 in 4 people in Ontario is expected to die of cancer. Effective screening and early diagnosis are crucial to reducing the burden (morbidity and mortality) of cancer. Screening in the asymptomatic population can detect cancer at an earlier stage, when treatment has a better chance of working. To support early detection of cancer, Ontario Health operates four organized cancer screening programs: the Ontario Breast Screening Program and High Risk Breast Screening Program, the Ontario Cervical Screening Program, ColonCancerCheck and the Ontario Lung Screening Program.

As in most jurisdictions around the world, access to health services were impacted by the COVID-19 pandemic in Ontario. All non-urgent or emergent health services, including cancer screening, were suspended in the province from March 23 to May 26, 2020, after which they were permitted to gradually resume. During the pandemic, Ontario Health provided clinical guidance to support the delivery of health services, including on the prioritization of cancer screening services according to risk. As this report presents data up to 2021, the impact of the COVID-19 pandemic and pause in screening services on key cancer screening performance indicators is clearly demonstrated.

We have applied an equity lens to the entirety of this report, with specific focus on examining the impact of several types of neighborhood-level marginalization on screening participation and follow-up of abnormal results. This equity lens is in alignment with Ontario Health's strategic priorities, *Annual Business Plan* and the *Ontario Cancer Plan*.

The findings in this report will be used to continually strengthen our cancer screening programs to meet the needs of the people in Ontario, following international standards for organized cancer screening programs. Future plans for the programs include: improving access to screening for trans and nonbinary people in Ontario, implementing the human papillomavirus test as the recommended cervical screening test in Ontario, implementing screening recommendations for people at increased risk for colorectal cancer, and provincial expansion of the Ontario Lung Screening Program.

Together with our partners at the Ministry of Health, we are working to decrease the burden of cancer in Ontario through the delivery of high-quality organized cancer screening programs.

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Key Findings

Ontario Breast Screening Program (OBSP)

- Participation and retention decreased during the COVID-19 pandemic, but began to recover in 2021
- Almost all participants with an abnormal screening mammogram result received a definitive diagnosis within six months. Targets for timely follow-up were not met in the most recent years likely due to delays related to the COVID-19 pandemic and human resource challenges
- Cancer detection rates increased in 2021, likely related to the prioritization of screening for those with higher breast cancer risk during the pandemic
- Sensitivity and specificity remained consistently high

Ontario Cervical Screening Program (OCSP)

- Cervical screening participation has continued to decrease over time. A large decrease occurred in the 21–24 age group, related to new guidance which encouraged health care providers to delay initiation of cytology-based screening for immunocompetent people until age 25
- Retention decreased during the pandemic, but began to recover in 2021
- Most participants with a high-grade cervical cytology test result received follow-up within six months
- Cervical pre-cancer and cancer detection rates increased in the most recent year, likely related to the prioritization of people at higher risk for cervical cancer during the pandemic

ColonCancerCheck

- The percentage of people overdue for colorectal cancer screening was stable before the COVID-19 pandemic, after which it increased
- Participation in fecal-based colorectal cancer screening has remained stable. The COVID-19 pandemic minimally impacted fecal test participation likely because the test can be done at-home
- Following the implementation of the fecal immunochemical test in 2019, improved rates of follow-up following an abnormal fecal test, increased positive predictive value and cancer detection rate have been observed
- Colonoscopy quality remained consistently high

Ontario Lung Screening Program (OLSP)

- Ontario's Lung Cancer Screening Pilot for People at High Risk transitioned to an organized cancer screening program in 2021
- The percentage of low-dose computed tomography (LDCT) scans that had abnormal findings (Lung-RADS® 3, 4A, 4B, 4X) and rates of cancer detection have decreased over time; this is because the percentage of people having their first LDCT screen has decreased as the program matures
- Most lung cancers detected through the Ontario Lung Screening Program were early stages (78%), compared with only 35% of all lung cancers diagnosed in Ontario among people ages 55 to 74

Equity in Cancer Screening

- People living in neighborhoods with higher levels of material deprivation and ethnic concentration had lower rates of breast and cervical screening participation, lower rates of retention in the High Risk Ontario Breast Screening Program, lower rates of follow-up after an abnormal cervical and colorectal cancer screening test, higher rates of being overdue for colorectal screening, and lower rates of completing lung cancer screening after being determined eligible

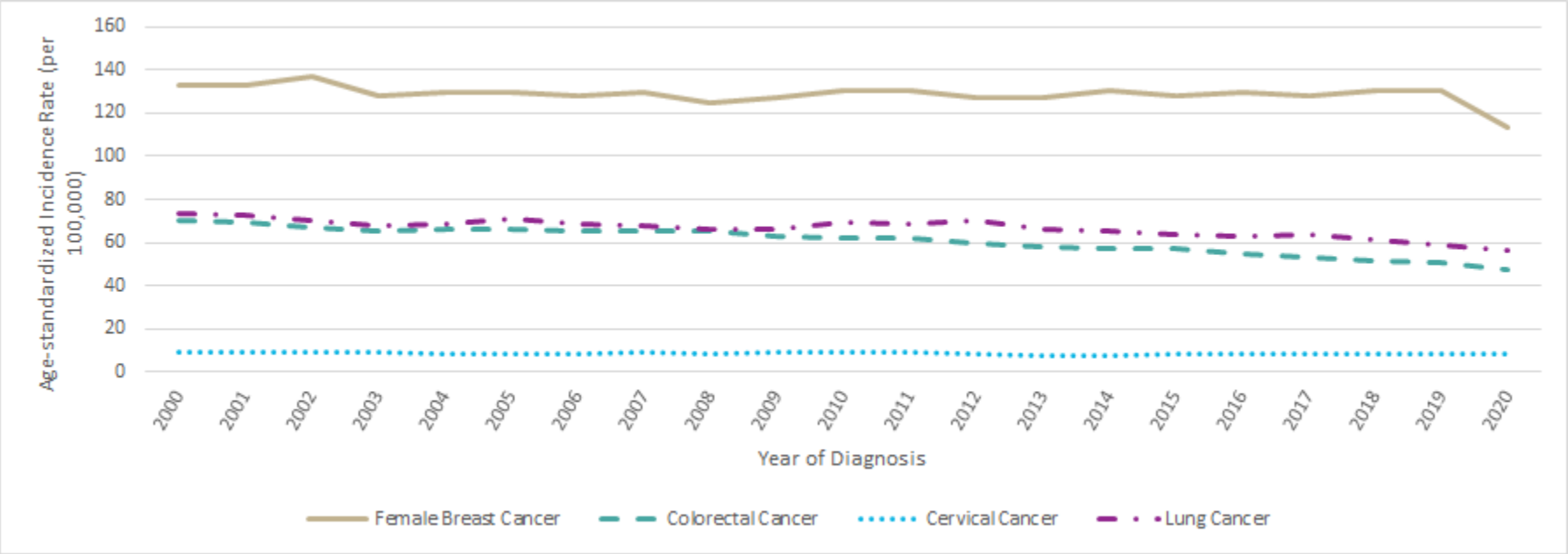
Burden of Disease

A Note About the Data in this Section

The statistics reported by sex in this section include female and male terms, which refer to the sex that is recorded in the Ontario Cancer Registry. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity and may incorrectly classify people whose gender identity differs from their sex assigned at birth.

Incidence of Female Breast, Colorectal, Cervical and Lung Cancer in Ontario, 2000 to 2020

Figure 1: Age-standardized Incidence Rate of Female Breast, Colorectal, Cervical and Lung Cancer in Ontario, 2000 to 2020



For data, see Table 1 in Appendix 1.

In 2018, female breast cancer was the most commonly diagnosed cancer in Ontario. With 11,728 cases diagnosed in 2018, it accounted for 27.8% of all new cancer cases (1). The age-standardized incidence rate for breast cancer in Ontario was 113.8 per 100,000 in 2020. Breast cancer incidence remained relatively consistent from 2000 to 2019. The decrease in incidence from 2019 to 2020 may reflect challenges with getting access to screening and diagnostic services during the COVID-19 pandemic, but more data are needed before drawing definitive conclusions.

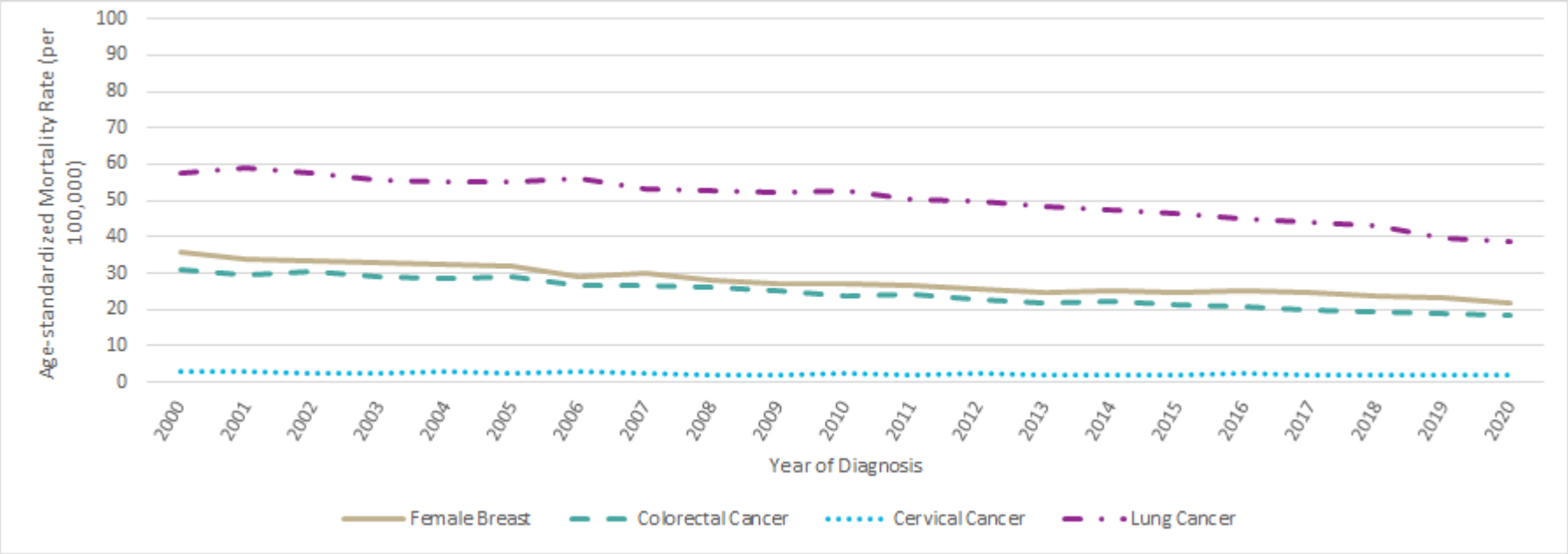
In 2018, lung cancer was the third most commonly diagnosed cancer in Ontario. With 10,337 cases diagnosed in 2018, lung cancer accounted for 12.2% of new cancer cases (1). The age-standardized incidence rate has been decreasing over time, from 73.4 per 100,000 in 2000 to 56.1 per 100,000 in 2020.

Colorectal cancer was the fourth most commonly diagnosed cancer in Ontario in 2018. There were 8,398 cases diagnosed in 2018, accounting for 9.9% of all new cancer diagnoses (1). The age-standardized incidence rate for colorectal cancer decreased from 69.7 per 100,000 in 2000 to 47.7 per 100,000 in 2020.

In 2018, cervical cancer accounted for 1.5% of all cancer cases in females (1). The age-standardized incidence rate for cervical cancer decreased slightly from 9.4 per 100,000 in 2000 to 7.9 per 100,000 in 2020. Cervical cancer is less common than other cancers that have organized screening programs in Ontario, partly due to the success of cervical screening with cytology in reducing cervical cancer incidence and mortality (2).

Mortality for Female Breast, Colorectal, Cervical and Lung Cancer in Ontario, 2000 to 2020

Figure 2: Age-standardized Mortality Rate for Female Breast, Colorectal, Cervical, and Lung Cancer in Ontario, 2000 to 2020



For data, see Table 2 in Appendix 1.

Of the four cancer types that Ontario provides organized screening for, lung cancer is the most fatal. In 2018, lung cancer deaths numbered 6,971, accounting for 23.5% of all cancer deaths (1). The age-standardized mortality rate for lung cancer decreased over time but remained higher than the age-standardized mortality rates for female breast, colorectal and cervical cancers at 38.8 per 100,000 in 2020.

In 2018, female breast cancer deaths numbered 2,003, accounting for 14.3% of all female cancer deaths (1). The age-standardized mortality rate for female breast cancer decreased over time and was 22.0 per 100,000 in 2020.

In 2018, there were 3,099 deaths due to colorectal cancer, accounting for 10.4% of all cancer deaths (1). Mortality for colorectal cancer also decreased over time, with an age-standardized mortality rate of 18.6 per 100,000 in 2020.

Similar to incidence trends, cervical cancer mortality is lower than mortality for female breast, colorectal and lung cancers. In 2018, cervical cancer was responsible for 1% of all cancer deaths (145 deaths) (1). Mortality for cervical cancer decreased slightly over time, with an age-standardized mortality rate of 1.9 per 100,000 in 2020.

Organized Cancer Screening in Ontario

Effective screening and earlier diagnosis are crucial to reducing the burden of cancer. Screening in the asymptomatic population detects pre-cancerous changes or cancers at an early stage, when treatment has a better chance of working (3). Screening that is delivered through organized programs is more likely to reduce cancer incidence and mortality, minimize the potential harms of screening and be cost-effective when compared to screening that happens outside of organized programs (4).

Ontario Health, which operates organized cancer screening programs in the province, is working to improve the quality, safety and accessibility of cancer services for all people in Ontario. These screening programs, which are guided by published evidence and high-quality research, include the Ontario Breast Screening Program (OBSP), the Ontario Cervical Screening Program (OCSP), ColonCancerCheck, and the Ontario Lung Screening Program (OLSP). Ontario's cancer screening recommendations are regularly updated to reflect emerging evidence and ensure that people in Ontario have access to high-quality care throughout their screening experience. Additional program-specific details, including eligibility criteria and screening pathways, can be found on pages 24-33.

Requirements for an Organized Cancer Screening Program

Building on the International Agency for Research on Cancer (IARC) recommendations for organized cancer screening (5,6), the World Health Organization and IARC convened a panel of experts beginning in 2020 to achieve international consensus on essential and desirable criteria for organized cancer screening programs (7). The 16 essential and eight desirable criteria for organized cancer screening are listed in Tables 1 and 2, along with a status note indicating whether the criterion is met by each of Ontario's cancer screening programs.

Table 1: Essential Criteria for Organized Cancer Screening Programs

Essential Criteria	Ontario Breast Screening Program[1]	Ontario Cervical Screening Program	ColonCancerCheck[2]	Ontario Lung Screening Program
A protocol or guideline describing at least the target population, screening intervals, screening tests, referral pathway and management of positive cases	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
A system in place for identifying the target population	●[3] Fully implemented	● Fully implemented	● Fully implemented	◑[3] Partially implemented
A system in place for inviting eligible individuals for screening	● Fully implemented	● Fully implemented	● Fully implemented	N/A[4]

[1] The information provided applies to both the average risk and High Risk Ontario Breast Screening Program (OBSP).

[2] The information provided does not apply to people at increased risk for colorectal cancer.

[3] The High Risk OBSP and the OLSP are programs for people at high risk for breast and lung cancer, respectively. Eligibility for screening is determined by assessing cancer risk by examining relevant risk factors. While a systematic approach for identifying the target population is not possible, Ontario Health provides evidence-based guidance and health care provider resources to support the referral of individuals for screening.

[4] The Ontario Lung Screening Program is only available to people determined to be at high risk for developing lung cancer based on specific smoking histories. Potentially eligible participants can self-present or be referred to the program by a health care provider to determine if they meet eligibility criteria.

Essential Criteria	Ontario Breast Screening Program[1]	Ontario Cervical Screening Program	ColonCancerCheck[2]	Ontario Lung Screening Program
A policy framework[5] from the implementing organization defining governance structure, financing, goals and objectives of the program[6]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented
Performance should be evaluated with appropriate indicators	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
The protocol or guideline should at least describe monitoring and evaluation[7]	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
A system in place for notifying of results and informing about follow-up	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
A system in place for sending recall notices to non-compliant individuals	● Fully implemented	● Fully implemented	● Fully implemented	●[8] Fully implemented

[5] A policy framework defines the financial support, governance structure, goals and objectives of the screening program to guide implementation and evaluation. It should describe the cooperation and the relationships between the stakeholders involved in the preparation, decision-making and implementation of the screening program.

[6] Criterion was assessed as partially met because most components of the framework have been separately developed but have not yet been incorporated into a fulsome policy framework.

[7] Cancer screening programs in Ontario are subject to robust monitoring, reporting and performance management processes. Focused evaluations are performed for all major program changes and overall program performance is evaluated on a regular basis in the Ontario Cancer Screening Performance Report.

[8] The system for recalling participants who are due for screening or surveillance scans is managed by Ontario Lung Screening Program sites.

Essential Criteria	Ontario Breast Screening Program[1]	Ontario Cervical Screening Program	ColonCancerCheck[2]	Ontario Lung Screening Program
Auditing of the program (defined as investigation of screening failures)[9,10]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented
A specified team or organization is responsible for quality assurance and improvement	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
Performance of the program is evaluated, published and widely disseminated on a regular basis	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
All activities along the screening pathway are planned, coordinated and evaluated through a quality improvement framework (quality assurance)	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented

[9] Screening failures are defined as 1) cancers occurring in people who were not screened within the recommended interval; 2) cancers occurring in people who were screened and found to have an abnormality, but who were not appropriately managed; 3) people who were adequately screened within the recommended interval with apparently normal results, but who developed cancer before the next screening round; 4) cancer occurring outside the target age group, overtreatment or screening-related complications.

[10] Ontario Health routinely monitors post-screen cancers in the OBSP, OCSP and CCC. Post-screen cancer case data are also provided to radiologists and endoscopists on an annual basis for quality improvement purposes. Post-screen breast cancers were evaluated after the first four years of screening in the High Risk OBSP. Post-screen lung cancers were evaluated during the piloting phase of the OLSP. A long-term reporting strategy for the OLSP is now being developed.

Essential Criteria	Ontario Breast Screening Program[1]	Ontario Cervical Screening Program	ColonCancerCheck[2]	Ontario Lung Screening Program
An evidence-based protocol or guideline is developed in consensus with the majority of stakeholders[11]	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
An information system with appropriate linkages (e.g., between population databases, screening information, cancer registry, etc.) for screening implementation and evaluation	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
Provision of continued training for service providers[12,13]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented
Performance of the screening program is evaluated with reference standards for the indicators[14]	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented

[11] The term 'stakeholder' is used in this table because it is the language used in the original source document. Ontario Health acknowledges that this terminology has racist origins. The term 'partner' is used throughout the remainder of this report.

[12] Continued training (both knowledge-based and skill-based) is ensured by the screening program for all personnel involved in the screening pathway, including periodic refresher training and the supervisory support for new health providers. Such training can be provided by the program or other stakeholders and is also regularly monitored. The service providers need regular feedback on their performance.

[13] Most training for service providers is provided independent from Ontario Health. Ontario Health incorporates some training and expertise requirements within the quality standards and creates and updates Mainpro+®-accredited continuing professional development courses that count towards continuing medical education or membership and designations with the College of Family Physicians of Canada.

[14] Targets and/or benchmarks are established for indicators where appropriate based on the availability of evidence.

Table 2: Desirable Criteria for Organized Cancer Screening Programs

Desirable Criteria	Ontario Breast Screening Program	Ontario Cervical Screening Program	ColonCancerCheck	Ontario Lung Screening Program
A specific organization or team is responsible for program implementation and coordination	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
Health care professionals comply with protocol or guideline of the screening program while delivering services[15]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented
Cancer screening program has a system in place to identify cancer occurrence in the target population (e.g., a population-based cancer registry)	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
Eligible individuals should be given informed choice, with information on benefits and harms	◑[16] Partially implemented	◑[16] Partially implemented	◑[16] Partially implemented	● Fully implemented

[15] Ontario Health undertakes a variety of activities to promote compliance with cancer screening guidelines. This includes the provision of tools for primary care providers and specialists to facilitate the adoption of best practices that are recommended by Ontario Health's screening guidelines and eligibility criteria, collaboration with provincial partners including laboratories and the Ministry of Health to develop strategies to discourage noncompliant screening activities (e.g., billing code restrictions), and routine monitoring of indicators that measure noncompliant screening; however, Ontario Health does not have the authority to enforce compliance.

[16] Referral to screening or screening participation is facilitated by individual health care providers; there is likely variability with respect to the delivery of informed participation discussions.

Desirable Criteria	Ontario Breast Screening Program	Ontario Cervical Screening Program	ColonCancerCheck	Ontario Lung Screening Program
The screening program has an operational plan to encourage participation of the target population through improved awareness[17]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented
An appropriate legal framework exists for registration of individuals in the program and establishing data linkages[18]	● Fully implemented	● Fully implemented	● Fully implemented	● Fully implemented
Availability of adequate infrastructure, workforce and supplies for delivery of screening, diagnosis and treatment services[19]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented
Equity of access to screening, diagnosis and treatment services should be built into the screening program[20]	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented	◑ Partially implemented

[17] Public cancer screening awareness campaigns are formally managed by the Ontario Ministry of Health, in consultation with Ontario Health. Regional partners and screening sites execute additional awareness and recruitment strategies locally.

[18] The legal framework provides a legal mandate for the appropriate data protection safeguards and recognizes that a balance between fundamental rights of privacy and access to health services is crucial. The regulation of personal data safety, cancer screening program registration, and the linkage between screening-related data and other relevant data sources are necessary for effective management of screening programs.

[19] All cancer screening programs in Ontario are experiencing performance challenges related to inadequate resources, primarily with respect to health human resources (HHR).

[20] Health equity is a strategic focus of Ontario Health. Ongoing efforts are required to address inequities in cancer screening. Ontario Health is undertaking various equity-focused initiatives to improve health equity in cancer screening (see the Future Directions section for additional details).

Delivery of Cancer Screening in Ontario

Ontario's organized cancer screening programs are planned, designed, implemented, operated, monitored, evaluated and refined by Ontario Health. Regional Cancer Programs, Ontario Health teams and health care providers are accountable for screening activities and performance at the regional and local levels. Having regional health system administrators and clinician leadership is critical for the delivery of evidence-based and high-quality cancer screening services.

Ontario Health

Ontario Health was established by the Government of Ontario to connect, coordinate and modernize Ontario's health system. Ontario Health was created through the amalgamation of 22 organizations, including Cancer Care Ontario, which was responsible for operating Ontario's cancer screening programs. These screening programs are now delivered by Ontario Health. The work of Ontario Health is guided by the Quintuple Aim (8) strategic priorities, an annual business plan and other strategic documents, including an *Equity, Inclusion, Diversity, and Anti-Racism Framework*, the *High Priority Community Strategy* and the *Black Health Plan*.

The *Ontario Cancer Plan* and the *First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy* guide the work of Ontario Health in the cancer system. The *Ontario Cancer Plan* is a multi-year provincial road map that guides how Ontario Health, the Regional Cancer Programs and other health system partners work together to reduce the risk of developing cancer and improve outcomes for those affected by cancer in Ontario. The *First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy* provides a road map for how Ontario Health, Indigenous communities and individuals, and health system partners will work together to improve the performance of the cancer system for Indigenous people in Ontario. This work should take place in a way that honours Indigenous concepts of well-being, improves the well-being of Indigenous people in Ontario, reduces the burden of cancer in these communities, and empowers supportive and healthy environments that build on the strengths of Indigenous individuals, families, communities and organizations.

Ontario Health has six administrative health regions (North East, North West, East, Central, Toronto, West) that link the organization with communities and provider partners to ensure that health system resources and supports are allocated to where they will best meet the diverse needs of people across the province.

Regional Cancer Programs

Ontario also has 14 Regional Cancer Programs, each led by a Regional Vice-President. Regional Cancer Programs are networks of hospitals and other agencies involved in providing cancer prevention, screening, diagnostic, treatment and support services in each of the six Ontario Health regions. Each Regional Cancer Program, supported by a network of regional clinical leads, is responsible for implementing provincial standards and programs for cancer care (including prevention and screening) and ensuring that facilities meet the requirements and targets set out in their agreements with Ontario Health. Regional Cancer Programs respond to issues related to screening, diagnosis, treatment and management of cancer based on regional and local needs, coordinate care across local and regional health care providers, and work to continually improve access to care, wait times and quality.

Ontario Health supports the Regional Cancer Programs in the delivery of cancer screening by:

- Reporting regularly on cancer screening program performance at regional, facility and provider levels
- Sharing recommendations and clinical guidance for cancer screening and diagnostic management that were developed in collaboration with primary care providers, specialist physicians, cancer system administrations and public advisors
- Maintaining a centralized correspondence program for the Ontario Breast Screening Program, Ontario Cervical Screening Program, and ColonCancerCheck to encourage routine screening and timely follow-up of screening results

The Hamilton-Niagara-Haldimand-Brant Regional Cancer Program and the North West Regional Cancer Program each operate a mobile screening coach, which travels from community to community to provide breast, cervical and colorectal screening for screen-eligible people who experience barriers to accessing screening.

Ontario Health Teams

In 2019, Ontario Health Teams were introduced to provide a new way of organizing and delivering care that is more connected to patients in their local communities. Under Ontario Health Teams, health care providers – including hospitals, doctors, and home and community care providers – work in a coordinated way to provide care, no matter where they provide it. Since 2019, 57 teams have been approved and are seeing successes, such as more efficient hospital-to-home transitions, a stronger voice for primary care within Ontario Health Team decision making and leadership structures, more extensive primary care organization, improved digital health and virtual care access, better data and analytics, and more meaningful partnership and engagement with patients, families and caregivers.

A formal link between the work of Ontario Health Teams and Cancer Screening was established through the Collaborative Quality Improvement Plan (cQIP). The cQIP is Ontario Health Teams' formal commitment to quality and serves as a process for Ontario Health Team partners to work together towards better coordinated, integrated care that delivers improvements in alignment with the Quintuple Aim. With cross-sectoral partnerships and a growing role in the health care system, OHTs are uniquely positioned to have a significant impact on long-standing challenges affecting our health system. The cQIP program fosters this opportunity by aligning its areas of focus with provincial and local health system priorities aimed at improving population health, and patient and provider experience through an equity lens. The OHTs report on their progress for each area of focus in an annual plan. They also share lessons learned through an OHT community of practice.

For the 2022/23 fiscal year, the cQIP program's three areas of focus had corresponding quality indicators and were tied to health system issues affected by the COVID-19 pandemic: overall access to care in the most appropriate setting, overall access to mental health and addictions services in the community, and overall access to preventative care. Preventative care in this context refers to decreasing the burden of cancer in Ontario through cancer screening using the following indicators:

- Percentage of screen-eligible people up to date with cervical screening (i.e. cytology tests)
- Percentage of screen-eligible people up to date with breast cancer screening (i.e. mammography)
- Percentage of screen-eligible people up to date with colorectal cancer screening

Building on lessons learned from the fiscal year 2022/23 cQIP program, these areas of focus will be maintained for fiscal year 2023/24 and Ontario Health Teams will be encouraged to continue their efforts in these areas with the added option to customize their improvement efforts based on their unique needs. The cQIP presents an opportunity for OHTs to work with their Regional Cancer Programs on common goals. A key requirement of the Ontario Health Team Transfer Payment Agreement and a fundamental part of the future performance framework for Ontario Health Teams, cQIPs play a role in supporting performance objectives, promoting a culture of quality improvement, and contributing to the development of a robust learning health system.

Primary Care Providers

Primary care providers, including family doctors and nurse practitioners, play a critical role in the success of cancer screening programs by encouraging and facilitating screening participation, performing screening tests (in the case of cervical screening) and supporting timely follow-up of abnormal screening results. Ontario Health provides tools for primary care providers and specialists to facilitate the adoption of best practices that are recommended by Ontario Health's screening guidelines and eligibility criteria.

Another way that Ontario Health supports primary care providers is by providing the Screening Activity Report. This electronic report can be accessed through the OneID® system and allows physicians working in a patient enrolment model practice to identify which of their patients are due (or overdue) for screening and which require follow-up of abnormal screening results. It also provides primary care providers with key performance data, such as how they compare against other primary care providers across Ontario and within their Regional Cancer Program. In the future, the Screening Activity Report will be incorporated with the *MyPractice* report (a similar primary care report for family physicians and executive directors of family health teams and community health centres) into the Primary Care Integrated Report.

Ontario Health also creates and updates Mainpro[21]-accredited continuing professional development courses that count towards continuing medical education or membership and designations with the College of Family Physicians of Canada. There are currently three accredited continuing professional development courses: one for the Ontario Lung Screening Program and two for ColonCancerCheck, with a fourth one planned for the Ontario Cervical Screening Program.

[21] Mainpro+® (Maintenance of Proficiency) is the College of Family Physicians of Canada program designed to support and promote continuing professional development for family physicians. Mainpro sets standards, as well as reviews and accredits continuing professional development programs.

Ontario Cancer Screening Programs

Table 3: Ontario Cancer Screening Program Summary: Average Risk Programs

Screening Program	Target Population	Screening Test	Screening Interval
Ontario Breast Screening Program	Women, trans people and nonbinary people ages 50 to 74	Mammography	Every 2 years[22]
Ontario Cervical Screening Program	People with a cervix ages 21 to 70[23] who are or have ever been sexually active	Cytology	Every 3 years[24]
ColonCancerCheck	People ages 50 to 74	Fecal immunochemical test	Every 2 years[25]

[22] Some Ontario Breast Screening Program participants may be called back for screening in 1 year instead of 2 years because of a documented pathology of high risk lesions, a personal history of ovarian cancer, 2 or more first-degree relatives assigned female at birth with breast cancer at any age, 1 first-degree relative assigned female at birth with breast cancer under age 50, 1 first-degree relative with ovarian cancer at any age, 1 relative assigned male at birth with breast cancer at any age, BI-RADS breast density Category D at the time of screening or as recommended by the radiologist at the time of screening.

[23]The Ontario Cervical Screening Program will formally change the age of initiation for cervical screening from 21 to 25 with the implementation of human papillomavirus testing in the program, except for people who are immunocompromised. Until the change is formally implemented, health care providers are encouraged to consider delaying screening until age 25 for people who are immunocompetent.

[24]Immunocompromised people may be at elevated risk and should receive annual screening. Screening annually with cytology is also recommended for some people who are discharged from colposcopy (i.e., those with a positive human papillomavirus test, atypical squamous cells of undetermined significance or low-grade squamous epithelial lesion).

[25]People at average risk for colorectal cancer who choose to be screened with a flexible sigmoidoscopy should be screened every 10 years.

Table 4: Ontario Cancer Screening Program Summary: Increased or High Risk Programs

Screening Program	Target Population	Screening Test	Screening Interval
High Risk Ontario Breast Screening Program	Women, trans people and nonbinary people ages 30 to 69 who meet the program eligibility criteria	Mammography and breast magnetic resonance imaging[26]	Every year
ColonCancerCheck	People with 1 or more first-degree relatives who have been diagnosed with colorectal cancer[27]	Colonoscopy	Every 5 or 10 years[28]
Ontario Lung Screening Program	People ages 55 to 74 who have smoked cigarettes daily for at least 20 years[29]	Low-dose computed tomography	Every year[30]

[26] Screening breast ultrasound is scheduled if breast magnetic resonance imaging is not medically appropriate.

[27] The definition of increased risk for colorectal cancer is currently under review.

[28] Frequency of screening with colonoscopy depends on family history. People with a first-degree relative who was diagnosed with colorectal cancer before age 60 should be screened every 5 years starting at age 50, or 10 years earlier than the age their relative was diagnosed, whichever occurs first. People with a first-degree relative who was diagnosed with colorectal cancer at age 60 or older should be screened every 10 years starting at age 50. However, some people who have first-degree relatives who were diagnosed with colorectal cancer may need colonoscopy more often if they meet criteria for a genetic syndrome.

[29] Refers to 20 years of cumulative smoking (there could be times when the person did not smoke). These people can be referred for a risk assessment to determine eligibility for screening in the Ontario Lung Screening Program.

[30] The Ontario Lung Screening Program uses the American College of Radiology's Lung-RADS® system to manage nodules. People may be required to come in for scans earlier than 1 year or could be sent for diagnostic assessment based on their Lung-RADS® score.

Table 5: Eligibility Criteria by Screening Program: Average Risk

Screening Program	Eligibility Criteria
Ontario Breast Screening Program	Women, trans people and nonbinary people ages 50 to 74 who have: • No breast cancer symptoms • No personal history of breast cancer • Not had a mastectomy, and • Not had a screening mammogram within the last 11 months People ages 40 to 49 who are at average risk for breast cancer are encouraged to make a personal decision about breast cancer screening in consultation with their family doctor or nurse practitioner. If someone in this age group would like to get screened, their family doctor or nurse practitioner can provide a referral for a mammogram. Currently, people in this age group are not eligible to be screened through the Ontario Breast Screening Program. However, beginning in fall 2024, the Ontario Breast Screening Program will expand eligibility to include people ages 40 to 49. People will be encouraged to have a conversation with a health care provider on the risks and benefits of screening as well as their values and preferences, to determine if screening is right for them. Those who decide to screen will be able to self-refer for a mammogram and receive the benefits of organized screening.

Screening Program	Eligibility Criteria
Ontario Cervical Screening Program	People with a cervix (women, transmasculine people and nonbinary people) who are ages 21 to 70[31] and: • Have no symptoms that could be caused by cervical cancer, and • Are or have ever been sexually active – sexual activity is defined as having contact with another person's genitals using the hands, mouth or genitals Cervical screening can stop at age 70 if someone has been regularly screened and has had 3 or more normal cervical screening test results in the previous 10 years.
ColonCancerCheck	People ages 50 to 74 who have: • No symptoms that could be caused by colorectal cancer • No first-degree relative (parent, sibling or child) who has been diagnosed with colorectal cancer • No personal history of pre-cancerous colorectal polyps requiring surveillance, and • No history of inflammatory bowel disease (i.e., Crohn's disease involving the colon or ulcerative colitis) ColonCancerCheck does not send letters to people under age 50 or over age 74 about participating in the program. Primary care providers can order a fecal immunochemical test (FIT) for people who are age 49 at their discretion to support screening initiation in people who will soon be turning age 50. Additionally, people ages 75 to 85 may choose to get screened if the benefits of screening outweigh the risks. ColonCancerCheck strongly recommends against colorectal cancer screening in people older than age 85; people older than age 85 are not eligible for a program FIT.

[31] The Ontario Cervical Screening Program will formally change the age of initiation for cervical screening from 21 to 25 with the implementation of human papillomavirus testing in the program, except for people who are immunocompromised. Until the change is formally implemented, health care providers are encouraged to consider delaying screening until age 25 for people who are immunocompetent.

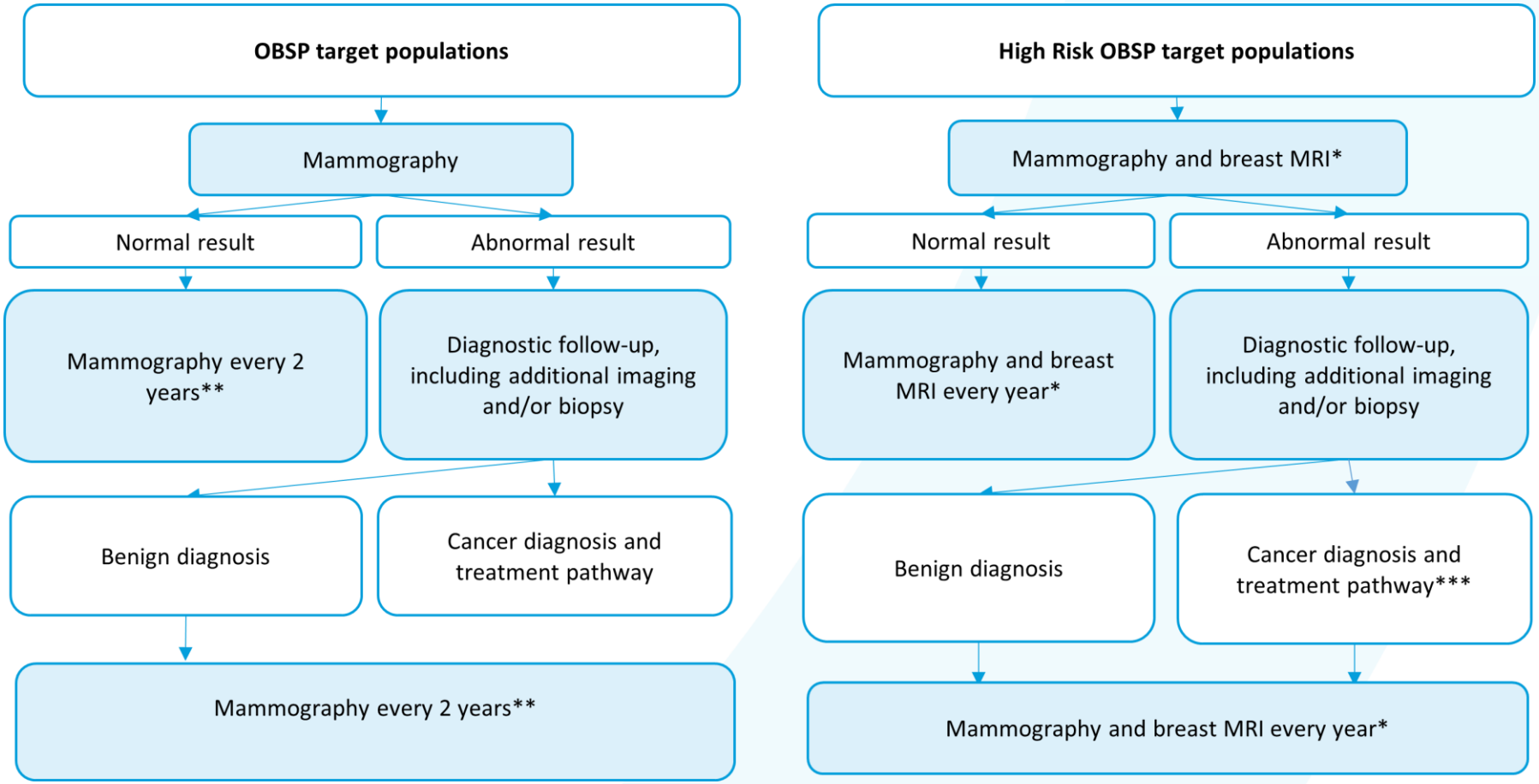
Table 6: Eligibility Criteria by Screening Program: Increased or High Risk

Screening Program	Eligibility Criteria

High Risk Ontario Breast Screening Program (OBSP)	Women, trans people and nonbinary people ages 30 to 69 who:
	
	• Have a referral from a doctor or nurse practitioner
	• Have no breast cancer symptoms
	• Have valid Ontario Health Insurance Plan coverage, and
	• Fall into one of the following risk categories:
	  ○ Have gene changes that increase their chance of getting breast cancer (e.g., changes in the BRCA1, BRCA2, TP53 or PALB2 genes)
	  ○ Have not had genetic testing, but have had genetic counselling because they have a first-degree family member with gene changes that increase their chance of getting breast cancer (e.g., changes in the BRCA1, BRCA2, TP53 or PALB2 genes)
	  ○ Have a ≥25% lifetime chance of getting breast cancer based on personal and family history (confirmed at a genetics clinic using the International Breast Cancer Intervention Study or CanRisk risk assessment tools), and
	  ○ Had radiation therapy to the chest to treat another condition (e.g., Hodgkin Lymphoma) before age 30 and at least 8 years ago
	
	The High Risk OBSP does not accept new participants over age 70. However, when participants already in the High Risk OBSP turn 70, the program will continue to screen them with just mammography every year until they are age 74.
	
	The High Risk OBSP does not send letters to people over age 74 about participating in the program. People over age 74 are encouraged to make a personal decision about breast cancer screening in consultation with their doctor or nurse practitioner and can continue to be screened with just mammography through the High Risk OBSP with a referral from their doctor or nurse practitioner.

Screening Program	Eligibility Criteria
ColonCancerCheck	People with a family history of colorectal cancer that includes 1 or more first-degree relatives who have been diagnosed with colorectal cancer, but do not meet the criteria for hereditary colorectal cancer syndromes. ColonCancerCheck is reviewing the definition of increased risk for colorectal cancer.
Ontario Lung Screening Program	People ages 55 to 74 who have: • A referral from a doctor or nurse practitioner • No lung cancer symptoms • Valid Ontario Health Insurance Plan coverage, and ○ A lung cancer risk score of ≥2.0% as determined by the PLCOm2012 risk prediction model (8–10)

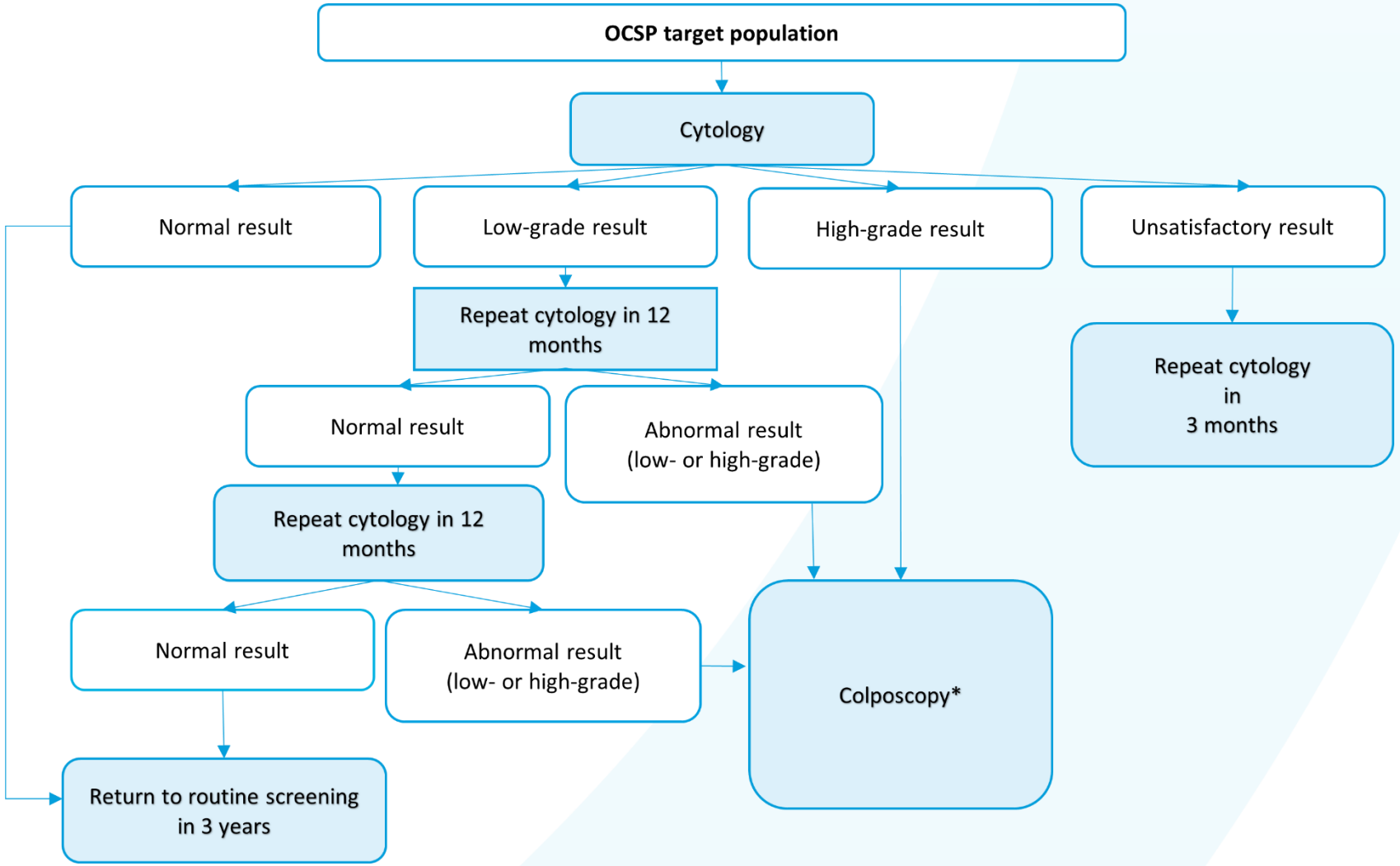
Figure 3: Ontario Breast Screening Program (OBSP) Pathway



* Screening breast ultrasound is scheduled if breast magnetic resonance imaging (MRI) is not medically appropriate.
**Some OBSP participants may be called back for screening in 1 year instead of 2 years because of a documented pathology of high-risk lesions, a personal history of ovarian cancer, 2 or more first-degree relatives assigned female at birth with breast cancer at any age, 1 first-degree relative assigned female at birth with breast cancer under age 50, 1 first-degree relative with ovarian cancer at any age, 1 relative assigned male at birth with breast cancer at any age, BI-RADS breast density Category D at the time of screening or as recommended by the radiologist at the time of screening.
***High Risk OBSP participants who are diagnosed with breast cancer are eligible to return to screening once they have completed treatment and have no breast cancer symptoms.

For a text version of Figure 3, refer to Appendix 2: Figure Descriptions.

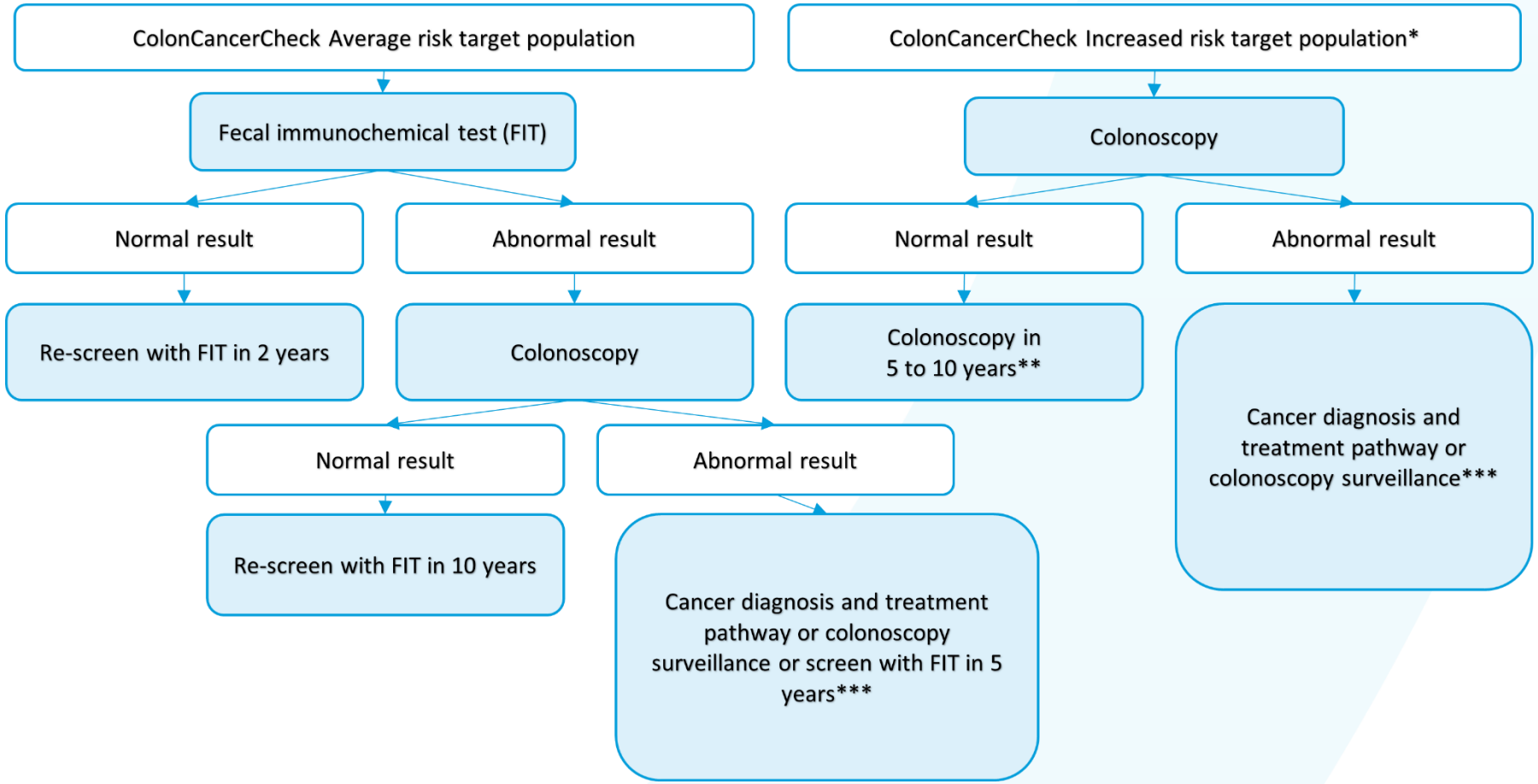
Figure 4: Ontario Cervical Screening Program (OCSP) Pathway



*Please refer to Colposcopy Clinical Guidance for clinical management in colposcopy pathways.

For a text version of Figure 4, refer to Appendix 2: Figure Descriptions.

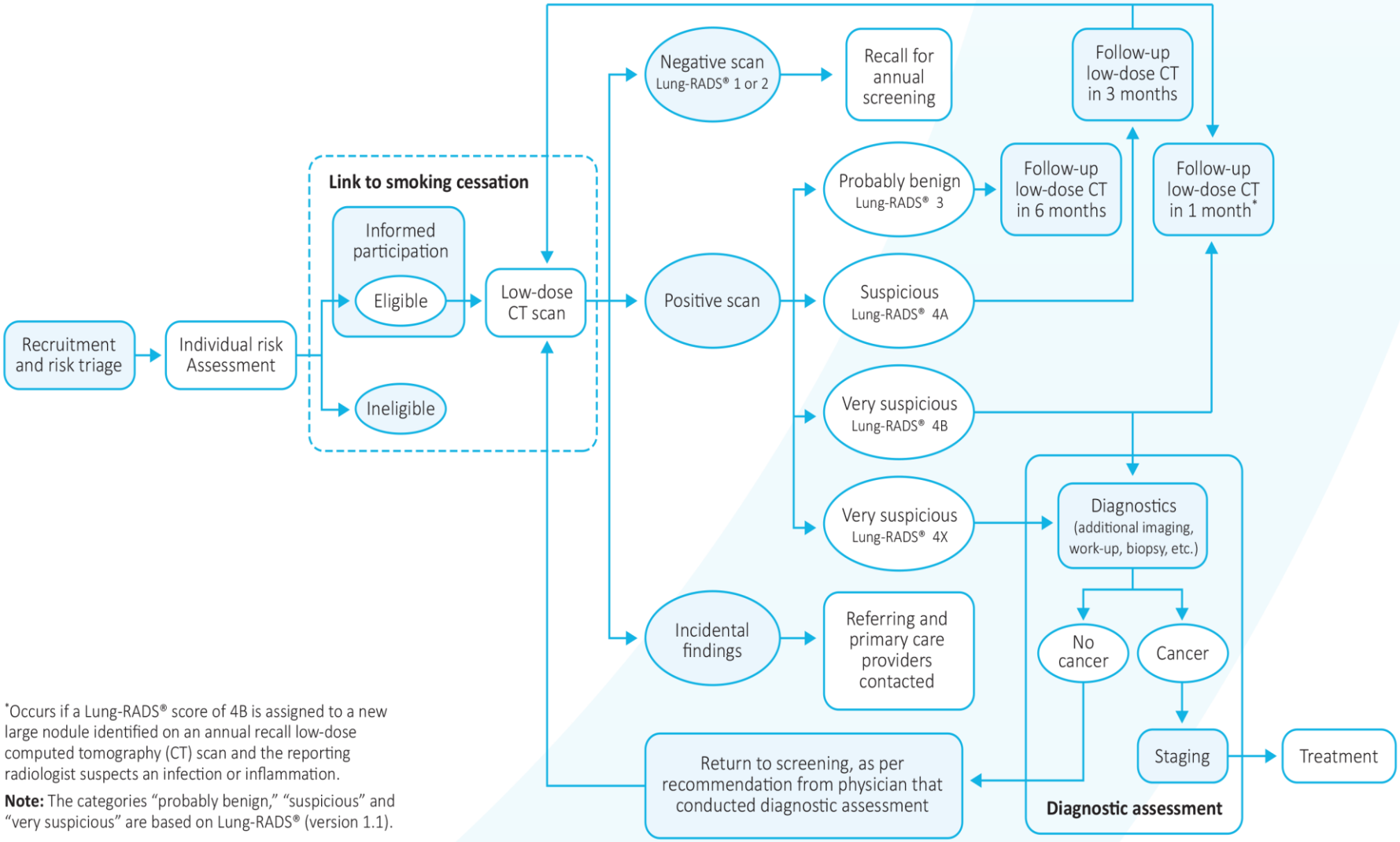
Figure 5: ColonCancerCheck Program Pathway



*The screening recommendations for people at increased risk for colorectal cancer are currently under review.
**Frequency of screening with colonoscopy depends on family history. People with a first-degree relative who was diagnosed with colorectal cancer before age 60 should be screened every 5 years starting at age 50, or 10 years earlier than the age their relative was diagnosed. People with a first-degree relative who was diagnosed with colorectal cancer at age 60 or older should be screened every 10 years starting at age 50. However, some people may need colonoscopy more often depending on the findings at their initial colonoscopy.
***Please refer to ColonCancerCheck's Recommendations for Post-Polypectomy Surveillance at cancercareontario.ca/CCCsurveillance

For a text version of Figure 5, refer to Appendix 2: Figure Descriptions.

Figure 6: Ontario Lung Screening Program (OLSP) Pathway



*Occurs if a Lung-RADS® score of 4B is assigned to a new large nodule identified on an annual recall low-dose computed tomography (CT) scan and the reporting radiologist suspects an infection or inflammation.

Note: The categories "probably benign," "suspicious" and "very suspicious" are based on Lung-RADS® (version 1.1).

For a text version of Figure 6, refer to Appendix 2: Figure Descriptions.

Health Equity in Cancer Screening

Health equity exists when people have a fair opportunity to reach their fullest health potential (12), and achieving health equity requires reducing unnecessary and avoidable differences in access and care that are unfair and unjust (13). Many causes of health inequities relate to social and environmental factors, such as income, social status, race, gender, education and physical environment. In addition, past or existing health policies may create or reinforce existing health inequities. Inequities may be unintended consequences of a health policy; however, in some cases policies are created to purposely reinforce structural or institutional racism. Ontario Health is committed to reducing health inequities; equity has been identified as a strategic priority and an Equity, Inclusion, Diversity and Anti-Racism Framework (14) has been developed to guide future directions.

This report includes a focus on health equity, which is achieved in several ways:

- Sharing information about how Ontario Health is committed to advancing equity, inclusion and diversity, and addressing racism
- A Spotlight on Cancer Screening in First Nations, Inuit, Métis and Urban Indigenous Peoples
- Providing equity stratifications for key performance indicators
- Regional reporting and mapping to understand variations in program performance across different areas of the province
- Sharing information about initiatives aimed to improve equity in cancer screening in Ontario

Cancer affects all groups of people in the province of Ontario; however, some groups experience a higher burden of cancer due to social, environmental and economic disparities. Cancer disparities are differences in cancer outcomes (e.g., new cases of cancer, cancer deaths, quality of life) experiences and access to quality cancer care for certain groups of people.

Cancer disparities reflect the interplay among many factors, such as social determinants of health, behaviour, biology and genetics, all of which can have profound effects on health, including cancer risk and outcomes. Some people in Ontario experience cancer disparities because they are more likely to encounter obstacles in accessing health care. Someone's income may impact their access to primary care or screening services in a number of ways, such as where they can afford to live, how far they have to travel to get services and whether they have access to paid leave from work. Other barriers to accessing cancer screening services could include physical barriers to completing screening tests, level of health literacy, past trauma, and past experiences of racism, sexism, homophobia or transphobia in the health system.

Disparities in cancer screening have been well-documented in Ontario and other settings. For example, we reported in the 2016 *Ontario Cancer Screening Performance Report* (15) that not being cared for by a patient enrolment model physician and living in a low-income neighbourhood were associated with a higher likelihood of being overdue for breast, cervical and colorectal cancer screening. Other provincial and Canadian analyses have demonstrated that people who are immigrants, have a low income or live in rural areas experience disparities in cancer screening-related care (16–22). Cancer disparities also exist for Indigenous populations in Ontario (see page 41 for more information) (23–30).

Key Concepts and Definitions in Health Equity

Systemic racism (14): Organizational culture, policies, directives, practices or procedures that exclude, displace or marginalize some racialized groups or create unfair barriers for them to access valuable benefits and opportunities. **This is often the result of institutional biases in organizational culture, policies, directives, practices, and procedures that may appear neutral but have the effect of privileging some groups and disadvantaging others.**

Anti-racism (14): **A systematic method of analysis and a proactive course of action. The anti-racism approach recognizes the existence of racism, including systemic racism, and actively seeks to identify and prevent actions that sustain these inequities.**

Anti-Black racism (14): **The policies and practices rooted in Canadian institutions, such as education, health care and justice, that mirror and reinforce beliefs, attitudes, prejudice, stereotyping and discrimination towards Black people and communities.**

Anti-Indigenous racism (14): **Ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous Peoples in Canada. It includes ideas and practices that establish, maintain and perpetuate power imbalances, systemic barriers and inequitable outcomes that stem from the legacy of colonial policies and practices in Canada.**

Health (12): **A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.**

Health equity (13): **When all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions.**

Health inequality (13): **Measurable differences in health between individuals, groups or communities. It is sometimes used interchangeably with the term "health disparities."**

Health inequity (13): A subset of health inequality and refers to differences in health associated with social disadvantages that are modifiable and considered unfair.

Inclusion (14): Inclusion recognizes, welcomes and makes space for diversity.

Equity, Inclusion, Diversity and Anti-Racism at Ontario Health

Ontario Health is committed to advancing equity, inclusion and diversity, and addressing racism to achieve better outcomes for all people with health conditions, their families and providers in Ontario's health system. Working together with health system partners from across the province, Ontario Health has developed a framework that builds on existing legislated commitments and relationships with Indigenous peoples and Francophone communities, and recognizes the need to take an intersectional approach to this work. To learn more about this framework, visit the *Equity, Inclusion, Diversity and Anti-Racism* page on the Ontario Health website.

The *Ontario Cancer Plan 5 (2019–2023)* (31) also provided a road map for how Ontario Health will work with the Regional Cancer Programs and other health system partners. The plan identified improving health equity across the cancer system as one of six goals and linked this goal to detailed strategic objectives that the organization made progress towards achieving during this period. At the time of writing, development of the *Ontario Cancer Plan 6* is underway with plans to expand on the equity goals in the *Ontario Cancer Plan 5*.

Since 2004, multi-year provincial Indigenous cancer strategies have addressed and led to improvements in cancer care for Indigenous people in Ontario. The *First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy 2019–2023* continues the work set out in the first three strategies. At the time of writing, development of Strategy 5 is underway with First Nations, Inuit, Métis and Urban Indigenous partners across the province.

Analysis of Neighbourhood-Level Equity Using the Ontario Marginalization Index

Identifying health disparities is one of the steps required to addressing them. To assess equity in cancer screening in Ontario, a series of analyses that use the Ontario Marginalization Index (ON-Marg) were completed and are presented in this report. The ON-Marg was created by Public Health Ontario in collaboration with the Centre for Urban Health Solutions at St. Michael's Hospital using 2016 census data. The ON-Marg (32) is a composite index that combines multiple demographic indicators into four dimensions of marginalization. See Table 7 for detailed definitions of each dimension and a list of included indicators. For the analyses performed in this report, the material deprivation and ethnic concentration domains were used to stratify selected key performance indicators for each program.

In the absence of individual-level equity data, neighbourhood-level measures, such as the ON-Marg, are the best available source of data on equity and marginalization for population-based analyses in Ontario. However, the ON-Marg has some limitations. People living in institutions (e.g., penitentiaries, care homes) are not counted in census data and are not included in the ON-Marg. Additionally, people living on First Nations reserves are under-counted in the census and therefore under-represented in the ON-Marg. Finally, as an area-level measure, the ON-Marg does not provide information about individual levels of marginalization.

Table 7: ON-Marg Dimension Definitions and Included Indicators (32)

ON-Marg Dimension	Definition	Included Indicators
Residential Instability	Concentration of people in an area who experience high rates of family or housing instability	• Proportion of population living alone • Proportion of population who are not ages 5 to 15 • Average number of people per dwelling • Proportion of dwellings that are apartment buildings • Proportion of the population that is single, divorced or widowed • Proportion of dwellings that are not owned • Proportion of the population who moved during the past 5 years

ON-Marg Dimension	Definition	Included Indicators
Material Deprivation	Inability of individuals and communities to access basic material needs	• Proportion of population age 20 and older without a high school diploma • Proportion of families that are lone parent families • Proportion of total income for people age 15 and older from government transfer payments • Proportion of population age 15 and older who are unemployed • Proportion of population considered low income • Proportion of households living in dwellings in need of major repair
Dependency	Concentration of people in an area who do not get income from employment, including seniors, children and adults whose work is not compensated	• Proportion of population age 65 and older • Dependency ratio (total population ages 0 to 4, and 65 and older/total population ages 15 to 64) • Proportion of population age 15 and older not participating in the labour force
Ethnic Concentration	Area-level concentration of people who are recent immigrants and/or people belonging to a visible minority group (defined by Statistics Canada as "persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour")	• Proportion of the population who are recent immigrants, having arrived in the past 5 years • Proportion of people who self-identify as a visible minority

Spotlight on Cancer Screening in First Nations, Inuit, Métis and Urban Indigenous Peoples

Shared with permission from the Grand Council Treaty #3 Cancer Survivorship Campaign

While historically uncommon in Indigenous populations in Ontario, cancer is now a leading cause of morbidity and mortality (33,34). Ontario Health's *First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy* identifies cancer screening as one of seven priority areas for improving cancer care (35). The Canadian Partnership Against Cancer has also identified the lack of cancer screening programs for First Nations, Inuit and Métis peoples as a key gap in cancer control in Canada (36).

Although cancer screening has been shown to be effective in reducing cancer burden and there are four organized cancer screening programs in Ontario, Indigenous people in Ontario experience disparities in cancer screening. First Nations people living off-reserve are less likely than other people in Ontario to have completed cervical, colorectal and breast cancer screening (37). Métis women are less likely to be screened for colorectal and breast cancer than other women in Ontario (27,30,37,38). Although similar data for cervical, colorectal and breast cancer screening are not available for Inuit in Ontario, other Canadian data suggest that Inuit may be less likely to be screened than the general population (22,39).

Lung cancer screening has only recently been introduced in Ontario and there are no data on the participation of First Nations, Inuit and Métis people at the population level. This work has been foundational in terms of describing screening in Indigenous populations in Ontario, but it has methodological limitations, such as lack of or limited datasets with First Nations, Inuit and Métis identifiers in Ontario, relying on postal codes geography to approximate Indigenous identity and relying on self-reported screening participation data.

Many factors might contribute to observed disparities in cancer screening for Indigenous people. They can be classified in terms of individual barriers (e.g., limited awareness of cancer screening, fear, distrust in the health system), community or interpersonal barriers (e.g., competing priorities, negative experience with health care providers), structural barriers (e.g., shortage of health care providers in or near communities, poor integration of services, difficulties with travel required for screening, lack of cultural safety throughout cancer care systems) and social or historical factors (e.g., consequences of colonialism, such as legislated health inequities resulting from Indian hospitals and intergenerational trauma resulting from the residential school system) (40–42). Further exploration and attention to improving the cancer screening experience for Indigenous people in Ontario is warranted.

Overview of Ontario Health's Indigenous Cancer Screening Work

In line with strategic priority 4 in Ontario Health's *First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy 2019-2023*, Ontario Health's Indigenous Cancer Care Unit (ICCU) continues to work with First Nations, Inuit, Métis and urban Indigenous communities throughout Ontario to understand and address barriers to cancer screening. This work includes efforts to improve access to and participation in screening, improve coordination and integration of screening services, and support specific initiatives to improve the organized screening programs so that they better meet the needs of First Nations, Inuit, Métis and urban Indigenous peoples. Examples of these efforts include the Sioux Lookout and Zone Screening Activity Report, the Sioux Lookout and Area fecal immunochemical test kit initiative, the

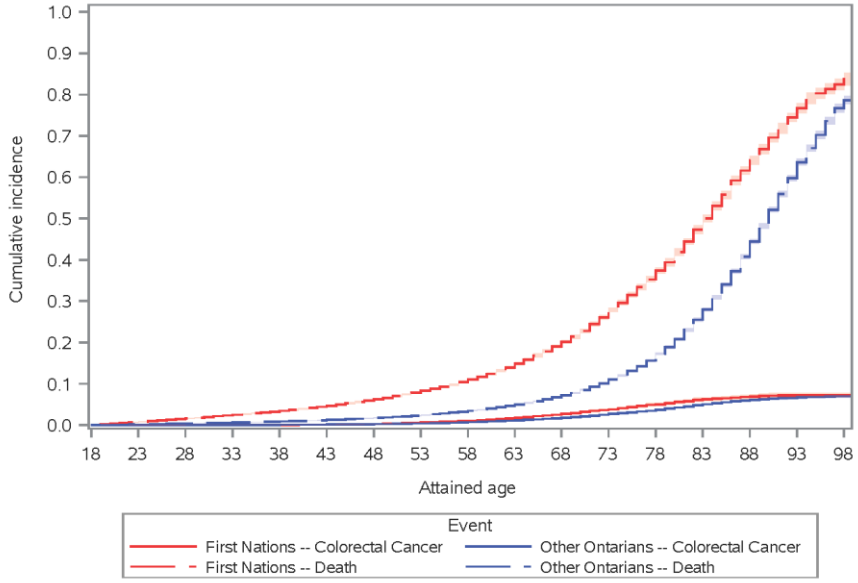
development of distinct First Nations, Inuit and Métis-specific screening education resources, and a collaborative Canadian Institutes of Health Research-funded program that aims to understand and better support cancer screening in Indigenous communities in Ontario. We have provided a brief overview of three selected projects as examples of the ICCU's work with First Nations, Inuit and Métis community partners and have highlighted urban Indigenous community involvement throughout each project overview.

"Catching Cancers Early" Research Project

The Catching Cancers Early research project is co-led by the ICCU, scientists from the screening programs at Ontario Health and the Sunnybrook Research Institute, and it is funded by the Canadian Institutes of Health Research. It was initiated at the direction of the Joint Ontario Indigenous Cancer Care Committee (JOICC), which provides input and guidance to Ontario Health as it develops, implements and evaluates its Indigenous cancer strategies.

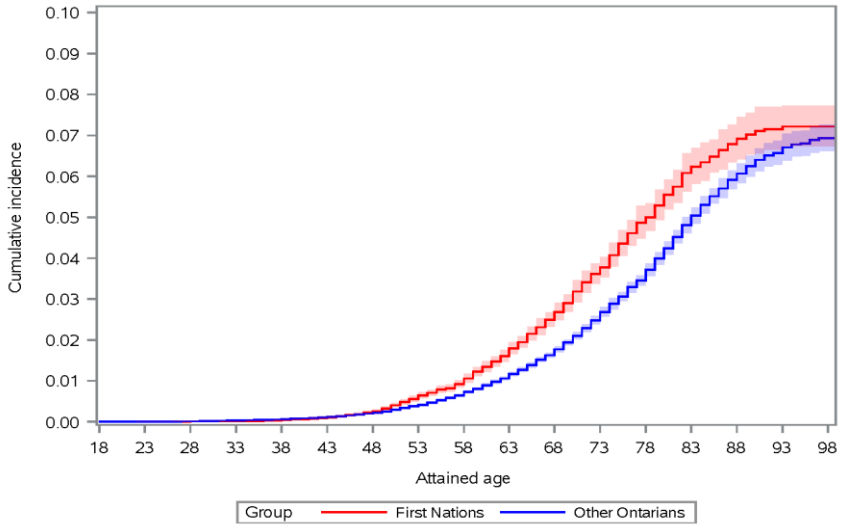
JOICC highlighted concerns from Indigenous communities across Ontario that screening program cancers are presenting in community members before they reach screen-eligible ages, these cancers present at later stages and community members experience challenges accessing screening services in the province. These reports are concerning because cancer screening has been shown to improve outcomes by either preventing cancer or detecting it at an earlier stage when treatment is more likely to be effective. To investigate these concerns, the research team examined the time to screening cancer diagnosis in matched cohorts of First Nations and other people in Ontario, accounting for the competing event of death. Datasets held at IC/ES linked to Ontario Health screening program datasets were used. Indigenous datasets were used in accordance with formal data governance and data sharing agreements, and research was carried out collaboratively with communities. This project also included additional research aims, which are reported elsewhere.

Figure 7: Example* of Cumulative Incidence of Colorectal Cancer Diagnosis (Primary Event) and Death (Competing Event), Comparing First Nations People To Other People in Ontario



*** Similar curves were generated for breast, cervix and lung cancers and are summarized in Table 8.**

Figure 8: Example* of Cumulative Incidence of Colorectal Cancer Taking Death As The Competing Event, Comparing First Nations People To Other People in Ontario



* Similar curves were generated for breast, cervix and lung cancers and are summarized in Table 8.

First Nations people are 42% more likely to develop colorectal cancer compared to other people in Ontario (adjusted hazard ratio of 1.42, 95% CI 1.32 – 1.53).

The findings from this work validate concerns that Ontario Health's First Nations partners about their community members developing certain screening program cancers at an earlier age and later stage than other people in Ontario (see Figure 8 and Table 8). These findings are concerning and merit closer attention. Investigators have shared the results from this study with the screening programs, which are reviewing the results and considering implications for screening recommendations for Indigenous people in Ontario.

Table 8: Summary of Selected Study Findings: "Catching Cancers Early"

Screening program cancer type	Age at diagnosis for First Nations people compared to other people in Ontario	Cancer stage of diagnosis for First Nations people compared to other people in Ontario
Breast	No difference	No difference
Cervical	First Nations women are diagnosed at a younger age	No difference
Colorectal	First Nations people are diagnosed at a younger age	First Nations people are diagnosed at later cancer stages
Lung	First Nations people are diagnosed at a younger age	First Nations people are diagnosed at later cancer stages

First Nations people experience higher risk of death from causes other than cancers covered by Ontario Health screening programs (breast, cervical, colorectal, and lung cancer).

Building Pathways to an Inuit-Informed Lung Cancer Screening Initiative in Ontario

This project is co-led by Akausivik Inuit Family Health Team and Ontario Health's Indigenous Cancer Care Unit, and is funded by the Canadian Partnership Against Cancer. Approximately 73% of Inuit in Canada live in 53 communities across the northern regions of Canada in Inuit Nunangat. A growing percentage of Inuit live in other parts of Canada, particularly in southern urban centres (43). According to the 2021 census, Ottawa-Gatineau had the largest Inuit population in a southern urban centre (44). The Ontario Lung Screening Program (OLSP) is for people ages 55 to 74 who have accumulated at least 20 years of tobacco smoking. The program was launched after a multi-site pilot for people at high risk for lung cancer. Approximately 4% of participants in the pilot identified as First Nations, Inuit or Métis, with Inuit participation being very low (45).

First Nations, Inuit and Métis populations are often under-represented in screening programs and experience barriers in accessing screening services. Smoking rates in these populations are the highest in the province (27,30,38). Given the higher prevalence of smoking and higher incidence of lung cancer in these populations, more effort and tailored recruitment strategies are necessary. Akausivik Inuit Family Health Team, the province's only Inuit primary care provider, has raised concerns that the provincially established age criteria set for participation is too high (especially because Inuit life expectancy is 10 years lower than other people in Canada) and that a risk predictor criterion (as opposed to age-based criterion only) would enable more Inuit participants. These discussions also revealed other barriers to cancer screening participation stemming from Inuit-specific determinants of health, such as jurisdictional challenges and a mistrust of colonial systems.

The three project aims are to:

1) Develop an increased understanding of the systemic barriers within the journey to lung cancer screening participation, to receiving test results, to treatment and to follow up care for Inuit in the Ottawa/Champlain region of Ontario from the perspective of both a) health care providers who serve Inuit and b) Inuit community members.

2) Examine lung cancer risk factors among Indigenous people and apply them to the existing risk prediction model to assess feasibility of younger age eligibility for lung cancer screening in this population.

3) Use the knowledge gained to identify a suitable model and age for starting screening. Data for aim 2 will come from retrospective clinical chart review from the Akausivik Inuit Family Health Team to assess risk for Inuit in the Ottawa/Champlain region of Ontario and longitudinal cohort data from the *Ontario Health Study on First Nations, Inuit and Métis Peoples in the Province.*

Métis Cancer Screening Research Project

The Métis Cancer Screening Research Project was co-led by Métis Nation of Ontario, Sunnybrook Research Institute and the Ontario Health's Indigenous Cancer Care Unit and was funded by the Canadian Institutes of Health Research. Embedded within a larger Canadian Institutes of Health Research-funded community-policy-research grant that focused on improving cancer screening in Ontario First Nations, Inuit and Métis communities, the Métis Cancer Screening Research Project built on Métis Nation of Ontario's program of participatory research to explore perceptions of and experiences with cancer screening in the Métis Nation of Ontario (citizens, families and the community at large).

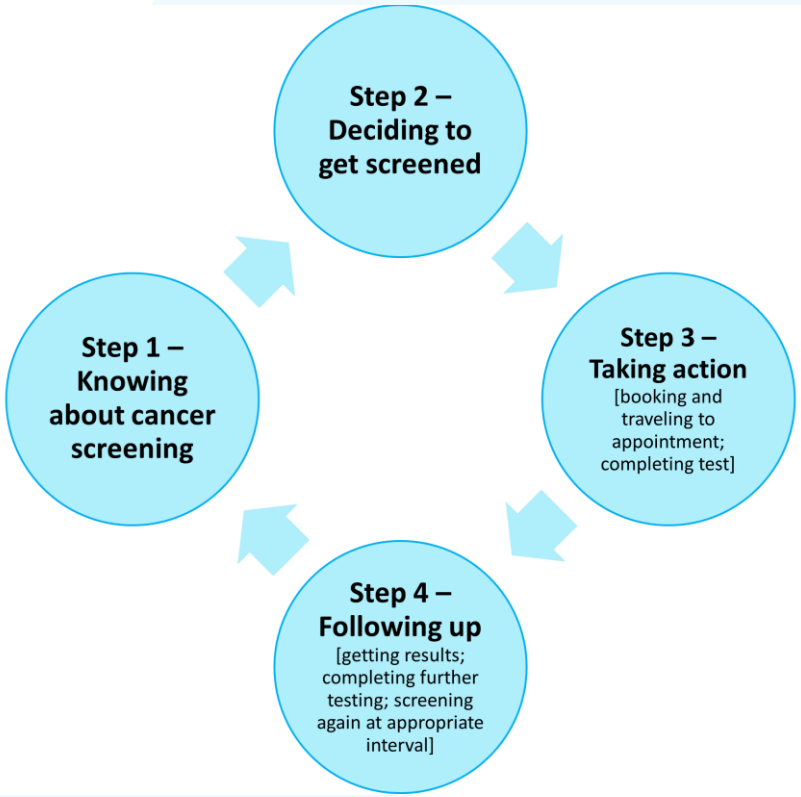
Relationships, Governance and Research Approach

The research partners developed a research collaboration agreement that formalized a commitment to respecting Métis collective and self-determined data management and governance. The Métis Cancer Screening Research Project Working Group designed and implemented the project with ongoing direction from leadership from each of the project partners. Mixed methods were used to learn about barriers and facilitators of cancer screening in Métis Nation of Ontario communities. Focus groups and surveys were conducted with 66 Métis Nation of Ontario healing and wellness frontline workers and Métis Nation of Ontario citizens across Ontario.

Summary of Key Findings

Using Ontario Health's proposed 'ideal state' cancer screening pathway as a frame of reference, the research data were analysed collaboratively. The pathway was streamlined into four key steps in cancer screening, as understood by the Métis Nation of Ontario (Figure 9).

Figure 9: Key Steps in the Cancer Screening Pathway, as Understood by Métis Nation of Ontario Citizens



Factors that impede participation in cancer screening among the Métis Nation of Ontario, as well as those that serve as supports, were identified in relation to this streamlined pathway. Three overarching factors that are central to cancer screening experiences among the Métis Nation of Ontario were identified and are included along with an illustrative participant quote.

1) Awareness and perceptions (e.g., education needed for providers who serve Métis Nation of Ontario citizens about Métis culture and healthcare experiences; screening education needed for Métis Nation of Ontario citizens).

"…in the Métis community, you have to find a more creative way to connect…using…storytelling or symbolisms…might hit home…a little bit better than just having a poster, or an ad with some statistics…" (MNO Healing & Wellness staff)

2) Access to cancer screening services (e.g., geographic and socioeconomic factors that make it difficult to access primary care and screening).

"I think a huge barrier in the north, and I hear time and again…it's transportation…for the Métis. How to get there. It's not easy. They can't just hop a bus and get to this." (MNO citizen)

3) Cultural safety of cancer screening services (e.g., cultural safety among providers and health systems needed to respect and support Métis Nation of Ontario citizens throughout the screening process).

"You're treated like a piece of meat and it's just like bang, bang, bang and there's no information passed to the family, to the patient all the way through that whole process and it's just…so rushed…" (MNO citizen)

This research identified key service gaps and culture-based strategies for improving cancer screening services among Métis Nation of Ontario. Several recommendations to improve cancer screening uptake for Métis Nation of Ontario were proposed, and are detailed in the community research report.

Cancer Screening Among First Nations, Inuit, Métis and Urban Indigenous Peoples: Focused Cancer and Screening Resources

Cancer and Screening Toolkit

The toolkit helps people talk with their health care providers about cancer screening. It has culturally appropriate cancer information for First Nations, Inuit, Métis and urban Indigenous peoples, and their health care providers.

Steps in Cancer Screening – Guide for First Nations Community Members in Northwestern Ontario

The screening guide outlines the steps in breast, colorectal and cervical screening. It provides information for First Nations communities in Northwestern Ontario. It was developed in partnership with Wequedong Lodge of Thunder Bay as part of a cancer screening research project.

Cancer Screening Posters and Postcards

These culturally appropriate, Nation-distinct posters and postcards promote cancer screening and support prevention initiatives in First Nations, Inuit, Métis and urban Indigenous communities. Health centres, Friendship Centres, community centres and other groups that support these communities can use the posters and postcards to raise awareness about the importance of cancer screening.

Cancer Screening Fact Sheets

The fact sheets provide summaries of breast, colorectal and cervical screening. Each set of fact sheets is customized with culturally appropriate information for First Nations, Inuit or Métis peoples.

Cancer 101 Toolkit for First Nations, Inuit and Métis Peoples

The toolkit provides basic cancer information for First Nations, Inuit and Métis peoples. It can be used to learn or help teach others about cancer, and how to prevent and treat it.

Cancer Comic Books

Silent Enemy is a comic designed to provide education and awareness to First Nations youth about cancer. ᓇᒧᖕᒐᐅᕙᓪᓕᐊᓂᖅᐳᑦ *(Our Journey)* is a comic that aims to provide education and awareness about cancer prevention, screening, treatment and survivorship for Inuit community members and their families. *Miyoo Kiikew (Well-Healed)* is a comic that aims to provide education and awareness about cancer prevention, screening, treatment and survivorship for Métis community members and their families.

Health Equity Impact Assessment (HEIA) – Indigenous Lens Tool

The HEIA is a Ministry of Health decision support tool that guides users through the steps of identifying how a program, policy or similar initiative will impact population groups in different ways. The Indigenous Lens Tool supplement aims to support people using the HEIA to further consider Indigenous health experiences and perspectives, so they can more effectively identify and address unintended impacts of initiatives on the health and well-being of Indigenous people. The tool provides suggestions on how to include Indigenous knowledge and values about health and well-being in program and policy development, while also recognizing the diversity within First Nations, Inuit, Métis and urban Indigenous populations.

Ontario Cancer Screening Program Performance: 2017 to 2021

Integrated Evaluation Framework and Indicators

In 2008, with support from Cancer Care Ontario (now Ontario Health), the Canadian Partnership Against Cancer developed an integrated evaluation framework for cancer screening programs (46) in Canada through the Screening Performance Measures Group. This framework has been adopted by other screening programs. The goal of the framework is to promote consistency when reporting, calculating and interpreting cancer screening performance measures. The framework identifies five performance domains that reflect the screening pathway, and each performance domain has recommended performance indicators. In this report, this framework is used to present data on key cancer screening program performance indicators.

Table 9: Cancer Screening Program Evaluation Framework

Domain	Recommended Performance Measures
Coverage	• Participation • Retention
Follow-Up	• Proportion of results that are abnormal • Follow-up of abnormal results • Diagnostic interval (time between abnormal screening test result and diagnosis)
Quality of Screening	• Sensitivity of screening test • Positive predictive value of screening test
Detection	• Pre-cancer detection rate • Invasive cancer detection rate
Disease Extent at Diagnosis	• Early stage invasive cancer detection rate

Understanding Cancer Screening Performance in the context of the COVID-19 Pandemic

On March 11, 2020, the outbreak of coronavirus disease 2019 (COVID-19) was declared a global pandemic affecting countries worldwide, including Canada. In March 2020, the Ontario government directed all hospitals and regulated health care professionals to ramp down elective and non-emergent clinical services to limit the transmission of COVID-19, and to preserve health system capacity to treat COVID-19 cases and other critical illnesses. In response, Ontario Health recommended that all routine cancer screening services be deferred as of March 23, 2020. It also suspended the mailing of cancer screening correspondence (except for normal and abnormal results letters) and fecal immunochemical test kits.

Following a decrease in COVID-19 transmission in Ontario at the end of May 2020, the gradual resumption of deferred health services was permitted. Ontario Health released several pandemic clinical guidance documents to support Regional Cancer Programs, health care providers and health system partners with the deferral, prioritization and gradual resumption of cancer screening and associated diagnostic services during all pandemic waves.

As a result of the directive to pause non-emergent health services, including cancer screening, substantial reductions in the overall volume of cancer screening tests and follow-up procedures were observed (47–51). Screening services were deferred from March 23 to May 26, 2020, with a phased approach to resumption according to Ontario Health guidance.

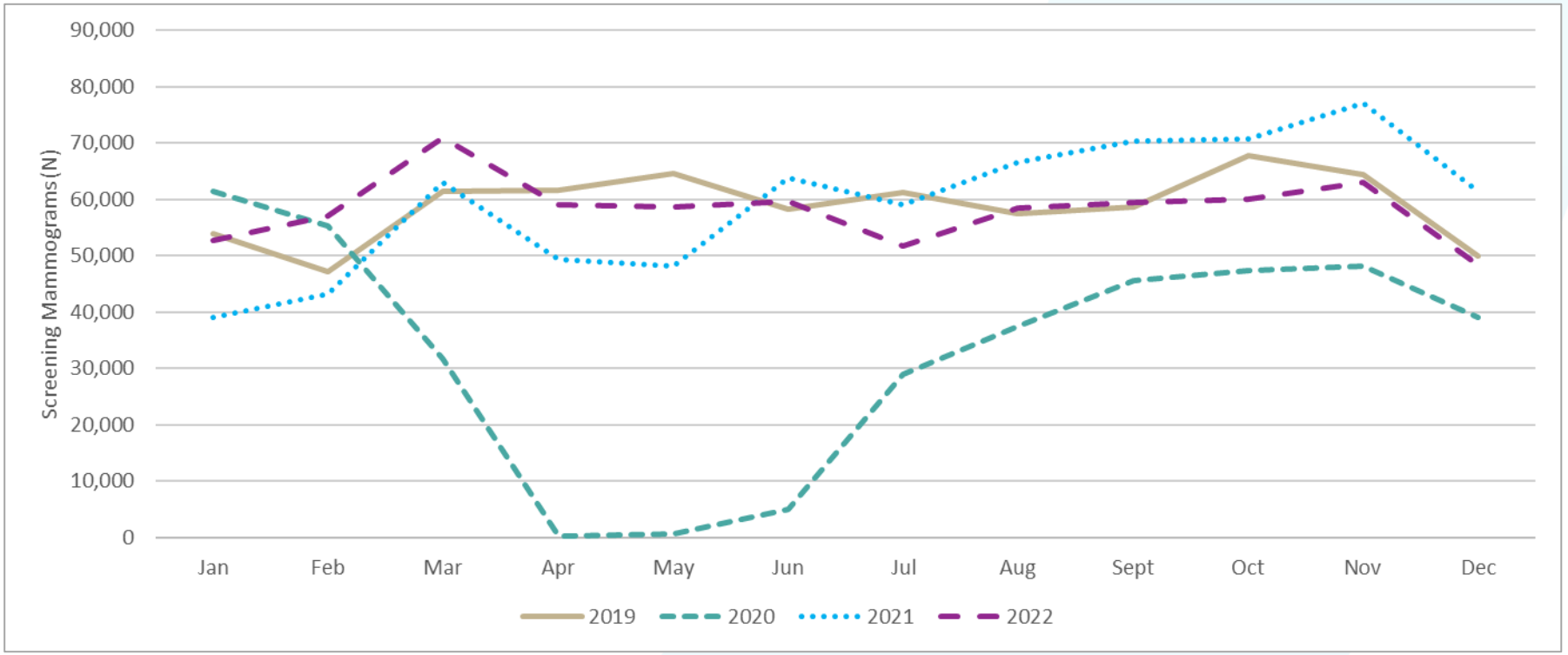
While some programs were able to recover screening volumes to pre-pandemic levels more quickly, recovery for other programs has taken longer. For example, recovery of cervical screening volumes may have been impacted by ongoing challenges with access to in-person health care visits due to the shift towards virtual models of care and limited opportunities for preventive care during ongoing pandemic waves. Resumption of mailing FIT kits was also done gradually to ensure that downstream health services would not be overwhelmed. The initial priority was to clear the backlog of requests for kits that had accumulated during the deferral of screening services, and it was not until October 20, 2020, that primary care providers were able to request FIT kits for all screen-eligible people. In addition, full resumption of all correspondence letter campaigns was not complete until September 2021.

Ontario Health continues to support the recovery of cancer screening services through ongoing initiatives to reduce backlogs and promote uptake of cancer screening among screen-eligible people, such as releasing monthly planning tools for all programs to help Regional Cancer Programs monitor and manage screening service backlogs. Additional activities included providing inserts with correspondence letters to promote screening, translating cancer screening awareness materials into more languages and providing additional tools for primary care providers; such as scripts for phoning patients who are overdue or due for screening and images to share on waiting room video monitors.

Ontario Breast Screening Program (OBSP) and High Risk OBSP Performance

OBSP Volumes

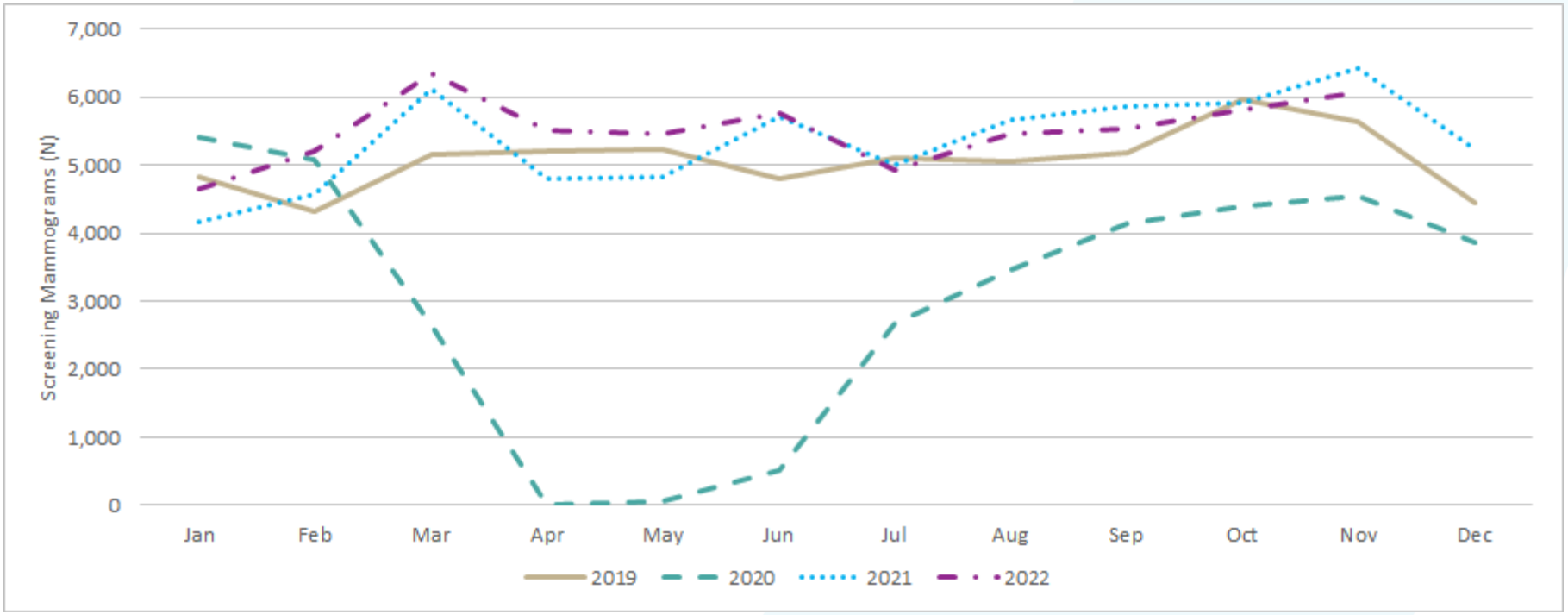
Figure 10: Number of Ontario Breast Screening Program (OBSP) and High Risk OBSP Screening Mammograms, by Month, 2019 to 2022



For data, see Table 3 in Appendix 1.

Mammogram volumes were reduced substantially from March to May 2020 due to the deferral of all non-emergent or urgent health care services in Ontario during this period. Volumes began to recover in June 2020 once cancer screening services were able to resume on a gradual basis, although mammogram volumes were still below 2019 levels as of December 2020. Volumes began to consistently meet or exceed pre-pandemic levels in mid-2021, with some fluctuation corresponding to pandemic waves and regular screening trends (e.g., travel patterns in winter and summer, fluctuations in recall volumes).

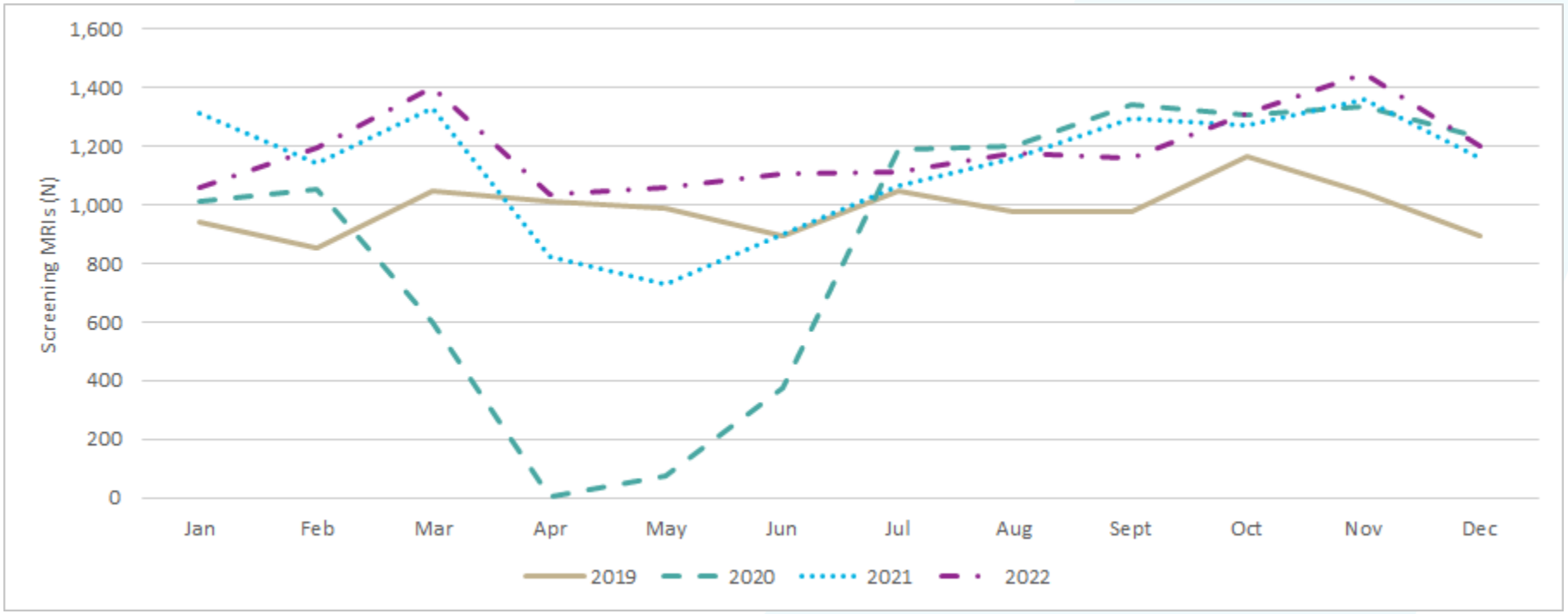
Figure 11: Number of Abnormal Screening Mammograms with Breast Assessment Performed in Ontario, by Month, 2019 to 2022



For data, see Table 4 in Appendix 1.

The volume of abnormal OBSP screening mammograms followed by breast assessment was impacted by the COVID-19 pandemic and the deferral of routine cancer screening services from March to May 2020. Volumes began to recover in June 2020 as screening gradually resumed, although volumes were still below 2019 levels by December 2020. Volumes had recovered by early 2021. Breast assessments for people with abnormal OBSP screening mammogram results were classified as the highest priority in Ontario Health's clinical guidance for prioritization of breast cancer screening services during the COVID-19 pandemic.

Figure 12: Number of High Risk OBSP Magnetic Resonance Imaging (MRIs) Performed in Ontario, by Month, 2019 to 2022

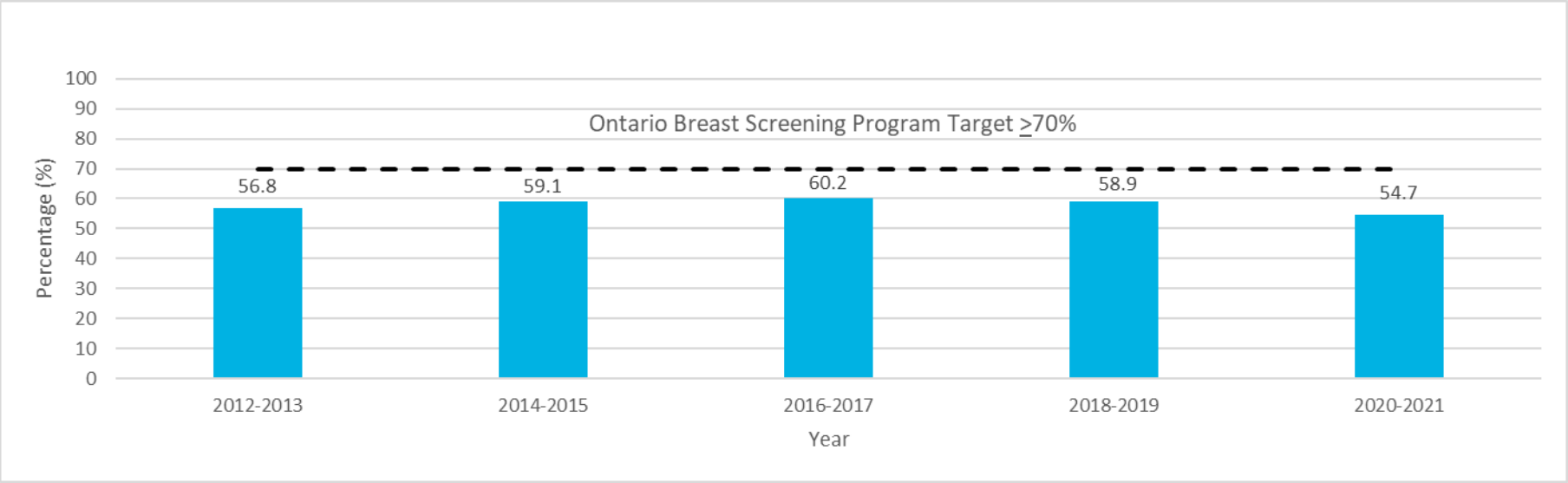


For data, see Table 5 in Appendix 1.

The volume of breast MRIs performed in the High Risk OBSP was impacted by the COVID-19 pandemic and the pause in routine screening services that occurred from March to May 2020, but it recovered to pre-pandemic levels by July 2020. High Risk OBSP screening breast MRI volumes recovered more quickly than screening mammogram volumes because these services were prioritized according to Ontario Health COVID-19 clinical guidance. Additionally, because there are fewer people eligible for the High Risk OBSP, the pandemic backlog was likely smaller.

OBSP Coverage

Figure 13: Percentage of Ontario Screen-Eligible Women*, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period, 2012–2013 to 2020–2021



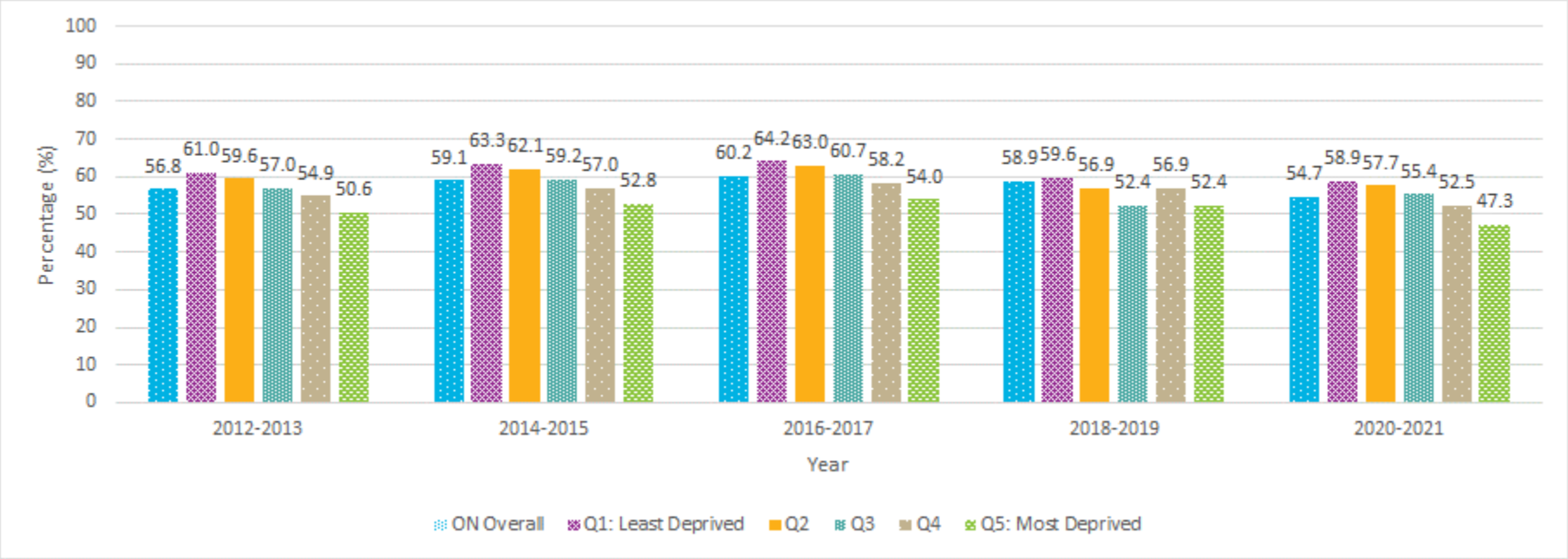
* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

For data, see Table 6 in Appendix 1.

In 2020–2021, 54.7% of screen-eligible people in Ontario had at least one screening mammogram within a 30-month period. Performance for 2020–2021 falls below the OBSP target of greater than or equal to 70% (52). Breast screening participation has varied over time; it was 56.8% in 2012–2013, then increased to 60.2% in 2016–2017 before decreasing again. The decrease observed in 2018–2019 (58.9%) and 2020–2021 (54.7%) is likely due to the deferral of cancer screening services during the first wave of the COVID-19 pandemic and the prioritization of services based on breast cancer risk according to Ontario Health pandemic clinical guidance during subsequent pandemic waves. Screening outside of the OBSP continues to decrease over time, with only 2.1% of all breast screening mammograms performed outside the program in 2020–2021 (data not shown). This means that most people accessing breast cancer screening in Ontario are receiving the full benefits of an organized screening program.

OBSP Participation - Equity Analyses: Material Deprivation

Figure 14: Percentage of Screen-Eligible Women* in Ontario, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period, by Material Deprivation, 2012–2013 to 2020–2021



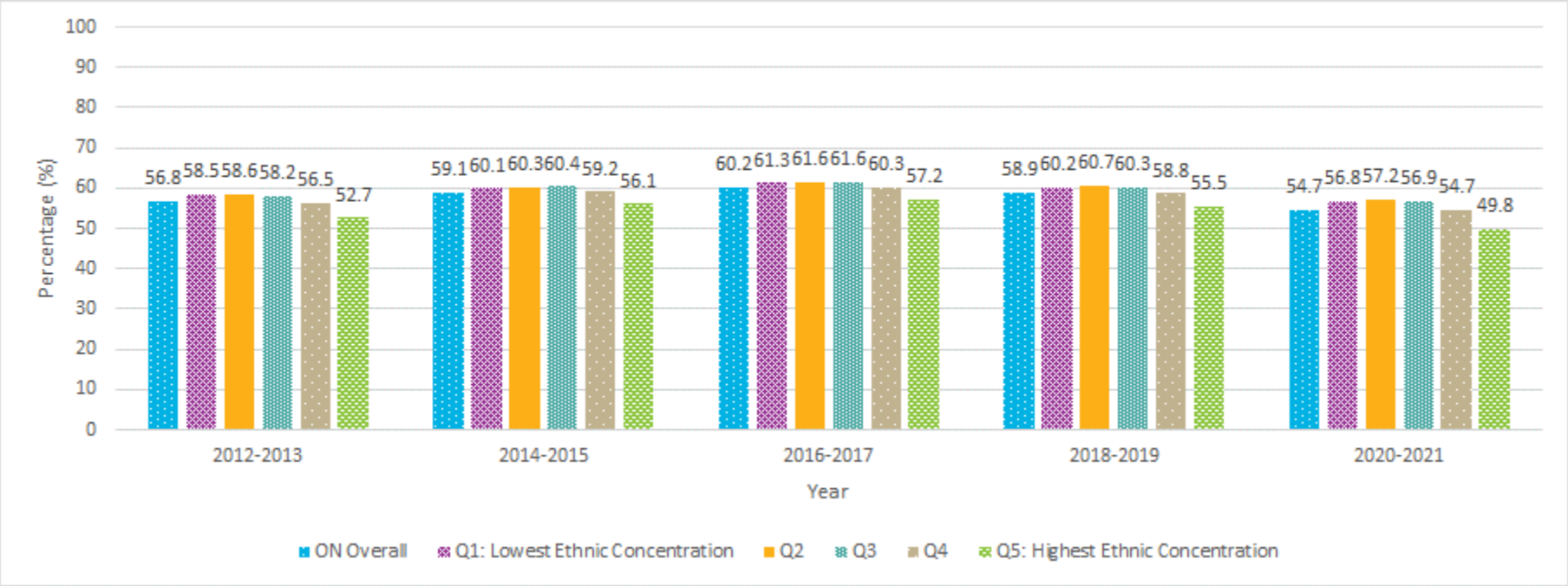
* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

For data, see Table 7 in Appendix 1.

In most reporting years, there was a relationship between breast cancer screening participation and material deprivation. People living in more materially deprived neighbourhoods had lower breast cancer screening participation rates than those living in less materially deprived neighbourhoods. Breast cancer screening participation rates in the most materially deprived neighbourhoods (Q5) were lower than the overall participation rates in Ontario and the OBSP target of greater than or equal to 70% (52). The gap in screening participation between people living in the least deprived (Q1) and the most deprived (Q5) neighbourhoods remained relatively consistent from 10.2% in 2012–2013 to 10.5% in 2018–2019, but increased to 11.5% in 2020–2021. This may be related to worsening of health disparities during the COVID-19 pandemic.

OBSP Participation - Equity Analyses: Ethnic Concentration

Figure 15: Percentage of Screen-Eligible Women* in Ontario, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period, by Ethnic Concentration, 2012–2013 to 2020–2021

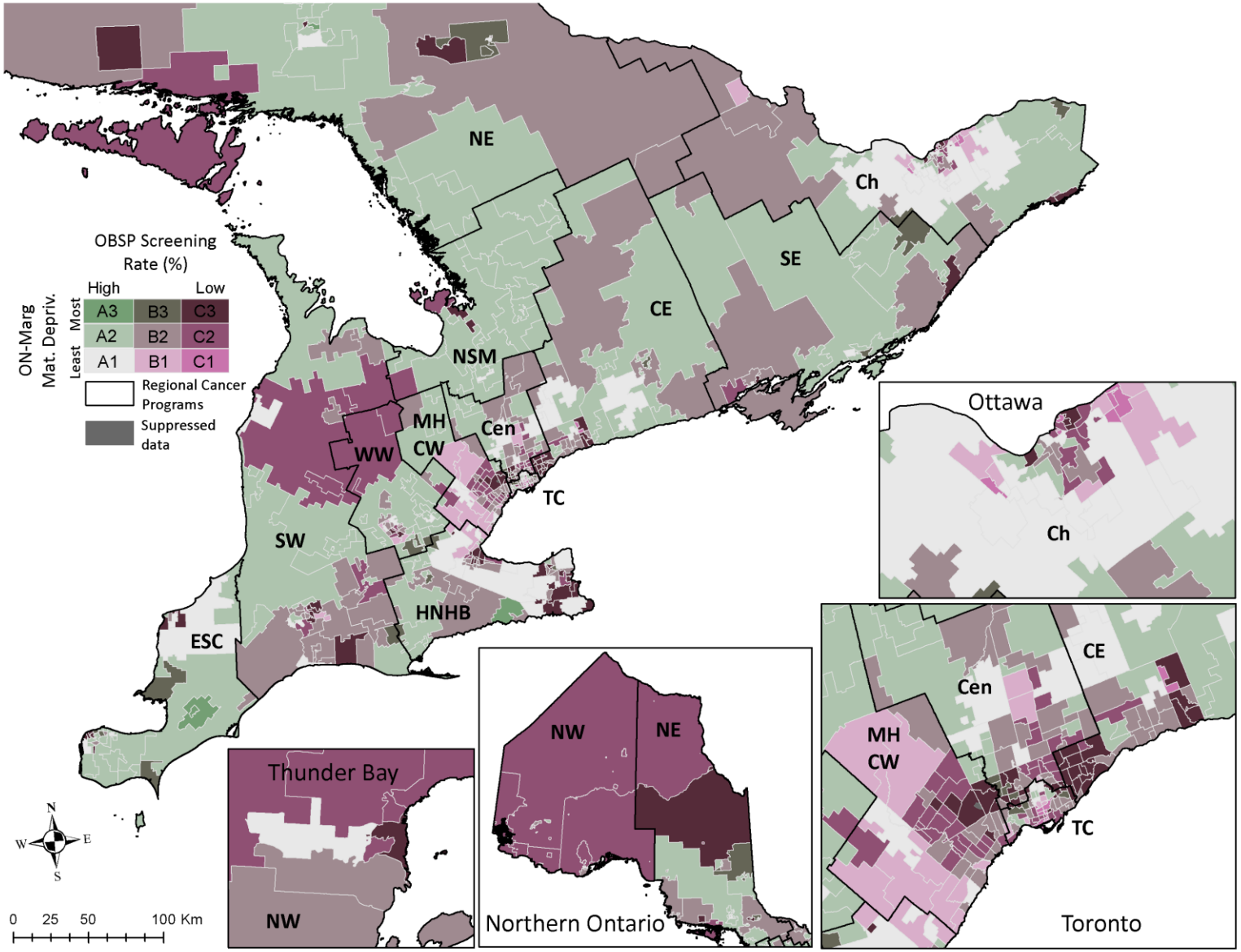


* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

For data, see Table 8 in Appendix 1.

Across all reporting years, people living in the most ethnically concentrated neighbourhoods (Q5) had lower breast cancer screening participation rates than people living in less ethnically concentrated neighbourhoods. Breast cancer screening participation rates in the most ethnically concentrated neighbourhoods (Q5) were lower than overall participation rates in Ontario and the OBSP target of greater than or equal to 70% (52). While the gap in screening participation between people living in the least ethnically concentrated (Q1) and most ethnically concentrated (Q5) neighbourhoods decreased from 5.8% in 2012–2013 to approximately 4% in 2014–2015 and 2016–2017, it increased to 7.0% in 2020–2021. This may be related to worsening of health disparities during the COVID-19 pandemic.

Figure 16: Map Showing Percentage of Screen-Eligible Women* in Ontario, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period by Material Deprivation



Regional Cancer Programs: ESC = Erie St. Clair, SW = South West, WW = Waterloo Wellington, HNHB = Hamilton Niagara Haldimand Brant, CW = Central West, MH = Mississauga Halton, TC = Toronto Central, Cen = Central, CE = Central East, SE = South East, Ch= Champlain, NSM = North Simcoe Muskoka, NE = North East, NW = North West

Data notes: Neighbourhoods are mapped at the forward sortation area level. Participation data is for the 2020-2021 reporting period. Bivariate choropleth (shaded) map. Major boundary lines reflect Regional Cancer Program boundaries. If you require data in an alternative format, please contact us by email (OH-CCO_ScreeningPerformanceReport@OntarioHealth.ca).

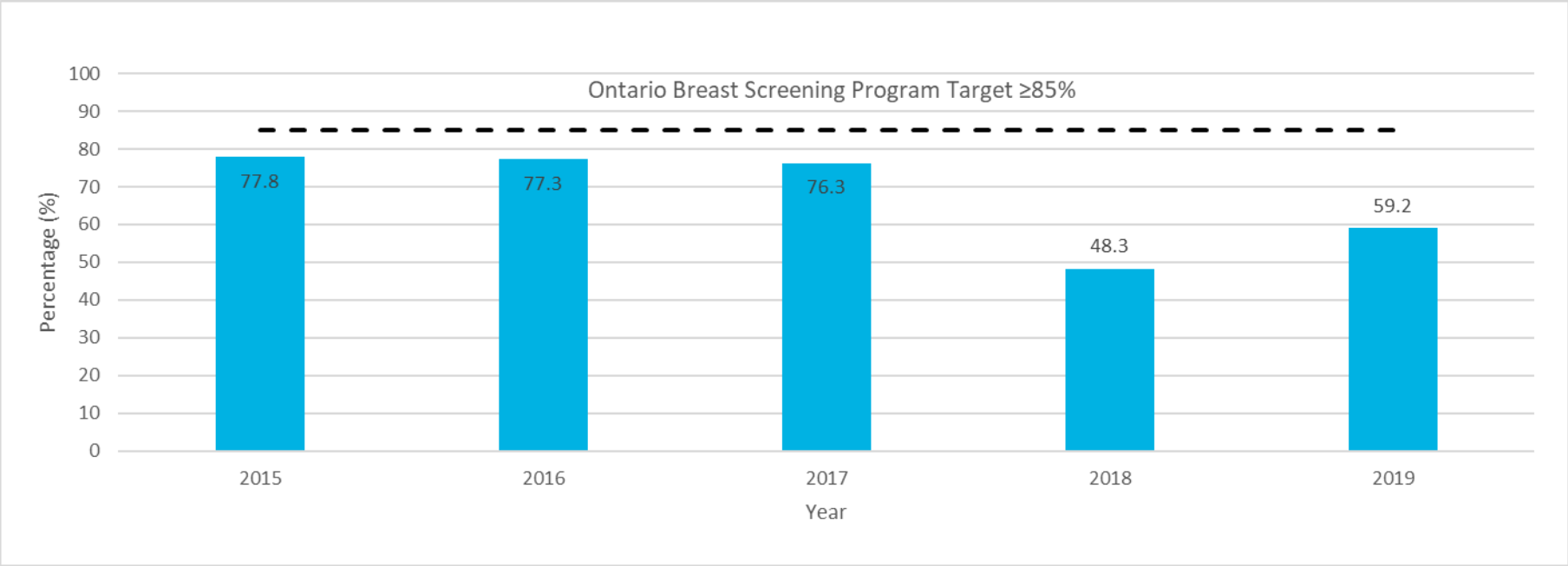
Breast Screening Participation

- **A (high participation): >57.8%**
- **B (medium participation): 52.5% to 57.8%**
- **C (low participation): <52.5%**

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Within the boundaries of each Regional Cancer Program, there are areas of high screening participation with low material deprivation, as well as areas of low screening participation with high material deprivation. The North West and North East Regional Cancer Programs have a large proportion of neighbourhoods containing the greatest level of material deprivation with low breast screening participation (less than 52.5%), including the area surrounding Thunder Bay. There are also clusters of neighbourhoods containing the highest level of material deprivation with low screening participation throughout the greater Toronto area, including neighbourhoods around the downtown core (Toronto Central Regional Cancer Program), West North York and North Etobicoke (Central Regional Cancer Program), Scarborough and parts of Oshawa (Central East Regional Cancer Program), Brampton and Mississauga (Mississauga Halton and Central West Regional Cancer Programs).

Figure 17: Percentage of Ontario Screen-Eligible People, Ages 50 to 74, Who Had a Subsequent Mammogram Within 30 Months of a Previous Program Mammogram, 2015 to 2019

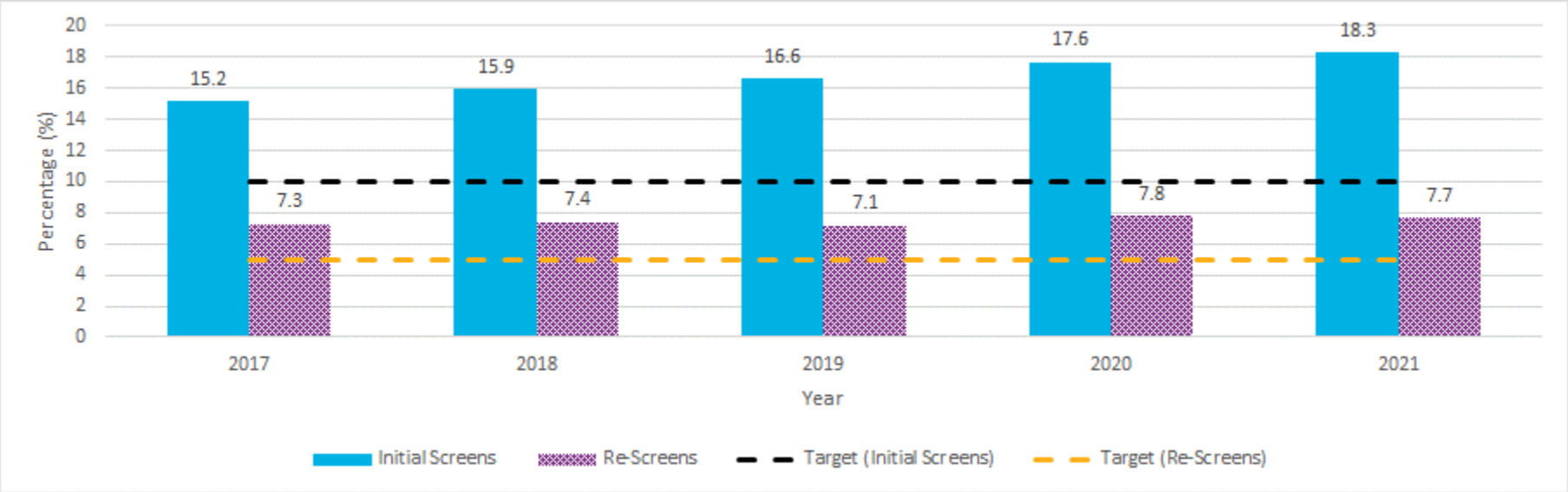


For data, see Table 9 in Appendix 1.

Breast cancer screening retention decreased (worsened) from 77.8% in 2015 to 59.2% in 2019 and did not meet the OBSP target of ≥85% (52). While retention was stable at approximately 76% to 78% from 2015 to 2017, it decreased to 48.3% in 2018. The 2018 reporting year reflects people who would have been due for a subsequent screen in 2020. Thus, this decrease may be due to impacts of the COVID-19 pandemic, including the deferral of cancer screening services during the first pandemic wave, participant or provider deferrals of screening during subsequent pandemic waves, prioritizing screening for people at highest risk for breast cancer according to Ontario Health pandemic guidance, and the pause and gradual restart of cancer screening correspondence. Retention improved by more than 10 percentage points from 2018 to 2019, suggesting that screening retention is beginning to recover.

OBSP: Follow-Up of Abnormal Results

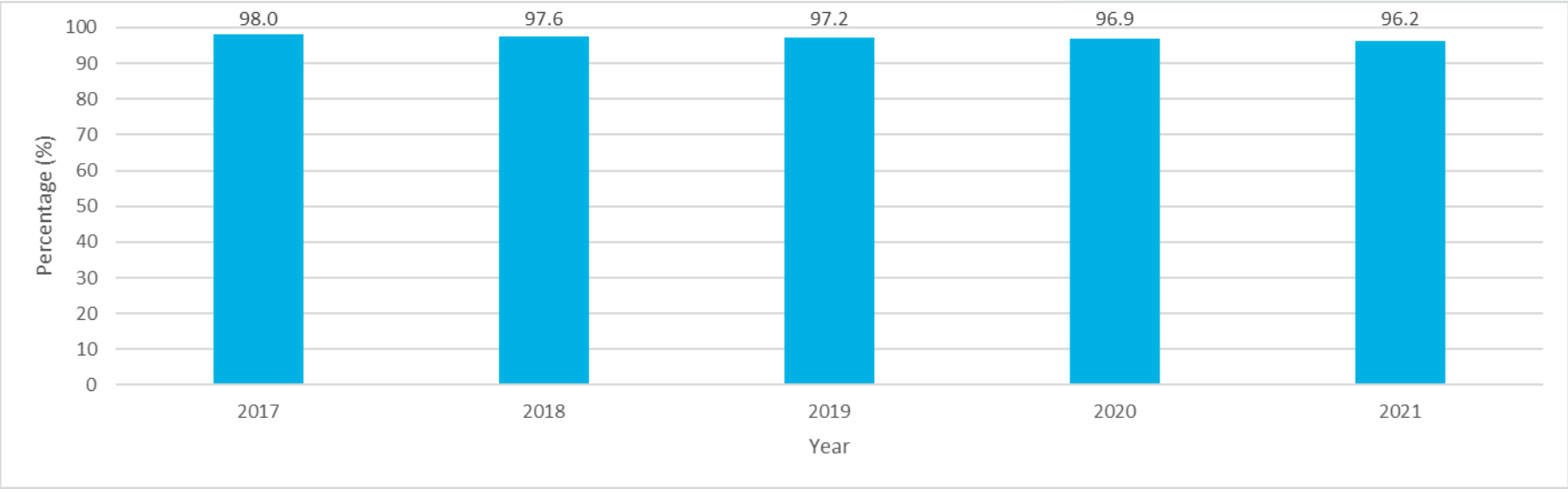
Figure 18: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Ontario Breast Screening Program Mammogram Result, 2017 to 2021



For data, see Table 10 in Appendix 1.

Abnormal call rate measures the percentage of OBSP participants referred for further testing after an abnormal screening mammogram. This indicator is an important measure of screening program performance because screening programs with very low abnormal call rates may have lower cancer detection rates and higher post-screen cancer rates, and programs with very high abnormal call rates may have higher rates of potential harms to screening participants. In the OBSP, the abnormal call rate for initial screens increased from 15.2% in 2017 to 18.3% in 2021. Performance on this indicator did not meet the program target of less than 10% (52). The abnormal call rate for re-screens remained stable from 2017 (7.3%) to 2019 (7.1%) and increased in 2020 (7.8%) and 2021 (7.7%). The abnormal call rate for re-screens did not meet the national or program target of less than 5% (52). The increase in abnormal call rate for re-screens in 2020 and 2021 may reflect prioritizing mammograms for participants at higher risk for breast cancer screening during the pandemic according to Ontario Health guidance.

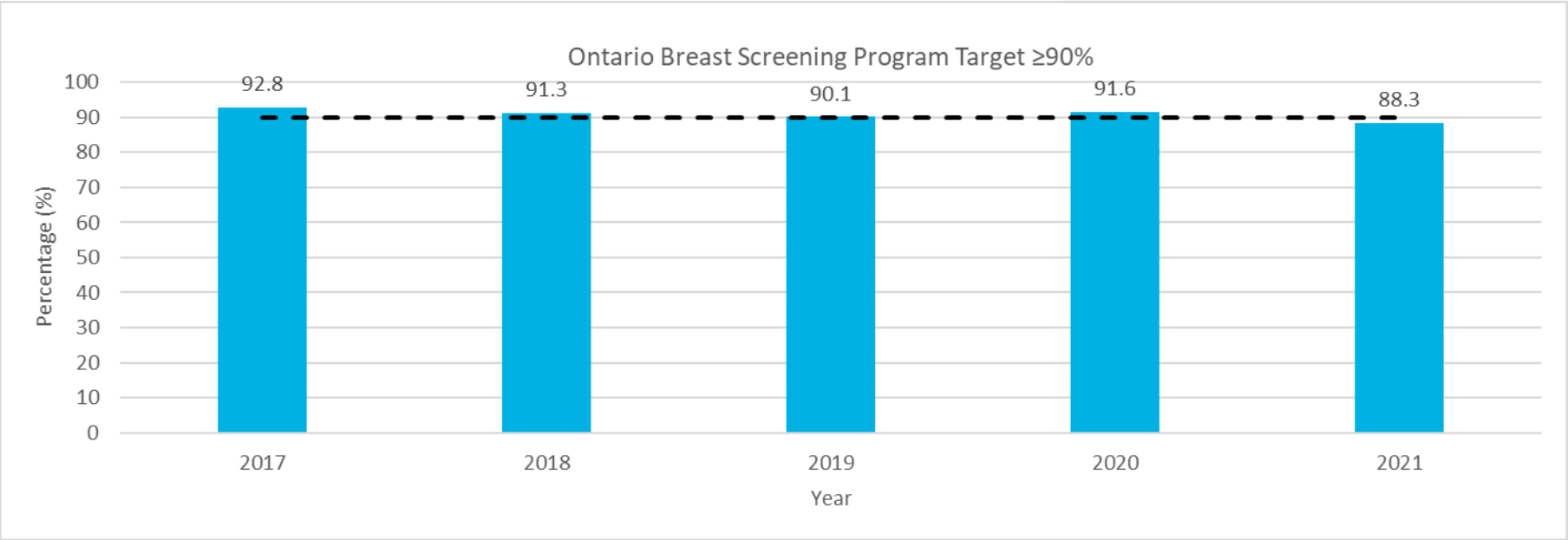
Figure 19: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Who Were Diagnosed (Benign or Cancer) Within 6 Months of the Abnormal Screen Date, 2017 to 2021



For data, see Table 11 in Appendix 1.

The percentage of people with an abnormal OBSP screening mammogram who received a definitive diagnosis within six months has remained consistently high (greater than 95%) since 2017. The stable performance for this indicator through the COVID-19 pandemic in 2020 and 2021 likely reflects prioritizing follow-up of abnormal mammogram results based on Ontario Health guidance during the pandemic.

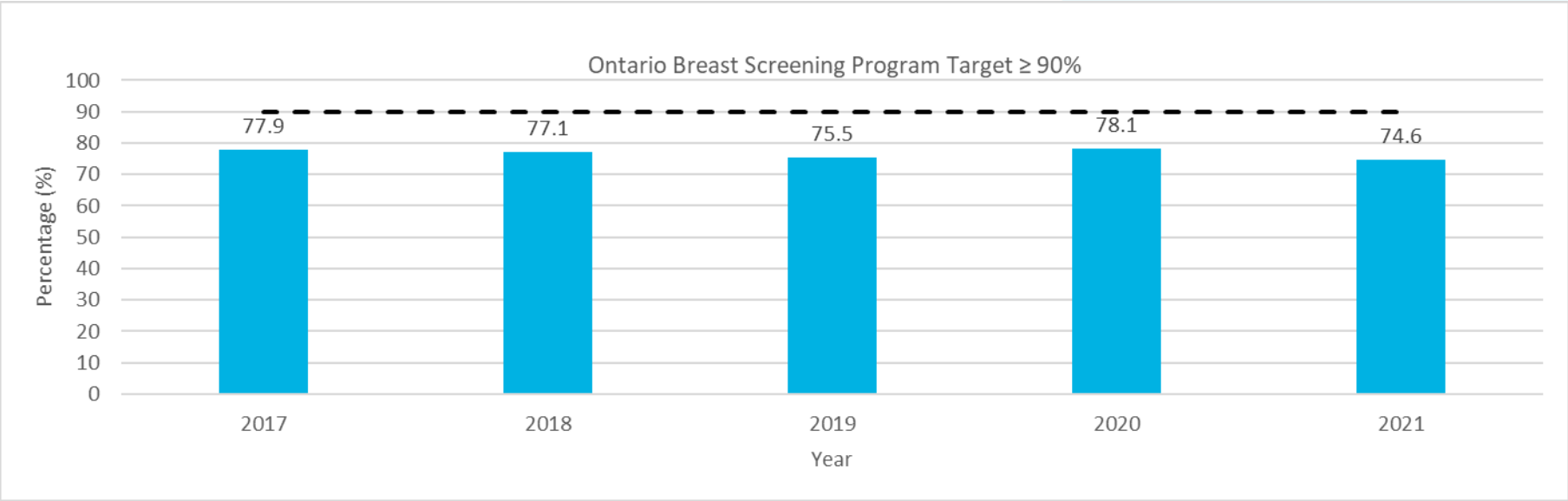
Figure 20: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Did Not Need Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 5 Weeks of the Abnormal Screen Date, 2017 to 2021



For data, see Table 12 in Appendix 1.

The percentage of people with an abnormal OBSP screening mammogram result who did not need a tissue biopsy and were diagnosed within five weeks was 88.3% in 2021. This is the first time since 2017 that performance did not meet the program target of 90% or greater (52). The decrease in performance in 2021 may reflect the higher number of abnormal mammograms in 2021 that did not require tissue biopsy, which could have led to increased wait times for breast assessment services. This decrease in performance may also have been partly due to the widespread health human resource challenges that currently exist in the Ontario health care system, which may have impacted wait times for breast assessment and diagnostic services.

Figure 21: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Needed Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 7 Weeks of the Abnormal Screen Date, 2017 to 2021

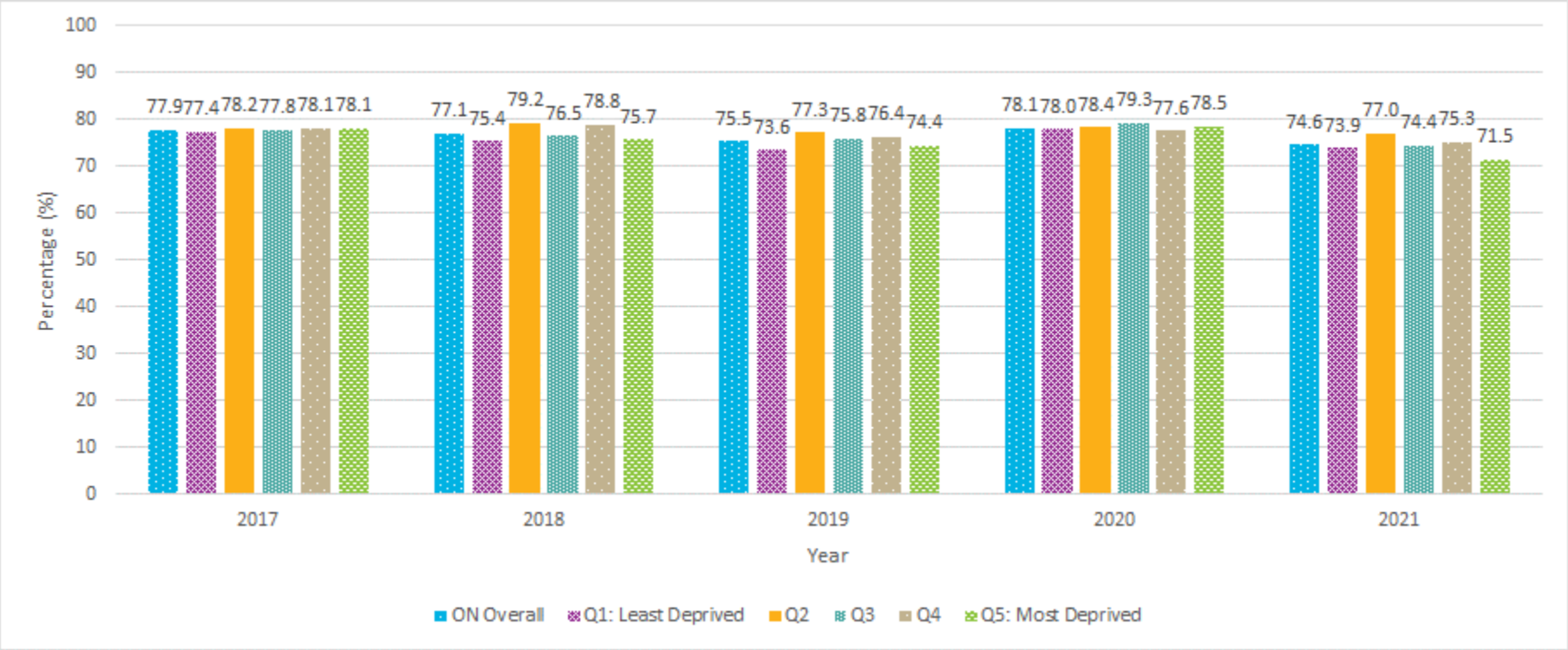


For data, see Table 13 in Appendix 1.

The percentage of people with an abnormal OBSP screening mammogram result who needed a tissue biopsy and were diagnosed within seven weeks of their abnormal screen date decreased (worsened) from 77.9% in 2017 to 74.6% in 2021. Performance for this indicator did not meet the program target of 90% or greater (52). There was a short-term increase (improvement) in performance for this indicator from 2019 to 2020, which may have been due to several factors, including prioritizing diagnostic assessments following abnormal screening mammograms during the pandemic according to Ontario Health guidance and the lower volume of screening mammograms performed in 2020 due to the deferral of all cancer screening during the first wave of the COVID-19 pandemic. The decrease in performance in 2021 may reflect the return of mammogram volumes to pre-pandemic levels and the widespread health human resource challenges that currently exist in the Ontario health care system which may have impacted wait times for breast assessment and diagnostic services.

OBSP Follow-Up of Abnormal Results – Equity Analyses: Material Deprivation

Figure 22: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Needed a Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 7 Weeks of the Abnormal Screen Date, by Material Deprivation, 2017 to 2021

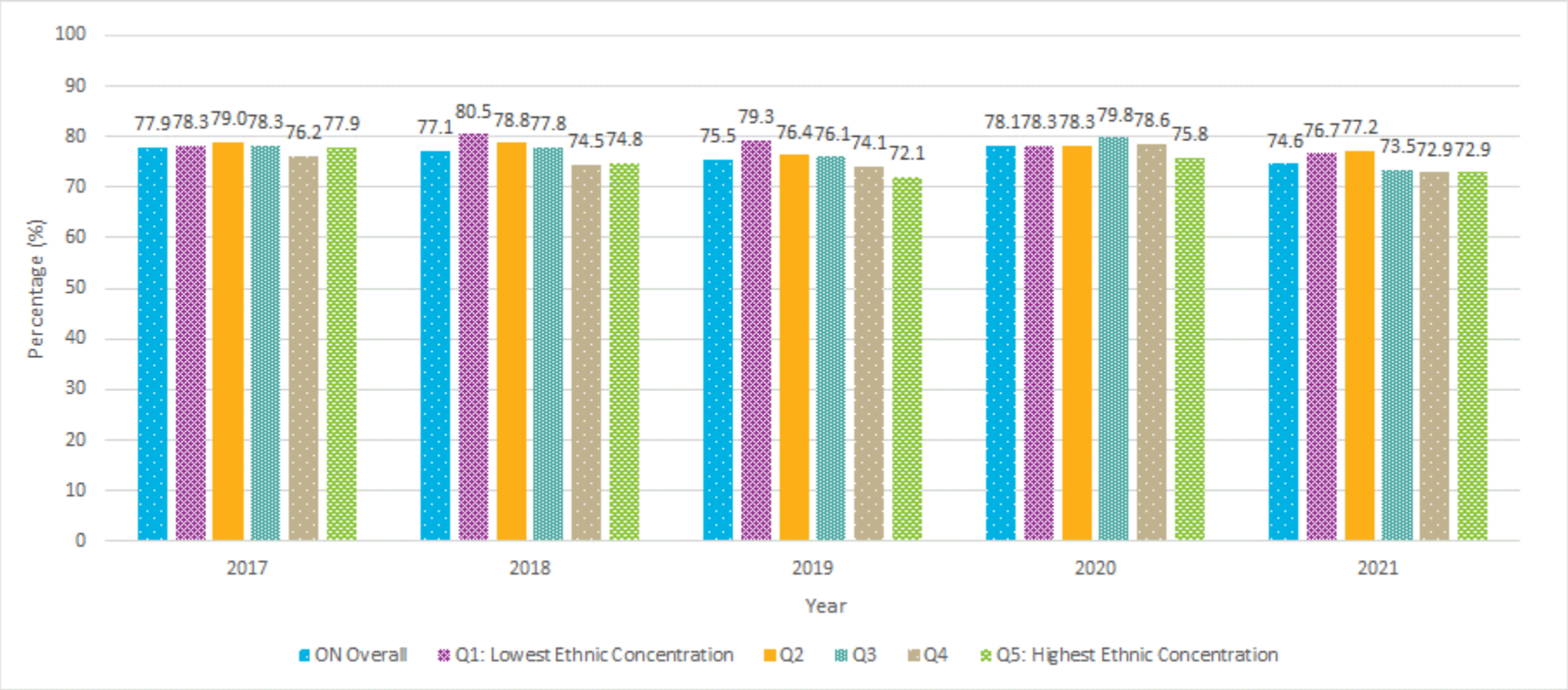


For data, see Table 14 in Appendix 1.

No consistent relationship was observed between neighbourhood material deprivation and diagnostic interval (seven weeks with tissue biopsy) in the OBSP. In the 2017 to 2020 reporting years, the percentage of people diagnosed within seven weeks of their abnormal mammogram was approximately the same between the least deprived (Q1) and most deprived (Q5) neighbourhoods; however, the percentage of people diagnosed within seven weeks was lower in the most deprived quintile in 2021. This finding will be monitored to assess whether it persists over time.

OBSP Follow-Up of Abnormal Results – Equity Analyses: Ethnic Concentration

Figure 23: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Needed a Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 7 Weeks of the Abnormal Screen Date, by Ethnic Concentration, 2017 to 2021

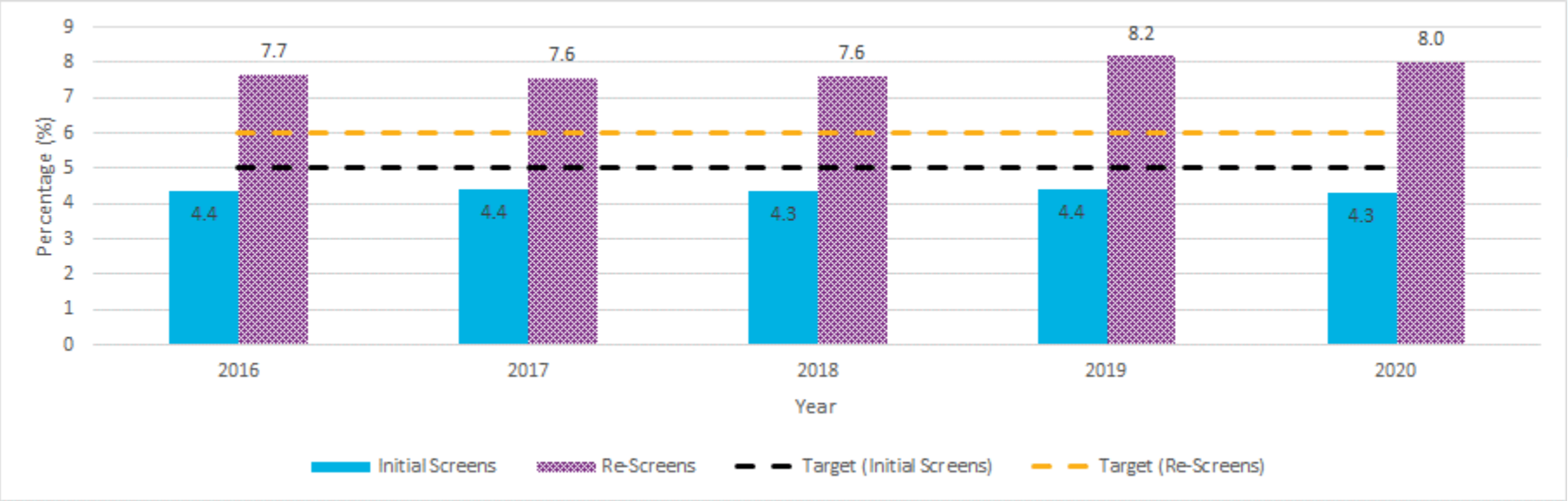


For data, see Table 15 in Appendix 1.

Across all reporting years, there was a relationship between neighbourhood ethnic concentration and diagnostic interval (seven weeks with tissue biopsy) in the OBSP. The percentage of people diagnosed within seven weeks of their abnormal screening result was higher in less ethnically concentrated neighbourhoods. The gap between the least concentrated (Q1) and most concentrated (Q5) neighbourhoods fluctuated over this period, with the largest gap observed in 2019.

OBSP: Quality of Screening

Figure 24: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Were Diagnosed With Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer) After Diagnostic Workup, 2016 to 2020

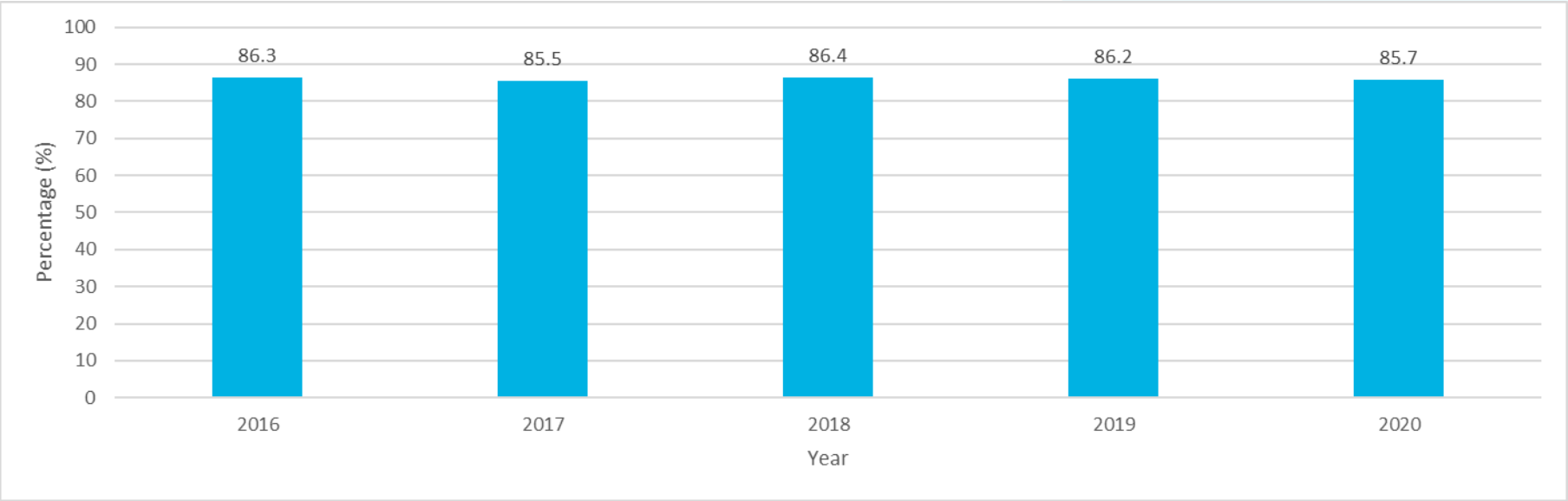


For data, see Table 16 in Appendix 1.

Positive predictive value (PPV) is the probability that someone with a positive cancer screening test has pre-cancer or cancer. The PPV of a screening test depends on the underlying prevalence of a disease in the population being screened and increases with age. The PPV for initial screens in the OBSP remained stable at 4.3% to 4.4% from 2016 to 2020. Performance on this indicator did not meet the program target of 5% or greater (52) for initial screens from 2016 to 2020.

PPV is typically higher for re-screens than initial screens, which is observed in Ontario. The PPV for re-screens in the OBSP remained consistent (from 7.6% to 7.7%) from 2016 to 2018 and then increased above 8% in 2019. Performance on this indicator for re-screens met the program target of 6% or greater (52) from 2017 to 2020. The increase in PPV for re-screens from 2019 to 2020 may be related to prioritization of screening for people at highest risk for breast cancer according to Ontario Health pandemic guidance, the return to screening by people who are overdue because of pandemic deferrals and population aging.

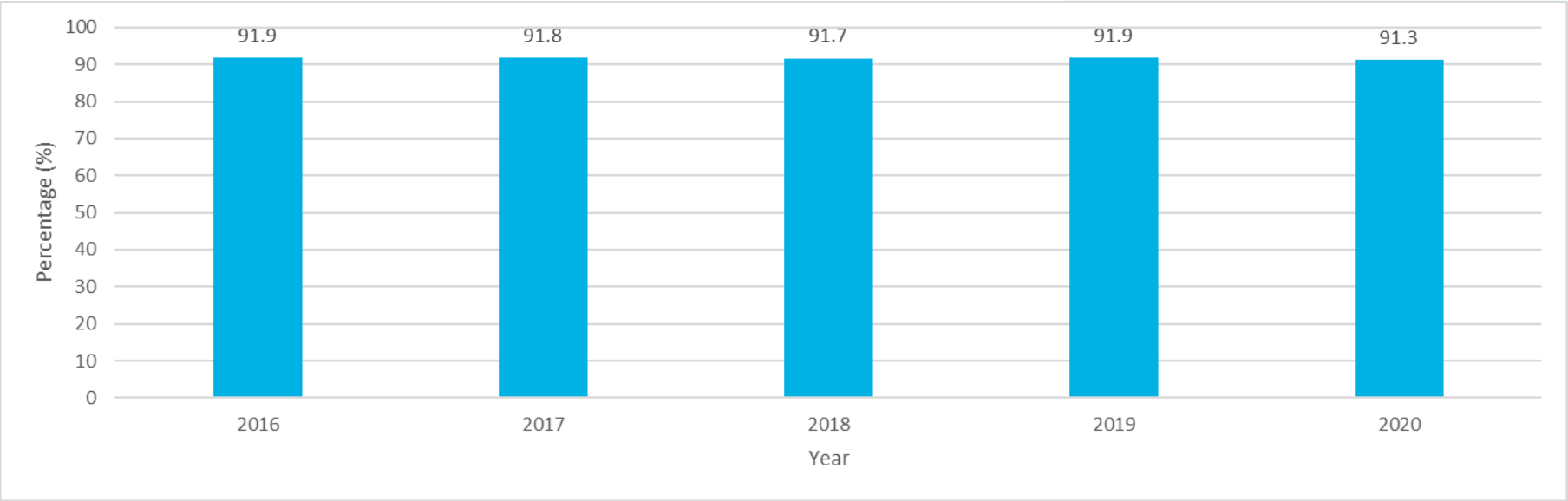
Figure 25: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Correctly Diagnosed With Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer) After an Abnormal Ontario Breast Screening Program Mammogram And Diagnostic Workup, 2016 to 2020



For data, see Table 17 in Appendix 1.

Sensitivity is the effectiveness of a screening test in detecting cancer in people who truly have cancer. Maintaining a high sensitivity for a screening test is important as this means there will be a lower rate of interval cancers (cancers found between routine screening tests). Mammogram sensitivity in the OBSP remained steady (from 85.5% to 86.4%) from 2016 to 2020.

Figure 26: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Without A Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer) Diagnosis Who Were Correctly Identified As Having A Normal Ontario Breast Screening Program Mammogram, 2016 to 2020

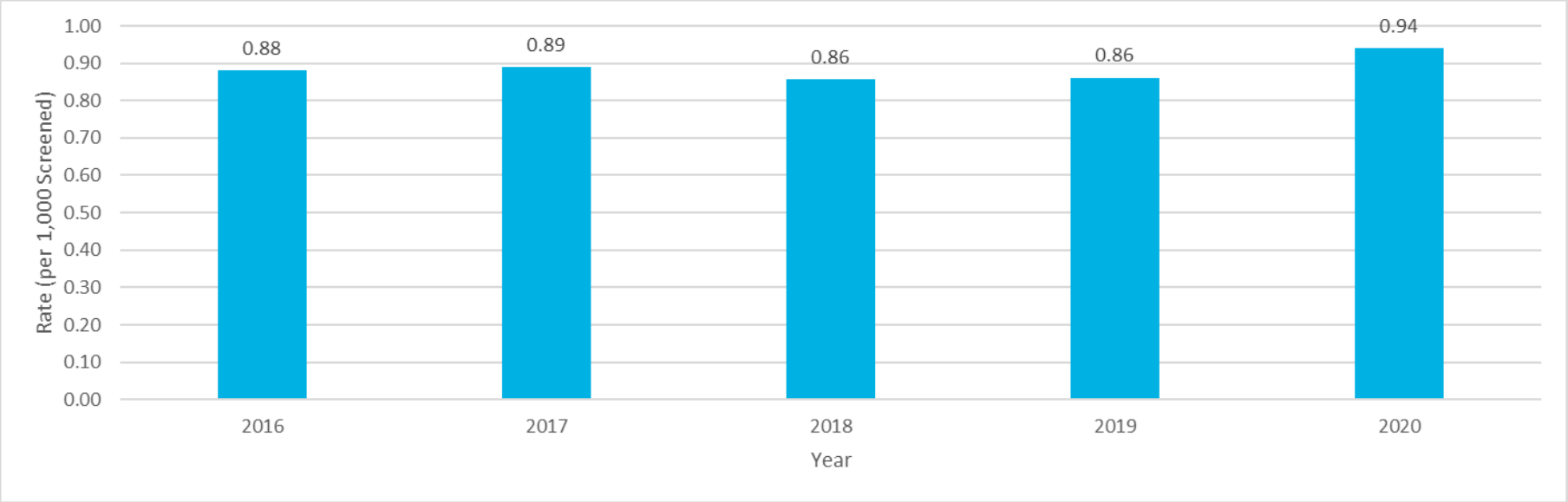


For data, see Table 18 in Appendix 1.

Specificity is the effectiveness of a screening test in accurately identifying people who truly do not have cancer. High specificity of a screening test results in fewer false-positive results (e.g., people with an abnormal OBSP screening mammogram who receive follow-up, but do not have cancer). The specificity of mammography in the OBSP remained consistently high at over 90% from 2016 to 2020.

OBSP: Breast Cancer Detection

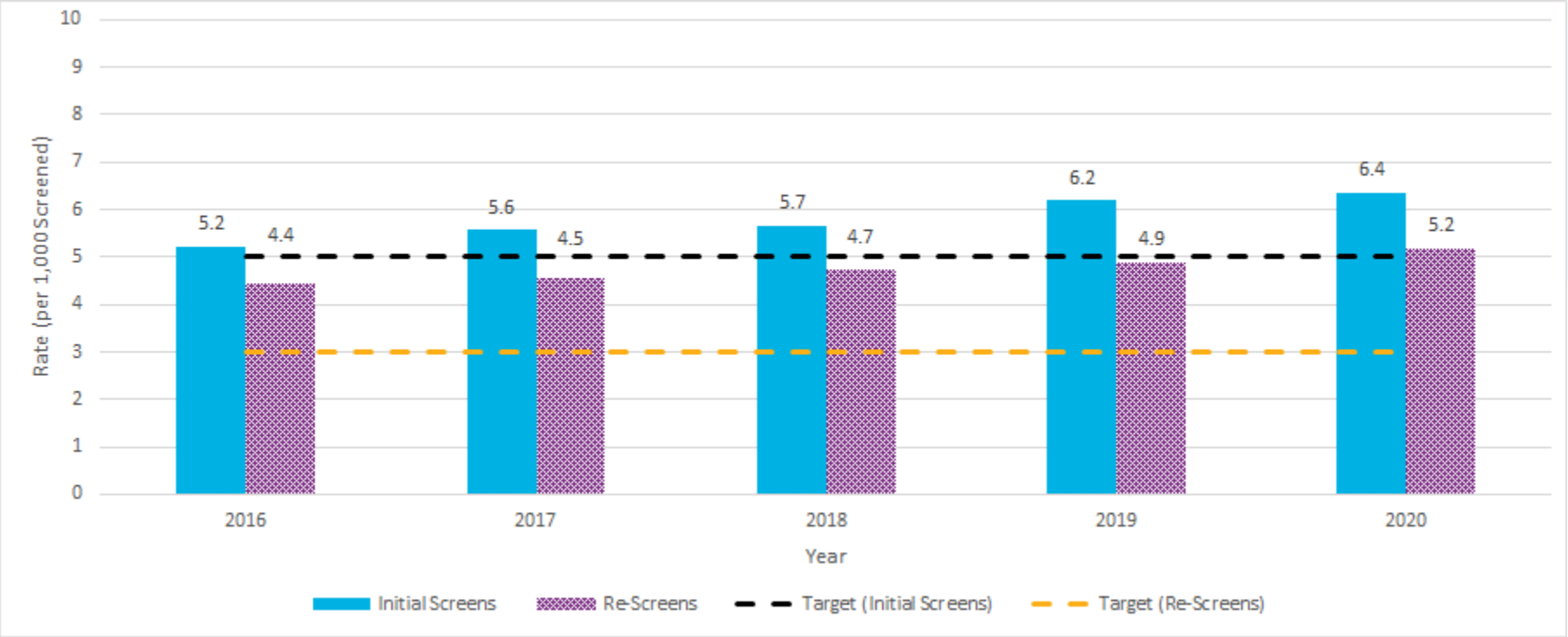
Figure 27: Number of Screen-Eligible People in Ontario, Ages 50 to 74, With a Screen-Detected Ductal Carcinoma In Situ per 1,000 People Screened, 2016 to 2020



For data, see Table 19 in Appendix 1.

From 2016 to 2019, the ductal carcinoma in-situ (DCIS) detection rate was stable from 0.86 to 0.89 per 1,000 people screened. However, the rate increased in 2020 to 0.94 per 1,000. The increase in the DCIS detection rate in 2020 may reflect the prioritization of screening for people at highest risk for breast cancer according to Ontario Health pandemic guidance.

Figure 28: Number of Screen-Eligible People in Ontario, Ages 50 to 74, With a Screen-Detected Invasive Breast Cancer per 1,000 People Screened, 2016 to 2020



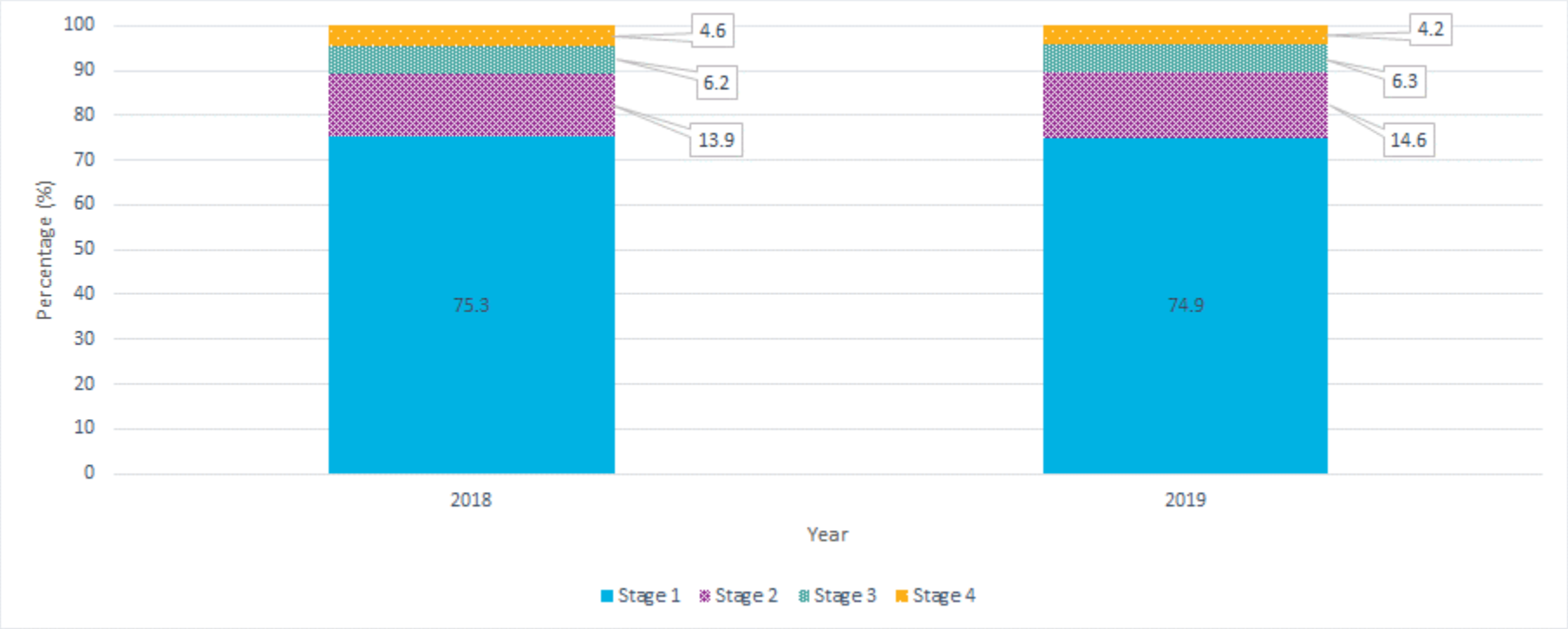
For data, see Table 20 in Appendix 1.

The invasive breast cancer detection rate for initial screens increased steadily from 5.2 per 1,000 people screened in 2016 to 6.4 per 1,000 people screened in 2020. Performance on this indicator for initial screens met the program target of greater than 5.0 per 1,000 (52) from 2016 to 2020. The invasive cancer detection rate is typically higher for initial screens than re-screens because initial screens detect mostly prevalent cancers. The invasive breast cancer detection rate for re-screens also increased over time, from 4.4 per 1,000 in 2016 to 5.2 per 1,000 in 2020. Performance for re-screens also consistently exceeded the Canadian target of greater than 3 per 1,000 (52).

The increase in invasive cancer detection rate for both initial and re-screens over time may be due to several factors, such as population aging and the transition of mammography technology from screen film and computed radiography to digital direct radiography. The increase seen in 2020 may also reflect the prioritization of breast cancer screening services according to breast cancer risk in alignment with Ontario Health pandemic guidance during the early waves of the COVID-19 pandemic.

OBSP: Disease Extent at Diagnosis

Figure 29: Stage Distribution of All Invasive Breast Cancers Diagnosed in Ontario, Ages 50 to 74, 2018 to 2019

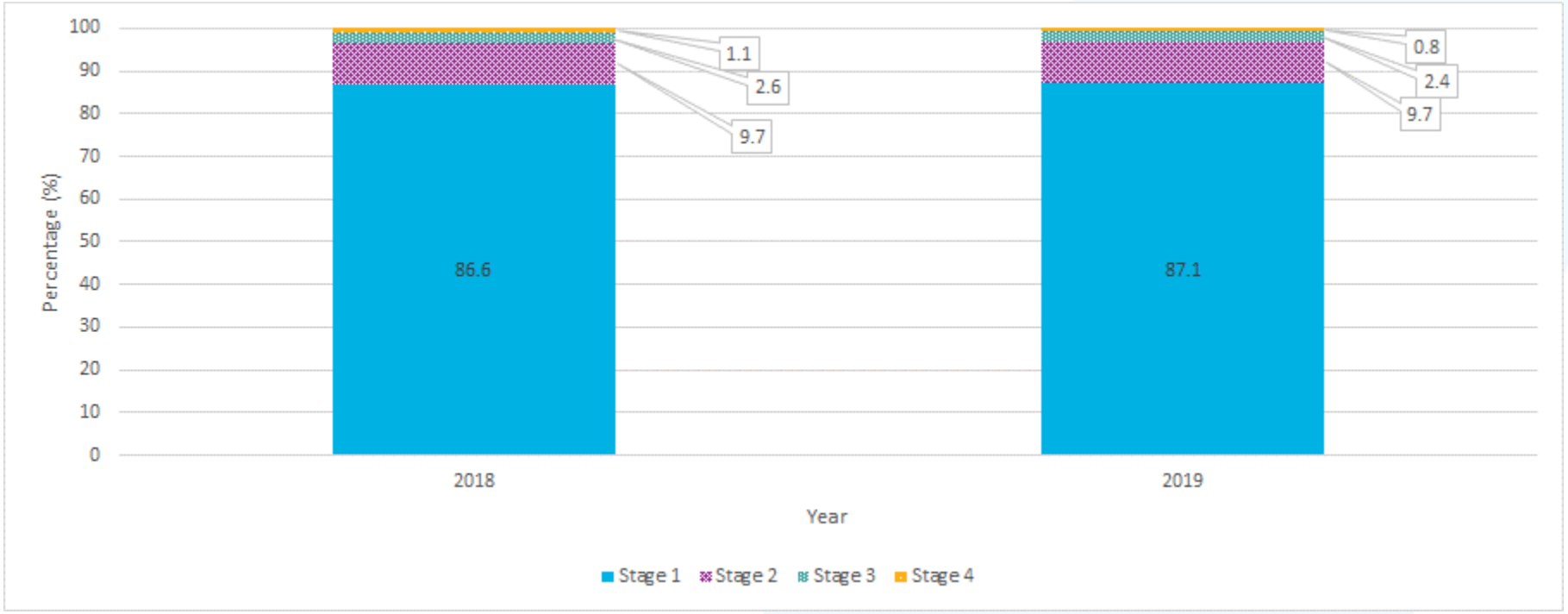


Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

For data, see Table 21 in Appendix 1.

This indicator reports the stage at diagnosis for all invasive breast cancers diagnosed in Ontario. Early-stage (stage 1) breast cancers accounted for approximately 75% of all breast cancers diagnosed in 2018 and 2019. The percentages of breast cancers diagnosed at later stages (stages 3 and 4) were also comparable for 2018 (6.2% stage 3 and 4.6% stage 4) and 2019 (6.3% stage 3 and 4.2% stage 4.) The proportion of breast cancers diagnosed at stage 2 increased slightly, from 13.9% in 2018 to 14.6% in 2019.

Figure 30: Stage Distribution of Screen-Detected Invasive Breast Cancers Diagnosed in Ontario, Ages 50 to 74, 2018 to 2019



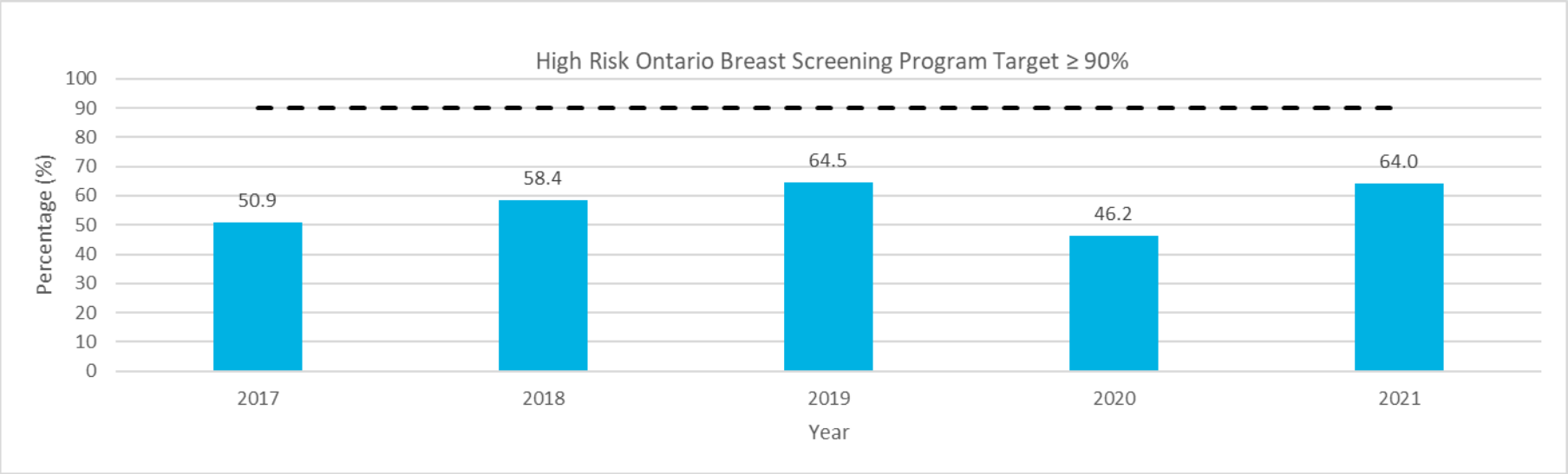
Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

For data, see Table 22 in Appendix 1.

Compared to all invasive breast cancers diagnosed in Ontario (Figure 29), more screen-detected invasive breast cancers were diagnosed at an early stage (stage 1). In 2018 and 2019, approximately 87% of screen-detected invasive breast cancers were detected at stage 1. This finding reflects the benefits of organized breast cancer screening in detecting breast cancers at an earlier stage when treatment is more likely to be effective.

High Risk OBSP: Coverage

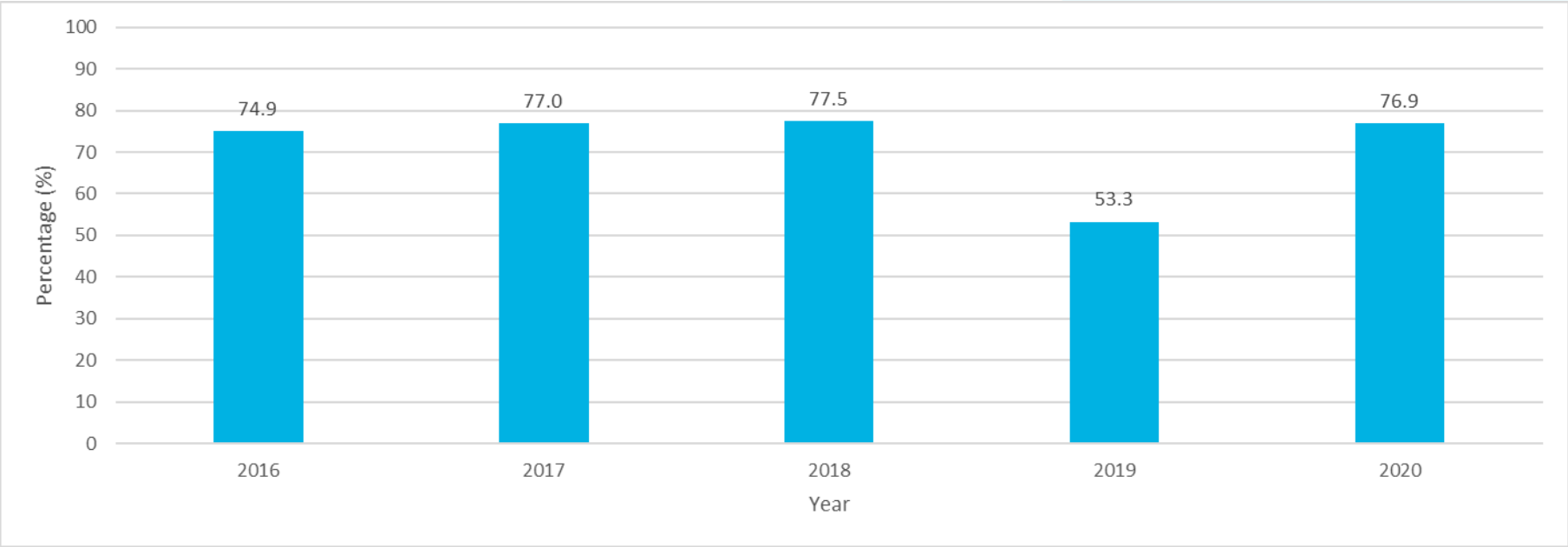
Figure 31: Percentage of People in Ontario, Ages 30 to 69, Screened With Magnetic Resonance Imaging or Ultrasound Within 90 Days of Confirmation of Eligibility for the High Risk Ontario Breast Screening Program, 2017 to 2021



For data, see Table 23 in Appendix 1.

This indicator measures the percentage of participants screened with breast magnetic resonance imaging (MRI) or ultrasound within 90 days of confirming their eligibility for the High Risk OBSP. For High Risk OBSP participants, screening with breast MRI in addition to mammography is recommended because mammography alone is less sensitive than breast MRI and mammography combined (53). Overall, performance on this indicator was below the program target of at least 90% from 2017 to 2021. A key challenge that impacts performance on this indicator is limited MRI capacity within the province. Despite MRI capacity constraints, performance improved from 50.9% in 2017 to 64.5% in 2019. Performance worsened in 2020, when only 46.2% of people were screened within 90 days of confirmation of their eligibility for the High Risk OBSP. This decrease was likely due to the deferral of cancer screening services during the first wave of the COVID-19 pandemic. In 2021, 64.0% of people were screened within 90 days of confirmation of their eligibility for the High Risk OBSP, which is sightly below 2019 performance. This improvement may reflect ongoing prioritization of heath care services for people at highest risk for breast cancer in accordance with Ontario Health pandemic guidance.

Figure 32: Percentage of People in Ontario, Ages 30 to 68, Who Had a Subsequent High Risk Ontario Breast Screening Program (OBSP) Screen (i.e., Breast Magnetic Resonance Imaging or Ultrasound) Within 15 Months of a Previous High Risk OBSP Screen, 2016 to 2020

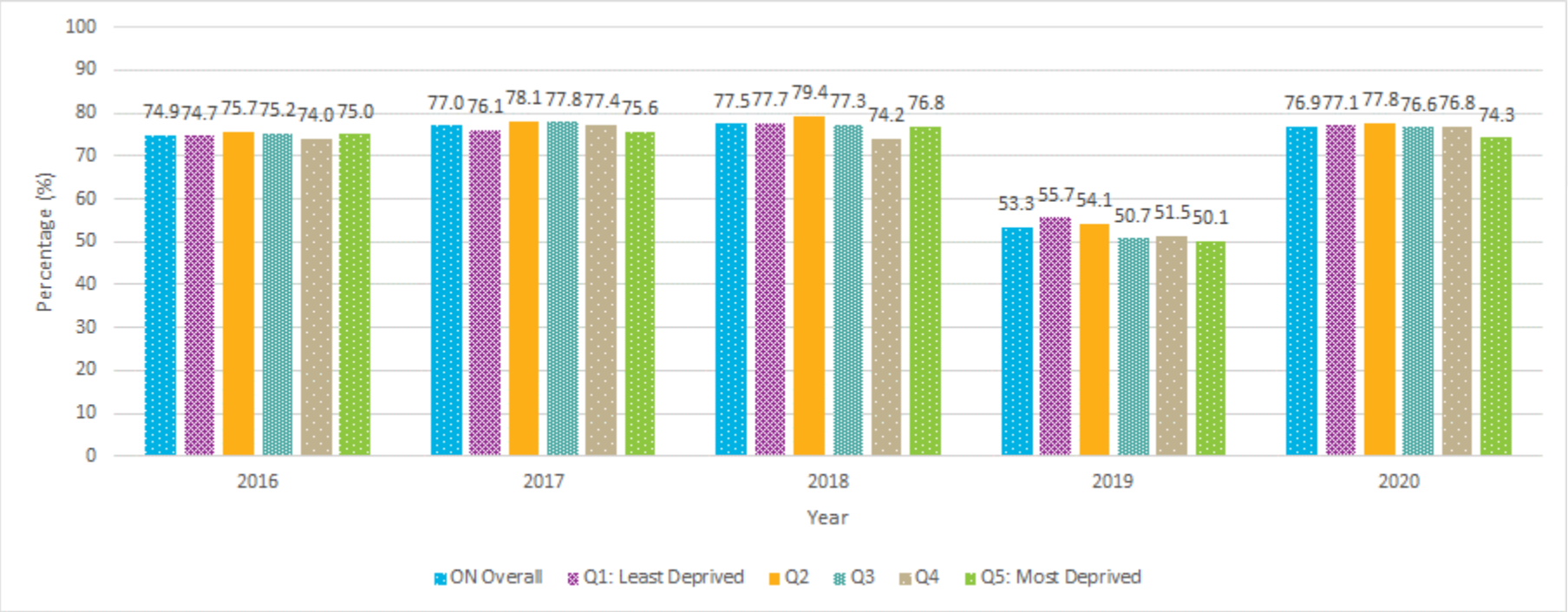


For data, see Table 24 in Appendix 1.

The percentage of people returning to the High Risk OBSP for screening within 15 months increased from 74.9% in 2016 to 77.5% in 2018. The years in the graph represent the date of the initial screening test that the return date is measured against. However, performance declined substantially in 2019 to 53.3%. This decline may be due to impacts of the COVID-19 pandemic, such as deferral of cancer screening during early waves of the pandemic. Deferral of screening services during the first wave of the pandemic may have affected people with a normal screening result in 2019 who would have been due for screening in 2020. The percentage of people who had a normal result in 2020 and returned for their next annual screen improved substantially to 76.9%, which is slightly below the peak performance in 2018. This improvement in performance likely reflects continued prioritization of High Risk OBSP screening services according to Ontario Health pandemic guidance.

High Risk OBSP Retention - Equity Analyses: Material Deprivation

Figure 33: Percentage of People in Ontario, Ages 30 to 68, Who Had a Subsequent High Risk Ontario Breast Screening Program (OBSP) Screen (i.e., Breast Magnetic Resonance Imaging or Ultrasound) Within 15 Months of a Previous High Risk OBSP Screen, by Material Deprivation, 2016 to 2020

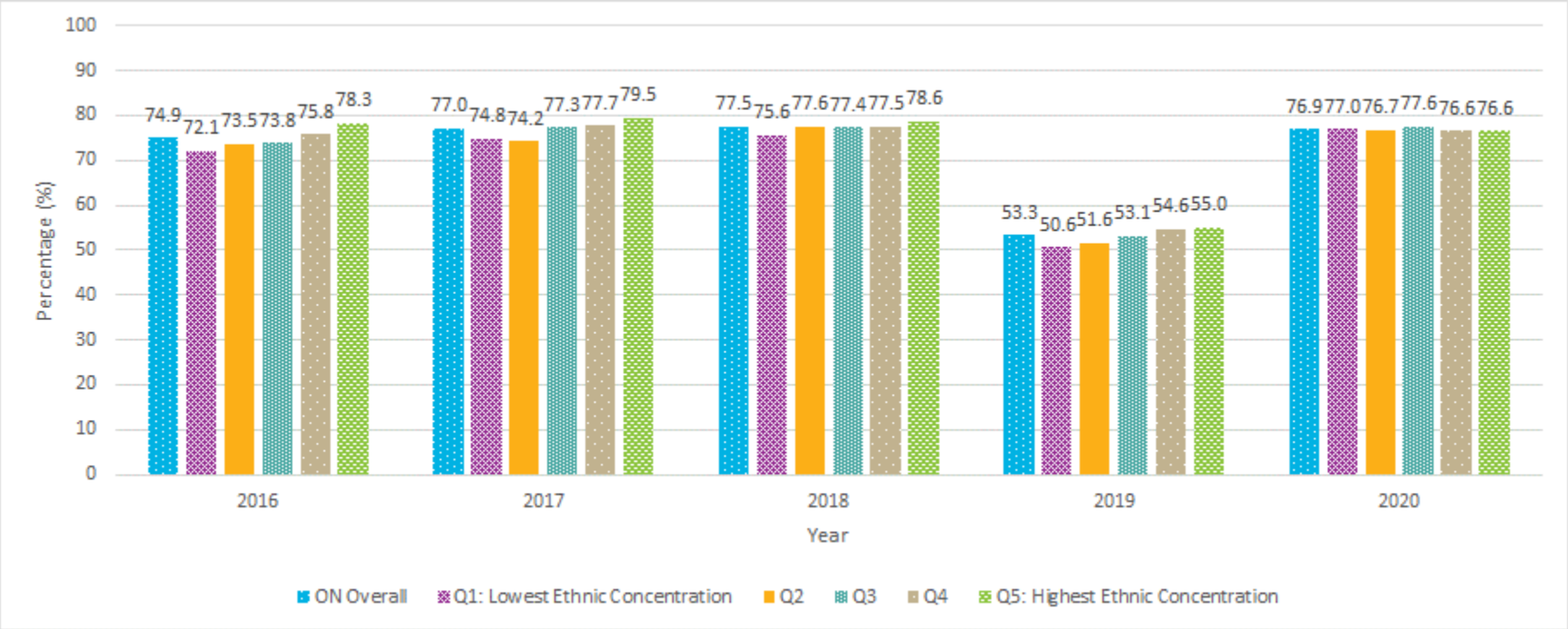


For data, see Table 25 in Appendix 1.

Retention in the High Risk OBSP was impacted by the COVID-19 pandemic, with people in the most materially deprived neighbourhoods being more affected. People in all neighbourhoods of material deprivation who were screened in 2019 and due for annual re-screening in 2020 had lower retention rates, which may reflect the deferral of cancer screening during early pandemic waves. In 2019 and 2020, retention rates were also lower among people living in more materially deprived neighbourhoods (e.g., 55.7% in Q1 vs. 50.1% in Q5 in 2019). This pattern was not seen in other reporting years and may reflect health disparities that were worsened by the COVID-19 pandemic.

High Risk OBSP Retention - Equity Analyses: Ethnic Concentration

Figure 34: Percentage of People in Ontario, Ages 30 to 68, Who Had a Subsequent High Risk Ontario Breast Screening Program (OBSP) Screen (i.e., Breast Magnetic Resonance Imaging or Ultrasound) Within 15 Months of a Previous High Risk OBSP Screen, by Ethnic Concentration, 2016 to 2020

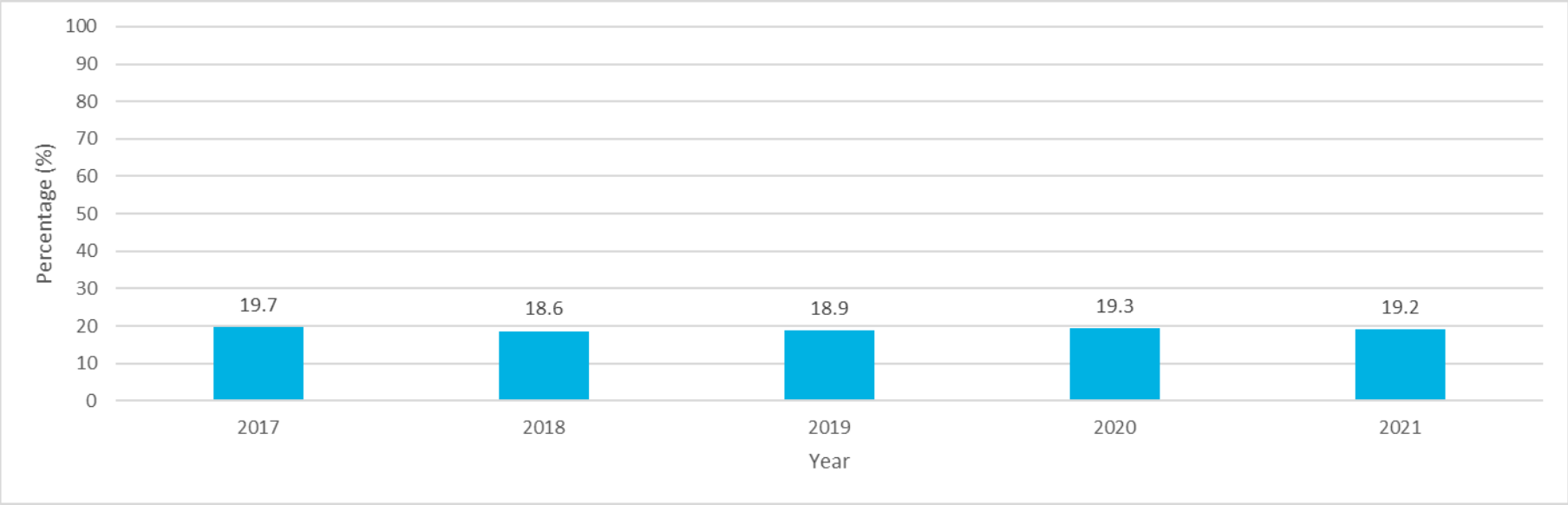


For data, see Table 26 in Appendix 1.

From 2016 to 2019, people living in the most ethnically concentrated neighbourhoods had higher rates of retention in the High Risk OBSP than people in neighbourhoods with the lowest ethnic concentration. In 2020, retention in the High Risk OBSP was similar across all neighbourhoods, by ethnic concentration. This finding may reflect efforts by the High Risk OBSP to ensure that eligible people returned for screening as soon as they were able to in accordance with Ontario Health COVID-19 pandemic guidance. The high retention of people living in the most ethnically concentrated neighbourhoods is a positive finding that may also reflect broader efforts by the High Risk OBSP to ensure that eligible people return for screening on an annual basis.

High Risk OBSP: Follow-Up and Quality of Screening

Figure 35: Percentage of People in Ontario, Ages 30 to 69, Screened in the High Risk Ontario Breast Screening Program With an Abnormal Screening Result, 2017 to 2021

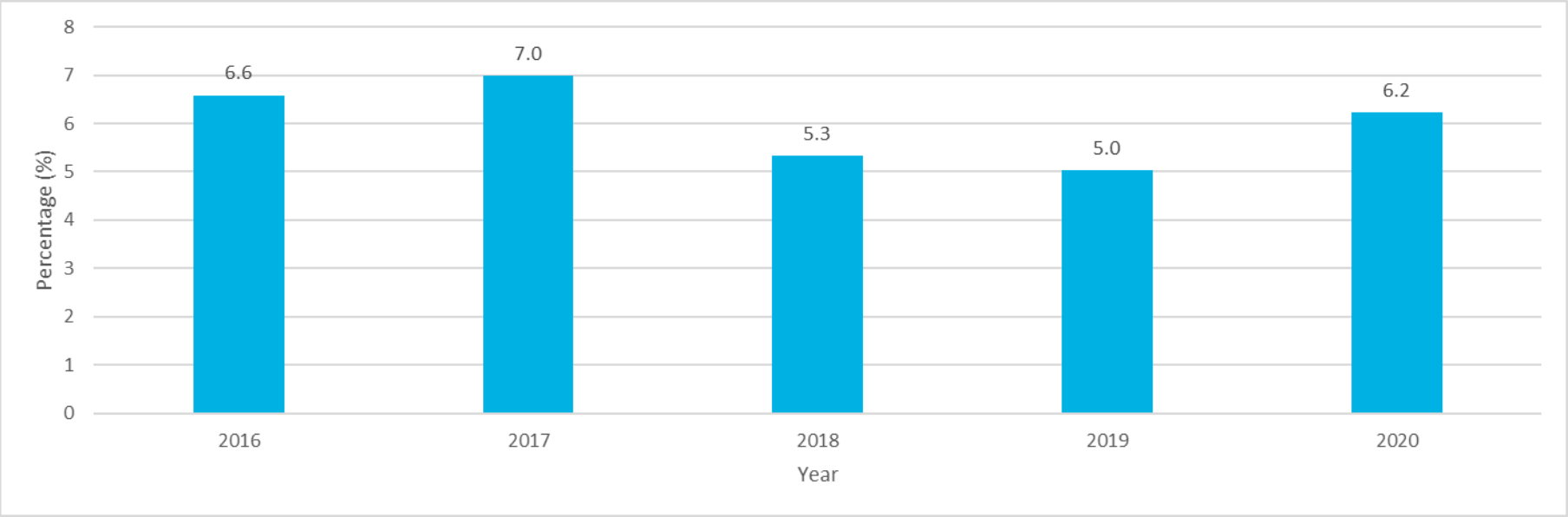


For data, see Table 27 in Appendix 1.

Abnormal call rate (percentage of people with an abnormal screening result) in the High Risk OBSP remained stable at 18.9% to 19.7% from 2017 to 2021.

Participants in the High Risk OBSP are at higher risk for breast cancer, so as expected, their abnormal call rate is greater than in the average risk OBSP cohort. In addition, participants in the High Risk OBSP undergo two screening tests (breast MRI and mammography or ultrasound), which are read independently. Discrepancies between the results of the two tests can also increase abnormal call rates.

Figure 36: Percentage of People in Ontario, Ages 30 to 69, With an Abnormal High Risk OBSP Screening Result Who Were Diagnosed With Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer), 2016 to 2020



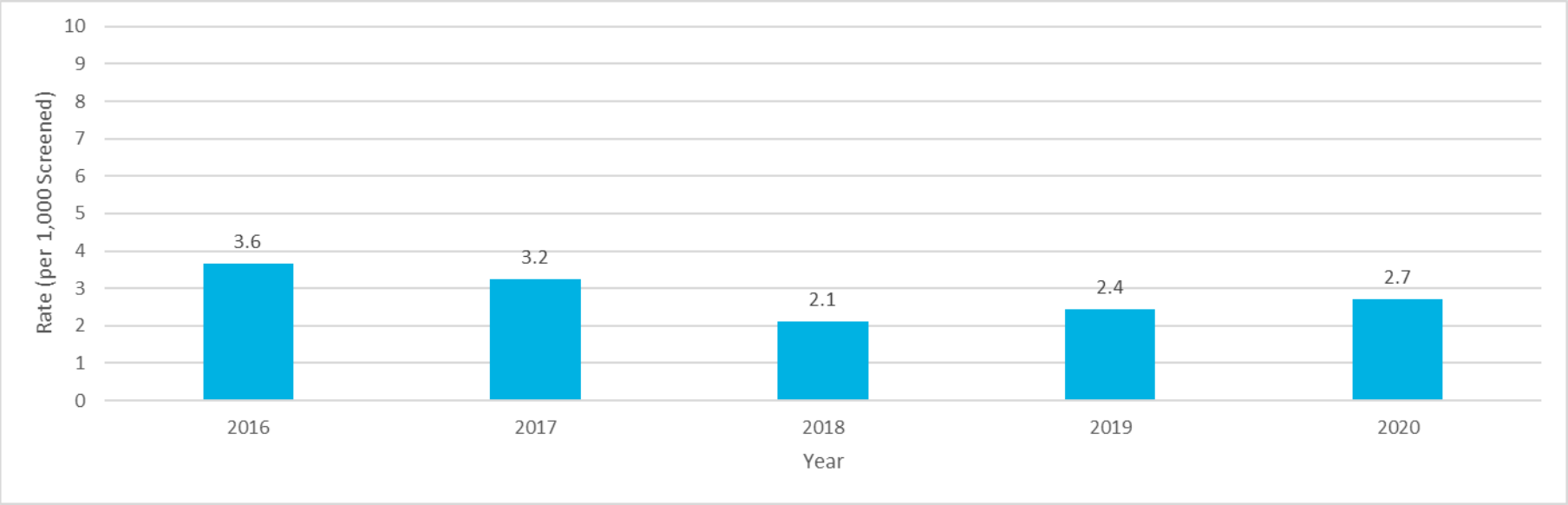
Note: This indicator is presented as a combined value for initial screens and re-screens.

For data, see Table 28 in Appendix 1.

From 2016 to 2020, the PPV for screening breast MRI and mammography in the High Risk OBSP fluctuated from 5.0% to 7.0%. The increase in PPV seen in 2020 compared to 2019 is likely due to prioritizing high risk breast cancer screening services according to breast cancer risk (e.g., the High Risk OBSP prioritized screening for people who are known mutation carriers and had never been screened or were overdue for screening) according to Ontario Health pandemic guidance.

High Risk OBSP: Breast Cancer Detection

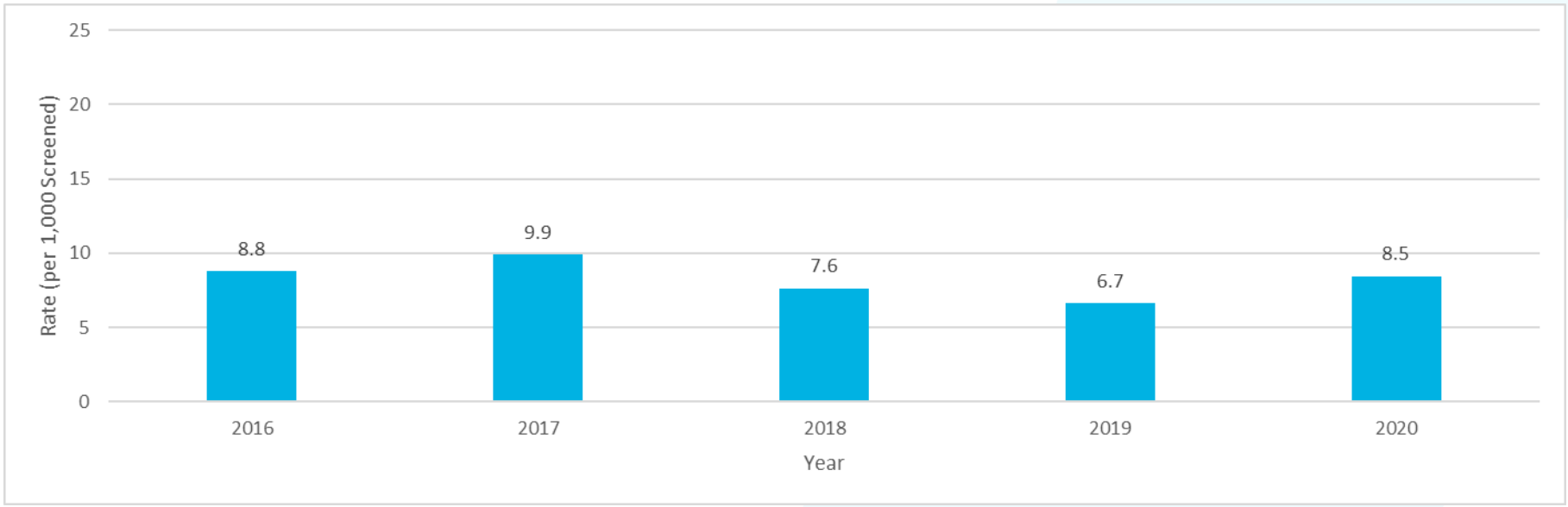
Figure 37: Number of People in Ontario, Ages 30 to 69, With Ductal Carcinoma In Situ per 1,000 People Screened in the High Risk Ontario Breast Screening Program, 2016 to 2020



For data, see Table 29 in Appendix 1.

There was variation in the DCIS detection rate in the High Risk OBSP from 2016 to 2020. The number of cases of DCIS detected each year in the High Risk OBSP is low, so small changes may lead to observable variability in the detection rate. The DCIS detection rate was highest (3.6 per 1,000 people screened) in 2016 and declined to 2.1 per 1,000 in 2018. The DCIS detection rate has been trending upward from 2018 to 2020, when it reached 2.7 per 1,000. The increase in DCIS detection rate in 2020 may reflect prioritizing breast cancer screening services based on breast cancer risk according to Ontario Health pandemic guidance during the early waves of the COVID-19 pandemic.

Figure 38: Number of People in Ontario, Ages 30 to 69, With Invasive Breast Cancer per 1,000 People Screened in the High Risk Ontario Breast Screening Program, 2016 to 2020

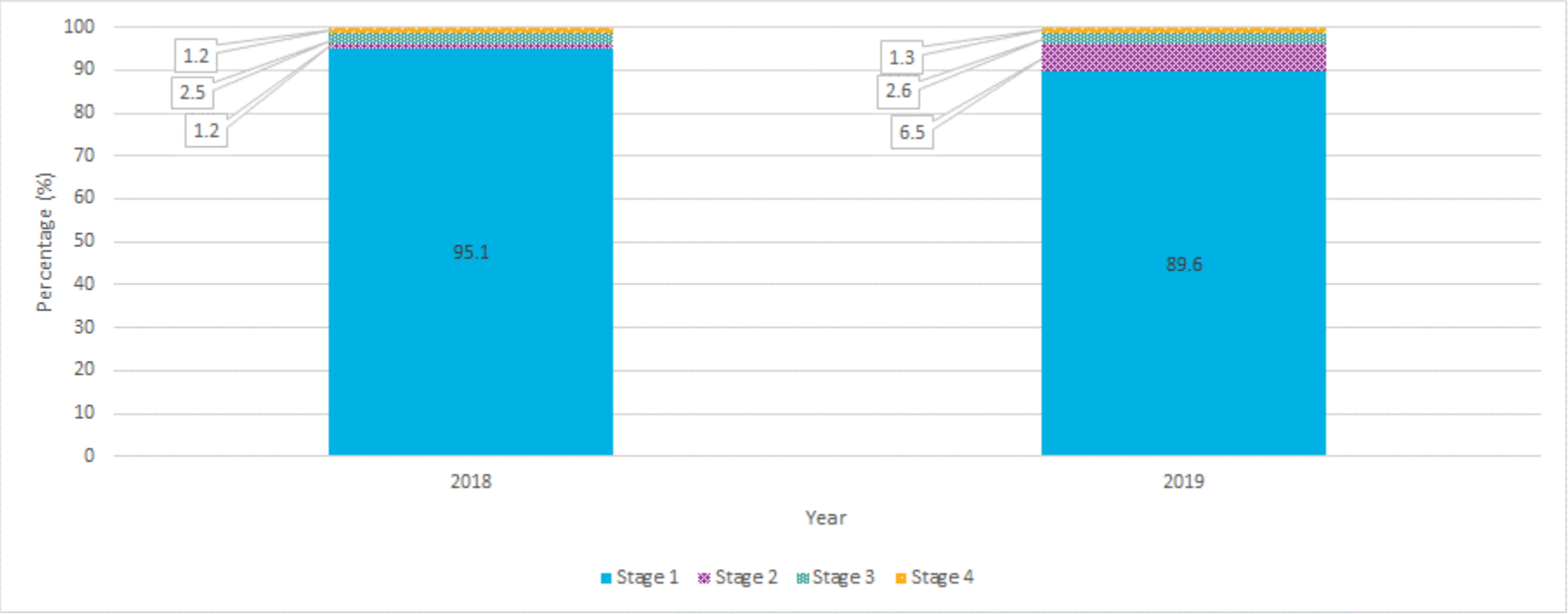


For data, see Table 30 in Appendix 1.

From 2016 to 2020, the invasive cancer detection rate in the High Risk OBSP fluctuated from 6.7 to 9.9 per 1,000 people screened. The number of cases of invasive breast cancer detected each year in the High Risk OBSP is low, so small changes may lead to observable variability in the detection rate. The increase from 6.7 per 1,000 in 2019 to 8.5 per 1,000 in 2020 may reflect the prioritization of high risk breast cancer screening services based on breast cancer risk according to Ontario Health pandemic guidance.

High Risk OBSP: Disease Extent at Diagnosis

Figure 39: Stage Distribution of Screen-Detected Invasive Breast Cancers Among People Ages 30 to 69 in The High Risk Ontario Breast Screening Program, by Stage at Diagnosis, 2018 to 2019



Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

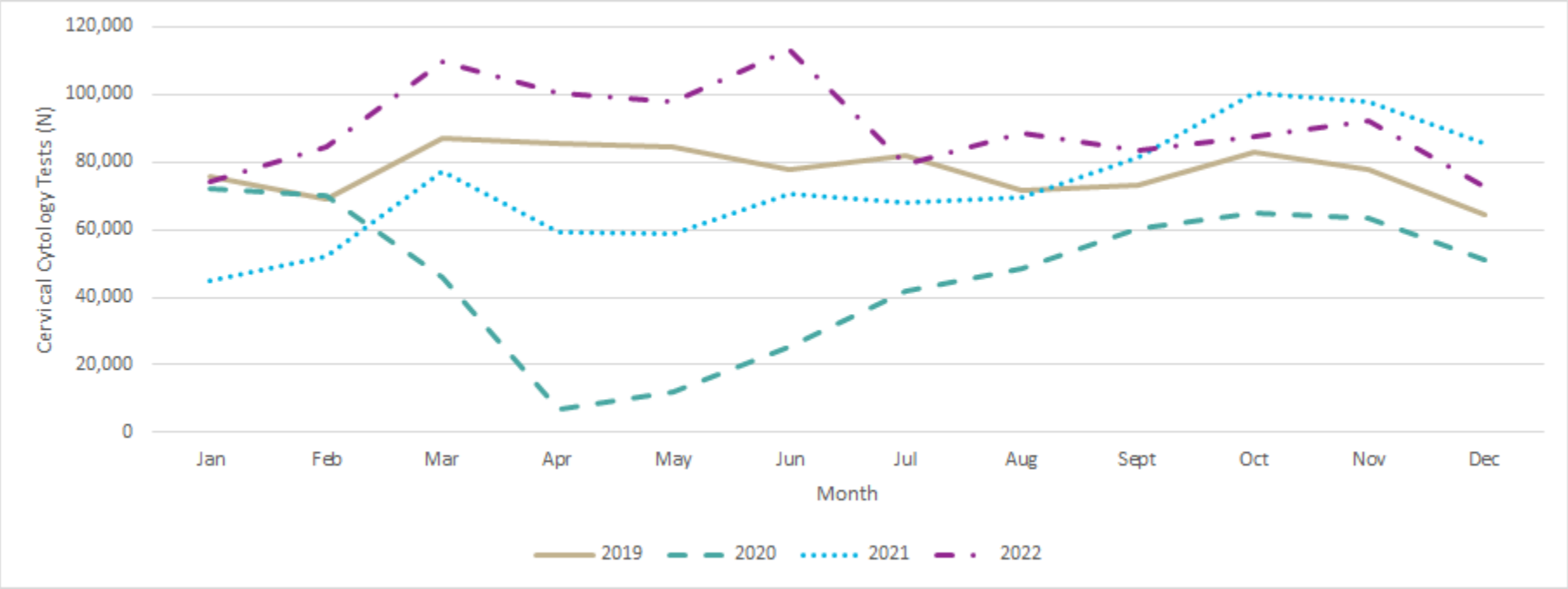
For data, see Table 31 in Appendix 1.

Most invasive breast cancers detected in the High Risk OBSP were stage 1 in 2018 (95.1%) and 2019 (89.6%). A small number of cancers are detected in the High Risk OBSP every year, which can lead to observable variability in stage distribution year-to-year (e.g. stage 2 breast cancers increased from 1.2% to 6.5% from 2018 to 2019).

Ontario Cervical Screening Program (OCSP): Program Performance

OCSP: Volumes

Figure 40: Number of Cervical Cytology Tests Performed in Ontario, Ages 21 to 69, by Month, 2019 to 2022

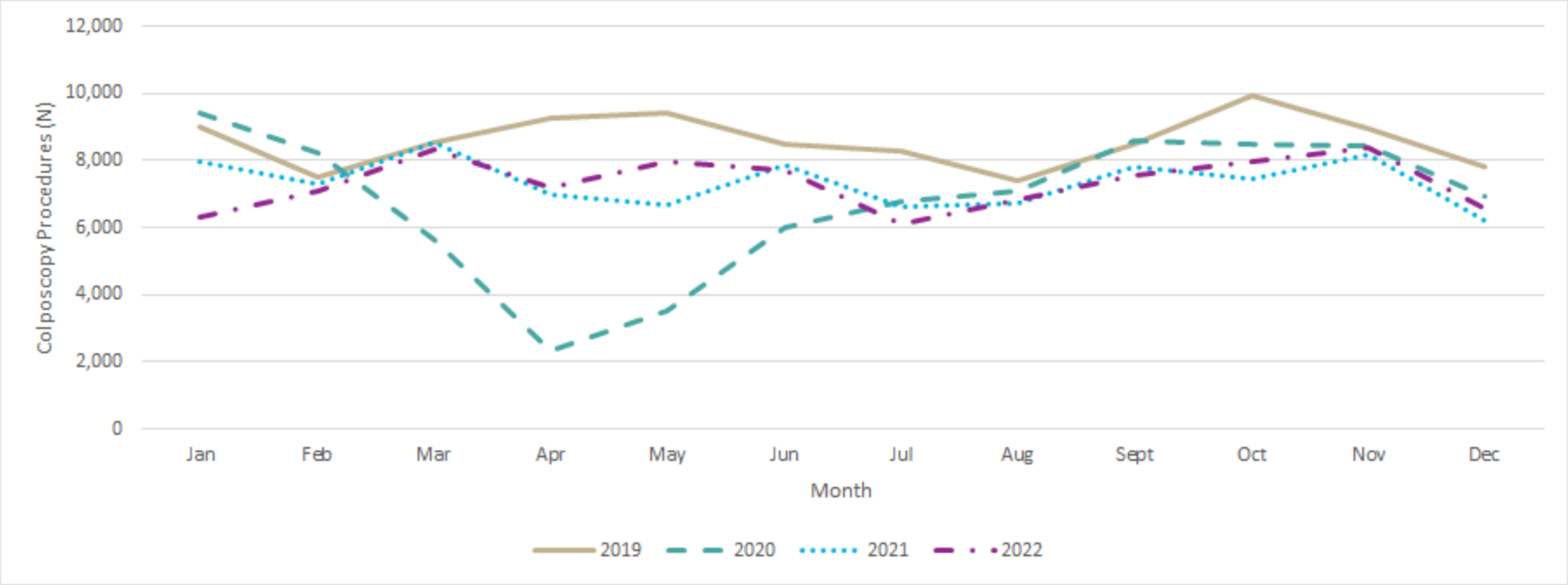


Note: These data are for cervical cytology tests performed in community labs only. Some of the cervical cytology tests may not be Ontario Cervical Screening Program screening tests and are done during colposcopy. Data for 2022 may be incomplete due to testing and reporting delays.

For data, see Table 32 in Appendix 1.

The decrease in volumes from March to May 2020 reflects the temporary pause in cancer screening in late March 2020 due to the COVID-19 pandemic. A gradual recovery began in May 2020, with cytology volumes returning to pre-pandemic levels in August 2021. Recovery to pre-pandemic volumes for cytology may have been delayed because cervical screening requires an in-person appointment with a health care provider.

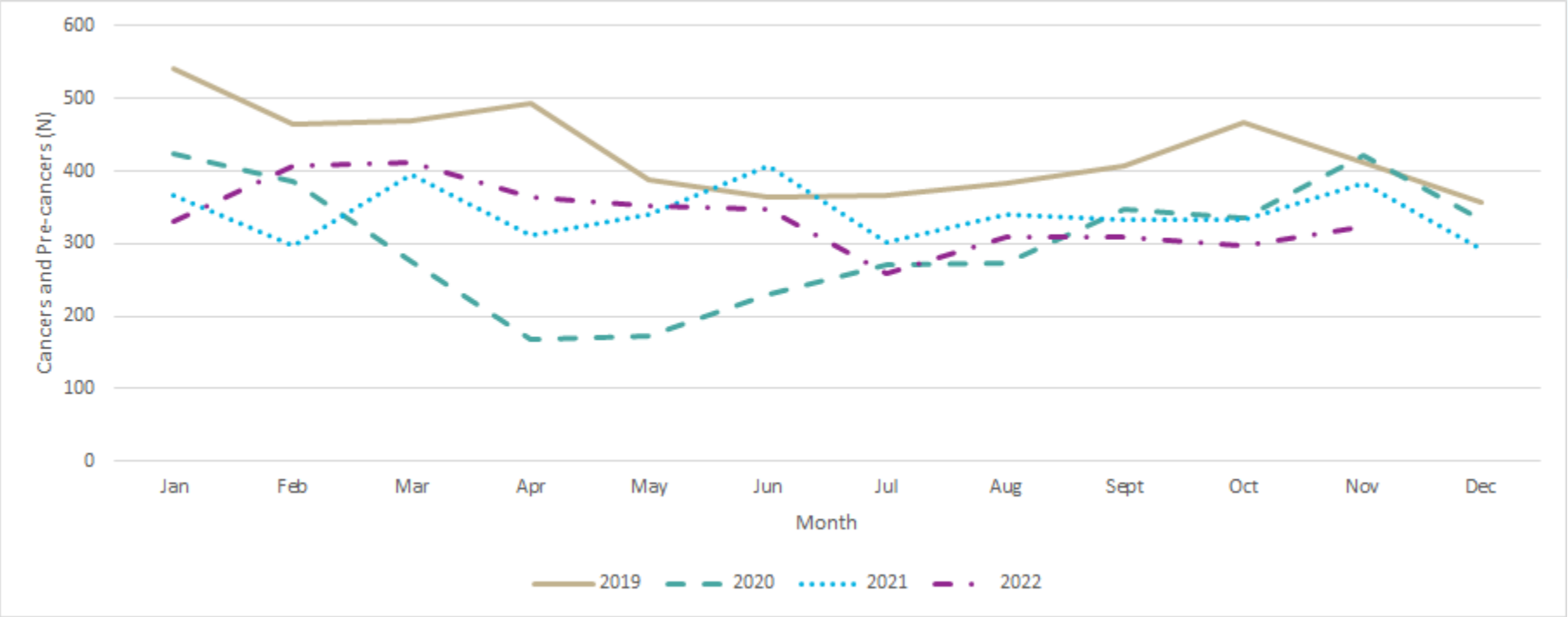
Figure 41: Number of Colposcopy Procedures Performed in Ontario, Ages 21 to 69, by Month, 2019 to 2022



For data, see Table 33 in Appendix 1.

Colposcopy volumes were also impacted by COVID-19. A decrease in volumes was observed beginning in March 2020 after the deferral of routine cancer screening due to the COVID-19 pandemic. Colposcopy volumes returned to pre-pandemic volumes starting in September 2020 and annual volumes increased by 8.5% from 2020 to 2021.

Figure 42: Number of Cervical Cancers and Pre-Cancers (Combined) in Ontario, Ages 21 to 69, by Month, 2019 to 2022

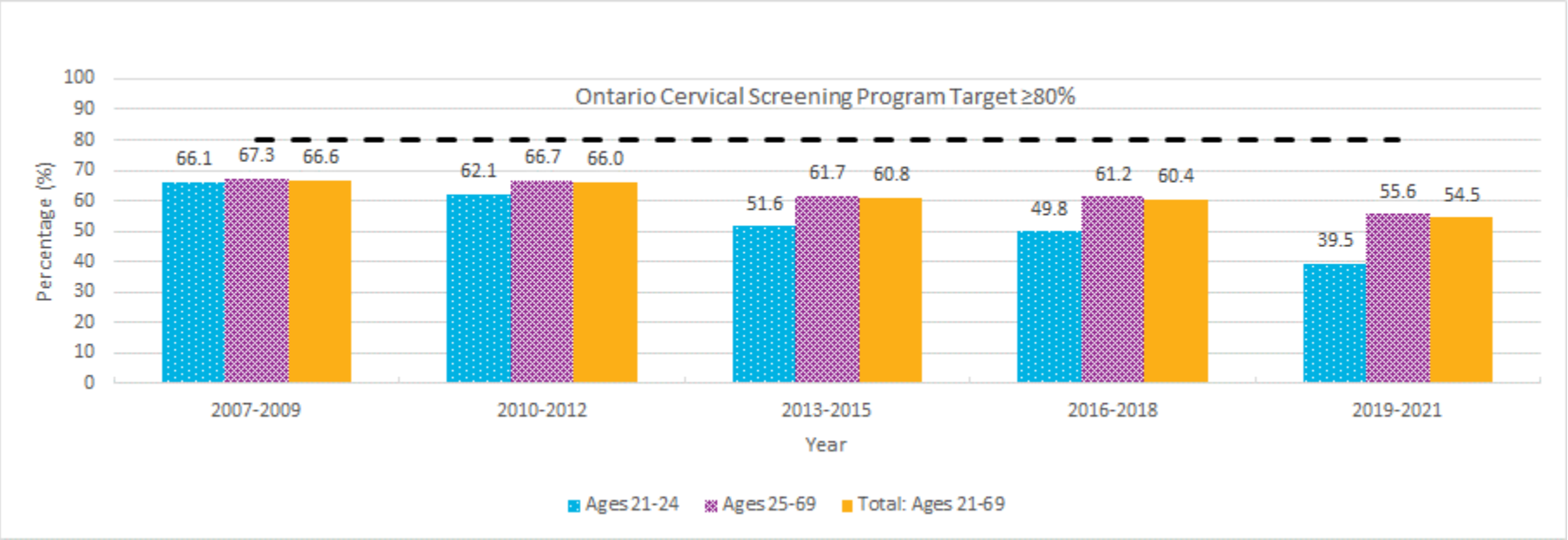


For data, see Table 34 in Appendix 1.

The number of cervical cancer and pre-cancers detected decreased from March to May 2020 after the deferral of routine screening in late March 2020 due to the COVID-19 pandemic. The number of cervical cancers and pre-cancers detected had not returned to pre-pandemic levels as of 2022. Fluctuations in numbers of pre-cancers and cancers detected month-to-month are expected and normal. There is a significant lag for 2022 data, which may impact the completeness of the 2022 data shown.

OCSP: Coverage

Figure 43: Percentage of Screen-Eligible Women* in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period by Age Group, 2007–2009 to 2019–2021



* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for cervical screening, as well as the inclusion of some people who are not eligible for screening.

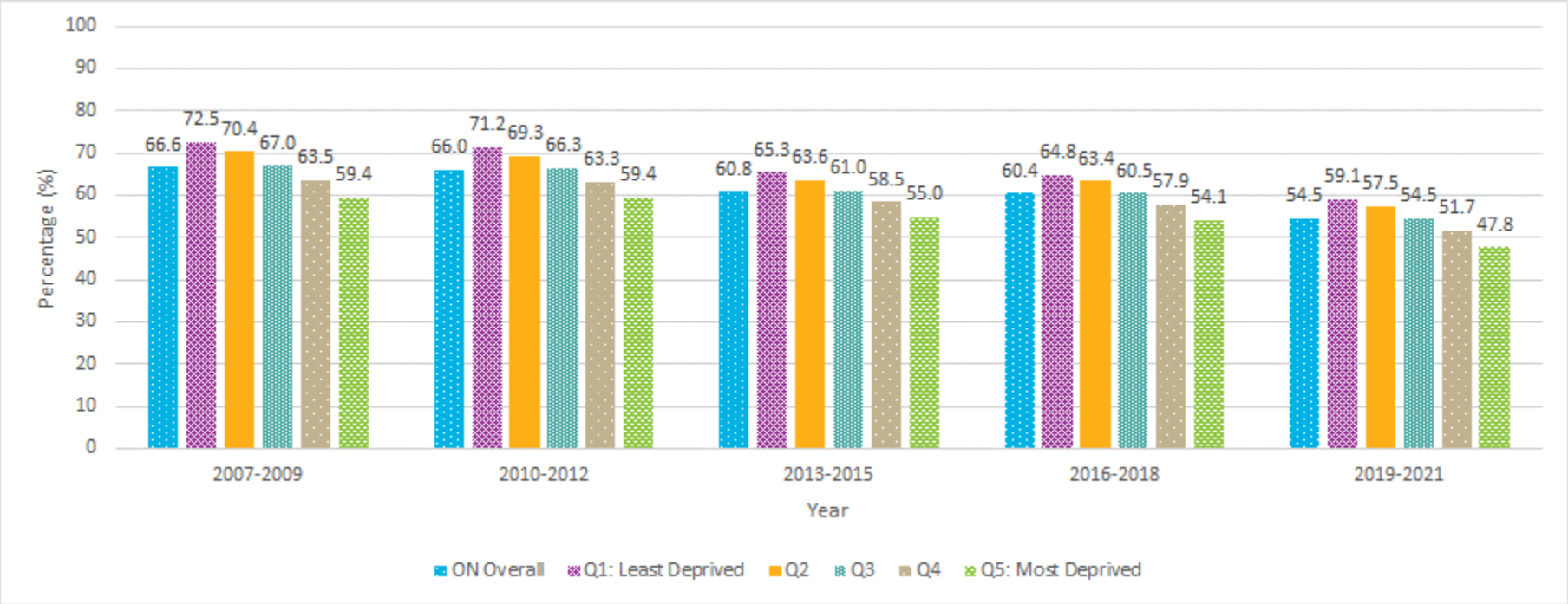
For data, see Table 35 in Appendix 1.

Participation in the OCSP has been decreasing over time, from 66.6% in 2007–2009 to 54.5% in 2019–2021. Performance has consistently not met the program target of 80% or greater (54). The decrease in participation seen in 2019–2021 may have been due to the impacts of the COVID-19 pandemic, such as the deferral of routine screening during the first pandemic wave in Ontario, which included the pause and gradual restart of the screening correspondence program (i.e., invitation, recall and reminder letters to participants). Additionally, the COVID-19 pandemic led to an increase in the use of virtual care and fewer in-person visits with health care providers for preventive care. This decrease in in-person visits may have reduced participation in cervical screening with cytology, which requires in-person care. Participants may have also been reluctant to screen during pandemic waves.

In 2020, health care providers were encouraged to initiate cytology-based screening at age 25 instead of age 21, except in people who are immunocompromised. This guidance was based on moderate quality evidence suggesting that people under age 25 do not benefit from cervical screening and it may have resulted in fewer people screening in 2019–2021. A substantial decrease in cervical screening by people ages 21 to 24 occurred in Ontario, with participation for this age group decreasing from 66.2% in 2007–2009 to 40% in 2019–2021. This trend is expected to continue and accelerate in the coming years as the age change policy (start screening at age 25 instead of age 21) becomes formalized as part of OCSP guidance.

OCSP Participation - Equity Analyses: Material Deprivation

Figure 44: Percentage of Screen-Eligible Women* in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period, by Material Deprivation, 2007–2009 to 2019–2021



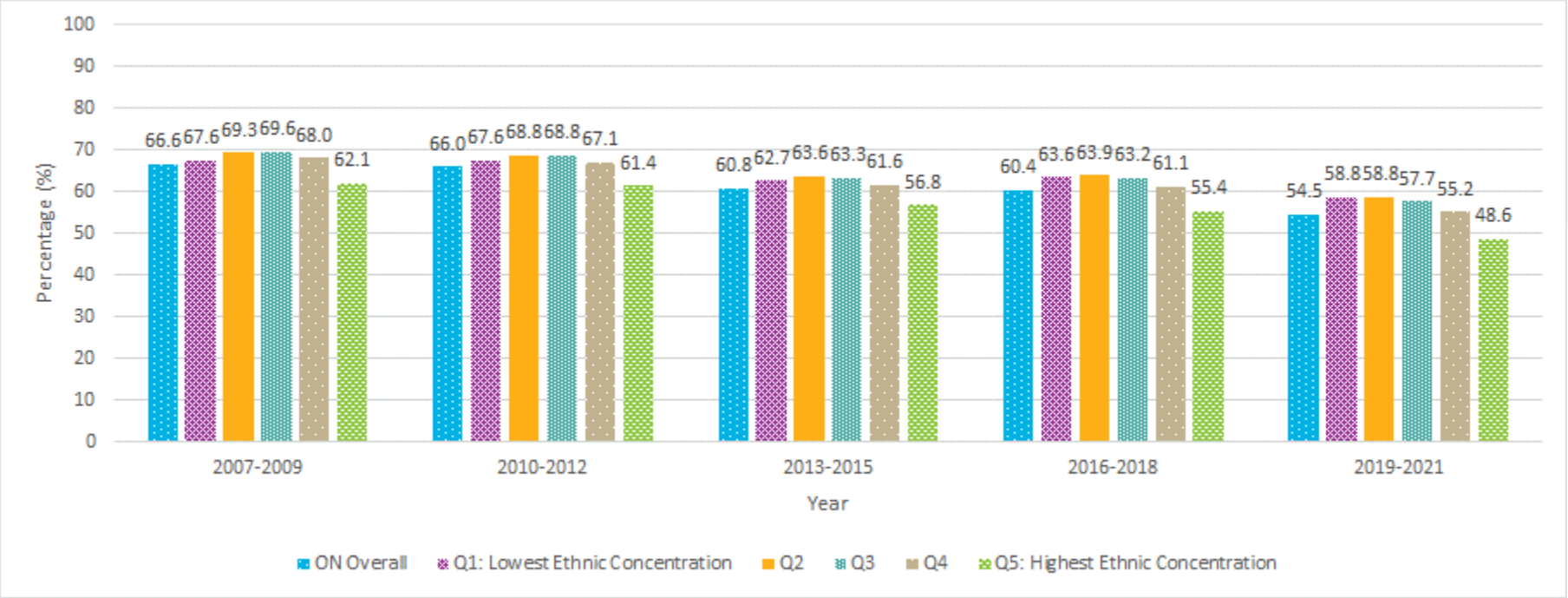
* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data and defines sex as "male" or "female" only). This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for cervical screening, as well as the inclusion of some people who are not eligible for screening.

For data, see Table 36 in Appendix 1.

Across all reporting periods, there was a relationship between material deprivation and cervical screening participation. People living in neighbourhoods with the least material deprivation (Q1, Q2) had higher participation in cervical screening than people living in more materially deprived neighbourhoods (Q3, Q4, Q5). While the gap between the least deprived quintile (Q1) and most deprived quintile (Q5) decreased slightly from 2007–2009 (when it was 13.1%) to 2019–2021, people living in more materially deprived neighbourhoods in 2019–2021 still had screening participation rates that were substantially below overall provincial rates and the program target of greater than or equal to 80% (54).

OCSP Participation - Equity Analyses: Ethnic Concentration

Figure 45: Percentage of Screen-Eligible Women* in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period, by Ethnic Concentration, 2007–2009 to 2019–2021

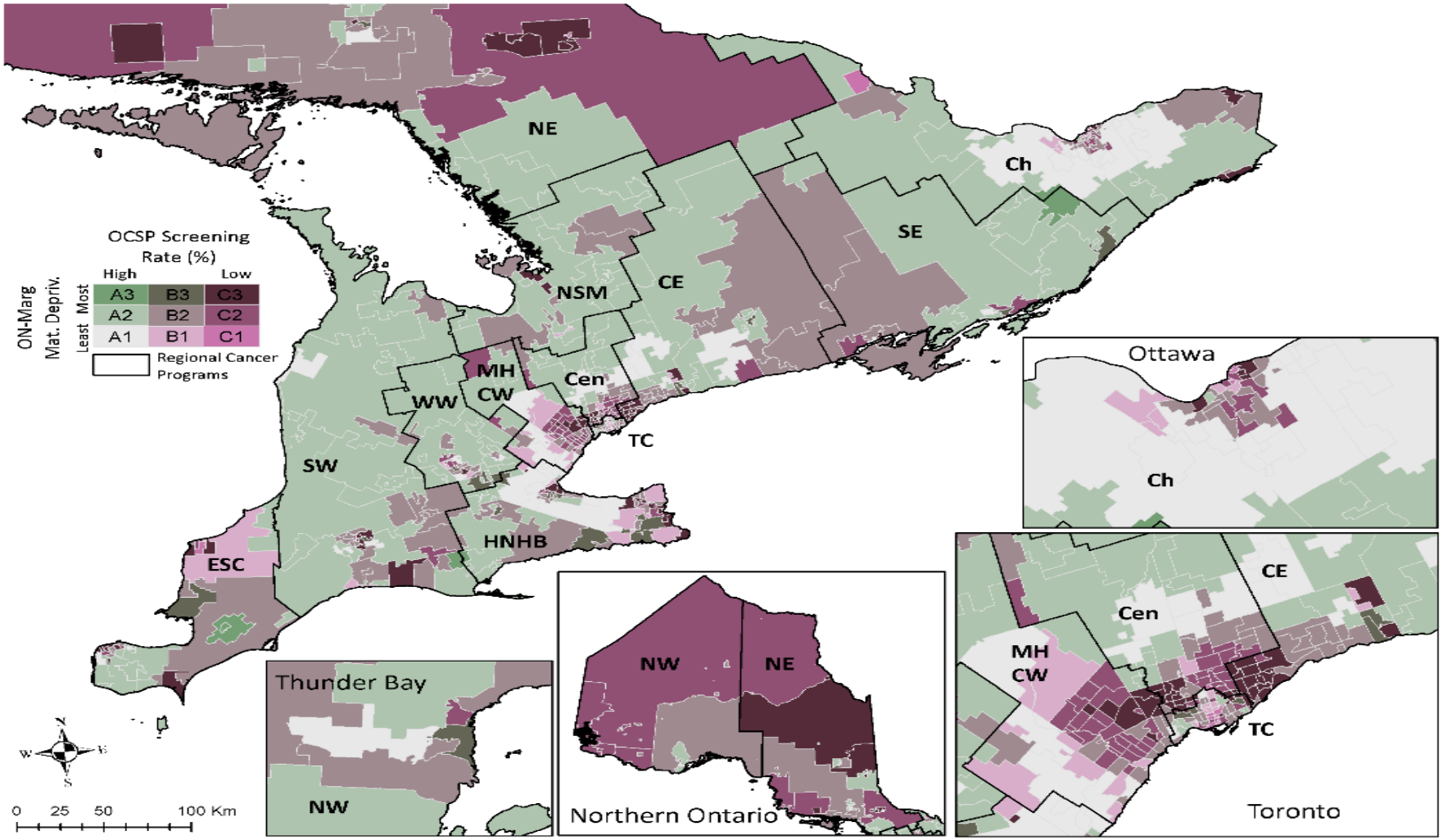


* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data and defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for cervical screening, as well as the inclusion of some people who are not eligible for screening.

For data, see Table 37 in Appendix 1.

Across all reporting periods, people living in the most ethnically concentrated neighbourhoods, (Q5) had lower cervical screening participation than people living in less ethnically concentrated neighbourhoods (Q1, Q2). People living in the most ethnically concentrated neighbourhoods had screening participation rates that are substantially below overall provincial rates and the program target of greater than or equal to 80%. The gap between the least ethnically concentrated neighbourhoods and the most ethnically concentrated neighbourhoods widened steadily, increasing from 5.5% in 2007–2009 to 10.1% in 2019–2021. The substantial increase in the gap in 2019–2020 may reflect health disparities that were worsened by the COVID-19 pandemic.

Figure 46: Map Showing Percentage of Screen-Eligible Women* in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period, by Material Deprivation



Regional Cancer Programs: ESC = Erie St. Clair, SW = South West, WW = Waterloo Wellington, HNHB = Hamilton Niagara Haldimand Brant, CW = Central West, MH = Mississauga Halton, TC = Toronto Central, Cen = Central, CE = Central East, SE = South East, Ch= Champlain, NSM = North Simcoe Muskoka, NE = North East, NW = North West

Data notes: Neighbourhoods are mapped at the forward sortation area level. Participation data is for the 2019-2021 reporting period. Bivariate choropleth (shaded) map. Major boundary lines reflect Regional Cancer Program boundaries. If you require data in an alternative format, please contact us by email (OH-CCO_ScreeningPerformanceReport@OntarioHealth.ca).

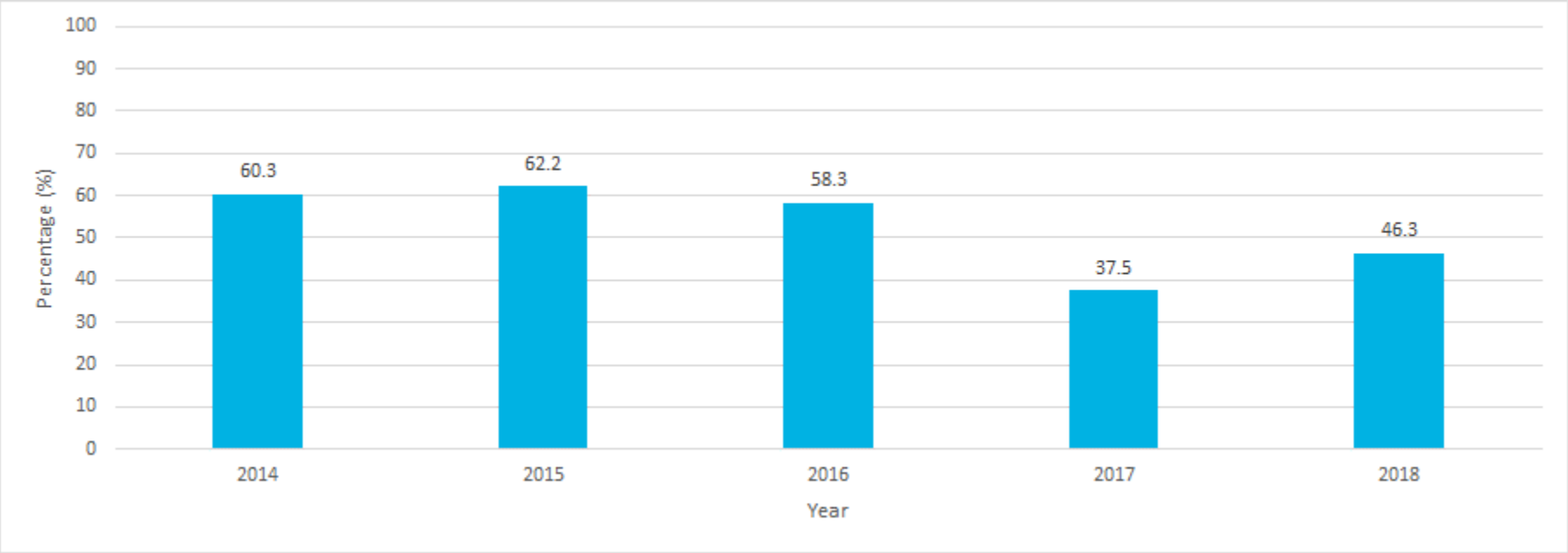
Ontario Cervical Screening Program Participation:

- **A (high participation): >58.7%**
- **B (medium participation): 52.2% to 58.7%**
- **C (low participation): <52.2%**

*The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data and defines sex as "male" or "female" only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for cervical screening, as well as the inclusion of some people who are not eligible for cervical screening.

There was variability across the province and within most regional cancer programs in cervical screening participation by level of material deprivation. The North West and North East regional cancer programs had a large proportion of neighbourhoods with the highest level of material deprivation (the darkest purple colour on the map) and low cervical screening participation (less than 52.2%). Similar to the patterns observed in other screening programs, neighbourhoods throughout the Greater Toronto Area with the highest level of material deprivation also had low cervical screening participation. These neighbourhoods include areas around the downtown core in Toronto Central, West North York and North Etobicoke in the Central regional cancer program, Scarborough and parts of Oshawa in the Central East regional cancer program, and parts of Brampton and Mississauga in the Mississauga Halton and Central West regional cancer programs.

Figure 47: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, Who Had a Subsequent Cervical Cytology Test Within 42 Months of a Normal Cytology Test Result, 2014 to 2018



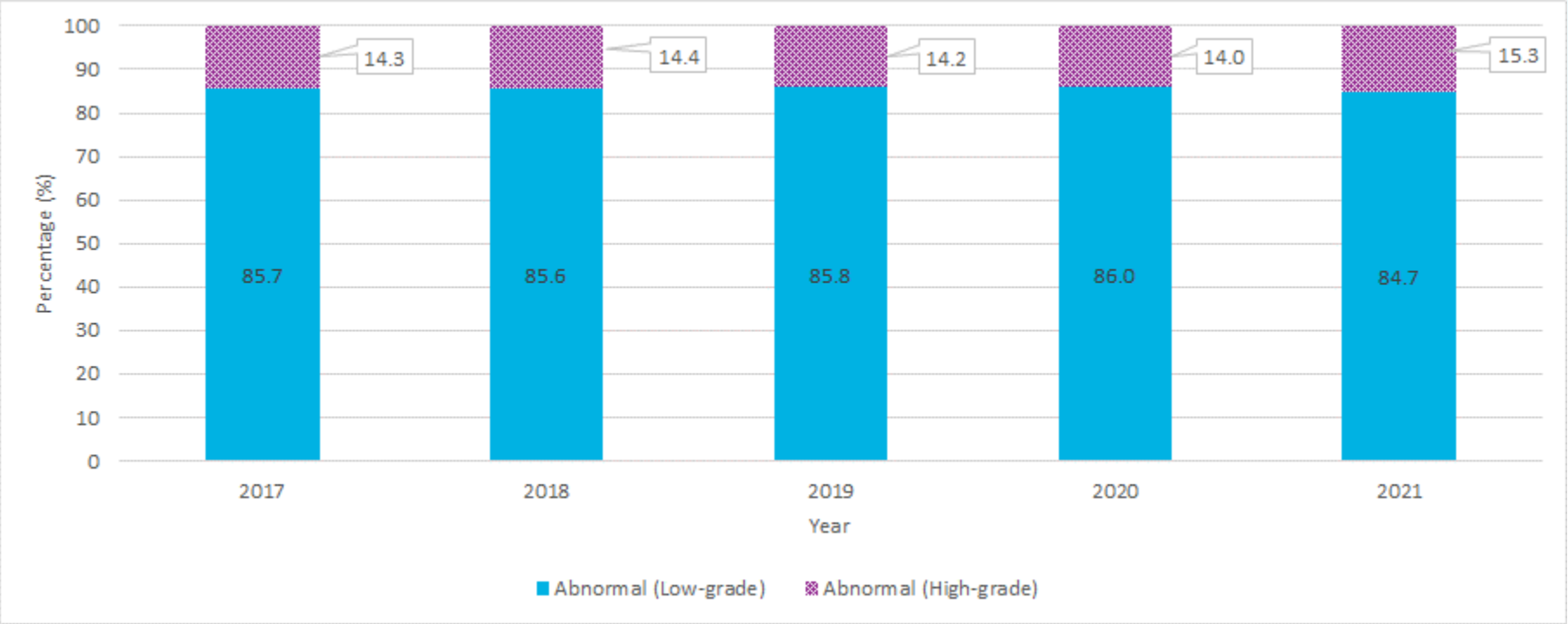
For data, see Table 38 in Appendix 1.

Cervical screening retention represents the proportion of participants returning for a screening test within 42 months (3.5 years) of a normal cytology test. The years in the graph represent the date of the initial screening test that the return date is measured against. Retention in the OCSP decreased from 60.3% in 2014 to 46.3% in 2018. The substantial decrease in retention observed in 2017 may be due to the impacts of the COVID-19 pandemic because people screened in 2017 were due to re-screen in 2020.

Possible pandemic impacts include the deferral of cervical screening during the first pandemic wave in Ontario, the pause and gradual restart of screening correspondence, and participant or provider screening deferrals during subsequent pandemic waves (i.e., the increase in virtual care during the pandemic led to fewer in-person appointments and less cervical screening, which requires in-person care). Retention improved by almost 10 percentage points in 2018, suggesting that screening retention was beginning to recover.

OCSP: Follow-Up

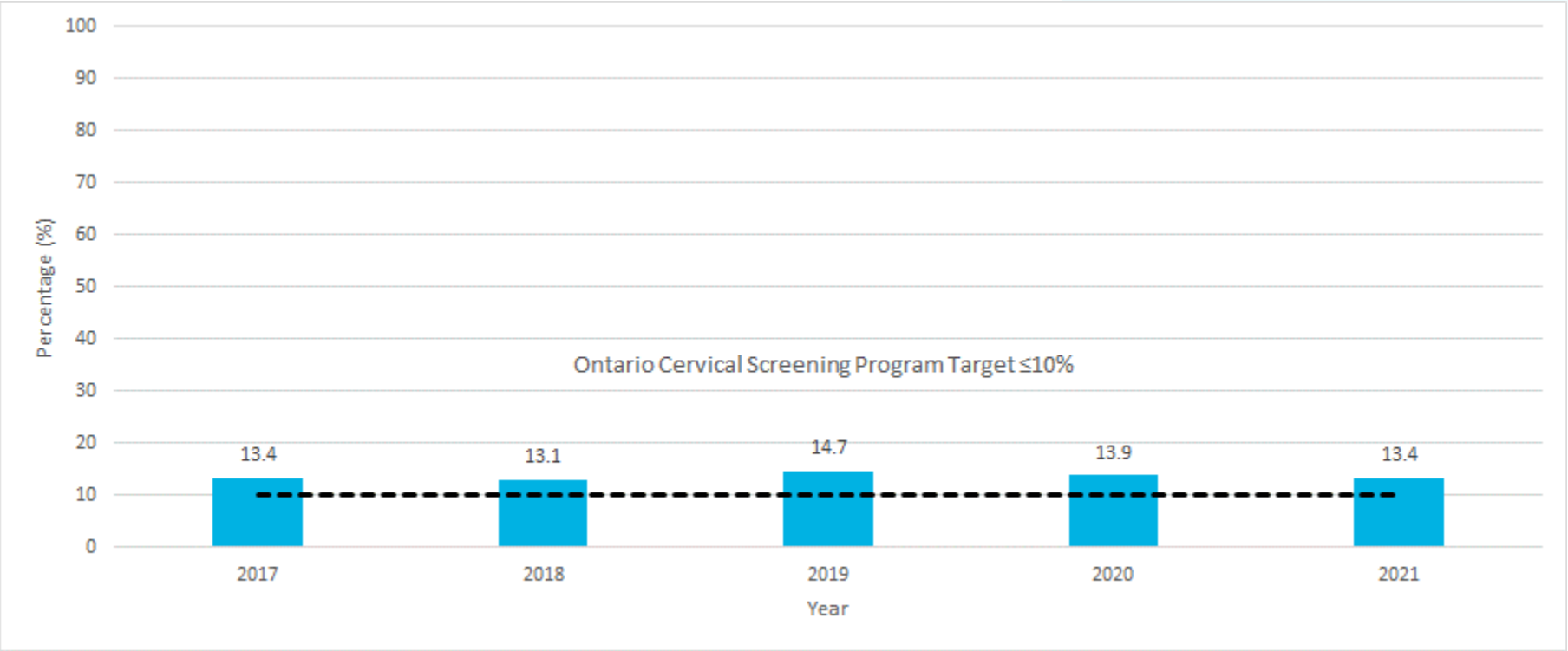
Figure 48: Distribution of Abnormal Cervical Cytology Results, 2017 to 2021



For data, see Table 39 in Appendix 1.

The proportion of abnormal cytology tests with low-grade results remained steady at approximately 86% from 2017 to 2020 and then decreased slightly to 84.7% in 2021. The proportion of abnormal cytology tests with high-grade results was also steady at approximately 14% from 2017 to 2020, but then it increased to 15.3% in 2021. These trends may be due to providers prioritizing cervical screening for higher risk participants (e.g., people who are immunocompromised) early in the pandemic, leading to more abnormal findings. The increase in high-grade results may also be because people overdue for cytology testing returned to screening after pandemic deferrals, which meant their cervical cell changes had more time to develop.

Figure 49: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With a High-Grade Cervical Cytology Result Who Did Not Undergo Colposcopy or Definitive Treatment Within 6 Months of the High-Grade Abnormal Result, 2017 to 2021

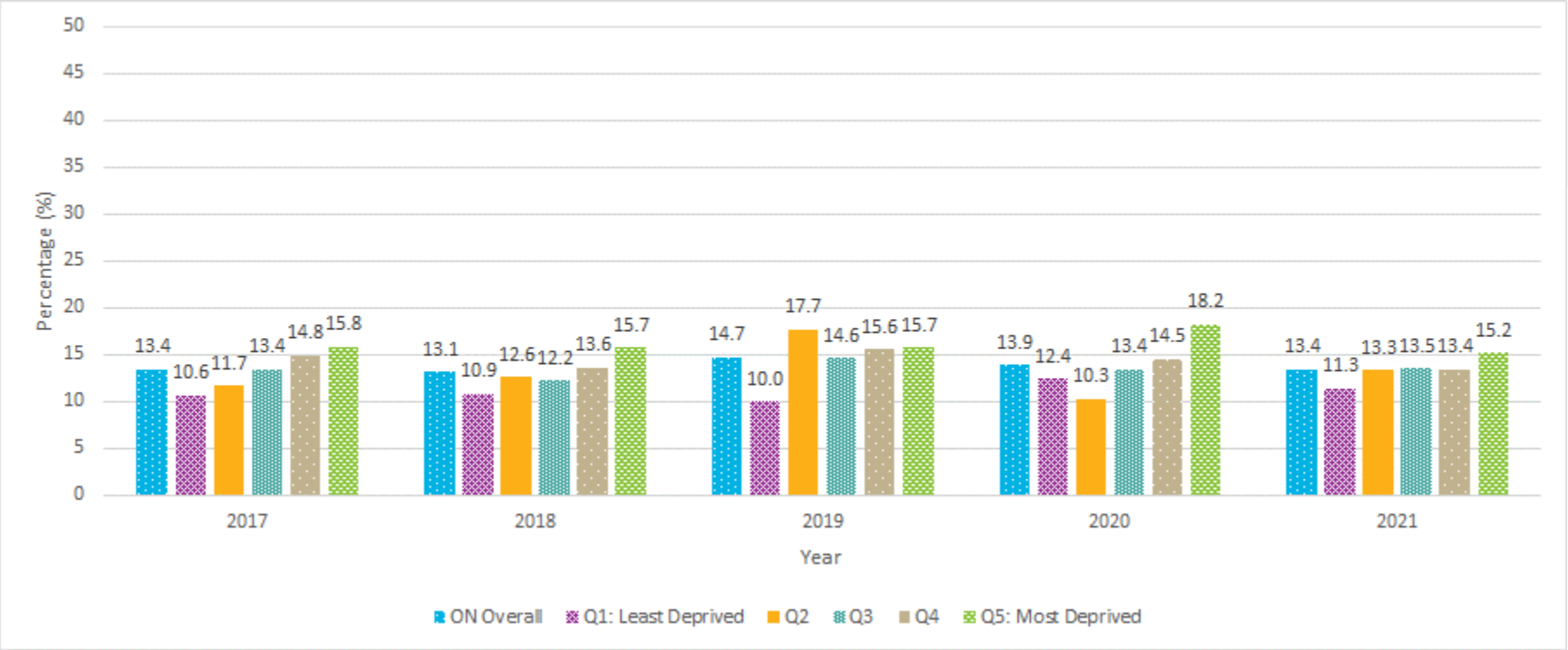


For data, see Table 40 in Appendix 1.

The percentage of participants that did not receive colposcopy or definitive treatment within six months of a high-grade abnormal cytology test result was stable at about 13% from 2017 to 2021, with the exception of 2019 when it increased (worsened) to 14.7%. The increase observed in 2019 may be because people with high-grade cytology results later that year may have experienced delays in accessing colposcopy during the first wave of the COVID-19 pandemic when colposcopy capacity was reduced. Recovery of this indicator in 2020 and 2021 may reflect uptake of Ontario Health pandemic clinical guidance to prioritize colposcopy services for people with high-grade cytology results. Performance for this indicator has not met the program target of less than or equal to 10% (54) since 2017.

OCSP Follow-Up of Abnormal Results - Equity Analyses: Material Deprivation

Figure 50: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With a High-Grade Abnormal Cervical Cytology Test Result Who Did Not Undergo Colposcopy or Definitive Treatment Within 6 Months of the High-Grade Abnormal Result, By Material Deprivation, 2017 to 2021

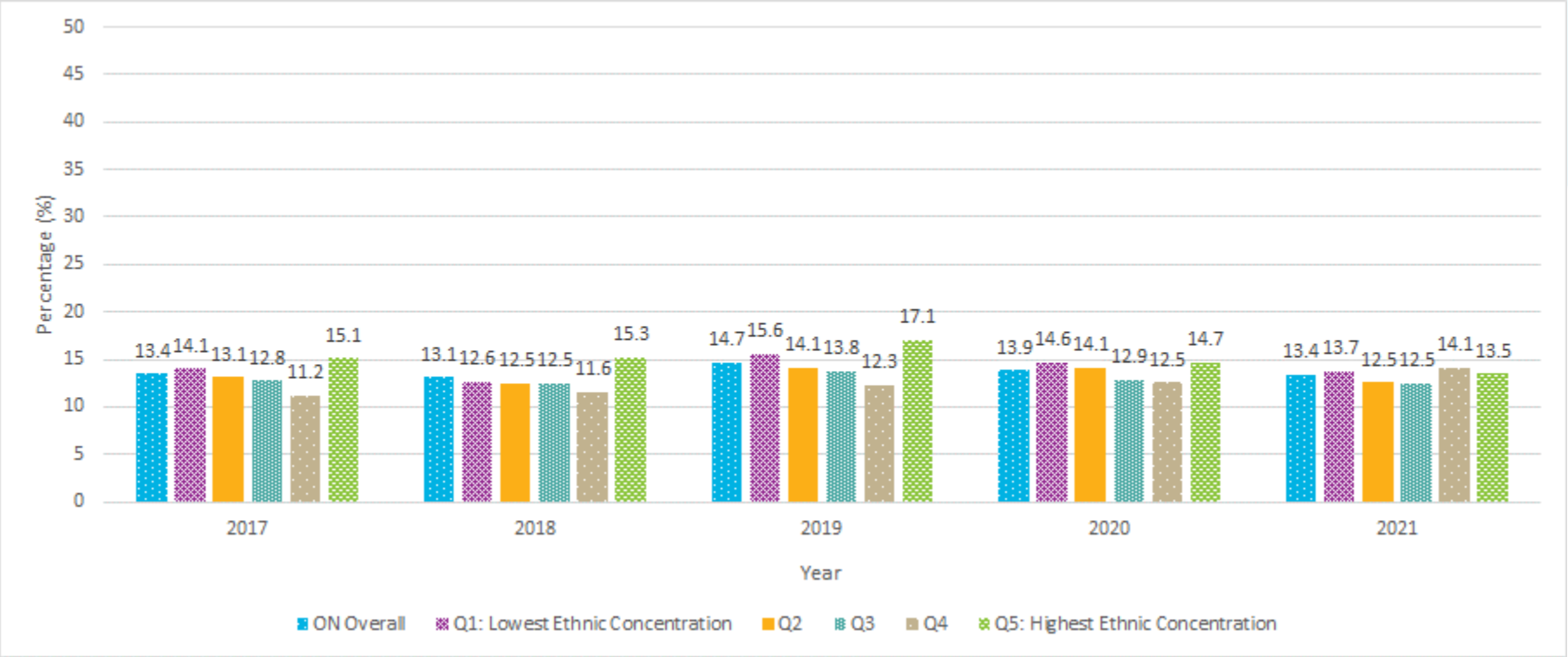


For data, see Table 41 in Appendix 1.

In most reporting years, people living in the most materially deprived neighbourhoods were less likely to receive follow-up of abnormal cytology test results than people living in less materially deprived neighbourhoods. The gap between the most deprived (Q5) and least deprived (Q1) neighbourhoods ranged from 3.9% (2021) to 5.8% (2020). The larger gap observed in 2020 may reflect health disparities that were worsened during the first year of the COVID-19 pandemic.

OCSP Follow-Up of Abnormal Results - Equity Analyses: Ethnic Concentration

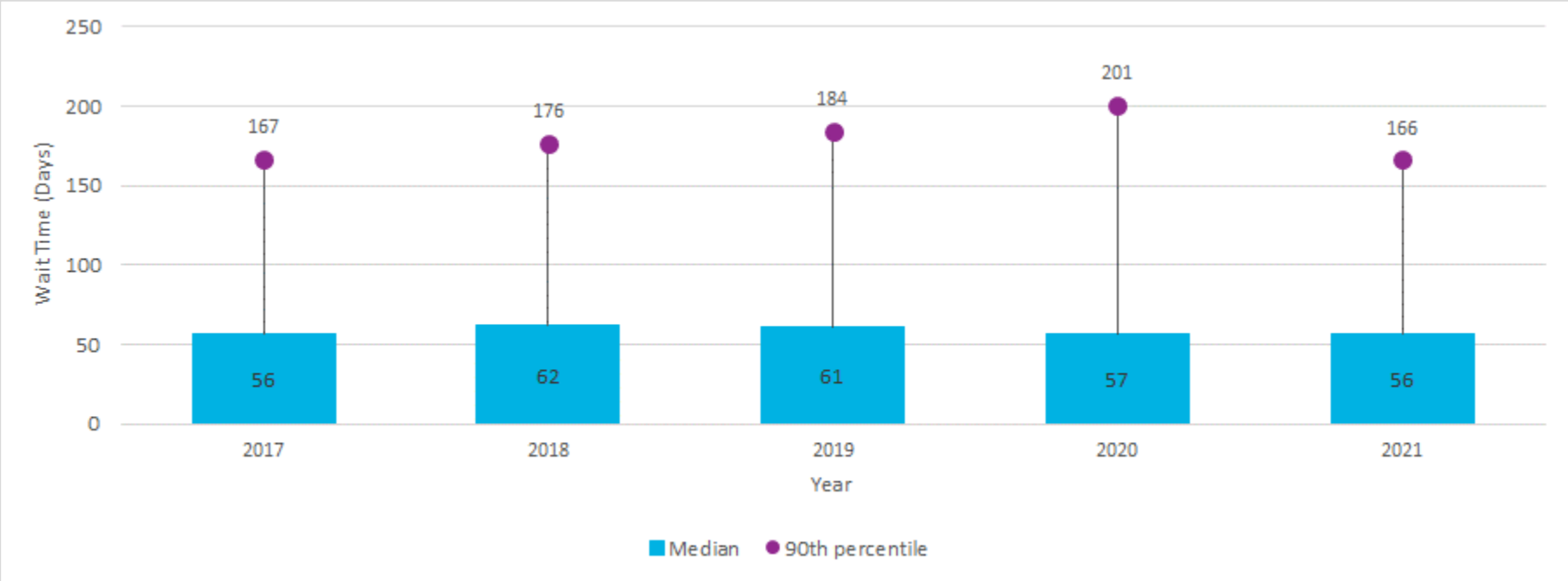
Figure 51: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With a High-Grade Cervical Cytology Test Result Who Did Not Undergo Colposcopy or Definitive Treatment Within 6 Months of the High-Grade Abnormal Result, by Ethnic Concentration, 2017 to 2021



For data, see Table 42 in Appendix 1.

From 2017 to 2020, people living in the most ethnically concentrated neighbourhoods (Q5) were less likely to undergo follow-up of a high-grade abnormal cytology test result within six months, compared to people living in less ethnically concentrated neighbourhoods. The gap between the most and least ethnically concentrated neighbourhoods decreased over time and was nearly eliminated in 2020 and 2021. It is unclear what contributed to this positive finding. Performance of this indicator will continue to be monitored to inform relevant program improvements.

Figure 52: Wait Time (in Days) for Screen-Eligible People in Ontario, Ages 21 to 69, From High-Grade Cervical Cytology Test Result to Colposcopy, 2017 to 2021

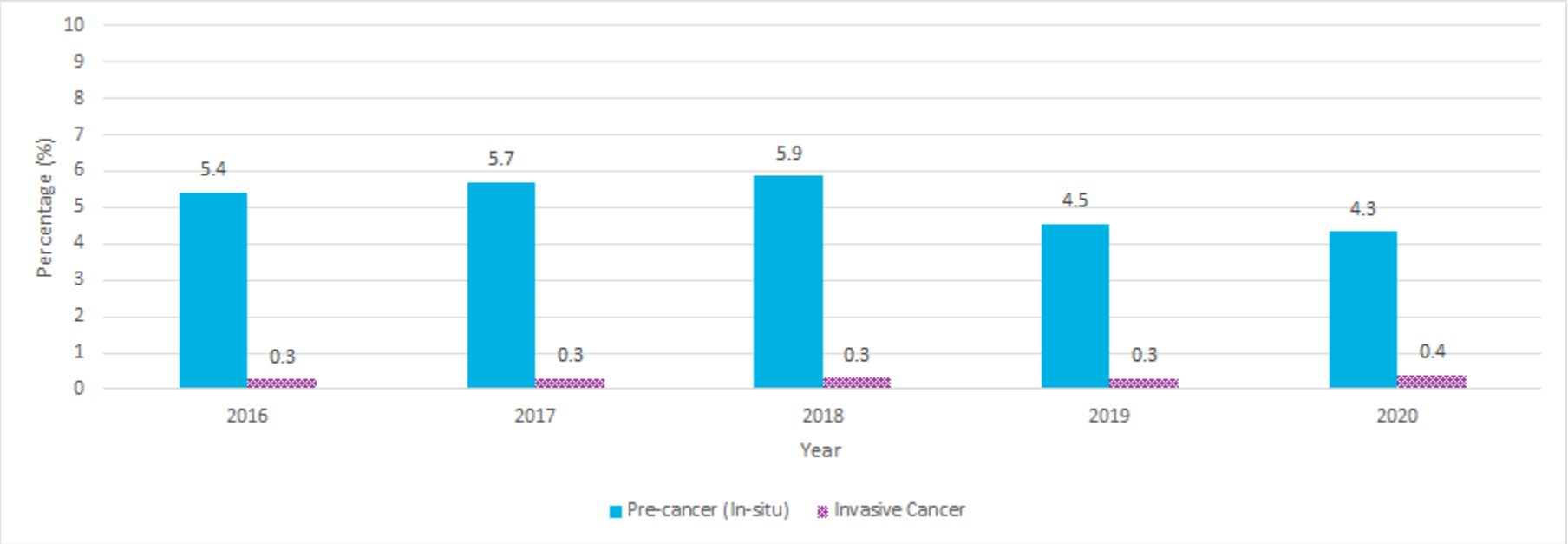


For data, see Table 43 in Appendix 1.

The wait time to colposcopy after a high-grade result varied from 2017 to 2021 (median and 90th percentile). The median wait time ranged from 56 days to 62 days, and the 90th percentile wait time ranged from 166 days to 201 days. The peak 90th percentile wait time of 201 days was observed in 2020, which may be due to the impact of the first wave of the COVID-19 pandemic when routine cervical screening services were deferred and colposcopy capacity was impacted.

OCSP: Quality of Screening

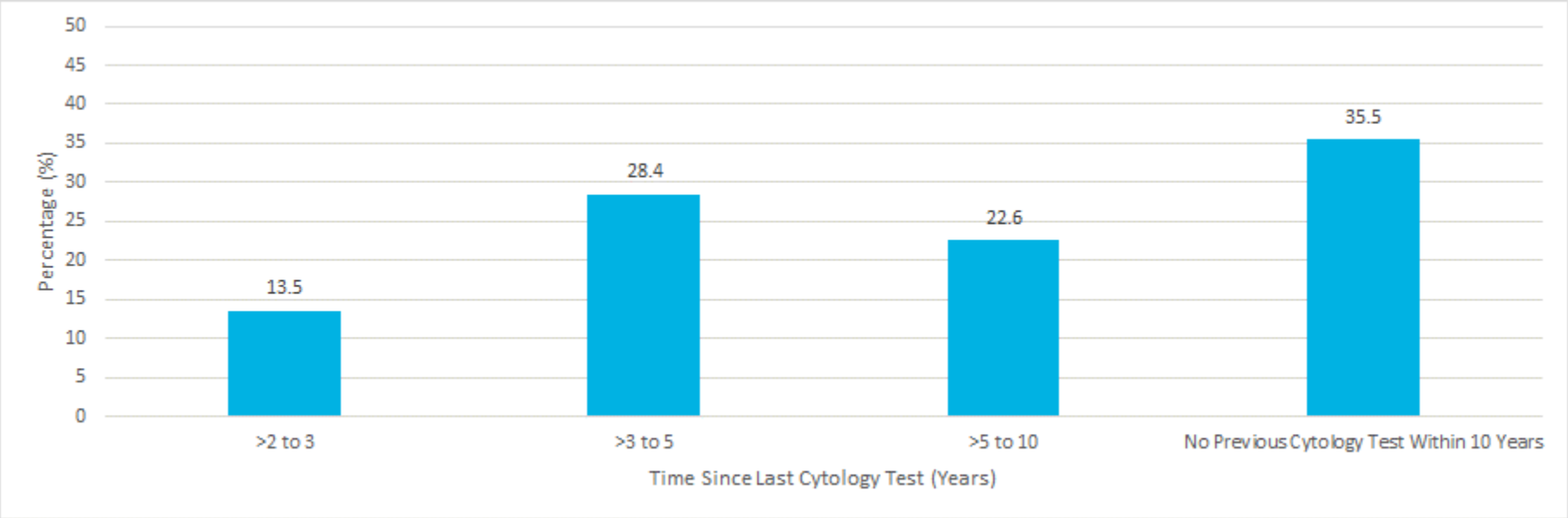
Figure 53: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With an Abnormal Cervical Cytology Test Result Who Were Diagnosed With an Invasive Cervical Cancer or Pre-Cancer After a Follow-Up Colposcopy or Surgical Procedure Involving the Cervix, 2016 to 2020



For data, see Table 44 in Appendix 1.

The PPV is the probability that someone with a positive cancer screening test has pre-cancer or cancer. The goal of cervical screening with a cytology test is to identify pre-cancerous lesions that may develop into cervical cancer if they are not treated. Therefore, the PPV of cytology tests for pre-cancer (in situ) provides a more accurate measure of the effectiveness of the cytology test than the PPV of cytology tests for invasive cervical cancer (55). From 2016 to 2018, the PPV for cervical cytology increased slightly from 5.4% to 5.9%. In 2019, the PPV for cervical pre-cancer decreased to 4.5%, followed by a further decrease in 2020 to 4.3%. From 2016 to 2019, the PPV for invasive cervical cancer was stable at approximately 0.3% and in 2020, the PPV for invasive cervical cancer increased slightly to 0.4%. It is not known why there were fluctuations in PPV for pre-cancer from 2016 to 2020 or why there was a slight increase in PPV for cervical cancer in 2020 after relative stability from 2016 to 2019. Performance will continue to be monitored.

Figure 54: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, Who Were Diagnosed With Invasive Cervical Cancer, by History of Cervical Screening With Cytology, 2017 to 2019



For data, see Table 45 in Appendix 1.

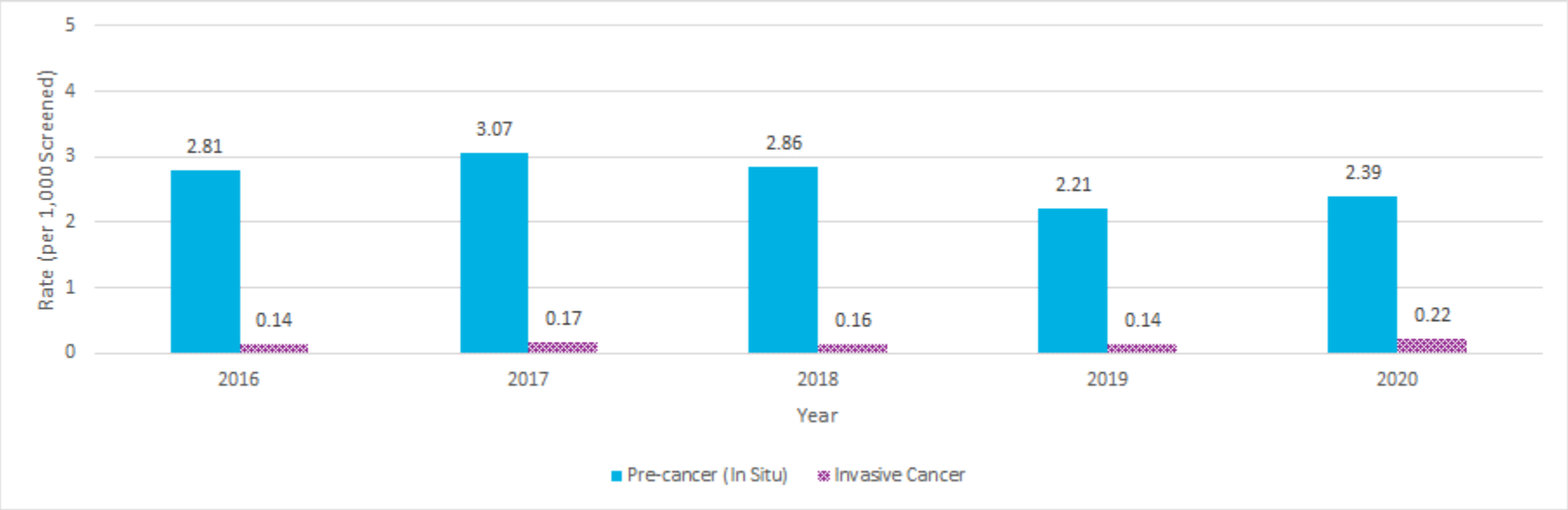
Most cervical cancers occur in people who have never been screened or screened less often than recommended (56,57). From 2017 to 2019, 35.5% of the people diagnosed with invasive cervical cancer had not been screened in the 10 years before their diagnosis.

Of the people diagnosed with invasive cervical cancer, 13.5% had a cytology test within two to three years of their diagnosis. There are several reasons some people might be diagnosed with cancer before they are due for re-screening (e.g., within two to three years of a previous cytology test). First, the cytology test may miss some pre-cancers (false-negative results). Second, while the cytology test may be able to identify invasive cervical cancers, the test is not made for that purpose and can miss some cancer cells. Third, follow-up of abnormal screening results is important for detecting and, if appropriate, treating pre-cancers. Although the percentage of people with abnormal results who have follow-up has increased, there is room for improvement. It is possible that some people diagnosed with cervical cancer who had a cytology test in the last two to three years had a prior abnormal screening result that had not been followed-up.

Over time, a decrease in missed pre-cancers is expected. Ontario is planning to implement the human papillomavirus test as the primary cervical screening test in Ontario in 2025, which is better at detecting pre-cancers and cervical cancers (58).

OCSP: Detection

Figure 55: Number of Screen-Eligible People in Ontario, Ages 21 to 69, With a Screen-Detected Pre-Cancer (In Situ) or Invasive Cervical Cancer, per 1,000 People Screened, 2016 to 2020



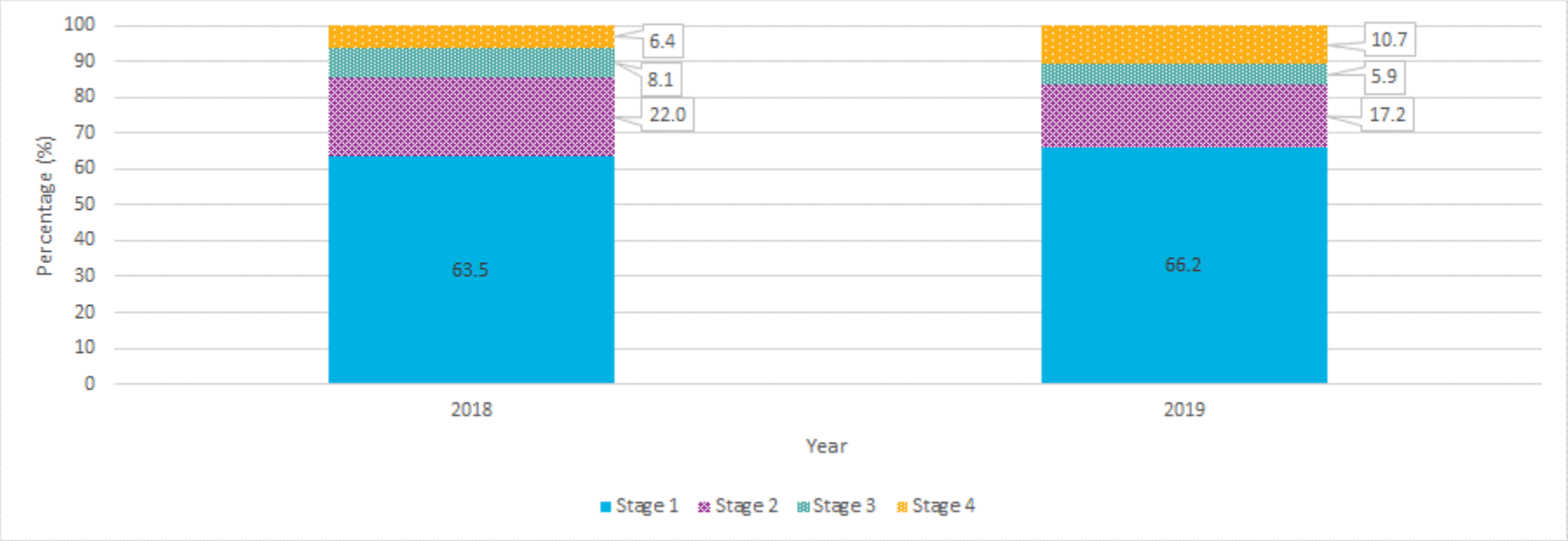
For data, see Table 46 in Appendix 1.

The cytology test is designed to identify cervical pre-cancers that may develop into invasive cervical cancer over time. As a result, it is expected that the pre-cancer detection rate would be higher than the invasive cervical cancer detection rate (59,60). The cervical pre-cancer (in situ) detection rate remained steady from 2016 to 2018 at around 3 cases per 1,000 people screened, before decreasing in 2019 to 2.21 cases per 1,000 people screened. In 2020, the rate increased slightly to 2.39 cases per 1,000 people screened. For invasive cervical cancers, the detection rate increased from 0.14 cases per 1,000 people screened in 2016 to 0.22 cases per 1,000 people screened in 2020.

The increase in cervical pre-cancer and cancer detection rates in 2020 may be due to providers prioritizing cervical screening for higher risk participants (e.g., people who are immunocompromised) early in the pandemic, leading to a greater detection of pre-cancer and cancer. The increase in pre-cancer and cancer detection may also be because overdue people returned to screening after pandemic deferrals, which meant their cervical cell changes had more time to develop.

OCSP: Disease Extent at Diagnosis

Figure 56: Stage Distribution of All Invasive Cervical Cancers Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019



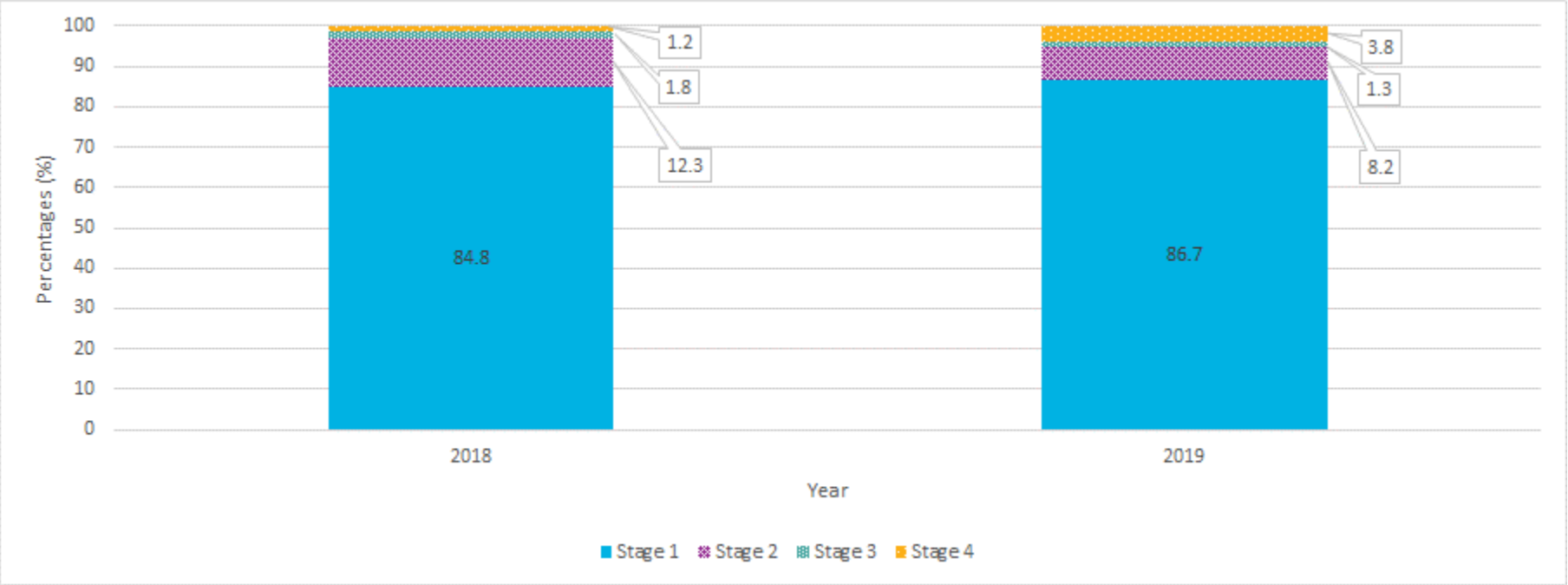
Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

For data, see Table 47 in Appendix 1.

Most invasive cervical cancers were diagnosed at stage 1 in 2018 (63.5%) and 2019 (66.2%). More screen-detected invasive cancers were found at stage 1 in 2018 (84.8%) and 2019 (86.7%) (see Figure 57) than cancers not detected by screening, which highlights the benefits of cancer screening for early detection. From 2018 to 2019, the proportion of invasive cervical cancers (screen-detected and non-screen-detected combined) found at stage 2 decreased from 22.0% in 2018 to 17.2% in 2019. A similar decrease was noted for the proportion of invasive cancers found at stage 3, from 8.1% in 2018 to 5.9% in 2019. A corresponding increase in the proportion of invasive cervical cancers found at Stage 4 was observed, rising from 6.4% in 2018 to 10.7% in 2019.

Note that cervical screening with the cytology test is designed to detect pre-cancer. While it may be able to identify invasive cervical cancers, the test is not made for that purpose and can miss some cancer cells (55).

Figure 57: Stage Distribution of Screen-Detected Invasive Cervical Cancers Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019

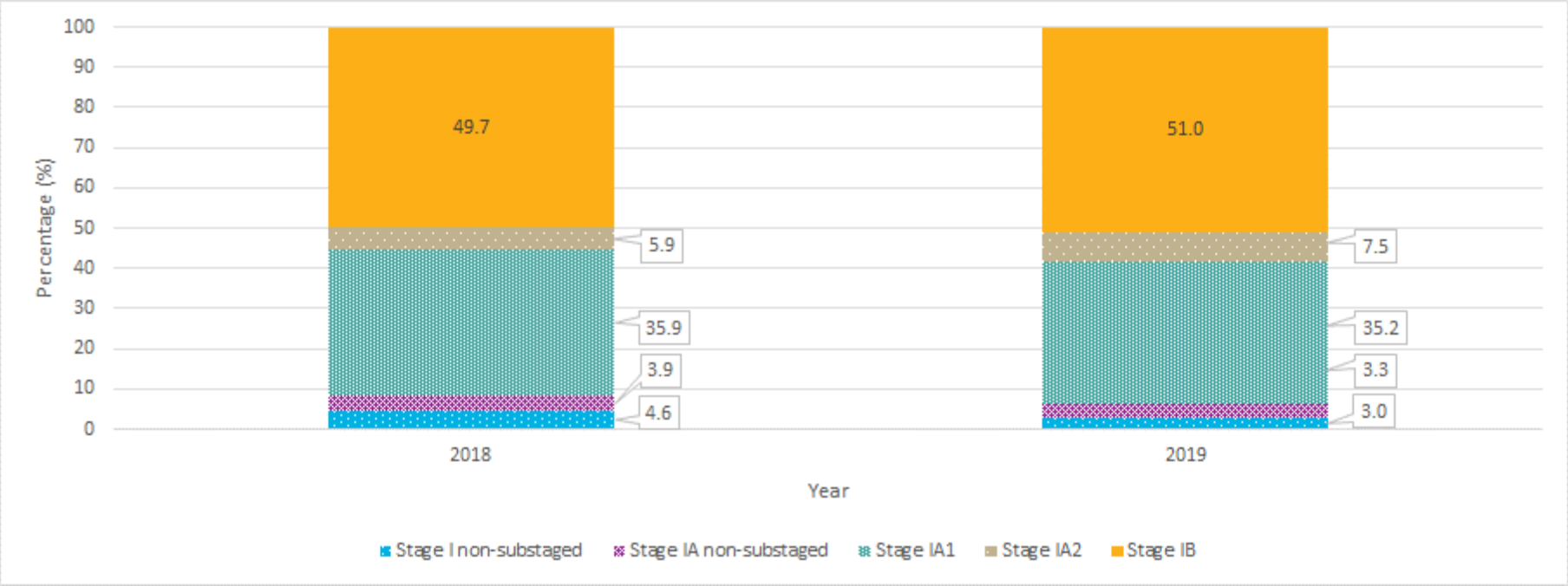


Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

For data, see Table 48 in Appendix 1.

Most screen-detected invasive cervical cancers were stage 1 in 2018 (84.7%) and 2109 (86.7%). The percentage of invasive cervical cancers diagnosed at stage 2 decreased from 12.3% in 2018 to 8.2% in 2019, while the percentage of stage 3 screen-detected invasive cervical cancers remained stable in this period. From 2018 to 2019, the percentage of invasive cervical cancers detected at stage 4 increased from 1.2% to 3.8%. It is unclear what attributed to this observed change in staging distribution. Performance for this indicator will continue to be monitored.

Figure 58: Stage 1 Sub-Stage Distribution for All Invasive Cervical Cancers in People Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019



Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

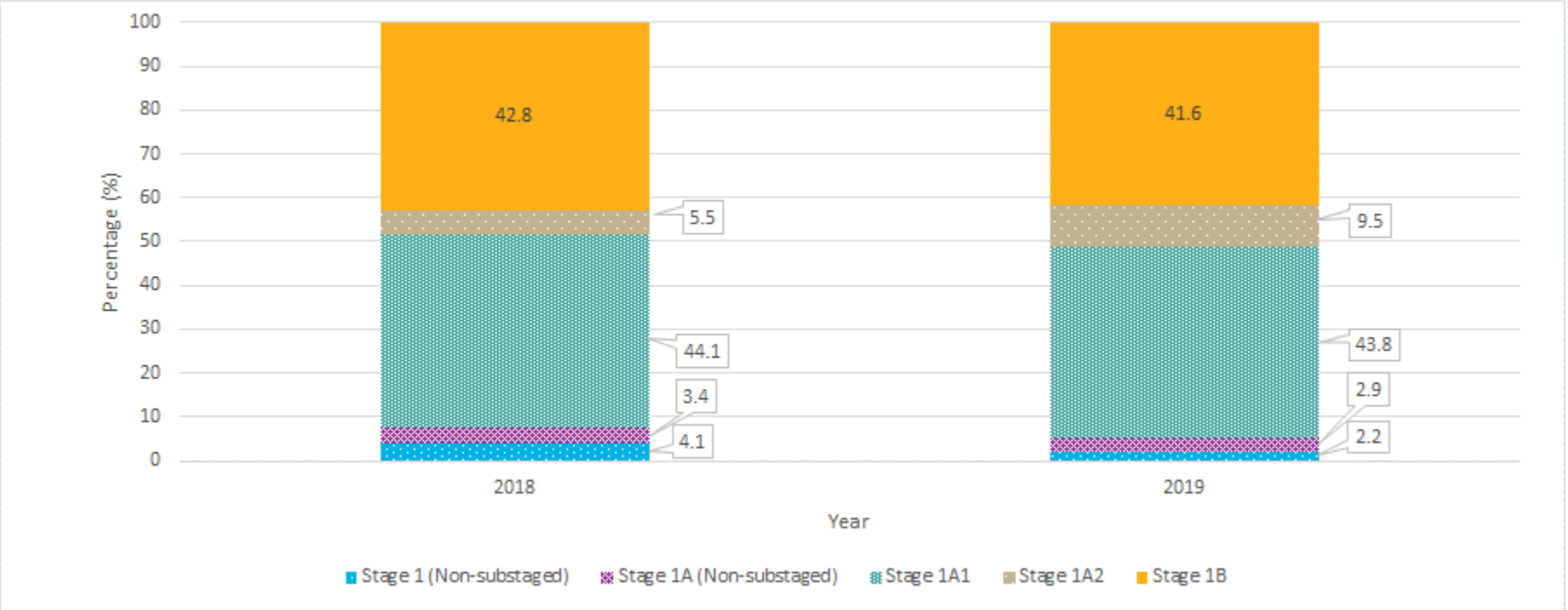
Stage definitions (60–63):

- Stage 1A1 is defined as an invasive tumour less than 3 millimetres deep, which can only be detected under a microscope.
- Stage 1A2 is defined as an invasive tumour 3 to 5 millimetres deep, which can only be detected under a microscope.
- Stage 1B is defined as more than 5 millimetres deep and can be further broken down into 3 sub-stages based on tumour size; however, here it is combined and reported only as stage 1B.

For data, see Table 49 in Appendix 1.

The majority of all stage 1 invasive cervical cancers (screen-detected and non-screen-detected) were diagnosed at stage 1B in 2018 (49.7%) and 2019 (51.0%). Stage 1A1 cancers made up about 35% to 36% of all stage 1 invasive cervical cancers in 2018 and 2019. More screen-detected invasive cervical cancers were diagnosed at stage 1A, 1A1 and 1A2 (Figure 59) than all invasive cervical cancers (Figure 58), highlighting the benefits of cervical screening for early detection of invasive cancer.

Figure 59: Stage 1 Sub-Stage Distribution for Screen-Detected Invasive Cervical Cancers in People Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019



Note: Data prior to 2018 are not shown because of a change in the cancer staging classification system in 2018.

Stage definitions (60–63):

- Stage 1A1 is defined as an invasive tumour less than 3 millimetres deep, which can only be detected under a microscope.
- Stage 1A2 is defined as an invasive tumour 3 to 5 millimetres deep, which can only be detected under a microscope.
- Stage 1B is defined as more than 5 millimetres deep and can be further broken down into 3 sub-stages based on tumour size; however, here it is combined and reported only as stage 1B.

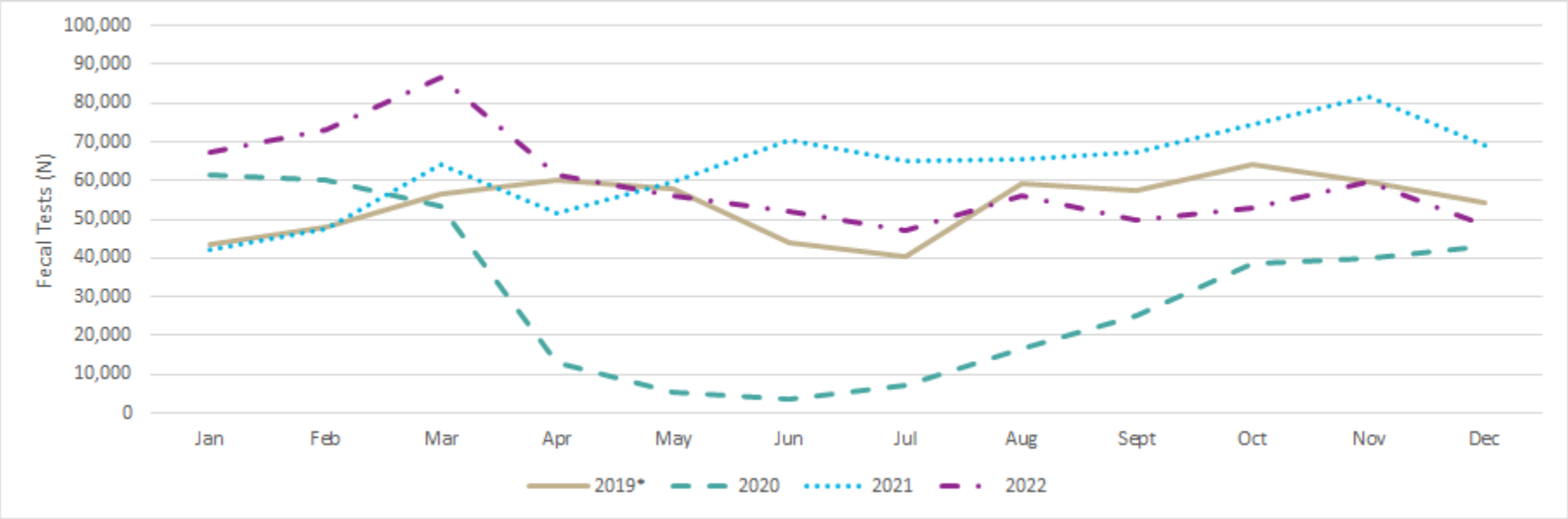
For data, see Table 50 in Appendix 1.

In 2018 and 2019, the majority of screen-detected stage 1 invasive cancers were stage 1A1 (44.1% in 2018 and 43.8% in 2019) and stage 1B (42.8% in 2018 and 41.6% in 2019). Detecting cervical cancers at earlier stages is important for health outcomes including preservation of fertility: the earlier the stage (or sub-stage within a stage), the better the prognosis is for the person diagnosed (64).

ColonCancerCheck Program Performance

ColonCancerCheck: Volumes

Figure 60: Number of Fecal Tests Completed by People in Ontario, Ages 49 to 85, By Month, 2019 to 2022



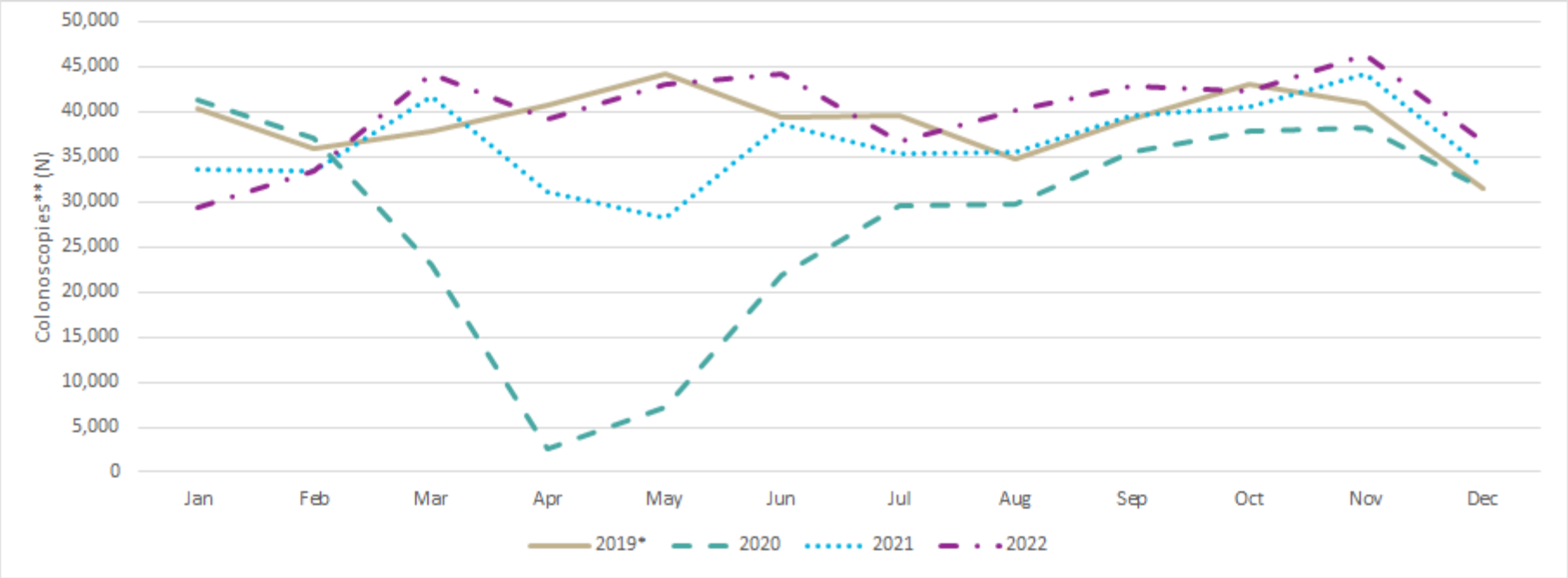
*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 51 in Appendix 1.

The volume of completed fecal tests decreased from March 2020 to June 2020. Volumes then increased month by month until March 2022, when fecal test volumes exceeded monthly volumes observed in previous years. Beginning in April 2022, the monthly volumes decreased again back to comparable pre-pandemic values. Fecal test volumes were 10% higher in 2022 than in 2019* before the COVID-19 pandemic; however, volumes were 6% lower in 2022 than in 2021, the year in which the most recovery occurred.

The COVID-19 pandemic contributed significantly to the trends observed in 2020, 2021 and 2022. Possible pandemic impacts include the pause in screening and correspondence in 2020, reduced access to primary care providers for screening purposes, and the gradual resumption of invitation and recall correspondence letters in 2021 and 2022, with high volumes of letters sent in 2021 to clear the letter backlog. The pandemic likely contributed to results observed in 2020, 2021 and 2022, with fecal test volume fluctuations corresponding to pandemic waves and regular screening trends (e.g., travel patterns in winter and summer, fluctuations in recall volumes).

Figure 61: Number of Outpatient Colonoscopies Performed for People of All Ages in Hospitals or Out-Of-Hospital Premises in Ontario, 2019 to 2022



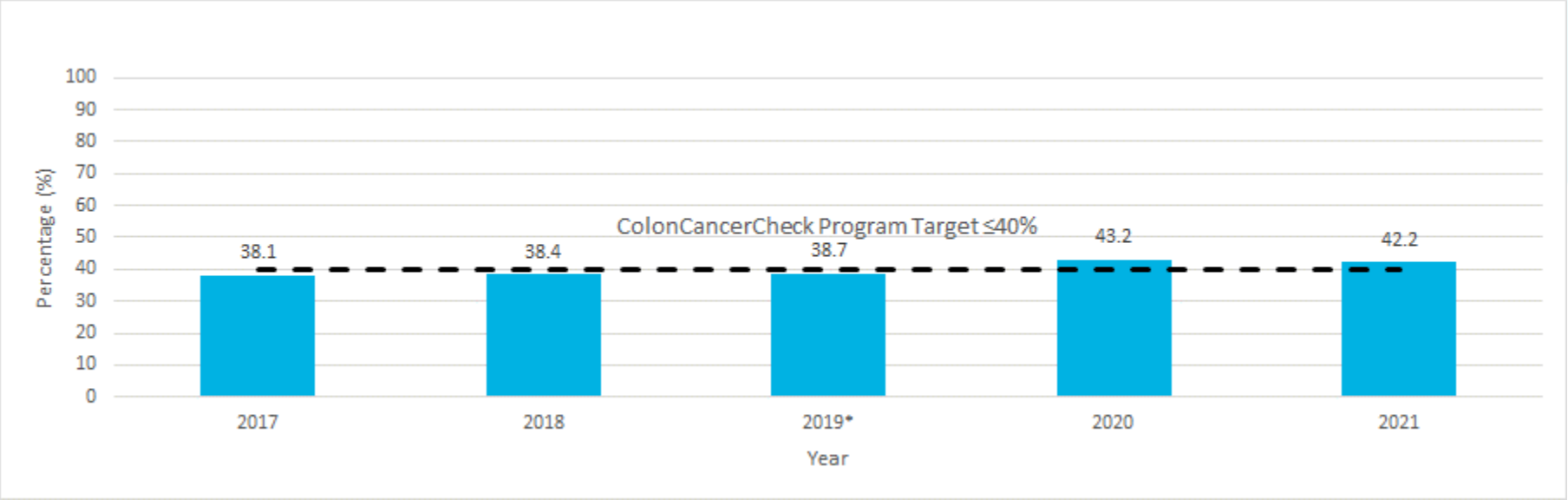
*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.
**Includes colonoscopies for fecal immunochemical test-positive results, surveillance, family history, symptoms and other screening.

For data, see Table 52 in Appendix 1.

The number of outpatient colonoscopies performed in hospitals or out-of-hospital premises decreased from February to April 2020 due to significant constraints on colonoscopy resources during the COVID-19 pandemic. In 2022, outpatient colonoscopy volumes increased by 7.3% compared to 2021, reflecting a return to pre-pandemic 2019 volumes. However, volumes have not yet exceeded pre-pandemic levels which indicates that there is still a backlog of colonoscopies in Ontario as a result of the COVID-19 pandemic.

Colorectal Cancer Screening: Coverage

Figure 62: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, 2017 to 2021



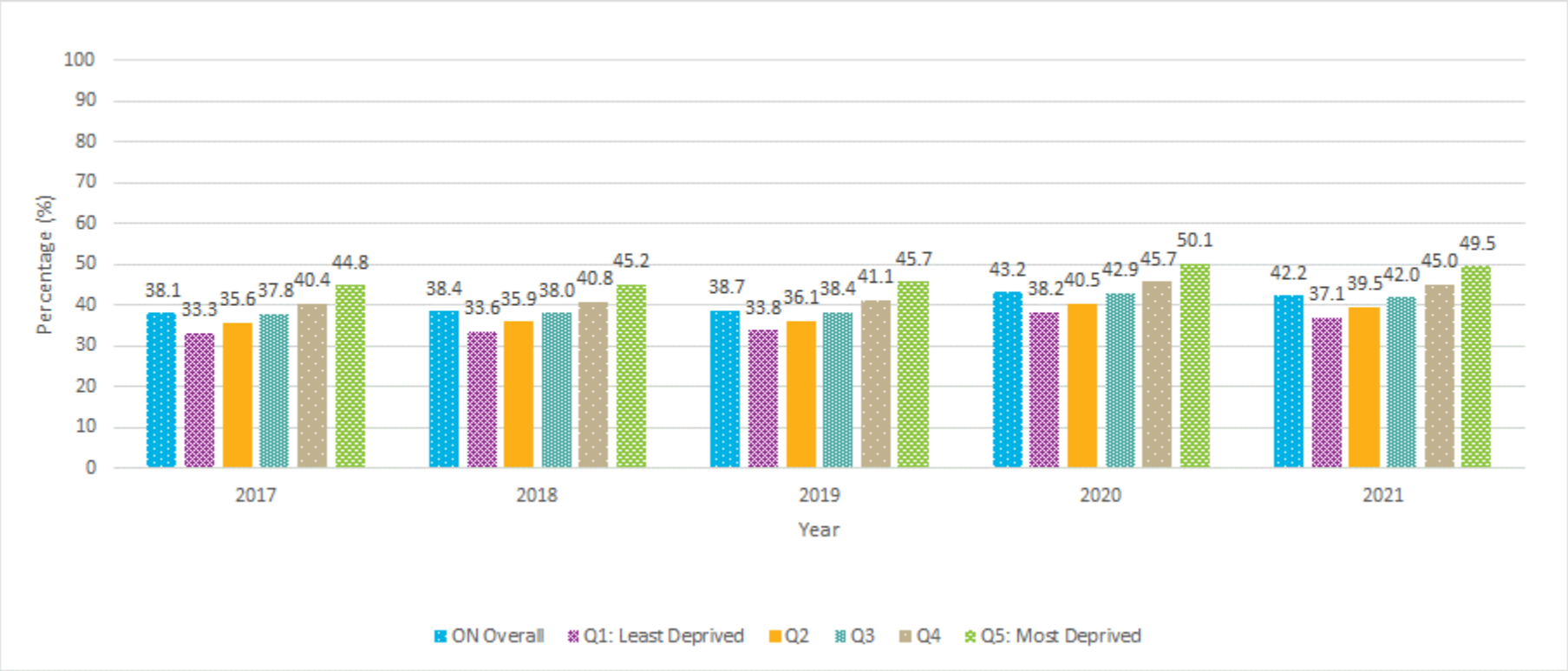
*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 53 in Appendix 1.

This indicator represents the percentage of screen-eligible people in Ontario who had not had colorectal cancer screening (i.e., no fecal test in two years, flexible sigmoidoscopy in 10 years or colonoscopy in 10 years). The percentage of people overdue for screening was stable at approximately 38% from 2017 to 2019, followed by an increase to 43.2% in 2020. This increase may have been due to impacts of the COVID-19 pandemic, including the deferral of cancer screening during the first pandemic wave. Performance improved slightly in 2021 (42.2%), suggesting that colorectal cancer screening participation is beginning to recover from the effects of the pandemic. Ontario's performance on this indicator did not meet the program performance target of no more than 40% in 2020 and 2021.

Overdue for Colorectal Cancer Screening - Equity Analyses: Material Deprivation

Figure 63: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, by Material Deprivation, 2017 to 2021

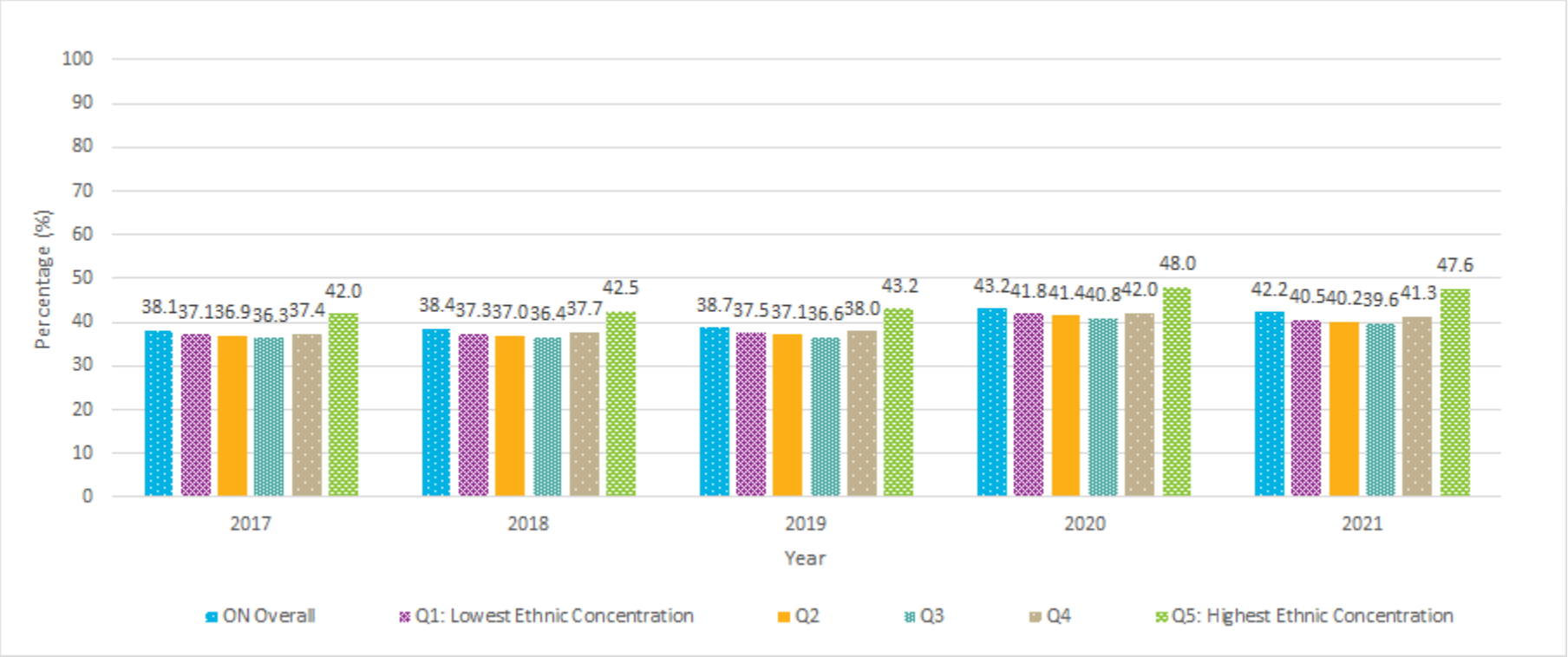


For data, see Table 54 in Appendix 1.

Across all reporting years, people living in more materially deprived neighbourhoods were more likely to be overdue for colorectal cancer screening than people living in less materially deprived neighbourhoods. The percentage of people overdue for screening in the most deprived neighbourhoods (Q5) was higher than the percentage of people overdue overall in Ontario and the program target of 40% or less. The gap between the least deprived (Q1) and the most deprived (Q5) neighbourhoods widened slightly from 11.5% in 2017 to 12.4% in 2021.

Overdue for Colorectal Cancer Screening - Equity Analyses: Ethnic Concentration

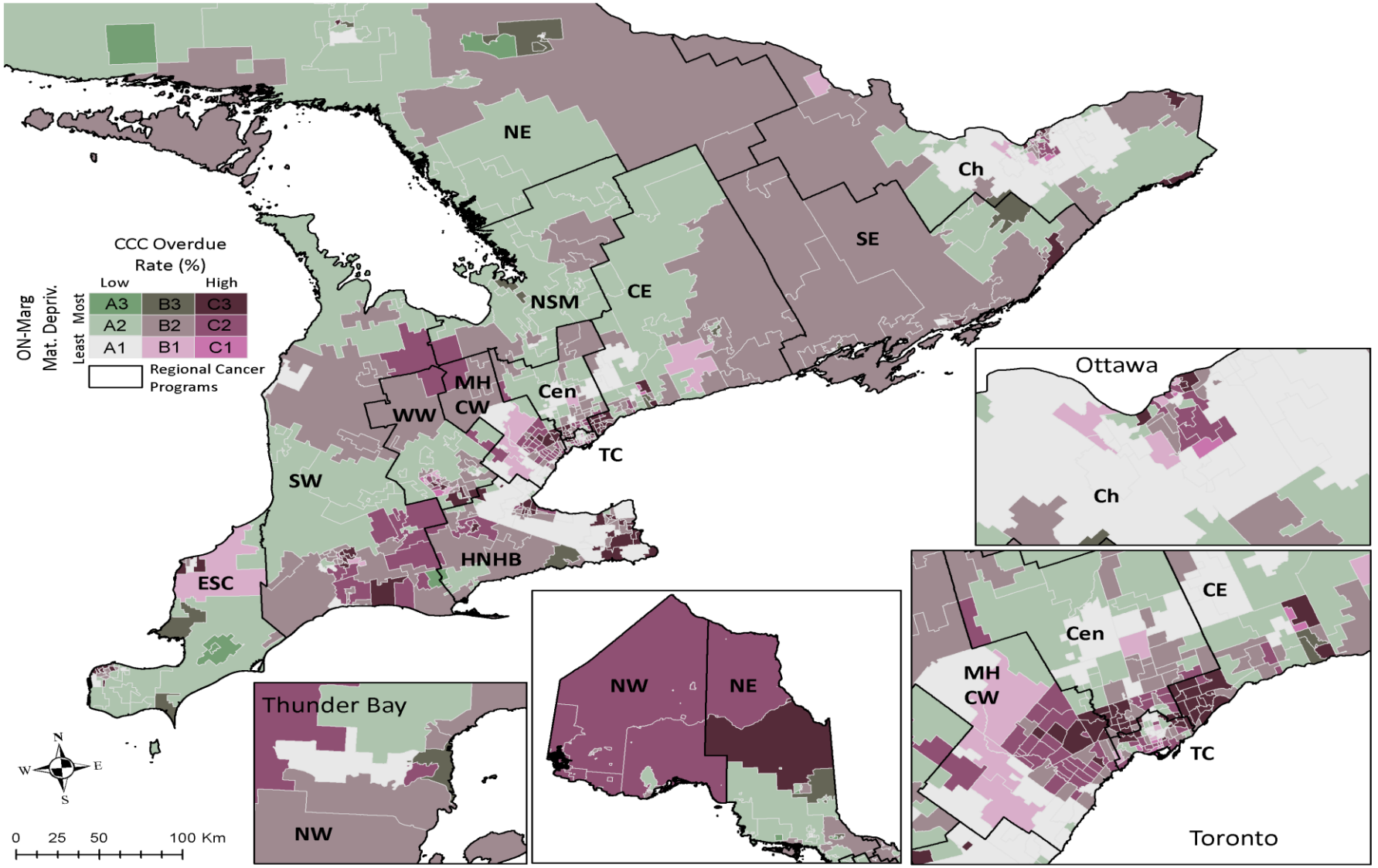
Figure 64: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, by Ethnic Concentration, 2017 to 2021



For data, see Table 55 in Appendix 1.

Across all reporting years, people living in the most ethnically concentrated neighbourhoods were more likely to be overdue for colorectal screening than people living in less ethnically concentrated neighbourhoods. The percentage of people overdue for screening in the most ethnically concentrated neighbourhoods was higher than the overall overdue rate in Ontario and the program target of 40% or less. The gap between the least ethnically concentrated (Q1) and most ethnically concentrated (Q5) neighbourhoods widened from 4.9% in 2017 to 7.1% in 2021, with most of the increase taking place in 2020. The increased gap in 2020 and 2021 may reflect health disparities that were worsened by the COVID-19 pandemic.

Figure 65: Map Showing Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, by Material Deprivation



Regional Cancer Programs: ESC = Erie St. Clair, SW = South West, WW = Waterloo Wellington, HNHB = Hamilton Niagara Haldimand Brant, CW = Central West, MH = Mississauga Halton, TC = Toronto Central, Cen = Central, CE = Central East, SE = South East, Ch= Champlain, NSM = North Simcoe Muskoka, NE = North East, NW = North West

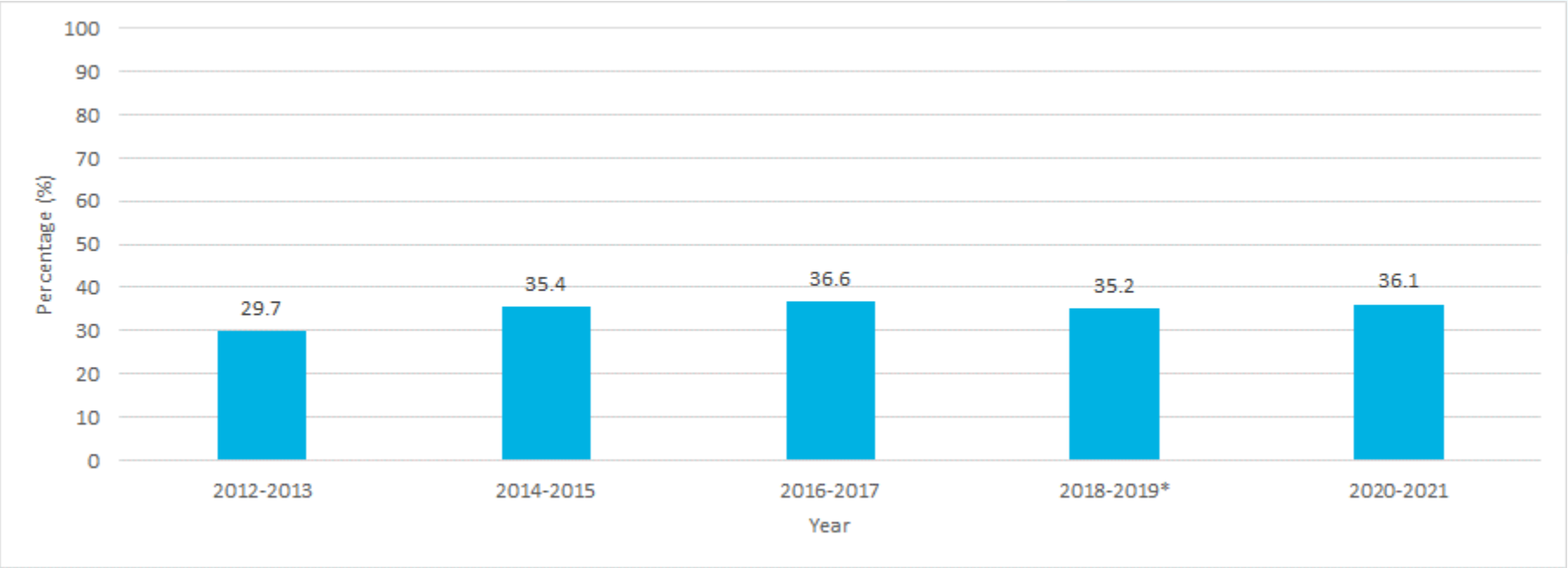
Data notes: Neighbourhoods are mapped at the forward sortation area level. Participation data is for the 2021 reporting period. Bivariate choropleth (shaded) map. Major boundary lines reflect Regional Cancer Program boundaries. If you require data in an alternative format, please contact us by email (OH-CCO_ScreeningPerformanceReport@OntarioHealth.ca).

Colorectal Cancer Screening Participation:

- **A (high participation): <38.4%**
- **B (medium participation): 38.4% to 42.8%**
- **C (low participation): >42.8%**

In neighbourhoods with the highest proportion of people overdue for screening, more than 42.8% of eligible people were overdue for colorectal cancer screening, meaning that they have not had a recent fecal test within two years, a flexible sigmoidoscopy within 10 years or a colonoscopy within 10 years. Much of northern Ontario (the North West and North East Regional Cancer Programs) have high proportions of people who are overdue for colorectal cancer screening and who live in neighbourhoods with high degrees of material deprivation (the darkest purple colour on the map). In the Toronto Central regional cancer program, a high proportion of eligible people overdue for colorectal cancer screening were clustered around the downtown core in the most materially deprived neighbourhoods. In the Central and Central East regional cancer programs, a high proportion of eligible people who were overdue for colorectal cancer screening lived in the most materially deprived neighbourhoods in West North York, North Etobicoke, Scarborough and Oshawa. In the Mississauga/Halton regional cancer program, a high proportion of people who are overdue for colorectal cancer screening live in the most materially deprived neighbourhoods in Brampton and Mississauga.

Figure 66: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Completed at Least 1 Fecal Test in a 30-Month Period, 2012-2013 to 2020-2021



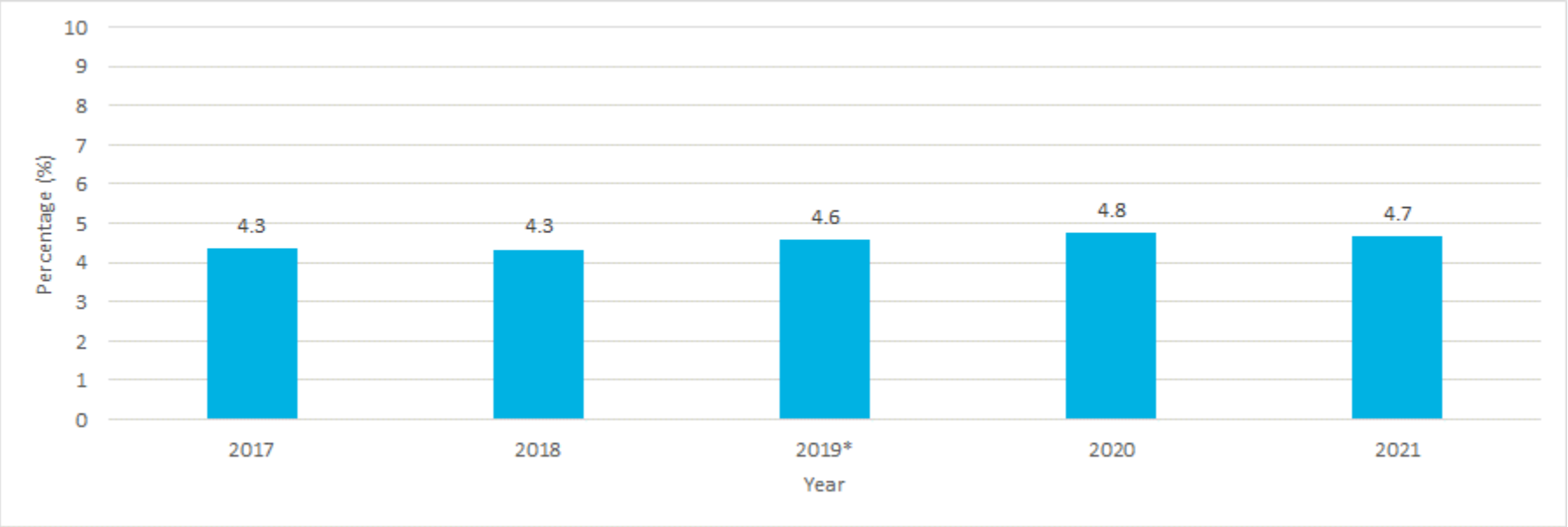
*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 56 in Appendix 1.

The percentage of people who completed at least one fecal test in a 30-month period has remained stable at about 35% to 36% since 2014–2015. Unlike the trend observed for the percentage of people overdue for colorectal cancer screening (which includes colonoscopy and flexible sigmoidoscopy in addition to the fecal test), the COVID-19 pandemic did not significantly impact fecal test participation, likely because the test can be done at home.

ColonCancerCheck: Follow-Up of Abnormal Results

Figure 67: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result, 2017 to 2021

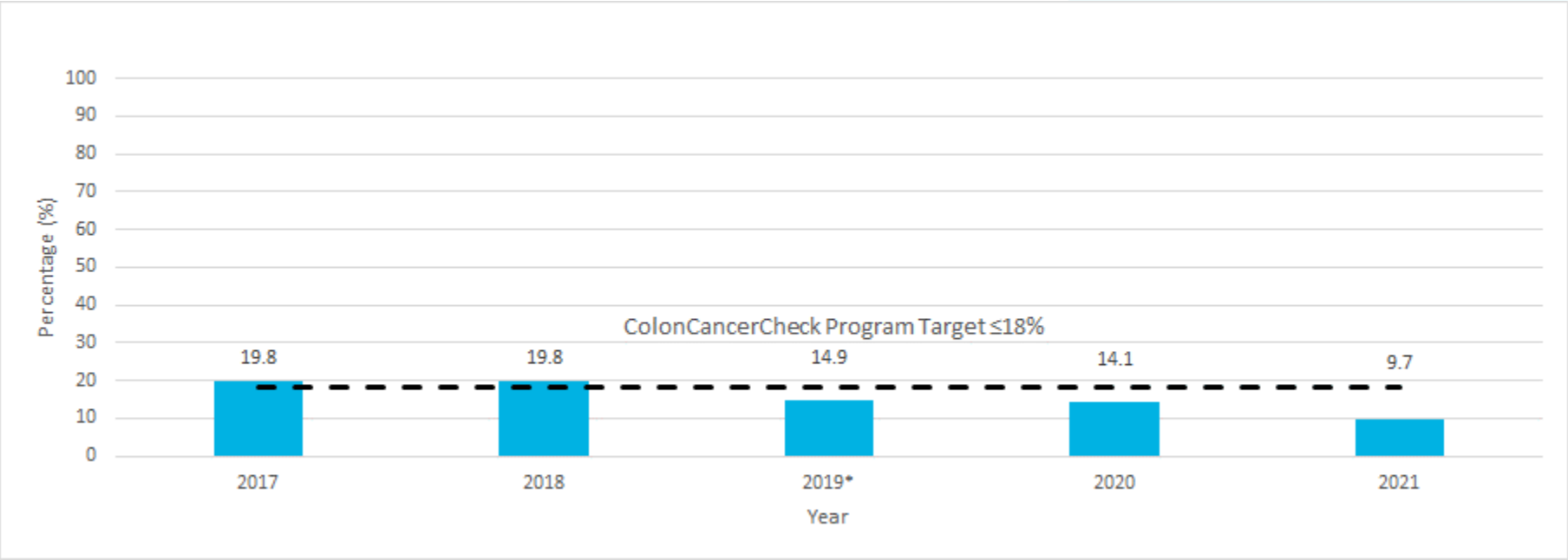


*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 57 in Appendix 1.

The percentage of people screened who had an abnormal fecal test result increased from 4.3% in 2017 to 4.7% in 2021. There was an increase in abnormal fecal test results from 4.3% to 4.6% in 2019, which may be due to the implementation of the fecal immunochemical test (FIT) in June 2019. The FIT detects smaller quantities of blood in the stool than the guaiac-based fecal occult blood test (the test previously recommended by ColonCancerCheck), leading to more abnormal fecal test results (65).

Figure 68: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Did Not Undergo Colonoscopy Within 6 Months of Their Abnormal Fecal Test Result, 2017 to 2021



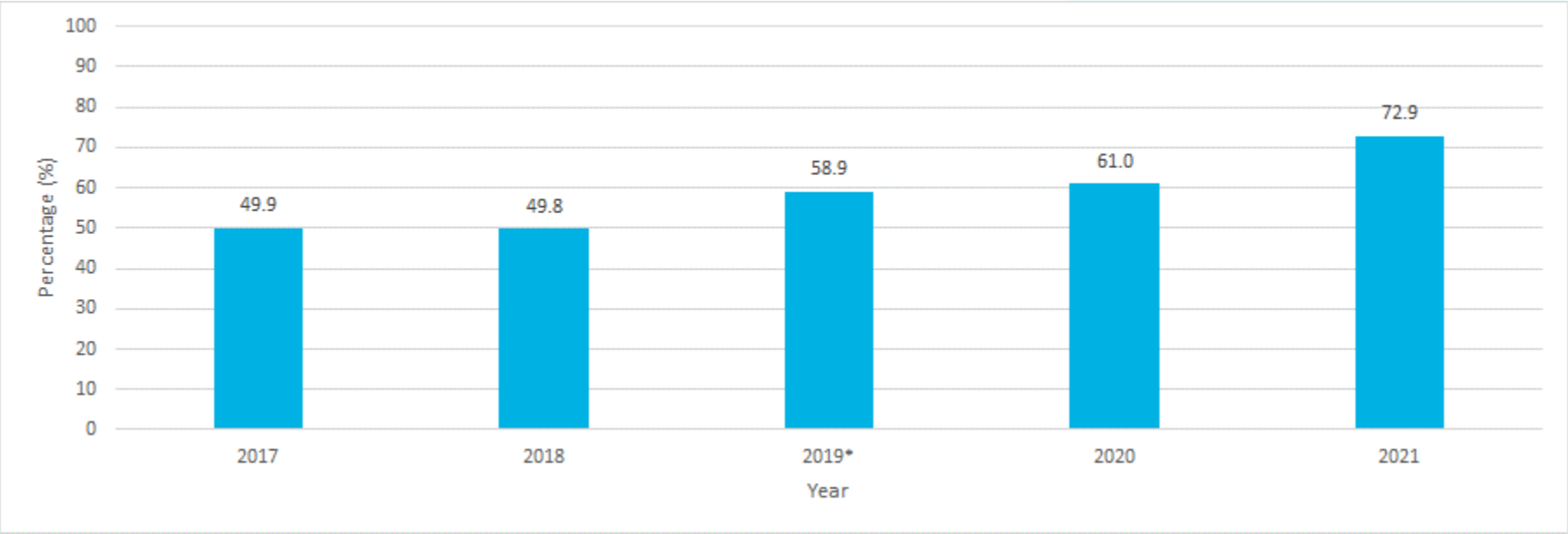
*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 58 in Appendix 1.

The percentage of people who did not have a follow-up colonoscopy within six months of an abnormal fecal test result decreased (improved) from 19.8% in 2017 to 9.7% in 2021. Performance has met the program target of 18% or less since 2019 when the FIT was implemented.

This improvement likely reflects efforts undertaken by Regional Cancer Programs to support appropriate and timely follow-up for people with abnormal fecal test results in preparation for the launch of FIT in the program (e.g., by providing primary care provider and endoscopist education, and implementing regional- or facility-level centralized intake and booking processes). Performance continued to improve following the onset of the COVID-19 pandemic, which may be due to prioritizing colonoscopies for people with abnormal fecal tests according to Ontario Health pandemic guidance.

Figure 69: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Underwent Colonoscopy Within 8 Weeks of the Abnormal Result, 2017 to 2021



*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

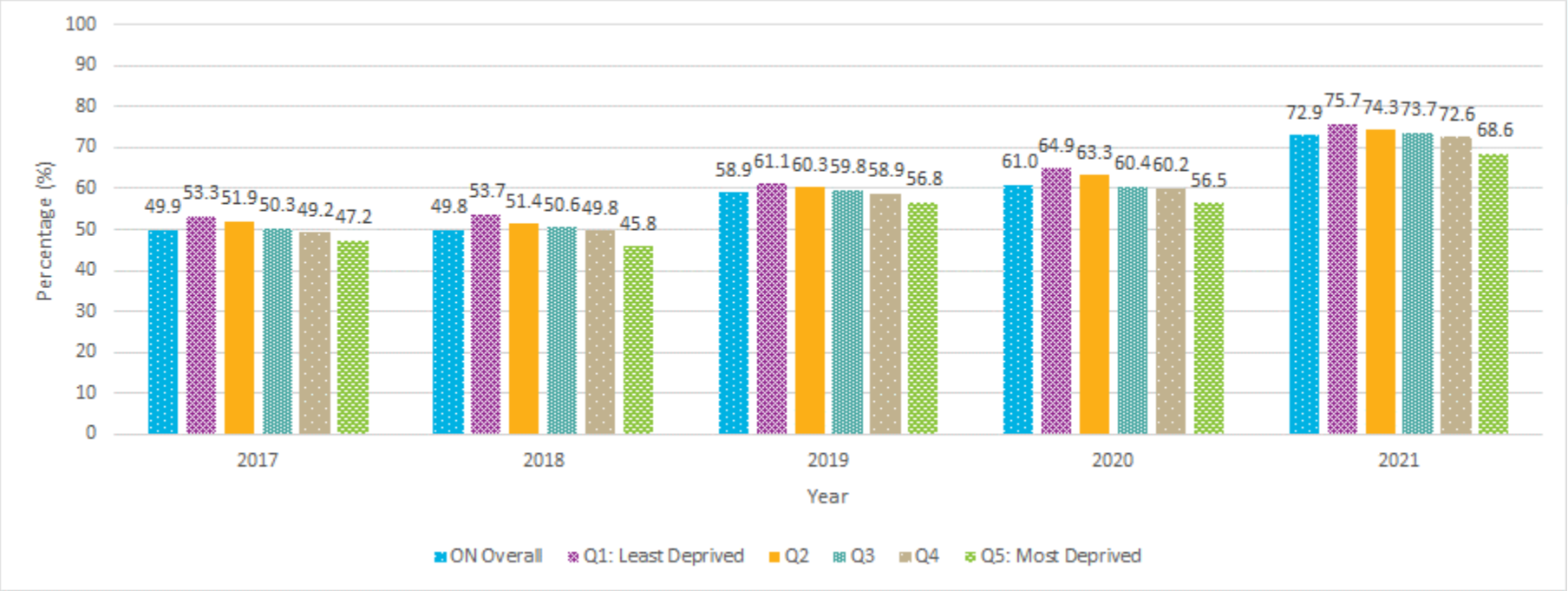
For data, see Table 59 in Appendix 1.

The percentage of screen-eligible people who underwent colonoscopy within eight weeks of an abnormal fecal test result increased (improved) from 49.9% in 2017 to 72.9% in 2021. The improvement in performance for this indicator from 2019 onwards is likely related to prioritizing timely follow-up colonoscopy for people with an abnormal FIT result. This indicator is aligned with Canadian consensus guidelines on acceptable wait times for endoscopy (66).

This improvement in performance despite the impacts of the COVID-19 pandemic may be a result of Regional Cancer Programs, primary care providers and endoscopists in Ontario following through on ColonCancerCheck's recommendation for people with abnormal fecal test results to have a colonoscopy within eight weeks.

ColonCancerCheck Follow-up of Abnormal Results - Equity Analyses: Material Deprivation

Figure 70: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Underwent Colonoscopy Within 8 Weeks of the Abnormal Result, by Material Deprivation, 2017 to 2021

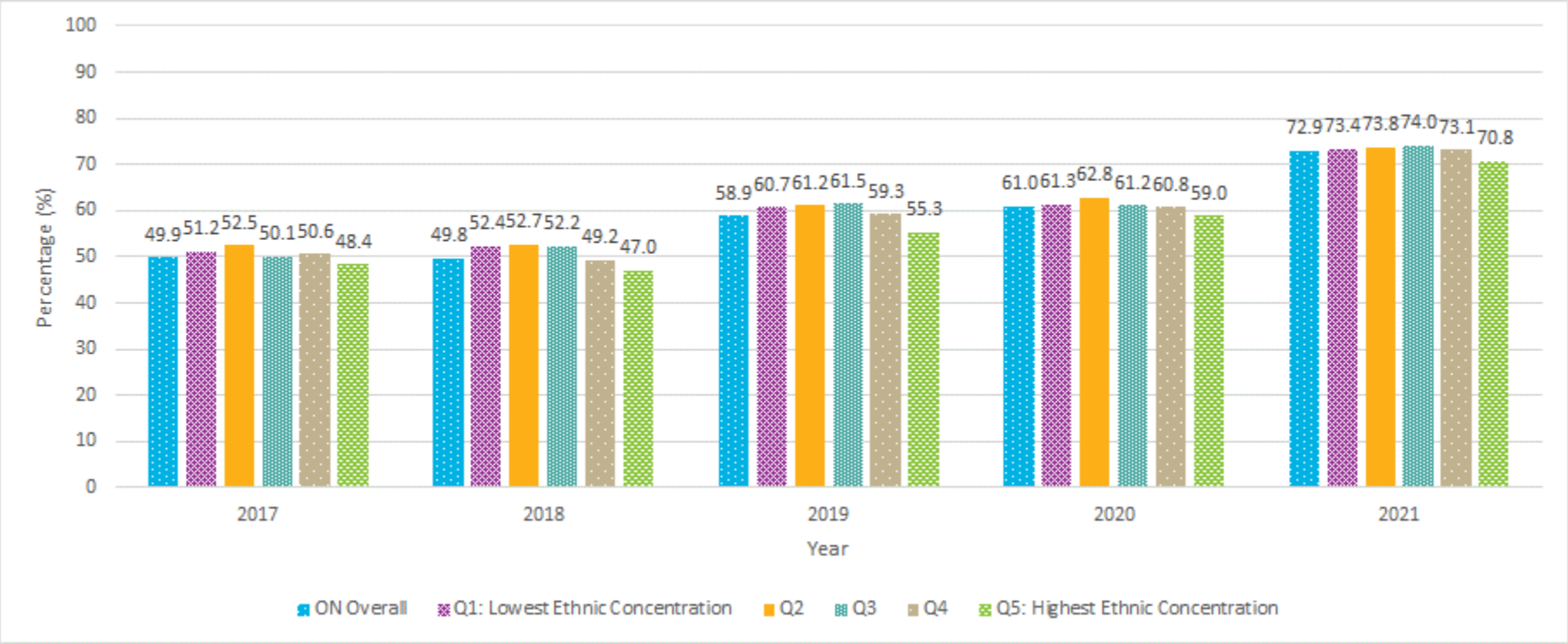


For data, see Table 60 in Appendix 1.

Across all reporting years, there was a relationship between material deprivation and timely follow-up of abnormal fecal test results. People living in the most materially deprived neighbourhoods had lower proportions of follow-up within 8 weeks of an abnormal fecal test result compared to people living in less materially deprived neighbourhoods. This difference was largest in 2020, with 64.9% of people living in the least deprived neighbourhoods (Q1) receiving colonoscopy within eight weeks of an abnormal fecal test result compared to 56.5% of people in the most deprived neighbourhoods (Q5). These data suggest that the effects of COVID-19 and the deferral of screening and diagnostic services related to the pandemic were magnified for people living in more materially deprived neighbourhoods. Performance on this indicator improved from 2019 onwards for all quintiles of material deprivation, coinciding with the implementation of the FIT in 2019.

ColonCancerCheck Follow-up of Abnormal Results - Equity Analyses: Ethnic Concentration

Figure 71: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Underwent Colonoscopy Within 8 Weeks of the Abnormal Result, by Ethnic Concentration, 2017 to 2021

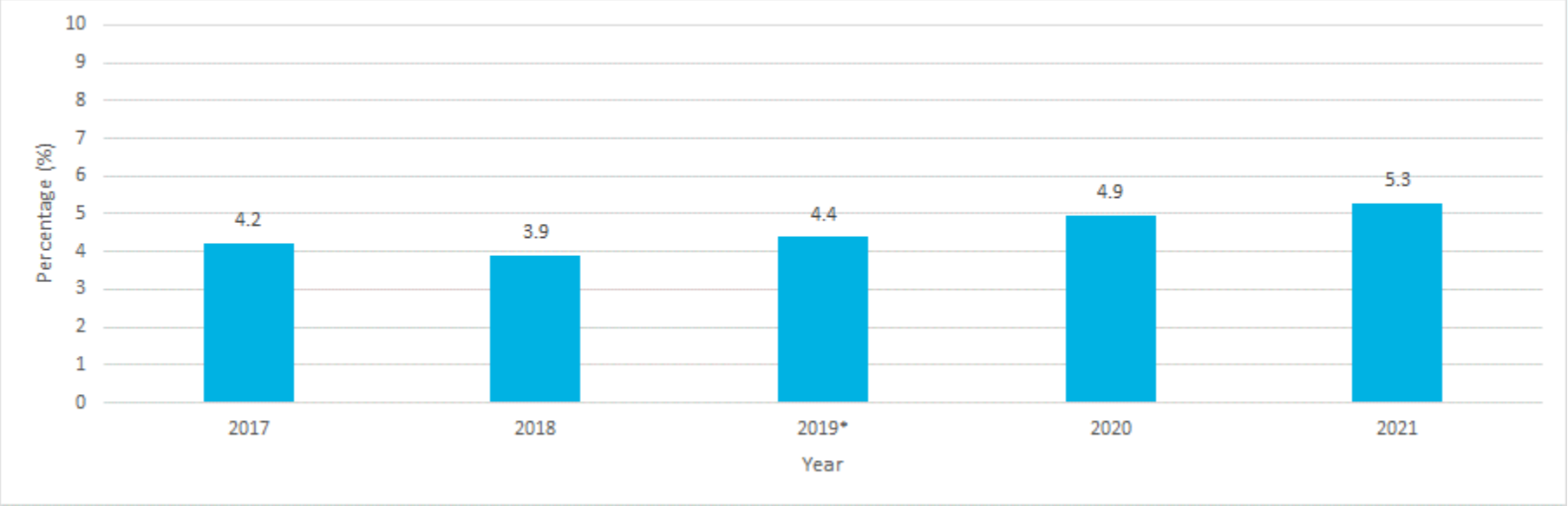


For data, see Table 61 in Appendix 1.

Across all reporting years, people living in the least ethnically concentrated neighbourhoods (Q1), had higher proportions of follow-up within 8 weeks of an abnormal fecal test result compared to people living in more ethnically concentrated neighbourhoods (Q4, Q5). Performance on this indicator improved annually from 2019 onwards for all quintiles of ethnic concentration, coinciding with the implementation of the FIT in 2019.

Colorectal Cancer Screening: Quality of Screening

Figure 72: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Fecal Test Result Who Were Diagnosed With a Program Screen-Detected Invasive Colorectal Cancer After a Large Bowel Endoscopy or Surgical Resection, 2017 to 2021

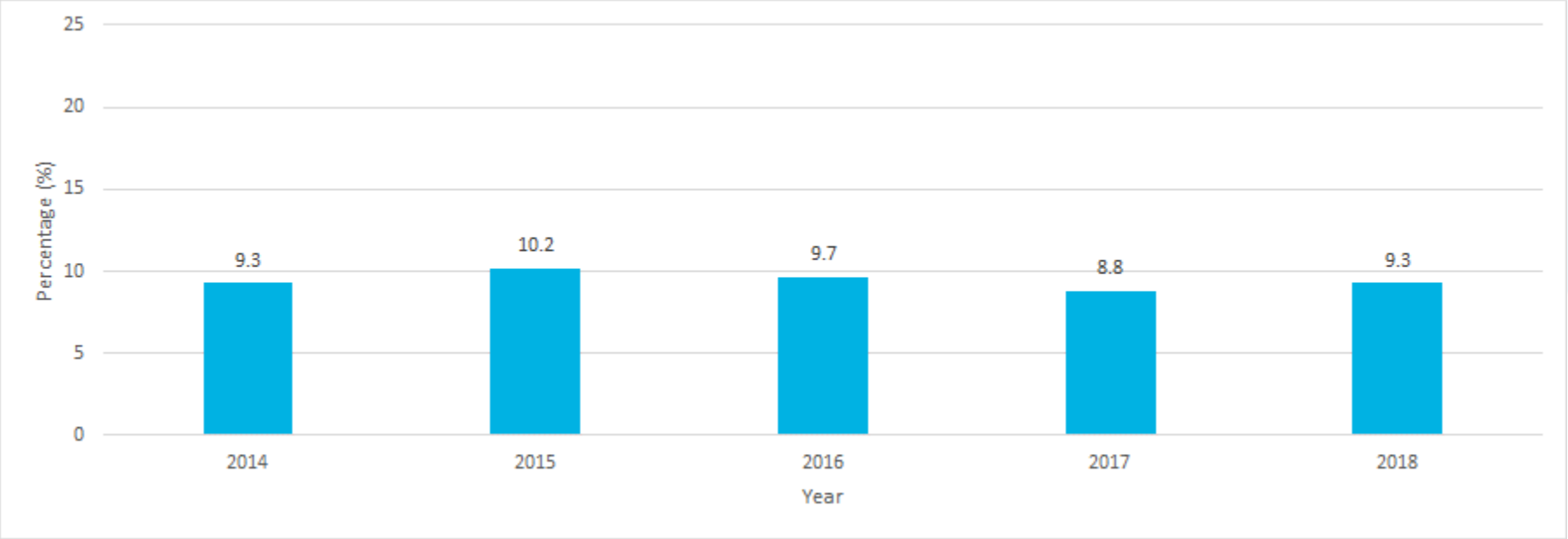


*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 62 in Appendix 1.

The positive predictive value (PPV) is the probability that someone with an abnormal fecal immunochemical test (FIT) result has cancer. The percentage of screen-eligible people with a program screen-detected invasive colorectal cancer following an abnormal fecal test result has increased (improved) year over year since the June 2019 implementation of the FIT, which detects more colorectal cancers than the guaiac fecal occult blood test previously used by ColonCancerCheck (65). This improvement suggests that the FIT is working as intended to identify people at risk of colorectal cancer. The COVID-19 pandemic may have also contributed to the increase seen in 2020 and 2021 because people at higher risk of colorectal cancer were prioritized for screening during the pandemic, according to Ontario Health's COVID-19 pandemic guidance.

Figure 73: Percentage of Colorectal Cancers Detected That Are Post-Colonoscopy Colorectal Cancers, 2014 to 2018

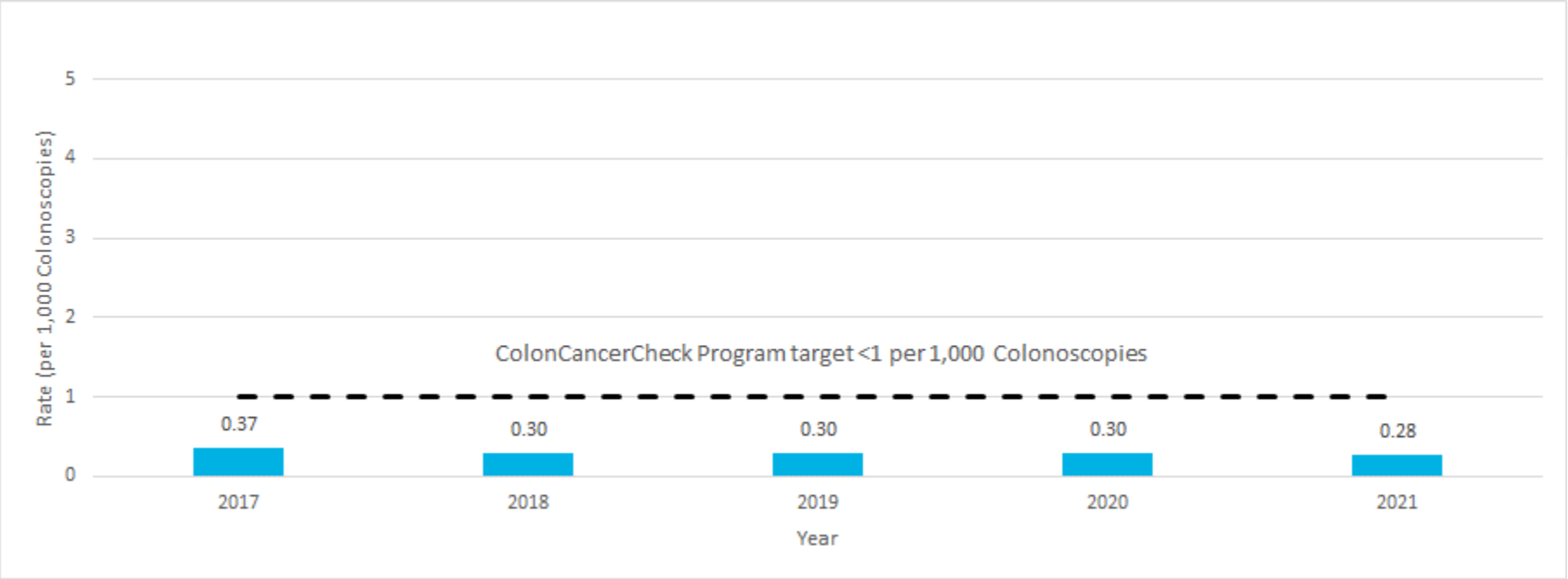


For data, see Table 63 in Appendix 1.

Post-colonoscopy colorectal cancers are cancers diagnosed after a colonoscopy in which cancer was not detected (i.e., a negative colonoscopy). This indicator uses the World Endoscopy Organization methodology that defines post-colonoscopy colorectal cancers as colorectal cancers diagnosed within six to 36 months after a colonoscopy (67). The post-colonoscopy colorectal cancer rate is calculated as the number of post-colonoscopy colorectal cancers divided by the sum of post-colonoscopy colorectal cancers and colorectal cancers detected at the time or within six months of the colonoscopy. The indicator is reported based on the year of the colonoscopy. The post-colonoscopy colorectal cancer rate remained stable at approximately 9% from 2014 to 2018.

Colorectal Cancer Screening: Colonoscopy Quality

Figure 74: Number of Outpatient Colonoscopies* in People Ages 18 and Older Followed by Hospital Admissions for Perforations Within 7 Days of Colonoscopy, per 1,000 Colonoscopies in Ontario, 2017 to 2021



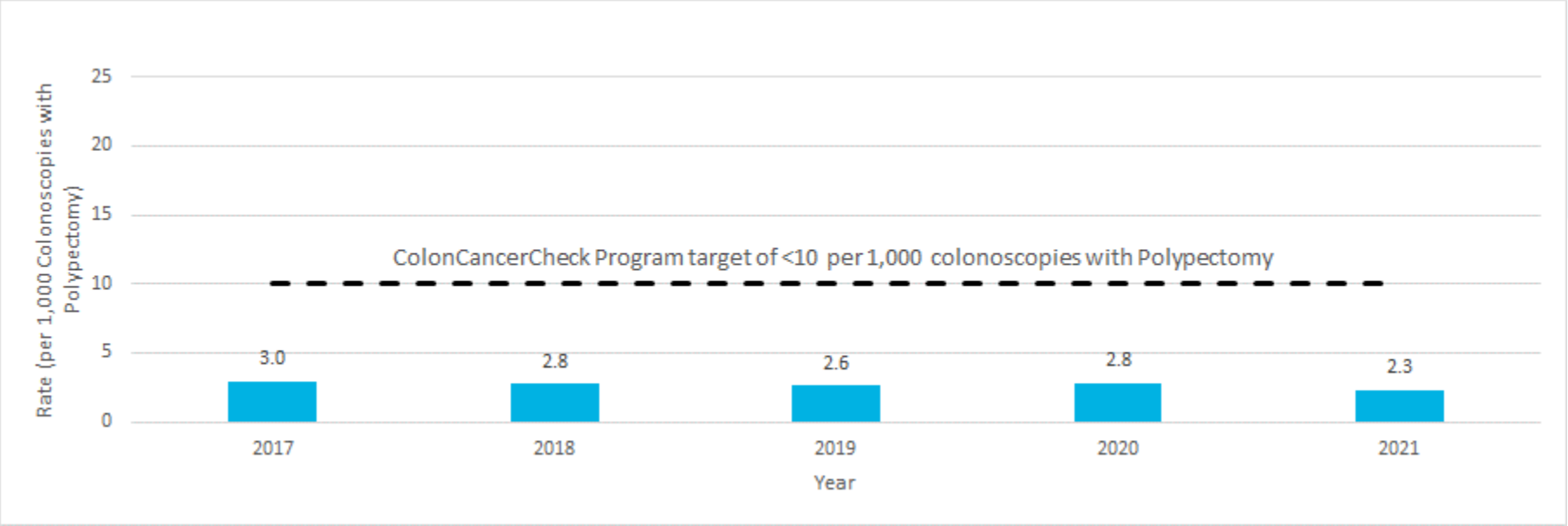
*Includes colonoscopies for abnormal fecal immunochemical test results, surveillance, family history, symptoms, and other screening.

For data, see Table 64 in Appendix 1.

Although colonoscopy is a safe test, there is a very small risk of perforation (making a small hole) of the bowel, which may need to be fixed with surgery. A low perforation rate is a measure of high-quality care.

In 2017, the outpatient perforation rate was 0.37 per 1,000 colonoscopies and decreased in 2018 to 0.30 per 1,000 colonoscopies. The perforation rate remained stable from 2018 to 2021 and was consistently below the program target of <1 per 1,000 colonoscopies (68).

Figure 75: Number of Outpatient Colonoscopies With Polypectomy Among People Ages 50 and Older Followed by Hospital Admissions for Lower Gastrointestinal Bleeding Within 14 Days of Colonoscopy, per 1,000 Colonoscopies with Polypectomy in Ontario, 2017 to 2021

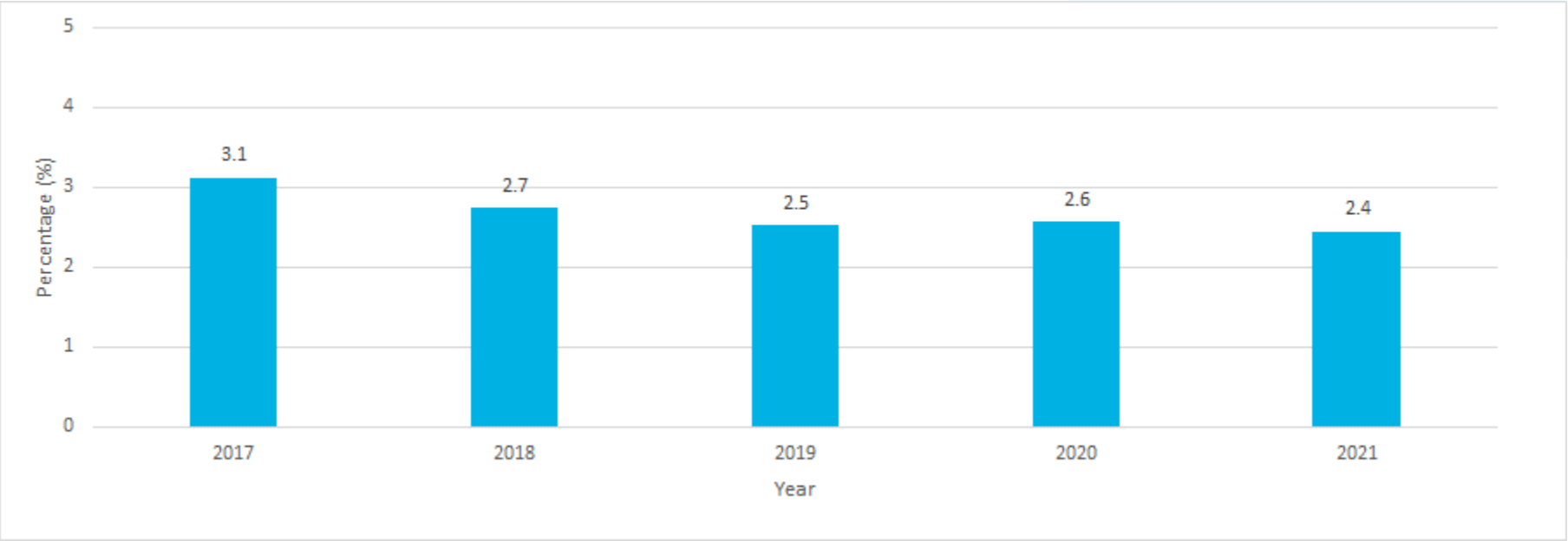


For data, see Table 65 in Appendix 1.

During a colonoscopy, the endoscopist may also perform a polypectomy. This is a procedure done to remove one or more polyps, which are abnormal growths on the lining of the colon. In the days following this procedure, some people may experience bleeding from the lower part of the bowel, called post-polypectomy bleeding.

The rate of post-polypectomy bleeding is another important measure of colonoscopy quality. The rate of post-polypectomy bleeding decreased (improved) from 3.0 per 1,000 colonoscopies with polypectomy in 2017 to 2.3 per 1,000 colonoscopies with polypectomy in 2021. This improvement occurred despite prioritizing colonoscopies for people with abnormal FIT results or urgent indications (e.g., gastrointestinal symptoms that require urgent care) during the COVID-19 pandemic, which could have resulted in more people requiring polypectomy in 2020 and 2021. Performance on this indicator continues to meet the provincial target of <10 per 1,000 colonoscopies where polypectomy is performed (69).

Figure 76: Percentage of Hospital Outpatient Colonoscopies Performed in People Ages 18 and Older With Poor Bowel Preparation, 2017 to 2021

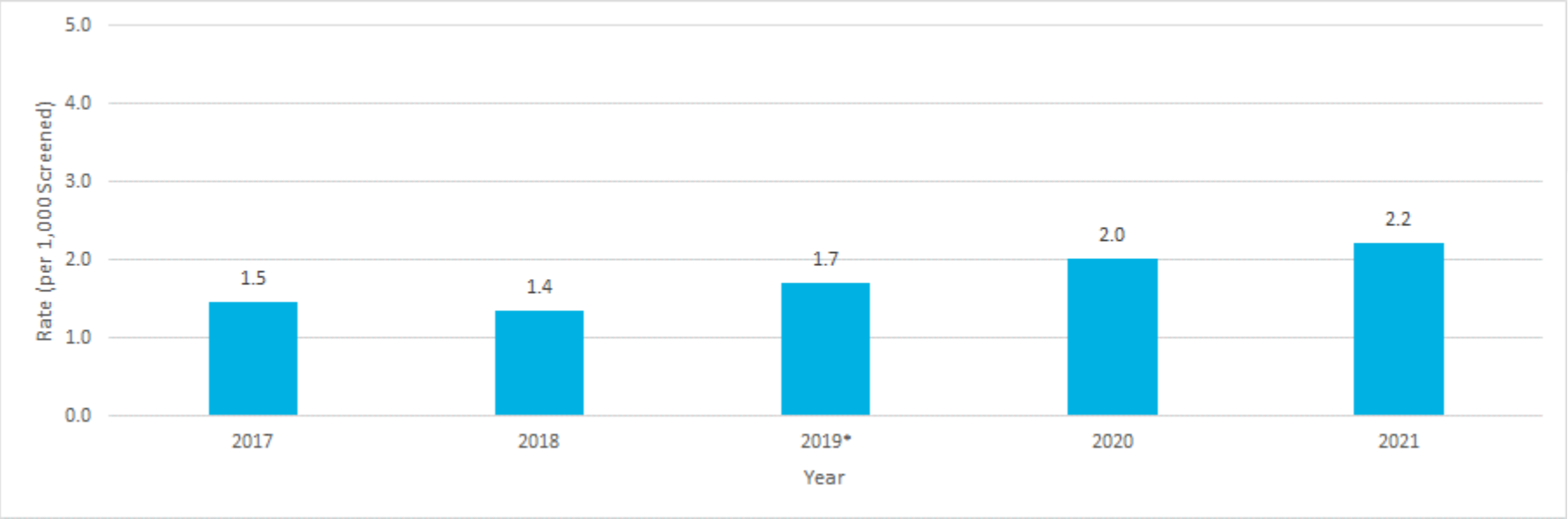


For data, see Table 66 in Appendix 1.

Poor bowel preparation affects the quality of a colonoscopy and can lead to patient discomfort, incomplete procedures and decrease the ability to detect pre-cancerous and cancerous lesions (70). The percentage of outpatient colonoscopies performed with poor bowel preparation in hospitals decreased (improved) from 3.1% in 2017 to 2.4% in 2021.

ColonCancerCheck: Detection

Figure 77: Number of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had a Screen-Detected Invasive Colorectal Cancer, per 1,000 Screened Using a ColonCancerCheck Fecal Test, 2017 to 2021

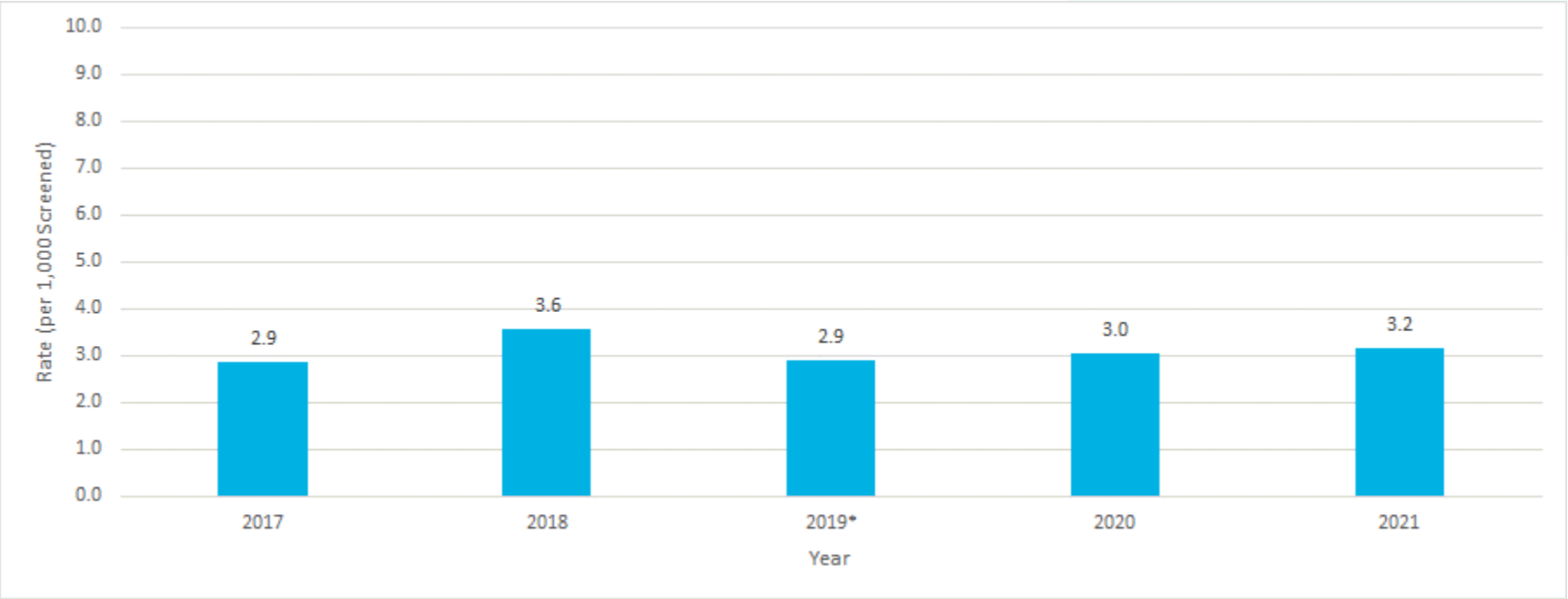


*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 67 in Appendix 1.

The invasive colorectal cancer detection rate increased from 1.5 per 1,000 fecal tests in 2017 to 2.2 per 1,000 fecal tests in 2021. This increase is likely due to the June 2019 implementation of the fecal immunochemical test (FIT), which detects more colorectal cancers than the guaiac-based fecal occult blood test that was previously used by ColonCancerCheck (65). The COVID-19 pandemic may have also contributed to the increase in cancer detection seen in 2020 and 2021. Possible pandemic effects include prioritizing screening for people at higher risk for colorectal cancer according to Ontario Health COVID-19 pandemic guidance.

Figure 78: Number of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had a Screen-Detected Invasive Colorectal Cancer, per 1,000 Screened With Colonoscopy Due to a Family History of Colorectal Cancer, 2017 to 2021



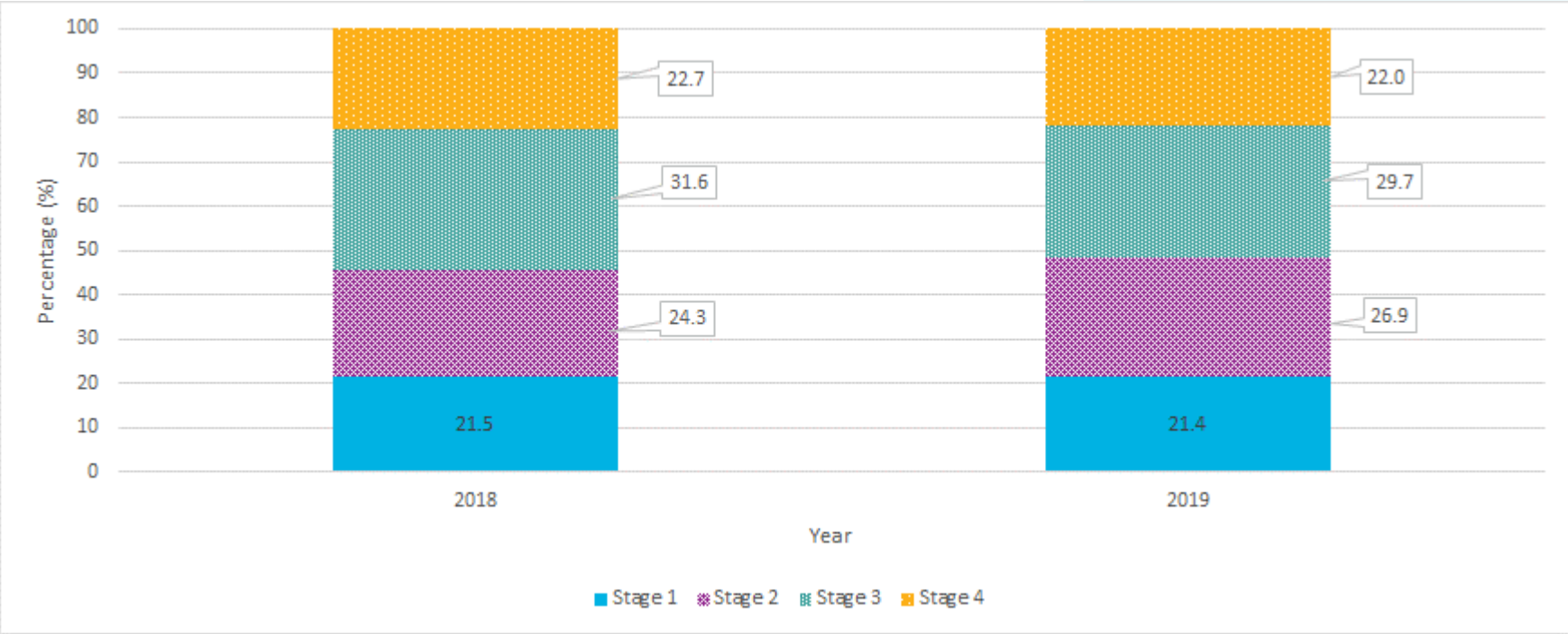
*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

For data, see Table 68 in Appendix 1.

The invasive cancer detection rate among people with a family history of colorectal cancer remained relatively stable from 2017 to 2021, at about 3 per 1,000 people screened with colonoscopy.

ColonCancerCheck: Disease Extent at Diagnosis

Figure 79: Stage Distribution of All Invasive Colorectal Cancers in Ontario in People Ages 50 to 74, 2018 to 2019

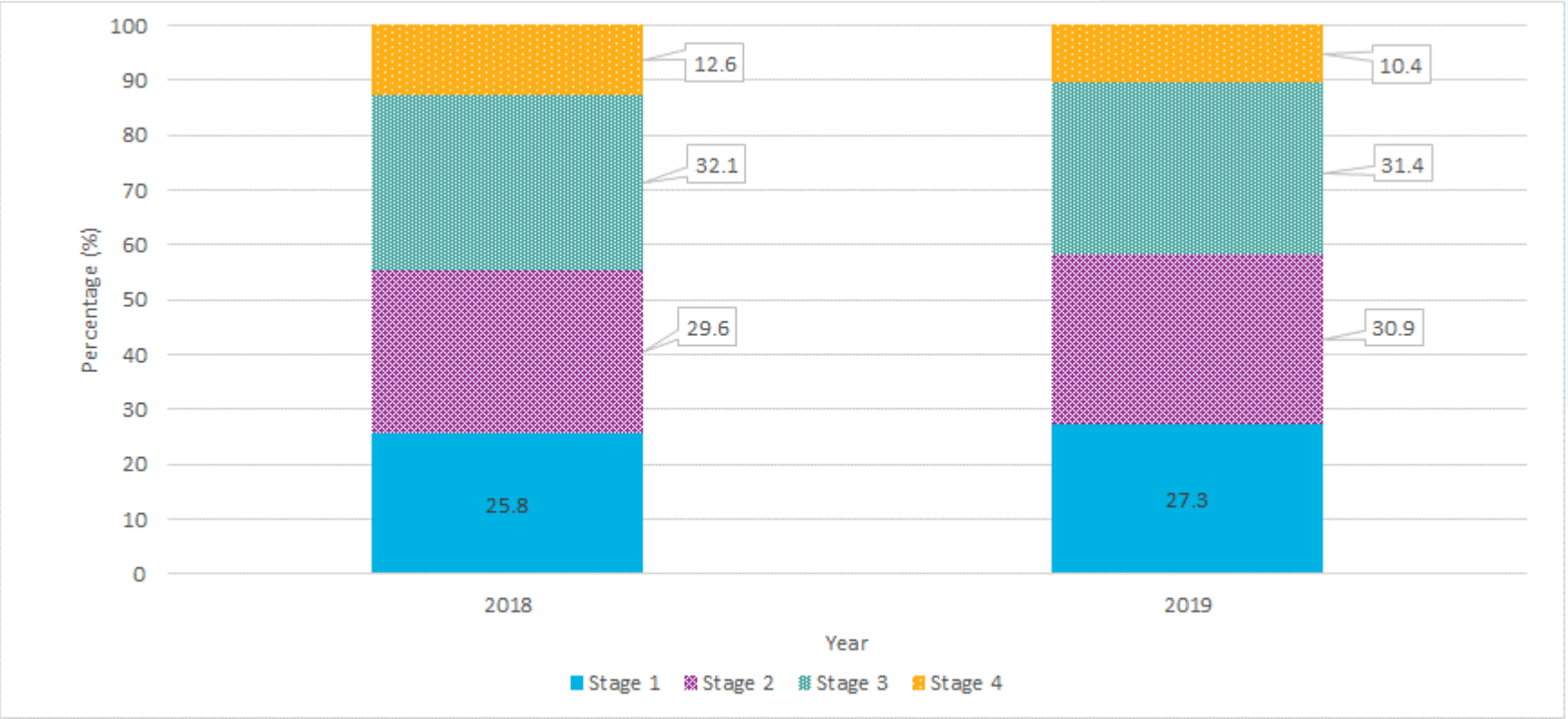


Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

For data, see Table 69 in Appendix 1.

When looking at all invasive colorectal cancers diagnosed in Ontario, most were diagnosed at later stages (stages 3 or 4) than screen-detected invasive cancers. While 55% to 58% of screen-detected invasive colorectal cancers were diagnosed at stage 1 or 2 in 2018 and 2019 (Figure 80), 45.8% of all invasive colorectal cancers in Ontario were diagnosed at stage 1 or 2 in 2018 and 48.3% were diagnosed at stage 1 or 2 in 2019. This finding reflects the benefits of colorectal cancer screening for early detection, when treatment has a better chance of working.

Figure 80: Stage Distribution of Screen-Detected Invasive Colorectal Cancers In Ontario In People Ages 50 to 74, 2018 to 2019

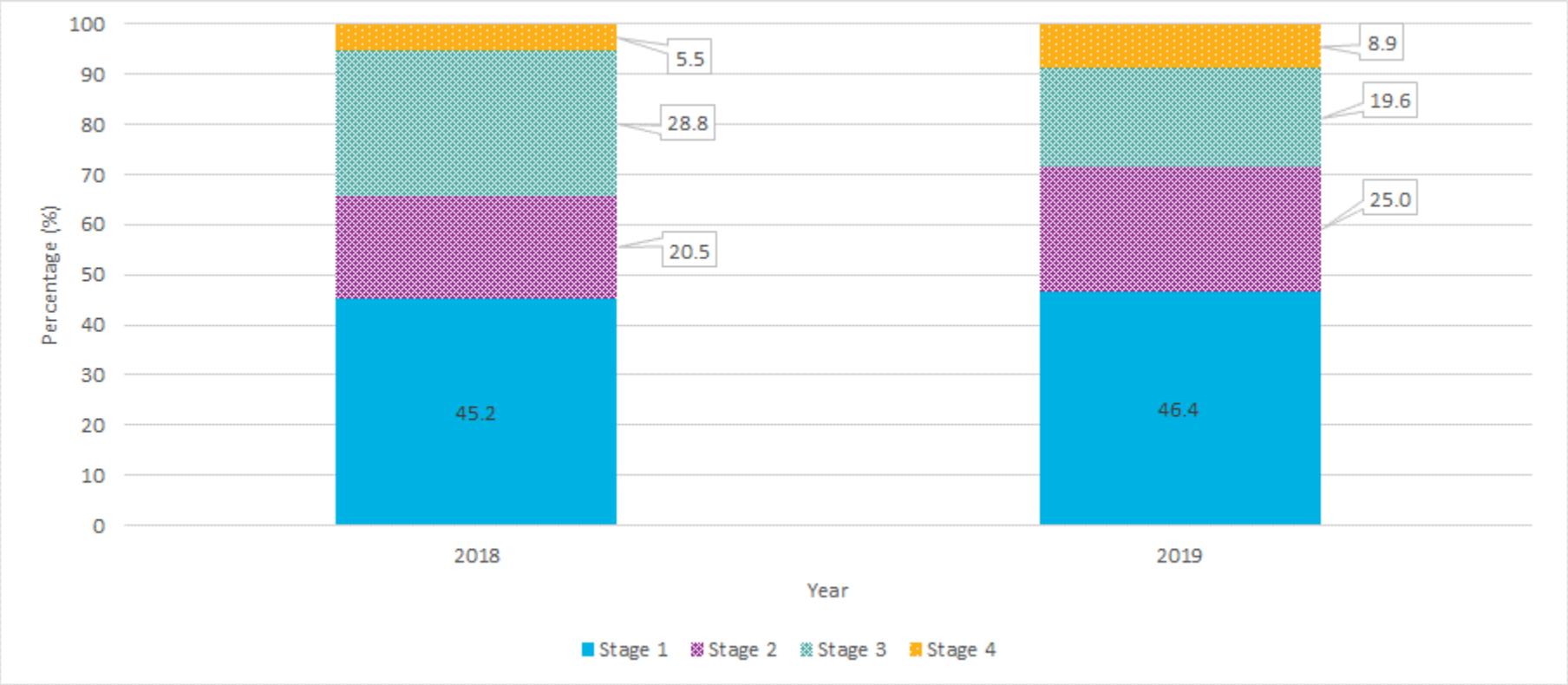


Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

For data, see Table 70 in Appendix 1.

From 2018 to 2019, the percentage of screen-detected invasive colorectal cancers found at an early stage (stage 1) increased from 25.8% to 27.3%. During this time, the proportion of screen-detected invasive colorectal cancers diagnosed at stage 2 increased slightly from 29.6% to 30.8%. From 2018 to 2019, there was a decrease in the percentage of invasive colorectal cancers diagnosed at a later stage (stage 3 or 4).

Figure 81: Invasive Colorectal Cancer Stage Distribution at Diagnosis in People Who Were Screened With a Colonoscopy Due to a Family History of Colorectal Cancer, 2018 to 2019



Note: Data prior to 2018 are not shown because of a change in the cancer staging classification system in 2018.

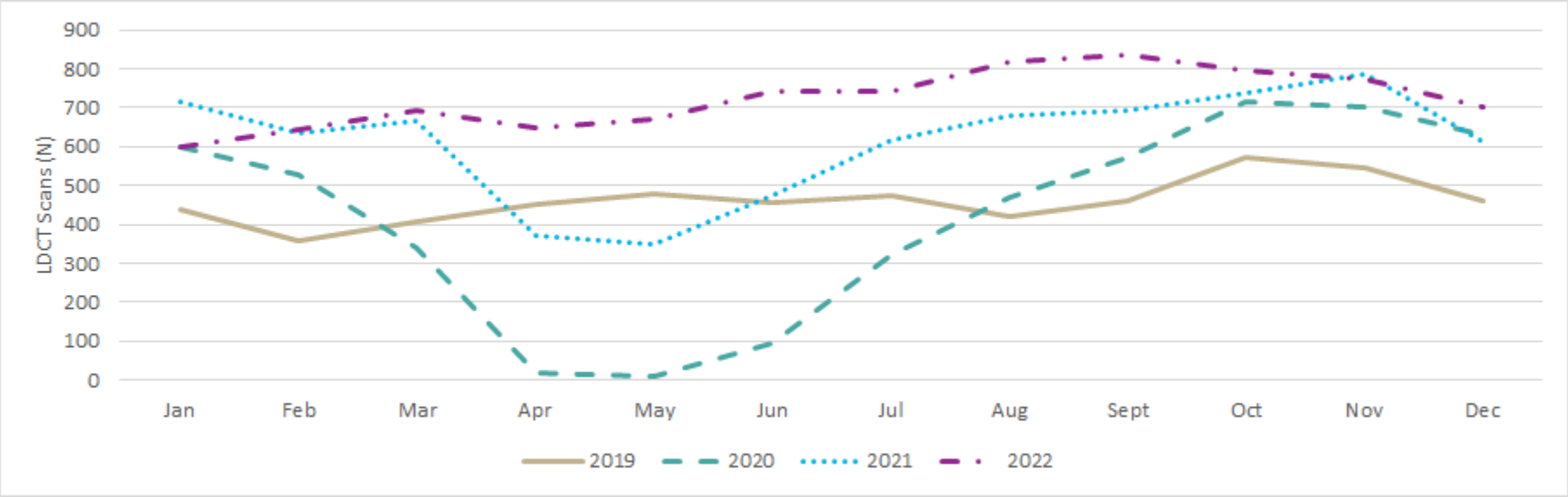
For data, see Table 71 in Appendix 1.

From 2018 to 2019, the percentage of screen-detected stage 1 invasive colorectal cancers in people with a family history of colorectal cancer increased from 45% to 46%, while the percentage of people with stage 2 invasive cancers increased from 21% to 25%. The percentage of stage 3 invasive cancers decreased from 29% to 20% and the percentage of stage 4 invasive cancers increased from 5% to 9%.

Ontario Lung Screening Program (OLSP) Performance

OLSP: Screening Volumes

Figure 82: Number of Low Dose Computed Tomography (LDCT) Scans Performed for People Age 55 and Older in Ontario Confirmed to be at High Risk for Lung Cancer, 2019 to 2022

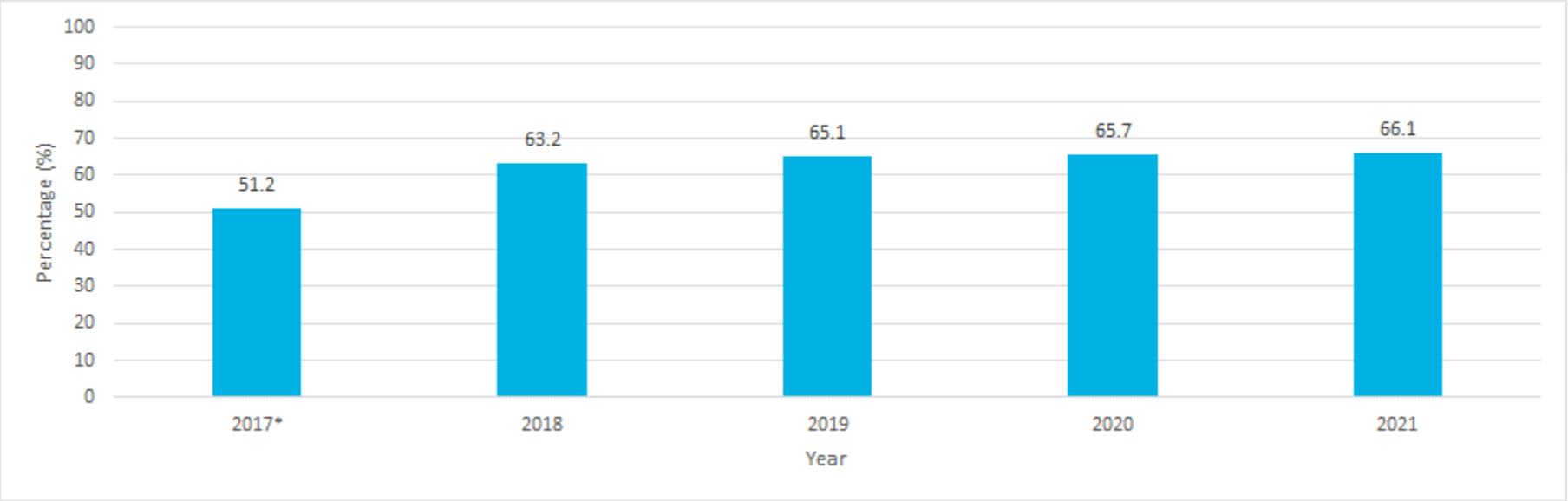


For data, see Table 72 in Appendix 1.

Low-dose computed tomography (LDCT) scan volumes were significantly impacted by the COVID-19 pandemic. Volumes decreased substantially from March to May 2020 as a result of the deferral of all non-emergent or urgent health care services. The LDCT scan volumes in 2021 exceeded 2020 levels, but they were impacted by subsequent COVID-19 waves, which can be seen by the decrease in volumes from March to May 2021. LDCT scan volumes increased by 56.8% from 2019 (pre-pandemic) to 2022, reflecting ongoing increases in recruitment and participation.

OLSP: Smoking Cessation

Figure 83: Percentage of People Who Completed a Baseline Risk Assessment and Reported That They Currently Smoke, 2017 to 2021



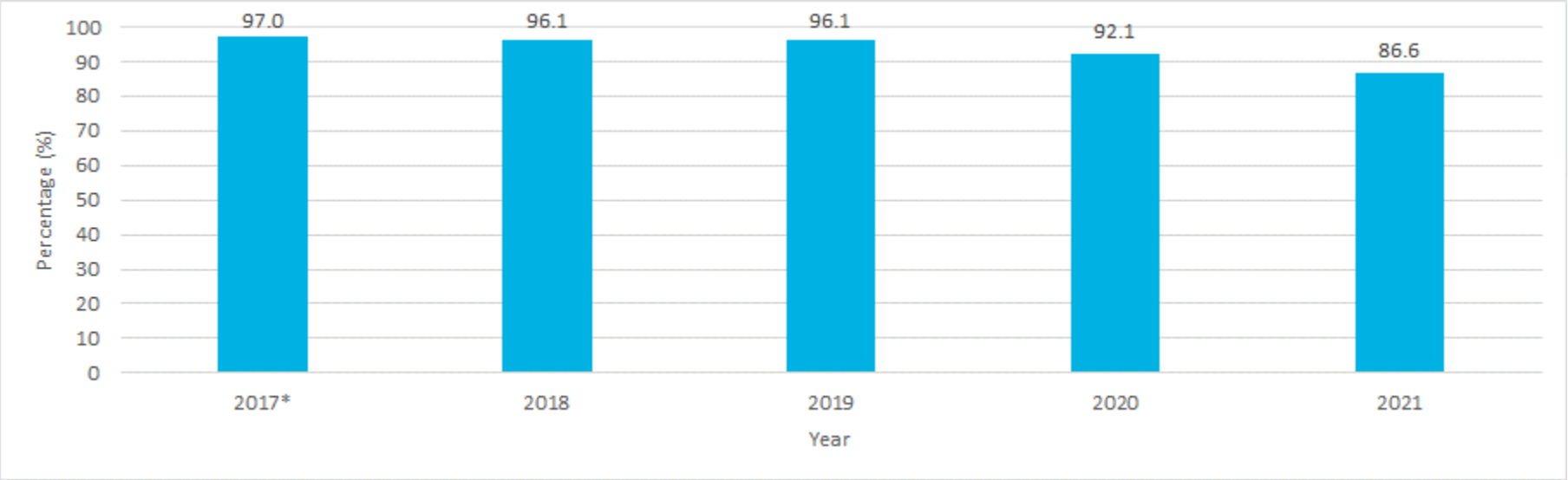
*Data began June 2017.

For data, see Table 73 in Appendix 1.

From 2018 to 2021, the percentage of people who reported that they currently smoke at baseline risk assessment was stable at 63.2% to 66.1%. The lower percentage of risk-assessed people who reported that they currently smoke in 2017 (51.2%) likely reflects the larger number of people who reported that they formerly smoked who were recruited during the first year of the Ontario Lung Cancer Screening Pilot for People at High Risk. These data suggest that a large percentage of people recruited to the OLSP could benefit from the smoking cessation services that are offered by the program.

OLSP: Coverage

Figure 84: Percentage of Screen-Eligible People, Ages 55 to 74, Who Underwent a Low-Dose Computed Tomography Scan After Risk Assessment, 2017 to 2021



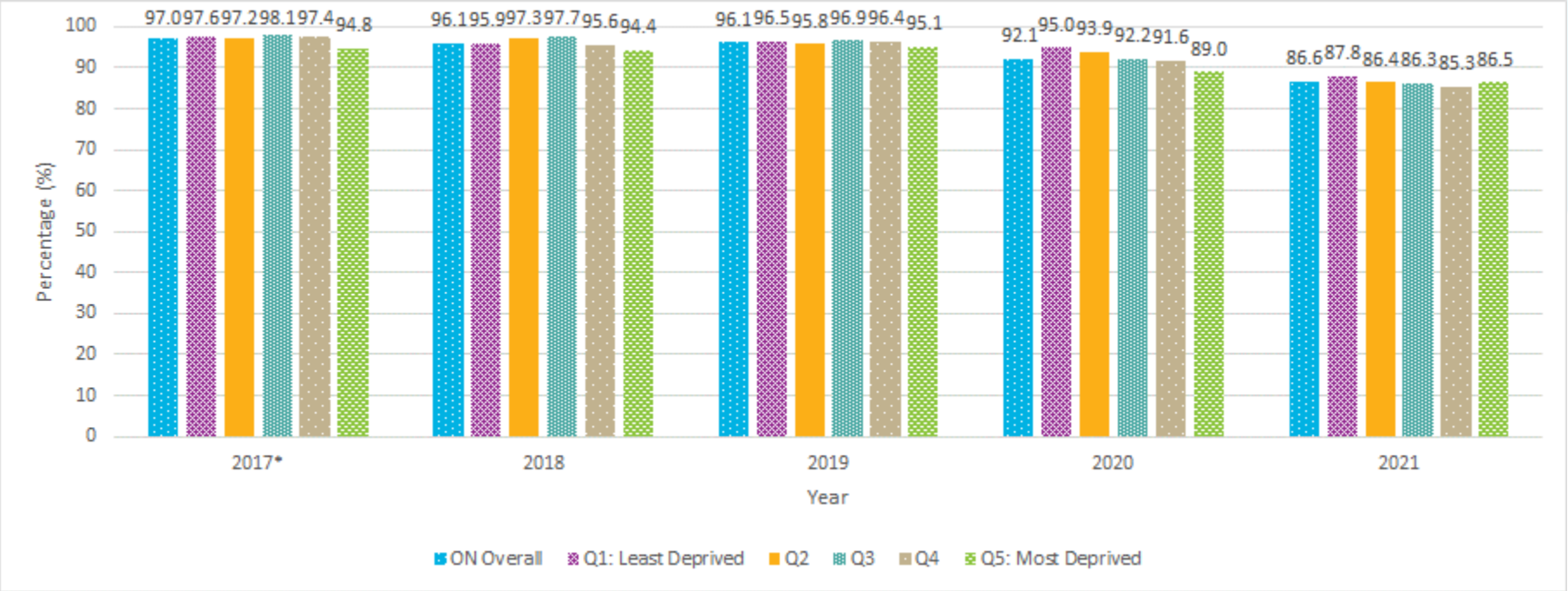
*Data began June 2017.

For data, see Table 74 in Appendix 1.

The percentage of people in Ontario who had an LDCT scan following risk assessment decreased from 97.0% in 2017 to 86.6% in 2021. This indicator was stable at around 96% to 97% from 2017 to 2019, but it decreased to 92.1% in 2020, likely due to the deferral of all cancer screening services during the first pandemic wave in Ontario. The percentage of people who had an LDCT scan after risk assessment decreased further from 2020 (92.1%) to 2021 (86.6%), most likely due to subsequent waves of the COVID-19 pandemic and the widespread health human resource challenges that exist in the Ontario health care system which may have impacted wait times for LDCT scans.

OLSP LDCT Scan After Risk Assessment - Equity Analyses: Material Deprivation

Figure 85: Percentage of Screen-Eligible People, Ages 55 to 74, Who Underwent a Low-Dose Computed Tomography Scan After Risk Assessment, by Material Deprivation, 2017 to 2021



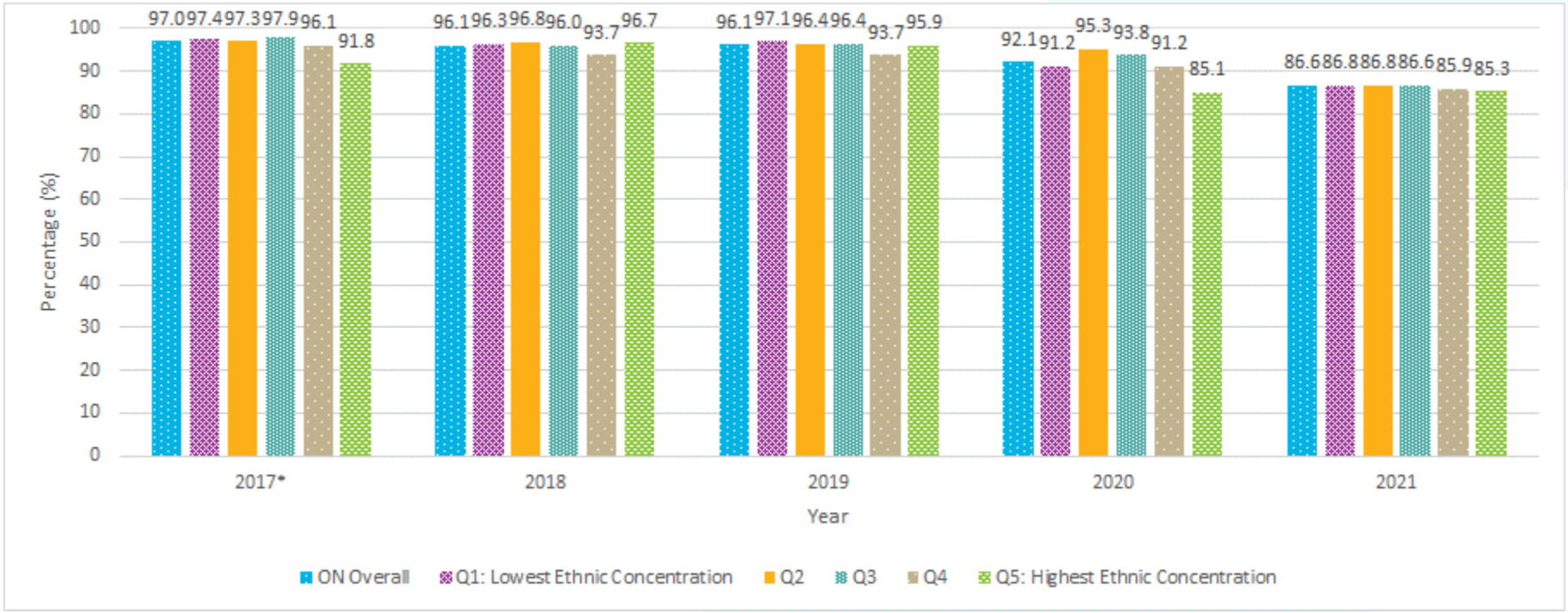
*Data began June 2017.

For data, see Table 75 in Appendix 1.

Across all reporting years, there was a relationship between material deprivation and completion of an LDCT scan after risk assessment. People living in the most materially deprived neighbourhoods (Q5) were less likely to complete an LDCT scan after risk assessment than people living in the least materially deprived neighbourhoods (Q1). The difference between the highest and lowest quintile was greatest in 2020, with 89.0% of people in the most deprived quintile completing an LDCT scan after risk assessment and 95.0% of people in the least deprived quintile completing an LDCT scan after risk assessment. The increased difference between Q1 and Q5 in 2020 may reflect health disparities that were worsened by the COVID-19 pandemic.

OLSP LDCT Scan After Risk Assessment - Equity Analyses: Ethnic Concentration

Figure 86: Percentage of Screen-Eligible People, Ages 55 to 74, Who Underwent a Low-Dose Computed Tomography Scan After Risk Assessment, by Ethnic Concentration, 2017 to 2021



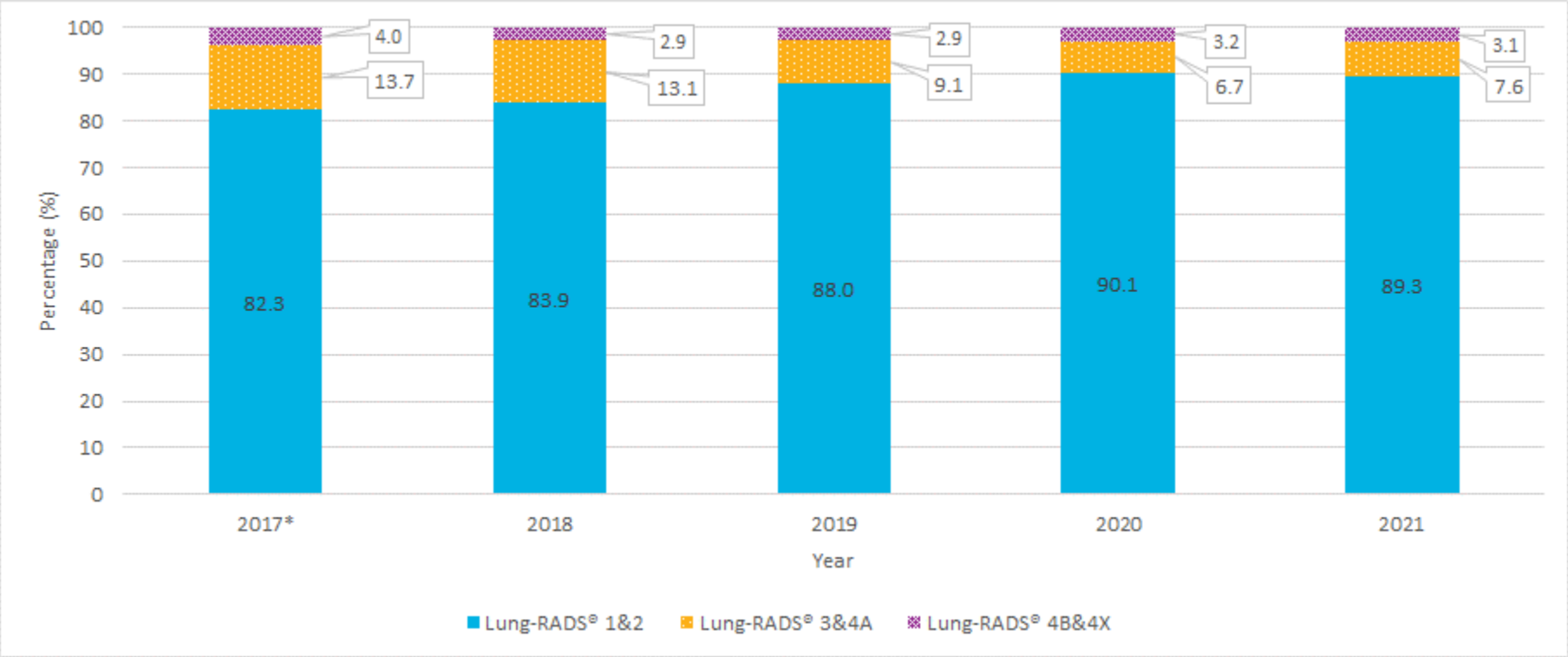
*Data began June 2017.

For data, see Table 76 in Appendix 1.

In 2017 and 2020, there was a relationship between neighbourhood ethnic concentration and LDCT scans after risk assessment, with people living in the most ethnically concentrated neighbourhoods (Q5) being less likely to complete an LDCT scan after risk assessment than people living in the least ethnically concentrated neighbourhoods (Q1). The difference between people in the most ethnically concentrated neighbourhoods and least ethnically concentrated neighbourhoods was largest in 2020, when 85.1% of people living in the highest ethnic concentration neighbourhoods completed an LDCT scan after risk assessment, compared to 91.2% of people living in the least ethnically concentrated neighbourhoods. The increased difference between Q1 and Q5 in 2020 may reflect health disparities that were worsened by the COVID-19 pandemic.

OLSP: Follow-Up of Abnormal Results

Figure 87: Low-Dose Computed Tomography Scan Lung-RADS® Score Distribution, 2017 to 2021

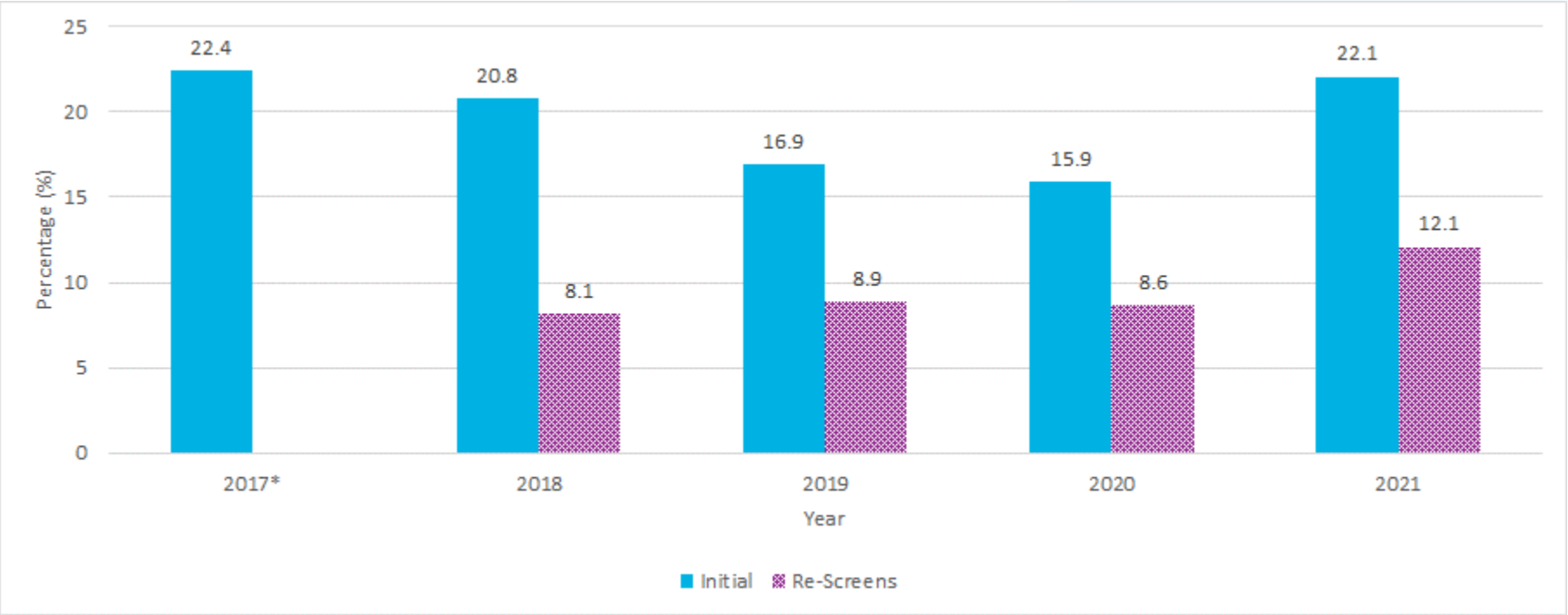


*Data began June 2017.

For data, see Table 77 in Appendix 1.

From 2017 to 2021, the percentage of LDCT scans with a Lung-RADS® score of 1 (negative) or 2 (benign) increased from 82.3% to 89.3%. Decreases were seen in the percentage of scans with a Lung-RADS® score of 3 (probably benign) or 4A (suspicious) (from 13.7% to 7.6%), as well as in the percentage of scans with a Lung-RADS® score of 4B or 4X (very suspicious) (from 4.0% in to 3.1%). These decreases over time in the percentage of scans that had abnormal findings (Lung-RADS® 3, 4A, 4B, 4X) were expected because the percentage of people having their first LDCT screen was decreasing.

Figure 88: Percentage of Low-Dose Computed Tomography Scans With Actionable Incidental Findings Detected, 2017 to 2021

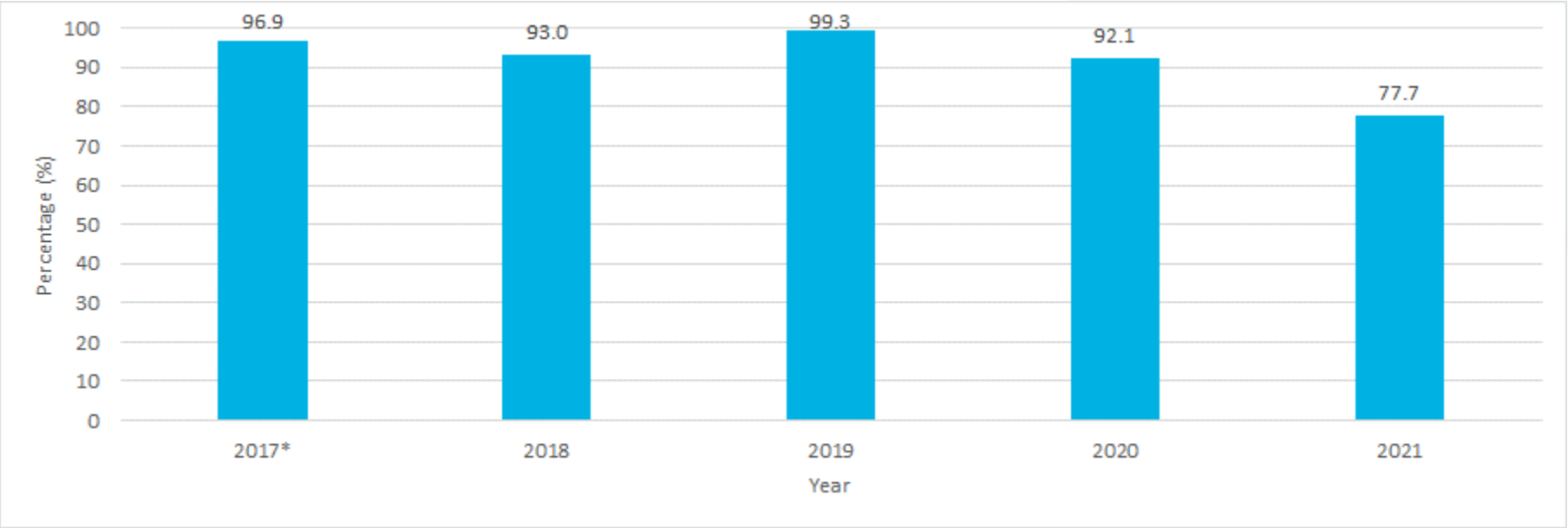


*The Lung Cancer Screening Pilot for People at High Risk began in June 2017, so no annual re-screens were performed in 2017.

For data, see Table 78 in Appendix 1.

Actionable incidental findings are findings not related to lung cancer detected on the LDCT scan and determined by the radiologist to be potentially clinically significant (e.g., an infection). From 2017 to 2021, the overall percentage of LDCT scans with actionable incidental findings decreased from 22.1% to 14.5%. This decrease may be related to radiologist experience and comfort with distinguishing clinically significant findings from those that are not clinically significant. The percentage was higher in baseline or initial scans (15.9% to 22.4%) than in follow-up scans from 2018 to 2021 (8.1% to 12.1%) because incidental findings are more likely to be identified in baseline scans. Incidental findings on re-screens remained at 8.1% to 8.9% from 2018 to 2020, before increasing in to 12.1% in 2021. The increase in incidental findings on baseline scans in 2021 coincides with the release of clinical guidelines by Ontario Health for classifying and managing actionable incidental findings in the OLSP (71).

Figure 89: Percentage of Screen-Eligible People, Ages 55 to 74, With a Suspicious or Very Suspicious Screening Result (Lung-RADS® 4A, 4B or 4X) Who Underwent Diagnostic Assessment Within 3 Months, 2017 to 2021**



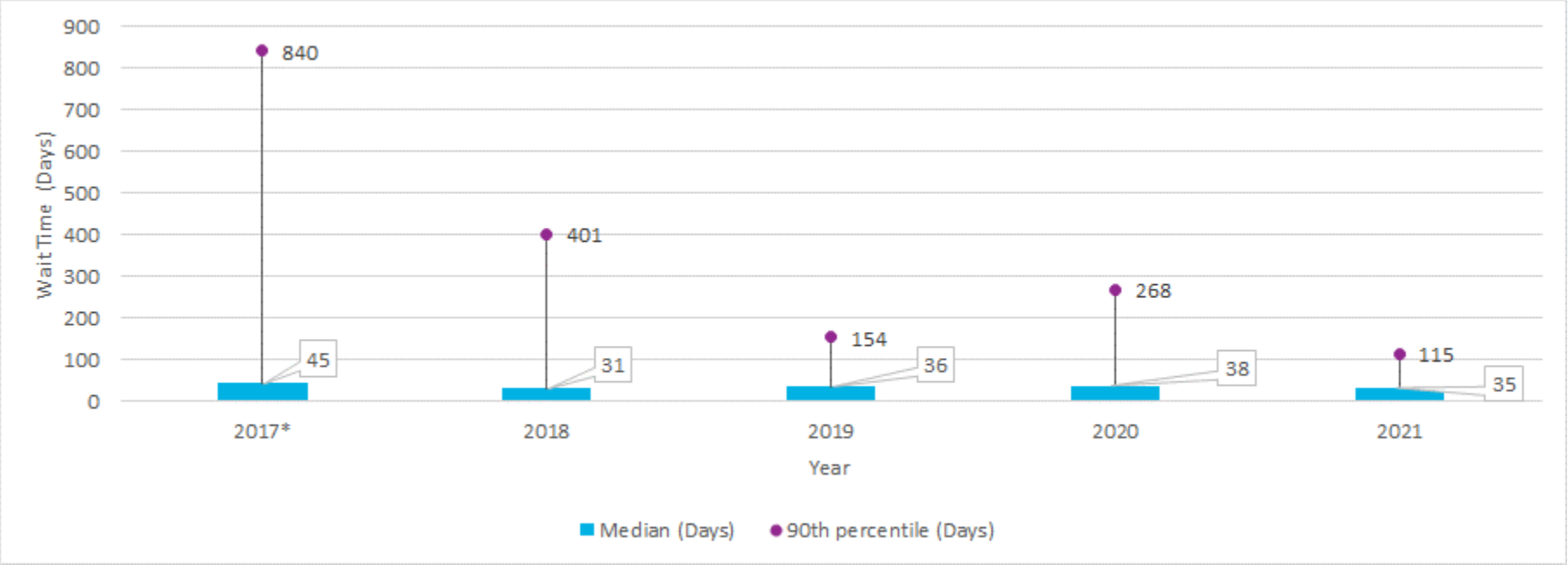
*Data began June 2017.

**Beginning on October 1, 2018, people with Lung-RADS® score of 4A were scheduled to have a 3-month surveillance low-dose computed tomography scan instead of being referred for a diagnostic assessment consult. Only people with a Lung-RADS® score of 4B or 4X were referred for diagnostic assessment on or after October 1, 2018 in alignment with the Lung-RADS® system.

For data, see Table 79 in Appendix 1.

The percentage of screen-eligible people with an LDCT scan with a Lung-RADS® score of 4A (suspicious), 4B or 4X (very suspicious) who underwent diagnostic assessment within three months of the abnormal result date decreased (worsened) from 96.9% in 2017 to 77.7% in 2021. The worsening of performance in 2020 and 2021 may be due to the COVID-19 pandemic, the widespread health human resource challenges that exist in the Ontario health care system and higher demand (i.e., increased number of people requiring assessments as the program grows), all of which may have lengthened wait times for diagnostic services. Ontario Health will continue to monitor the performance of this indicator in order to inform program quality improvements.

Figure 90: Wait Time in Days From the Date of the LDCT Scan With a Suspicious (Lung-RADS® 4A) or Very Suspicious (Lung-RADS® 4B or 4X) Result to Definitive Diagnosis of Lung Cancer, 2017 to 2021**



*Data began June 2017.

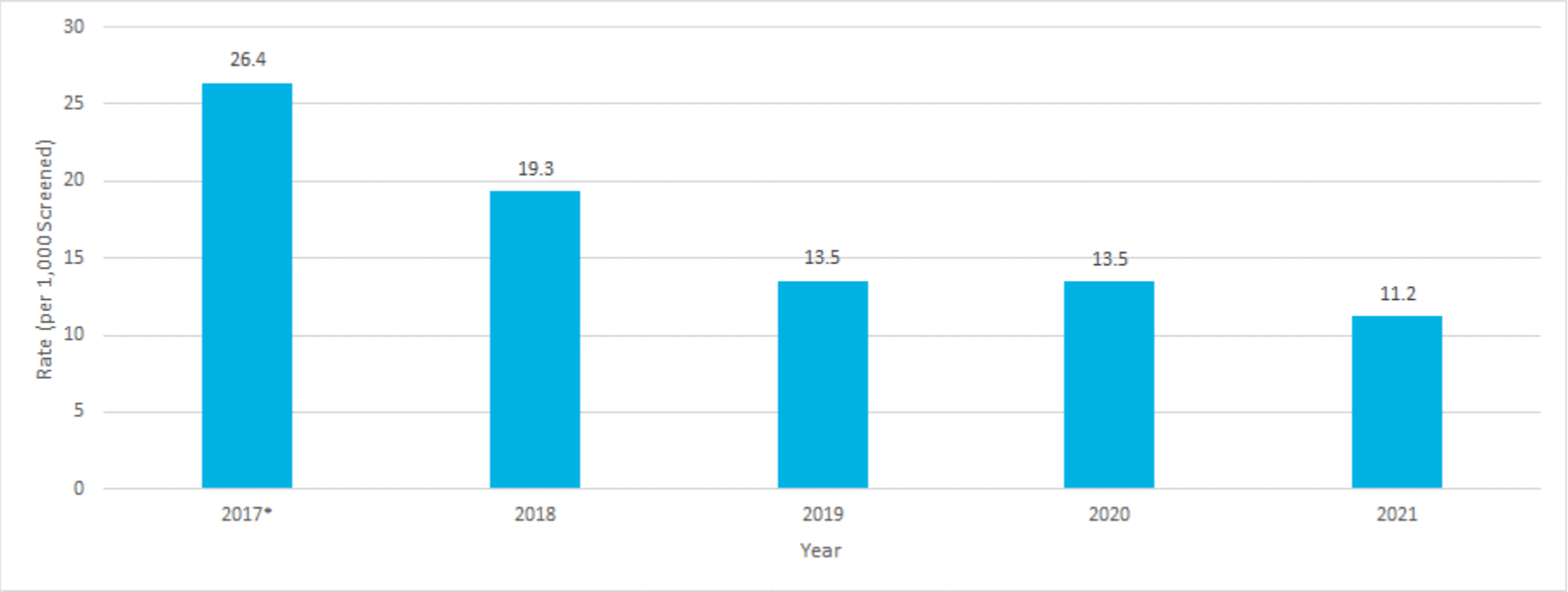
**Beginning on October 1, 2018, people with Lung-RADS® score of 4A were scheduled to have a 3-month surveillance LDCT scan instead of being referred for a diagnostic assessment consult. Only people with a Lung-RADS® score of 4B or 4X were referred for diagnostic assessment on or after October 1, 2018 in alignment with the Lung-RADS® system.

For data, see Table 80 in Appendix 1.

For people who were diagnosed with lung cancer after having an LDCT scan with a suspicious or very suspicious result, the median wait time from abnormal scan to diagnosis of lung cancer decreased (improved) from 45 days in 2017 to 35 days in 2021. This is a positive trend that suggests that most people with screen-detected lung cancer receive a timely diagnosis following an abnormal screening result. The longer 90th percentile wait time in 2020 was likely due to the impacts of the COVID-19 pandemic on wait times for diagnostic assessment services in Ontario.

OLSP: Detection

Figure 91: Number of Screen-Eligible People, Ages 55 to 74, With a Screen-Detected Invasive Lung Cancer per 1,000 People Screened, 2017 to 2021



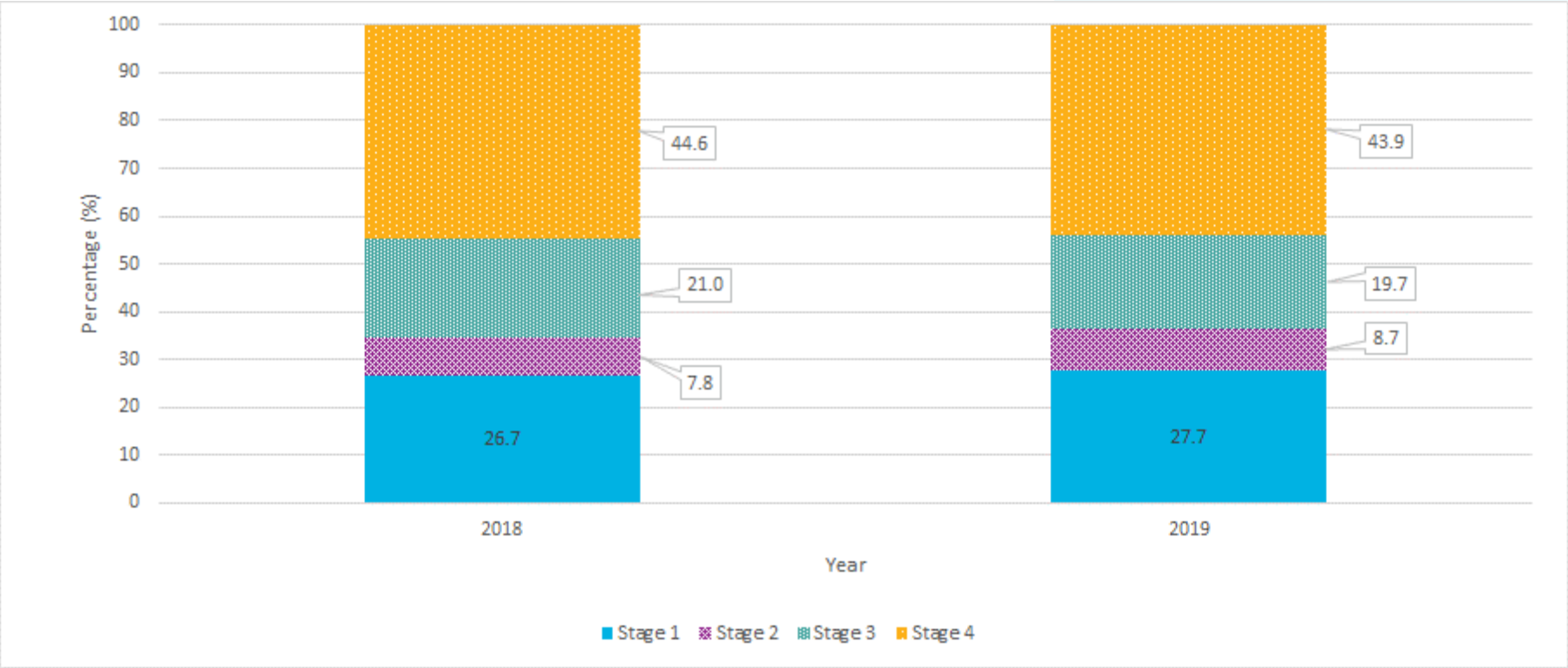
*Data began June 2017.

For data, see Table 81 in Appendix 1.

The invasive lung cancer detection rate decreased from 26.4 per 1,000 people screened in 2017 to 11.2 per 1,000 people screened in 2021. This decrease in the invasive cancer detection rate over time was expected because the percentage of people who were screened with their first LDCT scan continued to decrease. The stability in the invasive cancer detection rate seen from 2019 to 2020 is likely due to prioritizing screening services by lung cancer risk in 2020 according to Ontario Health COVID-19 pandemic guidance.

OLSP: Disease Extent at Diagnosis

Figure 92: Stage Distribution of All Invasive Lung Cancers Diagnosed in People Ages 55 to 74 in Ontario, 2018 to 2019

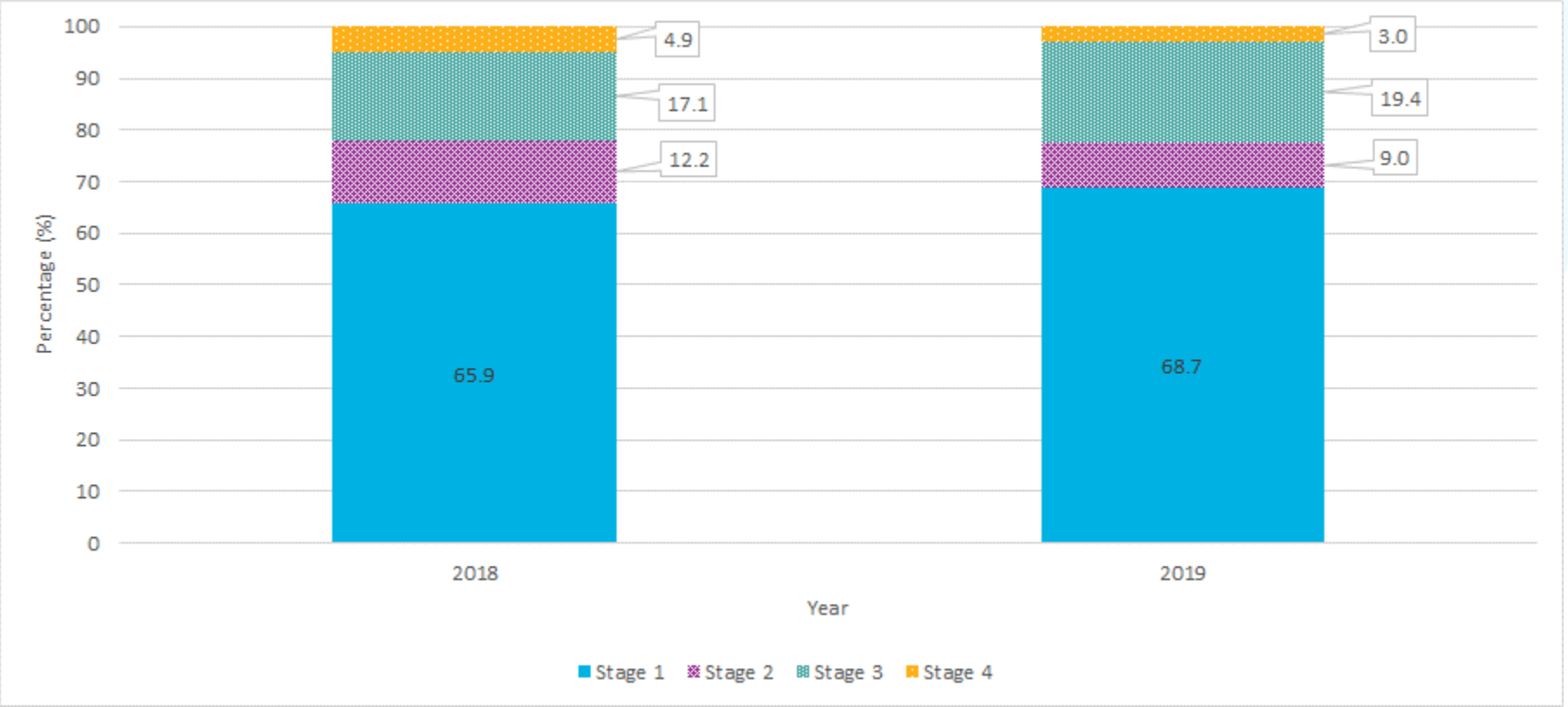


Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

For data, see Table 82 in Appendix 1.

In 2018 and 2019, most lung cancers diagnosed in Ontario in people ages 55 to 74 were advanced stage. Approximately 20% were stage 3 and approximately 44% to 45% were stage 4. Only 35% to 36% of invasive cancers were detected at stage 1 or 2 (early stages), when treatment has a better chance of working.

Figure 93: Stage Distribution of Screen-Detected Invasive Lung Cancers Diagnosed in People Ages 55 to 74 in Ontario, 2018 to 2019



Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

For data, see Table 83 in Appendix 1.

Unlike the distribution observed for all invasive lung cancers, approximately 78% of screen-detected invasive lung cancers were diagnosed at stage 1 or 2 (early stages) in 2018 and in 2019. Only 22% of screen-detected invasive lung cancers were detected at stage 3 or 4 (advanced stages). This demonstrates the effectiveness of lung cancer screening in detecting lung cancers early, when treatment has a better chance of working.

Future Directions

Future Directions

The findings of this report, along with other ongoing monitoring and evaluation efforts, will be used to refine Ontario's organized cancer screening programs so that they best meet the needs of the people of Ontario. This report highlighted many achievements in cancer screening across the province, as well as opportunities for continued improvement. For example, participation and retention rates are lower than optimal, and inequities in participation and timely follow-up were observed across the programs. The Spotlight on Cancer Screening in First Nations, Inuit, Métis and Urban Indigenous Peoples section (page 41) also highlighted disparities in cancer care and outcomes that need to be addressed through additional commitment from Ontario Health together with Indigenous partners. In addition to a commitment to addressing disparities in cancer care and outcomes in First Nations, Inuit, Métis and Urban Indigenous Peoples, Ontario Health is guided by an *Equity, Inclusion, Diversity, and Anti-Racism Framework*, the *High Priority Community Strategy* and the *Black Health Plan* in addressing the needs of underserved groups in Ontario.

This section describes a few of the initiatives that Ontario Health is undertaking to address these disparities and improve the quality of organized cancer screening in Ontario.

Expansion of the Ontario Breast Screening Program (OBSP)

In fall 2024, the OBSP will expand eligibility to include people ages 40 to 49. People will be encouraged to have a conversation with a health care provider on the risks and benefits of screening as well as their values and preferences, to determine if screening is right for them. Those who decide to screen will be able to self-refer for a mammogram and receive the benefits of organized screening.

Screening for Trans and Nonbinary People

In 2017, a suite of evidence reviews was completed to help develop a policy for breast cancer and cervical screening in trans and nonbinary people in Ontario. This evidence was evaluated by two expert working groups and a steering committee, which helped inform specific recommendations. These recommendations were published in 2019 in the *Overarching Policy for the Screening of Trans People in the Ontario Breast Screening Program and the Ontario Cervical Screening Program*. The policy has led to important program improvements, including more inclusive eligibility criteria for the Ontario Breast Screening Program. The evidence reviews are now being updated to reflect

more current evidence, which will eventually result in an update to the policy.

Future work in cancer screening will focus on further improving access to screening for trans and nonbinary people. For example, Ontario Health is working to implement gender neutral and inclusive language in all screening correspondence, evidence products, clinical guidelines, and other public and provider content. Ontario Health is also working on reviewing emerging evidence on cancer in trans and nonbinary people undergoing medical and surgical transition.

Human Papillomavirus (HPV) Testing Implementation

Like other leading cervical screening programs around the world, the Ontario Cervical Screening Program (OCSP) is planning to transition from cytology (Pap smear) to HPV testing for primary cervical screening. Almost all cervical cancers are caused by an infection with a cancer-causing type of HPV (72). The HPV test looks for the presence or absence of cancer-causing HPV and can provide information on the specific type of HPV. HPV testing is increasingly considered to be the standard of care for organized cervical screening programs because the HPV test is better at detecting cervical pre-cancers and cancers, including glandular cancers (73). In addition, unlike cytology testing, which relies on subjective interpretation of results, the HPV test is an objective test, so results are highly consistent and reproducible (74).

The OCSP will not only implement HPV testing in cervical screening, where it will be combined with reflex cytology testing (a subsequent test that is performed in people with a positive HPV test result to help determine appropriate next steps), but it will also be implemented in colposcopy. In colposcopy, HPV testing will help health care providers decide whether to discharge their patients from colposcopy and determine subsequent risk-based screening intervals.

The transition to HPV testing is a multi-year, multi-phase implementation that will involve updates to the OCSP, including new laboratory and test requirements, as well as revised screening and colposcopy recommendations (e.g., appropriate test, ages of initiation and cessation, and screening interval). There will also be changes to legislation and regulations (e.g., changes to the Schedule of Benefits for Physician Services and the Schedule of Benefits for Laboratory Services). This transition will require updates to the OSCP's information management and information technology systems to support data collection, quality reporting for facilities and providers, and participant correspondence. A comprehensive change management and education strategy will be developed to help health care providers with the transition. The OCSP anticipates launching HPV testing in 2025.

OCSP Correspondence Redesign

This initiative is linked to the planned implementation of the HPV test for primary cervical screening. Like many other province-wide screening programs in Ontario, the OCSP uses mailed letters to invite, recall and remind eligible people who are due for screening, and to communicate screening test results.

As part of the correspondence redesign, letters were developed to reflect the new screening recommendations. These letters were extensively tested and revised to meet the needs of screen-

eligible people. Letter revisions were based on feedback provided by a group of people who were diverse in terms of Indigenous identity, level of education, age, country of birth, cervical screening history, gender identity, sexual orientation and region of residence in Ontario.

Digital Correspondence

In 2019, the province of Ontario announced the *Digital First for Health* strategy (75), which sets out a path for achieving a modern and fully connected health care system. In alignment with the strategy, Ontario Health is undertaking a phased, multi-year project to design and introduce a digital cancer screening correspondence strategy. This strategy will modernize Ontario's cancer screening correspondence program and provide people who are eligible for cancer screening with more options for how they receive communications about cancer screening.

Colorectal Cancer Screening for People at Increased Risk

People with a family history of colorectal cancer that includes one or more first-degree relatives (i.e., parent, sibling or child) who have been diagnosed with the disease may be at increased risk for colorectal cancer. Since the launch of the ColonCancerCheck program in 2008, screening with colonoscopy has been recommended for people at increased risk of colorectal cancer starting at age 50, or 10 years earlier than the age of diagnosis of their youngest affected relative, whichever comes first. If their relative was diagnosed before age 60, screening with colonoscopy is recommended every five years. If their relative was diagnosed at or after age 60, screening with colonoscopy is recommended every 10 years.

The evidence base on the risk of developing colorectal cancer and appropriate screening strategies to reduce colorectal cancer related-mortality has evolved since program inception. As a result, the program convened an expert panel to review the available evidence and provide input on updating the program's screening recommendations for people in Ontario with a family history of the disease. The expert panel had representatives from gastrointestinal endoscopy, primary care, epidemiology, organized colorectal cancer screening programs in other jurisdictions, the Ontario provincial cancer system, endoscopy associations in Ontario and the general public.

In 2022, following a period of partner consultation, the ColonCancerCheck program is working towards revised recommendations and implementing the new recommendations in the future. This will include updating materials for the public, as well as developing and updating materials to support education and change management for primary care providers and endoscopists.

Sioux Lookout and Area Fecal Immunochemical Test (FIT) Kit Initiative

Following the implementation of FIT as the recommended average-risk screening test for colorectal cancer in Ontario, some communities in Ontario were experiencing barriers to access. Some of these communities are located in Sioux Lookout and

Area (a geographically remote area with a large percentage of First Nations people).

In response, Ontario Health, the Sioux Lookout First Nations Health Authority, Indigenous Services Canada, LifeLabs and the Ontario Ministry of Health launched an initiative in 2023 that delivered a tailored FIT kit distribution model to 28 Sioux Lookout and Area communities and the Municipality of Sioux Lookout. The initiative also improved access to FIT in Sioux Lookout and Area communities by implementing a solution to reduce the number of requisition rejections due to OHIP card issues. This solution was expanded beyond Sioux Lookout and Area to the rest of Ontario and has resulted in more people being screened with FIT.

The goals of this initiative are to improve access to colorectal cancer screening with FIT in Sioux Lookout and Area communities and the Municipality of Sioux Lookout, support improvements in colorectal cancer screening participation in these communities, and inform the implementation of similar strategies in other populations. A mixed methods, participatory program evaluation is being conducted to evaluate the initiative.

Personalized Breast Cancer Risk Assessment Research Project

Currently, breast screening recommendations are based primarily on age. Individualized risk assessment through a combination of genomic profiling and other breast cancer risk factors would provide more tailored screening recommendations and improve the balance of benefits and harms in breast cancer screening. A research project on breast cancer screening based on individualized risk is underway, co-led by investigators at Ontario Health and the Université Laval. The project is also partnered with researchers from other jurisdictions in Canada and internationally.

People ages 40 to 69 who have had a mammogram were recruited to the PERSPECTIVE I&I (Personalized Risk Assessment for Prevention and Early Detection of Breast Cancer: Integration and Implementation) project funded by Genome Canada and by the Canadian Institutes of Health Research (76). All eligible participants completed an entry questionnaire that asked about family history information and other lifestyle and hormonal risk factors, provided a saliva sample for genetic testing, and had breast density measured from their recent mammogram. Of the 3,753 people participating, a 10-year breast cancer risk was estimated using the CanRisk multi-factorial prediction tool (canrisk.org). Participants were estimated to be at average (79.8%), higher than average (15.7%) or high risk (4.4%), and received a screening action plan based on their risk level. Clinical care pathways were developed to support participating Ontario Breast Screening Program (OBSP) sites with study referrals.

All participants are being asked to fill out two follow-up questionnaires; one immediately after receiving their risk level and the second 12-months later to collect information on their screening behaviours and any further testing or breast cancer diagnoses. A valuable cohort is being assembled that could be followed into the future to examine long-term outcomes, including mortality. Further testing on bio-banked genetic material collected will also be possible. Evidence generated could potentially lead to a personalized approach to risk assessment and screening in the current OBSP infrastructure.

Expansion of the Ontario Lung Screening Program (OLSP)

Ontario Health is working to expand the OLSP to equitably increase access to lung cancer screening across the province. Next steps include developing expansion plans and program enhancements, as well as onboarding additional sites into the program over the next few years.

Equity-Focused Research

In addition to the research projects highlighted in the Spotlight on Cancer Screening in First Nations, Inuit, Métis and Urban Indigenous Peoples section (page 41), there are several other ongoing research projects that will generate evidence aimed at improving cancer screening for Indigenous peoples in Ontario, which are summarized below.

Canadian Institutes for Health Research Project Grant: Improving Indigenous Cultural Safety in Ontario's Cancer Screening Programs (2019 to 2024)

This research aims to improve cultural safety in the Ontario cancer screening system and create a better experience for First Nations, Inuit, Métis and urban Indigenous peoples who undergo breast, cervical and colorectal cancer screening. The research is being conducted in partnership with First Nations, Inuit, Métis and urban Indigenous communities, and is focused on three aims: 1) Improving cultural safety in the cancer system; 2) developing culturally safe communication strategies; and 3) developing shared decision-making processes for cancer screening.

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Appendix 1: Data Tables

Burden of Disease

Table 1: Age-standardized Incidence Rate of Female Breast, Colorectal, Cervical and Lung Cancer in Ontario, 2000 to 2020

Year of Diagnosis	Female Breast Cancer	Colorectal Cancer	Cervical Cancer	Lung Cancer
2000	133.4	69.7	9.4	73.4
2001	133.6	69.1	9.0	72.9
2002	137.3	66.8	8.9	69.9
2003	128.5	64.9	9.0	68.1
2004	129.8	65.9	8.6	68.7
2005	129.6	65.3	8.2	70.9
2006	128.5	64.6	8.3	68.9
2007	130.1	64.3	8.8	67.5
2008	125.4	64.9	8.3	66.1
2009	127.7	61.8	9.0	65.8
2010	130.9	61.1	9.2	69.6
2011	130.3	60.7	8.8	68.6
2012	127.5	57.9	8.2	70.4
2013	127.1	56.5	7.5	67.0
2014	130.8	55.3	7.2	66.0
2015	128.3	55.2	8.1	64.4
2016	129.6	52.6	8.2	62.9
2017	128.3	51.6	8.2	64.2
2018	131.0	49.7	8.4	62.0
2019	130.2	51.2	7.7	60.4
2020	130.4	50.6	7.6	59.3

Table 2: Age-standardized Mortality Rate for Female Breast, Colorectal, Cervical, and Lung Cancer in Ontario, 2000 to 2020

Year of Diagnosis	Female Breast Cancer	Colorectal Cancer	Cervical Cancer	Lung Cancer
2000	35.7	31.1	2.8	57.7
2001	34.1	29.6	3.0	58.9
2002	33.4	30.4	2.3	57.6
2003	32.8	28.8	2.5	55.7
2004	32.3	28.5	2.7	55.0
2005	32.0	28.8	2.5	55.0
2006	29.2	26.4	2.7	55.9
2007	29.9	26.4	2.5	53.0
2008	28.2	26.0	2.2	52.7
2009	27.3	25.1	2.0	52.1
2010	26.9	23.6	2.4	52.7
2011	26.7	24.1	2.2	50.2
2012	25.7	22.7	2.6	50.0
2013	24.5	21.5	2.0	48.3
2014	25.1	21.9	2.2	47.6
2015	24.5	21.0	2.2	46.4
2016	25.2	20.6	2.3	44.8
2017	24.9	19.7	2.0	43.8
2018	23.6	19.3	1.9	43.1
2019	23.8	19.2	2.0	41.4
2020	23.5	18.8	1.9	40.2

Ontario Breast Screening Program

Table 3: Number of Ontario Breast Screening Program (OBSP) and High Risk OBSP Screening Mammograms, by Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	53,896	47,159	61,481	61,655	64,616	58,166	61,220	57,463	58,720	67,796	64,359	49,834
2020	61,332	55,171	31,651	149	609	5,004	28,906	37,393	45,562	47,414	48,193	39,121
2021	39,058	43,106	63,003	49,289	48,133	63,790	59,013	66,526	70,292	70,689	77,085	61,418
2022	52,743	57,144	71,008	59,111	58,658	59,551	51,763	58,509	59,383	60,023	62,955	48,386

Table 4: Number of Abnormal Screening Mammograms with Breast Assessment Performed in Ontario, by Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	4,832	4,310	5,162	5,198	5,228	4,788	5,111	5,041	5,186	5,955	5,639	4,439
2020	5,394	5,078	2,650	15	59	511	2,667	3,461	4,147	4,393	4,536	3,864
2021	4,163	4,560	6,113	4,807	4,811	5,706	4,993	5,663	5,850	5,909	6,425	5,235
2022	4,649	5,191	6,351	5,511	5,453	5,754	4,928	5,457	5,530	5,807	6,054	-

Table 5: Number of High Risk OBSP Magnetic Resonance Imaging (MRIs) Performed in Ontario, by Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	940	855	1,046	1,012	990	897	1,045	979	978	1,166	1,039	895
2020	1,010	1,055	597	6	73	375	1,189	1,204	1,342	1,305	1,338	1,230
2021	1,314	1,142	1,332	822	727	903	1,065	1,157	1,297	1,273	1,358	1,160
2022	1,062	1,194	1,400	1,035	1,061	1,105	1,112	1,177	1,158	1,316	1,450	1,203

Table 6: Percentage of Ontario Screen-Eligible Women*, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period, 2012–2013 to 2020–2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2012-2013	1068574	1883705	56.8	70.0
2014-2015	1188208	2010434	59.1	70.0
2016-2017	1277441	2117238	60.2	70.0
2018-2019	1302470	2203494	58.9	70.0
2020-2021	1249532	2276219	54.7	70.0

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as “male” or “female” only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Table 7: Percentage of Screen-Eligible Women* in Ontario, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period, by Material Deprivation, 2012–2013 to 2020–2021

Year	Region	Numerator	Denominator	Percentage (%)
2012-2013	Ontario Overall	1068574	1883705	56.8
2012-2013	Q1: Least Deprived	248609	407327	61.0
2012-2013	Q2	236151	396242	59.6
2012-2013	Q3	202101	354725	57.0
2012-2013	Q4	199726	364294	54.9
2012-2013	Q5: Most Deprived	176527	349619	50.6
2014-2015	Ontario Overall	1188208	2010434	59.1
2014-2015	Q1: Least Deprived	278970	440243	63.3
2014-2015	Q2	264748	426338	62.1
2014-2015	Q3	224280	378626	59.2
2014-2015	Q4	219551	384575	57.0
2014-2015	Q5: Most Deprived	194614	368276	52.8
2016-2017	Ontario Overall	1277441	2117238	60.2
2016-2017	Q1: Least Deprived	301684	469377	64.2
2016-2017	Q2	285354	452316	63.0
2016-2017	Q3	241982	398075	60.7
2016-2017	Q4	233782	400366	58.2
2016-2017	Q5: Most Deprived	207734	384028	54.0
2018-2019	Ontario Overall	1302470	2203494	58.9
2018-2019	Q1: Least Deprived	310345	494184	62.6
2018-2019	Q2	292466	473421	61.6
2018-2019	Q3	247468	413357	59.6
2018-2019	Q4	235964	412339	56.9
2018-2019	Q5: Most Deprived	209075	396633	52.4
2020-2021	Ontario Overall	1249532	2276219	54.7
2020-2021	Q1: Least Deprived	305593	518068	58.9
2020-2021	Q2	285286	492841	57.7
2020-2021	Q3	236825	425798	55.4
2020-2021	Q4	222375	420934	52.5
2020-2021	Q5: Most Deprived	192777	404702	47.3

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as “male” or “female” only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Table 8: Percentage of Screen-Eligible Women* in Ontario, Ages 50 to 74, Who Completed at Least 1 Mammogram Within a 30-Month Period, by Ethnic Concentration, 2012–2013 to 2020–2021

Year	Region	Numerator	Denominator	Percentage (%)
2012-2013	Ontario Overall	1068574	1883705	56.8
2012-2013	Q1: Lowest Ethnic Concentration	234471	399483	58.5
2012-2013	Q2	211822	361299	58.6
2012-2013	Q3	198252	340661	58.2
2012-2013	Q4	197892	350794	56.5
2012-2013	Q5: Highest Ethnic Concentration	220677	419970	52.7
2014-2015	Ontario Overall	1188208	2010434	59.1
2014-2015	Q1: Lowest Ethnic Concentration	251794	417124	60.1
2014-2015	Q2	229480	379879	60.3
2014-2015	Q3	218440	361304	60.4
2014-2015	Q4	223918	378542	59.2
2014-2015	Q5: Highest Ethnic Concentration	258531	461209	56.1
2016-2017	Ontario Overall	1277441	2117238	60.2
2016-2017	Q1: Lowest Ethnic Concentration	263156	426321	61.3
2016-2017	Q2	242992	392547	61.6
2016-2017	Q3	233503	378285	61.6
2016-2017	Q4	243781	404492	60.3
2016-2017	Q5: Highest Ethnic Concentration	287104	502517	57.2
2018-2019	Ontario Overall	1302470	2203494	58.9
2018-2019	Q1: Lowest Ethnic Concentration	260759	427937	60.2
2018-2019	Q2	244240	399053	60.7
2018-2019	Q3	236580	390725	60.3
2018-2019	Q4	251922	428097	58.8
2018-2019	Q5: Highest Ethnic Concentration	301817	544122	55.5

Year	Region	Numerator	Denominator	Percentage (%)
2020-2021	Ontario Overall	1249532	2276219	54.7
2020-2021	Q1: Lowest Ethnic Concentration	245411	426809	56.8
2020-2021	Q2	232792	403413	57.2
2020-2021	Q3	229331	401184	56.9
2020-2021	Q4	246221	449927	54.7
2020-2021	Q5: Highest Ethnic Concentration	289101	581010	49.8

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as “male” or “female” only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Table 9: Percentage of Ontario Screen-Eligible People, Ages 50 to 74, Who Had a Subsequent Mammogram Within 30 Months of a Previous Program Mammogram, 2015 to 2019

Year	Numerator	Denominator	Percentage (%)	Target (%)
2015	437533	562342	77.8	85.0
2016	451685	584432	77.3	85.0
2017	465875	610687	76.3	85.0
2018	304554	630786	48.3	85.0
2019	386533	653448	59.2	85.0

Table 10: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Ontario Breast Screening Program Mammogram Result, 2017 to 2021

Initial Screens

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	19827	130750	15.2	10.0
2018	19642	123372	15.9	10.0
2019	19435	117162	16.6	10.0
2020	11453	64944	17.6	10.0
2021	18030	98619	18.3	10.0

Re-Screens

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	37420	514460	7.3	5.0
2018	40000	543022	7.4	5.0
2019	40971	573232	7.1	5.0
2020	24990	321797	7.8	5.0
2021	45664	594885	7.7	5.0

Table 11: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Who Were Diagnosed (Benign or Cancer) Within 6 Months of the Abnormal Screen Date, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017	56139	57274	98.0
2018	58242	59666	97.6
2019	58760	60426	97.2
2020	35328	36458	96.9
2021	61295	63717	96.2

Table 12: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Did Not Need Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 5 Weeks of the Abnormal Screen Date, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	44639	48109	92.8	90.0
2018	45495	49818	91.3	90.0
2019	45107	50075	90.1	90.0
2020	27683	30213	91.6	90.0
2021	46440	52574	88.3	90.0

Table 13: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Needed Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 7 Weeks of the Abnormal Screen Date, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	6637	8525	77.9	90.0
2018	7081	9181	77.1	90.0
2019	7244	9600	75.5	90.0
2020	4499	5757	78.1	90.0
2021	7687	10304	74.6	90.0

Table 14: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Needed a Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 7 Weeks of the Abnormal Screen Date, by Material Deprivation, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	6637	8525	77.9
2017	Q1: Least Deprived	1545	1997	77.4
2017	Q2	1439	1839	78.2
2017	Q3	1244	1599	77.8
2017	Q4	1207	1545	78.1
2017	Q5: Most Deprived	1171	1500	78.1
2018	Ontario Overall	7081	9181	77.1
2018	Q1: Least Deprived	1544	2047	75.4
2018	Q2	1599	2018	79.2
2018	Q3	1330	1739	76.5
2018	Q4	1395	1770	78.8
2018	Q5: Most Deprived	1177	1554	75.7
2019	Ontario Overall	7244	9600	75.5
2019	Q1: Least Deprived	1642	2231	73.6
2019	Q2	1672	2163	77.3
2019	Q3	1415	1866	75.8
2019	Q4	1331	1743	76.4
2019	Q5: Most Deprived	1148	1543	74.4
2020	Ontario Overall	4499	5757	78.1
2020	Q1: Least Deprived	1075	1379	78.0
2020	Q2	1036	1322	78.4

Year	Region	Numerator	Denominator	Percentage (%)
2020	Q3	856	1079	79.3
2020	Q4	779	1004	77.6
2020	Q5: Most Deprived	733	934	78.5
2021	Ontario Overall	7687	10304	74.6
2021	Q1: Least Deprived	1841	2491	73.9
2021	Q2	1777	2307	77.0
2021	Q3	1460	1963	74.4
2021	Q4	1403	1863	75.3
2021	Q5: Most Deprived	1161	1624	71.5

Table 15: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Needed a Tissue Biopsy and Were Diagnosed (Benign or Cancer) Within 7 Weeks of the Abnormal Screen Date, by Ethnic Concentration, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	6637	8525	77.9
2017	Q1: Lowest Ethnic Concentration	1351	1726	78.3
2017	Q2	1292	1635	79.0
2017	Q3	1270	1623	78.3
2017	Q4	1301	1708	76.2
2017	Q5: Highest Ethnic Concentration	1392	1788	77.9
2018	Ontario Overall	7081	9181	77.1
2018	Q1: Lowest Ethnic Concentration	1481	1840	80.5
2018	Q2	1287	1634	78.8
2018	Q3	1360	1747	77.8
2018	Q4	1375	1846	74.5
2018	Q5: Highest Ethnic Concentration	1542	2061	74.8
2019	Ontario Overall	7244	9600	75.5
2019	Q1: Lowest Ethnic Concentration	1521	1919	79.3
2019	Q2	1397	1829	76.4

Year	Region	Numerator	Denominator	Percentage (%)
2019	Q3	1376	1809	76.1
2019	Q4	1398	1887	74.1
2019	Q5: Highest Ethnic Concentration	1516	2102	72.1
2020	Ontario Overall	4499	5757	78.1
2020	Q1: Lowest Ethnic Concentration	887	1115	79.6
2020	Q2	871	1113	78.3
2020	Q3	838	1050	79.8
2020	Q4	941	1197	78.6
2020	Q5: Highest Ethnic Concentration	942	1243	75.8
2021	Ontario Overall	7687	10304	74.6
2021	Q1: Lowest Ethnic Concentration	1513	1972	76.7
2021	Q2	1493	1933	77.2
2021	Q3	1447	1970	73.5
2021	Q4	1490	2043	72.9
2021	Q5: Highest Ethnic Concentration	1699	2330	72.9

Table 16: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Ontario Breast Screening Program Mammogram Result Who Were Diagnosed With Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer) After Diagnostic Workup, 2016 to 2020

Initial Screens

Year	Numerator	Denominator	Percentage (%)	Target (%)
2016	809	18597	4.4	5.0
2017	864	19504	4.4	5.0
2018	838	19324	4.3	5.0
2019	845	19096	4.4	5.0
2020	485	11229	4.3	5.0

Re-Screens

Year	Numerator	Denominator	Percentage (%)	Target (%)
2016	2640	34390	7.7	6.0
2017	2811	37130	7.6	6.0
2018	3025	39675	7.6	6.0
2019	3322	40579	8.2	6.0
2020	1981	24741	8.0	6.0

Table 17: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Correctly Diagnosed With Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer) After an Abnormal Ontario Breast Screening Program Mammogram And Diagnostic Workup, 2016 to 2020

Year	Numerator	Denominator	Percentage (%)
2016	3363	3897	86.3
2017	3630	4248	85.5
2018	3825	4428	86.4
2019	4104	4761	86.2
2020	2434	2839	85.7

Table 18: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Without A Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer) Diagnosis Who Were Correctly Identified As Having A Normal Ontario Breast Screening Program Mammogram, 2016 to 2020

Year	Numerator	Denominator	Percentage (%)
2016	562854	612293	91.9
2017	587581	640385	91.8
2018	606392	661358	91.7
2019	629587	684944	91.9
2020	350067	383451	91.3

Table 19: Number of Screen-Eligible People in Ontario, Ages 50 to 74, With a Screen-Detected Ductal Carcinoma In Situ per 1,000 People Screened, 2016 to 2020

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2016	542	616160	0.88
2017	574	644597	0.89
2018	571	665751	0.86
2019	594	689663	0.86
2020	363	386268	0.94

Table 20: Number of Screen-Eligible People in Ontario, Ages 50 to 74, With a Screen-Detected Invasive Breast Cancer per 1,000 People Screened, 2016 to 2020

Initial Screens

Year	Numerator	Denominator	Rate (per 1,000 Screened)	Target (per 1,000 Screened)
2016	653	125026	5.2	5.0
2017	727	130427	5.6	5.0
2018	696	123054	5.7	5.0
2019	723	116823	6.2	5.0
2020	411	64720	6.4	5.0

Re-Screens

Year	Numerator	Denominator	Rate (per 1,000 Screened)	Target (per 1,000 Screened)
2016	2175	491134	4.4	3.0
2017	2339	514170	4.5	3.0
2018	2569	542697	4.7	3.0
2019	2802	572840	4.9	3.0
2020	1667	321548	5.2	3.0

Table 21: Stage Distribution of All Invasive Breast Cancers Diagnosed in Ontario, Ages 50 to 74, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	4708	6252	75.3
2018	Stage 2	869	6252	13.9
2018	Stage 3	389	6252	6.2
2018	Stage 4	286	6252	4.6
2019	Stage 1	4811	6422	74.9
2019	Stage 2	938	6422	14.6
2019	Stage 3	402	6422	6.3
2019	Stage 4	271	6422	4.2

Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

Table 22: Stage Distribution of Screen-Detected Invasive Breast Cancers Diagnosed in Ontario, Ages 50 to 74, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	2667	3080	86.6
2018	Stage 2	300	3080	9.7
2018	Stage 3	80	3080	2.6
2018	Stage 4	33	3080	1.1
2019	Stage 1	2878	3306	87.1
2019	Stage 2	320	3306	9.7
2019	Stage 3	80	3306	2.4
2019	Stage 4	28	3306	0.8

Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

High Risk OBSP

Table 23: Percentage of People in Ontario, Ages 30 to 69, Screened With Magnetic Resonance Imaging or Ultrasound Within 90 Days of Confirmation of Eligibility for the High Risk Ontario Breast Screening Program, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	991	1947	50.9	90.0
2018	1164	1994	58.4	90.0
2019	1297	2010	64.5	90.0
2020	733	1587	46.2	90.0
2021	1192	1862	64.0	90.0

Table 24: Percentage of People in Ontario, Ages 30 to 68, Who Had a Subsequent High Risk Ontario Breast Screening Program (OBSP) Screen (i.e., Breast Magnetic Resonance Imaging or Ultrasound) Within 15 Months of a Previous High Risk OBSP Screen, 2016 to 2020

Year	Numerator	Denominator	Percentage (%)
2016	5726	7640	74.9
2017	7133	9263	77.0
2018	8176	10555	77.5
2019	6367	11943	53.3
2020	8616	11211	76.9

Table 25: Percentage of People in Ontario, Ages 30 to 68, Who Had a Subsequent High Risk Ontario Breast Screening Program (OBSP) Screen (i.e., Breast Magnetic Resonance Imaging or Ultrasound) Within 15 Months of a Previous High Risk OBSP Screen, by Material Deprivation, 2016 to 2020

Year	Region	Numerator	Denominator	Percentage (%)
2016	Ontario Overall	5726	7640	74.9
2016	Q1: Least Deprived	1951	2612	74.7
2016	Q2	1409	1861	75.7
2016	Q3	1002	1333	75.2
2016	Q4	772	1043	74.0
2016	Q5: Most Deprived	576	768	75.0
2017	Ontario Overall	7133	9263	77.0
2017	Q1: Least Deprived	2439	3206	76.1
2017	Q2	1783	2282	78.1
2017	Q3	1242	1596	77.8
2017	Q4	960	1241	77.4

Year	Region	Numerator	Denominator	Percentage (%)
2017	Q5: Most Deprived	688	910	75.6
2018	Ontario Overall	8176	10555	77.5
2018	Q1: Least Deprived	2808	3612	77.7
2018	Q2	2069	2607	79.4
2018	Q3	1388	1796	77.3
2018	Q4	1076	1451	74.2
2018	Q5: Most Deprived	813	1058	76.8
2019	Ontario Overall	6367	11943	53.3
2019	Q1: Least Deprived	2281	4095	55.7
2019	Q2	1625	3004	54.1
2019	Q3	1031	2032	50.7
2019	Q4	820	1592	51.5
2019	Q5: Most Deprived	596	1189	50.1
2020	Ontario Overall	8616	11211	76.9
2020	Q1: Least Deprived	2985	3873	77.1
2020	Q2	2205	2834	77.8
2020	Q3	1463	1909	76.6
2020	Q4	1136	1480	76.8
2020	Q5: Most Deprived	805	1084	74.3

Table 26: Percentage of People in Ontario, Ages 30 to 68, Who Had a Subsequent High Risk Ontario Breast Screening Program (OBSP) Screen (i.e., Breast Magnetic Resonance Imaging or Ultrasound) Within 15 Months of a Previous High Risk OBSP Screen, by Ethnic Concentration, 2016 to 2020

Year	Region	Numerator	Denominator	Percentage (%)
2016	Ontario Overall	5726	7640	74.9
2016	Q1: Lowest Ethnic Concentration	747	1036	72.1
2016	Q2	983	1337	73.5
2016	Q3	1229	1665	73.8
2016	Q4	1542	2035	75.8
2016	Q5: Highest Ethnic Concentration	1209	1544	78.3
2017	Ontario Overall	7133	9263	77.0

Year	Region	Numerator	Denominator	Percentage (%)
2017	Q1: Lowest Ethnic Concentration	873	1167	74.8
2017	Q2	1188	1601	74.2
2017	Q3	1570	2031	77.3
2017	Q4	1936	2493	77.7
2017	Q5: Highest Ethnic Concentration	1545	1943	79.5
2018	Ontario Overall	8176	10555	77.5
2018	Q1: Lowest Ethnic Concentration	1014	1341	75.6
2018	Q2	1390	1792	77.6
2018	Q3	1773	2292	77.4
2018	Q4	2192	2828	77.5
2018	Q5: Highest Ethnic Concentration	1785	2271	78.6
2019	Ontario Overall	6367	11943	53.3
2019	Q1: Lowest Ethnic Concentration	780	1541	50.6
2019	Q2	1071	2075	51.6
2019	Q3	1368	2575	53.1
2019	Q4	1773	3245	54.6
2019	Q5: Highest Ethnic Concentration	1361	2476	55.0
2020	Ontario Overall	8616	11211	76.9
2020	Q1: Lowest Ethnic Concentration	1131	1469	77.0
2020	Q2	1503	1959	76.7
2020	Q3	1887	2433	77.6
2020	Q4	2287	2987	76.6
2020	Q5: Highest Ethnic Concentration	1786	2332	76.6

Table 27: Percentage of People in Ontario, Ages 30 to 69, Screened in the High Risk Ontario Breast Screening Program With an Abnormal Screening Result, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017	1891	9593	19.7
2018	2027	10876	18.6
2019	2329	12339	18.9
2020	2220	11475	19.3
2021	2701	14084	19.2

Table 28: Percentage of People in Ontario, Ages 30 to 69, With an Abnormal High Risk OBSP Screening Result Who Were Diagnosed With Breast Cancer (Ductal Carcinoma In Situ or Invasive Breast Cancer), 2016 to 2020

Year	Numerator	Denominator	Percentage (%)
2016	104	1579	6.6
2017	131	1876	7.0
2018	107	2006	5.3
2019	116	2304	5.0
2020	137	2200	6.2

Note: This indicator is presented as a combined value for initial screens and re-screens.

Table 29: Number of People in Ontario, Ages 30 to 69, With Ductal Carcinoma In Situ per 1,000 People Screened in the High Risk Ontario Breast Screening Program, 2016 to 2020

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2016	29	7948	3.6
2017	31	9578	3.2
2018	23	10856	2.1
2019	30	12315	2.4
2020	31	11456	2.7

Table 30: Number of People in Ontario, Ages 30 to 69, With Invasive Breast Cancer per 1,000 People Screened in the High Risk Ontario Breast Screening Program, 2016 to 2020

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2016	70	7948	8.8
2017	95	9578	9.9
2018	DS	DS	7.6
2019	DS	DS	6.7
2020	97	11456	8.5

DS: Data suppressed to prevent disclosure of small cell counts for stage distribution.

Table 31: Stage Distribution of Screen-Detected Invasive Breast Cancers Among People Ages 30 to 69 in The High Risk Ontario Breast Screening Program, by Stage at Diagnosis, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	LV	LV	95.1
2018	Stage 2	LV	LV	1.2
2018	Stage 3	LV	LV	2.5
2018	Stage 4	LV	LV	1.2
2019	Stage 1	LV	LV	89.6
2019	Stage 2	LV	LV	6.5
2019	Stage 3	LV	LV	2.6
2019	Stage 4	LV	LV	1.3

Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.
LV: Low volume, data suppressed

Ontario Cervical Screening Program

Table 32: Number of Cervical Cytology Tests Performed in Ontario, Ages 21 to 69, by Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	75,635	68,915	86,964	85,598	84,308	78,001	81,808	71,363	73,082	82,818	77,596	64,195
2020	72,328	70,242	45,943	6,622	12,045	25,317	41,886	48,601	60,181	65,046	63,623	51,213
2021	44,876	52,013	77,403	59,195	58,557	70,344	68,103	69,529	81,207	100,133	98,027	85,322
2022	74,291	84,652	109,388	100,143	97,771	113,204	79,440	88,797	83,465	87,535	92,254	72,478

Note: These data are for cervical cytology tests performed in community labs only. Some of the cervical cytology tests may not be Ontario Cervical Screening Program screening tests and are done during colposcopy. Data for 2022 may be incomplete due to testing and reporting delays.

Table 33: Number of Colposcopy Procedures Performed in Ontario, Ages 21 to 69, by Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	9,019	7,489	8,509	9,271	9,420	8,506	8,256	7,374	8,492	9,945	8,933	7,803
2020	9,411	8,250	5,625	2,330	3,525	5,981	6,788	7,061	8,561	8,469	8,421	6,952
2021	7,973	7,301	8,546	7,000	6,652	7,847	6,627	6,723	7,834	7,445	8,148	6,214
2022	6,332	7,093	8,312	7,166	7,967	7,724	6,127	6,835	7,545	7,972	8,360	6,560

Table 34: Number of Cervical Cancers and Pre-Cancers (Combined) in Ontario, Ages 21 to 69, by Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	540	465	469	494	387	364	367	382	406	467	413	356
2020	423	385	276	167	173	229	270	273	347	335	422	334
2021	366	296	394	312	341	406	301	339	334	333	383	292
2022	331	406	411	364	352	348	258	310	308	298	323	-

Table 35: Percentage of Screen-Eligible Women* in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period by Age Group, 2007–2009 to 2019–2021

Year	Age group	Numerator	Denominator	Percentage (%)	Target (%)
2007-2009	Ages 21-24	222260	336274	66.1	80.0
2007-2009	Ages 25-69	2512448	3735151	67.3	80.0
2007-2009	Ages 21-69	2734708	4071425	66.6	80.0
2010-2012	Ages 21-24	220481	355025	62.1	80.0
2010-2012	Ages 25-69	2553248	3828364	66.7	80.0
2010-2012	Ages 21-69	2773729	4183389	66.0	80.0
2013-2015	Ages 21-24	191454	371235	51.6	80.0
2013-2015	Ages 25-69	2442857	3959396	61.7	80.0
2013-2015	Ages 21-69	2634311	4330631	60.8	80.0
2016-2018	Ages 21-24	190167	381598	49.8	80.0
2016-2018	Ages 25-69	2533593	4140283	61.2	80.0
2016-2018	Ages 21-69	2723760	4521881	60.4	80.0
2019-2021	Ages 21-24	153283	387775	39.5	80.0
2019-2021	Ages 25-69	2407420	4329911	55.6	80.0
2019-2021	Ages 21-69	2560703	4717686	54.5	80.0

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data that defines sex as “male” or “female” only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Table 36: Percentage of Screen-Eligible Women* in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period, by Material Deprivation, 2007–2009 to 2019–2021

Year	Region	Numerator	Denominator	Percentage (%)
2007-2009	Ontario Overall	2734708	4071425	66.6
2007-2009	Q1: Least Deprived	618143	844705	72.5
2007-2009	Q2	599815	844642	70.4
2007-2009	Q3	512003	758570	67.0
2007-2009	Q4	502767	787472	63.5
2007-2009	Q5: Most Deprived	487486	811919	59.4
2010-2012	Ontario Overall	2773729	4183389	66.0
2010-2012	Q1: Least Deprived	625318	873914	71.2
2010-2012	Q2	600687	862147	69.3
2010-2012	Q3	516780	776164	66.3

Year	Region	Numerator	Denominator	Percentage (%)
2010-2012	Q4	511160	805202	63.3
2010-2012	Q5: Most Deprived	504306	840892	59.4
2013-2015	Ontario Overall	2634311	4330631	60.8
2013-2015	Q1: Least Deprived	615559	941298	65.3
2013-2015	Q2	573509	900313	63.6
2013-2015	Q3	488011	800055	61.0
2013-2015	Q4	476070	815452	58.5
2013-2015	Q5: Most Deprived	466111	846857	55.0
2016-2018	Ontario Overall	2723760	4521881	60.4
2016-2018	Q1: Least Deprived	668222	1032642	64.8
2016-2018	Q2	600865	949165	63.4
2016-2018	Q3	500377	828976	60.5
2016-2018	Q4	478331	829125	57.9
2016-2018	Q5: Most Deprived	460611	853749	54.1
2019-2021	Ontario Overall	2560703	4717686	54.5
2019-2021	Q1: Least Deprived	654962	1110043	59.1
2019-2021	Q2	570674	994498	57.5
2019-2021	Q3	467701	861371	54.5
2019-2021	Q4	438956	853236	51.7
2019-2021	Q5: Most Deprived	413832	869089	47.8

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data and defines sex as “male” or “female” only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Table 37: Percentage of Screen-Eligible Women in Ontario, Ages 21 to 69, Who Had at Least 1 Cervical Cytology Test Within a 42-Month Period, by Ethnic Concentration, 2007–2009 to 2019–2021

Year	Region	Numerator	Denominator	Percentage (%)
2007-2009	Ontario Overall	2734708	4071425	66.6
2007-2009	Q1: Lowest Ethnic Concentration	419351	629463	67.6
2007-2009	Q2	466062	674072	69.3
2007-2009	Q3	511683	731338	69.6
2007-2009	Q4	593779	861415	68.0
2007-2009	Q5: Highest Ethnic Concentration	729339	1151020	62.1

Year	Region	Numerator	Denominator	Percentage (%)
2010-2012	Ontario Overall	2773729	4183389	66.0
2010-2012	Q1: Lowest Ethnic Concentration	409598	613407	67.6
2010-2012	Q2	456953	665918	68.8
2010-2012	Q3	507404	734861	68.8
2010-2012	Q4	602813	890762	67.1
2010-2012	Q5: Highest Ethnic Concentration	781483	1253371	61.4
2013-2015	Ontario Overall	2634311	4330631	60.8
2013-2015	Q1: Lowest Ethnic Concentration	382757	616482	62.7
2013-2015	Q2	423703	669306	63.6
2013-2015	Q3	473142	747586	63.3
2013-2015	Q4	573616	928692	61.6
2013-2015	Q5: Highest Ethnic Concentration	766042	1341909	56.8
2016-2018	Ontario Overall	2723760	4521881	60.4
2016-2018	Q1: Lowest Ethnic Concentration	396432	627898	63.6
2016-2018	Q2	434581	682669	63.9
2016-2018	Q3	487374	773107	63.2
2016-2018	Q4	598804	980456	61.1
2016-2018	Q5: Highest Ethnic Concentration	791215	1429527	55.4
2019-2021	Ontario Overall	2560703	4717686	54.5
2019-2021	Q1: Lowest Ethnic Concentration	374014	639606	58.8
2019-2021	Q2	409133	698350	58.8
2019-2021	Q3	460375	799437	57.7
2019-2021	Q4	570050	1034829	55.2
2019-2021	Q5: Highest Ethnic Concentration	732553	1516015	48.6

* The screen-eligible population for this indicator is calculated using Ontario Health Insurance Plan data and defines sex as “male” or “female” only. This binary-only definition is a limitation of the data; defining sex in this way is not inclusive of all gender diversity (e.g., trans, nonbinary and Two-Spirit people) and may result in the exclusion of some people who are eligible for breast screening, as well as the inclusion of some people who are not eligible for screening.

Table 38: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, Who Had a Subsequent Cervical Cytology Test Within 42 Months of a Normal Cytology Test Result, 2014 to 2018

Year	Numerator	Denominator	Percentage (%)
2014	445510	739164	60.3
2015	556142	893922	62.2
2016	443754	761230	58.3
2017	271537	723336	37.5
2018	380679	821768	46.3

Table 39: Distribution of Abnormal Cervical Cytology Results, 2017 to 2021

Year	Cytology Result	Numerator	Denominator	Percentage (%)
2017	Abnormal (Low-grade)	40088	46752	85.7
2017	Abnormal (High-grade)	6664	46752	14.3
2018	Abnormal (Low-grade)	41159	48071	85.6
2018	Abnormal (High-grade)	6912	48071	14.4
2019	Abnormal (Low-grade)	39549	46087	85.8
2019	Abnormal (High-grade)	6538	46087	14.2
2020	Abnormal (Low-grade)	27804	32345	86.0
2020	Abnormal (High-grade)	4541	32345	14.0
2021	Abnormal (Low-grade)	33941	40054	84.7
2021	Abnormal (High-grade)	6113	40054	15.3

Table 40: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With a High-Grade Cervical Cytology Result Who Did Not Undergo Colposcopy or Definitive Treatment Within 6 Months of the High-Grade Abnormal Result, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	844	6276	13.4	10.0
2018	871	6630	13.1	10.0
2019	916	6236	14.7	10.0
2020	578	4164	13.9	10.0
2021	714	5322	13.4	10.0

Table 41: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With a High-Grade Abnormal Cervical Cytology Test Result Who Did Not Undergo Colposcopy or Definitive Treatment Within 6 Months of the High-Grade Abnormal Result, By Material Deprivation, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	844	6276	13.4
2017	Q1: Least Deprived	139	1313	10.6
2017	Q2	147	1259	11.7
2017	Q3	142	1061	13.4
2017	Q4	178	1199	14.8
2017	Q5: Most Deprived	219	1386	15.8
2018	Ontario Overall	871	6630	13.1
2018	Q1: Least Deprived	156	1436	10.9
2018	Q2	169	1345	12.6
2018	Q3	145	1187	12.2
2018	Q4	167	1227	13.6
2018	Q5: Most Deprived	216	1375	15.7
2019	Ontario Overall	916	6236	14.7
2019	Q1: Least Deprived	138	1384	10.0
2019	Q2	226	1280	17.7
2019	Q3	160	1095	14.6
2019	Q4	181	1162	15.6
2019	Q5: Most Deprived	198	1261	15.7
2020	Ontario Overall	578	4164	13.9
2020	Q1: Least Deprived	112	902	12.4
2020	Q2	87	844	10.3
2020	Q3	98	730	13.4
2020	Q4	119	822	14.5
2020	Q5: Most Deprived	153	840	18.2
2021	Ontario Overall	714	5322	13.4
2021	Q1: Least Deprived	138	1218	11.3
2021	Q2	148	1109	13.3
2021	Q3	122	903	13.5
2021	Q4	131	976	13.4
2021	Q5: Most Deprived	163	1072	15.2

Table 42: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With a High-Grade Cervical Cytology Test Result Who Did Not Undergo Colposcopy or Definitive Treatment Within 6 Months of the High-Grade Abnormal Result, by Ethnic Concentration, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	844	6276	13.4
2017	Q1: Lowest Ethnic Concentration	141	1003	14.1
2017	Q2	145	1108	13.1
2017	Q3	153	1197	12.8
2017	Q4	152	1362	11.2
2017	Q5: Highest Ethnic Concentration	234	1548	15.1
2018	Ontario Overall	871	6630	13.1
2018	Q1: Lowest Ethnic Concentration	135	1068	12.6
2018	Q2	146	1166	12.5
2018	Q3	156	1252	12.5
2018	Q4	174	1499	11.6
2018	Q5: Highest Ethnic Concentration	242	1585	15.3
2019	Ontario Overall	916	6236	14.7
2019	Q1: Lowest Ethnic Concentration	152	972	15.6
2019	Q2	157	1111	14.1
2019	Q3	171	1240	13.8
2019	Q4	171	1385	12.3
2019	Q5: Highest Ethnic Concentration	252	1474	17.1
2020	Ontario Overall	578	4164	13.9
2020	Q1: Lowest Ethnic Concentration	106	724	14.6
2020	Q2	108	766	14.1
2020	Q3	100	776	12.9
2020	Q4	116	925	12.5
2020	Q5: Highest Ethnic Concentration	139	947	14.7

Year	Region	Numerator	Denominator	Percentage (%)
2021	Ontario Overall	714	5322	13.4
2021	Q1: Lowest Ethnic Concentration	124	904	13.7
2021	Q2	116	925	12.5
2021	Q3	129	1032	12.5
2021	Q4	166	1177	14.1
2021	Q5: Highest Ethnic Concentration	167	1240	13.5

Table 43: Wait Time (in Days) for Screen-Eligible People in Ontario, Ages 21 to 69, From High-Grade Cervical Cytology Test Result to Colposcopy, 2017 to 2021

Calendar year	Number of People	Median (Days)	90th Percentile (Days)
2017	5613	56	167
2018	6017	62	176
2019	5626	61	184
2020	4176	57	201
2021	4669	56	166

Table 44: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, With an Abnormal Cervical Cytology Test Result Who Were Diagnosed With an Invasive Cervical Cancer or Pre-Cancer After a Follow-Up Colposcopy or Surgical Procedure Involving the Cervix, 2016 to 2020

Pre-cancer (In-situ)

Year	Numerator	Denominator	Percentage (%)
2016	2302	42514	5.4
2017	2401	42117	5.7
2018	2543	43326	5.9
2019	1881	41397	4.5
2020	1218	28109	4.3

Invasive Cancer

Year	Numerator	Denominator	Percentage (%)
2016	117	42514	0.3
2017	130	42117	0.3
2018	DS	DS	0.3
2019	DS	DS	0.3
2020	113	28109	0.4

DS: Data suppressed to prevent disclosure of small cell counts for stage distribution.

Table 45: Percentage of Screen-Eligible People in Ontario, Ages 21 to 69, Who Were Diagnosed With Invasive Cervical Cancer, by History of Cervical Screening With Cytology, 2017 to 2019

Time Since Last Cytology Test (Years)	Numerator	Denominator	Percentage (%)
>2 to 3	404	2985	13.5
>3 to 5	848	2985	28.4
>5 to 10	674	2985	22.6
No Previous Cytology Test Within 10 Years	1059	2985	35.5

Table 46: Number of Screen-Eligible People in Ontario, Ages 21 to 69, With a Screen-Detected Pre-Cancer (In Situ) or Invasive Cervical Cancer, per 1,000 People Screened, 2016 to 2020

Pre-cancer (In-situ)

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2016	2302	820565	2.81
2017	2401	783301	3.07
2018	2543	889261	2.86
2019	1881	849778	2.21
2020	1218	508862	2.39

Invasive Cancer

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2016	117	820565	0.14
2017	130	783301	0.17
2018	138	889261	0.16
2019	119	849778	0.14
2020	113	508862	0.22

Table 47: Stage Distribution of All Invasive Cervical Cancers Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	306	531	63.5
2018	Stage 2	106	531	22.0
2018	Stage 3	39	531	8.1
2018	Stage 4	31	531	6.4
2019	Stage 1	335	506	66.2
2019	Stage 2	87	506	17.2
2019	Stage 3	30	506	5.9
2019	Stage 4	54	506	10.7

Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

Table 48: Stage Distribution of Screen-Detected Invasive Cervical Cancers Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	LV	LV	84.8
2018	Stage 2	LV	LV	12.3
2018	Stage 3	LV	LV	1.8
2018	Stage 4	LV	LV	1.2
2019	Stage 1	LV	LV	86.7
2019	Stage 2	LV	LV	8.2
2019	Stage 3	LV	LV	1.3
2019	Stage 4	LV	LV	3.8

LV: Low volume, data suppressed

Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

Table 49: Stage 1 Sub-Stage Distribution for All Invasive Cervical Cancers in People Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1 (Non-substaged)	14	306	4.4
2018	Stage 1A (Non-substaged)	12	306	3.8
2018	Stage 1A1	110	306	35.3
2018	Stage 1A2	18	306	5.7
2018	Stage 1B	152	306	50.8
2019	Stage 1 (Non-substaged)	10	335	3.1
2019	Stage 1A (Non-substaged)	11	335	3.1
2019	Stage 1A1	118	335	34.3
2019	Stage 1A2	25	335	7.2
2019	Stage 1B	171	335	52.4

Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

Table 50: Stage 1 Sub-Stage Distribution for Screen-Detected Invasive Cervical Cancers in People Diagnosed in Ontario, Ages 21 to 69, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1 (Non-substaged)	LV	LV	4.1
2018	Stage 1A (Non-substaged)	LV	LV	3.4
2018	Stage 1A1	LV	LV	44.1
2018	Stage 1A2	LV	LV	5.5
2018	Stage 1B	LV	LV	42.8
2019	Stage 1 (Non-substaged)	LV	LV	2.2
2019	Stage 1A (Non-substaged)	LV	LV	2.9
2019	Stage 1A1	LV	LV	43.8
2019	Stage 1A2	LV	LV	9.5
2019	Stage 1B	LV	LV	41.6

LV: Low volume, data suppressed

Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

ColonCancerCheck

Table 51: Number of Fecal Tests Completed by People in Ontario, Ages 49 to 85, By Month, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019*	43,384	48,167	56,326	60,194	57,732	43,890	40,508	59,338	57,235	64,368	59,491	54,370
2020	61,631	60,314	53,341	12,872	5,391	3,756	7,034	16,550	25,198	38,780	39,979	43,258
2021	42,200	47,739	64,201	51,838	59,502	70,536	65,252	65,345	67,332	74,695	81,772	69,101
2022	67,427	73,033	86,536	61,450	55,894	52,015	47,078	56,311	50,029	53,179	59,644	48,491

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 52: Number of Outpatient Colonoscopies Performed for People of All Ages in Hospitals or Out-Of-Hospital Premises in Ontario, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019*	40,274	35,830	37,882	40,648	44,231	39,450	39,616	34,701	39,236	43,003	40,940	31,397
2020	41,327	37,133	22,999	2,643	7,288	21,801	29,523	29,790	35,511	37,756	38,277	31,386
2021	33,687	33,402	41,679	31,161	28,114	38,691	35,337	35,494	39,653	40,431	44,208	33,806
2022	29,270	33,451	44,199	39,218	43,062	44,266	36,588	40,182	42,904	42,238	46,226	36,656

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 53: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	1621622	4298136	38.1	40.0
2018	1660179	4384188	38.4	40.0
2019*	1699621	4469926	38.7	40.0
2020	1910785	4520086	43.2	40.0
2021	1898005	4604162	42.2	40.0

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 54: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, by Material Deprivation, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	1621622	4298136	38.1
2017	Q1: Least Deprived	313672	952946	33.3
2017	Q2	318278	901255	35.6
2017	Q3	317554	851291	37.8
2017	Q4	322551	808238	40.4
2017	Q5: Most Deprived	336661	756650	44.8
2018	Ontario Overall	1660179	4384188	38.4
2018	Q1: Least Deprived	323580	977384	33.6
2018	Q2	326858	922081	35.9
2018	Q3	324200	867061	38.0
2018	Q4	328857	820188	40.8
2018	Q5: Most Deprived	343627	769351	45.2
2019	Ontario Overall	1699621	4469926	38.7
2019	Q1: Least Deprived	333007	1001793	33.8
2019	Q2	334966	943052	36.1
2019	Q3	331277	882146	38.4
2019	Q4	334639	832028	41.1
2019	Q5: Most Deprived	352357	782362	45.7
2020	Ontario Overall	1910785	4520086	43.2
2020	Q1: Least Deprived	382926	1020564	38.2
2020	Q2	380993	958223	40.5
2020	Q3	373170	890598	42.9
2020	Q4	372709	836563	45.7
2020	Q5: Most Deprived	386604	785505	50.1
2021	Ontario Overall	1898005	4604162	42.2
2021	Q1: Least Deprived	379978	1046889	37.1
2021	Q2	378383	979582	39.5
2021	Q3	369221	904806	42.0
2021	Q4	369930	847368	45.0
2021	Q5: Most Deprived	386129	796560	49.5

Table 55: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Were Overdue for Colorectal Cancer Screening, by Ethnic Concentration, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	1621622	4298136	38.1
2017	Q1: Lowest Ethnic Concentration	304212	848867	37.1
2017	Q2	289634	802620	36.9
2017	Q3	280617	782407	36.3
2017	Q4	307071	822358	37.4
2017	Q5: Highest Ethnic Concentration	427182	1014128	42.0
2018	Ontario Overall	1660179	4384188	38.4
2018	Q1: Lowest Ethnic Concentration	304355	850488	37.3
2018	Q2	291592	809691	37.0
2018	Q3	285085	795372	36.4
2018	Q4	317941	846343	37.7
2018	Q5: Highest Ethnic Concentration	448149	1054171	42.5
2019	Ontario Overall	1699621	4469926	38.7
2019	Q1: Lowest Ethnic Concentration	302949	849736	37.5
2019	Q2	292209	814591	37.1
2019	Q3	289194	807845	36.6
2019	Q4	328174	870665	38.0
2019	Q5: Highest Ethnic Concentration	473720	1098544	43.2
2020	Ontario Overall	1910785	4520086	43.2
2020	Q1: Lowest Ethnic Concentration	335842	844215	41.8
2020	Q2	326194	815300	41.4
2020	Q3	324865	815029	40.8
2020	Q4	369809	888185	42.0
2020	Q5: Highest Ethnic Concentration	539692	1128724	48.0

Year	Region	Numerator	Denominator	Percentage (%)
2021	Ontario Overall	1898005	4604162	42.2
2021	Q1: Lowest Ethnic Concentration	321798	843480	40.5
2021	Q2	316315	821061	40.2
2021	Q3	318823	827838	39.6
2021	Q4	372598	912991	41.3
2021	Q5: Highest Ethnic Concentration	554107	1169835	47.6

Table 56: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Completed at Least 1 Fecal Test in a 30-Month Period, 2012-2013 to 2020-2021

Year	Numerator	Denominator	Percentage (%)
2012-2013	632544	1940330	29.7
2014-2015	757635	2117685	35.4
2016-2017	803241	2172521	36.6
2018-2019*	803219	2244776	35.2
2020-2021	849723	2320421	36.1

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 57: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017	22840	525507	4.3
2018	22004	507787	4.3
2019*	25057	548576	4.6
2020	16110	337740	4.8
2021	32120	689555	4.7

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 58: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Did Not Undergo Colonoscopy Within 6 Months of Their Abnormal Fecal Test Result, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)	Target (%)
2017	4469	22542	19.8	18.0
2018	4287	21687	19.8	18.0
2019*	3708	24873	14.9	18.0
2020	2263	16017	14.1	18.0
2021	3115	31964	9.7	18.0

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 59: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Underwent Colonoscopy Within 8 Weeks of the Abnormal Result, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017	11264	22563	49.9
2018	10806	21704	49.8
2019*	14673	24896	58.9
2020	9769	16024	61.0
2021	23327	31985	72.9

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 60: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Underwent Colonoscopy Within 8 Weeks of the Abnormal Result, by Material Deprivation, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	11264	22563	49.9
2017	Q1: Least Deprived	2034	3818	53.3
2017	Q2	2190	4218	51.9
2017	Q3	2105	4183	50.3
2017	Q4	2180	4428	49.2
2017	Q5: Most Deprived	2198	4652	47.2
2018	Ontario Overall	10806	21704	49.8
2018	Q1: Least Deprived	2087	3885	53.7
2018	Q2	2106	4098	51.4
2018	Q3	2014	3980	50.6
2018	Q4	2109	4238	49.8
2018	Q5: Most Deprived	1986	4333	45.8

Year	Region	Numerator	Denominator	Percentage (%)
2019	Ontario Overall	14673	24896	58.9
2019	Q1: Least Deprived	2744	4491	61.1
2019	Q2	2950	4890	60.3
2019	Q3	2748	4599	59.8
2019	Q4	2953	5011	58.9
2019	Q5: Most Deprived	2925	5153	56.8
2020	Ontario Overall	9769	16024	61.0
2020	Q1: Least Deprived	2034	3133	64.9
2020	Q2	2010	3177	63.3
2020	Q3	1852	3065	60.4
2020	Q4	1926	3201	60.2
2020	Q5: Most Deprived	1884	3333	56.5
2021	Ontario Overall	23327	31985	72.9
2021	Q1: Least Deprived	4849	6402	75.7
2021	Q2	4876	6559	74.3
2021	Q3	4372	5936	73.7
2021	Q4	4628	6377	72.6
2021	Q5: Most Deprived	4412	6428	68.6

Table 61: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had an Abnormal Fecal Test Result and Underwent Colonoscopy Within 8 Weeks of the Abnormal Result, by Ethnic Concentration, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017	Ontario Overall	11264	22563	49.9
2017	Q1: Lowest Ethnic Concentration	2007	3920	51.2
2017	Q2	1840	3503	52.5
2017	Q3	1640	3274	50.1
2017	Q4	2026	4002	50.6
2017	Q5: Highest Ethnic Concentration	3194	6600	48.4
2018	Ontario Overall	10806	21704	49.8
2018	Q1: Lowest Ethnic Concentration	2031	3876	52.4
2018	Q2	1762	3346	52.7

Year	Region	Numerator	Denominator	Percentage (%)
2018	Q3	1661	3180	52.2
2018	Q4	1874	3806	49.2
2018	Q5: Highest Ethnic Concentration	2974	6326	47.0
2019	Ontario Overall	14673	24896	58.9
2019	Q1: Lowest Ethnic Concentration	3162	5206	60.7
2019	Q2	2729	4461	61.2
2019	Q3	2483	4038	61.5
2019	Q4	2557	4312	59.3
2019	Q5: Highest Ethnic Concentration	3389	6127	55.3
2020	Ontario Overall	9769	16024	61.0
2020	Q1: Lowest Ethnic Concentration	2246	3661	61.3
2020	Q2	2039	3247	62.8
2020	Q3	1689	2761	61.2
2020	Q4	1710	2811	60.8
2020	Q5: Highest Ethnic Concentration	2022	3429	59.0
2021	Ontario Overall	23327	31985	72.9
2021	Q1: Lowest Ethnic Concentration	5456	7432	73.4
2021	Q2	4644	6296	73.8
2021	Q3	4213	5691	74.0
2021	Q4	4056	5546	73.1
2021	Q5: Highest Ethnic Concentration	4768	6737	70.8

Table 62: Percentage of Screen-Eligible People in Ontario, Ages 50 to 74, With an Abnormal Fecal Test Result Who Were Diagnosed With a Program Screen-Detected Invasive Colorectal Cancer After a Large Bowel Endoscopy or Surgical Resection, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017	764	18146	4.2
2018	683	17468	3.9
2019*	930	21232	4.4
2020	681	13769	4.9
2021	1527	28904	5.3

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 63: Percentage of Colorectal Cancers Detected That Are Post-Colonoscopy Colorectal Cancers, 2014 to 2018

Year	Numerator	Denominator	Percentage (%)
2017	563	6075	9.3
2018	613	6034	10.2
2019	589	6088	9.7
2020	515	5860	8.8
2021	542	5831	9.3

Table 64: Number of Outpatient Colonoscopies* in People Ages 18 and Older Followed by Hospital Admissions for Perforations Within 7 Days of Colonoscopy, per 1,000 Colonoscopies in Ontario, 2017 to 2021

Year	Numerator	Denominator	Rate (per 1,000 Colonoscopies)	Target (per 1,000 Colonoscopies)
2017	169	462131	0.37	1.0
2018	141	469147	0.30	1.0
2019	142	476012	0.30	1.0
2020	101	342340	0.30	1.0
2021	124	443171	0.28	1.0

*Includes colonoscopies for abnormal fecal immunochemical test results, surveillance, family history, symptoms, and other screening.

Table 65: Number of Outpatient Colonoscopies With Polypectomy Among People Ages 50 and Older Followed by Hospital Admissions for Lower Gastrointestinal Bleeding Within 14 Days of Colonoscopy, per 1,000 Colonoscopies with Polypectomy in Ontario, 2017 to 2021

Year	Numerator	Denominator	Rate (per 1,000 Colonoscopies with polypectomy)	Target (per 1,000 Colonoscopies with polypectomy)
2017	509	171,252	3.0	10.0
2018	493	178,762	2.8	10.0
2019	486	185,131	2.6	10.0
2020	378	135,301	2.8	10.0
2021	424	180,718	2.3	10.0

Table 66: Percentage of Hospital Outpatient Colonoscopies Performed in People Ages 18 and Older With Poor Bowel Preparation, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017	8436	270,341	3.1
2018	8348	305,201	2.7
2019	7772	308,393	2.5
2020	5715	222,888	2.6
2021	6837	279,162	2.4

Table 67: Number of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had a Screen-Detected Invasive Colorectal Cancer, per 1,000 Screened Using a ColonCancerCheck Fecal Test, 2017 to 2021

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2017	764	521,509	1.5
2018	683	503,349	1.4
2019*	930	545,847	1.7
2020	681	336,903	2.0
2021	1527	688,421	2.2

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.

Table 68: Number of Screen-Eligible People in Ontario, Ages 50 to 74, Who Had a Screen-Detected Invasive Colorectal Cancer, per 1,000 Screened With Colonoscopy Due to a Family History of Colorectal Cancer, 2017 to 2021

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2017	68	23,664	2.9
2018	DS	DS	3.6
2019*	DS	DS	2.9
2020	44	14,430	3.0
2021	57	17,932	3.2

*In June 2019, ColonCancerCheck transitioned from the guaiac fecal occult blood test to the fecal immunochemical test for people at average risk of colorectal cancer.
DS: Data suppressed to prevent disclosure of small cell counts for stage distribution.

Table 69: Stage Distribution of All Invasive Colorectal Cancers in Ontario in People Ages 50 to 74, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	759	3537	21.5
2018	Stage 2	859	3537	24.3
2018	Stage 3	1117	3537	31.6
2018	Stage 4	802	3537	22.7
2019	Stage 1	775	3621	21.4
2019	Stage 2	974	3621	26.9
2019	Stage 3	1077	3621	29.7
2019	Stage 4	795	3621	22.0

Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

Table 70: Stage Distribution of Screen-Detected Invasive Colorectal Cancers in Ontario in People Ages 50 to 74, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	156	605	25.8
2018	Stage 2	179	605	29.6
2018	Stage 3	194	605	32.1
2018	Stage 4	76	605	12.6
2019	Stage 1	196	719	27.3
2019	Stage 2	222	719	30.9
2019	Stage 3	226	719	31.4
2019	Stage 4	75	719	10.4

Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

Table 71: Invasive Colorectal Cancer Stage Distribution at Diagnosis in People Who Were Screened by a Colonoscopy Due to a Family History of Colorectal Cancer, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	LV	LV	45.2
2018	Stage 2	LV	LV	20.5
2018	Stage 3	LV	LV	28.8
2018	Stage 4	LV	LV	5.5
2019	Stage 1	LV	LV	46.4
2019	Stage 2	LV	LV	25.0
2019	Stage 3	LV	LV	19.6
2019	Stage 4	LV	LV	8.9

LV: Low volume, data suppressed

Note: Data before 2018 are not shown because of a change in the cancer staging classification system in 2018.

Ontario Lung Screening Program

Table 72: Number of Low Dose Computed Tomography (LDCT) Scans Performed for People Age 55 and Older in Ontario Confirmed to be at High Risk for Lung Cancer, 2019 to 2022

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2019	440	358	409	451	479	456	474	419	460	574	546	460
2020	598	527	342	18	10	95	320	470	571	717	703	630
2021	714	633	665	371	348	476	618	681	694	736	785	612
2022	600	645	694	648	671	744	740	818	835	796	771	703

Table 73: Percentage of People Who Completed a Baseline Risk Assessment and Reported That They Currently Smoke, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017*	921	1,799	51.2
2018	2,312	3,660	63.2
2019	2,801	4,301	65.1
2020	1,484	2,259	65.7
2021	1,936	2,929	66.1

*Data began June 2017.

Table 74: Percentage of Screen-Eligible People, Ages 55 to 74, Who Underwent a Low-Dose Computed Tomography Scan After Risk Assessment, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017*	1,113	1,147	97.0
2018	2,314	2,408	96.1
2019	2,723	2,833	96.1
2020	1,365	1,482	92.1
2021	1,768	2,041	86.6

*Data began June 2017.

Table 75: Percentage of Screen-Eligible People, Ages 55 to 74, Who Underwent a Low-Dose Computed Tomography Scan After Risk Assessment, by Material Deprivation, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017*	Ontario Overall	1,113	1,147	97.0
2017	Q1: Least Deprived	200	205	97.6
2017	Q2	205	211	97.2
2017	Q3	206	210	98.1
2017	Q4	262	269	97.4
2017	Q5: Most Deprived	217	229	94.8
2018	Ontario Overall	2,314	2,408	96.1
2018	Q1: Least Deprived	446	465	95.9
2018	Q2	433	445	97.3
2018	Q3	389	398	97.7
2018	Q4	504	527	95.6
2018	Q5: Most Deprived	502	532	94.4
2019	Ontario Overall	2,723	2,833	96.1
2019	Q1: Least Deprived	472	489	96.5
2019	Q2	503	525	95.8
2019	Q3	464	479	96.9
2019	Q4	618	641	96.4
2019	Q5: Most Deprived	626	658	95.1
2020	Ontario Overall	1,365	1,482	92.1
2020	Q1: Least Deprived	246	259	95.0
2020	Q2	216	230	93.9
2020	Q3	249	270	92.2
2020	Q4	307	335	91.6
2020	Q5: Most Deprived	316	355	89.0
2021	Ontario Overall	1,768	2,041	86.6
2021	Q1: Least Deprived	317	361	87.8
2021	Q2	331	383	86.4
2021	Q3	252	292	86.3
2021	Q4	360	422	85.3
2021	Q5: Most Deprived	409	473	86.5

*Data began June 2017.

Table 76: Percentage of Screen-Eligible People, Ages 55 to 74, Who Underwent a Low-Dose Computed Tomography Scan After Risk Assessment, by Ethnic Concentration, 2017 to 2021

Year	Region	Numerator	Denominator	Percentage (%)
2017*	Ontario Overall	1,113	1,147	97.0
2017	Q1: Lowest Ethnic Concentration	376	386	97.4
2017	Q2	252	259	97.3
2017	Q3	235	240	97.9
2017	Q4	171	178	96.1
2017	Q5: Highest Ethnic Concentration	56	61	91.8
2018	Ontario Overall	2,314	2,408	96.1
2018	Q1: Lowest Ethnic Concentration	737	765	96.3
2018	Q2	612	632	96.8
2018	Q3	482	502	96.0
2018	Q4	298	318	93.7
2018	Q5: Highest Ethnic Concentration	145	150	96.7
2019	Ontario Overall	2,723	2,833	96.1
2019	Q1: Lowest Ethnic Concentration	859	885	97.1
2019	Q2	635	659	96.4
2019	Q3	510	529	96.4
2019	Q4	445	475	93.7
2019	Q5: Highest Ethnic Concentration	234	244	95.9
2020	Ontario Overall	1,365	1,482	92.1
2020	Q1: Lowest Ethnic Concentration	425	466	91.2
2020	Q2	321	337	95.3
2020	Q3	270	288	93.8
2020	Q4	198	217	91.2
2020	Q5: Highest Ethnic Concentration	120	141	85.1

Year	Region	Numerator	Denominator	Percentage (%)
2021	Ontario Overall	1,768	2,041	86.6
2021	Q1: Lowest Ethnic Concentration	506	583	86.8
2021	Q2	361	416	86.8
2021	Q3	335	387	86.6
2021	Q4	281	327	85.9
2021	Q5: Highest Ethnic Concentration	186	218	85.3

*Data began June 2017.

Table 77: Low-Dose Computed Tomography Scan Lung-RADS® Score Distribution, 2017 to 2021

Year	Lung-RADS® Score	Numerator	Denominator	Percentage (%)
2017*	Lung-RADS® 1 & 2	633	769	82.3
2017*	Lung-RADS® 3 & 4A	105	769	13.7
2017*	Lung-RADS® 4B & 4X	31	769	4.0
2018	Lung-RADS® 1 & 2	2,545	3,032	83.9
2018	Lung-RADS® 3 & 4A	398	3,032	13.1
2018	Lung-RADS® 4B & 4X	89	3,032	2.9
2019	Lung-RADS® 1 & 2	4,847	5,509	88.0
2019	Lung-RADS® 3 & 4A	503	5,509	9.1
2019	Lung-RADS® 4B & 4X	159	5,509	2.9
2020	Lung-RADS® 1 & 2	4,495	4,988	90.1
2020	Lung-RADS® 3 & 4A	334	4,988	6.7
2020	Lung-RADS® 4B & 4X	159	4,988	3.2
2021	Lung-RADS® 1 & 2	6,526	7,304	89.3
2021	Lung-RADS® 3 & 4A	554	7,304	7.6
2021	Lung-RADS® 4B & 4X	224	7,304	3.1

*Data began June 2017.

Table 78: Percentage of Low-Dose Computed Tomography Scans With Actionable Incidental Findings Detected, 2017 to 2021

Initial Screens

Year	Numerator	Denominator	Percentage (%)
2017	170	758	22.4
2018	464	2,234	20.8
2019	461	2,725	16.9
2020	206	1,296	15.9
2021	394	1,786	22.1

Re-Screens

Year	Numerator	Denominator	Percentage (%)
2017*	0	11	0.0
2018	65	798	8.1
2019	248	2,784	8.9
2020	319	3,692	8.6
2021	667	5,518	12.1

*The Lung Cancer Screening Pilot for People at High Risk began in June 2017, so no annual re-screens were performed in 2017.

Table 79: Percentage of Screen-Eligible People, Ages 55 to 74, With a Suspicious or Very Suspicious Screening Result (Lung-RADS® 4A**, 4B or 4X) Who Underwent Diagnostic Assessment Within 3 Months, 2017 to 2021

Year	Numerator	Denominator	Percentage (%)
2017*	62	64	96.9
2018	147	158	93.0
2019	144	145	99.3
2020	117	127	92.1
2021	150	193	77.7

*Data began June 2017.

**Beginning on October 1, 2018, people with Lung-RADS® score of 4A were scheduled to have a 3-month surveillance low-dose computed tomography scan instead of being referred for a diagnostic assessment consult. Only people with a Lung-RADS® score of 4B or 4X were referred for diagnostic assessment on or after October 1, 2018 in alignment with the Lung-RADS® system.

Table 80: Wait Time in Days From the Date of the LDCT Scan With a Suspicious (Lung-RADS® 4A**) or Very Suspicious (Lung-RADS® 4B or 4X) Result to Definitive Diagnosis of Lung Cancer, 2017 to 2021

Year	Number of People	Median (Days)	90th Percentile (Days)
2017*	18	45	840
2018	51	31	401
2019	67	36	154
2020	67	38	268
2021	78	35	115

*Data began June 2017.

**Beginning on October 1, 2018, people with Lung-RADS® score of 4A were scheduled to have a 3-month surveillance low-dose computed tomography scan instead of being referred for a diagnostic assessment consult. Only people with a Lung-RADS® score of 4B or 4X were referred for diagnostic assessment on or after October 1, 2018 in alignment with the Lung-RADS® system.

Table 81: Number of Screen-Eligible People, Ages 55 to 74, With a Screen-Detected Invasive Lung Cancer per 1,000 People Screened, 2017 to 2021

Year	Numerator	Denominator	Rate (per 1,000 Screened)
2017*	20	758	26.4
2018	DS	DS	19.3
2019	DS	DS	13.5
2020	63	4,681	13.5
2021	76	6,785	11.2

*Data began June 2017.

DS: Data suppressed to prevent disclosure of small cell counts for stage distribution.

Table 82: Stage Distribution of All Invasive Lung Cancers Diagnosed in People Ages 55 to 74 in Ontario, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	1,244	4,657	26.7
2018	Stage 2	361	4,657	7.8
2018	Stage 3	977	4,657	21.0
2018	Stage 4	2,075	4,657	44.6
2019	Stage 1	1,295	4,676	27.7
2019	Stage 2	407	4,676	8.7
2019	Stage 3	922	4,676	19.7
2019	Stage 4	2,052	4,676	43.9

Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

Table 83: Stage Distribution of Screen-Detected Invasive Lung Cancers Diagnosed in People Ages 55 to 74 in Ontario, 2018 to 2019

Year	Stage at diagnosis	Numerator	Denominator	Percentage (%)
2018	Stage 1	LV	LV	65.9
2018	Stage 2	LV	LV	12.2
2018	Stage 3	LV	LV	17.1
2018	Stage 4	LV	LV	4.9
2019	Stage 1	LV	LV	68.7
2019	Stage 2	LV	LV	9.0
2019	Stage 3	LV	LV	19.4
2019	Stage 4	LV	LV	3.0

LV: Low volume, data suppressed

Note: Data before 2018 are not shown because of a major change in the cancer staging classification system in 2018.

Appendix 2: Figure Descriptions

Figure 3: Ontario Breast Screening Program (OBSP) Pathway

Description:
The figure is two side-by-side flow charts, each with nine labeled boxes linked by arrows. The flow charts are unidirectional. At each step, arrows point forward to one or two boxes. Here the flow charts are described as lists in which the possible next steps are listed beneath each numbered box label.

Flow chart one of two:

1. OBSP target populations
    a. Forward to Mammography
2. Mammography
    a. Forward to Normal result; or
    b. Forward to Abnormal result
3. Normal result
    a. Forward to Mammography every 2 years**
4. Abnormal result
    a. Forward to Diagnostic follow-up, including additional imaging and/or biopsy
5. Mammography every 2 years**
6. Diagnostic follow-up, including additional imaging and/or biopsy
    a. Forward to Benign diagnosis; or
    b. Forward to Cancer diagnosis and treatment pathway
7. Benign diagnosis
    a. Forward to Mammography every 2 years**
8. Cancer diagnosis and treatment pathway
9. Mammography every 2 years**

** Some OBSP participants may be called back for screening in 1 year instead of 2 years because of a documented pathology of high-risk lesions, a personal history of ovarian cancer, 2 or more first-degree relatives assigned female at birth with breast cancer at any age, 1 first-

degree relative assigned female at birth with breast cancer under age 50, 1 first-degree relative with ovarian cancer at any age, 1 relative assigned male at birth with breast cancer at any age, BI-RADS breast density Category D at the time of screening or as recommended by the radiologist at the time of screening.

Flow chart two of two:

1. High Risk OBSP target populations
    a. Forward to Mammography and breast MRI*
2. Mammography and breast MRI*
    a. Forward to Normal result; or
    b. Forward to Abnormal result
3. Normal result
    a. Forward to Mammography and breast MRI every year*
4. Abnormal result
    a. Forward to Diagnostic follow-up, including additional imaging and/or biopsy
5. Mammography and MRI every year*
6. Diagnostic follow-up, including additional imaging and/or biopsy
    a. Forward to Benign diagnosis; or
    b. Forward to Cancer diagnosis and treatment pathway***
7. Benign diagnosis
    a. Forward to Mammography and breast MRI every year*
8. Cancer diagnosis and treatment***
    a. Forward to Mammography and breast MRI every year*
9. Mammography and breast MRI every year*

*Screening breast ultrasound is scheduled if breast magnetic resonance imaging (MRI) is not medically appropriate.
*** High Risk OBSP participants who are diagnosed with breast cancer are eligible to return to screening once they have completed treatment and have no breast cancer symptoms.

Figure 4: Ontario Cervical Screening Program (OCSP) Pathway

Description:

The figure is a flow chart, with fifteen labeled boxes linked by arrows. The flow chart is unidirectional. At each step, arrows point forward to one to four boxes. Here the flow chart is described as lists in which the possible next steps are listed beneath each numbered box label.

1. OCSP target population
    a. Forward to Cytology
2. Cytology
    a. Forward to Normal result; or
    b. Forward to Low-grade result; or
    c. Forward to High-grade result; or
    d. Forward to Unsatisfactory result
3. Normal result
    a. Forward to Return to routine screening in 3 years
4. Low-grade result
    a. Forward to Repeat cytology in 12 months
5. High-grade result
    a. Forward to Colposcopy*
6. Unsatisfactory result
    a. Forward to Repeat cytology in 3 months
7. Repeat cytology in 12 months
    a. Forward to Normal result; or
    b. Forward to Abnormal result (low- or high-grade)
8. Colposcopy*
9. Repeat cytology in 3 months
10. Normal result
    a. Forward to Repeat cytology in 12 months
11. Abnormal result (low- or high-grade)
    a. Forward to Colposcopy*

12. Repeat cytology in 12 months
    a. Forward to Normal result; or
    b. Forward to Abnormal result (low- or high-grade)
13. Normal result
    a. Forward to Return to routine screening in 3 years
14. Abnormal (low- or high-grade)
    a. Forward to Colposcopy*
15. Return to routine screening in 3 years

*Please refer to Colposcopy Clinical Guidance for clinical management in colposcopy pathways.

Figure 5: ColonCancerCheck Pathway

Description:

The figure is two side-by-side flow charts. The first flow chart has ten labeled boxes linked by arrows. The second flow chart has six labeled boxes linked by arrows. The flow charts are unidirectional. At each step, arrows point forward to one or two boxes. Here the flow charts are described as lists in which the possible next steps are listed beneath each numbered box label.

Flow chart one of two:

1. ColonCancerCheck Average risk target population
    a. Forward to Fecal immunochemical test (FIT)
2. Fecal immunochemical test (FIT)
    a. Forward to Normal result; or
    b. Forward to Abnormal result
3. Normal result
    a. Forward to Re-screen with FIT in 2 years
4. Abnormal result
    a. Forward to Colonoscopy
5. Re-screen with FIT in 2 years
6. Colonoscopy
    a. Forward to Normal result; or
    b. Forward to Abnormal result
7. Normal result
    a. Forward to Re-screen with FIT in 10 years
8. Abnormal result
    a. Forward to Cancer diagnosis and treatment pathway or colonoscopy surveillance or screen with FIT in 5 years***
9. Re-screen with FIT in 10 years
10. Cancer diagnosis and treatment pathway or colonoscopy surveillance or screen with FIT in 5 years***

***Please refer to ColonCancerCheck's Recommendations for Post-Polypectomy Surveillance at cancercareontario.ca/CCCsurveillance

Flow chart two of two:

1. ColonCancerCheck Increased risk target population*
    a. Forward to Colonoscopy
2. Colonoscopy
    a. Forward to Normal result; or
    b. Forward to Abnormal result
3. Normal result
    a. Forward to Colonoscopy in 5 to 10 years**
4. Abnormal result
    a. Forward to Cancer diagnosis and treatment pathway or colonoscopy surveillance***
5. Colonoscopy in 5 to 10 years**
6. Cancer diagnosis and treatment pathway or colonoscopy surveillance***

*The screening recommendations for people at increased risk for colorectal cancer are currently under review.
**Frequency of screening with colonoscopy depends on family history. People with a first-degree relative who was diagnosed with colorectal cancer before age 60 should be screened every 5 years starting at age 50, or 10 years earlier than the age their relative was diagnosed. People with a first-degree relative who was diagnosed with colorectal cancer at age 60 or older should be screened every 10 years starting at age 50. However, some people may need colonoscopy more often depending on the findings at their initial colonoscopy.
***Please refer to ColonCancerCheck's Recommendations for Post-Polypectomy Surveillance at cancercareontario.ca/CCCsurveillance

Figure 6: Ontario Lung Screening Program (OLSP) Pathway

Description:

The figure is a flow chart, with twenty-three labeled boxes linked by arrows. The flow chart is unidirectional. At each step, arrows point forward to one to four boxes. Here the flow chart is described as lists in which the possible next steps are listed beneath each numbered box label.

1. Recruitment and risk triage
    a. Forward to Individual risk assessment
2. Individual risk assessment
    a. Forward to Informed participation – Eligible; or
    b. Forward to Ineligible
    c. Forward to Smoking Cessation (regardless of eligibility)
3. Informed participation – Eligible
    a. Forward to Low-dose CT scan
4. Ineligible
5. Low-dose CT scan
    a. Forward to Negative scan Lung-RADS® 1 or 2; or
    b. Forward to Positive scan; or
    c. Forward to Incidental findings
6. Negative scan Lung-RADS® 1 or 2
    a. Forward to Recall for annual screening
7. Positive scan
    a. Forward to Probably benign Lung-RADS® 3; or
    b. Forward to Suspicious Lung-RADS® 4A; or
    c. Forward to Very suspicious Lung-RADS® 4B; or
    d. Forward to Very suspicious Lung-RADS® 4X
8. Incidental findings
    a. Forward to Referring and primary care providers contacted
9. Recall for annual screening

10. Probably benign Lung-RADS® 3
    a. Forward to Follow-up low-dose CT in 6 months
11. Suspicious Lung-RADS® 4A
    a. Forward to Follow-up low-dose CT in 3 months
12. Very suspicious Lung-RADS® 4B
    a. Forward to Follow-up low-dose CT in 1 month*; or
    b. Forward to Diagnostics (Additional imaging, work-up, biopsy, etc.)
13. Very suspicious Lung-RADS® 4X
    a. Forward to Diagnostics (Additional imaging, work-up, biopsy, etc.)
14. Referring and primary care providers contacted
15. Follow-up low-dose CT in 6 months
16. Follow-up low-dose CT in 3 months
17. Follow-up low-dose CT in 1 month*
18. Diagnostics (Additional imaging, work-up, biopsy, etc.)
    a. Forward to No Cancer; or
    b. Forward to Cancer
19. No Cancer
    a. Forward to Return to screening, as per recommendation from physician that conducted diagnostic assessment
20. Cancer
    a. Forward to Staging
21. Return to screening, as per recommendation from physician that conducted diagnostic assessment
22. Staging
    a. Forward to Treatment
23. Treatment

*Occurs if a Lung-RADS® score of 4B is assigned to a new large nodule identified on an annual recall low-dose computed tomography (CT) scan and the reporting radiologist suspects an infection or inflammation.
Note: The categories “probably benign,” “suspicious” and “very suspicious” are based on Lung-RADS® (version 1.1).

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TAB 4

TITLE: Trends in patient attachment to an aging primary care workforce: a population-based serial cross-sectional study in Ontario, Canada

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ABSTRACT

Background: Population aging is a global phenomenon. Resultant healthcare workforce shortages are anticipated. To ensure access to comprehensive primary care, which correlates with improved health outcomes, equity, and costs, data to inform workforce planning are urgently needed.

Objectives: To explore temporal trends in early career, mid-career, and near-retirement comprehensive primary care physician characteristics, the medical and social needs of their patients, and the workforce's capacity to absorb patients of near-retirement physicians. Gender-based workforce trends and trends around alternative practice models were also explored.

Design: A serial cross-sectional population-based study using health administrative data.

Setting: Ontario, Canada, where most comprehensive primary care is delivered by family physicians (FPs) under universal insurance.

Participants: All insured Ontario residents at three time points: 2008 (12,936,360), 2013 (13,447,365), and 2019 (14,388,566) and all Ontario physicians who billed primary care services (2008: 11,566; 2013: 12,693; 2019: 15,054).

Exposure(s): Changes in the comprehensive FP workforce over three time periods.

Main Outcome(s) and Measure(s): The number and proportion of patients attached to near-retirement comprehensive FPs; the number and proportion of near-retirement comprehensive FPs; the characteristics of patients and their comprehensive FPs.

Results: Patient attachment to comprehensive FPs increased over time. The overall FP workforce grew, but the proportion practicing comprehensiveness declined from 77.2% (2008)

to 70.7% (2019), with shifts into other/focused scopes of practice across all physician career stages. Over time, an increasing proportion of the comprehensive FP workforce was near retirement age. Correspondingly, an increasing proportion of patients were attached to near-retirement comprehensive FPs. By 2019, 13.9% of comprehensive FPs were 65 years or older, corresponding to 1,695,126 (14.8%) patients. Mean patient age increased, and near-retirement comprehensive FPs served markedly increasing numbers of medically and socially complex patients.

Conclusions and Relevance: Primary care is foundational to high-performing health systems, but the sector faces capacity challenges as both patients and physicians age and fewer physicians choose to practice comprehensiveness. Nearly 15% (1.7 million) of Ontarians with a comprehensive FP may lose their physician to retirement by 2025. To serve a growing and increasingly complex patient population, innovative solutions that extend beyond simply growing the FP workforce are needed.

INTRODUCTION

Primary care is the foundation of high-performing health care systems worldwide,[1] and can be defined by four core functions ("the 4 Cs") articulated by Starfield and others: first *Contact* access to the healthcare system, *Continuity* (long-term person-focused care), *Comprehensiveness* (meeting the majority of each patient's physical and mental health care needs, including prevention, acute care, chronic care, and multimorbidity care), and *Coordination* of care across the healthcare system, including specialty care, hospitals, home care, and community services and support.[1 2] Access to primary care is associated with improved health outcomes, improved health equity, and reduced health system costs.[3-9]

An essential enabler of primary care access is an adequate health human resource (HHR) supply, but many jurisdictions are grappling with current and impending shortages. For example, 14.5% (4.6 million) Canadians are without a primary care provider.[10] Virtually every country world-wide is experiencing population aging,[11] with a high burden of medical complexity[12-15] and a HHR workforce that is aging into retirement.[16-18] Concurrently, many countries, including Canada, the United Kingdom, and the United States, are experiencing challenges attracting incoming physicians to primary care as a specialty,[19-22] and among those who do, a declining proportion are providing primary care reflective of Starfield's "4 Cs" (hereafter referred to as "comprehensive primary care"); instead, primary care physicians are increasingly limiting their scope of work to subspecialized areas such as sports medicine, dermatology, or palliative care, or to episodic acute care settings, such as walk-in clinics.[23-29] Moreover, the concentration of women in primary care may further reduce HHR capacity, as women primary care physicians have been found to spend more time with patients[30] and receive more patient requests outside of appointments than men.[31 32]

In the context of an aging population and shifting workforce demographics, HHR planning requires an understanding of the needs of patients who will soon lose their primary care provider due to retirement, as well as an understanding of the capacity of the remaining and incoming workforce. To anticipate future workforce needs, previous studies often use high-level supply indicators such as number of primary care physicians, and high-level demand indicators such as patient visit rates and durations.[33-36] In-depth analyses tend to be limited to sub-jurisdictional populations, such as the neighborhood[36] or early career clinicians,[24] and do not directly link supply (individual clinicians) to demand (patients served by clinicians).

We conducted an in-depth exploration linking supply and demand at a health system planning level in Ontario, Canada. We examined temporal trends in early career, mid-career, and near-retirement primary care physician characteristics, the medical and social needs of patients attached to these physicians, and the workforce's capacity to meet the needs of patients of near-retirement physicians. We explored hypothesis-generating differences in gender-based workforce trends, including differences in care provision,[30 31] and trends around alternative practice models, such as team-based care. As Canadian healthcare planning and delivery are provincial jurisdiction, we focused on the province-level (Ontario). In Ontario, most comprehensive primary care is delivered by family physicians (FPs), most physician services and nearly all residents are covered by government insurance, and health services data are stored centrally in health administrative datasets.

METHODS

The use of data in this study was authorized under section 45 of Ontario's Personal Health Information Protection Act (PHIPA) and did not require review by a research ethics board or

informed consent. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.[37]

Study Design, Population, and Data Sources

We conducted a serial cross-sectional population-level analysis using health administrative data housed at ICES. The study population included all registered Ontario residents covered by the Ontario Health Insurance Plan (OHIP) at three time points: March 31, 2008 (12,936,360), March 31, 2013 (13,447,365), and March 31, 2019 (14,388,566) and all Ontario physicians who billed primary care services (2008: 11,566; 2013: 12,693; 2019: 15,054).

Physician-level and patient-level data came from nine databases which were linked using unique encoded identifiers and analyzed at ICES (Supplement: eMethods).

Outcomes and Covariates

The primary outcomes were the number and proportion of patients attached to a near-retirement age comprehensive FP over three time points, and the number and proportion of near-retirement age comprehensive FPs over three time points. Based on previous literature finding the average Ontario FP retires at age 70.5 years (with women retiring on average 5 years earlier than men)[38] and accounting for the time needed to train new physicians,[39] three different "near-retirement" physician age cut-points were examined: $\geq$ 55 years, $\geq$ 65 years, and $\geq$ 70 years. Comprehensive FPs were defined by applying a previously validated algorithm described below in the Analysis section.[29]

We described the characteristics of both comprehensive FPs and their attached patients over the three time points. Physician characteristics served as exploratory indicators of both supply and, for near-retirement physicians, anticipated demand based on the populations of patients they serve. Patient characteristics served as indicators of demand based on medical and sociodemographic complexity. Detailed data source, cohort, and covariate definitions can be found in the Supplement (eMethods).

Analysis

For our patient cohort, we created cross-sections of patients attached to comprehensive FPs at three time points: 2008, 2013, 2019.

We began by applying our previously validated algorithm for primary care physician attachment[40] to the population of OHIP-registered Ontario residents; identifying patients attached to a physician providing longitudinal primary care services based on billing codes and physician-level continuity of care (see Supplement eMethods – continuity of care). We removed patients seen at Community Health Centres because they cannot be attached to a specific physician, patients that the algorithm attached to non-FPs such as pediatricians and surgeons, and patients attached to a FP with missing covariates.

We next created the cohort of FPs linked to the attached patients we identified (2008, 2013, 2019). We stratified our patient and FP cohorts by physician practice type (scope). For this, we used a previously published algorithm for determining comprehensiveness of primary care practice, where physicians are identified as providing comprehensive care if more than half of their services were for core primary care and if these services fell into at least 7 of 22 activity areas.[29] This resulted in four groups of patients with attachments to four types of FP practice

scopes: Comprehensive, Focused (for example, sports medicine or palliative care), Other, and those who worked less than 44 days/year. Focusing on the "comprehensive FP" group, we described the characteristics of these physicians and their patients.

Physician analyses were stratified by physician sex and physician age, including the three "near-retirement" cut-points. Proportions and means with standard deviations were reported for each time point (2008, 2013, 2019).

RESULTS

Patient Cohort

Excluding long-term care home residents, the population of OHIP-eligible Ontario residents in the patient cohort over time was 12,863,036 (2008), 13,371,946 (2013), and 14,312,309 (2019), of whom the following were attached to a comprehensive FP: 2008: n = 9,537,353 (77.3%); 2013: n = 10,398,003 (85.1%); 2019: n = 11,480,975 (86.1%) (Figure 1a).

Physician Cohort

The overall FP workforce grew from 9,944 physicians in 2008 to 13,269 in 2019 (Figure 1b). The proportion of FPs practicing comprehensive primary care declined from 77.2% in 2008 (n = 7,673) to 70.7% in 2019 (n = 9,377) (Supplement: eFigure 1).

Table 1 stratifies comprehensive FP data by age and sex. The mean (SD) physician age remained relatively stable over time (2008: 50.3 (11.0) years; 2013: 51.4 (11.8) years; 2019: 49.7 (12.9) years). The mean age (SD) for female physicians was lower than for males at each time point (2008 male 53.0 (10.9) years, female 46.0 (9.7) years; 2013 male 54.7 (11.6) years, female 47.2 (10.6) years; 2019 male 53.1 (13.2) years, female 46.3 (11.6) years). Career stage (years in

practice) closely followed physician age group for both males and females, and the youngest cohort (age <35) comprised an increasing proportion of the workforce over time, shifting from 7.7% in 2008 to 15.1% in 2019. The older cohorts were also found to comprise an increasing proportion of the workforce over time, and the absolute numbers of older physicians increased.

Among family physicians with patient attachments, a shift away from comprehensiveness and into other/focused scopes of practice was seen across all physician age groups, with the most pronounced shifts in the youngest and oldest physician groups (Supplement: eTable 1). Instead of comprehensive primary care, these FPs increasingly worked in focused or other scopes of practice. The proportion of FPs identified as practicing exclusively without patient attachments or in low-continuity ("walk-in clinic") settings fluctuated: 2008: 7.2% (n = 715), 2013: 4.9% (n = 558); 2019: 5.2% (n = 688) (Figure 1b).

Temporal Trends of Near-Retirement Comprehensive Family Physicians and their Patients

When looking at our three near-retirement cut-points (55+, 65+, 70+) over time, an increasing proportion of the comprehensive FP workforce was near retirement age (Figure 2). Correspondingly, an increasing proportion of patients were attached to near-retirement comprehensive FPs (Table 2). In the 55+ age group, the proportion of comprehensive FPs increased from 35.7% in 2008 to 38.2% in 2019. In 2019, this corresponded to 3,586 physicians and 4,935,992 (43.0%) patients (2019). In the 65+ group, the proportion increased from 10.0% in 2008 to 13.9% in 2019 (1,307 physicians, 1,695,126 (14.8%) patients). In the 70+ age group, the proportion increased from 4.6% in 2008 to 6.4% in 2019 (599 physicians, 666,000 (5.8%) patients).

Temporal Characteristics of Comprehensive Family Physicians and their Patients

Comprehensive FP Capacity/Workload

Table 1 shows the mean (SD) roster size for the total population of comprehensive FPs remained consistent over time (2008: 1213 (927); 2013: 1272 (909); 2019: 1209 (837)). Male FPs had consistently larger roster sizes in each age group and at each time point. Both male and female FP roster sizes followed an inverted U pattern with FP age, with practice sizes starting and ending smaller at the extremes of FP age and peaking during mid-career. This pattern was observed at all three time points with older (65+) male and female physicians and younger (<35) male and female physicians caring for larger roster sizes over time.

Working full time equivalent (FTE) also followed an inverted U pattern according to FP age (Table 1). Older physicians increasingly practiced FTE (2008: 58.4%, 2013: 67.0%, 2019: 72.6%). This was driven by an increasing proportion of female FTE comprehensive FPs. Among younger physicians, by 2019, females comprised the majority of FTE workforce (52.2% of FTE comprehensive FPs <35 years; 55.2% of FTE comprehensive FPs 35-44 years).

Mean (SD) annual core primary care visits provided per patient declined over time (Table 1): 2008: 7.3 (3.1) visits; 2013: 6.5 (2.6) visits; 2019: 6.0 (2.3) visits. In most comprehensive FP age groups, male and females provided similar numbers of annual visits. Older physicians provided more annual visits compared with their younger counterparts.

In the patient cohort (Table 2), at all near-retirement physician cut-offs (55+, 65+, 70+), a declining proportion over time made a high number (5+) primary care visits in the preceding year, but these proportions remained consistently over 50% in all near-retirement groups and at each time point.

Comprehensive FP Practice Settings

A declining proportion of comprehensive FPs over time practiced in fee-for-service (FFS) models of care. Alternate payment plan models (APPs), specifically capitation/team-based models of care, were an increasingly common setting over time (Supplement: eFigure 2). In these APP models, physician compensation is primarily a lump sum payment per attached patient, with or without additional government funding for interdisciplinary health professional supports. In 2008, most comprehensive FPs worked in FFS-based models (76.6%), but by 2019, most practiced in APPs (55.4%). This shift was seen across all comprehensive FP age groups (Supplement: eTable 2). Correspondingly, an increasing proportion of patients were served in APP models: 2008: 26.5% (n = 2,526,116); 2013: 54.3% (n = 5,643,862); 2019: 61.5% (n = 7,064,109).

Over time, a stable majority of comprehensive FPs practiced in large urban and urban settings (Supplement: eTable 3A). After a decline in 2013, an increasing proportion and number practiced in rural/remote areas by 2019, but numbers did not return to 2008 levels (2008: 6.7%, n = 513; 2013: 5.1%, n = 410; 2019: 5.3%, 492). Trends around age and sex of rural comprehensive FPs resembled trends seen in the overall comprehensive FP population (Supplement: eTables 3B, 3C).

Patient complexity

The mean age (SD) of comprehensive FPs' patients increased over time (Table 1): 2008: 33.5 (13.2) years; 2013: 36.5 (12.1) years; 2019: 38.1 (12.0) years. When stratified by physician age and sex, each physician age group served increasingly older patients. Male physicians cared for slightly older patients than did women in each physician age group and at each time point.

The number and proportion of patients aged 65 and older increased over time in each near-retirement group (Table 2). This number nearly quadrupled in the oldest (70+ years) FP group (2008: N = 45,414, 2019: N = 176,473).

Comprehensive FPs cared for a stable mean (SD) proportion of female patients over time (Table 1) (2008:53.2% (12.9); 2013: 53.1% (12.5); 2019: 52.9% (12.0). Female comprehensive FPs had a greater proportion of female patients than male physicians at all time points and in all age groups. The overall proportion of female patients was higher in younger physician age groups at all time points, equalizing as physicians aged.

When examining the patient cohort by near-retirement physician age groups, the proportion of female patients also remained stable at each time point (Table 2), with slightly lower proportions of female patients in the oldest near-retirement group.

Over time, an increasing proportion of comprehensive FPs' practices were comprised of the highest morbidity patients (Resource Utilization Band (RUB) 4+): 2008: 16.5%; 2013: 18.1%; 2019: 19.8% (Table 3). When stratified by comprehensive FP age and sex, older male physicians cared for higher proportions of the highest morbidity patients than did older female physicians in 2008 (65-69 years) and 2013 (65-69 years, 70+ years), but by 2019, males and females cared for similar proportions of highest morbidity patients within each and across all physician age groups.

Table 2 shows the number and proportion of highest morbidity patients attached to near-retirement physicians grew over time. By 2019, 983,818 patients in the highest morbidity patients were attached to a physician aged 55+, representing 19.9% of all patients attached to a 55+ physician. 350,439 were attached to a 65+ physician (20.7% of patients attached to a 65+

physician). 146,298 were attached to a 70+ physician (22.0% of patients attached to 70+ a physician), representing a tripling of the absolute number.

While proportions of patients with chronic illness (COPD, CHF, diabetes, frailty, mental illness) remained relatively stable over time, the absolute numbers increased markedly in each near-retirement group (Table 2).

The proportions and means of socially complex patients cared for within each comprehensive FP age and sex group increased over time for most indicators (Table 3) and the number of higher social complexity patients increased markedly over time for most near-retirement groups (Table 2).

DISCUSSION

In our population-level serial cross-sectional analyses, the proportion of patients attached to a comprehensive FP in Ontario, Canada, grew over time. However, we found an increasing proportion of the comprehensive FP workforce is nearing retirement. Given the average FP retires at age 70.5 years,[38] we anticipate that by 2025, nearly 1.7 million Ontarians may lose their comprehensive FP to retirement, eroding gains made to date.

This number may be an underestimate for several reasons. First, half of all comprehensive FPs are now female, and female FPs retire on average 5 years earlier than males.[38] Second, a decreasing proportion of FPs are practicing comprehensive family medicine. This trend was seen across every physician age group, indicating practicing FPs are leaving comprehensive primary care earlier in their careers than in previous years while a smaller proportion of incoming FPs are choosing to enter comprehensive practice. Third, due to limitations in data availability for more recent years, our analyses predate the COVID-19 pandemic, and surveys from Ontario indicate

the pandemic has hastened retirement plans, with almost double the usual proportion of FPs closing their offices during the pandemic (3%, compared with the usual rate of 1.6%/year),[41] and one in five indicating an intention to retire within five years.[42]

Several other trends identified likely apply to other jurisdictions nationally and internationally and, when taken together, indicated limited capacity in the workforce to absorb the workload of near-retirement physicians. Comprehensive FPs cared for increasingly older groups of patients with increasing complexity over time. As of 2019, all physician age groups served similar proportions of complex patients, and near-retirement physicians cared for an increasing number and proportion of older patients with increasing medical and social complexities. Females, who comprised an increasing proportion of the comprehensive FP workforce, served similar proportions of highest morbidity patients but smaller roster sizes compared with males, which may reflect previous research finding women primary care physicians spend more time with and receive more requests from patients.[31 32] That said, both the oldest and youngest male and female comprehensive FP groups served increasingly larger rosters, and an increasing proportion of older (65+) physicians practiced FTE.

Ontario continues to add a net positive number of FPs to the workforce each year, but this number has declined from 453 in 2017 to 303 in 2020.[43] Over the past 7 years, a smaller proportion of medical school graduates ranked family medicine as their first choice discipline,[44] echoing trends in other jurisdictions including the United Kingdom and the United States.[20-22] The future supply of incoming FPs may therefore be inadequate to meet needs identified in our study, especially considering the 1.6 million Ontarians already without a regular primary care provider in our 2019 cohort.

Solutions to FP workforce shortages identified in the literature focus on addressing deterrents to the practice of comprehensive primary care, including perceived poor respect for primary care as a profession, inadequate compensation, inadequate training supports for developing and maintaining comprehensive skills, and inadequate administrative and interdisciplinary health supports to manage increasing patient complexity.[21 24 45-49] Our finding of a shift toward APP models underscores the desire among comprehensive FPs for financial stability and team-based supports. Further, we identified large numbers of patients with chronic diseases and complex social needs, all of which are highly amenable to team-based care.[50-52]

There are some limitations to our study. The FTE indicator is based on physician billings and excluded non-billable administrative time. Almost half of Canadian FPs report 10-19 hours per week of administrative tasks,[53] so the indicator may underestimate workload, and thus the number of FTE FPs. Rural FPs often practice in both primary care and hospital settings;[54] since the comprehensiveness algorithm is based on primary care billings,[29] it may underestimate the number of rural comprehensive FPs. Further, the rurality index scores and methodology have not been updated since 2008. Some physician analyses could not be fully stratified by both age and sex due to small cell sizes. Community Health Centre patients are not included and we did not examine other clinicians who may provide primary care; however, these clinicians are the main primary care source for only a small minority of Ontarians.[55 56] Finally, our analyses do not account for the rise of virtual care and its potential impact on capacity.[57-59]

CONCLUSIONS

Primary care faces many capacity challenges as physicians age into retirement and fewer choose to enter or remain in comprehensive practice. Incentives and supports are needed to grow the comprehensive FP workforce to serve a growing and increasingly complex patient population.

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Drafting of the manuscript: Premji

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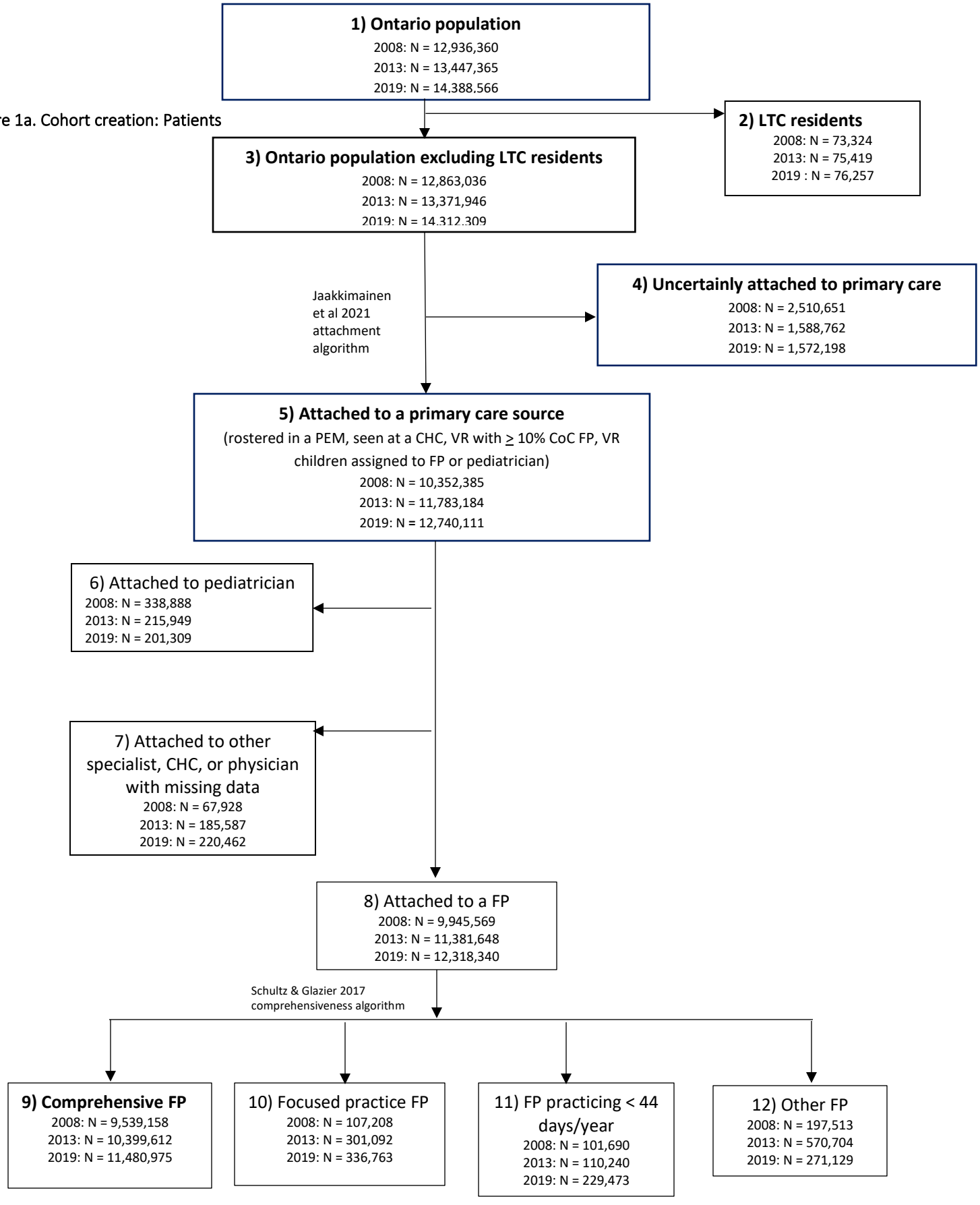
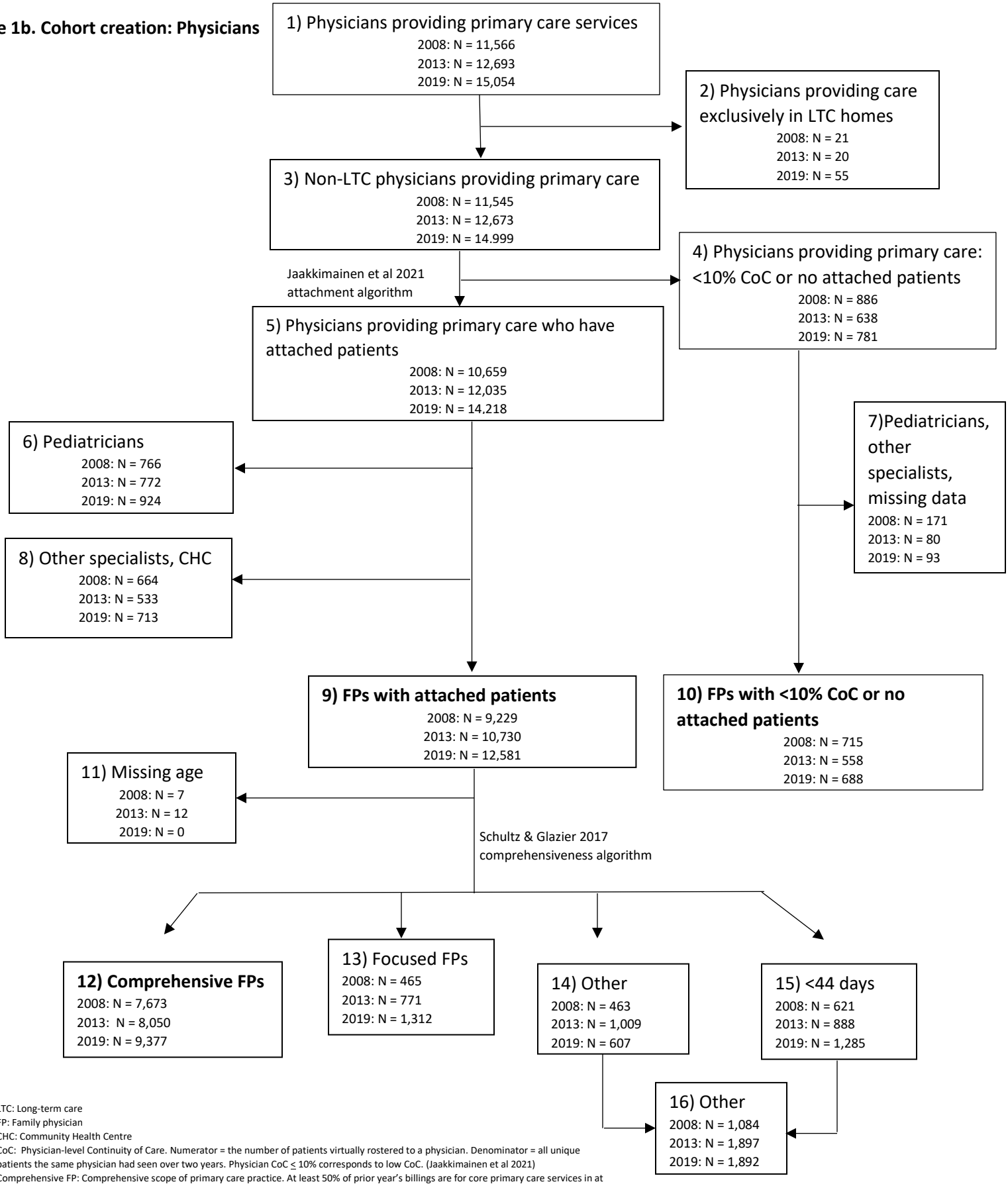
Figure 1a. Cohort creation: Patients

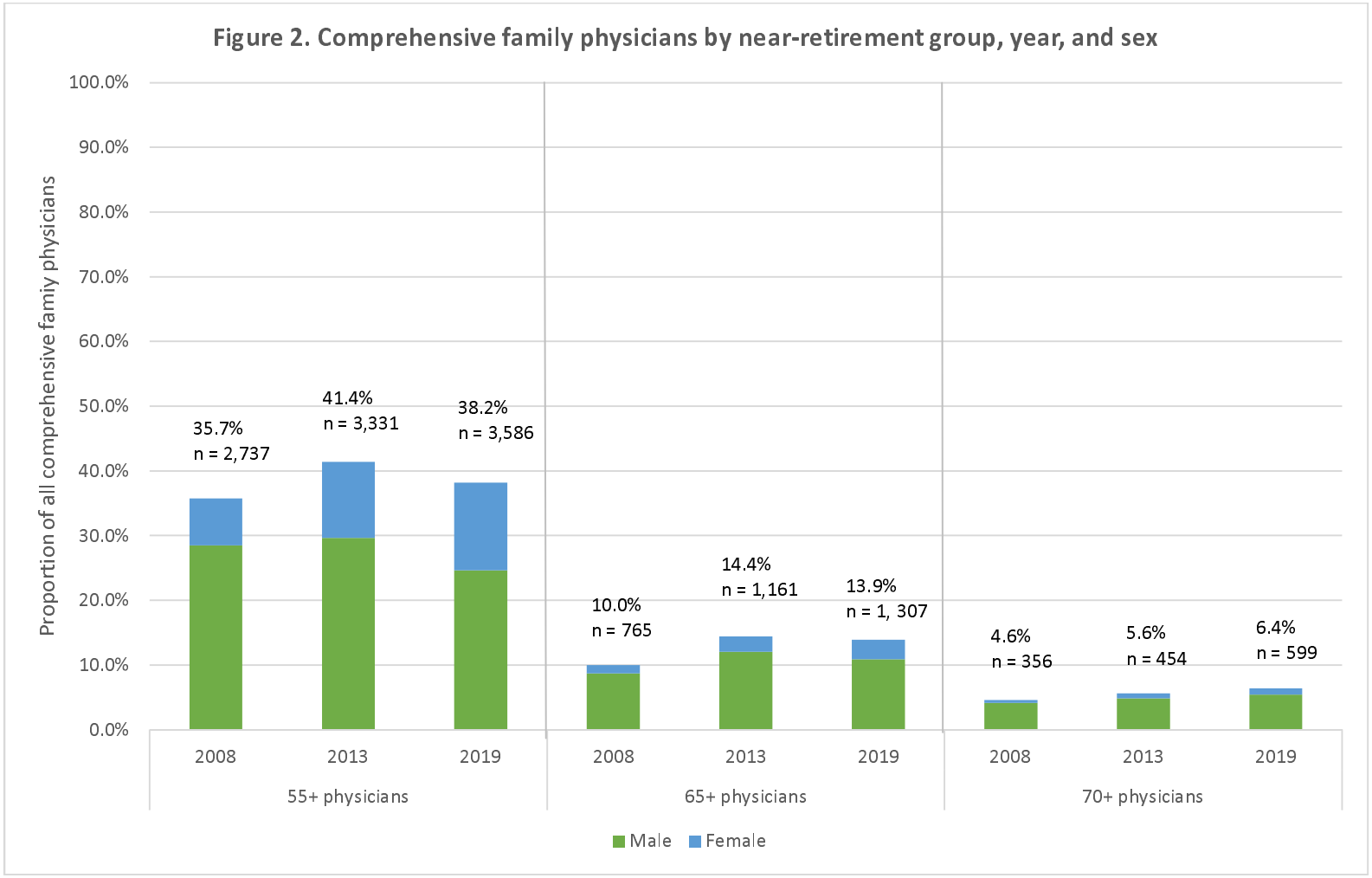


LTC: Long-term care home
FP: Family physician
CHC: Community Health Centre
VR: Virtually Rostered. Patient is considered VR to the physician with whom the majority of their primary care core visits were made over the preceding two-year period (Jaakkimainen et al 2021)
CoC: Physician-level Continuity of Care. Numerator = the number of patients virtually rostered to a physician. Denominator = all unique patients the same physician had seen over two years. Physician CoC ≤ 10% corresponds to low CoC. (Jaakkimainen et al 2021)
Comprehensive FP: Comprehensive scope of primary care practice. At least 50% of prior year's billings are for core primary care services in at least 7 different primary care activity areas (Schultz & Glazier 2017)
Focused FP: Narrowed scope of practice, such as sports medicine, palliative care, hospitalist.
Other: Not comprehensive and not focused practice
<44 days: Worked less than 44 days/year

Figure 1b. Cohort creation: Physicians



LTC: Long-term care
FP: Family physician
CHC: Community Health Centre
CoC: Physician-level Continuity of Care. Numerator = the number of patients virtually rostered to a physician. Denominator = all unique patients the same physician had seen over two years. Physician CoC $\leq$ 10% corresponds to low CoC. (Jaakkimainen et al 2021)
Comprehensive FP: Comprehensive scope of primary care practice. At least 50% of prior year's billings are for core primary care services in at least 7 different primary care activity areas (Schultz & Glazier 2017)
Focused FP: Narrowed scope of practice, such as sports medicine, palliative care, hospitalist.
Other: Not comprehensive and not focused practice
<44 days: Worked less than 44 days/year



Total Ns (all comprehensive family physicians):

2008: 7,673

2013: 8,050

2019: 9,377

Table 1. Practice characteristics of comprehensive family physicians

		<35 Years			35-44 Years			45-54 Years			55-64 Years			65-69 Years			70+ Years			Total Comprehensive FPs		
		Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F		M	F	Total	M	F
Comp. FPs N (%)	2008	592 (7.7)	211 (35.6)	381 (64.4)	1877 (24.5)	922 (49.1)	955 (50.9)	2467 (32.2)	1422 (57.6)	1045 (42.4)	1972 (25.7)	1522 (77.2)	450 (22.8)	409 (5.3)	347 (84.8)	62 (15.2)	356 (4.6)	319 (89.6)	37 (10.4)	7673 (100.0)	4743 (61.8)	2930 (38.2)
	2013	741 (9.2)	245 (33.1)	496 (66.9)	1666 (20.7)	674 (40.5)	992 (59.5)	2312 (28.7)	1227 (53.1)	1085 (46.9)	2170 (27.0)	1415 (65.2)	755 (34.8)	707 (8.8)	576 (81.5)	131 (18.5)	454 (5.6)	392 (86.3)	62 (13.7)	8050 (100.0)	4529 (56.3)	3521 (43.7)
	2019	1414 (15.1)	528 (37.3)	886 (62.7)	2135 (22.8)	806 (37.8)	1329 (62.2)	2242 (23.9)	1048 (46.7)	1194 (53.3)	2279 (24.3)	1290 (56.6)	989 (43.4)	708 (7.6)	519 (73.3)	189 (26.7)	599 (6.4)	505 (84.3)	94 (15.7)	9377 (100.0)	4696 (50.1)	4681 (49.9)
Years in pract. (mean (SD))	2008	6.0 (±2.3)	6.3 (±2.3)	5.9 (±2.2)	14.4 (±3.9)	14.7 (±3.8)	14.1 (±3.9)	23.7 (±4.2)	23.8 (±4.2)	23.5 (±4.2)	33.4 (±4.4)	33.6 (±4.2)	32.8 (±4.8)	41.3 (±3.0)	41.2 (±3.0)	42.0 (±3.2)	48.0 (±5.1)	48.0 (±4.9)	47.8 (±6.4)	24.6 (±11.4)	27.3 (±11.2)	20.2 (±10.1)
	2013	5.7 (±2.1)	5.4 (±2.1)	5.9 (±2.1)	13.8 (±4.2)	14.0 (±4.2)	13.7 (±4.1)	23.9 (±4.2)	23.9 (±4.0)	23.8 (±4.4)	33.2 (±4.4)	33.6 (±4.4)	32.5 (±4.5)	41.2 (±3.5)	41.1 (±3.4)	41.6 (±4.0)	48.7 (±4.9)	48.7 (±4.9)	49.0 (±4.9)	25.6 (±12.3)	28.8 (±12.1)	21.4 (±11.1)
	2019	5.8 (±2.0)	5.7 (±2.0)	5.8 (±1.9)	12.5 (±4.2)	12.5 (±4.4)	12.5 (±4.0)	23.7 (±4.7)	23.9 (±4.7)	23.5 (±4.6)	33.3 (±4.7)	33.4 (±4.5)	33.2 (±4.9)	40.8 (±3.6)	41.0 (±3.4)	40.3 (±4.0)	48.5 (±5.1)	48.4 (±5.3)	48.7 (±4.1)	23.7 (±13.4)	27.0 (±13.8)	20.3 (±12.0)
Roster size (mean (SD))	2008	638.3 (±622.5)	790.7 (±722.0)	553.9 (±542.7)	1131.8 (±873.2)	1323.5 (±981.3)	946.7 (±707.0)	1345.1 (±920.7)	1470.3 (±996.7)	1174.6 (±774.4)	1432.1 (±945.2)	1494.0 (±961.5)	1222.7 (±856.4)	1123.1 (±955.5)	1186.1 (±981.7)	770.7 (±701.1)	566.3 (±770.9)	584.9 (±785.4)	406.5 (±618.7)	1212.8 (±927.0)	1338.8 (±991.1)	1008.8 (±770.0)
	2013	620.0 (±605.9)	725.2 (±690.9)	568.0 (±552.6)	1152.8 (±836.0)	1348.6 (±935.1)	1019.7 (±732.6)	1407.1 (±927.1)	1567.8 (±1013.4)	1225.4 (±780.2)	1490.2 (±894.6)	1593.1 (±937.6)	1297.2 (±772.4)	1366.1 (±905.8)	1420.3 (±921.3)	1128.0 (±794.3)	898.1 (±895.7)	946.7 (±922.9)	591.1 (±622.7)	1272.1 (±909.2)	1425.0 (±975.2)	1075.4 (±773.4)
	2019	734.0 (±644.2)	834.7 (±712.0)	674.0 (±592.4)	1074.5 (±720.3)	1217.2 (±841.6)	987.9 (±620.1)	1394.8 (±876.2)	1529.3 (±946.5)	1276.7 (±791.2)	1405.6 (±847.2)	1531.6 (±902.2)	1241.1 (±738.3)	1434.4 (±900.5)	1502.5 (±932.8)	1247.6 (±777.3)	1098.0 (±804.3)	1125.7 (±815.1)	949.2 (±729.6)	1208.9 (±837.4)	1351.9 (±908.8)	1065.4 (±731.6)
Core PC visits (mean (SD))	2008	6.2 (±2.7)	6.2 (±2.8)	6.2 (±2.7)	7.3 (±4.2)	7.5 (±5.6)	7.2 (±2.3)	7.3 (±2.3)	7.4 (±2.5)	7.3 (±2.1)	7.7 (±2.6)	7.7 (±2.6)	7.7 (±2.4)	7.5 (±3.1)	7.6 (±3.2)	6.9 (±2.7)	6.8 (±3.5)	6.9 (±3.5)	6.2 (±2.9)	7.3 (±3.1)	7.4 (±3.5)	7.1 (±2.4)
	2013	5.3 (±2.3)	5.4 (±2.3)	5.3 (±2.3)	6.3 (±2.1)	6.2 (±2.2)	6.3 (±2.0)	6.5 (±2.4)	6.6 (±2.7)	6.4 (±2.0)	6.7 (±2.8)	6.8 (±3.2)	6.4 (±1.9)	6.9 (±2.4)	6.9 (±2.4)	7.0 (±2.3)	7.3 (±4.0)	7.5 (±4.2)	6.5 (±2.4)	6.5 (±2.6)	6.6 (±2.9)	6.3 (±2.1)
	2019	5.6 (±2.5)	5.5 (±2.6)	5.6 (±2.4)	6.0 (±2.5)	5.9 (±2.8)	6.0 (±2.4)	6.1 (±2.1)	6.1 (±2.3)	6.1 (±1.9)	6.1 (±2.1)	6.2 (±2.3)	6.0 (±1.8)	6.4 (±2.2)	6.5 (±2.3)	6.2 (±2.0)	6.7 (±3.0)	6.5 (±2.9)	7.2 (±3.1)	6.0 (±2.3)	6.1 (±2.5)	6.0 (±2.2)
Pt age (mean (SD))	2008	27.9 (±13.8)	29.4 (±14.0)	27.1 (±13.6)	31.7 (±11.7)	32.8 (±12.6)	30.5 (±10.7)	34.3 (±11.9)	35.4 (±12.5)	32.7 (±10.8)	36.7 (±13.1)	37.6 (±13.2)	33.7 (±12.2)	35.1 (±16.2)	36.0 (±16.1)	30.5 (±15.9)	28.2 (±18.5)	28.5 (±18.5)	25.5 (±17.8)	33.5 (±13.2)	34.9 (±13.8)	31.3 (±11.8)
	2013	28.2 (±13.7)	30.0 (±13.7)	27.4 (±13.6)	34.0 (±10.8)	35.0 (±11.6)	33.4 (±10.1)	36.4 (±10.7)	37.8 (±11.2)	34.8 (±9.9)	39.4 (±10.7)	40.5 (±11.1)	37.3 (±9.8)	40.9 (±12.6)	42.0 (±12.4)	36.3 (±12.7)	39.1 (±17.0)	39.7 (±17.1)	35.0 (±16.0)	36.5 (±12.1)	38.5 (±12.5)	34.0 (±11.2)
	2019	31.8 (±14.5)	33.5 (±14.2)	30.7 (±14.5)	36.4 (±10.9)	37.1 (±11.8)	36.0 (±10.3)	38.4 (±9.8)	39.4 (±10.6)	37.5 (±9.0)	40.6 (±10.5)	42.0 (±10.8)	38.7 (±9.8)	43.0 (±11.5)	43.9 (±11.6)	40.8 (±10.9)	43.3 (±14.3)	43.6 (±14.5)	41.2 (±13.1)	38.1 (±12.0)	40.0 (±12.3)	36.2 (±11.3)
Prop. Fem. Pts (mean (SD))	2008	55.7 (±15.1)	46.9 (±10.7)	60.7 (±14.9)	55.2 (±13.2)	46.2 (±7.5)	63.8 (±11.6)	54.3 (±13.0)	46.3 (±7.4)	65.3 (±10.9)	51.0 (±11.0)	46.8 (±7.0)	65.0 (±10.7)	49.5 (±11.1)	47.3 (±8.5)	61.5 (±15.7)	47.8 (±13.2)	46.7 (±11.1)	57.6 (±22.6)	53.2 (±12.9)	46.6 (±7.8)	64.0 (±12.1)
	2013	55.3 (±15.6)	47.8 (±13.7)	59.0 (±15.1)	55.1 (±12.1)	46.1 (±8.3)	61.2 (±10.4)	53.7 (±12.3)	45.6 (±7.4)	62.9 (±9.9)	52.4 (±12.1)	45.9 (±7.5)	64.7 (±9.3)	48.9 (±10.1)	45.9 (±7.2)	62.2 (±10.5)	49.6 (±12.2)	47.2 (±10.4)	64.8 (±11.9)	53.1 (±12.5)	46.1 (±8.3)	62.3 (±11.0)
	2019	54.3 (±13.7)	47.7 (±11.2)	58.2 (±13.6)	54.3 (±11.8)	45.0 (±8.2)	59.9 (±10.0)	53.5 (±11.2)	45.4 (±7.6)	60.6 (±8.9)	52.4 (±11.8)	44.8 (±7.8)	62.2 (±8.5)	49.9 (±11.7)	45.1 (±7.9)	63.0 (±10.2)	48.2 (±9.9)	45.9 (±8.1)	60.7 (±9.6)	52.9 (±12.0)	45.5 (±8.4)	60.4 (±10.3)
FTE (N (%))	2008	290 (49.0)	146 (50.3)	144 (49.7)	1210 (64.5)	754 (62.3)	456 (37.7)	1802 (73.0)	1173 (65.1)	629 (34.9)	1481 (75.1)	1209 (81.6)	272 (18.4)	239 (58.4)	220 (92.1)	19 (8.0)	114 (32.0)	107 (93.9)	7 (6.1)	5136 (66.9)	3609 (70.3)	1527 (29.7)
	2013	335 (45.4)	152 (45.4)	183 (54.6)	1073 (64.4)	556 (51.8)	517 (48.2)	1694 (73.3)	1014 (59.9)	680 (40.1)	1634 (75.3)	1156 (70.8)	478 (29.3)	474 (67.0)	415 (87.6)	59 (12.5)	189 (41.6)	177 (93.7)	12 (6.4)	5399 (67.1)	3470 (64.3)	1929 (35.7)
	2019	734 (51.9)	351 (47.8)	383 (52.2)	1401 (65.6)	628 (44.8)	773 (55.2)	1722 (76.8)	881 (51.2)	841 (48.8)	1681 (73.8)	1052 (62.6)	629 (37.4)	514 (72.6)	402 (78.2)	112 (21.8)	327 (54.6)	288 (88.1)	39 (11.9)	6379 (68.0)	3602 (56.5)	2777 (43.5)

Comp. FPs: Comprehensive family physicians; Pract.: Practice; PC: Primary care; Pt(s): Patient(s); Prop: Proportion; Fem: Female; FTE: Full-time equivalent

Table 2. Characteristics of patients attached to near-retirement comprehensive family physicians over time, by near-retirement group

		Age 55+ Comprehensive FPs		Age 65+ Comprehensive FPs		Age 70+ Comprehensive FPs	
Patient Characteristics		N	%	N	%	N	%
OVERALL (N, % of all patients attached to all comprehensive FPs)	2008	3,571,661	37.5	690,642	7.2	214,861	2.3
	2013	4,676,625	45.0	1,399,119	13.5	419,172	4.0
	2019	4,935,992	43.0	1,695,126	14.8	666,404	5.8
Aged 65+ (N, % of patients attached to near-retirement physician group)	2008	597,707	16.7	136,394	19.8	45,414	21.1
	2013	846,974	18.1	298,545	21.3	95,833	22.8
	2019	1,003,769	20.3	402,430	23.7	176,473	26.5
Female patients (N, % of patients attached to near-retirement physician group)	2008	1,804,585	50.5	338,656	49.0	103,386	48.1
	2013	2,371,923	50.7	678,971	48.5	201,104	48.0
	2019	2,498,453	50.6	823,090	48.6	317,967	47.7
Rural patients (RIO score 40+) (N, % of patients attached to near-retirement physician group)	2008	233,045	6.5	48,860	7.1	14,323	6.7
	2013	292,357	6.3	88,311	6.3	20,294	4.8
	2019	274,099	5.6	83,691	4.9	33,545	5.0
Highest (4+) RUB (N, % of patients attached to near-retirement physician group)	2008	677,436	19.0	137,995	20.0	44,067	20.5
	2013	878,340	18.8	283,013	20.2	88,182	21.0
	2019	983,818	19.9	350,439	20.7	146,298	22.0
Highest (5+) annual core primary care visits (N, % of patients attached to near-retirement physician group)	2008	2,109,950	59.1	403,026	58.4	127,050	59.1
	2013	2,462,236	52.7	753,388	53.9	227,090	54.2
	2019	2,480,395	50.3	876,487	51.7	346,668	52.0

COPD (N, % of patients attached to near-retirement physician group)	2008	233,498	6.5	51,856	7.5	16,411	7.6
	2013	326,748	7.0	115,669	8.3	37,477	8.9
	2019	337,202	6.8	132,395	7.8	59,350	8.9
CHF (N, % of patients attached to near-retirement physician group)	2008	69,573	2.0	15,645	2.3	4,952	2.3
	2013	80,026	1.7	28,187	2.0	9,214	2.2
	2019	90,436	1.8	35,567	2.1	15,832	2.4
Diabetes (N, % of patients attached to near-retirement physician group)	2008	327,127	9.2	68,392	9.9	21,389	10.0
	2013	506,014	10.8	170,115	12.2	52,815	12.5
	2019	555,358	11.3	215,696	12.7	92,395	13.9
Frailty (N, % of patients attached to near-retirement physician group)	2008	66,559	1.9	14,875	2.2	4,964	2.3
	2013	98,490	2.1	33,005	2.4	10,794	2.6
	2019	114,085	2.3	43,032	2.5	18,597	2.8
Any mental health illness in last 2 years (N, % of patients attached to near-retirement physician group)	2008	825,520	23.1	166,257	24.1	51,802	24.1
	2013	979,987	21.0	311,771	22.3	96,543	23.0
	2019	1,022,523	20.7	355,911	21.0	150,153	22.5
Lowest income quintile (N, % of patients attached to near-retirement physician group)	2008	706,504	19.8	150,381	21.8	48,403	22.5
	2013	876,982	18.8	282,922	20.2	91,236	21.8
	2019	944,888	19.1	348,869	20.6	142,881	21.4
Highest housing instability quintile (N, % of patients attached to near-retirement physician group)	2008	761,397	21.3	165,525	24.0	54,275	25.6
	2013	934,472	20.0	295,059	21.1	92,653	22.2
	2019	1,031,506	20.9	374,322	22.1	155,859	23.4
Highest material deprivation	2008	736,903	20.6	163,835	23.7	52,733	24.9

quintile (N, % of patients attached to near-retirement physician group)	2013	1,045,136	22.4	338,012	24.2	112,097	26.9
	2019	926,043	18.8	352,849	20.8	145,084	21.8
Highest racialized neighborhood quintile (N, % of patients attached to near-retirement physician group)	2008	962,252	26.9	177,586	25.7	63,167	29.8
	2013	1,335,124	28.6	397,430	28.4	124,062	29.8
	2019	1,521,975	30.8	584,512	34.5	213,182	32.0
Recent immigrant (N, % of patients attached to near-retirement physician group)	2008	269,131	7.5	52,717	7.6	21,202	10.9
	2013	289,772	6.2	83,484	6.0	27,024	7.0
	2019	277,755	5.6	82,560	4.9	28,449	4.3

Interpretation of Table 2 rows:

Interpretation of the "Overall" category: For example, in 2019, 1,695,126 patients were attached to a comprehensive FP aged 65+. This represents 14.8% of all patients who are attached to a comprehensive FP.

Interpretation of each patient category: For example, in 2019, of the 666,404 patients attached to comprehensive FPs over the age of 70 years, 28,449 (4.3%) were recent immigrants

FPs: Family physicians

RIO: Rurality Index of Ontario

RUB: Morbidity, based on Resource Utilization Band

COPD: Chronic obstructive pulmonary disease

CHF: Congestive heart failure

Table 3. Practice characteristics: Medical and social complexity of patients attached to comprehensive family physicians over time by physician age and sex

		<35 Years			35-44 Years			45-54 Years			55-64 Years			65-69 Years			70+ Years			TOTAL		
		Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
		%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Highest morbidity (RUB (4+))	2008	15.3	14.7	15.6	16.2	15.8	16.7	16.4	16.5	16.2	17.3	17.5	16.6	16.8	17.2	14.0	14.0	14.1	13.0	16.5	16.7	16.3
	2013	17.5	17.6	17.4	18.2	17.5	18.7	17.7	17.8	17.6	18.1	18.5	17.3	19.5	20.0	17.5	20.1	20.5	17.9	18.1	18.3	17.8
	2019	19.3	19.4	19.2	20.6	20.2	20.8	19.4	19.4	19.4	19.5	20.2	18.7	20.3	20.4	20.1	21.4	21.5	21.3	19.8	19.9	19.7
Lowest income quintile	2008	18.5	19.2	18.1	18.1	19.6	16.6	18.4	19.8	16.4	19.9	20.2	18.8	22.6	22.5	23.6	23.9	20.1	17.2	19.0	20.1	17.2
	2013	18.9	20.6	18.0	17.2	19.1	16.0	18.0	19.4	16.4	18.4	19.5	16.5	20.5	20.4	21.2	24.0	24.2	22.5	18.3	19.6	16.7
	2019	20.4	21.9	20.7	18.8	20.7	17.6	18.3	20.5	16.5	18.8	20.4	16.8	19.9	20.7	17.9	22.1	22.2	21.4	19.0	20.7	17.5
Highest housing instability quintile	2008	24.5	22.8	25.5	20.6	20.7	20.4	20.4	20.4	20.4	21.9	21.6	23.0	24.0	23.1	29.2	25.5	25.6	24.2	21.4	21.2	21.7
	2013	26.0	23.6	27.2	21.8	20.9	22.5	19.9	20.4	19.4	20.8	20.6	21.3	21.7	21.8	21.2	24.5	24.1	26.6	21.4	20.9	21.9
	2019	26.5	25.3	27.2	24.5	24.7	24.5	21.1	21.8	20.4	21.4	21.5	21.3	22.6	21.7	24.9	25.5	25.2	27.1	23.0	22.7	23.3
Highest material deprivation quintile	2008	18.6	19.8	17.9	17.4	19.3	15.5	18.2	20.1	15.6	20.5	21.3	18.1	23.7	23.9	22.4	25.7	26.2	21.3	19.0	20.6	16.4
	2013	22.9	24.6	22.0	20.5	22.1	19.4	21.2	22.9	19.3	21.4	22.6	19.2	23.7	23.2	25.7	29.2	29.4	27.8	21.5	22.8	19.9
	2019	18.2	19.7	17.3	17.3	19.9	15.8	17.0	19.3	15.0	18.1	19.8	15.9	19.7	20.9	16.7	21.8	22.1	19.9	17.8	19.8	15.9
Highest racialized neighborhood quintile	2008	27.4	30.8	25.5	27.5	28.4	26.5	26.0	26.1	25.9	27.2	26.3	30.4	28.0	26.4	37.2	32.6	32.8	30.7	26.9	26.9	27.0
	2013	29.9	31.1	29.2	28.6	29.2	28.2	27.9	29.2	26.6	27.2	27.2	27.3	27.7	25.5	37.3	33.0	32.0	39.4	28.0	28.1	28.0
	2019	26.0	26.6	25.7	25.8	27.2	25.0	28.5	29.2	27.8	27.0	26.8	27.3	33.2	33.7	31.9	32.1	30.9	38.5	27.4	28.3	26.7

Interpretation: For example, in 2008, within the group of comprehensive family physicians under the age of 35 years, 15.3% of patients in those practices had the highest level of morbidity (RUB 4+). When further stratified by physician sex, 14.7% of patients attached to male comprehensive family physicians belonged to the highest morbidity (RUB 4+) group.

RUB: Morbidity, based on Resource Utilization Band

TAB 5

BRIEFING

News

Ontario family physicians call for health minister's resignation

The petition was started after the government claimed there was no family physician shortage during last week's rounds of arbitration with the OMA over doctors compensation.

Published May 13, 2024 at 4:17pm

By Barbara Patrocinio

The Ontario Union of Family Physicians (OUFP), an advocacy group for the over 2,100 family doctors in the province, has started a petition calling for the resignation of Health Minister Sylvia Jones.

The petition, which has over 2,000 signatures so far, came after the Health Ministry claimed there was no physician shortage in the province during an arbitration session with the Ontario Medical Association (OMA) last week.

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Have a tip?

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TAB 6

SpellTower, Flipart, Crosswords and more. *Try PUZZMO puzzles today >>*

Opinion / Columnists

Adam: It's ridiculous for Ontario to say it's not worried about 'diminished' supply of doctors

2.3 million people without a doctor is not just a number. There are faces — real people — behind these numbers, whom the Ford government is choosing to ignore.

Mohammed Adam

Published May 14, 2024 • Last updated 6 days ago • 3 minute read

Join the conversation

Ontario Health Minister Sylvia Jones makes an announcement on health care with Premier Doug Ford. The Ford government says, in an arbitration brief on contract negotiations with the Ontario Medical Association, that it has no concern over the "diminished supply" of doctors in the province. PHOTO BY FRANK GUNN /The Canadian Press

Arbitration hearings are, in a way, a game of one-upmanship. Protagonists and antagonists alike try to put their best foot forward to win the argument and secure the best deal.

So, quite often, there is posturing, exaggeration and fudging of the facts. One side or the other can create an alternate universe of facts, and it is up to the arbitrator to sift through the conflicting presentations and come up with a compromise.

But the claim by the Ford government in its arbitration brief on contract negotiations with the Ontario Medical Association that it has no concern over the "diminished supply" of doctors in the province is beyond the pale. It is irresponsible in the midst of an obvious shortage of family doctors for a government to make such a claim. It is a slap in the face to millions of Ontarians who don't have a family doctor, or access to primary care, and are sweating everyday over their health.

"We will illustrate that there is no concern of a diminished supply of physicians. Across Canada, Ontario has the best record in attracting medical students to train in Ontario," the brief from the Ministry of Health says. "Further, Ontario has enjoyed a growth in physicians that far outstrips population growth." In effect, there is nothing to worry about, the province says.

Here's the puzzle: If Ontario has no doctor shortage and everything is fine in the province, why are 2.3 million people without a family doctor or access to primary care? Perhaps Ontarians are being misled. Perhaps all the claims about people not having a family doctor are a big ruse. Perhaps the Ontarians lining up at walk-in clinics for hours and not getting to see a doctor are faking it. In February, hundreds of people in Kingston lined up for hours starting at dawn, in bitter cold, in hopes of signing up for a family doctor. Perhaps, what we see with our own eyes, and what friends and family experience is just a figment of our imagination.

The truth is that the 2.3 million without a doctor is not just a number. There are faces — real people — behind these numbers, whom the Ford government is choosing to ignore. I have a friend who has no family doctor, but needs to have breast screening done, and can't find a doctor to book one. Twice, she took time off work and lined up at a walk-in clinic to see a doctor about it. Twice, she waited for hours and just as she got to the door, was told the day's roster has been filled and she had to come back. I am sure there are many more like her out there, and they are the people the government is abandoning with its claim that there is no problem with the supply of doctors.

Here's another thing: There is a government agency called HealthForceOntario, part of whose mandate is to recruit doctors, and its data shows 3,000 physician job vacancies. There are numerous vacancies from Ottawa to Toronto to Concord and Hamilton, says the Ontario Medical Association. As of January, Ottawa had 171 job openings, Toronto had 305 and Hamilton 114. On and on it goes in communities across the province.

So, if Ontario is producing more doctors than population growth, where are these physicians when they are needed? Are they sitting at home collecting welfare as jobs go a-begging? "Over the next decade, the physician shortage (in Canada) will become more severe," the Fraser Institute warned. That was in 2011. If, today, the government can't acknowledge the crisis in family medicine, how can it solve the problem?

Pressed on the issue, Health Minister Sylvia Jones said her ministry wasn't saying there is no doctor shortage, but that Ontario physicians are important to health care "and we'll continue to work with them to grow the workforce." This is the lamest attempt at damage control you'll ever hear from a government that is abdicating its responsibilities. We should demand better.

Mohammed Adam *is an Ottawa journalist and commentator. Reach him at nylamiles48@gmail.com*

TAB 7

May 14, 2024

43rd Parliament, 1st Session

< Previous sitting day (www.ola.org/en/legislative-business/house-documents/parliament-43/session-1/2024-05-13/hansard)

Next sitting day > (www.ola.org/en/legislative-business/house-documents/parliament-43/session-1/2024-05-15/hansard)

Hansard Transcript 2024-May-14 vol. A (PDF) (www.ola.org/sites/default/files/node-files/hansard/document/pdf/2024/2024-05/14-MAY-2024_L158A.pdf)

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

Tuesday 14 May 2024 Mardi 14 mai 2024

Richard Crosby Investments Limited Act, 2024 (www.ola.org#P1396_307663)

2038778 Ontario Ltd. Act, 2024 (www.ola.org#P1402_308246)

2038778 Ontario Ltd. Act, 2024 (www.ola.org#P1407_308690)

The House met at 0900.

The Speaker (Hon. Ted Arnott): Good morning. Let us pray.

Prayers.

Orders of the Day

Strengthening Accountability and Student Supports Act, 2024 / Loi de 2024 pour renforcer la responsabilisation et les mesures de soutien aux étudiants

Resuming the debate adjourned on May 7, 2024, on the motion for third reading of the following bill:

Bill 166, An Act to amend the Ministry of Training, Colleges and Universities Act / Projet de loi 166, Loi modifiant la Loi sur le ministère de la Formation et des Collèges et Universités.

The Speaker (Hon. Ted Arnott): Further debate?

Mr. John Fraser: Good morning, everyone. I'll be brief. I know you don't believe me—

Mr. Graham McGregor: Hear, hear.

Mr. John Fraser: There we go. I knew I would get a response for that.

There are three things that this bill does. The one that I can see that has—

Mr. Will Bouma: Merit?

Mr. John Fraser: I don't know if I would use merit, but the transparency of cost. I think that's good for families. But when I take a look at what's in the rest of this bill, it's an overreach. On top of that, it's fine to say that we want you to do this and we think this is important, and then not provide the resources necessary to do the things that you want them to do? That's what this bill does, right?

You have the tools available already, but you're putting more demands and giving yourself more power in relation to universities and colleges. All of us in this building are against all forms of hate: anti-Semitism, Islamophobia, transphobia. We're all there. We did have tools inside government in 2018 in the Anti-Racism Directorate to address all of those things, but this government cut them all.

This doesn't happen very often. It's not very often that I agree with the Premier of this province, but I want to tell you why or tell you the thing that the Premier said with regard to this bill: "It's really up to the dean to govern his own university. I think we shouldn't get involved in that, that's my personal opinion. Like I said, there's a lot of tools ministers have that they don't use. It's up to the people, that's what we believe in." And I agree.

The Speaker (Hon. Ted Arnott): Questions to the member for Ottawa South?

Mr. Joel Harden: I want to thank the member for his remarks. I'm wondering if he could elaborate for us—because he and I both share a city where a number of our residents don't feel safe right now. They're talking to us through our community offices about not feeling safe on campus. I'm wondering if the member could give this government some advice about what it can do.

I note that the blue-ribbon panel had asked for $2.5 billion in additional funding from this government. Most of the mental health supports on post-secondary campuses in Ottawa Centre are struggling, with wait-lists in excess of six months for mental supports for students. So I'm wondering what the funding message could be to this government to make sure that people do feel supported and safe on campus.

Mr. John Fraser: The recommendations to the blue-ribbon panel are critical. Mental health and anti-racism and hate, they go together. The pressures that are on people can often lead to those biases because people are struggling. My colleague is correct: There are a lot of people in our ridings that don't feel safe on their campuses, that don't feel like they're getting support that is needed.

To actually make programs and then not provide the support that is needed to make those programs that you say are important work is not really doing a heck of a lot. That's why this bill is hard to support.

The Speaker (Hon. Ted Arnott): The member for Brampton North.

Mr. Graham McGregor: I want to thank the member opposite. I note that the Liberal Party hasn't released a full-scale post-secondary education plan, and I know that students are worried about what that might mean in terms of tuition increases. We froze tuition—we actually cut it and then froze it.

I'm wondering if the member can confirm that when the Liberals release their plan for post-secondary education, tuition increases will be off the table.

Mr. John Fraser: That's a great question. What I want to say is, yes, you froze tuition, but you didn't put any supports there for the colleges and universities. And then you drove them to accept more and more foreign students to be able to support the colleges and universities, thereby, in some ways, creating grade inflation and reducing opportunities for Ontario students, to a certain extent. I'm not going to take any lessons from this government on post-secondary education.

I was part of a government—I worked for a Premier who put a focus on post-secondary education. Campuses expanded. We made sure more people had access to post-secondary education, like first generation, and then programs later to add grants and supports for people of very low income to be able to get an opportunity.

I'm not going take any lessons from you. So your demand of knowing what I'm going to say or what I'm going to do, I'm not going to buy that. You guys haven't done what you're supposed to do.

The Speaker (Hon. Ted Arnott): I'll remind the members to make their comments through the Chair.

The next question?

Mr. Joel Harden: I just want to ask again to the member from Ottawa South: It's gotten to the point, because of the cuts to post-secondary institutions and universities which I'm familiar with, that almost 50% of the teaching at Carleton University—a great university that I'm proud to serve—is done by sessional instructors with absolutely no job security, no pensions, no benefits. It's very common that these colleagues would be teaching at one, two or three campuses. I used to represent them as a union official for CUPE 4600. This is a problem not just unique to this government. We've been relying more and more on contract, precariously employed faculty and staff.

Is that something you think this government should change and is it something you're committed to change?

Mr. John Fraser: If you want to have a stable workforce that delivers what you need, then you have to give them support—that means pay, that means benefits, that means security. That means that they can raise a family, like we're all able to do here.

Post-secondary education is not just fun and good, it's actually about the economy. It's actually about having the most highly trained, highly skilled workforce. It's the best thing for our economy. To not actually ensure that we can keep our workforce stable, that we have enough people to teach our young people the things that they need to learn, the skills that they need to build, it just doesn't make economic sense.

For a government that talks about expanding the economy and about growing, I cannot believe the lack of support this government has for post-secondary education.

The Speaker (Hon. Ted Arnott): That concludes the questions and answers for this round of the debate.

Hon. Andrea Khanjin: Point of order, Speaker.

The Speaker (Hon. Ted Arnott): Point of order: the Minister of the Environment, Conservation and Parks.

Hon. Andrea Khanjin: Pursuant to standing order 7(e), I wish to inform the House that tonight's evening sitting is cancelled.

The Speaker (Hon. Ted Arnott): Thank you very much.

Further debate?

Mr. Joel Harden: I'm happy to speak to Bill 166. This is an issue near and dear to my own heart, as someone who taught at the post-secondary level for a number of years and had the privilege to work with students and colleagues towards, we would hope, the advancement of the future, the advancement of the country.

0910

As I understand Bill 166, now at third reading before this House, this is about making sure that there is accountability and student supports available to people on our campuses. As I mentioned in the Q&A with the member for Ottawa South, I am being contacted increasingly—our office is—by students, staff and faculty on post-secondary campuses who do not feel safe. So the timing for this bill is fortuitous. But what I want to say in the time I have, Speaker, is that the focus of the bill, in my opinion, is misplaced, and certainly the applications and the resources that I've heard the government say will arrive with this bill, I think, at the moment, at least, are not going to the right areas.

Again, just speaking as someone who has taught at post-secondary institutions, I want everybody, if you can, to put your mind in the mind of a 38-year-old university professor, who, on June 28, 2023, was attacked by a 24-year-old student who walked into a hall at the University of Waterloo. The first thing that 24-year-old asked the professor was, "What's being taught in this class?" And when the professor said to that 24-year-old student, himself a student at the University of Waterloo, that it was a gender studies class, the student pulled out two large knives and proceeded to attack the professor. The only reason the professor wasn't critically injured is that she resisted, but two other students in that class of 40 got up to try to resolve the matter.

I'll never forget that day and the reporting that came out of the University of Waterloo, because I have had situations—not violent situations in class, but I have had situations in classes where I've taught where tempers have flared and people have jumped to their feet and you thought altercations were going to break out, because, frankly, that is what post-secondary education should be about: It should be about exploring ideas, even when passions flame, even when things can get difficult in the classroom. Because I want to believe that that's what our colleges and universities should be doing: They should be challenging us to think about our place in the world and how we use the skills that we have. But I have never encountered a situation like that, Speaker.

I wish I could say that in recent years it's an isolated situation. But we also know that the same pattern that police studies and court evidence has shown was present in the mind of this 24-year-old student, who was asocial, who was troubled, who openly disliked Pride events at the University of Waterloo and who would regularly intervene in campus online groups, spewing hatred against queer and transgender groups on campus. The same pattern repeats itself with a college dropout in London, Ontario, on June 6, 2021, who, on the third occasion, he'd marshalled—he'd tried to marshal the courage twice before, but on the third occasion managed to run down an entire Muslim family. I asked myself in the aftermath of this, as we've had so much debate and reflection, given the terrorism charges that were laid against this 20-year-old, what can we do through post-secondary education to make sure that people who have fallen so deep down those rabbit holes of hatred that they would see Muslim neighbours as somehow a threat—what are we not doing on campuses?

And then, again, something that's less known about the Quebec City mass shooting on June 27, 2017, is that that 27-year-old—and purposely, Speaker, I'm not naming the perpetrators, because I'm not interested in giving them any infamy, because I know that's one of the reasons why they committed their lethal acts. I'm not going to name them—was a political science student at Université Laval and had been known in his class, on his campus and online to specifically target Muslim neighbours—to specifically target them, to at least a few times walk around the Sainte-Foy mosque. And for the 40 people that he found worshipping on that day and the six fathers and brothers who are dead as a consequence of those lethal actions, I again ask the question for this House posed by this bill: What are we doing on campuses to reach hatred and diminish it before it manifests in a lethal act? I think that's a very important question.

When I looked at the blue-ribbon panel that the government amassed to give it advice on what to do with colleges and universities, and when I listened to the member for London West, both in this House and at committee, ask questions—worthy questions—we kept coming back to a similar theme: We aren't putting the faith in the resources in colleges and universities to make sure that students, staff and faculty have access to the resources they need when they're in a troubled mental health state, when questions and difficult circumstances pop up. We are not providing the resources necessary.

The blue-ribbon panel asked for $2.5 billion; the government has given the post-secondary sector $1.2 billion, so half the ask. I know at Carleton University, as I said earlier in the question to the member from Ottawa South, there is often at least a six-month waiting list when students ask for urgent mental health supports on campus—six months; six months when you're exhibiting behaviours that suggest that you could harm yourself or perhaps others.

So what we've done in the city of Ottawa is, through our community health centres, created a program called Counselling Connect: that, within 48 hours of intake—that's the goal—it gets people access to three psychotherapy sessions that are culturally appropriate and as fast as possible. The goal is within 48 hours of intake. I know this program right now is helping over 700 people in the greater city of Ottawa. Some of those folks are students. That would make sense. That program, Counselling Connect, costs community health centres in our city, who are strapped for cash, believe me, $600,000. But I want to believe that if Bill 166 wanted to provide the supports to students, staff and faculty on our campuses, it could partner with an organization like Counselling Connect. That would have real impact to make sure that people got the help they needed when they needed it.

Speaker, I'm also mindful of the fact that this bill is before the House at a time when many of our neighbours, many of our citizens, are mobilizing—understandably, given the horrors that we are seeing in the war between Israel and Hamas. I know the members opposite, the minister—the Premier has openly asked for encampments that are cropping up on university campuses to be dismantled, that they believe these encampments to be embodiments of hatred.

What I want to encourage my friends opposite to consider—because I visited the encampment at the University of Ottawa, I visited at the end of the workday here the University of Toronto encampment. While I may not agree with everything I've seen and everything that's written down, I can honestly say that I have never seen better organized, empathetic young people trying to ask decision-makers in this country to do what they can to create more tolerance, peace and understanding. I am amazed. When I walked into the encampment at the University of Toronto, I had to go through almost a 10-minute interview intake. So I was aware, as a politician, that I was not to be photographing or videoing people. If I wanted to conduct media interviews on site, I needed to contact them first. It was their encampment and there were rules around how I behaved and how I treated others. On this site, there was an Indigenous part—I believe it's still there—with a sacred fire. I was blown away by the level of organization. The consistent message that I heard at least from students saying: "We want to be a voice for peace. We want Canada to be a voice for peace."

So I am discouraged, I'll be honest, when my colleagues in this House are asking for these encampments to be dismantled, without reckoning with that message that I hear loud and clear. I heard it at home and I heard it across the street at the University of Toronto. I would like to think that that is exactly the kind of message that should be embodied in our programs on campus: a greater understanding of each other; that we aren't intimidated by each others' symbols. We've had the debate in this House about the Palestinian kaffiyeh not being permitted in this chamber.

We have to see each other for our whole person. When heinous and horrible acts are committed with cultural symbols or religious symbols, we don't hold an entire culture accountable for that. We hold the individuals responsible for that. So I actually, earnestly, want my friends in government to hear that message. I want them to think about what is happening on campus across Canada—it's not a threat; it's an opportunity.

I look at two stories, and I will end with this from home, from the University of Ottawa. In the first story, I'm going to be protecting the student's identity because she fears reprisal. We're going to call her Miriam, for argument's sake. Miriam is an arts major, a Palestinian student. She recounted to me an instance where a colleague in her class, who had served in the Israeli military—serving in any military is an honourable thing—had said in class that he believed every Gazan needed to be eliminated for the goal of peace to be achieved. She was

stunned, absolutely stunned—mouth-dropped-open stunned. The gentlemen identified himself as a professional sniper and talked openly about how he believed that what he was doing was contributing to the cause of peace. She was stunned. She filed a formal complaint, and the response of the human rights office, sadly, at the university was to say, "Do you need counselling?" Do you need counselling?

0920

Again, our classrooms should be places of vigorous debate where people of different perspectives should be able to hold forth, but the kind of open anti-Palestinian racism—like open anti-Semitism, open Islamophobia—open forms of hatred that I am seeing on our campuses, where so many neighbours are falling down these wells of hatred, we have to provide the mental health resources and training to the campuses so they can respond. If we don't do that, what we don't respond to—which seems uncomfortable in a class on one day—could be a lethal event that we respond to later, and, frankly, we saddle the first responders who are there with the trauma of having to witness that, not only the people who live through it.

I also want to talk about Dr. Yipeng Ge, who has been a public advocate, who is a medical resident at the University of Ottawa who is suspended for his social media posting on Palestinian human rights—suspended. He was not given the grounds for his suspension for a week and a half, he was just told that he was not to go to the medical school anymore. This is a medical professional who has travelled the world, worked in refugee camps, seen horrible things, helped people in incredibly difficult circumstances, given an arbitrary suspension.

When Dr. Ge approached us, I simply listened, I tried to get a sense of how the university was dealing with the matter and I said to him, "What do you want from me?" He said, "Joel, I would love it if you would engage the university, love it if you would talk to them." I said, "Sure. The University of Ottawa are my friends. We work together all the time." I'm sad to say that there has been no public apology offered to Dr. Ge. There has been no public comprehensive investigation. He has decided—and this is really one of the more shameful things I can remember in recent history, at a very difficult time—not to go back to the University of Ottawa, even though his suspension has been lifted and he's allowed to, because he feels like his integrity has been questioned and he feels like the people responsible for castigating him for his beliefs have not been held accountable.

I would welcome the government's interest in making sure that there are student supports, that we do hold campuses accountable. I think it's worthy. I do see the rise of hatred on our campuses and I want to be part of the solution to deal with it, but we can't do this in an arbitrary manner and we have to make sure that the resources are available at a local level that people can seek help.

Again, I just want to be as clear as I end: I am not saying that the way we deal with this is that we label people as being hateful and we segregate them and we marginalize them. No—I am actually encouraging a strategy of dialogue and conflict resolution here, modelling what we want to see between countries in the world at a local level through the campuses. The most skilled conflict resolvers, mediators, that I've met at a campus level do precisely this all the time, but we ask them to do a lot with very little budget. I'll end with that.

I'll say that the bill is coming to the House at a very opportune time, fortuitous time, but I think its focus needs to be ensuring that you at least meet the demands of the blue-ribbon panel—the $2.5 billion—and that we have some trust and collaboration with our campus partners. When we feel they have misstepped and they haven't done their due diligence, as I think is the case with Dr. Ge, then we make sure that the province does insist that due process is followed at the campus level. I thank you for your attention.

The Deputy Speaker (Ms. Donna Skelly): It is now time for questions.

Ms. Peggy Sattler: Thank you to my colleague the member for Ottawa Centre for his remarks. He spoke about the financial crisis that is facing our post-secondary sector and the consequences for teaching faculty. Many of those faculty positions are filled by contract faculty who have very precarious job security—no job security, actually—very precarious employment, lack of benefits etc.

One of the things that we heard in committee is the same thing is happening in the mental health services offices on campus, the same thing is happening in the equity and diversity and inclusion offices on campus. They are terribly understaffed because universities and colleges don't have the resources. Has the member been hearing that in his community as well?

Mr. Joel Harden: Absolutely. And something I used to say when I was a union rep representing sessionals—and the member for Thunder Bay–Superior North has been a sessional professor; the member for Spadina–Fort York has; you have a lot of experience in this House, Speaker—is that there's an alarming amount of people that are living hand to mouth actually doing the work of working with students

directly, and it's not correct. If we're doing that also with our counselling support services, we're really selling ourselves short.

So again, I mentioned in my remarks a program called Counselling Connect that we've initiated in Ottawa, which I think could be grown across the province of Ontario and that could help our campuses deal with the wait-lists and the backlogs, because we don't want someone suffering on a wait-list when we could be helping them.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Mr. Lorne Coe: To the member from Ottawa Centre: This government believes that all students in Ontario deserve to learn in a healthy, safe and respectful environment. Our post-secondary institutions have a responsibility to provide a safe and supportive learning environment. When they fail to protect students, we end up with scenarios the likes of which we heard about first-hand in the standing committee—situations where students no longer feel safe to return to campus and finish their studies.

Will the member opposite support measures in Bill 166 to ensure institutions are inclusive and safe environments where students can complete their studies?

Mr. Joel Harden: As I said in debate, the objective is shared, absolutely. We want people to feel safe. We want them to finish their studies. We want them to go out there and make our communities and our country a better place. But we can't expect that to happen on a shoestring. Nothing any minister in this government does, I want to believe, is done on a shoestring. You have staff. You have people advising every single decision. You measure and you research and you act. Why are we asking our campuses to do any different? Why are we offering them half the amount of money that the blue-ribbon panel suggested we offer them so they can do their important work? That would be my question back to the member.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

MPP Lise Vaugeois: I want to thank the member from Ottawa Centre for your words.

There are a few things: We know that the resources aren't there to support the mental health of students when they're in crisis. We also know that campuses are places of very lively debate, and sometimes very intense debate. You spoke a bit about creating opportunities for dialogue.

What I see in this bill is that the minister is actually going to have unilateral powers to intervene, which makes me very uncomfortable. But there is a real need to have fora where students and professors can talk about really difficult issues and bring the temperature down at the same time. Can you speak to that, please?

Mr. Joel Harden: I thank the member for the question. You took me right back to Kingston and being an undergraduate in Kingston and being the first person in my family to go to university, encountering a world that was so much bigger than my small town of 2,000 people, and learning a lot from not just students who are Canadian but learning from students from all over the world. That was even more so when I went to York University, which is really one of the international universities that Ontario has. So it does concern me.

I agree with my colleague that ministerial directives are being contemplated when we aren't properly funding the campus programs. But I also think the minister does—and she has said so—have a responsibility to ensure that the province wants people to feel safe at work and at school, for sure. I noted in my comments instances where I do believe the campus has fallen short. Dr. Yipeng Ge's case, I think, is a real travesty, that that incredibly talented mind is not going be part of the University of Ottawa community anymore.

So again, I would like a more collaborative approach. I do think the minister has an important responsibility, but we can't do it on the cheap. We have to make sure it's well resourced.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Andrew Dowie: I want to thank the member opposite for his remarks. Listening to them, I was thinking of some of the students that I've met back home who have really found it tough to make ends meet. Under the leadership of Premier Ford, we've seen the government cut and freeze tuition by 10%, a policy that has saved students more than $760 million annually. I know the government proposes to build on this historic action by regulating ancillary fees to make sure that tuition remains affordable for students. So I just want to see if the member opposite will support the bill regarding textbook costs to help students make informed financial decisions.

Mr. Joel Harden: I guess what I would say to the member is, I think tuition reductions and freezes are fine, but, if on the other hand, the funding envelope coming into the university intensifies the financial crisis on campus, that ultimately doesn't serve anybody.

If you can't afford to have an educator in front of a classroom of 20 for a small seminar—instead, it has to be 42—what is that educator likely to do? Are they going to be testing people's writing skills, deliberative skills, debating skills, or are they going to be doing multiple-choice tests? Because, ultimately, that's all you manage when the school's funding is being cut because of the tuition revenue coming down.

I look at other countries around the world. I look at a great country like Germany. This is country where, if you meet the standards, you can study as an international student there for free at over 200 universities, paying modest ancillary fees. What do they get from that, one would ask, if you were a German citizen paying taxes? They get the benefit of people coming from all over the world to enrich the debate at that campus.

I actually see Ontario going in the opposite direction. We are using international students, often, as revenue sources, as cash cows—what many of them tell me—at a time when the funding to our campuses is cut off.

I salute the member's interest in keeping the costs for students low, but we can't do that at the expense of finances for the campus, which is what's happening now.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Peggy Sattler: To my colleague the member for Ottawa Centre: One of the things that we heard at committee is that there are two basic essentials for policies to be effective. One is the direct engagement and involvement of those who are directly affected by a policy, to be involved in the development of that policy, and the second is the resources to operationalize a policy, to implement it. I wondered if the member sees either of those two criteria included in the bill.

Mr. Joel Harden: No, I don't. And this is where, ultimately, we're not using the resources we have.

Let me just be a lot more specific. Saint Paul University, which is an independent campus at the University of Ottawa, which is in Ottawa Centre, they do what they can with what they have. One of the programs they have, which helps our mental health strategy for the city, their psychotherapy students participate in offering people in need of free or pay-what-you-can counselling sessions overseen by a trained professional. That's them maximizing their budget, collaboratively, doing whatever they can to help people in distress.

So when people come through our constituency, we have areas of referral: Counselling Connect, which I've already talked about; workplace sites, if there is one; an employee wellness program, where there is one; or the Saint Paul campus, playing a huge role for the city. That's collaborative. I would invite the minister to be as collaborative in this bill.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Lorne Coe: I want to take you back to standing committee again when we were deliberating on Bill 166. We heard disturbing accounts from students who lost lab positions, had members of their families threatened and who were physically assaulted on the basis of their race or ethnicity. We also heard from the students that their institutions did nothing, absolutely nothing, to help them or hold their perpetrators accountable. One said that it was futile to report anything since nothing would be done if they did.

To the member from Ottawa Centre, this legislation provides provisions to address the concerns that these students expressed. I hope you'll join me—

The Deputy Speaker (Ms. Donna Skelly): Thank you.

Response?

Mr. Joel Harden: You won't find any disagreement on this side of the House as to supporting students, staff and faculty in distress. But we also shouldn't unduly politicize it, and we should make sure that response is well-funded. That would be what I would say to my friend opposite.

The Deputy Speaker (Ms. Donna Skelly): It's now time for further debate. I recognize the Minister of Seniors and Accessibility.

Hon. Raymond Sung Joon Cho: I move that the question now be put.

The Deputy Speaker (Ms. Donna Skelly): Mr. Cho has moved that the question be now put. I am satisfied that there has been sufficient debate to allow this question to be put to the House.

Is it the pleasure of the House that the motion carry? The motion is carried.

Ms. Dunlop has moved third reading of Bill 166, An Act to amend the Ministry of Training, Colleges and Universities Act. Is it the pleasure of the House that the motion carry?

Interjection: On division.

The Deputy Speaker (Ms. Donna Skelly): Carried on division.

Be it resolved that the bill do now pass and be entitled as in the motion.

Third reading agreed to.

Keeping Energy Costs Down Act, 2024 / Loi de 2024 visant à maintenir la facture énergétique à un niveau abordable

Resuming the debate adjourned on May 8, 2024, on the motion for third reading of the following bill:

Bill 165, An Act to amend the Ontario Energy Board Act, 1998 respecting certain Board proceedings and related matters / Projet de loi 165, Loi modifiant la Loi de 1998 sur la Commission de l'énergie de l'Ontario en ce qui concerne certaines instances dont la Commission est saisie et des questions connexes.

The Deputy Speaker (Ms. Donna Skelly): Further debate?

Mr. Joel Harden: A question, as we see this bill, rather like the last, to its last moment in this place: If you could pinpoint a time when Ontario could have done its part for the climate crisis, as the member for Toronto–Danforth said many times, as others have said in this House before, this may be one of those moments. This may be one of those moments.

There was a moment a little over a decade ago—if I have my calendar in my mind correct—when Ontario decided to phase out coal-fired electricity. That was critically important. That was a decision that made the air cleaner for our kids, that made huge strides for Ontario in its climate responsibilities. I salute it, even though it was done by a government that has a different political shade than mine. It was the right move. Was it easy? According to people I know who served at that time, no, it wasn't easy. Did it involve a lot of discussion, planning, industrial policy, thinking through the impact on businesses and consumers? Absolutely it did, but it was a decision that was taken.

And now, when we're faced with the really important responsibility of deciding how the energy needs for Ontario are going to be met in the next 10, 20 or 30 years, what are we doing with this bill in this House? We are passing a specific piece of legislation to overturn a decision made by an independent regulator of this House, the Ontario Energy Board. Not a partisan organization, a research-based, adjunct entity of this House that is obliged to give us the right advice—and the energy partners in the sector—on what we do to make sure we do right by the energy needs of the province. And when we're living in a time of such climate chaos, that advice could not be more important.

I'm sure everybody did the same this morning when you got up and you checked the news on your phones. You saw the news from the west end of this country, the wildfires that are blazing. The member from Thunder Bay–Superior North has talked about the woodland firefighters who are putting themselves in harm's way. They did it last summer and—are they already doing it now? They are in the middle of prepping for it right now.

My wife's family lives in Calgary, Speaker. We are planning—we hope—a family reunion this summer where we can finally get together with some of her cousins from interior BC and from Calgary. But we're booking cancellation insurance on those plane tickets, believe me, because it's highly possible that by the time later July comes around, the air will be so thick with smoke that it will be impossible, particularly for the elders in our family, to safely have this family meeting. And we're just one anecdote in a larger scenario here, Speaker, but we're living in a time where climate chaos has real impact on people's lives.

So the decision the Ontario Energy Board made—for the record, it's been stated a number of times; I'll just repeat it here: The Ontario Energy Board told Enbridge, which holds the monopoly on the distribution of gas in the province of Ontario, that they needed to pay for the costs of all the infrastructure for new home developments up front. They gave that advice because they believed the gas sector was being unduly subsidized at a time when more climate-friendly options—heat pump and geothermal installations—were making huge inroads. The costs of these technologies are coming down, and the Ontario Energy Board looked at the evidence—10,000 pages of documents, extensive consultations, including housing providers, subject-matter experts—and they rendered the opinion, two of the three adjudicators on that board rendered the opinion that it was not feasible to tell Enbridge that they could continue to expect a subsidy from the province of Ontario for a particular kind of home heating fuel. If people wanted to choose gas for their homes, they could. If the developer community wanted to install it in those homes, they could. But the province of Ontario would not be on the hook for a significant subsidy to a highly profitable energy company whose CEO made $19 million last year at a time of climate chaos.

0940

My friend the Minister of Energy over there has installed, as I understood it from debate, a heat pump in his home. The PA, my neighbour from Glengarry–Prescott–Russell, a great riding where I grew up, has done the same thing for his home. I would like to see every single Ontarian, whether they live as a renter in an apartment building or whether they have their own home of any type, have the same options that the members of the government have shown through their own leadership. And we do have—we're groping towards it; we're inching towards it—the Independent Electricity System Operator of Ontario is offering some subsidies, modest as they are, to low-income Ontarians so they can start disconnecting from fossil fuel-based heating and cooling systems to electrical or geothermal systems.

But we're nowhere near the ambition of the province of Prince Edward Island, which is at the moment run by Conservatives. In that House, in Prince Edward Island, they set the objective much larger than we have here. They have, if I understood the Premier's latest comments correctly—35% of the homeowners and residents in that province had made the switch to heat pumps, because if you make less than $100,000 a year and if your home is worth less than $400,000, the province will buy you a heat pump. And I believe it's a similar strategy for the multi-level apartment buildings in the bigger communities like Charlottetown. I mean, that's an ambitious strategy.

I look at the city of Vancouver. The city of Vancouver decided to take the choice that for new hookups for new apartment buildings they were going to require that it not be automatically going to their monopoly natural gas holder, Fortis, in that province. They were going to say, "No. We see our climate obligations for what they are. We are going to insist that new hookups be electrical. You're not going to have a subsidy."

But for some reason, here in Ontario, we are absolutely determined to do Enbridge a favour, and I don't understand why. Over the last four years, profits for the fossil fuel industry, oil and gas, are up 1,000%. And have those companies done anything to help consumers at the pump or at their homes for their heating costs, their transportation costs? Have they paid any of that forward? Absolutely not. The only instances where they have been compelled to pay that forward are in countries that have made conscious policy decisions.

Let me just cite another one: A Conservative government in England brought in a windfall profits tax, and with that windfall profits tax, they are generating billions in revenue to make life more affordable in England—a Conservative government. But what are we doing with this bill before the House here? Will Enbridge be required to make energy costs more affordable? No. Will Enbridge be required, as they say they are, by law to hit certain targets in the transition to cleaner heating and cooling options in Ontario? No. We're essentially saying we're going to continue the regime we have.

The primary reason I got into this job, Speaker, when my family and I decided to make the leap back in 2017, of all the issues—they are all important, but ensuring that there was a viable future for our children was the first one. When I look at independent research organizations that look at the decisions made by this government on this particular matter with Enbridge and reversing the OEB decision, or the decision to embrace gas-fired electrical as we refurbish nuclear stock, this is going to absolutely impact our ability to deliver on our climate obligations in the province of Ontario.

I honestly don't understand why we're making that decision, except for the fact that Enbridge likes it; except for the fact that the lobbyists who circulate in this building for Enbridge are well paid, I'm sure articulate and make all the right short-term calls to help this minister deal with the problem, the problem being that people need heating and cooling options. They have an affordability crisis, and half the people in

our country—that was the last comment I remember hearing from my federal leader, Jagmeet Singh: Half the people in this country are living from paycheque to paycheque. One in seven kids are still going to school hungry in Canada. We do have a huge problem. In that reality, I don't understand why we are making life easier for Enbridge.

I've also noticed that for months, my friends in government are very interested in having a debate about the federal price on carbon. That has been a big focus for them as they deal with the affordability crisis. But what I honestly don't understand—and I had to seek out a consultation with environmental experts at home—is how it becomes the only thing in the environmental policy file to talk about. It takes up all the space: the federal levy on carbon, the provincial carbon tax that we have because we decided to get rid of the cap-and-trade initiatives of the previous government. This has taken up all the space.

I went back home and had a specific consultation with environmental leaders back home who do a number of different things I'll talk about in a minute. I asked them, "Help me out. Is this the only thing worth talking about with environmental policy right now, given the obligations we have?" We talked specifically about the Ontario Energy Board's December 21, 2023, decision. They said, "No. Absolutely, Joel, it's not." That OEB decision was the first that they had seen that actually reckoned with the evidence of saying, "This is where we have to get to by 2030 in our climate emissions; this is where we're going, now that we're embracing gas-fired electrical," and the two didn't square.

I talked to my landlord back home, the Centretown Citizens Ottawa Corp. The biggest non-profit houser in Ontario is in Ottawa, my landlord at 109 Catherine Street. Sarah Button, who's their ED, said to me, "Joel, one thing we could do is bring back advantageous financing options for co-ops like ourselves, for non-profits like ourselves, for housing." With that advantageous financing—which Ontario could do, because we regulate credit unions—we could get back into the business of building the kinds of sustainable, environmental homes that people want to live in.

My office sits at Beaver Barracks. People know Ottawa; it's an old military base that was transformed into a series of residential properties powered, heated and cooled by geothermal sources. It is absolutely even heat and even cool when you're in there. Come visit us any time if you'd like to sample it yourself. It's wonderful. We don't have a big space, but it's a great place for residents to interact with us.

The folks in the buildings all around us really appreciate their living conditions, too. But it required a significant investment by CCOC on the infrastructure side. They took on a large debt obligation, because they didn't get the help they needed from the federal or provincial governments. They got some, but not enough. Sarah Button said to me, "Joel, can you imagine what we could do for environmentally conscious housing if there was an active partner at Queen's Park and an active partner at the federal government?"

Just in case my colleagues in government think I'm only holding them to account, let me just say clearly for the record that the federal housing strategy, the 10-year housing strategy, insofar as how it has done its job to provide affordable, sustainable housing, has met 3% of its target. Those 3% of the homes built under the strategy five years in are 30% of the residents' income. We are subsidizing highly profitable corporate landlords to build housing that people can't afford at the federal level. Just in case the government thinks I'm only having concerns about them, I have massive concerns with how the federal government has fallen short of its obligations—some changes lately, but that's the reality.

0950

But back to Enbridge. If you think about the amount of money we are shovelling to Enbridge, and you think about what we could use it for—I think about a subject near and dear to my heart: public transit. Talk to a transit user in the city of Ottawa, and you will get a look back of massive consternation. We, through this bill, are going to be offering a subsidy to Enbridge of billions of dollars. But our city right now, in this year, is 74,000 service hours less with the buses we have on the road, bringing people around to where they need to go because of cuts from Queen's Park.

The latest new deal we signed with the government which has some stuff in there that we could work with on community safety, security, emergency housing. There is absolutely a goose egg for transit. There's nothing for transit.

And hey, I'm not sure what the Premier is thinking. Maybe his view is that everybody works for the federal government, has a wonderful salary with benefits, and that's what Ottawa is. That is not—some people in our city meet that description, but in Ottawa Centre, we have the highest number of rooming houses in Ottawa. A rooming house is a multi-unit building where people rent out a room. Conditions are often squalor in many of these buildings that I've had occasion to visit neighbours in. We have a lot of deep poverty in Ottawa Centre too. What do those people rely on to get around? Transit.

So I think if we were to propose a climate solution, following the advice we've given to this government, through all levels of this bill, it makes a lot more sense—excepting the fact that the OEB made a decision that upset Enbridge, certainly. But it set us on track, were we to have followed it, to do a lot more by the climate. Ottawa has been the recipient of some significant weather emergencies. We've had tornados rip through the west end of our community. We've had floods on the east and west. We've had a historic derecho that happened literally during the provincial election where all of us were competing for our seats. We had to shut down our campaign for two days so we could check in on neighbours who had power lines falling across their verandas or their apartment buildings by phone and signalling to emergency services where there were emergencies—like this is the world we're living in. We're having more and more significant weather events, and the decisions we make on the big files—the big files being housing, transportation and this one, energy—set the pattern for everything else.

Some 45% of the emissions in the city of Ottawa come from buildings, come from housing. When I think about one in particular, I've got a great relationship with many of the residents in the apartment buildings all over the downtown. But I think of one in particular, on McLeod Street, the Golden Triangle area of Ottawa Centre. If you walk up to McLeod—it's a community housing building—in the dead winter in January, you will see at the top of the building, the windows are wide open. Ottawa winter; the windows are wide open. Why are they wide open? Because literally the families and the people living in those units, because of the nature of the heating system they have, which works in one direction only: on 100%—they're sweltering. They might as well be living in a sauna. They find mould all over their units, because of the amount of condensation that drips into their homes.

If you talk to Ottawa Community Housing, you talk to people like Stéphane Giguère, the executive director or Brian Billings who is the properties manager. They shrug their shoulders, like "Joel, we're doing our very best, but there's no magic pot of money for us to be able to refurbish our buildings and to embrace the technologies that are becoming more and more affordable right now." So windows are left wide open in the middle of January. And we are paying, the province is paying—as we direct subsidies to municipalities for community housing, because they are unsustainable—to have heat escape into the air. Oil boilers in these buildings makes absolutely no sense.

So instead of giving a multi-billion dollar gift to Enbridge and continuing that regime, why wouldn't we consider doing what we ran on in the last provincial election and the NDP proposed, which is a significant retrofit program for community housing and apartment buildings right across the whole province, where we would make a big upfront investment, create a lot of jobs for skilled trades workers, create jobs for manufacturers of heat-efficient windows and heating in cooling units? We could make sure that people don't live in a sauna in the winter if they live in community housing. We could spend the people's money wisely, but instead, no, we're not doing that. We're giving a gift to Enbridge.

Now, Enbridge has also said that they want to be part of the energy transition, they see the value of homes making this shift towards electrification or geothermal sources of heating and cooling. The words are nice, and the anecdotes that you see every now and again in the Enbridge brochures are great, but, ultimately, this is a company that has a lot of influence in this province. This is a company that has a monopoly agreement in the province for the transmission and distribution of gas. We here in this House get to sell the rules by which they exercise that monopoly right.

I want to believe that if a Conservative government in Prince Edward Island can undergo a revolution in the heating and cooling of homes there, we can do it here. I want to believe that if a Conservative government in England can say to energy giants like Enbridge or other oil companies that, "Hey, you've been doing fantastically well. Time for you to share some of that wealth with the societies in which you live so people can get access to the things they need"—that makes a lot sense, but I don't see that in this bill.

What I see in this bill is continuing a very favourable playing ground for Enbridge. I didn't get elected in this House to work for Enbridge; I got elected to work for the people of Ottawa Centre. All of us have our responsibility to look our residents in the eyes and say in this moment we made the right climate decisions, and that involves voting no to this bill.

The Deputy Speaker (Ms. Donna Skelly): It is now time for questions and answers.

Mr. Andrew Dowie: I want to thank the member for Ottawa Centre for his impassioned speech. I certainly understand where he's coming from, but I know in my community there is a development called Little River Acres. It was, I'll call it, a modern development in the 1970s, and none of the homes were built with natural gas, and, boy, are they regretting that decision today, because the cost to power these homes is significant through electric heating and cooling.

I know that the Keeping Energy Costs Down Act speaks not just to my constituents, who need affordability at their homes, but all Ontarians. By reversing the Ontario Energy Board decision, we're saving families tens of thousands of dollars on the price of a new home and will save, down the road, heating and cooling costs for those people like my constituents at Little River Acres.

So I ask the opposition why their party is trying to make housing more expensive than it already is rather than working with the government to keep the cost of housing affordable down, not just on the capital but on the operating side too.

Mr. Joel Harden: I guess to properly answer the member's question I'd ask, through a head nod, are those electrical systems electrical baseboards or heat pumps?

Interjection.

Mr. Joel Harden: Okay, well, they're not the same thing. If we put electrical baseboard heating in a home, you're absolutely right, that's hugely expensive. I think the last government prior to you guys in 2018 suffered because they didn't pay attention to energy poverty because of the situations you're describing there. But that's not what I was talking about in my 20 minutes. I was talking about the province here following the lead of Conservatives in Prince Edward Island that have looked at brand new technologies that can make sure that communities like the ones the member mentioned don't get saddled with energy poverty because of terrible decisions.

Buying into this market right now, the electrification of heating and cooling right now, is getting more and more affordable, and what will cost us a lot is stranded assets of natural gas-heated communities that may not even be relevant 20 or 30 years from now.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Terence Kernaghan: I'd like to thank my colleague from Ottawa Centre for an excellent presentation. It seems that with Bill 165 it's yet the next installment of must-miss theatre. Its quite unselfconsciously yet ironically titled bills are part of a pattern of this government, but this bill represents unprecedented political interference with an independent regulator. Does this political interference help consumers or put them at risk?

Mr. Joel Harden: Thanks for the question. It absolutely puts them at risk. When I read the decision the first time and I saw the words in the report, they made me stand up in my chair. I mean, stranded assets in 20 or 30 years—when you look all over Europe, because of the terrible invasion of Ukraine and the impact that's had on all of those countries, the rate of the shift going on in Europe right now is beyond belief. They are embracing this. But we, however, seem to be stuck in our servitude to Enbridge, and I don't know why we're doing that except to make Enbridge and its lobbyists happy. But, to the member's question, that's not why we're here. We're here to make homeowners and renters, people who want to live in a home that's healthy, happy. That should be the objective of this bill; that's not what it is.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

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Mr. Lorne Coe: To my colleague from Ottawa Centre: When I'm knocking on doors, one of the main issues I hear is affordability, and I'm sure he does in Ottawa Centre, as well; there's no question about it. But with the policies like the federal government's carbon tax that I know that the opposition supports, Ontarians are being forced to give up their hard-earned money.

I'd like the member from Ottawa Centre to speak to affordability challenges—and I know they're top concerns in Ottawa Centre, as well—and whether he would welcome the changes, and his constituents, in this particular legislation that he spoke on.

Mr. Joel Harden: He's right; the member from Whitby is right. We do care about affordability all over the province. Ottawa Centre, Whitby—people are having a really, really hard time out there. But we're not going to make it better, Speaker, by embracing a technology that will be obsolete in 20 or 30 years. If somebody is investing into a natural gas-powered community now or in five years and is later reckoning with the fact that they may not even get that service anymore because the entire sector is moving towards electrification but it didn't 10 or 15 years prior—we don't want to put anybody in that situation, not a renter, not a property owner, not a homeowner.

If you look at the province, a third of our emissions are coming from energy. We have to make the right choices to make sure that we can make people's lives more affordable right now but also going forward.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Peter Tabuns: I want to thank the member for an excellent speech. You touched on this, but I would appreciate it if you would expand on what you see as the climate impact if this bill is passed as proposed by the government.

Mr. Joel Harden: If we follow it to the letter, I actually don't think—as you've said in debate too, even if this bill is passed and the government continues to do favours for Enbridge, I think ultimately industry itself is going to shift. But consumers are going to be left with the debt of this decision, and that's got a huge climate price.

There's a few things happening now, and the member knows it well. If we embrace gas-fired heating and cooling and we continue the Enbridge subsidy, we create a preference for that in new home construction. That will have a huge climate impact. But in addition to that, we're embracing gas-fired electricity too. There are climate costs to every single one of these decisions, and the wildfires that are going to be happening this summer are not abstract from this; they contribute to this. It's the environment in which we live. And the people we put in harm's way, the woodland firefighters, that deal with the moment, these are the people we push into the emergency when we could be making the decisions to reduce emissions. But that's not what's going to happen with this bill.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

MPP Lise Vaugeois: Thank you to the member from Ottawa Centre for your remarks. A couple of things that stood out to me: $19 million for the CEO of Enbridge and profits at 1,000%. That represents a lot of money, and we are continuing to subsidize that. Now, I should say that in my region, there's a lot of desire to have natural gas. The chamber of commerce has said they want natural gas. They want to have that access. They want that subsidy to remain. I appreciate that, but it's also installing an older technology that we know is going to become more and more expensive. The problem in our region is there's no investment in the electrical lines to carry the volume of electricity needed in order to have heat pumps and EVs in our communities. That, to me, would be a very valuable investment of some of this money that's going into a much older technology.

Mr. Joel Harden: The situation is the same as the member for Windsor–Tecumseh mentioned, that there are communities that are in an older form of electrical heating that are going broke because they can't pay the costs of their homes. So I totally understand where people are coming from, but there are other choices people can make. Mattamy Homes right now is embarking upon a number of geothermal-inspired district heating communities. This is someone in the private sector that's saying, "This is better for our business. It's better for the environment. These are homes that people will want to live in." So Mattamy is leading—good for Mattamy. But the province should be encouraging this.

In Thunder Bay, if the electrical capacity is a question, geothermal, if there is space, could potentially be an option. And the drilling technology is getting even more effective in smaller urban areas. So, we do have choices, but one of the choices I would hope we don't make is doing Enbridge a favour and continuing a multi-billion dollar subsidy for them, when we could be helping people out on energy affordability by making the right investments.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Lorne Coe: Speaker, through you to the member from Ottawa Centre: From time to time, the government highlights some of the cuts that we're making to red tape. That's because we're committed to building more than 1.5 million new homes and because we're looking to land historic investments that our Minister of Economic Trade and Job Creation has secured thus far, and more to come.

Can the member from Ottawa Centre speak to the leave-to-construct change in the legislation that he spoke about earlier, another great example of how we are cutting red tape?

Mr. Joel Harden: I don't think you're going to have objection anywhere in this House to the urgency for housing. We are agreed on that. The question is, what kind of housing? What are going to be the heating and cooling systems in these units? Where are people going to live? Are they going to live near transit if they need it? Will that bus come on time? Will people be living in a neighbourhood with good schools? Will the schools get all the resources they need? Will we be supporting small businesses and local enterprises, and not just the big guys? These are the questions that come to mind with housing. You can't just look at housing in a silo; it has got to be surrounded with an industrial strategy for all of the other things.

So I'm very glad, and I hear we're getting good news today on the industrial policy front. But we need to make sure that the housing that we put in the ground works, and that it's good for the planet, too.

The Deputy Speaker (Ms. Donna Skelly): It's now time for further debate.

Mr. Trevor Jones: Good morning, Speaker. I really appreciate the opportunity to speak to Bill 165, Keeping Energy Costs Down Act, 2024, because this is a significant matter. It's one that touches the lives and livelihoods of hard-working families, farmers and business owners all across Ontario.

The landscape of energy consumption is changing. Our government understands the importance of developing infrastructure that addresses Ontario's expanding energy requirements, fosters innovation and drives economic progress, while remaining affordable and keeping Ontario competitive. High interest rates, skilled trades shortages, lack of supply and increased demand in housing have increased building costs and increased housing prices.

Our government is focused on working to make life more affordable for everyone. We're delivering solutions that will help power the province's growing economy. As Ontario's population continues to grow, the proposed Keeping Energy Costs Down Act, 2024, would ensure that the province can build new homes, and people from across the province can continue to access reliable, cost-effective energy, where and when it's needed.

My riding of Chatham-Kent–Leamington spans from the beautiful town of Leamington, my hometown, to Pelee Island and across the southern half of Chatham-Kent, along the shores of Lake Erie, through Wheatley, Blenheim, Ridgetown and Highgate. I'm proud to share that my riding hosts 3,800 acres of controlled-environment agriculture, the largest concentration of greenhouse agriculture in Canada. These farms produce fresh, safe, locally grown fruits and vegetables with exceptional quality and yield, while conserving water, recycling nutrients and implementing cutting-edge technology solutions right here in Ontario.

I have personally witnessed a technological revolution in sustainability, innovation and entrepreneurship on our farms, in our orchards and in our high-tech greenhouses. To maintain our momentum as global leaders, our government is taking decisive action to keep energy costs down and empower our farmers to reinvest in their operations while remaining competitive. Lower energy costs help keep family farms viable to reinvest in their operations, remain profitable and respond quickly to changing consumer preferences, all while enhancing long-term resilience.

By prioritizing policies that keep energy costs down, we're strengthening our Grow Ontario Strategy and empowering our entire agricultural sector and Ontario's farming families to continue to grow fresh food for families in Ontario, Canada and the world. By supporting safe, reliable, affordable energy to grow our own food, we can maintain food sovereignty while nurturing the technological industries and innovation that support it, right here in Ontario.

The latest report from Ontario's Electrification and Energy Transition Panel highlights that natural gas plays a crucial role in Ontario's energy landscape, serving three vital functions: powering electrical generation, providing home and water heating and supporting various industrial and agricultural sectors.

Our government knows that this bill is a step in the right direction to preserve consumer energy choices by ensuring that natural gas remains viable, safe and affordable for all consumers. Bill 165 is a pivotal piece of legislation that supports safe, affordable, reliable options for farm operations like grain drying, which contributes to broader agricultural stability and security. By prioritizing measures to minimize energy costs and promote affordability, this act ensures that grain farmers all across Ontario have access to cost-effective energy solutions, including natural gas, for their critical drying operations.

This is essential for farmers across the province, especially during harvest season, to ensure these precious crops can be safely stored, make it to processors and make it to our markets. By using natural gas, grain farmers can effectively manage moisture levels in a wide variety of harvested grains. That prevents spoilage and ensures the highest quality of production that Ontario is known for.

As global leaders in fresh food production, Ontario greenhouse growers rely on safe, affordable natural gas, which is essential during our cooler months while enabling us to grow crops year-round. This, in turn, enhances exports, increases prosperity and strengthens food sovereignty. This is growing Ontario.

Greenhouses, of course, require precise temperature and humidity controls for optimal plant growth, and this is exactly what natural gas can deliver: safe, consistent and reliable power. By using natural gas, greenhouse farmers can maintain ideal growing conditions for a variety of crops with higher yields and world-renowned quality year-round.

The Keeping Energy Costs Down Act would, if passed, also provide an ability to reverse the Ontario Energy Board's split decision which would have required any new home buyer, farm or business to pay 100% of the cost of a natural gas connection up front—very, very difficult. Reversing this decision would save at least $4,400 on the price of every new home for my family, for our constituents and for your families.

Through the Keeping Energy Costs Down Act, our government is dedicated to promoting fair and inclusive decision-making processes within the Ontario Energy Board. This ensures affordability for everyone. The legislation, if passed, will mandate the OEB to engage specific stakeholders or economic sectors, ensuring voices from diverse backgrounds are hard, particularly those who could be affected by forthcoming decisions. By prioritizing inclusivity and transparency, we're taking meaningful steps toward building a more equitable and sustainable landscape in energy for everyone.

Speaker, I'm going to share some local and highly credible voices who are supporting this act, if I have time.

First, Mr. George Gilvesy, chairman of the board of directors of Ontario Greenhouse Vegetable Growers: "Natural gas is an essential crop input, as heat and carbon dioxide are captured to optimize and enhance greenhouse vegetable production." That's right here in Ontario. "Legislation such as this will continue to drive investment in Ontario's agricultural sector, growing food, jobs and economic prosperity."

Similarly, the president of the Ontario Federation of Agriculture, Drew Spoelstra, stated, "The Ontario Federation of Agriculture is supportive of the decision taken by the Minister of Energy to address the Ontario Energy Board's decision, which threatens to increase costs for new homes relying on natural gas for heating, jeopardizes housing affordability and future access to this energy"—

The Deputy Speaker (Ms. Donna Skelly): I apologize to the member, but it is now time to move on to members' statements.

Third reading debate deemed adjourned.

Wearing of pins

The Deputy Speaker (Ms. Donna Skelly): On that note, I'm going to recognize the Minister of Children, Community and Social Services.

Hon. Michael Parsa: Speaker, if you seek it, you'll find unanimous consent to allow members to wear pins in recognition of May 14 being the Ontario Association of Children's Aid Societies' Children and Youth in Care Day.

The Deputy Speaker (Ms. Donna Skelly): The minister is asking for unanimous consent to wear pins recognizing children's aid societies. Agreed? Agreed.

Members' Statements

First responders

Mr. Sheref Sabawy: On May 4, we were happy to celebrate International Firefighters' Day. This was an opportunity to thank the firefighters of Mississauga for their service, recognize their extraordinary efforts and acknowledge the sacrifices that many firefighters have undertaken to keep us safe.

I was happy to hear the government's announcement about increasing coverage for firefighters with cancer. And I had the opportunity to visit the three fire stations in my riding, Stations 107, 115 and 122, to meet with the hard-working firefighters and thank them for their service.

Speaker, this week also serves as national police week and road safety week. We know the police play a critical role keeping our roads safe for all of us to enjoy. The dedicated personnel at Peel Regional Police are working hard to take criminals off the streets and enforce traffic laws.

The latest provincial budget announced $46 million to support response times, including purchasing four police helicopters. This will help keep our streets safe. Our government's committed to supporting police and giving them the resources they need.

I am proud to be part of a government that supports our front-liners.

Rod Brawn

Mr. Terence Kernaghan: Today, I mark the passing of Rod Brawn, a good friend of mine, beloved of Tina, a staunch New Democrat and a kind, gentle and loving person to all lucky enough to meet him.

Rod was born in Sarnia on May 19, 1954, and earned three degrees at the University of Western Ontario: honours history, honours music and bachelor of education.

Rod had a variety of jobs: James Reaney Sr.'s research assistant, a journalist for several small-town newspapers and an elementary and secondary supply teacher.

Rod was passionate about music and was active in his church, St. John the Evangelist. He sang in the choir and played the trumpet for special occasions. Rod often played the Last Post at the funerals of WWII veterans and refused to be paid for the service; it was his way of honouring veterans.

Craig Smith writes, "Rod's trumpet may have been silenced, but his music will still be heard."

Rod tutored refugee children and volunteered with the Amabile choir. He was adamant about helping the underdog. As Rod and Tina were fond of saying, "Jesus was a socialist." Now if that confuses anyone, please be sure to go back and read it again.

Rod fought for universal health care and public education. He truly believed J.S. Woodsworth's words, "What we desire for ourselves, we wish for all."

In his final years, Tina had to fight for Rod's health care, trudging him through snow in the middle of winter to a clinic for his so-called home care. Rod fought for a system that wasn't cut to the bone and privatized. Throughout, Tina has been the example of selfless love, caring for Rod without a word of complaint.

Rod died on May 12, a week shy of his 70th birthday. He was well loved by all.

Rod, I commit to you that I will keep you at the heart of all of my work and every decision I make here in this Legislature. Rest in peace, Rod.

Hockey

Mr. Brian Saunderson: It's my pleasure to rise to talk about the long and proud hockey tradition that is part of the DNA of my riding of Simcoe–Grey. In Collingwood, the tradition of junior and senior hockey goes back generations, to the late 1800s, with storied teams like the Shipbuilders from the early 1900s, the Greenshirts in the 1950s, the Glassmen in the 1970s, the Blues in the 1980s and the Blackhawks in the early 2000s.

Speaker, that tradition continued with the return of the Collingwood Blues Junior A hockey team to Collingwood in 2019. In four short years, the team raised the Buckland Cup in 2023 as Ontario's champions.

This year, the Blues picked up where they left off last season, finishing the regular hockey season ranked number one in Canada, and last month, they defended their Buckland Cup title. The Blues are now playing for the Centennial Cup in Oakville as one of 10 teams from across Canada vying to be Canada's Junior A hockey champions for 2024.

1020

The success of the Blues is a testament to the dedication of the ownership and management, the talent and tenacity of the players and the support of the hard-working volunteers, but it is the fans that are the team's special sauce, faithfully packing the arena for home games. The Blues led the league again in attendance this year, averaging over 1,100 fans per game.

I want to thank the Blues, the local Junior C teams, the Alliston Hornets and the Stayner Siskins, and the many vibrant minor hockey associations throughout my riding for continuing our proud hockey tradition. Go, Blues, go!

Tenant protection

Ms. Jessica Bell: We recently had a tenant contact our office to raise a very concerning issue. The tenant had read about the recent court decision that forced a tenant to pay his landlord's delinquent tax bill to the CRA, the Canada Revenue Agency, and he was concerned that this rule could affect him.

Since his landlord was refusing to tell them if they were paying their taxes, the tenant contacted the CRA and asked them what he should do. The CRA told him to withhold 25% of his rent and pay it directly to the CRA.

Now, if a tenant doesn't pay on time, the CRA's website says they will pay interest and they may be fined. The tenant went back to the landlord with the bad news and the landlord said, "If you withhold your rent to pay this tax bill, I'm going to evict you for arrears."

Okay, so this tenant is now caught between a rock and a hard place, between having the CRA go after him for someone else's tax bill or risking eviction. And this renter isn't alone. Every renter who is living in a property owned by a non-resident landlord could be in the same horrible predicament.

No tenant should have to risk eviction for paying their non-resident landlord's delinquent tax bill. This is fundamentally unfair. In this incredibly expensive housing market, renters have it hard enough.

We are requesting the following measures to resolve this situation: The province should direct the Landlord and Tenant Board to deny any landlord's application to evict a tenant if the tenant is withholding rent to pay the landlord's own tax bill, and second, the CRA should work with the federal government to reverse this rule immediately and not force tenants to pay their landlord's delinquent taxes ever.

Sunderland ringette

Ms. Laurie Scott: It was my pleasure to attend the Sunderland girls Stingerz ringette year-end ceremony this month to celebrate all their many team accomplishments. It was a special day for the under-14 A girls' team as they were the gold-winning provincial champions.

Sunderland ringette celebrates over 40 years of providing opportunities for female athletes to excel at competitive sport in a positive way, providing on-ice skill and enhancing physical health and well-being, higher levels of confidence and leadership, and a lot of fun.

Many of these athletes start their ringette journey from as early as four years old and continue to train and compete all throughout high school. The coach of our champions, Coach Carson, was also a past ringette star before she took on the mantle of coach, and she was assisted by her dad on the job. It is this generational mentorship that makes the Sunderland Stingerz a formidable force on the ice in Ontario. The celebrations filled the arena with family, friends, current and former coaches and players to mark this celebration.

I'd like to thank the president of the association, Jennifer Smallwood and her team of volunteers, athletes, coaches and parents for their hard work and dedication to the girls' ringette program, and I'd also like to thank the Sunderland Legion, which always plays a supporting role in the town and for the girl athletes.

Soins de longue durée

M. Guy Bourgouin: Un résident de Kapuskasing veut transférer sa mère d'un centre de soins de longue durée à Toronto pour un centre à Kapuskasing ou Hearst, plus près de chez lui, où il pourra la visiter plus souvent. Mais il y a une liste d'attente de deux ans avant qu'elle ne puisse être transférée—deux ans, monsieur le Président. Sa mère, qui commence à montrer des signes de régression de mémoire, se sent seule à Toronto sans sa famille. Imaginez vivre à neuf heures de votre famille, simplement parce qu'il n'y a pas de lits dans votre village natal.

Le maire d'Opasatika a écrit au ministre Cho :

« On the third of May, my mom with dementia was told in the morning that she would have a bath at around 2 o'clock in the afternoon. So she was ready to go for her bath in her room at that time. She waited for an hour, nobody came, turns out they forgot....

« We lost almost all the local staff and know we have agencies staff that speaks only English with lots of residents that only speak French. »

Il y a deux ans, le gouvernement a annoncé haut et fort la création de 68 lits de longue durée à Kapuskasing. Extendicare prévoit demander une prolongation et de mettre ce projet en arrière-plan. Le gouvernement se traîne les pieds, même si les subventions sont adéquates pour bâtir. Cette situation est tout à fait inacceptable.

On est conscient qu'en Ontario il y a un lit de longue durée pour 170 anglophones, mais seulement un lit pour 3 400 francophones. Les habitants du Nord et les francophones méritent de recevoir le même niveau de soins que les Ontariens du Sud, proche de leur famille, et en français.

Jerseyville Baptist Church

Ms. Donna Skelly: Good morning, Mr. Speaker. I'm so pleased to rise today to recognize the Jerseyville Baptist Church, a church in my riding of Flamborough–Glanbrook that recently celebrated its 200th anniversary. I had the privilege of attending this celebration and witnessing the sense of community the organization provides for residents in the surrounding area. I was genuinely moved.

I asked Pastor Matthew Richards what this 200th anniversary means to him and his church. He said, "For many years, the church's stated mission has been, 'We will, by prayer and faith, in action, under the guidance of the Holy Spirit, impact our community with the love of Jesus Christ and walk in fellowship with those who trust Him.' This takes place in formal times of worship and Bible teachings and also in genuine friendships within our congregation. We ... support with our prayers, time and resources other charities, local and global, which complement our mission."

Pastor Richards explained that many of the last names of those who were instrumental in the establishment of the church are still prevalent in the community today. Clearly these deep community roots are evident as the church celebrates 200 years of offering fellowship and support throughout the community.

Mr. Speaker, I would like to again congratulate Pastor Richards and the congregation at Jerseyville Baptist Church on their remarkable longevity. I wish them many, many more years of service to Jerseyville and beyond.

Pauline Shirt

Ms. Mary-Margaret McMahon: Good morning, Mr. Speaker and everyone here.

“We celebrate, we acknowledge spirit and spirit will come alive.” This sentiment from Pauline Shirt will never be forgotten, and her spirit will continue to come alive through generations to come.

We sadly lost Pauline, one of Canada’s most beloved Indigenous elders, from the physical world on May 7, 2024. Her spirit lives on not only through her children and loved ones but in the stories told in Indigenous languages which she had a hand in preserving.

Grandmother (Nokomis) Pauline Shirt, Nimikiiquay, or Thunder Woman, as she was also known, was a knowledge keeper, leader and visionary.

A Plains Cree Elder from the Red-Tail Hawk Clan, Pauline and her late husband, Vern Harper, first established the Ontario leg of the Native People’s Caravan to Ottawa in 1974. Their critical work did not stop there. In 1976, Pauline and Vern founded Canada’s first Indigenous-run and -focused school, because they wanted a culturally safe and appropriate space for their son to learn. Kapapamahchakwew, Wandering Spirit School, still operates in the east end of Toronto today.

As city councillor, I had the pleasure of engaging with Pauline on a student beading installation at Raindrop Plaza, the first stormwater demonstration site in the city.

In 2023, I watched Pauline Shirt be inducted into the Order of Ontario, the province’s highest civilian honour, for a lifetime of contributions.

Pauline Shirt chose to live in our Beaches–East York community at the end of her remarkable life, and there is no greater honour for me than to have represented her.

Meegwetch, Pauline. You will be forever remembered.

1030

Vision Health Month

Mr. Will Bouma: Good morning, everyone. As you may know, May is Vision Health Month in Ontario and across Canada. Vision Health Month is traditionally a time when optometrists take a few extra moments to enlighten their patients and their communities about the significance of regular eye examinations.

Maintaining good vision health is not hard. In fact, 75% of vision loss can be averted through simple steps, and this starts with an eye exam. An eye exam does more than test your vision, it can also detect symptoms of diseases like diabetes, Parkinson’s disease, brain tumours, multiple sclerosis and cancer.

Being able to see clearly is a critical part of maintaining a healthy and happy life. As a practising optometrist, I am acutely aware of the importance of regular eye health examinations. Eye exams are essential for updating prescriptions for glasses or contact lenses as vision can change over time, especially as we get older. Glasses not only correct vision but also contribute to better eye health, safety, performance and overall well-being, making them an essential part of many people’s lives.

As we celebrate Vision Health Month in Ontario, our government reaffirms our commitment to prioritizing eye health. By raising awareness, encouraging regular eye exams and ensuring access to quality eye care services, we can all contribute to a brighter and clearer future for all of Ontario.

Government investments

Mr. Lorne Coe: Last Friday, the Associate Minister of Housing, the Honourable Rob Flack, and I announced that our government is providing $1.2 million to help create housing units in Whitby that will support youth 19 to 24 years old experiencing or at risk of homelessness, mental health and addiction issues. This investment is part of the province’s social services relief fund which has provided over $1.2 billion of support to help municipal service managers and Indigenous program administrators create longer-term housing solutions and help vulnerable people in Ontario.

The Ontario government is also investing an additional $202 million this year in homelessness prevention programs. This includes an allocation of $18.7 million to the Homelessness Prevention Program for the region of Durham in 2023-24, looking after the hard-working families in the region of Durham.

Introduction of Visitors

The Speaker (Hon. Ted Arnott): We have with us today, in the Speaker's gallery, a delegation from the Republic of Fiji. The delegation is led by the Honourable Manoa Kamikamica, Deputy Prime Minister and Minister for Trade, Cooperatives, Small and Medium Enterprises, and Communications.

Please join me in warmly welcoming our guests to the Legislative Assembly today.

L'hon. Greg Rickford: Chers collègues, j'aimerais vous présenter mon collègue et ami du Québec le député de Vachon, le ministre responsable des Relations avec les Premières Nations et les Inuit, Ian Lafrenière. Il est accompagné de sa conseillère principale, Alana Boileau. Bienvenue.

Ms. Peggy Sattler: I'm pleased to welcome my constituent Craig Smith who is here in the public gallery. Craig and I worked together in this place in 1990. He is now the president of ETFO Thames Valley, and I'm here. Welcome to the Legislature, Craig.

Hon. Michael A. Tibollo: I'm thrilled to welcome today from the riding of Vaughan–Woodbridge, Rhys Tweedie, who is our page captain today, as well as his sister and his mother Pauline. Welcome to Queen's Park.

Ms. Marit Stiles: I'm so happy to be able to welcome to the Legislature today members of the Elementary Teachers' Federation of Ontario. I know others will also be welcoming many members today, but I particularly want to mention Karen Brown, president; David Mastin, first vice-president; Shirley Bell, vice-president; Gundi Barbour, vice-president; and my brother-in-law, the president of the Kawartha Pine Ridge District School Board ETFO local, David Berger. Welcome to your House.

Hon. Stephen Lecce: I want to welcome the Friends and Advocates of Catholic Education, who are with us, as well as Bishop Bergie, who's with us.

Thank you to the head of OECTA as well as the Ontario Catholic School Trustees' Association.

Likewise, as mentioned by the Leader of the Opposition, welcome to all the Elementary Teachers' Federation of Ontario colleagues who are with us today.

Welcome to Queen's Park.

Ms. Chandra Pasma: I would like to join in welcoming Friends and Advocates of Catholic Education, including Bishop Gerard Bergie, president of the Assembly of Catholic Bishops of Ontario, from his St. Catharines diocese; Michael Bellmore, newly elected president of the Ontario Catholic School Trustees' Association, from the Sudbury Catholic District School Board; René Jansen in de Wal, president of OECTA, from the Toronto Catholic District School Board; and from the Elementary Teachers' Federation of Ontario, executive members Mary Fowler, Carolyn Proulx-Wootton, Mario Spagnuolo, Tamara DuFour, Juan Gairey, Michael Thomas, Sylvia van Campen, Jenn Wallage and Nathan Core.

Thank you so much for being here today.

Ms. Mary-Margaret McMahon: I'd like to welcome sensational Sebastian and terrific Taddy, who are representing superb Scarborough with the Boys and Girls Clubs of Canada. Welcome to your House.

Mr. Billy Pang: I would like to welcome Friends and Advocates of Catholic Education to Queen's Park today. Some of their members are here: Bishop Gerard Bergie, president of the Assembly of Catholic Bishops of Ontario, St. Catharines diocese; Patrick Daly, OCSTA past president and chair, Hamilton-Wentworth Catholic District School Board; René Jansen in de Wal, president of the Ontario English Catholic Teachers' Association; and Luz del Rosario, school board trustee for the Dufferin-Peel Catholic District School Board. Please join them at their reception tonight at 5 p.m. in the dining room.

Welcome to Queen's Park.

Miss Monique Taylor: Mr. Speaker, today is youth in care day, so I welcomed some guests this morning for a press conference. With us, we have the former Provincial Advocate for Children and Youth, Irwin Elman; Fred Hahn, president of CUPE Ontario, and members Zenee Maceda, Jesse Mintz, Janet Dassinger, Jo-Anne Brown, Lorrie Peppin, Karen Trench, Kim Leonard, Aubrey Gonsalves, Juanita Forde, Dhananjai Kohli and Eric Bell.

Welcome to Queen's Park, and thank you for all of the work that do you.

I have one more guest who I see up in the gallery above. Patrick Daly is here with the Friends and Advocates of Catholic Education.

It's nice to see you.

Ms. Aislinn Clancy: I'd like to warmly welcome members of ETFO today who are having a lunch reception, if you can join, especially President Karen Brown; Carolyn; my sister Michaela Kargus from Upper Grand. And we have some great Waterloo region folks: Jeff Pelich, Lisa Tonner, Marsha Auxilly.

I also want to do a shout-out to Janice and Robin, who are here from KWFamous. Look them up on Instagram.

You guys put the "U" in fun. Thanks for being here.

Hon. Michael Parsa: A very warm welcome to the representatives from the Ontario Association of Children's Aid Societies who are here today in recognition of the 10th anniversary of Children and Youth in Care Day—a day to honour and celebrate current and former kids in care across our province. Welcome to Queen's Park.

Ms. Teresa J. Armstrong: I want to say hello to all the members who came today to advocate for the Boys and Girls Clubs of Canada. Today, Marit, the leader of the NDP, and I met with Owen Charters, president of BGC Canada; Adam Joiner, CEO of BGC Ottawa; Utcha Sawyers, CEO of BGC East Scarborough; Chris Harvey, executive director of BGC London; Howard Moriah, executive director of BGC Durham; Pablo Vivanco, executive director of BGC Albion; and Sam Lapensee, manager of digital media at BGC Canada. And a special welcome to the youth of the year, Sebastian, of BGC West Scarborough. Welcome to the Legislature today.

1040

Mr. Adil Shamji: It gives me great pleasure to welcome two very bright young stars, both students from McMaster, Hayley Kupinsky and Ori Epstein. I must admit, I learned today that Ori will be attending law school at McGill next year, and I want to congratulate him as well.

Mrs. Jennifer (Jennie) Stevens: I want to give a warm welcome to the Legislature today. MPP Gates and I met with Brian Barker, Kim Finlayson and Stacy Sullivan with ETFO to discuss immediate attention to the rise of violence towards educators in our classrooms.

I'd also like to give a warm welcome to Bishop Gerard Bergie, president of the Assembly of Catholic Bishops of Ontario.

Welcome to our House.

Mr. Rick Byers: It's my pleasure to welcome Julie Stanley to the Legislature today. She is president of the ETFO Bluewater local. Welcome to the Legislature.

Mrs. Karen McCrimmon: I'd like to warmly welcome representatives from the Elementary Teachers' Federation of Ontario, the First Nations Technical Institute and the Friends and Advocates of Catholic Education in Ontario. Welcome to your House.

Hon. Michael Parsa: I'm very pleased to welcome representatives from Boys and Girls Clubs of Canada and the different Boys and Girls Clubs of Canada from across the province who are here for their advocacy day. Welcome to Queen's Park. It's wonderful to have you.

Mr. Terence Kernaghan: It gives me great pleasure to welcome good friends and talented educators Craig Smith, president of ETFO Thames Valley Teacher local, as well as Mike Thomas, first vice-president of ETFO Thames Valley Teacher local as well as a provincial executive member. Thank you for standing up for public education.

MPP Kristyn Wong-Tam: I'd like to extend our welcome and congratulations to the First Nations Technical Institute for hosting their morning reception. It was wonderfully attended, and everybody had a lot of good times but we also learned a lot. I want to welcome Suzanne Brant and Cathie Stewart Findlay.

Ms. Catherine Fife: I just want to welcome Nathan Core, the president of the Waterloo Region Occasional Teachers' local, as well as my friend Jeff Pelich from ETFO. Welcome to your House.

Flag-raising ceremony

The Speaker (Hon. Ted Arnott): I recognize the member for Thornhill on a point of order.

Ms. Laura Smith: I want to welcome everyone to join us at the flag-raising for Israel in celebration of their independence day, Yom Ha'atzmaut, just outside, right after question period.

Question Period

Education funding

Ms. Marit Stiles: This question is for the Premier. Yesterday, we gave the government an opportunity to put children, to put kids, first, an opportunity that this government passed on. We asked the government a simple question on behalf of our children: Will you fix our schools? The failure of this government to take inflation into its budget calculations is resulting in more crowded classrooms, more growing incidents of violence and more school programs that are disappearing day by day by day.

So I want to ask the Premier again: Will the Premier explain to the children of this province why he doesn't like funding their schools?

The Speaker (Hon. Ted Arnott): To respond, the Minister of Education.

Hon. Stephen Lecce: When we came to office in 2018, the funding in Ontario was at $23 billion. Today it stands at north of $28 billion, a 22% increase in funding, proof positive of our government and Premier's commitment to invest in publicly funded schools.

We are also the government that delivered stability for children, which your party and the Liberals could not achieve: four years of peace with Catholic and public and English and French. Two million kids have stability in the classroom, and I believe that is worthy of praise. All the parties came together for the benefit of children in Ontario.

When it comes to mental health, when it comes to preventing violence and injury of our staff and of our kids, we, as the government, are working with the Minister of Mental Health and Addictions to have increased funding in mental health by 577%. It is the most significant investment, and we mandated learning on mental health—the first in the country to do so. We're going to keep investing to support our kids.

The Speaker (Hon. Ted Arnott): Supplementary question?

Ms. Marit Stiles: A budget that ignores inflation is a budget that ignores reality. We have already lost 5,000 qualified educators since this government came into office, and with this budget we're going to lose thousands and thousands more qualified, caring adults in our schools. The government thought that if they gave the funding formula a different name, they rebranded it, families weren't going to notice that their kids are being shortchanged again. Well, I've got news for you: They're noticing.

Why is this government so determined to leave our education system worse than when they found it?

Interjections.

The Speaker (Hon. Ted Arnott): Members will please take their seats.

Minister of Education.

Hon. Stephen Lecce: Mr. Speaker, last Friday, I joined the member from Kitchener South–Hespeler in Hamilton at Interval House, where we announced a historic $875,000 investment to train high school coaches and teachers and students about the issue of violence against women, building healthy relationships in our schools, specifically tackling the issue of safety when it comes to kids and our staff. That was an investment we made together because we believe there's more to do as we bring forth our policy on restricting cellphones, removing social media and banning vaping from Ontario schools. Two hundred high schools will receive this education, 400 coaches will benefit from this investment, and it wouldn't have been achieved if the member from Kitchener South–Hespeler didn't initiate this action and get it to the finish line for the benefit of the families.

That is how we make a difference in Ontario schools: by investing in prevention and upstream investments and through curriculum. We're working across ministries, from health to education to social services, to make a difference and keep our kids safe.

The Speaker (Hon. Ted Arnott): Final supplementary?

Ms. Marit Stiles: Well, Speaker, 14 cents per day per student on student safety, 22 cents per day per student on mental health—that, to me, is a shameful lack of investment in our children's well-being.

When the government cuts education funding it is parents who have to make up the difference—parents who are right now struggling already with the cost of living and are increasingly having to pay out of pocket for education supports, for activities and, yes, even for mental health supports. This government is cutting education funding for our schools to the tune of $1,500 per student. That's a fact.

I want to know what the Premier thinks our children should do without. Is it breakfast programs? Is it counsellors? Is it music and sports—the things that bring joy in your life? What is it that this government expects our schools to cut and our children to do without?

Interjections.

The Speaker (Hon. Ted Arnott): Members will please take their seats.

Minister of Education.

Hon. Stephen Lecce: We increased staffing in Ontario schools by 9,000 additional education workers in the province of Ontario—an inconvenient truth for the member opposite—3,000 additional front-line educators. They don't just happen by chance; they happen because of investment, not in spite of it.

And Mr. Speaker, I found it very curious, the member's motion yesterday includes a component about supporting parents financially, but the Leader of the Opposition led the charge against our support for parent payments when we gave $200 and $400—

Interjections.

Hon. Stephen Lecce: You're laughing—$1.8 billion of investment as you trivialize giving funding directly to parents.

This is what's ironic about your motion: On one hand, you call for us to back parents, but if only parents knew that you voted against five iterations of payments to parents. It is regretful, it is shameful and it's consistent with your support for higher taxation in this province.

The Speaker (Hon. Ted Arnott): I'll remind the members to make their comments through the Chair.

The next question.

Health care

Ms. Marit Stiles: I've got to say, I was so disappointed yesterday in the government's responses to the questions that Ontarians are asking. I didn't get the answers that we were looking for. I'm going to ask again and see if we get somewhere today.

1050

The Minister of Health said that recruitment and retention of family doctors was "not a major concern." I want to say that again: "not a major concern." A quarter of patients in the Soo are without a family doctor. That's not a major concern for this minister? Some 30,000 patients in Kingston are without access to primary care—not a major concern?

These comments are insensitive considering there are 2.3 million to 2.4 million people in this province without a family physician, but they are also dangerous. So I want to ask this government again, to the Premier: Does he really think it's not a concern that millions of people are going without primary care?

The Speaker (Hon. Ted Arnott): The parliamentary assistant, the member for Stormont–Dundas–South Glengarry.

Mr. Nolan Quinn: Facts matter. The records matter, Speaker. In the NDP government, when they were in power for those short five years, and hopefully never again—and the Leader of the Opposition was a staffer at that time—they cut medical school enrolment by 10%. In 2015, the Liberal Premier cut 50 resident spots, which amounts to hundreds of fewer doctors serving in our province today.

We expanded the Learn and Stay grant—which, again, the opposition voted against—which provides tuition, books, supplies for nurses and other health care workers who work in underserved areas in our province. We're also funding the largest expansion of the medical school spots in over 15 years, adding 1,212 undergraduate and 1,637 postgraduate seats across Ontario; 60% of these seats will be dedicated to family medicine.

What I do recommend is that the Leader of the Opposition gets her party to support our budget, Speaker.

Interjections.

The Speaker (Hon. Ted Arnott): Order.

Supplementary question?

Ms. Marit Stiles: Speaker, I'm going to ask the member there, the parliamentary assistant to the Minister of Health, to really think about this: people being diagnosed with cancer, not in the comfort and the safety of their family doctor's office, but in an overcrowded emergency room, how did they get there? Because they don't have a family doctor. So by the time they get there—just imagine for a moment, to the member opposite, being the emergency room physician who then has to tell that patient that not only do they have cancer, but it has metastasized, because they couldn't get to see their family doctor. They couldn't get screening. This is not a major concern?

So I want to ask the member opposite: They're having you answer all the questions today. Is this not a major concern for you?

The Speaker (Hon. Ted Arnott): Again, I remind the members to make their comments through the Chair.

The parliamentary assistant to the Minister of Health.

Mr. Nolan Quinn: What is a concern for me is the short-sighted policies of both the NDP and Liberals that cut those seats, Speaker. That is why we are currently where we are today.

Since 2018, we've registered over 80,000 new nurses in Ontario, as well as 12,500 new physicians, with 10% of those being family physicians. Last year alone, we registered 2,400 new doctors to practise in Ontario. That was a record-breaking year for nurses in Ontario, but we're not stopping there. We will continue to ensure that the people of Ontario have what they need for health care.

We have 17,500 new nurses registered last year, which was a historic number, over 33,000 over the last two years. We'll continue.

We're investing significantly into our health human resources. In this year's budget, we have over $740 million to address immediate staffing needs, supporting the expansion of over 3,000 new nursing seats across Ontario.

We'll continue to do what needs to be done to ensure that we have the best publicly funded health care system.

The Speaker (Hon. Ted Arnott): The final supplementary?

Ms. Marit Stiles: Historic wait times, historic emergency room closures, historic numbers of Ontarians without family doctors—own it. Take some responsibility. You've been in government for six long years. You are responsible for the state of our health care system today.

It is unimaginable, Speaker, that this minister doesn't see this as a concern; that this Premier and this member don't see this as a concern. We are losing doctors and nurses and health care workers faster than we can recruit them.

I want the members opposite for just a moment to imagine being the mother of a newborn. You have so many questions; you have nowhere to go for answers. Imagine you're the parent of a sick child and you live in the Soo and you find out now you have no family doctor. Where are you going to go?

Take some responsibility, own up to it.

Will this government admit that they have a problem on their hands and that it is unimaginable that their minister, who was supposed to be responsible for this, refused to live up to her responsibility?

Interjections.

The Speaker (Hon. Ted Arnott): Members will please take their seats.

The member from Stormont–Dundas–South Glengarry to reply.

Mr. Nolan Quinn: Let me correct the Leader of the Opposition—sometimes facts hurt—we have some of the shortest wait times in Canada, with over 80% of the people of Ontario getting their surgery within the recommended time.

Speaker, we understand that more needs to be done. That's why we've invested $110 million into interprofessional primary care teams, and then in this year's budget, we actually added another $546 million. Over 600,000 Ontarians are going to receive the care they need.

We'll continue to ensure that the health care system in Ontario is the best publicly funded system across all of Canada.

Child and family services

Miss Monique Taylor: My question is for the Premier. Today is the 10th anniversary of Children and Youth in Care Day, a day promised to kids who shared their stories, lived experiences and recommendations.

This morning, CUPE front-line child protection workers—many are here today—released their survey results of young people who are being warehoused instead of being afforded safe homes. The results are shocking: children and youth as young as two years old in hotel rooms, Airbnbs, for-profit facilities and on cots in children's aid offices.

Will the Premier and his minister, today on Children and Youth in Care Day, commit to sustainable funding for safe homes for our most vulnerable children and youth?

The Speaker (Hon. Ted Arnott): Minister of Children, Community and Social Services.

Hon. Michael Parsa: Thanks to my colleague for the question.

First and foremost, I'd like to thank the women and men who are doing great work to make sure children and youth in our province are served and protected. That's what's driving the redesign of the child welfare system in the province of Ontario.

It was this government that took action. It was this government that said more reports, more discussions are not going to cut it. We need action, which is why we have more inspectors now hired across the province, which is why we have more unannounced inspections being conducted across the province.

I've said it many times in this House, and I'll say it again: When it comes to children and youth, they may be a portion of our population, but they're 100% of our future, and we will never give up on them. We will do whatever it takes to make sure that they're served and protected, and back that up by investment.

Mr. Speaker, thanks to the leadership of the Premier and the Minister of Finance and the President of the Treasury Board and this caucus, the Ministry of Children, Community and Social Services has received increased funding two years in a row, more than $1.6 billion—

The Speaker (Hon. Ted Arnott): Thank you.

Supplementary?

Miss Monique Taylor: This minister needs a reality check. Things have never been as bad as they are today. Tonight, on the 10th annual Children and Youth in Care Day, dozens of young people in care will be going to sleep in motels, hotels, short-term rentals because there are not enough foster beds or treatment facilities. A young person with autism will be sleeping in an agency's office, as they have been for months. Workers will be scrambling to provide a healthy meal in rooms which are dangerous and leave kids vulnerable to the exposure of bedbugs, human trafficking, drug use. This is the state of too many children who have been separated by their families. This is the state of a system that, for the first time in history, is running millions of dollars in deficits.

Will the Premier and his minister commit today to honour their duty to Ontario's most vulnerable children and properly fund our child welfare system?

Interjections.

The Speaker (Hon. Ted Arnott): Members will take their seats.

Minister of Children, Community and Social Services.

Hon. Michael Parsa: The member talks about a reality check? It's unbelievable, hearing a member of the NDP, who held the balance of power, who could have done so much for children and youth in this province, that did nothing.

It was this government, through the child welfare redesign, who said we don't need any more report writing. We want to stand up for children and youth in care in this province now. We want to make sure every child, every youth that is in care is treated the same as every child regardless of their circumstance. That's what's driving our redesign. We will never give up on children and youth.

1100

When it comes to the redesign, part of that is the Ready, Set, Go Program, which provides support for children in care as low as 13, supporting them, providing them with the life skills they need at 13, at 15, right up to their 23rd birthday, with financial support, something the previous government didn't do and something that certainly was not a priority for the—

Interjections.

The Speaker (Hon. Ted Arnott): Order.

Stop the clock.

Interjections.

The Speaker (Hon. Ted Arnott): The member for Hamilton Mountain will come to order. The member for St. Catharines will come to order. The member for Hamilton West–Ancaster–Dundas will come to order. The member for Niagara Falls will come to order.

The Speaker (Hon. Ted Arnott): Start the clock.

The next question.

Taxation / Imposition

Mr. Matthew Rae: Ma question est pour le ministre du Développement du Nord et le ministre des Affaires autochtones.

The Prime Minister has a new flashy video, but he's not fooling anyone. Ontarians are paying more for food, gas and home heating. And at a time when we are facing a 40-year-high inflation rate the Prime Minster and the federal Liberals decided to hike the carbon tax by an additional 23%. You can hear the groans already from the independent Liberals. It's clear that the Liberals in this place do not care about affordability and addressing that. Under their leader, carbon tax queen Bonnie Crombie, they are content with seeing the tax continue to rise and eventually triple by 2030. This is unfair to Ontarians that are paying for the expense of failed Liberal policies. The Liberal carbon tax must come to an end.

Speaker, with the summer quickly approaching, can the minister please explain how the carbon tax continues to burden every Ontarian?

L'hon. Greg Rickford: Merci au député de Perth–Wellington. C'est vrai que, ce matin, nous avons un ami du Québec. C'est tellement agréable d'avoir des gens qui partagent les mêmes idées ici. Le membre du Québec qui est ici en Ontario partage la même position en matière de ce qui concerne la taxe carbone.

C'est une taxe inutile. Ce n'est pas un plan d'environnement; c'est un plan budgétaire. Et notre voisin a le même message que notre gouvernement. C'est clair. En anglais, c'est « scrap the tax ». En français, c'est « restez à l'écart de nos affaires ». Le message est clair : il faut qu'on « scrap the tax ».

The Speaker (Hon. Ted Arnott): Supplementary question?

Mr. Matthew Rae: Merci au ministre. The carbon tax drives up the price of everything, and it is costing Ontarians who can least afford it. This is a regressive tax, and it's an utter failure. It's disgraceful that the carbon tax queen, Bonnie Crombie, and her Liberal caucus support this tax grab that punishes the hard-working people of this province when they are just trying to get by.

While the members opposite have no regard for fiscal discipline, as the people in Ontario truly understand after 15 years under the previous Liberal government, our government will continue to put Ontarians first, protect their hard-earned paycheques and savings.

Can the minister please share with our House today how our government remains steadfast in investing in the priorities that resonate with the people of Ontario while the NDP and Liberals across the aisle continue to support the carbon tax?

Hon. Greg Rickford: As incredible as it sounds, Mr. Speaker, yesterday, I introduced a new actor to the very complicated carbon tax royal love story. We talked about the king of the carbon tax, Prime Minister Trudeau, and his failure to rein in his friends and folks in the Liberal family and, of course, Prince Carney—a very smart man in his own right; just ask him—read the tea leaves. He said this is not a very good tax for Canadians right now. That's interesting. I'm not sure whether it's driven from his intellect or from polls, but here's what's clear: This introduced increased costs on every conceivable thing that the people of Ontario and the people of Quebec buy. From fuel to food, from appliances to planting their gardens this spring, there's only one thing that's going to pop up every single time, and that's the carbon tax. That's why we take the position to just scrap this tax.

Health care workers

M^{me} France Gélinas: Ma question est pour la ministre de la Santé. According to ministry data, Ontario is presently short 13,000 nurses; in a few short years, this number will rise to 33,000 nurses. The number one reason for this shortage is the workload that nurses face on each and every shift. What is this government doing to improve the workload of our nurses?

The Speaker (Hon. Ted Arnott): The parliamentary assistant to the Minister of Health and the member for Stormont–Dundas–South Glengarry.

Mr. Nolan Quinn: Since Minister Jones was sworn in as Minister of Health, our government has registered a record number of new nurses two years in a row, registering a total number of 32,000 nurses in Ontario. We achieved this by directing the College of Nurses of Ontario and the college of physicians of Ontario to break down barriers for internationally trained and educated health care workers, and expanding programs like the Learn and Stay grant, which, I will remind the House, the opposition voted against.

Our government has invested nearly $1 billion into the home and community care sector. This funding has not only added thousands of PSWs—in fact, we've added nearly 25,000 since 2021—but it has also increased compensation for the PSWs, nurses and other front-line health care providers to further stabilize the workforce.

We know that more needs to be done, and that's why as part of our 2024 budget, our government is investing another $743 million to continue to grow our health care workforce.

We will continue to do what needs to be done to ensure that we have the best publicly funded health care system.

The Speaker (Hon. Ted Arnott): Supplementary question?

M^{me} France Gélinas: It gets worse: The ministry data tells us that Ontario is short 38,000 PSWs; in three years, this number will be 50,000 PSWs short. It doesn't matter how many PSWs we train; 25% of them, a quarter of them, leave their profession each and every year. Why are dedicated PSWs leaving their profession? Their working conditions. What is this government doing to improve the working conditions of PSWs?

The Speaker (Hon. Ted Arnott): The Minister of Colleges and Universities.

Hon. Jill Dunlop: You know what we are doing? Training more PSWs, more nurses, initiatives like the Ontario Learn and Stay program. We have 3,500 graduates coming through the program that are nurses, lab techs and paramedics in underserved regions of the province. These students have their educational costs covered by the government in order to fill those spaces. In fact, there are actually six students

for every nursing space in Ontario. This is a growing profession, and we have students across the province who are looking to become nurses.

We are going to continue to work with our post-secondary partners to ensure that we have nurses, paramedics, lab techs and PSWs across Ontario.

Taxation

Ms. Donna Skelly: My question is for Minister of Labour, Immigration, Training and Skills Development. The Liberal carbon tax raises the price of absolutely everything in our province and is hurting our economy and our workers. It drives up the costs of everyday essentials like food, heating and transportation.

With a rapidly growing population, we need all hands on deck to start building right across Ontario, but the costly carbon tax is hurting our workers' ability to invest in their skills and development to build a better future for Ontario. The federal government needs to finally listen to what our government has been asking from day one and eliminate this job-killing tax.

Speaker, can the minister outline the steps that our government is taking to fight the carbon tax and to ensure Ontario has the workforce that we need to start building for the future?

The Speaker (Hon. Ted Arnott): The parliamentary assistant and member for Ajax.

Ms. Patrice Barnes: Thank you to the member for that question.

On this side of the House, we know that Ontario's prosperity hinges on our ability to address the pressing issue of our province's labour shortage, particularly in the skilled trades. Sadly, the carbon tax is only increasing these issues.

Ontarians are deeply concerned about the cost-of-living crisis that the carbon tax has created. While the Crombie Liberals would like to separate this issue, we, on this side of the House, know that the cost of workers don't just end at the workplace. Whether it's being able to cover the cost of one's commute or the ability to invest in the tools and skills that you need, we know that it's just essential for workers' success.

1110

We see the Liberals at every turn working hard to make it harder for Ontarians to survive. In stark contrast, our government has adopted a wholly different approach. We're committed to empowering our workforce by launching a comprehensive skilled trades strategy, supporting nearly $1.5 billion in funding over the next four years.

Together, we are unified in our effort to build a future our province deserves.

The Speaker (Hon. Ted Arnott): The supplementary question?

Ms. Donna Skelly: Back to the parliamentary assistant: The Liberal carbon tax is hurting the household budgets for individuals and families right across Ontario. Ontarians should not be subjected to a tax that does nothing but burden them with unnecessary costs. To make matters worse, the Liberals in this Legislature, under the leadership of a woman who loves the carbon tax, Bonnie Crombie, ignore the hard-working women and men of our province who oppose this punitive tax.

But, Speaker, it's not surprising, considering for 15 years, the previous Liberal government failed all Ontarians and drove 300,000 manufacturing jobs right out of Ontario. Now they want to make it harder for young people to get the skills and the tools they need to enter the skilled trades by supporting the federal Liberal carbon tax. That's unacceptable.

Speaker, can the parliamentary assistant tell the House what our government is doing to get more people into the skilled trades, despite the Liberals advancing their anti-worker carbon tax agenda?

Ms. Patrice Barnes: Thank you to the member for that question. For years, the previous Liberal government has neglected the skilled trades. Their failure to prioritize these crucial sectors resulted in a significant decline in apprenticeship applications, leaving thousands of well-paying jobs unfilled and undermining Ontario's economy. If this wasn't bad enough, for a decade and a half of complete neglect, their

federal Liberal friends are discouraging more Ontarians from entering the trades.

Yet our government is resolute in its commitment to rectifying this Liberal mess and ensuring that Ontario's economy works for everyone. We're accomplishing this by investing in our workforce. We have launched our over $1.5-billion Skills Development Fund aimed at training Ontario's next generation of workers.

And Mr. Speaker, we've seen the results. To date, over half a million workers have benefited and 597 training and workforce development projects have received funding.

We continue to be steadfast in our determination to clean this mess.

Forest firefighting / Lutte contre les incendies de forêt

Mr. Guy Bourgouin: My question it to the Minister of Natural Resources. We know we are 200 firefighters short. Last week, the minister said our crews were so ready that we will be able to send them to other provinces. Minister, if this government is that ready to face wildfires, how many firefighters are we going to share with other provinces when we are short 200 firefighters today?

Hon. Graydon Smith: I must say that one of the hallmarks of our firefighting service here in Ontario is that we do help out other jurisdictions at their time of need. So we know that the forest fires right now in BC, Alberta and Manitoba are significant. We hope and pray that the situations there go well, but we stand at the ready to help. Because that's what Ontario does. That's what firefighters throughout all the jurisdictions in Canada do: They help one another when they have the resources to help.

Here in Ontario, where we had a firefighting budget of $69 million when we took over, it was disrespected and neglected by the previous government, supported by the NDP. We upped that budget to $135 million a year to build capacity to be able to help, to be able to be there for others in this country when they need that assistance. We're here for Ontarians every single day. We're here for Canadians every single day.

The Speaker (Hon. Ted Arnott): The supplementary question?

M. Guy Bourgouin: Monsieur le Président, les conservateurs de l'Alberta ont fait la même chose que l'Ontario fait depuis 2018 : coupé sans cesse dans la prévention des feux de forêt. Aujourd'hui, on voit des conséquences désastreuses du choix politique de l'Alberta.

Monsieur le Ministre, allez-vous répéter les mêmes erreurs que vos homologues albertains et nous rendre vulnérables et dépendants des autres provinces?

Hon. Graydon Smith: I can't repeat enough—because I've said it time and time again and the opposition just doesn't seem to get it—that we continue to make more investments in firefighting in Ontario than any previous government ever has. Again, 15 years of disrespect and neglect by the members opposite—the Liberal independents, supported by the NDP. We had to clean up that mess.

We're the ones that had to make the investments, and it's not only in the base budget that we made those investments. Last fall, an additional $20 million to look at alternative ways to fight fires in Ontario. How can we bring new aerial technologies in? How can we work with universities on collaborative research agreements about the changing dynamics of wildfires? How can we continue to support our great wildfire rangers that are out there doing the work every day? The Ministry of Labour stepped up with presumptive coverage. We've stepped up with more things for them to make sure that they can do the job the best they can every single day, including a recruitment and retention bonus, including supports for training. So we're there every day, Mr. Speaker.

Government accountability

Ms. Stephanie Bowman: We learned recently that this government is once again hiding information from the people of Ontario. This time, it's about how many health care workers they will be short because of their damaging, unconstitutional Bill 124.

But, Speaker, this behaviour is not a surprise from this government. They are experts at pulling down the blinds on the press's right to light and transparency. Whether it's ministerial mandate letters, the details of the shameful 95-year lease with a foreign-owned spa, the real reason they're closing the Ontario Science Centre and building a parking lot for their spa friends, the criminal investigation into the

greenbelt scandal or how they've doubled the number of staff riding the gravy train in the Premier's office, this government has no qualms about hiding their flaws.

My question to the Premier: Why does he like hiding information from the people of Ontario?

The Speaker (Hon. Ted Arnott): Government House leader.

Hon. Paul Calandra: Speaker, do you know what? These guys get—I think they get one question every 11 days. Now, that's not a rule that I put in place; that is something that the people of the province have put in place, because for not one but two elections, they have punished the Liberal Party of Ontario. And now they just punished them again in a by-election, right?

And did they ask about the economy? No, because when they were in office, they destroyed the economy. Do they ask about health care? No, because when they were in office, they closed hospitals, fired nurses and didn't hire doctors, so they don't want to ask about that. They don't ask about infrastructure, because when they were in charge of infrastructure, you remember, they built bridges upside down. So what else? Not long-term care, because they didn't build any long-term-care homes; not about taxes, because they actually increased taxes; not about red tape, because they made us the most overly regulated province in the country. So they're asking about—

The Speaker (Hon. Ted Arnott): Thank you.

And the supplementary question?

Ms. Stephanie Bowman: Speaker, I'm not surprised that I didn't get an answer to this question. Maybe the House leader's new-found penchant for transparency means the Premier will finally release his phone records.

Speaker, this government forgets that the privilege of governing comes with the responsibility of transparency, so their disdain for transparency is at odds with their endless crowing about their record. If their crowing is justified, then there should be nothing to hide. But the press had to go to court again to get the information about the shortage of health care workers. The documents pried out of the government's hands by the Canadian Press show the information was hidden because—wait for it—the government thinks that it would help nurses to get fair wages.

To the Premier: If the state of our health care system is not a concern, why did the government try to hide this information?

Interjections.

The Speaker (Hon. Ted Arnott): The member for Mississauga Centre will come to order. The member for Brampton North will come to order.

Government House leader may reply.

Hon. Paul Calandra: This is a Liberal Party, of course, that, when they were in office, again, raised taxes, made us the most indebted sub-sovereign government in the world—and then have nothing to show for it, right? It's not like they built hospitals. It's not like they built roads. It's not like they built long-term-care homes. It's not like they invested in health or education. In fact, they closed 600 schools across the province. They raised taxes for the people of the province of Ontario.

1120

You want to talk about accountability? The chief of staff to the Premier, under the Liberals, went to jail, Mr. Speaker. That is what we inherited in 2018.

Since 2018, we have been executing a plan across the province of Ontario. That plan includes making sure we are a fiscally responsible government, ensuring that we unleash the power of northern Ontario to protect the prosperity of all Ontarians. They called the north a wasteland. We're opening up the Ring of Fire—

Interjections.

The Speaker (Hon. Ted Arnott): Stop the clock.

The member for Renfrew–Nipissing–Pembroke will come to order. The member for Ottawa South will come to order.

We can start the clock. The next question.

Taxation / Imposition

Mr. Stephen Crawford: My question is for the Minister of Energy. It has been a month and a half since the federal Liberal government increased the carbon tax by a whopping 23%. Everything seems to be getting more expensive. Food, gas and energy prices are all on the rise, while paycheques are failing to keep pace. Life is getting harder and harder with this punitive Liberal carbon tax.

The Liberal members in this House, instead of asking their federal counterparts to cut the carbon tax, are doubling down in support of this tax, which is hurting Ontario families and businesses.

Can the minister please explain how the carbon tax continues to hurt every single person living in this province?

Hon. Todd Smith: Thanks to the member from Oakville for the great question. The carbon tax is a terrible tax, and it's hurting us right now, but the worst part of this tale is that the tax is going to go up and up and up every April 1.

Our good friend from Quebec is here as well: La taxe de carbone va augmenter de plus en plus en plus, and that's bad news. That's bad news for the people of Ontario. It's bad news for the people in Quebec. It's bad news for the people right across our country.

Our government is doing things differently.

The queen of the carbon tax, Bonnie Crombie, is in full support of the Prime Minister and the federal carbon tax. The NDP are in full support of the carbon tax. Mr. Green over here is in full support of the carbon tax, as well.

The Premier and our government are not in support of a carbon tax. As a matter of fact, we're continuing to lead the country in driving down emissions without a carbon tax.

The Speaker (Hon. Ted Arnott): I'll remind the members to make reference to each other either by their riding name or their ministerial title.

The supplementary question?

Mr. Stephen Crawford: Thank you to the minister for your response and for your continued advocacy, fighting for the people of Ontario.

It's simply unacceptable that the federal Liberals are pricing Ontarians out of grocery stores, out of their homes and into situations where they have to choose between eating and heating. Families are struggling now more than ever, and they need our help.

Let's ensure we do this right. It's time for the Liberals to stop this vicious carbon tax and give real financial relief to the people of Ontario.

Can the minister please tell the House what our government is doing to ensure Ontario has a clean, reliable and emission-free energy system without taking a step backwards and imposing a carbon tax on the people of Ontario?

Hon. Todd Smith: Again, we're refurbishing our nuclear facilities, the 18 Candu reactors that we have in Ontario that provide almost 60% of our baseload, emissions-free electricity every day. We count on those nuclear facilities. And we're planning on expanding on our expertise, with a new Bruce C and small modular reactors on site at Darlington, which are going to lead the way into the future and help other jurisdictions do what we've already done, and that's eliminate our reliance on coal-fired generation.

We are investing in our hydro facilities. Over the last two weeks, I've been in Cornwall, with the great member from Stormont–Dundas–South Glengarry, and down in Niagara at the Sir Adam Beck facility, announcing refurbishments of our hydroelectric fleet.

We just had the largest procurement of battery storage in Canada's history last week, to make sure that our non-emitting resources are working more efficiently and that we have the power we're going to need to continue to attract the multi-billion dollar investments, like the ones that are being made today down in Niagara,

Violence in schools

Ms. Chandra Pasma: Our schools are experiencing a violence crisis and it is taking a serious toll on teachers. Some 80% of ETFO members have either personally experienced or witnessed violence. Some of these are life-changing injuries, yet the minister's plan to address violence is to spend 14 cents per day per child on student safety. That's just not enough when teachers are already going to school in Kevlar and classes are being evacuated daily.

When will we see a serious plan from the Minister of Education to protect children and workers in our schools?

Hon. Stephen Lecce: One of the ways by which we keep kids safe is by removing distractions in our publicly funded schools. That's why we announced a plan to remove social media from school devices—

Interjections.

Hon. Stephen Lecce: The members opposite seem to find it comical—with an increase of cyberbullying and increasing levels of distractions where teachers feel powerless to enforce basic policies. Members opposite don't want us to enforce policies in our schools is the mindset of members of the New Democratic Party, but we understand. We've got to have some enforcement and educational tools to get back to basics and restoring order and common sense in our schools.

It's why we announced $17 million of mental health supports, leveraging community-based mental health. It's why we finally annualized funding for mental health services through the summer to make it better for the family so they get access to the same practitioner.

I've been working with the Minister of Mental Health and Addictions for the past years to build capacity in our schools and in our communities to keep our kids safe.

The Speaker (Hon. Ted Arnott): Supplementary question?

Ms. Chandra Pasma: Removing cellphones from the classroom is not going to protect a single student or teacher who is currently being punched, kicked or bitten. This minister just doesn't seem to grasp the severity of the situation.

A quarter of elementary schools and a third of secondary schools have daily staff shortages. There are more resignations than retirements in the education system. High-quality education requires a qualified educator, but this minister is doing everything he can to drive them away.

Parents know that teachers and education workers are the backbone of our education system. Why doesn't the minister think they deserve respect?

Hon. Stephen Lecce: Mr. Speaker, I love that the member opposite spoke about qualified educators and yet the NDP and the Liberals oppose the return of merit-based hiring when it comes to qualifications of educators. You cannot have it both ways. You cannot articulate or advance the cause of qualified educators and yet deny principals the ability to hire based on their experience in the classroom. There's a reason why we revoked regulation 274 because we believe that merit should triumph and the best educators should get the job. That is what parents expect.

Mr. Speaker, we've increased the funding and the staffing in Ontario's publicly funded schools. What we're also doing, a matter of contention with members opposite, is we're elevating the expectations on our school boards to deliver better outcomes for the investments we make in Ontario.

Violence in schools

Ms. Aislinn Clancy: Today we're joined by ETFO members and Catholic educators from across the province. They're here today to teach us about the rising levels of violence in schools.

Imagine going to work every day worried you'll be attacked, sworn at or threatened, or being off work because of a concussion, mental health concern or injury. A recent ETFO study reported that 75% of members experienced or witnessed violence against a staff member.

Speaker, anyone who has spent time in our classrooms knows that we need adequate support for our students, especially those with complex needs, exacerbated by the COVID pandemic. The kids are not okay.

School boards are facing staff shortages and the impact of crowded classrooms.

To the Premier: Will your government develop a plan to address the alarming rise in violence in our schools to keep people safe?

The Speaker (Hon. Ted Arnott): Minister of Education.

Hon. Stephen Lecce: I want to thank the member opposite for the question. I know in her former experience as a social worker and education worker in Ontario's publicly funded schools we are grateful to you—and all the educators who are with us today.

It is an issue. It is a serious concern. And there's a reason why the government of Ontario, under our Premier's leadership, was the first in Canada to initiate an anti-human-trafficking protocol, the first of its kind, and to initiate a plan to counter bullying and cyberbullying in every publicly funded school.

We've added thousands of EAs, 3,000 additional EAs, to our schools, more social workers, more mental health workers, but we're also building that capacity in the community.

1130

The establishment of the youth mental health hubs has been a massive positive intervention for kids. A one-stop shop of access, and it's because of the leadership of the Minister of Mental Health and Addictions that we have these access points.

We're working together to bridge the gaps, reduce the wait times and support every child in Ontario.

The Speaker (Hon. Ted Arnott): The supplementary question?

Ms. Aislinn Clancy: I appreciate that. I hope we can go further.

I was taught that you measure what you value, and you change what you measure. In recent years, kids are struggling from a lack of support for their mental health and development in the community and at school, which makes education work overwhelming. Folks are leaving the profession and recruitment is a challenge, which I know as a former school social worker. Boards are struggling to hire EAs, bus drivers, teachers. The vacancy rates in the Waterloo region and across the province are breaking records. This, and the budget shortfall mean that support staff ratios are alarmingly low. In the elementary schools alone, the ratio of support staff to students is 1.73 per 1,000 students.

Will the Premier value and measure the realities of workplace violence and the increasing needs for student supports and create a plan to change this trend?

The Speaker (Hon. Ted Arnott): The Associate Minister of Mental Health and Addictions.

Hon. Michael A. Tibollo: Thank you to the member opposite for that question.

When we talk about the mental health of children and youth, it doesn't begin and end during the school day. We know that we need to have supports in place. Those supports have to be there, they have to be reliable but they also have to be there beyond the time that the kids are in school.

Since 2019, we've increased annual funding for children and youth by $130 million through the Roadmap to Wellness—in addition, in the last two budgets, another $43 million. Unlike previous governments, we're actually innovating and collaborating with partners to support children and youth. We've opened 22 youth wellness hubs, and an additional five will be opening this year. This fund includes the virtual supports, the One Stop Talk program.

Our plan for children and youth—and there is a plan for children and youth mental health—is clear: early interventions to keep kids from harmful behaviours, easy accessibility to them. Children and youth are our future—

The Speaker (Hon. Ted Arnott): Thank you very much.

The next question.

Taxation

M^me^ Dawn Gallagher Murphy: My question is for the Minister of Education. The Liberal carbon tax is increasing the cost of everything for everyone in this province. Not only is it forcing Ontarians to pay more for their groceries and their home heating, but it is driving up prices for building materials and transportation.

Speaker, our government has made historic investments to support the building of critical infrastructure in Ontario like new schools and child care spaces. Unfortunately, the Liberal carbon tax imposes significant financial hurdles for the people who are building our province. It's time for the federal Liberals to do the right thing and scrap this tax.

Speaker, can the minister please tell the House how the federal carbon tax is making building more schools more expensive?

Interjections.

The Speaker (Hon. Ted Arnott): Order.

The parliamentary assistant and the member for Burlington.

Ms. Natalie Pierre: I want to thank the member for their question. She's right, Ontario needs more state-of-the-art schools and more child care spaces. Over the next 10 years, our government is investing an historic $16 billion in capital grants, including a doubling of capital school funds by 136%, from $550 million to $1.3 billion for the 2023-24 year, to ensure these capital investments are brought online in half the time it took to build schools under the Ontario Liberals.

But, Mr. Speaker, the member opposite is right: These historic investments in education are being hindered by the federal Liberals' failed carbon tax. A report from the Canadian Energy Centre found that Ontario industries such as mining, utilities, concrete, iron and steel will bear the highest impacts of the federal carbon tax.

As our government increases its spending on critical capital files in education, the federal Liberals are taking Ontario backwards by overtaxing the industries we need to support our new and redeveloped—

The Speaker (Hon. Ted Arnott): Thank you.

Supplementary question?

M^me^ Dawn Gallagher Murphy: Thank you to the parliamentary assistant for her response. From groceries to gas, families are suffering from the price of the federal Liberals' failed carbon tax. People in my riding of Newmarket–Aurora tell me that the cost of living in Ontario is becoming unsustainable as a result of this regressive tax. It is driving up the cost of everyday essentials and making it more expensive for parents to drive their children to school and extracurriculars.

Ontario families need economic stability to ensure that they can properly invest in their children's educational success. That's why our government must continue to advocate for Ontarians and call on the federal government to scrap this tax.

Speaker, can the parliamentary assistant please tell the House how our government is making life more affordable—

The Speaker (Hon. Ted Arnott): Thank you very much.

The member for Markham–Unionville and parliamentary assistant.

Mr. Billy Pang: The federal Liberals are playing politics with our children's future by making it harder for parents to invest in their children's success. But here in Ontario, under the leadership of Premier Ford, we understand that parents, not governments, know what is the best for their children. Parents should not have to choose between heating their homes and feeding their families. That's why we extended the gas tax cut of 10 cents a litre and scrapped the licence plate sticker fee, saving hundreds of dollars, which supports parents who drive their kids to school—money that they can use to help keep the lights on and heat their homes and schools while their children work, play and study.

We introduced the Ontario Childcare Tax Credit, allowing families to claim up to 75% of their child care expenses, putting more money back into their pockets to invest in their children's future.

Yes, Mr. Speaker, time and time again, the opposition, propped up by the Ontario—

The Speaker (Hon. Ted Arnott): Thank you very much.

The next question.

Consumer protection

Ms. Sandy Shaw: My question is to the Premier. Parents have been calling me, distressed with the skyrocketing costs of baby formula. We all know that the cost of groceries is a huge burden on Ontario families. Baby formula prices are completely unaffordable. Sadly, families in Ontario in all of our ridings are forced to water down formula to make it last longer. While food prices continue to soar, continue to rise, grocery stores like Loblaws continue to post massive profits—straight-up price gouging.

So my question to the Premier is, why are you hiding from the pleas of parents and sitting on your hands while powerful retailers profit at the expense of our Ontario families?

The Speaker (Hon. Ted Arnott): To reply, the Minister of Finance.

Hon. Peter Bethlenfalvy: Thank you, Mr. Speaker, through you to the member opposite, for that question. Obviously, food prices going up hurts many people across this province. But do you know what, Mr. Speaker? What is a big part of that is the gas tax. The carbon tax is going up in Ottawa, 17 cents since they've started. We've reduced the gas tax and, through other measures, the price at the pumps by almost 10.7 cents a litre, so one is going down; the other is going up. The price of gas goes into the food processing; it goes into the farmers—the member from Huron–Bruce representing farmers right across this great province.

This is unacceptable. We're the party that's putting money back into the pockets of the people in Ontario, the businesses in Ontario so food prices will come down. This is a government that's got the backs of the people of Ontario.

The Speaker (Hon. Ted Arnott): The supplementary question?

Ms. Sandy Shaw: That is a shameful answer from the Minister of Finance, and I invite your constituents to call you and tell you what they are truly experiencing.

I would remind the House, through the Speaker, that my question was about feeding babies, and this government chose to hide behind the carbon tax.

Ontarians see through your excuses. Ontarians are fed up with this government taking the side of powerful billionaires. They see skyrocketing grocery costs while at the same time corporations like Loblaws are shamelessly making record profits. And they—

Interjections.

1140

The Speaker (Hon. Ted Arnott): Stop the clock.

The member for Etobicoke–Lakeshore will come to order. The member for Brampton North will come to order. The member for Mississauga–Erin Mills will come to order. The Associate Minister of Small Business will come to order.

I apologize to the member. Start the clock. The member for Hamilton West–Ancaster–Dundas has the floor.

Ms. Sandy Shaw: Thank you, Speaker. I wish I saw the same kind of passion from this government for babies that can't be fed properly in this province.

The people of Ontario see this government doing nothing, absolutely nothing, to help them feed their babies.

So, my question to the Premier, to this government: What will you do today for struggling parents to ensure that their babies do not go hungry?

Interjections.

The Speaker (Hon. Ted Arnott): Members will please take their seats.

The Minister of Finance.

Hon. Peter Bethlenfalvy: What the member opposite and her party can do is vote for the budget, which has the backs of the people of Ontario. In that budget is cutting the gas tax—continuing the cut in the gas tax. That budget has the integrated One Fare. It has guaranteed annual income supplements for our seniors so that their payments are indexed to inflation.

Do you know what the member opposite could do? Do you know what is really shameful? Watching 300,000 manufacturing jobs—the tail lights—leave Ontario. But do you know what's really good? The 700,000 headlights of jobs that are coming into Ontario.

This member opposite's party supported the Liberal government that raised taxes. They invented red tape over there. They drove jobs from Ontario. We're building Ontario. We're supporting the workers and we're protecting the taxpayers.

Interjections.

The Speaker (Hon. Ted Arnott): The member for Hamilton West–Ancaster–Dundas will come to order. The member for Hamilton Mountain will come to order.

The next question.

Taxation / Imposition

Ms. Christine Hogarth: My question is for the Solicitor General. Firefighters hold an essential role in our communities. They risk their lives to keep us and our loved ones safe. I want to give a shout-out to the men and women of stations number 431, 432, 433, 434 and 435, from Etobicoke–Lakeshore. Thank you for your service.

Speaker, the Liberal carbon tax is placing additional financial burdens on our public safety system. People in my riding of Etobicoke–Lakeshore are concerned about how this punitive tax is impacting first responders in our province. They want to ensure that Ontario's firefighters have the support they need to protect our communities.

Speaker, could the Solicitor General discuss how the carbon tax is impacting firefighters' efforts in Ontario?

L'hon. Michael S. Kerzner: Je voudrais remercier ma collègue pour cette question excellente. Je suis fier de soutenir nos pompiers et tous ceux qui assurent la sécurité de l'Ontario tous les jours. Ce sont des gens formidables qui nous protègent au quotidien.

Bonnie Crombie, as mayor of Mississauga, knew proof positive every time a fire truck in Mississauga had to fill up its truck—an average truck is about 200 litres—and if you do the math, at 21.5 cents for diesel, that's $43—$43—a fill-up, which is ridiculous. It's time for Bonnie Crombie, as mayor of Mississauga, who had to approve the fire department budget, to come clean with Ontarians and say, "I am against this tax. It's affecting our firefighters."

The Speaker (Hon. Ted Arnott): Supplementary question?

Ms. Christine Hogarth: I want to thank the Solicitor General for his response. I'm proud to hear that our government is standing up for public safety and fighting this unfair carbon tax.

Unlike the carbon tax queen, Bonnie Crombie, and her party of nine, our government knows that this tax makes life harder and more expensive for hard-working families and businesses throughout our entire province. Not only does it increase the cost of goods, but it's also driving up the cost of fuel and gasoline for everyone in this province, including our firefighters and those trucks that drive right in front of me along the Gardiner on their way to the food terminal every day.

We have heard how the NDP and the Liberals won't stand up for our public safety heroes, but I know we, this party led by Premier Ford, will always stand up for our public safety heroes.

Speaker, can the Solicitor General further elaborate on the importance of cancelling the carbon tax for Ontario's firefighters?

Hon. Michael S. Kerzner: There is no government in the history of Ontario that has had the backs of the firefighters as our government, led by Premier Ford. And do you know what, Mr. Speaker? We're proud of this.

I speak to Greg Horton; I speak to Rob Grimwood, the association presidents of the chiefs and the professional firefighters. We have volunteer firefighters in this Legislature: the member from Brantford–Brant, the member from Sarnia–Lambton and others who have come forward to keep us safe.

But Bonnie Crombie, as mayor of Mississauga, knew to the last cent how much the carbon tax was affecting the firefighters. It is absolutely proof positive Bonnie Crombie needs to come clean and say this is the most regressive tax that is affecting our public safety. It's affecting our fire safety and she should say, "I'm not in favour of it. I will support cancelling it."

The Speaker (Hon. Ted Arnott): That concludes our question period for this morning.

There being no further business, this House stands in recess until 3 p.m.

The House recessed from 1146 to 1500.

Introduction of Bills

Cutting Taxes on Small Businesses Act, 2024 / Loi de 2024 pour réduire les impôts des petites entreprises

Ms. Bowman moved first reading of the following bill:

Bill 195, An Act to amend the Taxation Act, 2007 to increase Ontario small business deductions / Projet de loi 195, Loi modifiant la Loi de 2007 sur les impôts pour augmenter les déductions accordées aux petites entreprises exploitées en Ontario.

The Speaker (Hon. Ted Arnott): Is it the pleasure of the House that the motion carry? Carried.

First reading agreed to.

The Speaker (Hon. Ted Arnott): Would the member for Don Valley West like to briefly explain her bill?

Ms. Stephanie Bowman: I am pleased to rise today to introduce the Cutting Taxes on Small Businesses Act. This bill would provide essential tax relief for Ontario's small businesses by cutting the effective small business tax rate in half, from 3.2% to 1.6%, and by increasing the income threshold for this deduction from $500,000 to $600,000. If passed, this bill will be deemed to have come into effect on January 1, 2024, and will save small businesses up to $17,900 annually.

Some 450,000 Ontario small businesses employ over three million people—two thirds of workers in the private sector—and are vital to our economy and communities.

This bill will give small business owners more opportunity to thrive and grow, fostering economic prosperity and innovation across our province.

The other three parties have all talked about lowering taxes on small business; I am doing that today.

I hope all members will show their support to small businesses in their communities and across the province by supporting the Cutting Taxes on Small Businesses Act.

Motions

Consideration of Bill 189

Mr. Trevor Jones: Mr. Speaker, I move that, pursuant to standing order 77(a), the order for second reading of Bill 189, An Act to enact Lydia's Law (Accountability and Transparency in the Handling of Sexual Assault Cases), 2024, be discharged and the bill be referred to the Standing Committee on Justice Policy.

The Speaker (Hon. Ted Arnott): Mr. Jones, Chatham-Kent–Leamington, has moved that, pursuant to standing order 77(a), the order for second reading of Bill 189, An Act to enact Lydia's Law (Accountability and Transparency in the Handling of Sexual Assault Cases), 2024, be discharged and the bill be referred to the Standing Committee on Justice Policy.

Is it the pleasure of the House that the motion carry? I heard some noes.

All those in favour of the motion will please say "aye."

All those opposed will please say "nay."

In my opinion, the ayes have it.

Call in the members. This will be a 30-minute bell.

The division bells rang from 1504 to 1534.

The Deputy Speaker (Ms. Donna Skelly): Mr. Jones, Chatham-Kent–Leamington, has moved that, pursuant to standing order 77(a)—

Ms. Catherine Fife: Cowards. You're all cowards.

Interjections.

The Deputy Speaker (Ms. Donna Skelly): Order. Order. Order.

I am asking the member from Waterloo to come to order.

Interjection.

The Deputy Speaker (Ms. Donna Skelly): I will name the member.

Interjections.

The Deputy Speaker (Ms. Donna Skelly): Come to order.

Mr. Jones, Chatham-Kent–Leamington, has moved that, pursuant to standing order 77(a), the order for second reading of Bill 189, An Act to enact Lydia's Law (Accountability and Transparency in the Handling of Sexual Assault Cases), 2024, be discharged and the bill be referred to the Standing Committee on Justice Policy.

Interjection.

The Deputy Speaker (Ms. Donna Skelly): Come to order. I'm asking the member for Waterloo to come to order.

All those in favour, please rise one at a time and be recognized by the Clerk.

AYES

- Anand, Deepak
- Babikian, Aris
- Bailey, Robert
- Barnes, Patrice
- Byers, Rick
- Calandra, Paul
- Cho, Raymond Sung Joon
- Cho, Stan
- Clark, Steve
- Coe, Lorne
- Crawford, Stephen
- Cuzzetto, Rudy

- Dixon, Jess
- Dowie, Andrew
- Downey, Doug
- Dunlop, Jill
- Flack, Rob
- Gallagher Murphy, Dawn
- Ghamari, Goldie
- Grewal, Hardeep Singh
- Hardeman, Ernie
- Harris, Mike
- Hogarth, Christine
- Holland, Kevin
- Jones, Trevor
- Jordan, John
- Kanapathi, Logan
- Ke, Vincent
- Khanjin, Andrea
- Kusendova-Bashta, Natalia
- Leardi, Anthony
- Lecce, Stephen
- Martin, Robin
- McCarthy, Todd J.
- Mulroney, Caroline
- Pang, Billy
- Parsa, Michael
- Pierre, Natalie
- Pirie, George
- Quinn, Nolan
- Rae, Matthew
- Rasheed, Kaleed
- Sabawy, Sheref
- Sandhu, Amarjot
- Sarkaria, Prabmeet Singh
- Saunderson, Brian
- Scott, Laurie
- Smith, Dave
- Smith, David
- Smith, Graydon
- Smith, Laura
- Smith, Todd
- Thanigasalam, Vijay
- Thompson, Lisa M.
- Tibollo, Michael A.
- Triantafilopoulos, Effie J.
- Wai, Daisy
- Williams, Charmaine A.

- Yakabuski, John

The Deputy Speaker (Ms. Donna Skelly): All those opposed to the motion will please rise and be recognized by the Clerk.

NAYS

- Andrew, Jill
- Armstrong, Teresa J.
- Bell, Jessica
- Blais, Stephen
- Bourgouin, Guy
- Bowman, Stephanie
- Burch, Jeff
- Clancy, Aislinn
- Fife, Catherine
- French, Jennifer K.
- Gélinas, France
- Hazell, Andrea
- Karpoche, Bhutila
- Kernaghan, Terence
- Mamakwa, Sol
- Mantha, Michael
- McCrimmon, Karen
- McMahon, Mary-Margaret
- Pasma, Chandra
- Rakocevic, Tom
- Sattler, Peggy
- Schreiner, Mike
- Shaw, Sandy
- Stevens, Jennifer (Jennie)
- Stiles, Marit
- Taylor, Monique
- Vanthof, John
- Vaugeois, Lise
- West, Jamie

The Clerk of the Assembly (Mr. Trevor Day): The ayes are 59; the nays are 29.

The Deputy Speaker (Ms. Donna Skelly): I declare the motion carried.

Motion agreed to.

The Deputy Speaker (Ms. Donna Skelly): Motions?

Interjections.

The Deputy Speaker (Ms. Donna Skelly): I am going to call the member from Hamilton West–Ancaster–Dundas to order, and I will start warning people. If you want to remain for the rest of the day, be forewarned.

Petitions

Human rights education

MPP Jill Andrew: I've got a petition with 2,252 signatures, and this petition is being put forth by Nicole Crellin, who happens to be good friends with the member from Toronto–Danforth.

Over 40 people are in the Legislature today for this petition calling for mandatory human rights education—

Interjections.

1540

The Deputy Speaker (Ms. Donna Skelly): I apologize.

I am calling the member from Hamilton Mountain—you have been warned.

Miss Monique Taylor: Me?

The Deputy Speaker (Ms. Donna Skelly): You have been warned.

Interjections.

The Deputy Speaker (Ms. Donna Skelly): Excuse me? You have been warned.

I apologize to the member from Toronto–St Paul's—please, people, come to order. This is the Ontario Legislature.

Ms. Sandy Shaw: Really?

The Deputy Speaker (Ms. Donna Skelly): Yes, really.

The member from Hamilton West–Ancaster–Dundas has been warned.

The member from Toronto–St. Paul's, you have the floor.

MPP Jill Andrew: I'm putting forth this petition in the Legislature today on behalf of Nicole Crellin, who happens to be a dear friend of Peter Tabuns, the member for Toronto–Danforth.

Speaker, there are about 40 people in the audience today who have come to hear this petition.

Here in Ontario, we are a diverse, multicultural, multi-ethnic community, and at our best, we value equity and inclusion and human rights for all; not just for a select few.

Toronto, as we all know, is the most diverse city in the world. Our differences, when respected, are our superpower.

The United Nations adopted the Universal Declaration of Human Rights in 1948 as the first international recognition that all human beings are entitled to fundamental rights and freedoms which must be respected and protected by all nations of the world. It is crucial that all Ontarians are aware of the fundamental human rights enshrined in the Universal Declaration of Human Rights; too many are not.

For those who are watching, the government changed the rules on petitions, so we can't read the petitions. So I can't read the actual words on these petitions that have been signed by 2,252 people.

The petition calls for the Ontario government to implement consistent and robust mandatory human rights education through events, campaigns, publications and other methods, so every Ontarian knows the universal declaration and can be deeply rooted and invested in our collective pursuit for freedom, justice and peace in this province.

It's rather an ironic day, but I will affix my signature on this petition, and I am handing it to Lise for tabling.

And I would be remiss, Speaker, if I did not say hello to Rosemary Sadlier, literally one of our icons in the province of Ontario, if not our country, and someone who initiated much of the work done around Emancipation Day, recognized in this province, and Emancipation Month, recognized in this province, and most certainly Black History Month, as well.

Welcome to your House.

The Deputy Speaker (Ms. Donna Skelly): Before we continue with petitions, I'm going to warn the member from Kitchener South–Hespeler for using unparliamentary language.

Front-line workers

M^me^ France Gélinas: I would like to thank Joffre Labelle from Hanmer in my riding for these petitions. The petitions are called "Make PSW a Career."

As the document that we received from the ministry showed us, Ontario is short 38,000 PSWs right now. Every year, we will add 10,000 more PSWs to this shortage list. Why? Because the working conditions of PSWs are not adequate. A quarter of them leave their profession every single year. They love what they do. They want to care for us. They're good at what they do. But if they work as a PSW, they can't feed their kids and pay the rent. It's as simple as that.

Thousands and thousands of people have signed the petition, and they ask Premier Ford to make PSW a career; make sure that they have a permanent, full-time job that is well-paid; make sure that those jobs have sick days and vacation days and benefits and maybe a dream of a pension plan. We did this for nurses, way back in the 1970s. We mandated that 70% of jobs for nurses had to be permanent, full-time, well-paid. We can do this for PSWs. We can change the shortage of 50,000 PSWs to care for our loved ones in home care, in long-term care, in hospitals. We can change this today by passing this petition.

I fully support it. I'll affix my name to it and ask Victoria to bring it to the Clerk.

Social assistance

Ms. Bhutila Karpoche: I have a petition here entitled "To Raise Social Assistance Rates."

The rates for social assistance are well below the poverty line. Individuals on Ontario Works are receiving only $733 a month, and those on the Ontario Disability Support Program are receiving only $1,308 a month.

Community organizations—in fact, over 230 of them—have signed a letter to three cabinet ministers urging them to immediately double social assistance rates.

During the pandemic, the federal government decided that an unemployed individual needed a basic amount of $2,000 per month to survive. The rates for OW and ODSP are far below $2,000.

At this time, with the increasing affordability crisis, these rates of social assistance go even less than they used to.

So I join the petition signatories here, who are mostly from Grimsby, a Conservative riding, in calling on the Legislative Assembly of Ontario to immediately double social assistance rates for OW and ODSP.

Sexual violence and harassment

MPP Jill Andrew: This petition is entitled "Justice for Sexual Assault Survivors (Lydia's Law)."

This petition is calling for the Ontario government to do everything in its power to support victims of sexual violence. Women who have been raped, women who have experienced gender-based violence do not need to be retraumatized, reviolated by a "justice system" that is grossly underfunded, under-resourced, understaffed, to the point where there were 1,326 cases of sexual assault in 2022 withdrawn or stayed before trial. That means the perpetrators walked.

I stand in full support of this petition to adopt recommendations 1 and 3 of the Auditor General's 2019 annual report, to make the ILA program more accessible for survivors, and to review the Victim Quick Response Program to ensure it's meeting its mandate.

There are several of us in this room, in this Legislature, who are women—across party lines. We should be absolutely ashamed of this government's lack of treatment when it comes to women and survivors of gender-based violence.

I happily affix my signature to this petition—probably more angrily—and I table it with Alexander.

Sexual violence and harassment

Ms. Sandy Shaw: I have a petition entitled "Justice for Sexual Assault Survivors (Lydia's Law)."

As we have been hearing time and time again in this House, sexual assault survivors are not seeing their day in court. There were 1,326 cases of sexual assault thrown out before the court—there were over 1,000 this year, in 2023. So now we're looking at almost 3,000 sexual assault survivors whose cases were thrown out, and we know those are the people who came forward. We know that more than 80% of sexual assault cases go unreported.

1550

The MPP from Waterloo, Catherine Fife, brought this bill forward. It was her private member's bill. This bill is named after Lydia, to represent a woman who was denied justice in the court.

What we saw today with this government discharging this important bill to committee is another example of Lydia and all sexual assault survivors not getting justice.

This government needs to understand that we had all kinds of women and sexual assault survivors who were prepared to come tomorrow to hear debate on this bill—important debate that you need to listen to. It's your government. These are sexual assault survivors who are not seeing justice under your watch, but rather than hear what they had to say, rather than give them—they're not getting their day in court, and now they're not going to get their day in the Ontario Legislature to come forward and share their stories of survival, to help you act, to help you understand that the justice system is not working for sexual assault survivors under your watch.

We wanted to see recommendations 1 and 3 of the Auditor General's report put into law. We need to see a Victim Quick Response Program.

This government, understandably, is concerned with people who steal vehicles going free. Sure, we don't like to see that, but we also don't like to see sexual assault criminals walk free in this province, which is what's happening under your watch, and you discharged Lydia's Law so that you can't hear about it. I find that cowardly, and I'm disappointed.

I will absolutely add my name to this petition and give it to Glynnis to take to the table.

Sexual violence and harassment

Ms. Bhutila Karpoche: This petition is titled "Justice for Sexual Assault Survivors," and this bill is in support of Bill 189, Lydia's Law, that has been brought forward by my colleague from Waterloo.

Speaker, it is really a shame that, in Ontario, 1,326 cases of sexual assault in 2022 were withdrawn or stayed before trial. Already we know that 80% of sexual assault cases go unreported, so the Auditor General looked into this issue and made recommendations in their report. Recommendations 1 and 3 are part of Bill 189, which is Lydia's Law, which makes the Independent Legal Advice Program much more accessible for survivors, and also reviews the Victim Quick Response Program to ensure it's meeting its mandate.

Speaker, survivors of sexual assault need justice, and we cannot allow the current system to retraumatize them and have their cases thrown out of court simply because the system is not working.

I fully support this bill, and I will affix my signature to it.

Missing persons

Ms. Sandy Shaw: I have a petition entitled "Vulnerable Persons Alert." This petition is put forward on behalf of the MPP for Hamilton Mountain, Monique Taylor.

This petition speaks to a private member's bill that was brought before the Legislature. As we know, private members' bills are an important opportunity for us, as elected legislators, to fulfill our duty and to have an opportunity to bring the people's business before this Legislature. This was a very, very important private member's bill. It was addressing a gap in our current emergency alert system. It would ensure that vulnerable persons—would help to ensure the safety of those loved ones when they go missing, because we know when they go missing, time is critical.

Over 90,000 people have signed an online petition calling for a "Draven Alert." "Draven Alert," much like Lydia's Law, was named after a young child who could have used the benefit of an alert system that would have helped to find him in time. Unfortunately, it's a story that ended in tragedy. Speaker, 6,000 people signed a petition called "Love's Law"—same thing, for vulnerable people who go missing. This bill was a common-sense proposal and was non-partisan in nature, but just like Lydia's Law, this government discharged the bill directly to committee and did not allow Draven's family and all the families who supported this bill to come to the Legislature and hear debate.

It's a terrible precedent that this government is doing—discharging private members' bills that bring important business, important suggestions to this House. It's a slap on democracy when you don't allow MPPs and who they represent to debate their bills. So—

Mr. Trevor Jones: Point of order.

The Deputy Speaker (Ms. Donna Skelly): I apologize to the member from Hamilton West–Ancaster–Dundas.

I recognize the deputy government House leader.

Mr. Trevor Jones: Thank you, Speaker. I'll remind the experienced member that we're to briefly summarize our petitions for the benefit of all members in the House, not to go on a pulpit and go on and on and on and waste legislative time.

The Deputy Speaker (Ms. Donna Skelly): I will allow the member to continue with her petition.

Ms. Sandy Shaw: Thank you very much, Speaker.

Apparently, the member from Chatham-Kent–Leamington thinks that bills that support sexual assault survivors and vulnerable persons who go missing is a waste of taxpayers' time—

Mr. Trevor Jones: Point of order.

The Deputy Speaker (Ms. Donna Skelly): I apologize to the member from Hamilton West–Ancaster–Dundas.

I recognize the deputy government—

Mr. Trevor Jones: On the same point of order, Madam Speaker: The standing order is 42(b). This is clearly not the design or the intent for petitions in this House, and I am offended by the unparliamentary reference by the member.

The Deputy Speaker (Ms. Donna Skelly): I will allow the member to continue. I recognize the member from Hamilton West–Ancaster–Dundas. But I will caution the member.

Ms. Sandy Shaw: Thank you, Speaker.

I would just add that what you consider unparliamentary language is simply your words; I didn't add anything to it. You said "waste of taxpayers' time."

I will conclude by saying that this is an important private member's bill, as all private members' bills are, including Lydia's Law. Discharging it to committee is a real failure of democracy in this province and in this House.

I'm going to add my name to this petition. I'm going to give it to Diya to take to the table.

Orders of the Day

Keeping Energy Costs Down Act, 2024 / Loi de 2024 visant à maintenir la facture énergétique à un niveau abordable

Resuming the debate adjourned on May 14, 2024, on the motion for third reading of the following bill:

Bill 165, An Act to amend the Ontario Energy Board Act, 1998 respecting certain Board proceedings and related matters / Projet de loi 165, Loi modifiant la Loi de 1998 sur la Commission de l'énergie de l'Ontario en ce qui concerne certaines instances dont la Commission est saisie et des questions connexes.

The Deputy Speaker (Ms. Donna Skelly): Further debate? I believe we left off with the member from Chatham-Kent–Leamington.

Mr. Trevor Jones: Thank you, Madam Speaker. As I was saying, the Ontario Energy Board's decision—and this is a direct quote from President Drew Spoelstra from the Ontario Federation of Agriculture—"challenges Ontario's efforts and current policy to bring reliable and affordable natural gas to Ontarians across the province, which has been an investment priority for agriculture and rural communities over the last decade."

The last credible voice from our communities I want to share is Gail Hundt, president and CEO of the Chatham-Kent Chamber of Commerce. In a letter, she stated:

"While recognizing the vision towards energy efficiencies in our province, we also note where reduced access to natural gas grid recommendations of the" OEB "will have a dire effect on economic growth in our community, across Ontario and beyond. These recommendations will cause negative impacts to affordable, and all, housing developments, enhancements to our greenhouse industry and many other needed growth sectors. Beyond the direct effect this will have on business, the trickle effect of home purchasing, food costs—as examples—will be burdened on the general consumer, who are already bearing budget constraints.

"The Chatham-Kent Chamber of Commerce commends the Ontario government for their proposed actions to mitigate these negative recommendations and is pleased to provide our support of immediate action thereof."

Under the leadership of Premier Ford, our province is quickly becoming the global leader in manufacturing, by building electric vehicles and batteries and their components right here in Ontario, with historic investments throughout the province—including, of course, Stellantis, Volkswagen and, most recently, Honda.

Ontario is building in a deliberate and responsible manner to achieve one of the cleanest, most reliable electricity systems in the world.

1600

The proposed legislation safeguards the interests of hard-working families, farmers and businesses, while paving the way for a brighter, more prosperous future for all of Ontario.

As we build the critical infrastructure to electrify, natural gas needs to remain a vital component of our energy mix, particularly for essential sectors like agriculture.

The act ensures that individuals, families, farmers and, of course, small businesses will have access to cost-effective, safe and reliable energy solutions.

I urge all members to support this critical legislation, for it is through collective action and forward-thinking policies that we can truly, together, power up Ontario's growth and prosperity.

The Deputy Speaker (Ms. Donna Skelly): It's now time for questions.

Ms. Sandy Shaw: This bill essentially is the government weighing in and overturning the ruling of an independent regulator. So this government kneecapped a regulator, and it really reduces the transparency, accountability. It also raises the concern that important energy decision-making is being done via backroom lobbying. It furthers the practice of this government of not being transparent and open and not doing the people's business in this House.

I see a direct connection to you discharging Lydia's Law directly to committee and overturning the independent regulator's decision.

Can you speak to me about Lydia's Law and how this connects to your government's overturning of decisions that are made by regulatory bodies in this province?

Mr. Trevor Jones: Thank you for the important question.

I respect the member opposite for her passion and her advocacy.

The split decision by the OEB was just that: a split decision, with no stakeholder engagement, no stakeholder input, and dramatic effects on agriculture, on small and growing businesses, and on families and consumers wanting to buy and build a home.

Think of the energy spectrum, as you would say, as a pie. Every piece of that pie must be there for a fulsome, comprehensive, reliable energy structure. If one piece of that pie is missing, then consumers will end up paying the price. Nuclear, hydroelectric, renewables and, of course, natural gas are all critical components of that pie for consumers just like your constituents and mine.

The Deputy Speaker (Ms. Donna Skelly): Further questions? I recognize the member from Whitby.

Mr. Lorne Coe: Thank you, Speaker, and through you to our presenter and my colleague: When we were first elected in 2022, we told hard-working Ontarians that we're going to build 1.5 million homes by 2031 and tackle the housing supply crisis in communities across Ontario, including Whitby. We're making great strides in achieving this, but the decision by the Ontario Energy Board made last year burdens new home buyers by forcing them to pay high installation costs for affordable and reliable natural gas to heat their homes.

I know that we're continuing to work hard to get more homes built in Ontario.

Therefore, I want to ask the member, through you, Speaker, how would this bill help to keep housing more affordable?

Mr. Trevor Jones: Thank you to the seasoned member from Whitby, who, as a municipal elected official and a provincial elected official, understands this pain point.

At a time when Ontario, like the rest of Canada, is already dealing with difficult headwinds, with high interest rates, inflationary pressures, the OEB's decision would have significantly increased the price of new housing. We can't stand for this. We have to work together. We have to work across party lines. Reversing this decision is prudent. It's for people who want to have that dream of home ownership. It prevents an average of $4,400 to be tagged on to the price of an already expensive new home. Together, we could do better.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Sandy Shaw: The member from Chatham-Kent–Leamington moved a motion here today to discharge Lydia's Law directly to committee and avoid debate in this House.

You mentioned that the OEB decision didn't include stakeholders. In fact, there are 134 pages of that report, and many, many stakeholders were consulted—just like Lydia's Law, where End Violence Against Women Renfrew County spoke during the Renfrew inquest; the Centre for Research and Education on Violence Against Women and Children spoke; Women's Legal Education and Action Fund, LEAF, spoke; the Sexual Assault Support Centre Waterloo Region brought their information to this important private member's bill, on behalf of the MPP for Waterloo, Catherine Fife.

My question is, just like this government ignored the recommendations from your own regulator—keeping in mind that Enbridge is a regulated monopoly—just like you ignored decisions that you don't like, why are you ignoring the Auditor General's recommendations when it comes to Lydia's Law and keeping sexual assault survivors safe in this province?

Mr. Trevor Jones: I thank the member opposite again for the question.

We can't diminish in this House—through you, Madam Speaker—the power of committees in the legislative process, the power of democracy, the strength in committees, the strength to do wholesome, fulsome work with careful deliberation. Representation from all parties and all members in this House stand on committees. The same input we hear about the OEB's decision, that lacked stakeholder engagement, we listened to. Committees listened to this.

Committees that the member opposite sits on—they contemplate; they debate. It's televised; it's open; it's transparent, and they do good work that can actually yield the same results that debate in this House can do, in a more streamlined process.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Andrew Dowie: I want to thank the member for Chatham-Kent–Leamington for his speech. I know his community is home to—it was formerly Union Gas, then Enbridge. So, back 10 years ago, plus or minus, under the Green Energy Act, we saw these proposals to be rid of natural gas in the province of Ontario, which would have had a devastating impact on Chatham-Kent.

What I'm hearing today from some of the arguments is that the opposition seems to be saying they want to force Ontarians to move away from natural gas entirely. Can the member speak to whether that's a smart approach for his community and across Ontario for Ontario's energy system, and the impacts that this sort of ideological approach might have on your community?

Mr. Trevor Jones: Thanks to the member for Windsor–Tecumseh for that question.

Again, when we're talking about natural gas, it's one critical component in the entire energy spectrum. It's that critical piece of the pie that agriculture producers rely on, that homes rely on for heating.

In my riding of Chatham-Kent–Leamington, upwards of 90% of the homes rely on natural gas as safe, reliable, cost-effective heating.

Ontario's Electrification and Energy Transition Panel also stated three essential and distinct functions that natural gas plays a part in: obviously, space and water heating for homes; industrial-commercial; and, of course, agriculture industries, the food producers. We are the food producers of the world. By being food producers of the world, we're the technology experts and technology exporters of the world. To preserve natural gas in this critical function, that critical piece of the pie remains essential.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Sandy Shaw: Thank you very much again to the member from Chatham-Kent–Leamington, who moved the motion to discharge Lydia's Law to committee.

I sit on committee; you're absolutely right. Every single time, your government uses their supermajority to squash anything that they don't like.

With regard to this bill right now, we moved about 12 amendments, and your government voted every single one of them down. I have been in committee when you've moved into in camera for no reason; been in committee when you were reversing your greenbelt legislation, and you didn't even let the people come to debate that.

If I can take the member at his word that he will use the power of his government to bring Lydia's Law to the committee and that you will hold public and open hearings across the province—can I have your word on that?

Mr. Trevor Jones: I thank the member for that question.

I did have the distinct privilege of sitting on the Standing Committee on Justice Policy. It's a privilege, and each of those members contribute in a meaningful way. That's all about transparency.

1610

That's exactly what we're talking about in this energy bill—transparency and accountability. In everything we do, it's there; it's alive. It's what we do. It's why we're elected to be privileged to be in this place.

Madam Speaker, anyone impacted by a decision should be able to make their case before some place like the Ontario Energy Board. Stakeholders need that engagement. Stakeholder groups need that engagement. Consumers need that engagement.

We'll have that engagement here. We'll have that opportunity to speak to the OEB about decisions they may make that impact consumers who want to build homes, who want to grow food to feed Ontario and feed the world.

The Deputy Speaker (Ms. Donna Skelly): It's now time for further debate.

Ms. Sandy Shaw: I'm standing to speak to Bill 165, right on the heels of the member from Chatham-Kent–Leamington, who finished his debate by saying that anyone impacted should be able to make their case.

We have an example right here in this House. Lydia's Law was discharged to committee. Those survivors of sexual assault were not able to make their case in this House. So your words "transparency" and "accountability" ring hollow.

This government does not hesitate in any way to interfere whenever it suits them. This is not a government that's transparent and accountable. We only have to look to the RCMP investigation to understand how they've conducted themselves in the past. So while this government—

Mrs. Robin Martin: Point of order.

The Deputy Speaker (Ms. Donna Skelly): I apologize to the member for Hamilton West–Ancaster–Dundas.

I recognize the member for Eglinton–Lawrence.

Mrs. Robin Martin: On a point of order, pursuant to standing order 25(b)(i), I ask—through you, Speaker—that the member from Hamilton West–Ancaster–Dundas return to the subject matter of the bill. The member's remarks are not germane to the item currently being debated by the House.

The Deputy Speaker (Ms. Donna Skelly): I agree with the member from Eglinton–Lawrence, and I will ask the member from Hamilton West–Ancaster–Dundas to bring her debate back to the subject at hand.

Ms. Sandy Shaw: Thank you, Madam Speaker.

It is disappointing to hear the member from Eglinton–Lawrence say that transparency and accountability is not germane to this debate, because what we're talking about is the decision this government made to big-foot, to overturn, to politicize a very important energy decision in this province.

Make no mistake: You acted swiftly to overturn the Ontario energy decision ruling. I would like to see you act more swiftly when it comes to other important things in this province, like sexual assault survivors. But you acted so swiftly when it came to the OEB ruling.

The Ontario Energy Board is an independent regulator—a regulator. They oversee Enbridge. Enbridge is an energy monopoly. They should be a regulated monopoly. But when you kneecap the regulator, what you are left with is a monopoly.

Let's be clear: Your decision and this bill—it's bad for new home owners. It's bad for existing customers. And certainly, it's bad for the environment. That's just straight-up a no-brainer.

My question always remains: Who does this government listen to, and who does this government work for?

When it comes to the people of this province, this is a government that has sided with a huge corporation, Enbridge—against making sure that you could protect costs for them in an affordability crisis. This bill is called Keeping Energy Costs Down Act, but my question is, who is this keeping energy costs down for? Do you know who it's keeping energy costs down for? Enbridge. It's keeping energy costs down for developers. But who is stuck holding the bag? Four million consumers of methane—also known as natural gas—in this province. That's who is left holding the bag, because this government doesn't work for the people of the province.

Quite clearly, your actions, your policies, your bills and your lobbying registry shows who you work for, and that's big corporations; it is connected individuals.

When it comes to the Premier's office, this place is crawling with lobbyists who either did work for the Premier or are now working for the Premier or are working for corporations like Enbridge.

So you can stand up all you want and talk about transparency and accountability, but nobody is buying it. Remember Mel Lastman? "Nobody!" Nobody is buying it at all.

What I would like to say is that if you were truly concerned with the people of the province of Ontario, you would have listened to the Ontario Energy Board, whose job is to protect consumers. It should be what your job is—to protect consumers. Instead, what we saw is unprecedented political interference in order to help a powerful gas monopoly at the expense of consumers.

Again, this bill does exactly the opposite of keeping energy costs down for people in the province. It will only exacerbate their bills and make their bills go up higher, to the tune of $600 per customer. This bill would allow the government to add over $1 billion in costs to the gas bills of nearly four million consumers. How is this keeping costs down? It's not. And what you are doing is, you're taking away people's choice—especially vulnerable and low-income people—their ability to make choices when it comes to their energy choices.

This government had, possibly, a once-in-a-lifetime opportunity, with an OEB decision that was clearly on the side of people who had to pay these energy bills: consumers.

You had an option of putting money back into people's pockets. You had an option to finally start addressing the realities of climate change. Instead, you chose to stick with the same old. Instead of sticking with people who are going to be mostly impacted by climate change—the costs are going to be borne by homeowners, of climate change; we're going to see people with basements flooding, people denied insurance costs—you have stuck with billion-dollar corporations. You have sided with them, as usual. You're lining the pockets of billion-dollar corporations instead of looking out for the people you should be looking out for. I suppose I could say that I'm surprised, but I am not.

The government likes to stand up in here and say that, at the Ontario Energy Board hearings, they didn't consult with people; nobody was involved. That is straight-up malarkey—134 pages of documents. I think it was over a hundred testimonies.

The Ontario Energy Board took one and a half, possibly two years, to come up with this ruling, and your government tabled this bill to overturn the ruling in a New York minute—I think it was the very afternoon that this decision was tabled.

What I want to be clear about is that you sided with Enbridge over consumers in this province. And who is Enbridge? Can we just talk about Enbridge? Enbridge is a huge international energy company in the province of Ontario. They have a monopoly. They're not regulated anymore because you keep overturning any regulations. Enbridge made $45 billion last year—$45 billion. That's who you're sticking with, that's who you're trying to help: a corporation that made $45 billion.

The CEO of Enbridge earns $19 million—$19 million—and that's for one year, not 19 years. That's a lot of coin. At $19 million, the CEO, certainly, is not going to be concerned about the $600 that it's going to cost them on their energy bill.

So that's who you are siding with.

What I would also say is that people now are not given a choice, and what you're doing—you say you're overriding the regulator to support people, but evidence shows otherwise.

1620

More and more, people want to look at more efficient heating options for their homes, because it's expensive, and we know it's only going to get more expensive. What you are doing is making sure that people are tied into new gas hookups rather than giving people affordable options, and rather than moving forward with subsidies to help people insulate their homes, to help people be more energy-efficient, to help people afford a high-efficiency heat pump, which heats and cools their homes. This is the direction that the world is going in, but this government is still going to side with a dinosaur fossil fuel strategy that is going to cost—not developers, not Enbridge, but it's going to cost consumers a lot of money.

As has been said again by the member from Chatham-Kent–Leamington, that this government is all about transparency—and honestly, absolutely nobody believes that. Do you know what? You don't even have to listen to their words. Just look at their actions.

I will say that, at committee, we moved a number of amendments that would have, in fact, taken this bill—and it would have made some amendments to make sure that we put into place protections for consumers. If the government was hell-bent and twisting themselves in knots to support Enbridge, we thought the very least that they could do is to support some amendments.

What amendments did we put in there? We thought it was very important that the government understood that you were allowing Enbridge to determine the cost future for how long that they can cost out the return on the investments that they're making. Let's again be clear: What we're talking about is assets that belong to Enbridge. These are assets that belong to Enbridge, but who is paying for them? The people of the province who are relying on gas. That's who is paying for these assets that Enbridge will owe.

We made a number of amendments, really, to help what is essentially an indefensible bill be a little more palatable—not much. You can't polish everything. Do you know what I mean, Speaker?

We wanted to, number one, talk about the workers who work on these fossil fuel lines. It was something that I learned, that I didn't know until I sat in committee and heard from the workers—that Enbridge has no requirement to provide reporting on methane leakage. They have no requirement to report on how they are going to repair these leakages. that's really about the consumer interest, because not only is it a significant contributor to greenhouse gases and to carbon emissions; it also is an unsafe situation for workers. So we wanted the government to accept this amendment that would require Enbridge to report on these leaks, and they turned that down. Why wouldn't they want to prevent and report on methane leaks? I don't understand why the government used their supermajority to vote it down.

We also moved an amendment that would require the OEB to keep track of private contractors. I think this is really important, because this is a government that likes to talk about jobs, which are really important to the province, but they don't ensure that workers are kept safe. This is the perfect example—when we talk about methane leakages. Also, despite ruling on the side of Enbridge, they don't like to talk about the fact that Enbridge laid off a thousand workers in this province. Let's recap, shall we? They've got a $19-million CEO. They made $45 billion in profits. They were going to make sure that every consumer—I grew up in Toronto wit—every methane gas user in the province is going to pay another $600 on their bill. But they didn't say one single thing when Enbridge laid off a thousand workers in this province. So we moved that motion, and the government turned it down.

We also wanted to make sure that we had the notion of procedural fairness in there. A girl can only hope and dream, but given a government that we see just discharges the private members' bill Lydia's Law directly to committee so no one can have their day in court, if you will—this government voted against our amendment that would reaffirm procedural fairness. It actually says in the bill that procedural fairness doesn't apply. The member from Chatham-Kent–Leamington can stand and talk about transparency, accountability, but the bill he's defending says right in it that procedural fairness does not apply.

We moved an amendment that says the government cannot direct the OEB to approve a new gas pipeline if this harms consumer interests, because what we're seeing is the politicization of the energy file. There's no regulator left because you just overrule them. So is it going to be that all of these energy decisions are going to be made in the minister's office, with Enbridge executives sitting around? I think it's really important, if you're not going to allow the OEB to protect consumers' interests, that there's a bill—in the bill, there's the notion that we are going to protect consumers' interests in that bill.

We did move—I guess it was a tongue-in-cheek amendment, but we wanted to change the name of the bill to "make Enbridge customers pay more act," because this is the net effect of this bill. That's what it's all about. It's about forcing existing gas consumers to pay the costs the Ontario Energy Board would otherwise have disallowed. It will increase costs for a typical household consumer by $600—a cost that the Ontario Energy Board said consumers shouldn't have to pay. The government says consumers should pay it. They used their supermajority to make sure that your gas bills are going up. This is about making consumers pay more so who can make more profit? Enbridge. Because a $19-million CEO, $45 billion—not enough. We need to have a bill that ensures that they continue to be profitable.

A government that talks about working to keep costs down, making life affordable, is kind of ludicrous in the face of their actual bills that just drive up the cost of things that people have to pay. They cannot choose to not have heat in their homes. They may not have heat in their homes, not by choice, but because they've been cut off because they can't pay their high energy bills. This is something that this government should really be concerned with.

Who are you protecting? Clearly, it's not the people of the province of Ontario.

I could talk a little bit about stranded assets. Really, what that means is, as we move to decarbonize, to get off fossil fuels—which is happening all over the world, which we are supposed to do in this province—these pipelines will be obsolete. They'll be stranded. But guess what? Someone is still going to have to pay for them. So the more consumers who get off gas, the fewer and fewer consumers who are going to be forced to shoulder the costs of these stranded assets. What that means is—for example, the hardest-to-decarbonize industries will be left holding the bag with these obsolete pipelines, assets. Low-income people who cannot afford to transition, who cannot afford a heat pump or other options, are going to be stuck with higher and higher and higher bills, as fewer people and fewer industries are going to be paying the same amount. So this problem is really only going to get worse.

I could talk a lot about this government's climate denial and that this is a bill that will ensure that we continue to be hooked on methane gas longer than we should; that this is a government that has no programs in place to help people transition.

Let's be absolutely clear: In the face of forest fires that we are seeing in BC; a forest fire season that started extraordinarily early in the province of Ontario; wildland forest firefighter teams who are short—

Mr. Guy Bourgouin: It's 200.

1630

Ms. Sandy Shaw: —200. They're short 200 firefighters. Their equipment—you told me about a bomber that needs repair.

These are the impacts of climate change.

You don't have a climate plan whatsoever. You quite clearly continue carbonization support—a huge monopoly plan. Where is your climate plan? There isn't one. You couldn't point me to it because it doesn't exist.

I'm so disappointed. I continue to be disappointed that this government does not want to listen to an independent energy regulator, doesn't want to listen to the people of the province of Ontario, and dispatched an important bill about sexual assault survivors directly to committee. It's shameful.

The Deputy Speaker (Ms. Donna Skelly): It's now time for questions.

Mr. Rick Byers: Thank you to the member for her comments.

Broadly speaking, I want to ask a question that's a little bit about infrastructure—it's an area I spent much of my career doing.

What do we mean by infrastructure? Well, infrastructure is transit systems—and, oh, by the way, we're doing the biggest transit investment in the history of the province. Oh, by the way, that also gets cars off the road, which is an excellent climate plan. Electricity is infrastructure, and we are—I think 92%, if I'm not mistaken, of the electricity generated in Ontario is greenhouse-gas-free—

Interjections.

Mr. Rick Byers: Thank you very much. I'm very pleased with that—including Bruce Power in my riding.

Doesn't it make sense that infrastructure, which is long-term assets, gets paid over the long term—which is what this bill does. Doesn't the member agree with that?

Ms. Sandy Shaw: I absolutely agree that we should be investing in infrastructure, but who's paying over the long term? Why would you force consumers to pay the cost of Enbridge's infrastructure? Why would you do that?

You talk about your energy sector. Your government's emissions go up year after year. You're not reducing emissions, no matter what you may say. They're going up every year.

This plan to support Enbridge, a fossil fuel company that also has no plan to decarbonize—why should consumers pay for Enbridge's pipes in the ground? Why shouldn't a huge corporation like Enbridge pay for their own assets?

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Guy Bourgouin: Thank you for the presentation and your speeches.

We've seen this government use their majority to overturn the energy board's decision not to charge their customers, yet they abuse that.

When we heard the member from Chatham-Kent–Leamington when it came to Lydia's Law—what are the similarities of what you saw here today? I know you talked about it a bit during your presentation. I'd like to hear some more of what your thoughts are on this.

Ms. Sandy Shaw: First of all, I have to say, when they discharged Lydia's Law, which is a bill seeking justice for sexual assault survivors in Ontario, named after Lydia, who had justice denied in the courts and has clearly had justice denied by this government in the Legislature—it's very similar. It speaks to me that this government—I used the word "cowardly."

This government does not want to hear opinions from people they don't agree with. This is a government that doesn't want to allow people to have input in huge decisions, like the cost of energy in this province.

This is a government that has absolutely no hesitation to big-foot independent regulators and has absolutely no hesitation to take a bill and send it out of this House to silence sexual assault survivors in this province.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Hon. Todd Smith: Thanks to the member from Hamilton for her comments earlier, in her 20-minute speech.

We are very fortunate; we have one of the cleanest grids in the entire world here in Ontario.

I know that the NDP critic for energy is opposed to natural gas. He would like to rip out all the natural gas today. He's also opposed to nuclear, which provides almost 60% of our electricity, and that's emissions-free, baseload power that we keep investing in in the province.

Our goal at the Ministry of Energy is to ensure that we have affordable, reliable and clean energy production—and reliable is a big, big, big part of it, because if the lights go out, then there's going to be chaos in our province.

Don't you think—and this is to the member opposite—that it would have made sense for the Ontario Energy Board to have heard from the IESO at the hearings that would decide whether or not the next one and a half million homes we're going to build in our province would all move to electric?

Ms. Sandy Shaw: I would like to be clear on the record that the Independent Electricity System Operator were on the list for the OEB decision.

I would like to just say that transitioning from our dependence on fossil fuels is not going to be easy, and who would know that better than yourself, the Minister of Energy? Absolutely, it's going to be a long, hard road—but what I don't see is you taking this urgently. With this decision, I see business as usual—"We support big companies. We support the lobbyists. This can wait. We're going to punt this down to the next election, to 2026." But I would say that other levels of government are taking this very seriously.

Speaker, 35 Ontario municipalities said that they passed resolutions to phase out gas power.

The city of Hamilton had a unanimous motion that basically said that they would send this to the Premier and that they do not support you overturning the OEB decision.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Tom Rakocevic: I actually want to dedicate my question to the Minister of Energy and my respect for him. Quite often, I have been impressed by him in the last six years; usually, it's for his quick wit. But on this issue, I have never seen him move so fast—faster than the electricity in the wires—because when the OEB came out and said, "Make the shareholders, make Enbridge pay out of the profit margins," he said, "No. Make the consumers pay."

My question for our member is, who did it faster—Usain Bolt running 100 metres or this minister standing up for Enbridge in the media?

Mr. Guy Bourgouin: I put my money on the minister.

Ms. Sandy Shaw: Well, it's a good thing you didn't put money on Ben Johnson; I'll just say that.

Quite clearly, they had their ducks all in a row. They had been hearing—what is it you said? They've got two shoulders, they've got—

Interjection.

Ms. Sandy Shaw: —special interests and the lobbyists on one shoulder. And those special interests and those lobbyists, let's not make mistake it—Enbridge is a huge, powerful corporation, even more powerful than the Minister of Energy in this province. Imagine that. So it is absolutely telling that this legislation was tabled within hours of the OEB decision.

So, who—Usain Bolt, Ben Johnson? I would like to see—we have a big hallway down here. Ready, set, go—let's see how fast. Do you know what? You and I could see who can move faster.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Hon. Todd Smith: I used to be a lot faster than I am now, Madam Speaker.

We acted quickly. Why? Because reliability of our electricity system in our province is paramount, and ensuring that we're keeping new homes as affordable as possible is paramount. When you look at the fact that the IESO, the Independent Electricity System Operator, wasn't asked for their opinion on whether or not we had the electricity in the province to continue to power the one and a half million new homes that are going to be built, that's a big, big problem. The IESO was not called to testify at the hearings. And the OEB ruled, themselves, that it was going to cost about $5,000 more per home.

What I'd really like to know from the member opposite is, if she's against natural gas and she's against nuclear, how is she going to power our province?

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Ms. Sandy Shaw: Well, there's gas that could be trapped in this House, I would say. Some carbon capture could happen here in this House.

I've already shared that we need to decarbonize, and absolutely, we need to have a stable energy system. It's not easy. People rely on it in their homes, and industrial users rely on it.

This bill sets us back on our ability to decarbonize, because Bill 165 gives an incentive for developers to install new gas connections. Why? Because it requires no cost on their part.

So let's be clear: Bill 165 prevents a levelling of the playing field on upfront connections between gas and electricity consumers. Let's also be clear that the OEB said, "We don't think it's fair for consumers to pay." Enbridge said, "Well, I don't want to pay." And the developers said, "I don't want to pay"—

The Deputy Speaker (Ms. Donna Skelly): Further debate?

Mr. Mike Schreiner: I'm honoured to rise today to speak to Bill 165—the "keeping costs down for Enbridge act," I think is what it should be called, and "making the people of Ontario pay the bill for Enbridge's operations act." It's outrageous, frankly, for the government to take the unprecedented step, for the first time in Ontario's history, to intervene in the independent decision of the Ontario Energy Board, the regulator designed to protect the people of Ontario. It's outrageous for the government to intervene in that way in order to continue to subsidize Enbridge, a giant multinational corporation, to expand fossil fuel infrastructure in this province, especially at a time when we're facing a climate emergency.

Canada is on fire yet again. The toxic smoke from western Canada is blowing into Ontario as we speak, leading to more toxic air that we breathe.

The international energy association, an incredibly conservative organization, has made it absolutely clear that if we're going to meet our climate obligations, we can't continue to expand fossil fuel infrastructure.

The OEB, a very conservative organization, finally made a decision that actually takes into account the climate crisis and, quite frankly, what's good for energy consumers in this province, and in less than 24 hours, the government asked to overturn it. We now know from the FOI request around the emails around this decision that even the government's own lawyers were worried about the government taking this action, but the government said "No, no, no. We're not going to listen to the lawyers. We're not going to listen to the independent regulator. We're going to listen to Enbridge and their $19-million CEO and actually put Ontarians on the hook for the stranded assets associated with ruling out fossil gas infrastructure." And do you know what makes it more galling? If there was no alternative for people, then you might say the government has an argument here. But people can have heat pumps. The OEB decision, backed up by mounds of evidence, shows it will actually be 13% cheaper for people to install a heat pump rather than fossil gas infrastructure.

So we have to ask, who is the government acting for? Is it the people of Ontario or Enbridge Gas? It's clearly Enbridge Gas.

An analysis independently done by Brandon Schaufele from the Ivey school describes it as this: Effectively, the OEB decision "shifts the upfront gas connection cost onto home developers in a manner similar to development charges for water and sewer connections," other forms of infrastructure. "Unlike water and sewer, however, developers could decide to skip a natural gas connection altogether," and install heat pumps, which would actually save people money.

"The government's decision explicitly undermines the OEB and threatens credibility of" the independent regulator and "energy investment in the province."

It's a bad outcome for customers, but it's a good outcome for Enbridge. So why is the government doing this when we're in the midst of a climate crisis?

We know that investors around the world are pouring not billions, but trillions of dollars into the green energy transition. As a matter of fact, last year alone, $1.88 trillion went into the green energy transition—half of it into wind and solar, because they're now the lowest-cost sources of electricity generation, but a big and growing chunk of it into heat pumps. Do you know why? Because heat pumps save people money and reduce climate pollution at the same time. That's exactly why, over the last two years in the US, more new home developments have installed heat pumps over fossil gas. It's better for the climate and cheaper for the people.

In Europe, right now, a 40% year-over-year increase in heat pump sales—do you know why heat pumps are growing so fast in Europe? They're cheaper for people, good for people, good for the economy, good for creating jobs manufacturing heat pumps—not so good for giant corporations like Enbridge.

So which side of the ledger is the government on? I want to know.

What is especially infuriating about this is, not only are they ramping up fossil-gas infrastructure, which is going to increase climate pollution; they're doing it at a time when Ontario has the worst performance in climate pollution now. The data released just 10 days or so ago shows that the province with the largest increase in climate pollution in the entire country in 2021-22 is the province of Ontario. As a matter of fact, 60% of the increase in climate pollution in Canada during that period comes from the province of Ontario.

This government not only wants to expand fossil-gas infrastructure for buildings, but they want to ramp up gas plants, which is going to increase climate pollution from the electricity sector by 580%.

I've heard the members opposite say what a clean grid we had. Yes, it was 96% clean when they took office. Now it's 87% clean and going down, because they're going to increase climate pollution by 580% for the rest of this decade, at a time when we're all paying the price for the climate crisis.

Last year, in Ontario, one million acres burned. We had toxic air pollution all down the eastern seaboard. As a matter of fact, in just four days, from June 4 to June 8, in the province of Ontario, the health care system paid an additional $1.28 billion due to hospital admissions from toxic air exposure.

We know from the Financial Accountability Officer that the cost to infrastructure in the province of Ontario alone—just public infrastructure, just this decade, the next six years—is going to be $26.2 billion.

According to the Insurance Bureau of Canada, the damage to insured assets last year due to the climate crisis was $3.1 billion. They estimate that the cost of uninsured assets is three times that, almost $10 billion, costing everybody in this country an additional $750.

The cost of the climate crisis is only going up. We're all paying for it.

We have solutions that will save us money, like heat pumps. We have solutions that will create jobs—by installing things like heat pumps. And we have the opportunity to actually move in that direction. We have an incredibly conservative energy regulator actually saying, "Do you know what? We should maybe start thinking about this. If we're going to do a 40-year amortization period starting in 2025, that takes us to 2065, 15 years after the country's commitment to be net-zero, so why would we make a decision like that, leaving the stranded assets on the backs of energy consumers in this province?" It will be the people of Ontario who will pay for it. That's exactly what the OEB decision said.

When we have a truly competitive market, people would make a financial decision and say, “We’re not going to take on that risk.” But Enbridge doesn’t have to make that decision because they’re a regulated monopoly, and the regulator said, “Do you know what, Enbridge? We’re going to make you decide to take that risk by removing the 40-year amortization period, because the people of Ontario should not bear the risk of your business decisions, especially when there are cheaper, cleaner, better alternatives.”

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The Acting Speaker (Mr. Lorne Coe): Questions, please?

Hon. Todd Smith: I’d like to thank the leader of the Green Party for his always thoughtful commentary that he brings to the House. He does a great job. It was very enjoyable listening to his 10 minutes of comments. He cherry-picked a lot of interesting statistics that he threw out, and it’s a lot to unpack in a one-minute question.

He did touch on the fact that we do have very, very affordable and reliable natural gas home heating in our province. and it is rate-regulated. I think that’s really important.

The member talked about how people are moving en masse to heat pumps in Europe. Well, there’s a reason for that. It’s because the cost of natural gas across Europe has soared over the last number of years, far beyond the price of natural gas in our regulated province.

The question I have for the member opposite is, does he believe that the system operator, the IESO, is prepared to power all of those natural gas heaters—sorry, that would be coming off with heat pumps?

Mr. Mike Schreiner: I really appreciate the energy minister’s question, and I appreciate his spirited defence for the independent regulator, the Ontario Energy Board, which is sort of perplexing for me. This independent regulator that has kept gas prices relatively affordable compared to Europe made a decision to protect gas consumers in the province of Ontario, and less than 24 hours later, the energy minister made the unprecedented decision and announced we’re going to overturn the independent regulator’s decision that protects gas consumers. I’m just confused now, because the minister is saying, on the one hand, that the regulator has done a pretty good job over the years and we should be happy with that, but on the other hand, he’s actually overturning the decision of the regulator to protect the people of Ontario.

I’m going to stand with the regulator that’s protecting the people of Ontario.

The Acting Speaker (Mr. Lorne Coe): Questions?

Ms. Sandy Shaw: I always find it unusual when this government that is about the free market decides to put their thumb on the scale and tip in favour of a huge monopoly like Enbridge.

The Ontario Energy Board found that it was cheaper to build homes designed in the first place for heat pumps than to retrofit them afterwards for natural gas.

Even the minister, at the committee, talked about—I think it was about 900 metres of pipe for a new home in Peterborough and how expensive that is.

So this idea of only relying on natural gas, this idea of doubling down on stranded assets that consumers were paying for makes absolutely no sense. I think it’s $14 billion in capital expenditures that will be stranded assets, paid for by consumers.

If developers want to put natural gas in new hookups, that’s on them. Why should consumers be forced to have natural gas and not be given a choice between heat pumps and natural gas? Let the market decide.

Mr. Mike Schreiner: I appreciate the member’s question.

In a sense—I said this at committee—what the government is doing is kind of like socialism for Enbridge and capitalism for the rest of us, because a lot of this comes down to capital market risk. Who’s going to assume the risk of the death spiral of stranded assets as people transition away from fossil gas? Is it going to be Enbridge or is it going to be the people of Ontario? The OEB said it should be Enbridge, not the people of Ontario. The government is saying it should be the people of Ontario, not Enbridge.

Speaker, I'm going to stand up for the people of Ontario to help them save money, reduce their costs and fight climate change at the same time.

The Acting Speaker (Mr. Lorne Coe): We do have time for a quick question.

Hon. Todd Smith: Speaker, we've been taking our time to ensure we have a thoughtful energy transition, one that's pragmatic and realistic and is going to ensure that we're able to keep the lights on and see the multi-billion dollar investments that we've been seeing in our province—in other words, an orderly transition.

Does the leader of the Green Party believe in an orderly transition, or does he just believe in going all green and torpedoes be damned?

Mr. Mike Schreiner: I believe in a green transition that's good for the economy, good for people's pocketbooks, good for the climate.

It was this government that cancelled 750 renewable energy contracts, saying we didn't need the power. Now they're getting up and saying we don't have enough power to accommodate heat pumps. Which way is it?

The Acting Speaker (Mr. Lorne Coe): Further debate?

Ms. Goldie Ghamari: Mr. Speaker, I'm pleased to rise and speak in strong support of Bill 165, the Keeping Energy Costs Down Act, 2024. This legislation is a critical step forward in our ongoing efforts to ensure that energy remains affordable, reliable and accessible for all Ontarians, while also supporting our housing and economic growth.

Since day one, our government has been dedicated to making life more affordable for the people of Ontario. We have introduced policies that have cut costs, such as scrapping the cap-and-trade carbon tax, cutting the gas tax, and implementing the Ontario Electricity Rebate. These measures have saved families and businesses significant amounts of money.

The Keeping Energy Costs Down Act is another crucial piece of our comprehensive strategy to keep costs low and support the needs of our growing province.

Let me start by addressing a critical issue this bill tackles: the recent decision by the Ontario Energy Board to require new customers to pay 100% of natural gas connection costs up front. This decision, if left unchallenged, would add approximately $4,400 to the price of new homes, and tens of thousands of dollars for homes in rural Ontario. This is unacceptable.

Bill 165 gives the province the authority to reverse this decision, restoring the previous arrangement where these costs were spread over 40 years. This change will help prevent unnecessary financial burdens on new home buyers and ensure that we continue building homes across Ontario without delay. It will protect the dream of home ownership, especially for those in rural areas, and keep our housing market moving forward.

Natural gas is not only essential for heating our homes, but also for powering our economy. By restoring the natural-gas-connection-cost rules, we are ensuring that businesses—particularly small businesses and farms—do not face prohibitive upfront costs. This is vital for economic growth not just in my riding of Carleton, which has numerous small businesses and family-owned farms, but also for maintaining Ontario's competitiveness.

The proposed legislation also preserves the existing treatment of gas transmission projects. This means new customers will not have to incur upfront contributions, ensuring that these critical infrastructure projects can proceed without financial barriers. This is especially important for sectors like agriculture and manufacturing, which rely on affordable and reliable energy.

I have to look no further than my own riding of Carleton, where one such natural gas expansion helped bring natural gas, which was desperately needed, to the community of York's Corners in the eastern part of my riding, bringing natural gas to homes as well as Stanley's Olde Maple Lane Farm, a staple of the Ottawa agriculture industry—finally, after years of requesting it.

Again, this expansion is especially important for sectors like agriculture and manufacturing, which rely on affordable and reliable energy.

Another significant aspect of Bill 165 is the emphasis on public engagement. The OEB's recent decisions highlighted a lack of adequate consultation with affected sectors. This bill mandates broader engagement, ensuring that future decisions by the OEB reflect the priorities of all Ontarians. The legislation empowers the government to direct the OEB to conduct separate hearings on any matter of public interest.

This ensures that decisions are made with comprehensive input and are aligned with the public's needs and government policy priorities. By involving more stakeholders, we can ensure that the energy policies we implement are fair, informed and beneficial for everyone.

1700

Now let's focus specifically on how this bill will improve life in rural Ontario. Rural communities, such as those in my riding of Carleton—including North Gower, Richmond, Metcalfe, Ashton and more—are the backbone of our province, contributing significantly to our economy through agriculture, manufacturing and other vital industries. However, these communities often face unique challenges when it comes to energy access and affordability.

In rural areas, new home construction often requires more extensive infrastructure for natural gas connections, leading to higher upfront costs. The OEB's decision would have added tens of thousands of dollars to the cost of new homes in these areas. By reversing this decision, Bill 165 ensures that these costs are spread over 40 years, just like a mortgage. This will significantly lower the financial barriers to building new homes in rural Ontario, making home ownership more attainable for families, and supporting the growth and vitality of these communities.

Rural businesses, particularly small farms and local enterprises, are crucial to Ontario's economy. The high upfront costs for natural gas connections could deter new businesses from setting up in rural areas and hinder the expansion of existing ones. By restoring the previous cost structure, this bill will encourage more investment in rural Ontario, fostering economic development and job creation.

In rural areas, natural gas is often the most reliable and affordable heating option. The OEB's decision threatened to limit this choice by making natural gas connections prohibitively expensive. Bill 165 ensures that rural residents can continue to choose natural gas, preserving their ability to access reliable and cost-effective heating.

This bill also maintains the existing treatment of gas transmission projects, ensuring that new customers do not have to pay upfront contributions. This is especially beneficial for rural areas, where the infrastructure costs can be significantly higher. By alleviating these financial burdens, we are making it easier to expand and improve essential energy infrastructure in rural communities like those in my riding of Carleton and across the province.

Bill 165 also addresses concerns regarding the leave-to-construct process. Municipalities and agricultural organizations have raised valid concerns that the $2-million threshold for pipeline projects, set two decades ago, is outdated. Inflation and increased construction could mean that many projects now exceed this threshold, leading to unnecessary delays and regulatory burdens. This bill proposes to streamline the LTC process by allowing the government to prescribe conditions to exempt certain small projects from requiring LTC. This change will reduce delays and costs, helping to build housing and transit infrastructure faster. It will ensure that we can meet the needs of our growing population efficiently and effectively.

Let me illustrate the importance of this bill with a concrete example from rural Ottawa, in my riding of Carleton. The community of York's Corners recently benefited from a natural gas expansion project completed by Enbridge Gas. This project brought much-needed natural gas infrastructure to the area, significantly improving the quality of life for residents.

Prior to this expansion, families in York's Corners relied on more expensive and less efficient energy sources for heating. The introduction of natural gas has provided these households, as well as local business Stanley's Olde Maple Lane Farm, with a more affordable and reliable heating option. This has not only reduced their energy bills but has also improved the overall comfort and quality of their homes. It's also made the operation of Stanley's Olde Maple Lane Farm more feasible and efficient.

The success of the York's Corners project underscores the importance of making natural gas connections accessible and affordable across all rural communities in Ontario. By passing Bill 165, we can ensure that other rural areas will similarly benefit from natural gas expansions, fostering economic growth and improving the quality of life for residents.

In conclusion, Bill 165, the Keeping Energy Costs Down Act, is a comprehensive piece of legislation and I am proud to support it.

The Acting Speaker (Mr. Lorne Coe): Questions, please, from the opposition?

Ms. Sandy Shaw: I have a question. You didn't mention anything about climate change or the emissions that Enbridge is responsible for. There was a proposal at a shareholder meeting calling on Enbridge to disclose indirect emissions from pipelines. Those emissions are methane gas—that's what natural gas actually is. The CEO actually called employees and asked them to vote against this measure and also called shareholders. So I wonder if you think that a company should not be responsible to disclose when their business is emitting methane gas and that they have no responsibility right now to disclose.

Ms. Goldie Ghamari: Thank you to the member for that question.

Through the Keeping Energy Costs Down Act, the government is seeking to support fair and inclusive decision-making at the OEB to foster affordable communities. The OEB's December 2023 decision demonstrated opportunities for improvement. For example, the decision noted that it was reached without an understanding of the impacts to the province's electricity grid as the province's Independent Electricity System Operator was not invited to provide evidence on the change to the revenue horizon. The decision also noted that impacted sectors were not invited to participate or provide evidence.

I find it rich, Madam Speaker, that the member refuses to acknowledge the fact that the only dissenting opinion here was that of a strong, independent woman. And I find it rich, Madam Speaker, that the member can stand in this House and say that our government is not listening to women, yet that member is ignoring the only dissenting opinion on the OEB which actually supports this piece of legislation.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mrs. Robin Martin: Thank you to the member from Carleton for her presentation. I know you mentioned the importance for rural areas—of getting gas infrastructure there and getting the supply to those communities so that they can have natural gas. I know how important natural gas is as an energy source in rural communities as well. I just wonder if you could tell us, for your riding, is this an important addition to make sure we have the natural gas infrastructure to build new homes?

Ms. Goldie Ghamari: Thank you to the member for that excellent question. Natural gas expansion is critical in my riding of Carleton. There are so many communities that don't have it. As I mentioned, York's Corners has been fighting to get natural gas for decades, and I was happy to work with them to make sure that one of the first expansion projects by Enbridge Gas was in my riding of Carleton.

Madam Speaker, I don't even have natural gas. I have propane where I live in my riding of Carleton. For someone like me, a single person living in their house, the price of propane has gone up exponentially. It is almost unaffordable. So I can only imagine how much more expensive it is for those families who live in my riding of Carleton who rely on propane or even oil because they don't have access to natural gas.

Natural gas plays an important role in meeting Ontario's energy needs and that's why I support this piece of legislation and I encourage everyone to support it as well.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Joel Harden: To the member: I noticed in her presentation the member repeated something that the Minister of Energy said as well. The claim was made that the Independent Electricity System Operator was not a participant in the OEB's decision. I just want to direct the member to page 5 of the decision and order December 21, 2023. When you look at the list of, let's see, 33 different names of people who applied for intervenor status, right there, item number 17, is, in fact, the Independent Electricity System Operator.

So the question I then have for the member is, was she aware of this factual inaccuracy in her presentation? Secondly, if the IESO sought intervenor status and didn't actually follow through and participate, what's the bigger issue here?

The Deputy Speaker (Ms. Donna Skelly): Back to the member from Carleton for a final response.

Ms. Goldie Ghamari: I don't acknowledge anti-Semitic people, Madam Speaker. Thank you.

The Deputy Speaker (Ms. Donna Skelly): I will ask the member to withdraw.

Ms. Goldie Ghamari: Withdraw.

The Deputy Speaker (Ms. Donna Skelly): Further debate?

Mr. John Vanthof: It's always a pleasure, it truly is, to be able to speak in this House and today to talk about Bill 165, Keeping Energy Costs Down Act. This is a bill that the title doesn't really reflect what the actual goal of the bill is.

1710

We'll go back a little bit. The Ontario Energy Board is an independent regulator that regulates natural gas prices. The people in my riding who have natural gas—I'm not going to sugar-coat this—like natural gas, because the price is predictable, because it's regulated. Often in northern Ontario—and I have put bills forward that, actually, the price of gasoline should be regulated, because there's often 20 cents' difference between where I live and where it's cheapest on my trip, which is usually north of Barrie. Then, when you get down here, it gets to almost northern Ontario price again, and that has nothing to do with transportation. That's why we often say it should be regulated.

We hear this all the time: that while the government has taken 10 cents off the price of gas—they have foregone taxes, but in that legislation, they didn't put anything that that 10 cents actually goes to consumers. So that 10 cents could have just as easily gone to the profit margin of the oil companies who control gas prices.

Mr. Guy Bourgouin: That's what it did.

Mr. John Vanthof: That's what it likely did, right? Because no one is going to tell me that gas prices that have any semblance of the cost of getting the gas to northern Ontario or getting the gas—because it goes up and down so quickly. The last one—the government was talking, and we've heard this so many times. And let's make it clear that the NDP provincially have always been opposed to the individual carbon tax. The government blames every problem, every price increase, on the carbon tax. The increase in the carbon tax in April was two cents, I believe. Gas went up, like, 12 cents, so it wasn't just carbon tax. It's so frustrating.

That's why people like natural gas: because they believe, and rightfully so, that because it's regulated, they're paying a fair price. And it has gone up recently—we have lots of complaints—but they feel that it's fair.

It's the job of the Ontario Energy Board, an independent regulator, to look out for the stability of the system and the price for consumers, because they can't realistically—when a company that supplies the gas, like Enbridge, makes an application to the energy board that they need more money for their product, the way I understand the system, Speaker, is they make their case—I've been in business my whole life; if they can't make a profit selling their product, the market will no longer be stable. And so, the energy board takes that into account and makes their decisions on where the price should be based on that, based on the facts given by the energy company and also by other independent advice. That's where they make their decisions.

What makes this bill different is that the Ontario Energy Board ruled that it wasn't fiscally prudent to amortize costs for infrastructure for 40 years when that infrastructure may very well not be used for the next 40 years. That's important. We've heard a couple of people here, members on the government side, talk about, "It makes sense. It's like a mortgage." And I don't advise anyone to take a 40-year mortgage, but with the price of housing now, if you take a mortgage for 40 years, you do have an expectation that when you are finished paying the mortgage, you will still have a house or something that is usable, that has equity in it.

What the Ontario Energy Board was worried about is that those pipes that the consumers are paying for might not have a value in 40 years. In fact, they may not have a value in 10 or 15 because as we are facing—we are not facing climate change in the future; we are facing climate change now. And as a result, there are developments. Every day, we see advances in how to deal with climate change, how to transition to practices that impact the climate less. I would think that the government would believe that, since they are subsidizing the production of electric vehicles by billions of dollars, right? So the government recognizes that there is a need, that the world is going away from fossil fuels, from carbon fuels for vehicles. I think we all recognize that. But in this case, the Ontario Energy Board is basically saying the same thing, that those pipes that you are paying for now, that we are using now, might not be—and you're forcing people to put payments on for 40 years; they might only have a 10-year usable span.

So all of a sudden, people are making—someone has to pay these bills for those pipes. That's why the Ontario Energy Board said, "Hold it, hold it." So I welcome questions from the government. I might be totally wrong on this. But the Ontario Energy Board said, "Hold it, people should pay for those costs upfront when they build the home, and that way they can make a decision." So if you pay, I believe it's

$4,000 or whatever upfront, that adds to the cost of the new home. When you're doing that, then you have to make a decision: Okay, so $4,000 for the hookup. Let's say another—what does a natural gas furnace cost?

Interjection.

Mr. John Vanthof: Yes, four or five thousand, perhaps more. So are we going to put $10,000 into the fuel of the past or are we going to put $10,000 or $15,000 into something that is actually going to create not only less carbon but actually less cost for the individual?

The government has decided to overrule the energy board so that everyone has to pay for those pipes in new builds, even though they all know that those pipes might not be viable for 40 years. Basically, since everybody is paying for the pipes, not just the person buying a new house—and I get that. The incentive is, "Oh, well, since the pipes are there, we might as well put a natural gas furnace in."

Interjection.

Mr. John Vanthof: Yes, might as well put a natural gas furnace in.

So, basically, it's kind of an incentive to become an Enbridge customer.

One of the comments when we were listening to one of the speeches was that sometimes some of the government members accuse us of being socialists—

Mrs. Robin Martin: Not you, John.

1720

Mr. John Vanthof: No, not me. But when you have new subdivisions and you say, "Oh, and everyone else has got to pay for the gas hookups"—everyone else has to pay for the gas hookups so a company can have an advantage, so you're incentivized to go with one company. Man, that's like socialist capitalism. That's like, you know, you're forcing everyone or very incentivizing them, because why wouldn't you put a natural gas furnace in when the pipe is sitting there and everyone else is forced to pay for it, even though it may not be the right decision in the long run for you, for the economy, for your costs and for the environment, right? So that's why we're opposed to this bill.

If the OEB made the wrong decision, then we should go back and look at that and strengthen the OEB. I don't know if it needs to be. But to simply overrule it—I don't think anybody in the province is going to say, "You know what? We've got an independent regulator and they've kept our gas prices fair and even, but we'd rather go with the decision of the minister because this government has been very good at making long-term planning decisions." They've been excellent, except for the times where they have to backtrack and pretend that they never did these things; you know, the Men in Black bills: "Oh, we have to rescind this." Maybe they should actually think this through.

Now, I'm going to go in a place where many others haven't gone. Sometimes I pay the price for this. There are uses for natural gas, for propane in agriculture specifically, where we can't transition yet: grain drying, heating. Some places, we need to look at how to get natural gas or some—like, right now, it's natural gas. If some day we can figure out how to dry grain quickly electrically, that would change that, too. So it's not that we're opposed to natural gas installations where they're necessary and where they make sense. This isn't about being anti-natural gas. There are places specifically—I'm from a farm background—where natural gas makes sense, is needed, but not necessarily in new subdivisions where people have a choice or should have a choice. And when you subsidize one but not the other, then you're not giving people choice.

And when you're saying—every time I hear, "This makes sense because it will take 40 years to pay for it"—you know what? It's one thing to take a 40-year mortgage on something you know—I would have no problem taking a 40-year mortgage—I'm a farmer—on farmland because I know in 40 years that farmland is going to be worth as much or more. But man, I wouldn't want to be taking a 40-year mortgage on a car because a car is, at most, 10. But that's what the government is asking people—

Mr. Dave Smith: What about a 60-year-old car?

Mr. John Vanthof: My colleague has a beautiful car that's way older than 10, but I can tell you, I drive a lot for my job and your average car goes about 250,000 kilometres before you get lots of troubles.

That car that I put on 250,000 kilometres, I do that in just over two years. So I'm telling you, I don't take the payments on that car over eight years because after three years, it's toast. But the government has no problem telling people, "Do you know what? You need to hook up these new natural gas lines, and no problem; you can pay them off"—or, actually, everybody else can pay them off, $600 per customer across the province—"over 40 years, even though you won't be using them in 10." That doesn't make sense. It really doesn't, Speaker. It doesn't, and that's why we're opposed to this bill.

I get along great with the Minister of Energy, but you really have to start wondering if he's actually the minister of Enbridge, because this bill is so tilted. It is so tilted. The OEB is the independent regulator and, all of a sudden, the government doesn't like the ruling of an independent regulator and just—

Mr. Guy Bourgouin: Overrules.

Mr. John Vanthof: —and, in the words of my colleague, with lighting speed, just immediately overrules. Even that doesn't quite make sense, because this infrastructure isn't—it takes a while to build houses. This government is kind of behind the eight ball on some of their goals.

So it's not that you can't be careful and say, "Okay, we had better look at this. We had better look at how this decision was made. If there wasn't enough testimony, then we should maybe look back and ask if they can relook at this." It's not that it had to be done immediately. It was almost like they were more worried about the shareholder price of Enbridge than they were worried about the long-term energy sustainability not just of the province, but of the people who were buying those houses—or trying to buy those houses; it's certainly not an easy task in Ontario right now for people not just to buy, but to live.

Living in Ontario right now is very expensive, and I don't blame anyone who is trying, who has scraped together the funds to buy a house: "Oh, we'll buy a gas furnace, because it'll save us money in the short term." But it won't save money, or it very well might not, in the long term. So we would be much better off giving people the choice and focusing on the sectors that actually depend on the natural gas.

I'm going to close by—people say we don't understand. The difference with grain drying is that you harvest your thousands of acres of crops in a few short weeks, and those crops need to be dried as quickly as possible. That doesn't work with electricity. You need a lot of heat. In practical terms—we've got a big grain-drying facility next to my hometown, and the natural gas pipe going into my hometown is a couple of inches, but the pipe going into that grain-drying facility is three times as big—but it's only used for a short time, because you need a blast of energy. That is something that natural gas is good at, is good for. That's why most grain-drying facilities want natural gas over propane. It's cheaper. We get that.

But we really don't get why you're trying to force people to pay for something over 40 years that actually might only be feasible for a much shorter length of time.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Hon. Todd Smith: Such a pleasure to listen to a member of the NDP who actually understands that there is a need for natural gas, because not everyone over there—and I didn't hear all your remarks; I apologize. But I did hear some of them. Sometimes I wonder how this member continues to exist in the NDP caucus, because he thinks a lot like us at times.

1730

But seriously, we are going back and putting a natural gas policy statement in the window for the Ontario Energy Board, which should clearly understand our mandate, and that is to continue the type of growth and prosperity that our province is seeing. I think this member actually does understand that in order for us to continue to see the massive investments in our province, we have to have a reliable, stable, affordable grid, and that includes natural gas and nuclear. But I'll let him expand on that, if he would.

Mr. John Vanthof: I actually enjoy talking to the Minister of Energy. Actually, it's not that hard for me to be in the NDP caucus. It's much easier than it sometimes would be being in a caucus where you introduce legislation and then rescind it, and then introduce legislation again and then rescind it, and then introduce it again and then rescind it.

Yes, we need reliable energy sources. We need a reliable grid. But I question, again, having a 40-year amortization on parts of the grid that might only be feasible for 10 years, and whether that's good business for the people buying those homes.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Ms. Sandy Shaw: There is a need for natural gas in the province. Is there a need for consumers to pay on behalf of Enbridge, a multinational monopoly? I don't think so. Changing the amortization to 40 years is a gift to Enbridge and also ensuring that consumers are—if they had followed through with the OEB ruling, they would have saved a billion dollars over four years for consumers. Instead, now consumers are not given a choice whether they hook up to natural gas or whether they can choose, if they so choose, to have electric heat pumps—no choice, and they're stuck with the bill that developers don't want to pay.

My question to you is, why? Why would this government override an independent regulatory decision in favour of a multinational corporation and give consumers absolutely no choice?

Mr. John Vanthof: Thank you to my colleague for that question. I think the issue here is that perhaps 25 or 30 years ago, it made sense to amortize over 40 years, because you knew that you were likely going to use that for 40 years. Right now, I don't think anyone believes that 40 years from now, we will still be burning natural gas in our homes—very few people do.

It was brought up that in Europe, they've already transitioned. My family is from Holland. Even before gas went up, it was already illegal to hook up to natural gas, because they recognized it long before we did.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Brian Saunderson: I want to thank the member opposite for his comments. I'd like to be clear on a couple of points before I pose my question. First of all, the decision and what this bill is proposing is not to change. What it's doing is pausing the decision of the OEB, because already, in its regulations, it goes for a 40-year horizon. So we're not changing any of that.

I'm on natural gas, and I, like all my neighbours who are on natural gas, share those costs over a 40-year period. The decision—and, I think, the dissent by Commissioner Duff—doesn't say that we shouldn't be shortening the window. What she does say, though, is that we're shortening it from 40 years to zero years, and that's no ramp at all. That's no amortization period.

So what she's suggesting is that we look and have hearings in which we examine the nature of the implications of shortening that window. And so, my question to the member opposite: Does he not agree that that is an important discussion to have to prevent stranded assets, but also to allow an on-ramp to prevent barriers for homebuyers getting a home and having reliable, safe heat?

The Deputy Speaker (Ms. Donna Skelly): Back to he member for Timiskaming–Cochrane.

Mr. John Vanthof: Thank you, and I appreciate that question from the member. It was a thoughtful question. I think I already said that the 40-year horizon made sense before. It doesn't make sense now. The member also alluded to that.

The question is, this bill doesn't really address that. This bill just overrules the decision. That is the issue. That is the issue. I think we can all agree, and it's not very often we all agree in this House—very rarely. I don't think anyone would disagree that a 40-year horizon for natural gas installations for home heating makes sense. I don't think anybody disagrees with that.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

MPP Jamie West: I always appreciate hearing the NDP House leader speak. I'm always impressed how he can do it with no notes for such a long time.

But I do appreciate the context because there is a lot of rhetoric when we speak, and we all do it a little bit. But time and time again, we'll hear about how the NDP hates natural gas. That's not what the topic is. I appreciate the context of natural gas and what it will mean 40 years from now, and that really is the concern on this side of the House that we have with this bill.

We are not confident that natural gas will be as popular 40 years from now—not that it will be completely gone, but people will be transitioning over in the same way that the member from Carleton talked about propane and not having access to it. There may be better technology in the future. When I first got my house it was hydro for heat. It was incredibly expensive, and we barely used it. We used

anything else. So, why would the government want to have this amortization over 40 years for a company that makes billions of dollars?

Mr. John Vanthof: Thank you to my colleague from Sudbury for that question. I'm not going to venture why the government is doing this. I would venture why we don't think it's a good idea: because you're saddling costs for infrastructure that we all agree we're not going to be using for 40 years and we're saddling those costs on homeowners. We all agree we're not going to be using this infrastructure for 40 years, and yet this government thinks it's fine to basically help a company make money by helping them install home heating that actually isn't going to be feasible in the long term, and that we think is a gross mistake. Thank you.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Andrew Dowie: I want to thank the member opposite for his question. I've got the OEB's report on the natural gas expansion program here on my computer, and it shows that Charlton and Dack, Harley, Latchford and Timiskaming, Kincardine, Larder Lake, Virginiatown and Kerns have all asked for natural gas expansion in their communities. So I guess I'd like to ask you if—you're certainly saying it today—you wish to stop your constituents from heating their homes with natural gas even though they are asking for it.

Mr. John Vanthof: That's a very good question, because those municipalities have asked for it. Kerns specifically, it's as much for grain drying as it is for home heating. That makes sense; Latchford as well. The pipeline goes right by them.

But I will let you know that we're getting a lot less calls for natural gas right now than we were two, three years ago—a lot less calls because the price of natural gas has gone up and a lot of people are switching to heat pumps, and heat pumps aren't the total answer in northern Ontario.

Let's be clear. I'm not going to sugar-coat it, but we're getting a lot less calls for natural gas now than we were two or three years ago, but a lot of those are for industrial or farm applications, and that's a totally—

The Deputy Speaker (Ms. Donna Skelly): Further debate?

Mr. Andrew Dowie: It's such a privilege to rise in support of Bill 165 today. I think, just earlier this morning, during the debate, I engaged on this, and I thought of my community of Little River Acres. The entire development was built in 1972 by the province, and they foresaw a day without natural gas, so none was installed.

1740

Now, fast-forward to today, when a headline in the Windsor Star from—this is going back a bit, to March 25, 2014: "900 Riverside Families Jolted by Huge Electric Bills." They were reporting costs of over a thousand dollars a month because of electric heating. The decision to not put natural gas connections into that neighbourhood was fatal for the affordability of this neighbourhood, even though the express intent was to have an affordable community.

I could talk about this situation for, really, the remainder of the time, but honestly, I think we've had enough debate. So, Speaker, I move that the question now be put.

The Deputy Speaker (Ms. Donna Skelly): Mr. Dowie has moved that the question be now put. I'm satisfied there has been sufficient debate to allow this question to be put to the House.

Is it the pleasure of the House that the motion carry? I heard a no.

All those in favour of the motion that the question be now put, please say "aye."

All those opposed to the motion that the question be now put, please say "nay."

In my opinion, the ayes have it.

A recorded vote being required, it will be deferred to the next instance of deferred votes.

Vote deferred.

1000151830 Ontario Inc. Act, 2024

Mr. Saunderson moved second reading of the following bill:

Bill Pr40, An Act to revive 1000151830 Ontario Inc.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Second reading agreed to.

1000151830 Ontario Inc. Act, 2024

Mr. Saunderson moved third reading of the following bill:

Bill Pr40, An Act to revive 1000151830 Ontario Inc.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Be it resolved that the bill do now pass and be entitled as in the motion.

Third reading agreed to.

Qui Vive Island Club Inc. Act, 2024

Ms. Scott moved second reading of the following bill:

Bill Pr41, An Act to revive Qui Vive Island Club Inc.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Second reading agreed to.

Qui Vive Island Club Inc. Act, 2024

Ms. Scott moved third reading of the following bill:

Bill Pr41, An Act to revive Qui Vive Island Club Inc.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Be it resolved that the bill do now pass and be entitled as in the motion.

Third reading agreed to.

Richard Crosby Investments Limited Act, 2024

Ms. Hogarth moved second reading of the following bill:

Bill Pr43, An Act to revive Richard Crosby Investments Limited.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Second reading agreed to.

Richard Crosby Investments Limited Act, 2024

Ms. Hogarth moved third reading of the following bill:

Bill Pr43, An Act to revive Richard Crosby Investments Limited.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Be it resolved that the bill do now pass and be entitled as in the motion.

Third reading agreed to.

2038778 Ontario Ltd. Act, 2024

Mr. Harden moved second reading of the following bill:

Bill Pr44, An Act to revive 2038778 Ontario Ltd.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Second reading agreed to.

2038778 Ontario Ltd. Act, 2024

Mr. Harden moved third reading of the following bill:

Bill Pr44, An Act to revive 2038778 Ontario Ltd.

The Deputy Speaker (Ms. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

Be it resolved that the bill do now pass and be entitled as in the motion.

Third reading agreed to.

The Deputy Speaker (Ms. Donna Skelly): I recognize the deputy government House leader.

Mr. Trevor Jones: On a point of order, please: Madam Speaker, if you seek it, you'll find unanimous consent to see the clock at 6.

The Deputy Speaker (Ms. Donna Skelly): The deputy government House leader is seeking unanimous consent to see the clock at 6. Agreed? Agreed.

Report continues in volume B.

TAB 8

SOOTODAY.com

UPDATED: Shoemaker wonders why health minister responds to SooToday but not to him

David Helwig
May 15, 2024 2:10 PM

1 / 3 USW Local 2251 president Mike Da Prat speaks to fellow labour representatives during a health care demonstration outside yesterday's city council meeting | Kenneth Armstrong/SooToday

Listen to this article
00:06:21

1:53 p.m. Wednesday update

Mayor Matthew Shoemaker has referenced this *SooToday* article in an afternoon tweet on the social media platform X, wondering why our news outlet has better luck getting responses from Ontario health minister Sylvia Jones than he does.

“I wish @CitySSM could get a response as quickly as @SooToday has to the numerous letters and outreach we’ve made to Minister Jones and the Ministry of Health,” the mayor tweeted.

SooToday published an article at 9:37 p.m. last night about some sharp criticisms expressed by Shoemaker at this week’s city council meeting.

At 7:37 a.m. today, exactly 10 hours later and well outside normal office hours, we received a response from the minister’s office.

“Reaching out to provide comment, perhaps more of a clarification to your article,” Hannah Jensen, the minister’s deputy director of communications, told us.

"If you update your story, you can attribute the comments to myself as a spokesperson for the minister of health,” Jensen said.

“Perhaps press coverage is of greater concern than solutions,” the mayor said in his tweet.

Matthew Shoemaker
@SooShoe · **Follow**

I wish @CitySSM could get a response as quickly as @SooToday has to the numerous letters and outreach we've made to Minister Jones and the Ministry of Health. Perhaps press coverage is of greater concern than solutions.

> **SooToday.com** @SooToday
> Shoemaker blasts province over doctor shortage sootoday.com/local-news/sho...

1:19 PM · May 15, 2024

19 Reply Share

Read 2 replies

9:10 a.m. Wednesday update

Hannah Jensen, spokesperson for Ontario health minister Sylvia Jones, has provided the following response to Mayor Shoemaker's comments on our city's physician shortage:

Trillium Talk

To clarify the mayor's comments, in addition to building two new medical schools, in fact our government is also launching the largest expansion of medical school education seats in over 15 years – adding new undergraduate and residency positions at all six of Ontario's medical schools, including at NOSM [Northern Ontario School of Medicine University].

As part of this expansion, NOSM received 44 new undergraduate and 63 new residency positions, more details here.

We have also expanded the Northern Ontario Resident Streamline Training and Reimbursement program which is particularly popular at NOSM.

Additionally, as part of our government's historic expansion of interdisciplinary primary care teams, Sault Ste. Marie is receiving funding for two new and expanded teams to connect over 8,000 people to primary care.

Finally, it is important to note that even though Group Health Centre notified the ministry to their plans just a week before that planned to inform the patients this decision, we still tried to work with them on solutions and we continue to have those on going conversations.

Original story - 9.39 p.m. Tuesday

Mayor Matthew Shoemaker gave Doug Ford's Government of Ontario a choleric piece of his mind yesterday.

With 10,000 Group Health Centre patients two weeks away from losing their family doctors, the mayor blistered the backside of the provincial health ministry for claiming "there is no concern of a diminished supply of physicians."

The ministry statement was made in arbitration proceedings with the Ontario Medical Association over physician compensation, but Shoemaker and city councillors voted unanimously last night in favour of a resolution calling on the government to acknowledge our local doctor shortage and to ensure every Ontarian has access to physician care.

"On Jan. 25th of this year, the Group Health Centre announced that 10,000 patients are going to be de-rostered effective May 31," the mayor said.

"Since then, it has only been bad news in terms of physician recruitment. First, there is a lot of commentary on the impact that the capital gains changes will have from the federal government on physicians practising in Canada, so that is making it more difficult to retain physicians.

"Second, the province won't negotiate an agreement with the Ontario Medical Association to fairly compensate physicians as they have properly done in British Columbia and I think Alberta was the

other province.

"Instead, the province went to arbitration with the Ontario Medical Association, saying things like there is no concern for diminished supply of physicians in Ontario.

"That's not the Ontario we live in," Shoemaker said.

"The Ontario we live in up here in the north has a serious concern on diminished supply. It's like we're not part of the equation.

"The province really needs to return to the bargaining table and check what areas of Ontario they're talking about. Because I suspect if you ask any municipality in Ontario, they'd have a concern about diminished supply of physicians, not just in northern Ontario."

"So instead of adding physicians to a place like NOSM [Northern Ontario School of Medicine University], that is graduating more family physicians than any other med school in the country, they're building a new medical school in Vaughan.

"Nonsensical, if you ask me. There is a lot wrong on this file. And I think it all goes to show that the priorities on this file are completely backwards. This is hopefully one in a series of motions that will be passed by municipalities across the province urging them to get their head out of the sand on this file," the mayor said.

Also stunned by the province's failure to recognize the seriousness of our doctor shortage is Ward 5 Coun. Corey Gardi.

"That comment that there's no concern of a diminished supply of physicians – I don't like to think that the provincial government could be that out of touch," Gardi said.

"But when you go around cavalierly using language and statements as irresponsible as that, you kind of get a sense that they may very well be [out of touch], at least in terms of this file."

"It's a shame that we had to to call attention to it because you think they'd know by now about the struggles across the province, especially in northern Ontario, but I guess they don't know."

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Discussion (15)

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About the Author: **David Helwig**

David Helwig's journalism career spans seven decades beginning in the 1960s. His work has been recognized with national and international awards.
Read more

TAB 9

POLITICS

‘Fire that minister’: Ontario NDP calls on Ford to sack minister of health


By Isaac Callan & Colin D'Mello • Global News
Posted May 13, 2024 5:13 pm
3 min read

WATCH: Ontario's Ministry of Health is under fire after comments suggesting there is no doctor shortage in the province and how privacy officials handled requests for data about nursing shortages. Global News' Queen's Park Bureau Chief has the story of two contradictory access to information decisions and controversial negotiations with doctors – May 13, 2024

The **Ontario NDP** is calling for Ontario Premier Doug Ford to sack his health minister over the suggestion that the province is not struggling to recruit or retrain family doctors.

Speaking to reporters at Queen's Park on Monday, NDP Leader Marit Stiles accused the government of "trying to pretend" there weren't issues with the province's health-care system.

"When a government says to you it's not a major concern, the state of our health-care system, they're trying to pretend that nothing is going on here," she said.

"The government needs to take action today. And I would argue it needs to happen under a different minister of health. The premier should fire that minister."

The call comes after Health Minister Sylvia Jones and her ministry suggested Ontario was not struggling to either retain or recruit family doctors, comments that came out during ongoing negotiations.

As part of recent talks with the Ontario Medical Association, **the government claimed** recruitment and retention were "not a major concern" in the province when it came to physicians.

After the comments were made public, Jones said the ministry was not saying retention is not a big issue, nor was it saying there is no doctor shortage.

"What we're saying is that Ontario physicians are a really important part of our health-care system, and we'll continue to work with them to grow the workforce," she said Wednesday after question period.

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The ministry's arbitration submission, which contained the contentious suggestion, cited various data points to back up its arguments. The supply of doctors has grown 8.9 per cent from 2019-20 to 2023-24, while the population grew 7.1 per cent, it said.

Opposition politicians jumped on the submission, suggesting the government is trying to downplay problems in Ontario's health-care system.

During question period on Monday, Stiles asked Premier Ford several times if he would stand behind Jones or if she should step down as minister of health.

"Are you going to remove this Minister of Health from her role for those insensitive comments?" she said during one question, referencing recruitment and retention of doctors.

Ford responded, discussing the previous Ontario Liberal government's record on health-care and touting investments approved under his time as premier.

"We're making sure we're building medical universities that, again, neither of your parties have ever built in 30 years," Ford said.

"York University — they're going to graduate primary care doctors. The Brampton university — they're going to focus on primary care doctors. (The) University of Toronto is going to focus on primary care doctors."

A petition started by the Ontario Union of Family Physicians calling for Jones to be fired had just over 2,100 signatures as of Monday afternoon.

A spokesperson for Jones suggested that under previous governments the NDP and Liberals had "slashed residency positions, fired nurses and closed hospitals" in Ontario.

“When the NDP are faced with the choice to support growing our health care workforce, connecting more people to primary care and building new hospitals they continue to stand ideologically opposed to any innovation in the healthcare system,” the spokesperson said.

While the Ontario Liberals called for more transparency and accountability from Jones, neither said she should resign or be fired.

“Sylvia Jones needs to be held absolutely accountable,” Ontario Liberal MPP, and health critic, Adil Shamji said.

“She needs to stand up in the legislature and answer questions properly, take accountability for her mismanagement. Once we get a sense of what she is willing to do and whether she’s willing to address the health care worker attrition, whether she’s willing to address privatization in her health care system, then we can have that discussion.”

John Fraser, also a Liberal MPP, said Jones needed to step forward.

“Stand up and do the job,” he told reporters. “And if you don’t recognize there’s a problem, maybe somebody else should do it.”

— with file from The Canadian Press

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JOURNALISTIC STANDARDS REPORT AN ERROR COMMENT

TAB 10

Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

ORDER PO-4509

Appeal PA23-00026

Ministry of Health

April 16, 2024

Summary: The ministry received a request from the media for information from the Minister of Health's transition binder including records regarding human health resources in provincial hospitals. The ministry located responsive records and ultimately withheld information in part of one record relating to the specific numbers of the current and estimated future shortages of personnel in the health workforce in 2022, 2023 and 2024 and the estimated gaps in these areas of the health workforce at both 5 and 10 years in the future. The ministry claimed that disclosing the withheld information would prejudice its economic interests under section 18(1)(c) and would be injurious to the financial interests of the Government or the ability of the Government to manage the economy under section 18(1)(d) of the *Act*. The appellant appealed the ministry's decision and claimed that the public interest override applied to the withheld information. In this order, the adjudicator finds that section 18(1)(c) and 18(1)(d) apply to the withheld information and finds that while there is a compelling public interest in disclosure of the information at issue, this public interest does not clearly outweigh the purpose of the exemptions.

Statutes Considered: *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31, sections 18(1)(c), 18(1)(d) and 23.

Orders and Investigation Reports Considered: Orders P-441, P-532 and P-1398.

Cases Considered: *Ontario (Community Safety and Correctional Services)* v. *Ontario (Information and Privacy Commissioner)*, 2014 SCC 31, [2014] 1 S.C.R. 674 and *Participating Hospitals v. Ontario Nurses Association*, 2023 CanLII 33967 (ON LA).

OVERVIEW:

[1] The Ministry of Health (the ministry) received a request under the *Freedom of Information and Protection of Privacy Act* (the *Act*) that was clarified as follows:

> Please provide the following items from the Minister of Health's Transition Binder, prepared to aid Minister Jones in taking on her responsibility as the new Health Minister.
>
> - An index, table of contents, or another similar document listing the titles of all the individual sections or records that are contained within the Transition Binder.
> - All the records in the Minister's Transition Binder regarding human resources in provincial hospitals.
>
> Please provide scanned copies of the responsive records from the actual binder that the Minister uses including any hand-written notes, annotations, and mark-ups that the Minister has made. Please provide the responsive records in an electronic format.
>
> Time Period: [specified]

[2] The ministry issued a decision granting partial access to the responsive records. The ministry withheld some information pursuant to sections 12(1) (cabinet records), 13(1) (advice or recommendations) and 18(1) (economic and other interests) of the *Act*.

[3] The requester, now the appellant, appealed the ministry's decision to the Office of the Information and Privacy Commissioner of Ontario (the IPC).

[4] During mediation, the ministry issued a revised decision granting access to additional information. The ministry continued to rely on section 18(1) of the *Act* to withhold some information in one record.

[5] The appellant advised that she wished to move to adjudication to pursue the information withheld pursuant to section 18(1) of the *Act*. The appellant takes the position that the exemptions do not apply to the withheld information and also that the public interest override at section 23 of the *Act* applies to this information if the exemptions are found to apply.

[6] As no further mediation was possible, the file was transferred to the adjudication stage of the appeals process, and as the adjudicator assigned to this appeal, I conducted an inquiry. Representations were received and shared in accordance with IPC's *Code of Procedure*.

[7] In this appeal, I find that section 18(1)(c) and 18(1)(d) apply to exempt the withheld information from disclosure. I also find that while there is a compelling public interest in disclosure of the withheld information, such public interest does not clearly outweigh the purpose of the section 18(1)(c) and (d) exemptions.

RECORDS:

[8] The information withheld pursuant to section 18(1) of the *Act* is in one record entitled "Health Human Resources Overview" (9 pages, partially withheld).

[9] The redacted information in the record contains specific numbers of the current and estimated future shortages of personnel in the health workforce, among nurses, personal support workers and physicians and discusses estimated gaps in these areas.

ISSUES:

A: Does the discretionary exemption at section 18(1) for economic and other interests of the ministry/government apply to the records?

B: Did the ministry exercise its discretion under section 18(1)? If so, should the IPC uphold the exercise of discretion?

C: Is there a compelling public interest in disclosure of the records that clearly outweighs the purpose of the section 18(1) exemption?

DISCUSSION:

Issue A: Does the discretionary exemption at section 18(1) for economic and other interests of the ministry/government apply to the records?

[10] The purpose of section 18(1) is to protect certain economic and other interests of institutions. It also recognizes that an institution's own commercially valuable information should be protected to the same extent as that of non-governmental organizations.[1]

[11] Section 18(1) states:

> A head may refuse to disclose a record that contains,
>
> (c) information whose disclosure could reasonably be expected to prejudice the economic interests of an institution or the competitive position of an institution;
>
> (d) information whose disclosure could reasonably be expected to be injurious to the financial interests of the Government of Ontario or the ability of the Government of Ontario to manage the economy of Ontario;

[12] The purpose of section 18(1)(c) recognizes that institutions may have economic

[1] *Public Government for Private People: The Report of the Commission on Freedom of Information and Individual Privacy 1980*, vol. 2 (the Williams Commission Report) Toronto: Queen's Printer, 1980.

interests and compete for business with other public or private sector entities, and it provides discretion to refuse to disclose information on the basis of a reasonable expectation of prejudice to these economic interests or competitive positions.[2]

[13] The purpose of section 18(1)(d) of FIPPA is to protect the financial interests of the Government of Ontario and the ability of the Government of Ontario to manage the economy of the province and to protect the broader economic interests of Ontarians.[3]

[14] The exemptions found in section 18(1)(c) and (d) apply where disclosure of the record "could reasonably be expected to" lead to one of the harms specified.

[15] Parties resisting disclosure of a record cannot simply assert that the harms under section 18(c) and (d) are obvious based on the record. They must provide detailed evidence about the risk of harm if the record is disclosed. While harm can sometimes be inferred from the records themselves and/or the surrounding circumstances, parties should not assume that the harms under section 18(1)(c) and (d) are self-evident and can be proven simply by repeating the description of harms in the *Act.*[4]

[16] Parties resisting disclosure must show that the risk of harm is real and not just a possibility.[5] However, they do not have to prove that disclosure will in fact result in harm.

Representations

The ministry's representations

[17] The ministry submits that both exemptions at section 18(1)(c) and 18(1)(d) apply to the withheld information because disclosure could reasonably be expected to prejudice the ministry's economic interests and the financial interests of the Government of Ontario and be injurious to the Government's ability to manage the economy.

[18] The ministry states that the redacted information contains specific numbers of the current and estimated future shortages of personnel in the health workforce, including nurses, personal support workers and physicians and discusses estimated gaps in these areas. The ministry notes that the withheld information points to specific shortages within these professions in 2022, 2023 and 2024 and also includes estimated gaps in these areas of the health workforce at both 5 and 10 years in the future. The ministry submits that these numbers are generated using its own analytics which are not available publicly.

[19] The ministry explains that pursuant to the *Health Insurance Act*,[6] it funds physicians in Ontario through the setting of the insurance payment schedules under the Ontario Health Insurance Plan (OHIP). The ministry submits that the disclosure of the withheld information would very likely be used by the Ontario Medical Association (OMA)

[2] Orders P-1190 and MO-2233.
[3] Order PO-4277.
[4] Orders MO-2363 and PO-2435.
[5] *Merck Frosst Canada Ltd. v. Canada* (*Health*), [2012] 1 S.C.R. 23.
[6] R.S.O. 1990, c.H.6.

in upcoming negotiations to negotiate increases in physician billings through higher payment rates under OHIP, based on the economic principles of supply and demand.

[20] The ministry submits that increases in physician compensation has been used as a comparator or precedent for other professions who are publicly funded to negotiate increased rates. It notes that midwives have used physician compensation as a comparator in negotiations with the ministry and in recent human rights complaints regarding perceived disparities in compensation.

[21] The ministry also submits that pursuant to the *Connecting Care Act*,[7] it funds, through Ontario Health, hospitals, home and community care support services organizations and long-term care homes. The ministry notes that these organizations, which employ nurses and personal support workers (PSWs), are funded by the ministry, and any increases to their costs to provide health care services would ultimately fall back on the ministry to increase their transfer payments accordingly.

[22] The ministry submits that if the withheld information was disclosed, the organizations it funds would likely face increased costing pressures as employers because the withheld information would likely be used by their employees and/or their associations to achieve higher wages from those hospitals and long-term care homes, either through the collective bargaining or arbitration processes.

[23] The ministry refers to the previous central hospital collective agreement between the Ontario Hospital Association (OHA) and the Ontario Nurses' Association (ONA) noting that the ONA has publicly stated in relation to negotiations on a new agreement that their top two bargaining issues are staffing shortages and wages.

[24] Further, it notes that while the previous ONA-OHA central agreement provided annual 1% salary increases in accordance with the *Protecting a Sustainable Public Sector for Future Generations Act, 2019 (Bill 124)*, now that that legislation has been found unconstitutional by the Ontario Superior Court of Justice, it is possible that parties will leverage the reopener clauses within their agreements to obtain arbitration awards for higher wages, such as in a recent case involving the ONA and 131 hospitals. The ministry notes that in the case of the ONA-OHA central agreement, recent arbitration awards topped up the 1% salary increase by 0.75% in 2020, 1% in 2021 and 2% in 2022. Additionally, it notes that a wage reopener clause in the Unifor-Ornge collective agreement enabled an arbitrator in January 2023 to direct top up wage increases of 1% in 2020, 2021 and 2022.

[25] Therefore, the ministry submits that disclosing the withheld information could negatively impact salary increase negotiations the ministry is currently engaged in, as well as collective bargaining negotiations and/or arbitration hearings that other bargaining agents are presently engaged in.

[26] The ministry refers to Orders P-1190 and PO-2758 as support for the proposition

[7] 2019, S.O. 2019, c. 5, Sched. 1.

that the section 18(1)(c) exemption applies where sufficient evidence has been submitted that ongoing or upcoming negotiations could be negatively impacted by a disclosure of certain records (as opposed to contracts from negotiations that have concluded.)

[27] The ministry distinguishes Orders P-229 and P-441 where it was found that the relations of an institution with its employees, in and of itself, does not relate to the institution's legitimate economic interests when examining section 18(1)(c). In these cases, the adjudicators found that the exemption did not apply because the ministries did not provide sufficient evidence to meet the harm test. Specifically, the representations regarding the withheld information did not "bridge the evidentiary gap" to establish how the disclosure could reasonably be expected to prejudice the ministry's economic interests.[8]

[28] The ministry submits that the withheld information in this appeal relates to a key economic principle employed during collective bargaining and arbitration (supply and demand), and given the evidence provided, it has shown that the harm test under both section 18(1)(c) and section 18(1)(d) is met.

[29] The ministry submits that its position that disclosure could reasonably be expected to prejudice its economic interests is well-founded and supported by the evidence. It points to several arbitration decisions where evidence of issues with recruitment and retention were taken into account by arbitrators in deciding to award wage increases, particularly in relation to the healthcare sector.[9] The ministry submits that these precedents demonstrate that unions may use the withheld information relating to labour shortages to support their position that there is a recruitment and retention issue. It suggests that this position is further supported by a recent news article stating that unions relied on polling data relating to recruitment and retention of registered practical nurses in order to advocate for increased wages.[10]

[30] The ministry also submits that disclosure of the information could be injurious to the government's ability to manage the economy since some of these health care services are procured from the private sector. It argues that due to long-standing pressures on hospital resources, which were significantly exacerbated by the COVID-19 pandemic, many hospitals have been filling acute human resource needs by turning to private, for-profit agencies that contract out nurses and PSWs at a much higher rate.[11] The ministry

[8] Order P-441.

[9] The ministry refers to *Participating Hospitals v Ontario Nurses Association*, 2023 CanLII 33967 (ON LA), *Errinrung Thornbury Inc. v CLAC, Local 304*, 2015 CanLII 10861 (ON LA), *Homewood Health Centre Inc. v United Food and Commercial Workers, Local 75*, 2022 CanLII 46392 (ON LA), *Chartwell Oakville Retirement v Christian Labour Association of Canada*, 2015 CanLII 32028 (ON LA), and *Muskoka Landing* (*Huntsville Long-term Care Centre Inc.*) *v Canadian Union of Public Employees, Local 4645-00*, 2022 CanLII 85712 (ON LA). It also notes that these arbitrations were subject to the *Hospital Labour Disputes Arbitration Act*, R.S.O. 1990, c. H.14 . Section 9(1.1)(5.) of that Act requires boards of arbitration to consider an employer's ability to attract and retain qualified employees in making a decision or award.

[10] "Union survey suggests more than half of Ontario registered practical nurses considering leaving over pay". April 27, 2023. The Globe and Mail.

[11] "'It's corrosive. They're price gouging:' Agency staffing is costing hospitals, LTC homes, critics say," August 18, 2022. Ottawa Citizen; "Ontario Liberal MPP introduces bill to address 'price gouging' by

states that hospitals have already raised concerns about the cost of these private sector nursing fees and have requested additional funding to cover these higher rates. The ministry submits that if these private sector agencies have access to the withheld information, which shows current and future human resource gaps, such information would likely be used by them to negotiate even higher rates for their services, resulting in the affected organizations' need for more funding.

The appellant's representations

[31] The appellant refers to the ministry's representations and suggests that it is unlikely that the nurses' union would use the withheld information, if disclosed, given that the Ontario Hospital Association (OHA) and the Ontario Nurses' Association (ONA) have already completed bargaining, mediation and are awaiting an arbitration decision.

[32] The appellant submits that it is speculative for the ministry to argue that the union would use the reopener clause of their contract over the information contained in the record and even if it did that it would result in increased wages.

[33] The appellant disagrees that the withheld information could be used as an argument to increase physician billings in upcoming negotiations with the OMA. She notes that the disclosed parts of the record state that there are no anticipated large gaps in the overall supply of physicians and only mentions maldistribution within regions and specialties.

[34] The appellant submits that the health worker shortage is already a known problem within the Ontario healthcare system. She suggests that even if unions do not have current and future government estimates, the issue is constantly brought forward.

[35] She refers to the Financial Accountability Office of Ontario (the FAO), which has published a report with the expected shortages for nurses and personnel support workers until 2027. The appellant suggests that additional details contained in the withheld information would shed new light but suggests that it would not be significant enough to make an impact on the bargaining outcome.

[36] The appellant refers to IPC decisions where section 18(1) of the *Act* was upheld, and contrasts them with the information at issue in the present appeal. She says that the information at issue in those appeals would have revealed strategic information, such as how much an institution was willing to pay for a service[12] or revealed unknown weaknesses that could be exploited by competing organisations.[13] The appellant submits that the withheld information in this appeal does not reveal the government's strategy during wage negotiations or expose an unknown weakness of the healthcare system. The

temporary nursing agencies," February 23, 2023. CBC News; "Temporary staffing agencies overcharging Ontario long-term care homes: association," February 14, 2023. The Canadian Press; "'Laura' spoke on condition of anonymity. Her story of what's happening in nursing is a warning to us all". June 15, 2022. The Toronto Star.

[12] Orders PO-3572 and PO-4116.

[13] Orders P-1190, PO-3620, PO-4056 and PO-3943.

appellant submits that it is public knowledge that there are shortages of nurses and other health care professionals.

Reply representations

[37] In reply,[14] the ministry submits that while the negotiation with OHA and ONA has concluded, there are other negotiations involving the ONA, the OMA, and other healthcare employers that are still ongoing or still to occur. It suggests that these negotiations can pertain to wages both prospectively and retroactively. The ministry notes that it anticipates that these organizations are also likely to share information amongst each other to facilitate their negotiations. As such, it continues to suggest that the redacted information can still prove useful to these associations when negotiating wage increases.

[38] The ministry notes that although the disclosed portions of the record states there are no anticipated large gaps in the overall supply of physicians, it only mentions maldistribution within regions and specialties. The ministry submits that maldistribution is still a relevant factor in negotiations with the OMA, which are complex and not simply premised on overall physician shortages. Furthermore, the ministry points out that maldistribution means that there still exist shortages.

[39] The ministry submits that a general awareness of health worker shortage is different from the specific data it has generated. It confirms that the redacted information reveals exactly how much of a shortage is anticipated and reveals the ministry's bottom line in negotiations, and disclosure of this strategic information would weaken the ministry's position in negotiations if disclosed.

[40] The ministry states that the FAO's analysis, referenced by the appellant, differs from its own noting that the FAO collected its own data and developed its own methods and assumptions for projecting nursing and PSWs supply and future needs. The ministry notes that it was given the opportunity to review, and fact check the draft FAO report and while it provided feedback highlighting any data errors or inaccurate assumptions, the ministry did not provide its own data or methods to alter the FAO's projections.

[41] In her sur-reply, the appellant notes that negotiations between the OHA and the ONA is already settled and nurses were already granted retroactive payment in light of Bill 124 being struck down. She submits that even if the ONA was able to re-open negotiations, the ministry has not demonstrated that it is reasonably foreseeable that the nurses would be successful in negotiating a higher salary if the withheld information is disclosed.

[42] The appellant also submits that the withheld information does not seem to include a detailed breakdown of the shortage by specialty or by region and is unlikely to be used by physicians to increase their billings by leveraging maldistribution as a factor.

[14] The parties made reply and sur-reply representations much of which repeated their earlier submissions.

Analysis and findings

[43] For the section 18(1)(c) exemption to apply to the withheld information, there must be a reasonable expectation that disclosure of the information could reasonably be expected to prejudice the economic interests of the ministry or its competitive position. For the section 18(1)(d) exemption to apply, there must be a reasonable expectation that disclosure of the information could reasonably be expected to be injurious to the financial interest of the Government of Ontario or the ability of the Government to manage the economy of the province.

[44] As set out above, the law on the standard of proof is clear. In Ontario (Community Safety and Correctional Services) v. Ontario (Information and Privacy Commissioner),15 the Supreme Court of Canada addressed the meaning of the phrase "could reasonably be expected to" in two exemptions under the Act and found that it requires a reasonable expectation of probable harm. In addition, the Court observed that "the reasonable expectation of probable harm formulation… should be used whenever the 'could reasonably be expected to' language is used in access to information statutes."

[45] In order to meet that standard, the Court explained that:

> As the Court in *Merck Fross*t emphasized, the statute tries to mark out a middle ground between that which is probable and that which is merely possible. An institution must provide evidence well beyond or considerably above a mere possibility of harm in order to reach that middle ground; … This inquiry of course is contextual and how much evidence and the quality of evidence needed to meet this standard will ultimately depend on the nature of the issue and inherent probabilities or improbabilities or the seriousness of the allegations or consequences…

[46] I agree with and adopt this approach for the purposes of this appeal.

[47] In the circumstances of this appeal, based on my review of the withheld information in the record at issue and the parties' representations, I find that the exemption at section 18(1)(c) applies to the information at issue. In my view, there is a reasonable basis to find that disclosure of the information could reasonably be expected to prejudice the economic interests of the ministry or its competitive position. I also find that disclosure of the withheld information could reasonably be expected to be injurious to the financial interests of the government of Ontario or its ability to manage the economy of Ontario under section 18(1)(d).

[48] It is not disputed, and I accept that under the *Health Insurance Act*, the ministry is the source of funding for physicians as it sets the insurance payment schedules under OHIP. Also, under the *Connecting Care Act*, the ministry is the source of funding for hospitals, home and community care support organizations and long-term care homes

[15] 2014 SCC 31, [2014] 1 S.C.R. 674.

which employ nurses and PSWs.

[49] The ministry's submissions on the potential harms from disclosure of the withheld information are persuasive. Any resulting increase to the health and human resource costs of other affected organizations would revert to the ministry as funder for the health care system through increased OHIP rates for physicians, or the funding obligations to organizations that employ these health care professionals or procure private nursing and personal support worker (PSWs) services. Therefore, I find that disclosure of the withheld information could reasonably be expected to negatively impact the government's ability to manage the costs of providing health care and the overall budget on behalf of taxpayers.

[50] As noted by the ministry, the withheld information includes specific numbers of the current and estimated future shortages of health care workers by nurses, PSWs and physicians. The withheld information points to specific shortages in 2022, 2023 and 2024 and also estimates gaps in these areas at five and ten years in the future. If the withheld information was disclosed, bargaining units would be in possession of the ministry's specific numbers and, I agree that it is reasonable to expect that they would be used in negotiations to affect overall compensation. I also find that the information could be used by the private sector companies that are providing services to the health-care sector in their negotiations with the Hospitals or long-term care homes to advocate for higher rates for its services resulting in the organizations' need for more ministry funding.

[51] I accept that if the withheld information relating to physicians is released it would be reasonable to expect it to be used by the OMA in upcoming negotiations to attempt to increase physician billing based on the economic principle of supply and demand. In my view, the ministry's own numbers would be more persuasive than any other third-party numbers given the data available to it. Further, I accept that physician compensation is used as a comparator or precedent for other publicly funded professions which makes this information more likely to be relied upon if disclosed.

[52] Regarding the same principle of supply and demand, I accept that the organizations under the *Connecting Care Act*, that employ nurses and PSWs and are funded by the ministry, could face increased costing pressures as employers if the withheld information is disclosed, directly affecting the ministry.

[53] Both parties have referred to arbitration decisions dealing with the reopener clause that was used in relation to the recent striking down of Bill 124 as unconstitutional. After reviewing these decisions, it is clear that staff retention and recruitment are serious factors that are considered in making an award. For example, the Chair in *Participating Hospitals v Ontario Nurses Association*, 2023[16] stated:

> The evidence in this hearing clearly demonstrated that difficulties with staffing have undermined the provision of healthcare services. Both of

[16] Cited above.

these criteria weigh strongly in favour of significant increases in compensation.

[54] Although the Chair acknowledges the "staffing shortage crisis" already apparent in 2021, there is no reference to any actual numbers relating to shortages or projections of same. In my view, the arbitration decisions support the ministry's argument that if the withheld information was disclosed, bargaining units could use the ministry's information concerning labour shortages to further support their position, impacting negotiations and would also be impactful with a decision maker.

[55] The appellant suggests that since the reopener clauses for nurses has been utilized and the issue was arbitrated, that information should be disclosed because it is no longer at stake to re-open negotiations. However, I agree with the ministry that the withheld information can be used prospectively and retroactively in negotiations and therefore is always at risk to affect negotiations. I note this is one of the reasons that ministry claims that it never discloses this kind of information (addressed in more detail under Issue B).

[56] I have also reviewed the news articles referenced by the ministry including one article that references a poll released by two health care unions that suggested that more than 60 percent of registered practical nurses in Ontario are considering leaving the profession over pay.[17] This article notes that the unions are using the survey results to "press the province to increase wages." Another news article discusses a private member's bill to address issues with Hospitals, long term care homes and other health-care facilities that have relied on private, for-profit agencies to provide nurses, PSW's and other staff.[18] The article notes that critics of this model say it is unfair and lures workers away from permanent jobs. The article suggests that because of the severe shortage, the system has relied upon private agencies to a greater degree. The 1st vice president of the ONA is quoted saying that with 25,000 vacant nursing positions, they have seen some price-gouging from the private sector; "If they know it's a weekend and they desperately need someone, the price automatically drives up."

[57] The FAO report referenced by the parties sets out its own projection of the shortages in the relevant fields. After reviewing the report and the withheld information, I agree with the ministry that its own analysis differs from the FAO given the unique information and data sources available to the ministry (for example, its record level data regarding nurses in the province, data regarding the utilization of healthcare and nursing services across sectors, and insights from program areas within the ministry to improve future estimates). Despite the appellant's suggestion that the FAO already published expected shortages of nurses and PSWs until 2027, I agree with the ministry that its data differs from the FAO analysis in a way that could impact bargaining outcomes. Further, after reviewing the FAO report, I note that it addresses key risks to the FAO spending projections noting that "given recent elevated inflation, there is the potential for above-

[17] "Union survey suggests more than half of Ontario registered practical nurses considering leaving over pay," cited above.
[18] "Ontario Liberal MPP introduces bill to address 'price gouging' by temporary nursing agencies," cited above.

average wage settlements, which would lead to higher than projected spending." It also notes that if the Government is unsuccessful in its appeal of Bill 124, "provincial spending on wages would be higher than projected in the FAO forecast."

[58] Despite the appellant's reference to the disclosed part of the record mentioning that there are no anticipated large gaps in the supply of physicians, only mentioning maldistribution within regions and specialties, after reviewing the withheld information, I agree that maldistribution would be a relevant factor in negotiations with the OMA. I also accept that these negotiations are complex and not simply premised on overall physician shortages.

[59] While other organizations may have their own calculations of these shortfalls (such as bargaining units, the FAO and/or private sector providers), I accept that the ministry's numbers are generated using its own analytics that are not publicly available and therefore the projections are specific to the ministry.

[60] I have reviewed the various orders referenced by the appellant in her representations where section 18(1)(c) has been addressed and conclude that in each instance, the finding turns on whether the institution provided sufficient evidence to demonstrate that the harms set out could reasonably be expected to occur.

[61] In her sur-reply, the appellant argues that the adjudicator in Order P-441 dismissed the Ministry of Natural Resources' position that "disclosure of the record would result in the union being able to make use of the information during collective bargaining, rendering the employer less successful in negotiations, and causing higher settlements." However, the records at issue in Order P-441 concerned information dealing with the Ministry of Natural Resources own employees and the adjudicator found that section 18(1)(c) does not contemplate prejudice to any so-called "economic interests" of an institution in its relations with its employees; "rather, it provides institutions with a discretionary exemption which can be claimed for certain records if, in particular circumstances, disclosure could reasonably be expected to prejudice an institution in the competitive marketplace, interfere with its ability to discharge its responsibilities in managing the provincial economy, or adversely affect the government's ability to protect its legitimate economic interests."

[62] In my view, the facts of this appeal differ from those in P-441, as here the ministry is claiming that if the withheld information is disclosed it will affect health care employers such as the ONA and the OMA who will in turn require additional funds from the ministry. Therefore, I distinguish Order P-441 from this appeal.

[63] As stated, I find that the evidence supports a finding that disclosure of the withheld information would reveal specific labour gaps currently and anticipated by the government with respect to nurses, PSWs and physicians. It is reasonable that this information could be used by employees in government funded positions and/or their associations to achieve higher wages from the ministry, based on the economic principles of supply and demand, either through the collective bargaining or arbitration processes. This can reasonably be expected to increase the human resource costs in the provision

of health care, which are ultimately funded by the ministry.

[64] As a result, I uphold the ministry's claim that the exemptions at section 18(1)(c) and section 18(1)(d) apply to exempt the withheld information, subject to my review of the ministry's exercise of discretion and the public interest override.

Issue B: Did the ministry exercise its discretion under section 18(1)? If so, should the IPC uphold the exercise of discretion?

[65] The section 18(1) exemption is discretionary, meaning that the institution can decide to disclose information even if the information qualifies for exemption. An institution must exercise its discretion. On appeal, the IPC may determine whether the institution failed to do so where, for example,

- it does so in bad faith or for an improper purpose;
- it takes into account irrelevant considerations; or
- it fails to take into account relevant considerations.

[66] In either case, the IPC may send the matter back to the institution for an exercise of discretion based on proper considerations.[19] The IPC cannot, however, substitute its own discretion for that of the institution.[20]

Representations

[67] The ministry submits that it exercised its discretion in good faith, for the purpose of achieving best value for money with respect to public funds. The ministry submits that it took into account only relevant factors when exercising its discretion, including:

- The wording of the exemption and the interests it seeks to protect: The ministry submits that disclosure of the withheld information could reasonably be expected to negatively impact the government's ability to manage the costs of providing health care and the overall budget on behalf of taxpayers, which is at the very core of the interest ("ability to manage the economy of Ontario") meant to be protected under section 18(1)(c) and 18(1)(d).

- Whether the individual's request could be satisfied by severing the record and by providing the applicant with as much information as is reasonably practicable: The ministry notes that almost all of the HHR Slides were disclosed to the appellant with only very targeted, minor redactions remaining.

- The nature of the information and the extent to which it is significant and/or sensitive to the institution, the appellant or any affected

[19] Order MO-1573.
[20] Section 54(2).

person: The ministry submits that the pertinent information about the facts of systemic health human resource shortages is already disclosed as per the ministry's decision, therefore the redacted information would not be very significant to the appellant. On the other hand, the information at issue is highly sensitive to the ministry. The redacted numbers are generated using the ministry's own modeling methods and are used by the ministry for planning purposes. Disclosing this redacted information would affect the ministry's ability in future to freely consider sensitive information that is relevant to its decision making.

- The historic practice of the ministry with respect to the release of similar types of documents: The ministry notes that there is no past practice of disclosing this type of data, except in rare circumstances and with the understanding that the data be kept confidential. The ministry also has a history of keeping similar types of numerical information confidential.

[68] The appellant submits that the ministry did not properly exercise its discretion when choosing to redact information in the record at issue. She submits that linking the redacted information to the ability to control the cost of healthcare and the overall budget on behalf of taxpayers is an exaggeration, given the problem is already known by the public.

[69] The appellant acknowledges that several pages of the record were disclosed but submits that the information at the heart of the record at issue are the numbers that were redacted. She submits that the ministry cannot argue this is a minor redaction just because it only represents a few lines in the record at issue as the redacted information is precisely what the appellant was seeking in her request.

[70] The appellant notes that the ministry based its decision on its historic practice to keep this type of record confidential and suggest this should not be a relevant factor. The fact that the government usually chooses not to release this type of information does not justify denying the document when requested under the *Act*.

Finding

[71] After reviewing the factors the ministry considered when making its decision, I am satisfied that it did not exercise its discretion in bad faith or for an improper purpose. I am satisfied that it considered relevant factors and did not consider irrelevant factors in the exercise of its discretion. The ministry considered the purposes of the *Act* and has given due regard to the nature and sensitivity of the information in the specific circumstances of this appeal.

[72] It is evident that the ministry disclosed as much responsive information as it could without disclosing the actual numbers that show specific shortages in healthcare workers and some comments on the estimated gaps. It is evident from the submissions that the

ministry does not ordinarily release this kind of information and I agree that its historical practice to keep this type of information safe is a relevant factor, especially when considering the type of exemptions claimed for this information.

[73] Based on my review of the information at issue, I find the ministry's exercise of discretion was not improper and I am satisfied that the ministry properly considered the purpose of the exemption and the interests sought to be protected under section 18(1)(c) and 18(1)(d). The ministry considered the right factors and balanced them; it is not for me to substitute my discretion for the ministry's.

[74] Accordingly, I uphold the ministry's exercise of discretion.

Issue C: Is there a compelling public interest in disclosure of the records that clearly outweighs the purpose of the section 18(1) exemption?

[75] Section 23 of the *Act*, the "public interest override," provides for the disclosure of records that would otherwise be exempt under another section of the *Act*. It states:

> An exemption from disclosure of a record under sections 13, 15, 15.1, 17, 18, 20, 21 and 21.1 does not apply if a compelling public interest in the disclosure of the record clearly outweighs the purpose of the exemption.

[76] For section 23 to apply, two requirements must be met:

- there must be a compelling public interest in disclosure of the records; and
- this interest must clearly outweigh the purpose of the exemption.

[77] The *Act* does not state who bears the onus to show that section 23 applies. The IPC will review the records with a view to determining whether there could be a compelling public interest in disclosure that clearly outweighs the purpose of the exemption.[21]

Representations

[78] The ministry submits that, due the extensive news coverage already documenting current and expected health human resource shortages in Ontario, disclosure of the specific shortage numbers that are redacted from the HHR Slides would not further a compelling public interest.

[79] Alternatively, the ministry submits that any furtherance to the public interest that may result from a disclosure of the withheld information would be marginal, at best, as there already exists an abundance of public information about staffing shortages in the

[21] Order P-244.

healthcare sector.[22]

[80] In the event that the IPC were to find that there is a compelling public interest in the disclosure of the records, the ministry submits that this interest does not clearly outweigh the purpose of the exemptions under section 18(1)(c) and 18(1)(d).

[81] The ministry refers to Order P-1398[23] where the adjudicator addressed the public interest override and the exercise of discretion under section 18(1)(d). The request at issue concerned documents pertaining to the economic, social and budgetary impacts of a potential vote for Quebec independence. The ministry notes that in upholding the decision to withhold a number of relevant records, the adjudicator explained that an important consideration in balancing a compelling public interest in disclosure against the purpose of the exemption is the extent to which denying access to the information is consistent with the purpose of the exemption.

[82] The ministry submits that disclosure of the information at issue could reasonably be expected to negatively impact the government's ability to manage the costs of providing health care and the overall budget on behalf of taxpayers and that this is at the very core of the interest meant to be protected by the discretionary exemptions under section 18(1)(c) and 18(1)(d).

[83] The appellant submits that even if the exemptions claimed are upheld, the withheld information should be disclosed because it is in the public's best interest to know what information the government is using when making its decisions about the public health system. She submits that this is important for transparency and accountability noting that the quality of care in the Ontario health system affects the lives of all the residents in the province and its workers are a pillar of that system.

[84] The appellant submits that these considerations outweigh any risks to the government's economic interests because the human resources shortage is a challenge that will be felt for years to come and will have an important impact on the health services Ontarians will receive.

[85] The appellant compares this case to prior IPC orders where a compelling public interest was found, including:

- records relate to the economic impact of Quebec separation[24]

[22] The ministry refers to 30 items including news articles, Financial Accountability Office reports, various union news releases, addressing significant staffing shortages of nurses and PSWs, crisis in nursing, effect on public with nursing shortage, effects on home and community care, PSW shortage affecting people living with disabilities, salary issues, wage restraint, agency staffing costing hospitals, price gouging, Ontario's government debt.
[23] Upheld on judicial review in *Ontario v. Higgins*, 1999 CanLII 1104 (ONCA), 118 OAC 108.
[24] Order P-1398, upheld on judicial review in Ontario (Ministry of Finance) v. Ontario (Information and Privacy Commissioner), [1999] O.J. No. 484 (C.A.).

- the integrity of the criminal justice system has been called into question[25]
- public safety issues relating to the operation of nuclear facilities have been raised[26]
- disclosure would shed light on the safe operation of petrochemical facilities[27] or the province's ability to prepare for a nuclear emergency[28]
- the records contain information about contributions to municipal election campaigns.[29]

[86] The appellant argues that the withheld information in this appeal is similar because it involves issues with serious implications for the public.

[87] The appellant submits that disclosure of the withheld information would shed further light on the topic in addition to the information that has published on the same topic. For example, she notes that the Financial Accountability Office of Ontario's (FAO) report did not specify any projection of the shortages over a 10-year period, unlike the record at issue. Moreover, she notes that the FAO report does not state the ministry's targets for hiring and does not allow for comparison of the targets with the expected needs.

[88] The appellant submits that the withheld information would provide a clear picture of the need for healthcare workers and would reveal any remaining gaps and the government's hiring plans. She refers to the severances in the record and suggests that the withheld information may contain several observations by the ministry employees which may not be included in the FAO report or any other public document on the healthcare workforce. The appellant argues that while the media and various unions have reported about the shortage of nurses and PSWs, their numbers vary. She notes that other organisations do not have access to the same information and tools the ministry has to evaluate current workforce, future needs and the realistic increase of the health workforce noting that they do not have access to hospital data the same way the ministry does. She notes that no other organisation has produced 10-year projections. The appellant submits that because of the resources and access to information the ministry has, the record at issue has more credibility and provides more insight than other estimates.

[89] In reply, the ministry submits that the appellant has not identified a compelling public interest in disclosure of the information. The ministry submits that the redacted

[25] Order PO-1779.
[26] Order P-1190.
[27] Order P-1175.
[28] Order P-901.
[29] *Gombu v. Ontario* (*Assistant Information and Privacy Commissioner*) (2002), 59 O.R. (3d) 773

information would only marginally add to the already extensive debate and media coverage of the health staffing shortage. The ministry suggests that while there may be public curiosity about the information, it does not rouse strong interest or attention and is therefore not compelling.

[90] In her sur-reply representations, the appellant refers to Order P-984 where the adjudicator defined "compelling public interest" as follows:

> the public interest in disclosure of a record should be measured in terms of the relationship of the record to the *Act*'s central purpose of shedding light on the operations of government. In order to find that there is a compelling public interest in disclosure, the information contained in a record must serve the purpose of informing the citizenry about the activities of their government, adding in some way to the information the public has to make effective use of the means of expressing public opinion or to make political choices.

[91] The appellant states that the health care system in Ontario, and across Canada, is facing increased public scrutiny due to, among other matters, increased wait times and the difficulty in finding a family doctor. She suggests that the withheld information would permit public scrutiny of information pertaining to healthcare workers, which in turn sheds light on the operation of the provincial public healthcare system. She submits that at a time when the public is increasingly seeking answers to the government's shortcomings in this area, this information is more important than ever to ensure the citizenry is informed when participating in the democratic discourse.

[92] The appellant suggests that the withheld information also identifies some reasons behind retention issues in the healthcare sector and that it is in the public interest to link those factors to the gap itself. She notes that some of those factors are things beyond the government's control, like the pandemic, while other factors can be linked more directly to government's management, like working conditions and Bill 124.

[93] She argues that the compelling public interest clearly outweighs the purpose of the exemption because it is important for public scrutiny and for democracy as Ontarians ought to be able to make decisions based on facts in order to keep the government accountable. Moreover, she submits that the consequences of the shortage in healthcare workers are significant as it impacts the quality-of-care Ontarians are able to receive in regard to their health.

Analysis and finding

[94] I have considered the representations of the parties and have reviewed the information at issue in the context of the records and information already disclosed. In my view, and for the following reasons, I find that while there is a compelling public interest in disclosure of the information at issue, this public interest does not clearly outweigh the purpose of the exemptions at section 18(1)(c) and 18(1)(d).

[95] In considering whether there is a "public interest," the first question to ask is whether there is a relationship between the record and the *Act*'s central purpose of shedding light on the operations of government.[30] In previous orders, the IPC has stated that in order to find a compelling public interest in disclosure, the information in the record must serve the purpose of informing or enlightening the citizenry about the activities of their government or its agencies, adding in some way to the information the public has to make effective use of the means of expressing public opinion or to make political choices.[31]

[96] The IPC has defined the word "compelling" as "rousing strong interest or attention".[32] In my view, there is a compelling public interest in information concerning the shortage of healthcare workers. This is supported by the news reports, arbitration decisions, and the disclosed portion of the record at issue, which all confirm that there is a health staffing shortage. For example, the disclosed information in the record at issue states that there is a systemic shortage of nurses, attrition issues with PSWs and maldistribution issues regarding physicians. The disclosed information also acknowledges that the shortages have worsened and sets out the challenges discussing strategies and goals to address known gaps with healthcare providers.

[97] Although a compelling public interest has been found not to exist where a significant amount of information has already been disclosed,[33] in this appeal, I find that disclosure of the withheld information would contribute and add to the public discussion. Although the disclosed portions of the record discuss the shrinking gap in nursing and PSW staffing levels and address other issues that are the subject of public attention, it is my view that the withheld information, if disclosed would contribute additional and different information that is relevant to the ongoing public debate concerning healthcare workforce shortages. I agree that disclosure of the withheld information would provide the ministry's own estimates of the actual shortages and gaps which is obviously in the public interest and would add new information, that is more than marginal, to this debate. After reviewing the representations, various news articles, and the withheld information itself, I find that there is a compelling public interest in disclosure of the withheld information.

[98] Although I have found that there is a compelling public interest in disclosure of the information, for section 23 to apply, I must also be satisfied that the public interest clearly outweighs the purpose of the exemption. If a compelling public interest is established, it must be balanced against the purpose of any exemptions which have been found to apply. An important consideration in this balance is the extent to which denying access to the information is consistent with the purpose of the exemption.[34]

[99] In Order PO-2014-I the adjudicator explained that in certain circumstances the

[30] Orders P-984 and PO-2607.
[31] Orders P-984 and PO-2556.
[32] Order P-984.
[33] Orders P-532, P-568, PO-2626, PO-2472 and PO-2614.
[34] See Order P-1398 discussed below.

public interest in non-disclosure of records should be considered. He wrote:

> This responsibility to adequately consider the public interest in both disclosure and non-disclosure of records in the context of a section 23 finding was also pointed out by the Divisional Court in *Ontario Hydro v. Mitchinson,* [1996] O.J. No. 4636. Before upholding my decision to apply the public interest override in section 23 and order the disclosure of certain peer review reports on the operation of Hydro facilities, the court in that case stated that it needed to first satisfy itself that "... in deciding as to the existence of a compelling public interest [I took] into account the public interest in protecting the confidentiality of the peer review process". Once satisfied that I had, the court upheld my section 23 finding.
>
> In my view, the issue of whether there is a compelling public interest in disclosure of records is highly dependent on context. Certain key indicators of compellability can be identified, but each fact situation and each individual record must be independently considered and analysed on the basis of argument and evidence presented by the parties.

[100] Both parties referenced Order P-1398, where an adjudicator found that certain information was exempt under section 18(1)(d) and also found that there was a compelling public interest in that same information. The records before the adjudicator dealt with the possible consequences of Quebec independence, or a "Yes" victory in the referendum on that subject. However, in determining if the compelling public interest clearly outweighed the purpose of the exemption, the adjudicator weighed the competing interests as follows:

> In my view, the public interest in minimizing negative economic effects is more important than the importance of informed public discussion, and for this reason, I find that the compelling public interest in disclosure of the information I have just described above does **not** clearly outweigh the purpose of this exemption and section 23 does not apply to it.

[101] Like the adjudicator in Order P-1398, I find the ministry's submissions that the public interest in disclosing this information does not clearly outweigh the purposes of the exemption to be convincing. As elaborated on above in my discussion about section 18(1), disclosure of the withheld information would reveal specific current and anticipated labour gaps by the ministry with respect to nurses, PSWs and physicians which could reasonably be expected to lead to increased health and human resource costs to the ministry and the Government. Therefore, overriding this exemption could reasonably be expected to negatively impact the government's ability to manage the costs of providing health care and the overall budget on behalf of taxpayers.

[102] I considered the appellant's arguments that the public interest outweighs the purpose of the exemption because the human resources shortage is a challenge that will be felt for years and will have an important impact on the health services Ontarians receive. However, as noted above, the ministry has disclosed a significant amount of

information relating to staffing shortages without disclosing the actual estimates. Also, as described in more detail above, the interests protected by sections 18(1)(c) and (d) are significant. I found that disclosure of the specific shortfall estimate information could reasonably be expected to prejudice the economic interests of the ministry or its competitive position or be injurious to the financial interests of the government of Ontario or its ability to manage the economy. In these circumstances, considering that the health sector in Ontario accounts for a large proportion of public spending, I find that the interests protected by the exemptions are not outweighed by the compelling public interest in disclosure.

[103] As a result, I find that while there is a compelling public interest in disclosure of the information at issue, this public interest does not clearly outweigh the purpose of the exemptions at section 18(1)(c) and 18(1)(d).

ORDER:

The appeal is dismissed.

Original signed by: April 16, 2024
Alec Fadel
Adjudicator

TAB 11

Ministry of Health

Health Human Resources Overview

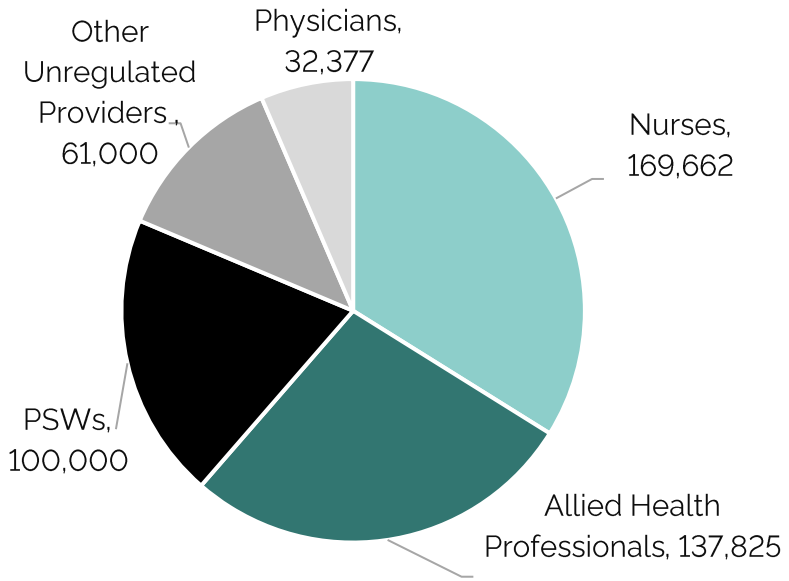
May 2022

Ontario

Overview

Ontario

- Ontario's healthcare workers are the backbone of the system and provide care for all Ontarians. There are over **500,000 health care providers** in Ontario.
- Stabilizing and maintaining a robust workforce would retain and drive value from health care spending.
- Health care provider churn leads to lower quality care, less efficient care delivery and inability to drive transformation.
- Health human resources (HHR) shortages predated the pandemic; however, shortages of nurses and personal support workers have become worse. Challenges include:



  - **Increasing supply takes time** and may not keep pace with the demand for health care services.
  - **Retention issues:** Pandemic related burn out and exhaustion, concerns about wage disparity via Bill 124, working conditions, national/global demand.
  - **Training/Skill:** Need to upskill workforce for more complex health care services.
  - **Access for internationally educated health care providers must improve**: Significant potential workforce of internationally educated health care providers experiencing barriers to practice in Ontario.

Health Workforce Challenge by Numbers

Ontario

NURSES

- Attrition is around 5% per year and has not increased. Nurses are not leaving the profession, but are leaving frontline positions.
- Lack of new nurses to replace those retiring and demand for nursing services has increased.
- Systemic shortage of nurses - by 2024, an additional 13,200 nurses needed over and above those we are now educating.
- **We must retain the nurses we have and educate more.**

Year	Total Nurses Needed
2022	6,000
2023	10,110
2024	13,200
2027 (5 Years)	20,700
2032 (10 Years)	33,200

PSWs

- Attrition can be as high as 25% per year (1/4 of the workforce leaving). If attrition remains stable at 14%, Ontario will have enough PSWs to meet demand.
- Significant investments in training are lost through attrition. Wages and working conditions continue as key drivers of attrition.
- By 2024, there is a need for 37,700 additional PSWs.
- **Key issue is not training more but keeping what we have.**

Year	Total PSWs Needed
2022	24,100
2023	30,900
2024	37,700
2027 (5 Years)	49,000
2032 (10 Years)	51,000

Physicians

- No overall shortage of physicians, but there is maldistribution on two fronts:
  1) Geographic (e.g., rural, northern and remote)
  2) Mix of physicians needs to improve – more family physicians and certain specialities like emergency medicine & anaesthesia
- **Need to expand postgraduate residency spots to respond to local supply issues and improve distribution without causing oversupply.**

Year	Population Growth to Family Medicine Growth Ratio
2022	1.6% POP / 1.4% FM
2023	1.4% POP / 1.1% FM
2024	1.3% POP / 1.0% FM
2027 (5 Years)	1.1% POP / 0.9% FM
2032 (10 Years)	1.1% POP / 0.5% FM

Note: We want the family medicine growth to rest at or slightly above the population growth.

Current Direction - Health Human Resources Plan

Ontario

- The Ministry's **Health Human Resources Plan** is focused on developing and maintaining a high quality health workforce with the right number, mix and distribution (e.g., northern and rural) of health care providers to meet the needs of patients, including priority populations, across the continuum of care (e.g., primary care, acute care, home and community care, long-term care).
- **Short-term targeted recruitment and retention initiatives** have been implemented to bolster the health workforce in response to the pandemic.
- **Medium and long-term initiatives** to mobilize, stabilize and develop the health workforce of the future are now being developed and implemented.

SUPPORTING SYSTEM CAPACITY

- Long-Term Care Expansion & Staffing
- Ongoing COVID Response
- Acute Care Recovery and Expansion
- Improving Access to key health services and sectors
- Increasing Paramedic Workforce

PROPOSED PRIORITY PROVIDERS

PSWS

NURSES

KEY PROVIDERS (e.g., Paramedics; Labs)

PHYSICIANS

Progress of Work To Date

Ontario

SHORT-TERM TARGET (WINTER 2020 to END OF 2022-23):
Support hiring of 13,947 health provider staff (all types) by end of 2022-23 (Achieved 69% of goal, hired 9,610 staff)

PSWs

Goals:
- Increase Supply
- Improve Retention

- **Over 16,000 PSWs** and supportive care workers hired and educated
- **Over $1.3 billion invested** to temporarily enhance wages for PSWs

Will educate/hire over 23,000 PSWs s.18 [redacted] by end of 2023, but attrition might widen or shrink remaining gap s.18 [redacted]

We must reduce attrition to avoid chronic shortages.

NURSES

Goals:
- Increase Supply
- Improve Training

- **Over 3,300 nurses hired and educated and over 4,500 nursing externs hired**
- **Helping Internationally Educated Nurses (IENs) work in system** while they await registration as a nurse (Extern Program)

Will support hiring/educating ~7,000 nurses s.18 [redacted] by end of 2023, but attrition might widen or shrink remaining gap s.18 [redacted]

Increasing supply and avoiding increased attrition are required to head off chronic shortages.

Other Providers

Goals:
- Bolster Labs Workforce

- **Hired 157 students to train through Michener and work in labs**.
- **Temporary regulation changes to expand labs workforce**
- **Amended regulations to maximize several professions' scope of practice** (e.g., pharmacists)

Working to determine current and future Medical Lab Tech (MLT) need

More MLTs will be needed in the coming years.

PHYSICIANS

Goals:
- Bolster Workforce
- Increase Family Medicine
- Improve Specialties / Distribution

- **Providing 43,500 of physician coverage hours in Emergency Departments** through Temporary Summer Locum Program
- Over **10,000 hours of resident coverage in hospitals** through the Medical Resident Redeployment Program

Not anticipating a large gap in supply overall.

Increasing supply now ensures we keep pace with population growth and helps improve distribution. We are on track.

The Way Forward: Ongoing Work and Opportunities

Ontario

A high quality health workforce with the right number, mix and distribution of health care providers to meet the needs of patients, including priority populations, across the continuum of care.

AREAS OF FOCUS:

1. **Train more health care providers**
2. **Improve retention, including improving working conditions**
3. **Better utilize the current workforce, including upskilling**
4. **Unlock available talent, including internationally educated**

MEDIUM TERM TARGET (BY END 2023):

Support hiring of 10,110 nurses and 30,900 PSWs

OPPORTUNITIES

- **Redesign Recruitment and Retention Programs** to grow supply and maintain the existing workforce
- **Reduce barriers to regulated health professions** through changes to the *Regulated Health Professions Act* framework.
- **Better utilize the current health workforce** to improve access to care. e.g. nurse practitioners working to their full scope of practice.

LONGER TERM TARGET (BY END OF 2027):

Support hiring of 20,700 nurses and 49,000 PSWs,

ONGOING – Continue Implementation

- **Medical School Expansion** to increase family physicians and improve distribution (e.g., in the north)
- **Nursing Enrollment Expansion and Bridging Programs** to increase nursing supply

OPPORTUNITIES

- **Improve working conditions** in Home Care and Long-Term Care to improve retention.
- **Better leverage internationally educated health provider** to increase supply

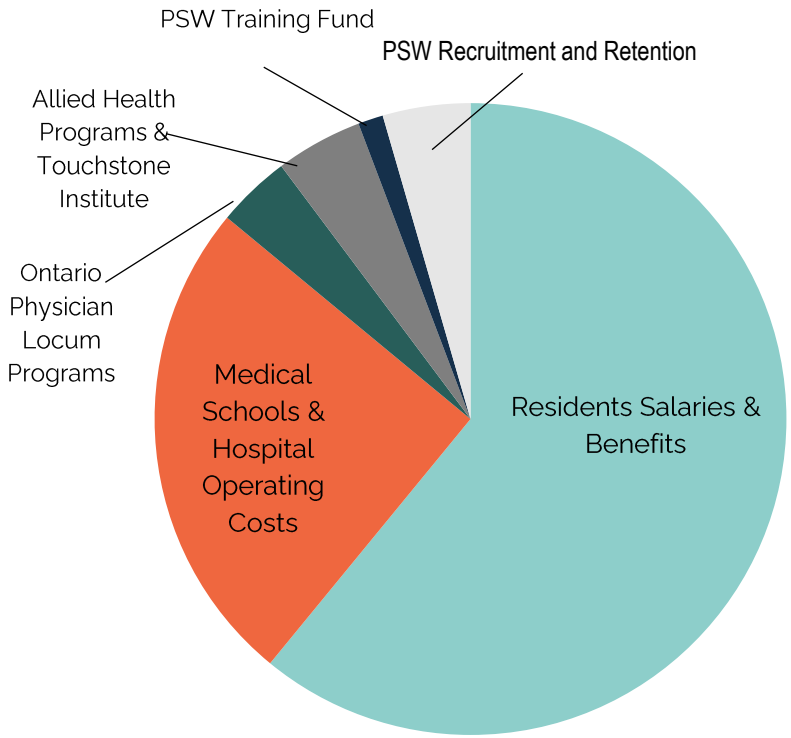
Appendices

Appendix A: Funding for HHR Programs: Clinical Education Budget

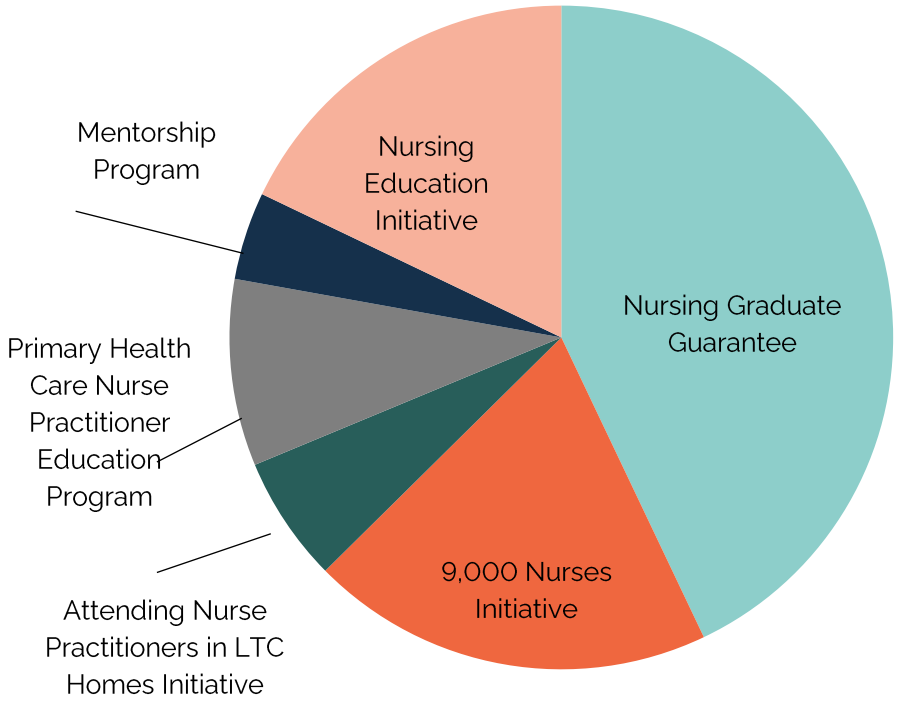
Ontario

Ontario's Clinical Education Transfer Payment Line is the primary source of funding for health human resources programs. The line has two components, health human resources (HHR) and nursing which supports medical, allied health and nursing initiatives. Total Clinical Education allocation for 2021/22 was $740.8M

HHR Allocation – Total $671.4M



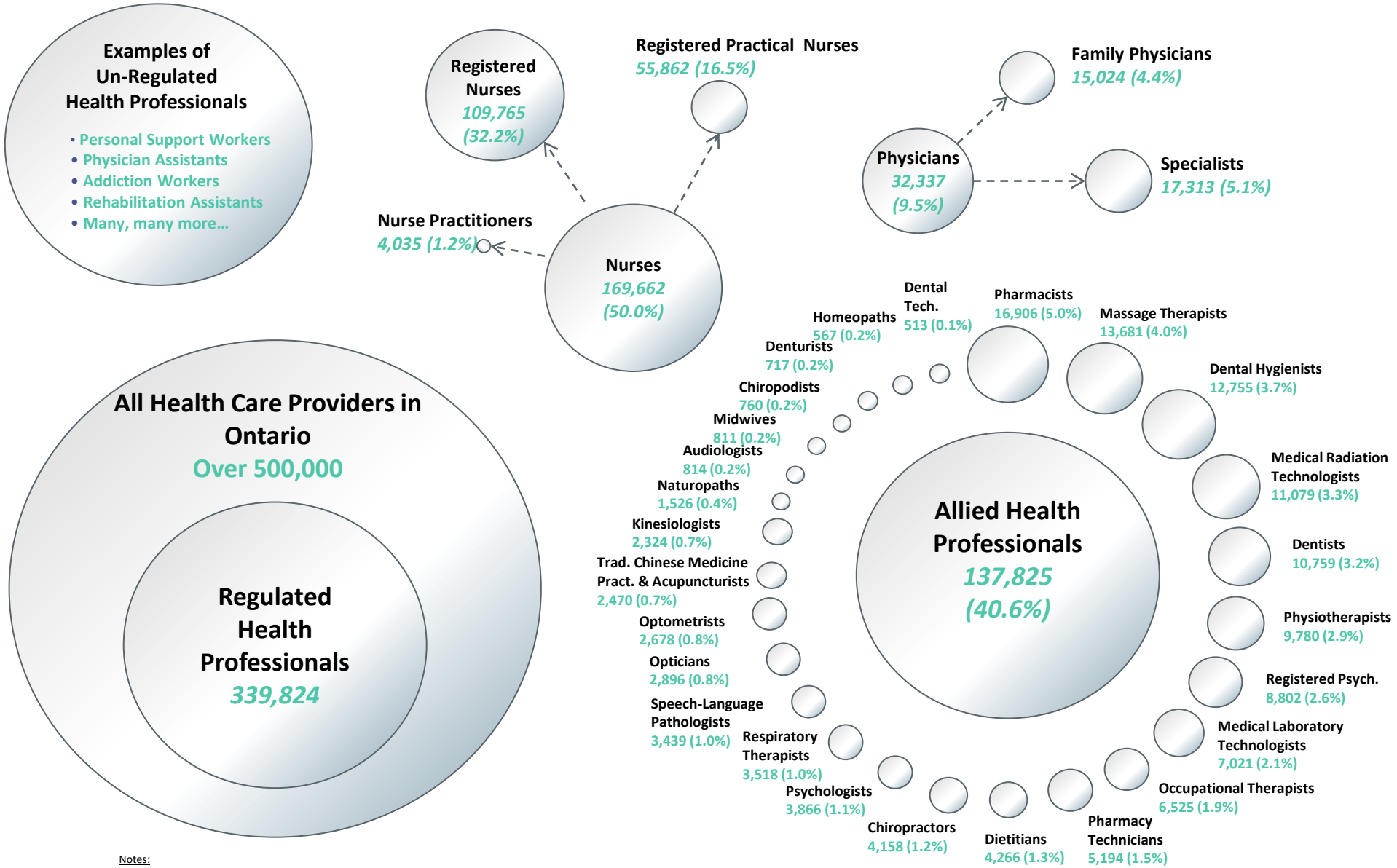
Nursing Allocation – Total $69.4M



The Capacity and Analytics Division is also responsible for the MOH *Health Workforce Programs* TP Line, which provides base funding to Ontario Health to operate health workforce recruitment and retention programs. Total *Health Workforce Programs* allocation for 2021/22 was $5.67M

Appendix B: Ontario's Health Workforce Supply, 2020

Ontario



Notes:

1. Supply is defined as those registered with their respective regulatory colleges (working & not working). It does not include those members who hold an educational license

TAB 12

Ministry of Health

Physician Workforce Evidence & Analytical Modelling

Capacity & Health Workforce Planning Branch
Nursing & Professionals Practice Division
November 2022

Ontario

Table of Contents

Physician Models

Physician Models

Created to support physician policy and program development

Suggests future trends

Identifies specialities that require detailed examination

Simulates the possible impact of policy changes

Results are at the Ontario level

Does not address other health professions, or technology changes

Not a crystal ball - another piece of evidence amongst many

Ontario

ADIN: Ontario's Physician Supply Model

Predicts the future number of doctors (supply only)

Does not anticipate the number of physicians the Ontario population may need

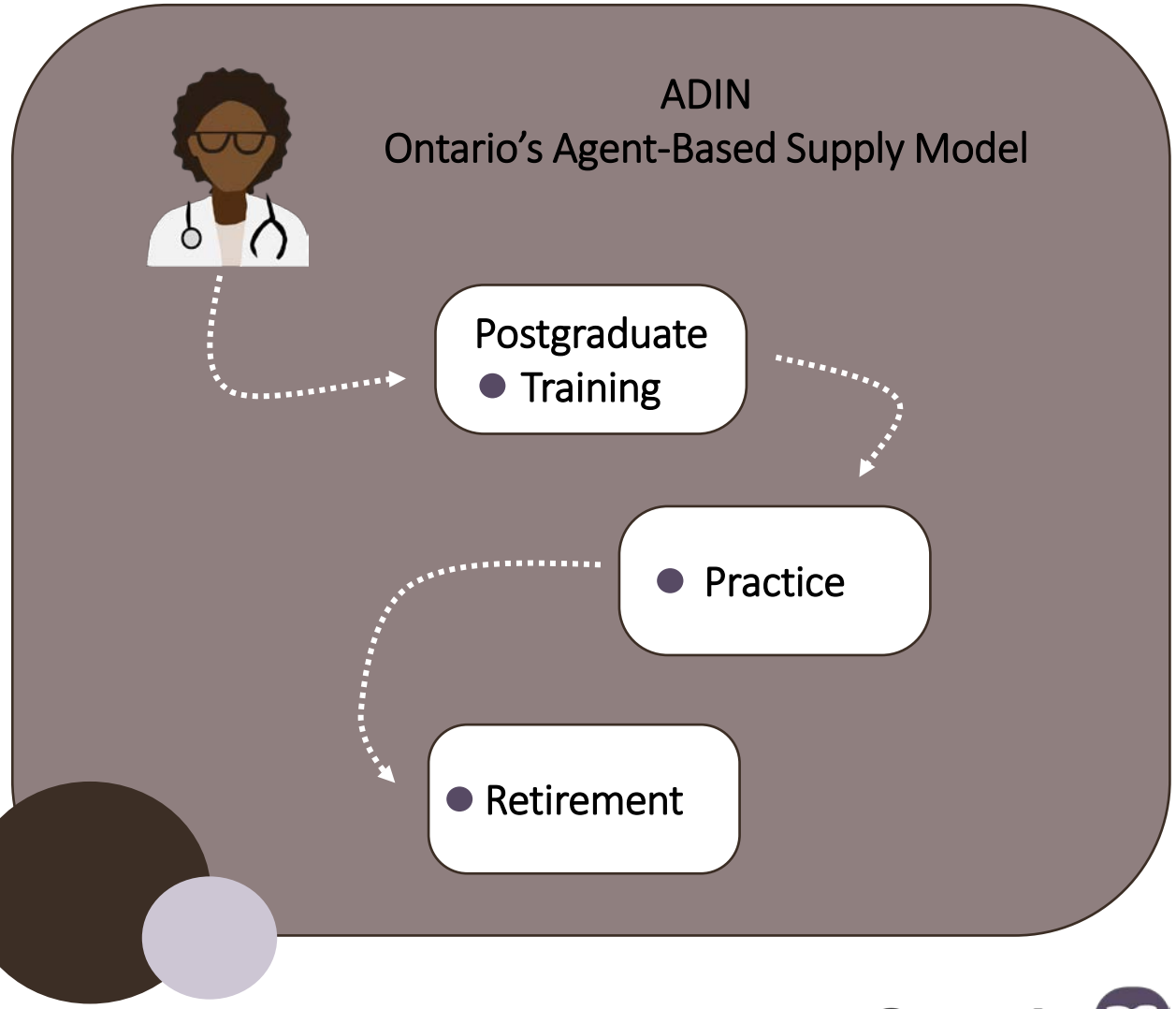
Very accurate

Tracks physicians from postgraduate training to practice through to retirement by age, sex and specialty)

Provides projections up to 10 years into the future

Currently has projections from 2020 to 2030

Results at provincial level only



ADIN Accuracy

Multi-Year Evaluation of ADIN (All Bases)

Ontario Physician Supply: Projection Versus Actual												
Base Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2020	2021
2006	23,206	23,621	24,015	24,408	24,799	25,308	25,823	26,354	26,889	27,422	29,346	29,791
2007		23,826	24,239	24,666	25,117	25,607	26,111	26,670	27,242	27,841	30,212	30,779
2008			24,353	24,833	25,252	25,752	26,274	26,944	27,580	28,303	30,787	31,453
2009				24,904	25,418	25,969	26,588	27,221	27,860	28,539	31,122	31,735
2010					25,417	26,006	26,671	27,419	28,128	28,849	31,959	32,735
2011						26,317	26,967	27,653	28,339	29,013	31,699	32,319
2012							27,116	27,847	28,598	29,364	32,303	32,975
2014									28,875	29,606	32,532	33,223
2016											32,493	33,161
2020												32,962
Actuals	23,266	23,767	24,358	24,875	25,480	26,382	27,125	28,087	28,805	29,633	32,337	33,170

Annual Projections Divided by Actuals

Ontario Physician Supply: Projection Versus Actual												
Base Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2020	2021
2006	100%	99%	99%	98%	97%	96%	95%	94%	93%	93%	91%	90%
2007		100%	100%	99%	99%	97%	96%	95%	95%	94%	93%	93%
2008			100%	100%	99%	98%	97%	96%	96%	96%	95%	95%
2009				100%	100%	98%	98%	97%	97%	96%	96%	96%
2010					100%	99%	98%	98%	98%	97%	99%	99%
2011						100%	99%	98%	98%	98%	98%	97%
2012							100%	99%	99%	99%	100%	99%
2014									100%	100%	101%	100%
2016											100%	100%
2020												99%

ADIN's projected physician headcount are extremely accurate when compared to the actual provincial headcount (as reported by OPHRDC).

As with most models, this accuracy decreases over time as policies and trends change (e.g., PG seats, retirement, etc.).

The headcounts by specialty are also accurate for larger specialties, but caution is advised when examining smaller (sub)specialties. Minor changes in small (sub)specialties can lead to large relative changes over time.

ADIN's greatest utility is in creating different scenarios, testing changes in policy/trends, and measuring the impact on physician supply.

Key Changes to ADIN Base 2020

Migration Data Source

In the past, CIHI migration data was used to calculate migration rates by physician specialty. In this iteration of ADIN, Ontario Physician Human Resources Data Centre (OPHRDC) data was used to maintain a higher level of consistency.

Temporary Attritions & Additions

Previously ADIN did not account for temporary attritions (e.g., maternity/paternity leave, sabbatical or leave of absence, late registration) or reinstatements (e.g., expired license renewed, entered from retirement, inactive license restored, OHIP billing status restored, entered from maternity/paternity leave, entered from sabbatical or LOA). In ADIN Base 2020, these temporary attritions and additions are taken into account.

Retirement vs. Permanent Attrition

In the past, ADIN calculated/modeled Retirements as one form of attrition and then separately calculated/modeled 'Other' Attrition (e.g., Inactive reason unknown, License expired, License revoked or suspended, OHIP status inactive) by specialty for gender. ADIN Base 2020 combined these into Permanent Attrition which included the attrition reasons: Retired, Over 85, Deceased, Licence Expired, Inactive Reason Unknown, OHIP Status Inactive, and License Revoked/Suspended.

Additionally, all additions and attritions information (i.e., across all age groups) were included in this model (previous iterations started at age 40). These changes were made to further enhance ADIN 2020 to capture physician flows in an even more comprehensive manner.

Ontario

Key Changes to ADIN Base 2020 Continued

Gender

OPHRDC data is now collecting “Other” as a data value under its Gender data element. Due to the small size of this category, it was too difficult to model separated. For this iteration it was grouped with “Male” and will be labelled “Male & Other” for accuracy.

Ensuring Accuracy

Before implementing the changes explained, extensive back-testing was conducted using the new methodology with Base 2016 data to compare with actuals and against the old method.

This updated method was slightly more accurate when comparing the overall supply total to actuals 4 years out than the old method(100.1% vs. 100.5% or a 35-physician difference instead of 156 physicians from the actuals in 2020).

We also examined the impact of the temporary additions and attritions and found that results were more accurate with these in/out-flows included.

Ontario's Utilization Model (UM)

Uses OHIP claims to determine the population's rate of visits by physician specialty

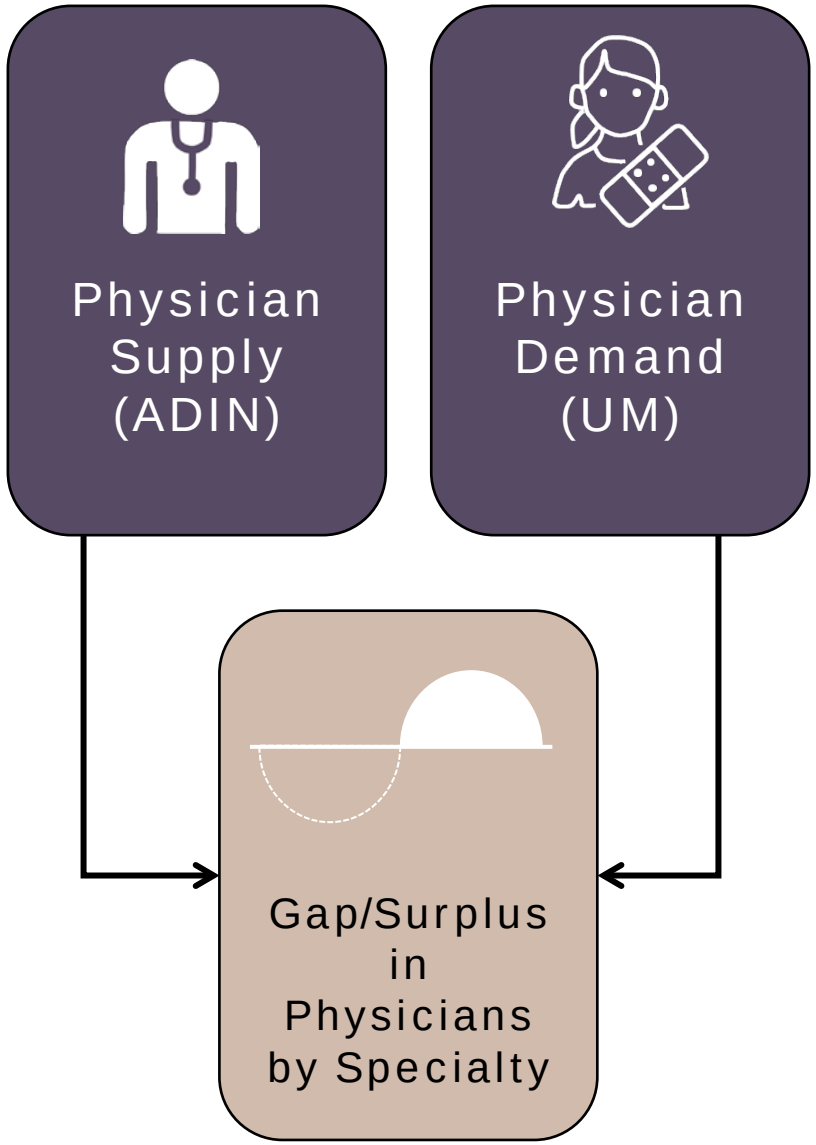
Rates are applied to population projections to determine future utilization

Future utilization is converted to the number of physicians required

Number of physicians required is compared to projected supply (from ADIN)

UM currently has projections from 2016 to 2035

UM results are at the provincial level only



Modeling Results

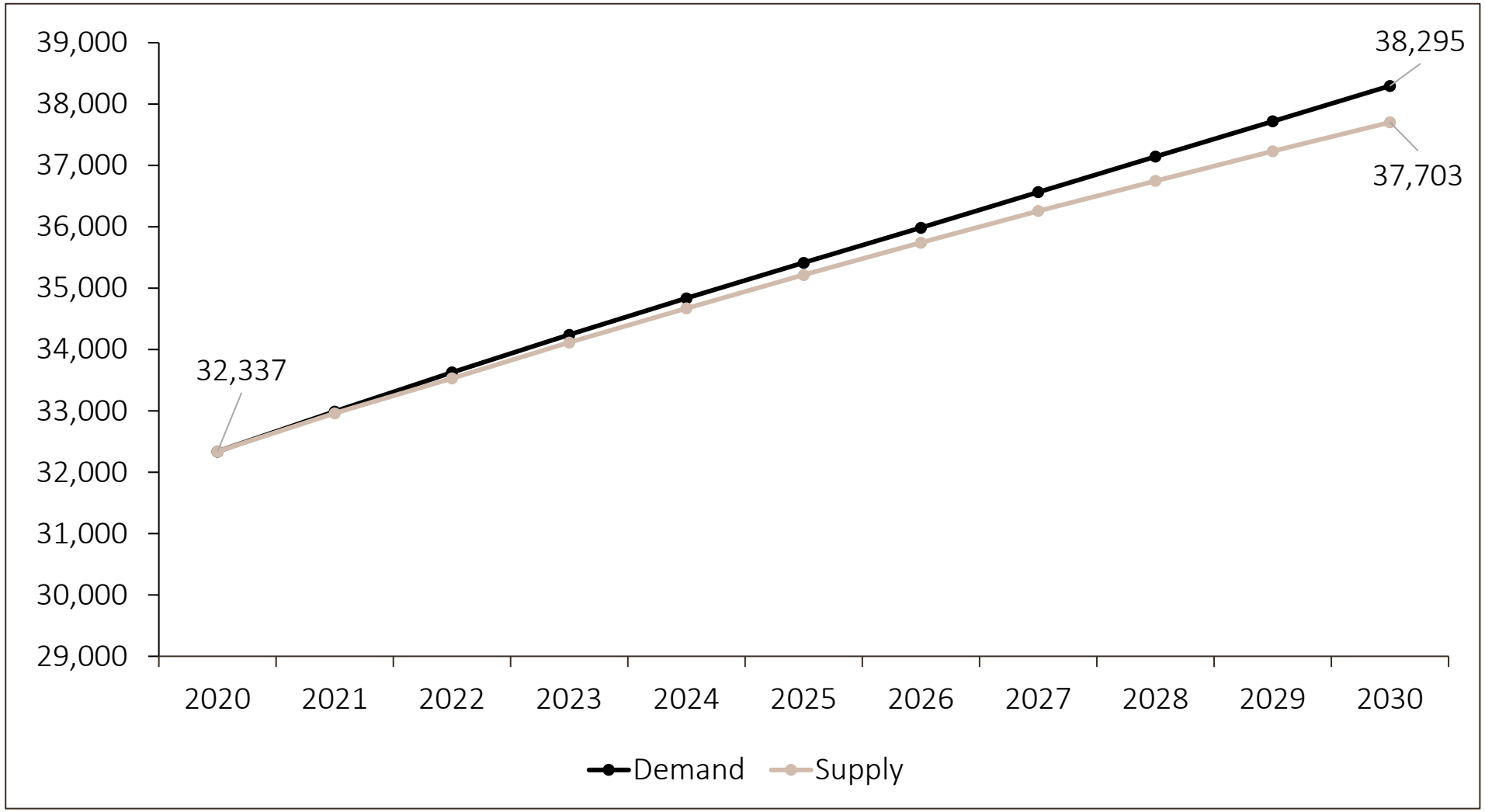
Interpreting the Evidence…

- Consider possible differences between the current state and the future state. Will a specialty that is not “in demand” today become “in demand” in the future?
- It is less about the actual numbers reported (e.g. Ontario needs 10 more ophthalmologists) and more about the pattern of the lines relative to one another.
    - How far apart/close do the lines look from one another?
    - After reviewing the modelling results what does the other additional evidence reveal and how might it be analyzed in conjunction with the modelling results?
    - Is there other evidence that is needed to better inform PG allocations?

Supply Versus Demand

Based on ADIN/UM, if conditions stay as they are, by 2030 demand for physicians will outpace supply of physicians by around 590 physicians.

Please Note:
Demand at the base year (2020) was assumed to be zero, which may not accurately reflect the situation on the ground.

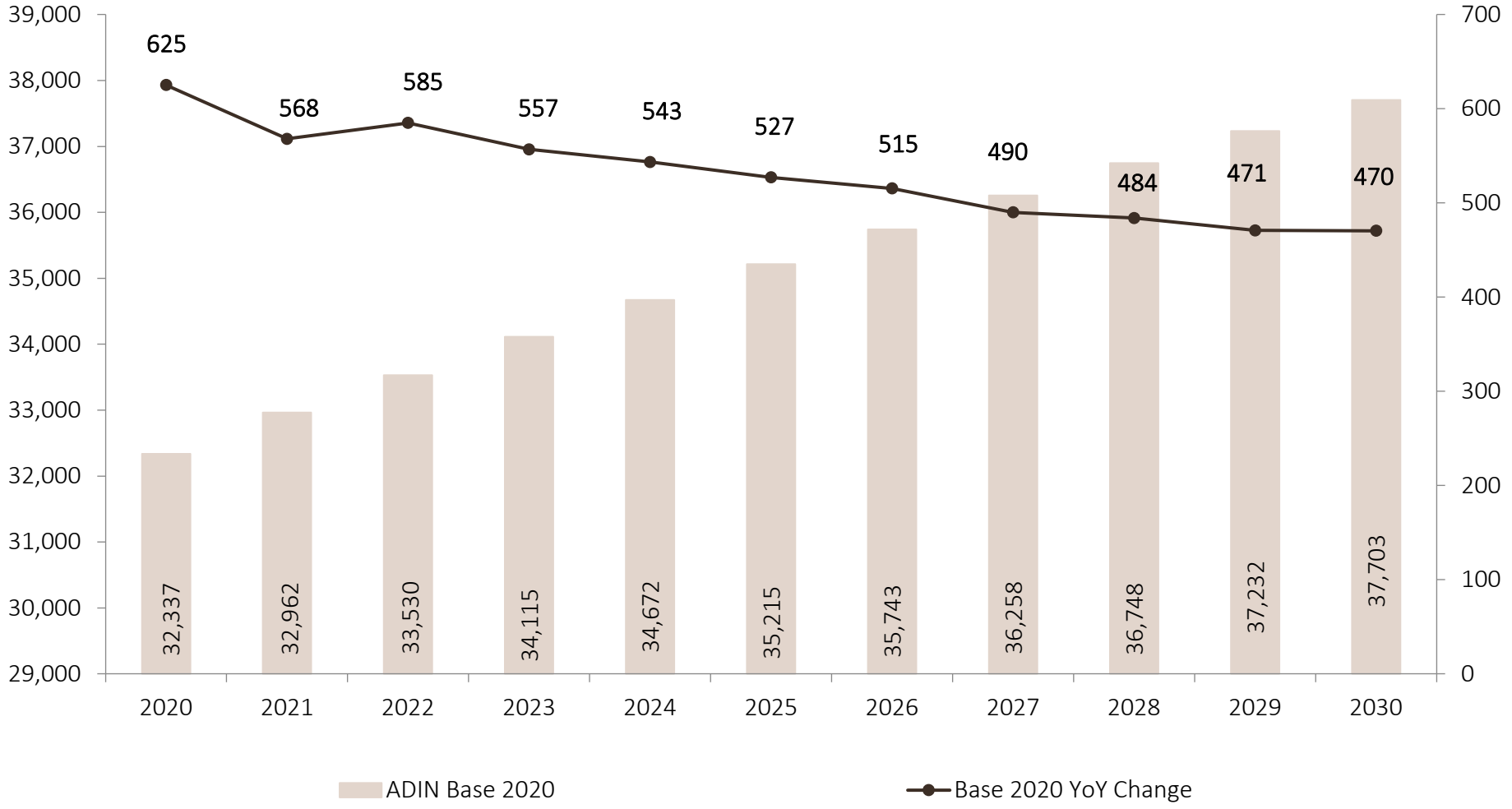


Ontario

ADIN Base 2020: Year Over Year Change

The graph depicts ADIN projections from 2020 to 2030.

Over this time, ADIN projects an average yearly increase of 537 physicians, with the growth in supply gradually slowing as the years progress.



Ontario

Family Medicine

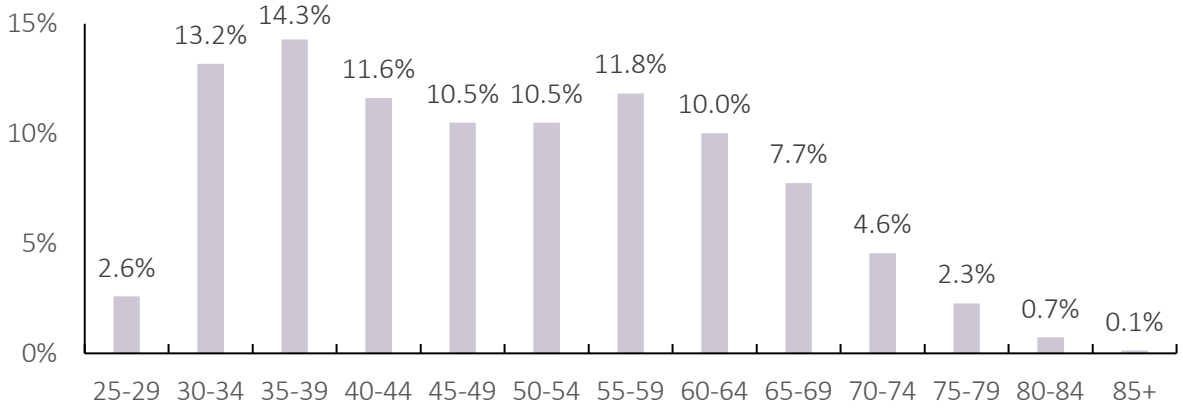
Family Medicine*

*Excludes FM-EM, Includes FM PGY3 except where explicitly listed

Supply

In 2021 there were 14,353 family physicians practising in Ontario, up 2.5% from 2020 (13,998) and up 30.7% from 2011 (10,979). (OPHRDC)

Age



In 2021, the average age of a family physician in Ontario was 49.4 and 12.1% of family physicians were between the ages of 65 and 74. (OPHRDC)

Average Weekly Practice Hours

In 2020, family physicians practicing primary care worked on average **33.2** hours/week (compared to **40.8** hours/week in 2016).

Over the past 5 years, the average weekly practice hours have decreased. However, a significant decrease in weekly practice hours between 2019 and 2020 could be attributed to the COVID-19 pandemic. (OPHRDC)

Includes FM-EM

Clinical Activity

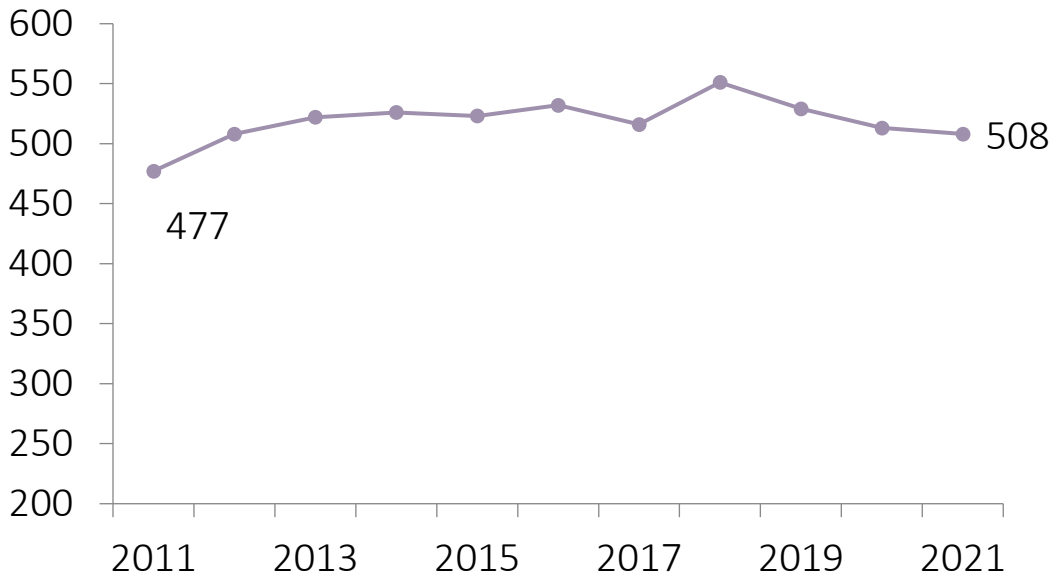
Between 2016 and 2020, the proportion of family physicians practicing primary care has slightly decreased from **75.3%** to **74.4%**. (OPHRDC/CPSO)

Ontario

Family Medicine*

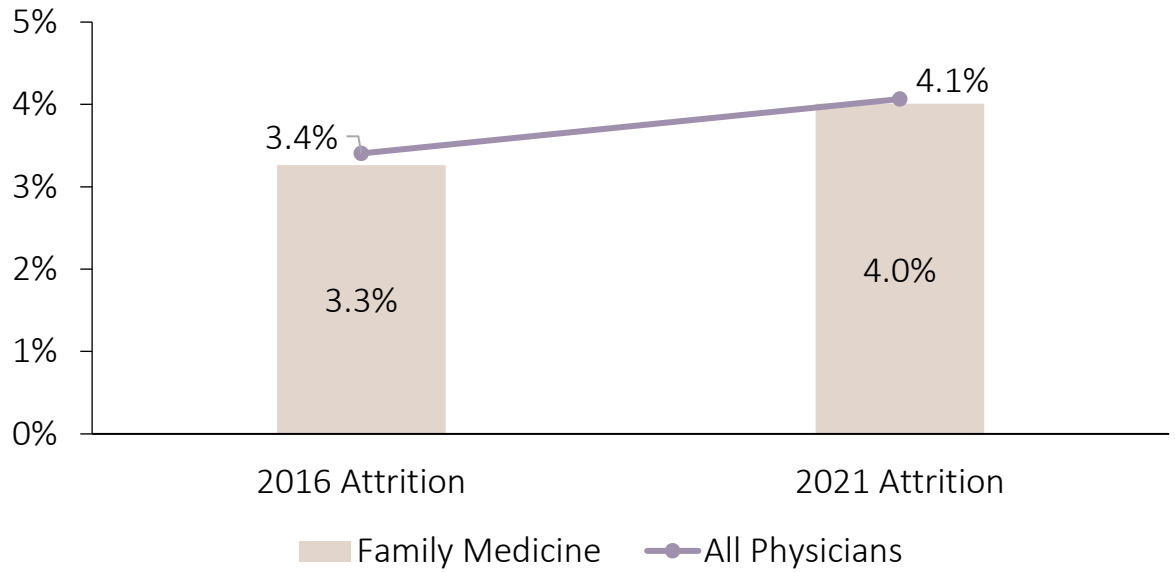
*Excludes FM-EM, Includes FM PGY3 except where explicitly listed

PGY1s



Between 2011 and 2021, the number of PGY1s increased by 6.5% (from 477 to 508). (OPHRDC)

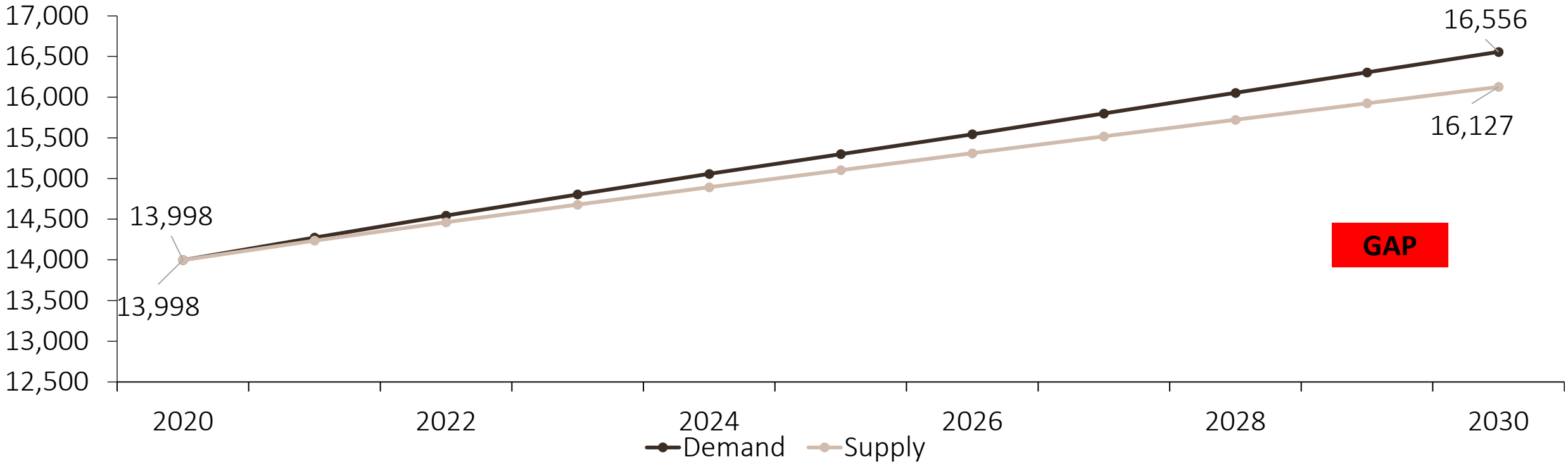
In Practice Attrition



In 2021 and 2016 the attrition rate of family physicians was lower than the average attrition rate for all physicians. (OPHRDC)

Family Medicine*

*Excludes FM-EM, Includes FM PGY3 except where explicitly listed



ADIN/UM Base 2020 modelling predicts that demand will outpace supply between 2020 and 2030 **without UG/PG expansion.** By 2030 we will need 429 additional family physicians to meet demand (if nothing is done). (ADIN/UM)

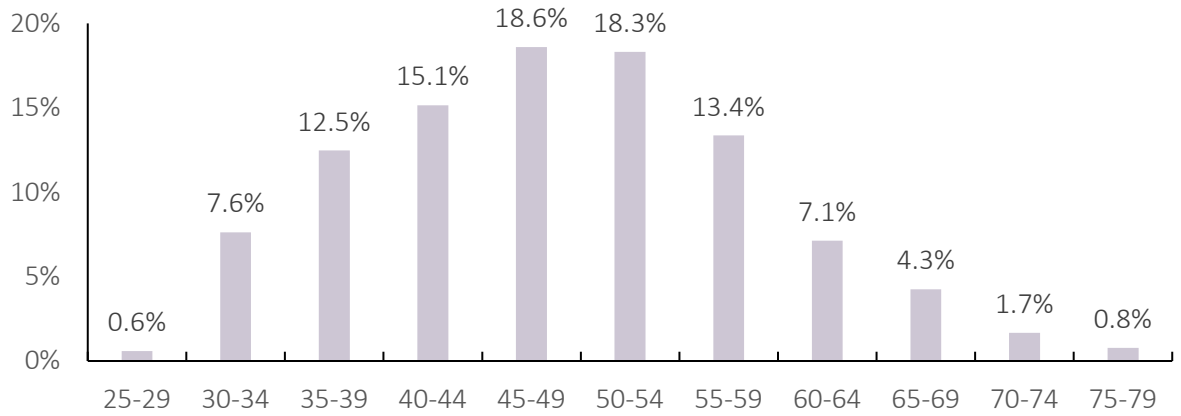
Ontario

Family Medicine-Emergency Medicine

Supply

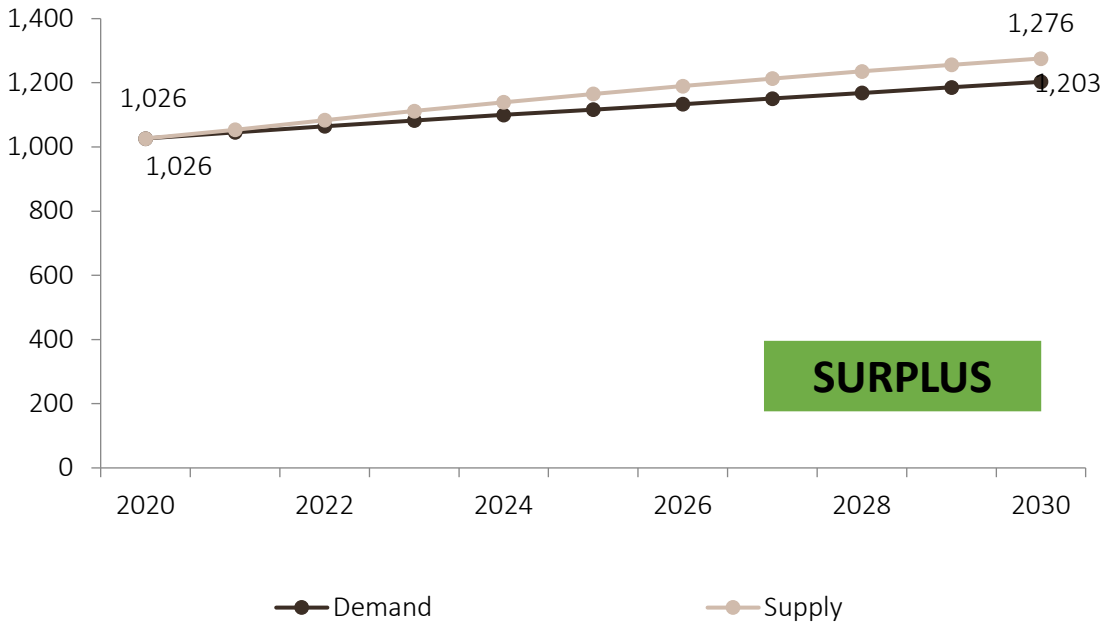
In 2021 there were 1,010 practising in Ontario, down 1.6% from 2020 (1,026) and up 9.4% from 2011 (923). (OPHRDC)

Age



In 2021, the average age of an FM-EM physician in Ontario was 48.6 and 5.9% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

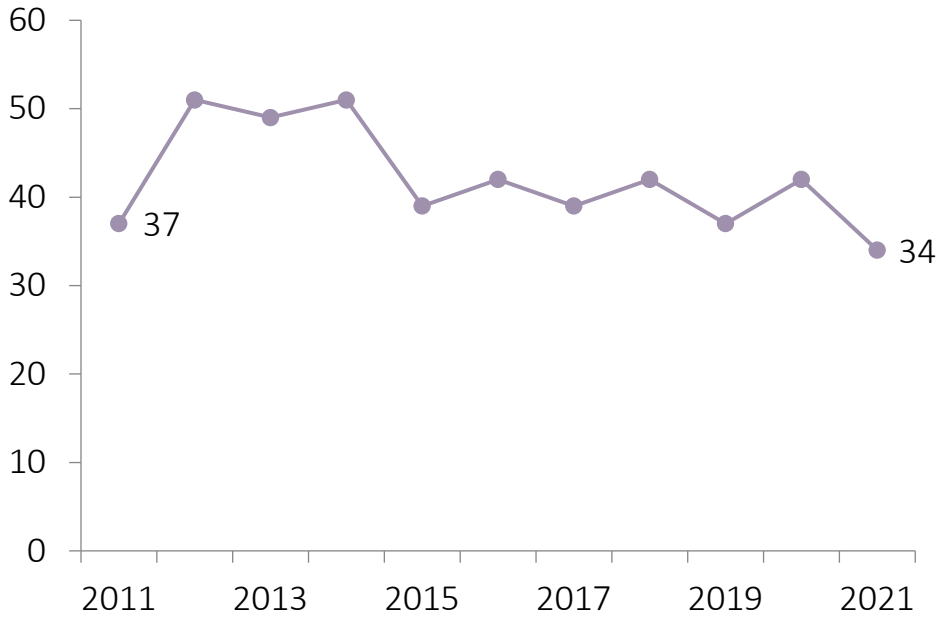


Our modelling is predicting supply to outpace demand. (ADIN/UM)

Ontario

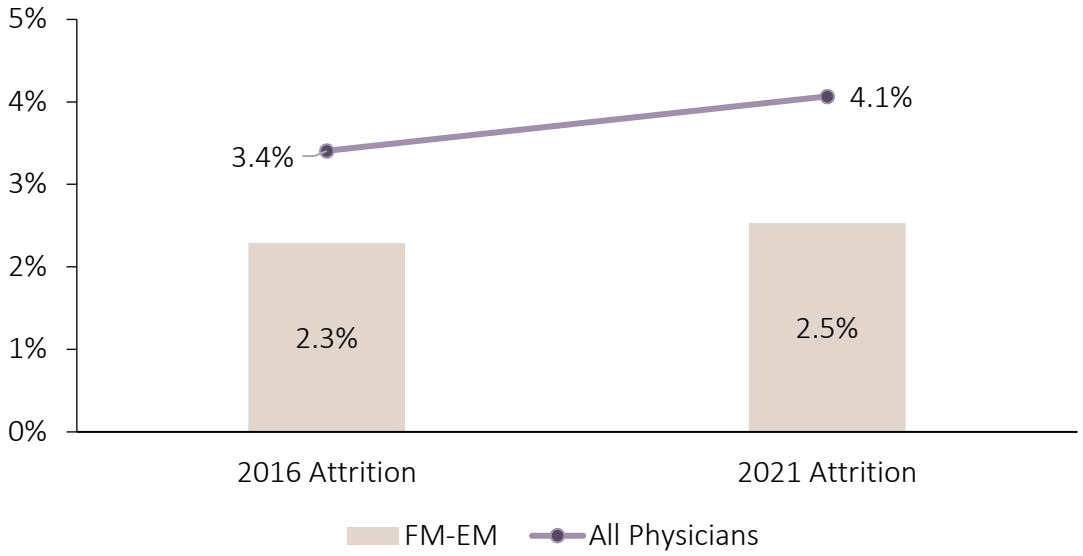
Family Medicine-Emergency Medicine

PGY3s



Between 2011 and 2021, the number of PGY3s decreased by 8.1% (from 37 to 34). (OPHRDC)

In Practice Attrition



In 2021 and 2016 the attrition rate of FM-EM physicians was lower than the average attrition rate for all physicians. (OPHRDC)

Ontario

CURRENT PRIMARY CARE PHYSICIAN NEED

The ministry examined:

- Primary Care Family Physician and NP to Population Ratios
- Age of Primary Care Family Physicians
- Overtime Worked by Primary Care Family Physicians
- Primary Care Attachment Rate of Ontarians; and
- Primary Care Health Needs of Ontarians Compared to the Health Services Delivered.

Based on this assessment the following census subdivisions (CSDs) (divided into urban/rural categories to ensure all geographic types are considered) had the highest ranking of primary care need.

CSD POPULATION 70K+
CSDs
Brampton
St. Catharines
Mississauga
Niagara Falls
Windsor

CSD POPULATION 20K to UNDER 70K
CSDs
Cornwall
Leamington
Lakeshore
Halton Hills
Quinte West

CSD POPULATION UNDER 20K
CSDs
Pikangikum 14
Sables-Spanish Rivers
North Kawartha
Armour
Kitchenuhmaykoosib Aaki 84 (Big Trout Lake)

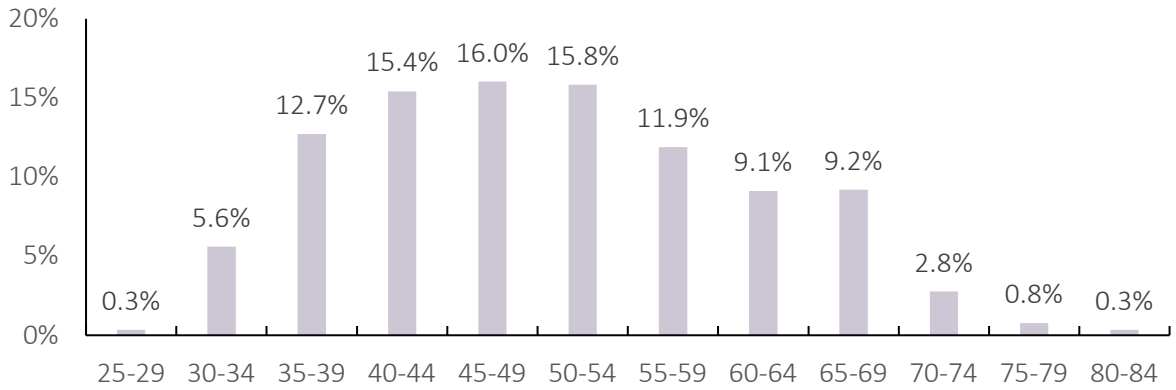
PGY1 Specialities

Anaesthesia

Supply

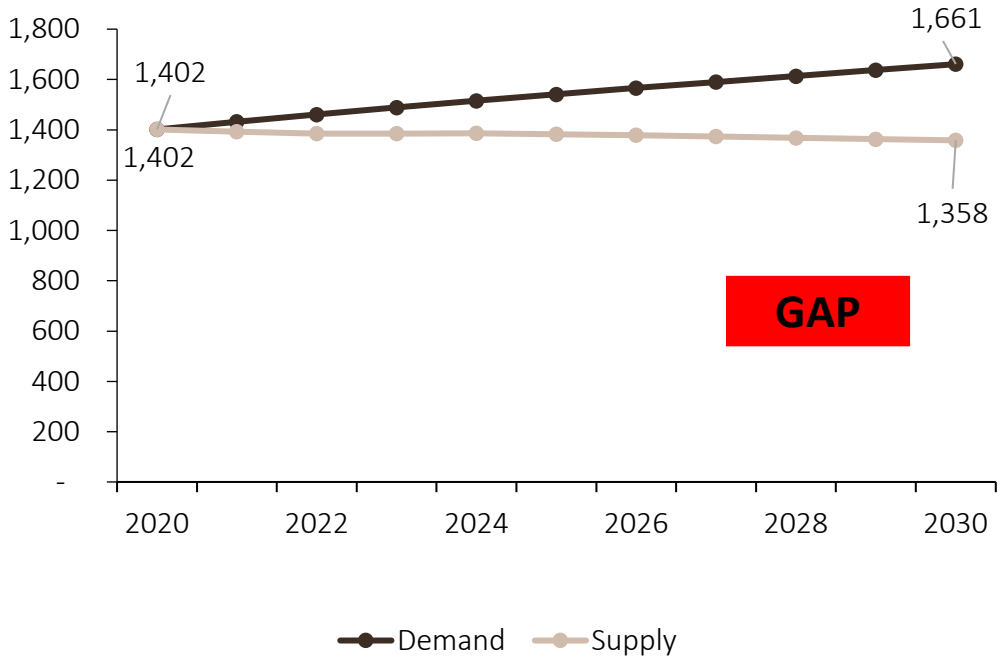
In 2021 there were 1,447 anaesthesiologists practising in Ontario, up 4.0% from 2020 (1,392) and up 22.7% from 2011 (1,179). (OPHRDC)

Age



In 2021, the average age of an anaesthesiologist in Ontario was 50.2 and 12.0% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030



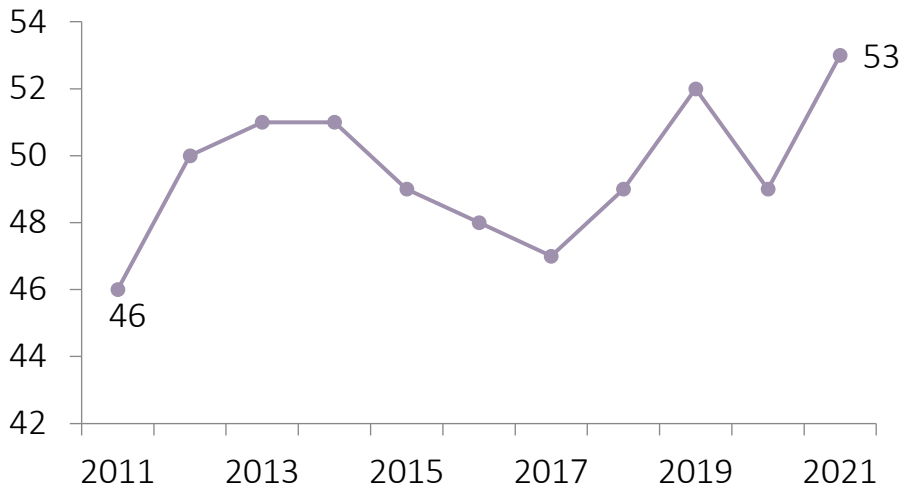
Our modelling is predicting a gap of over 300 anaesthesiologists by 2030, if nothing is done. This is primarily due to the high levels of PG attrition. (ADIN/UM)

Notes: Includes Anesthesiology and Pain Medicine

Ontario

Anaesthesia

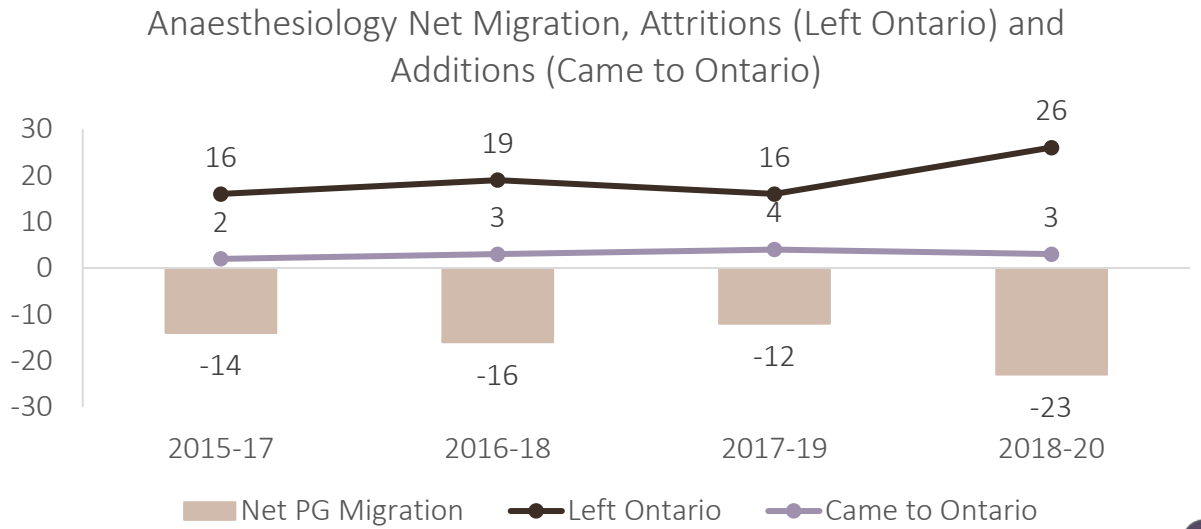
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 15.2% (from 46 to 53). (OPHRDC)

PG Migration

By examining the number of anaesthesiologists that exited Ontario training programs and their practice locations 2 years after exiting training between 2015-17, 2016-18, 2017-19 and 2018-20 and comparing that to the number of anaesthesiologists that didn't train in Ontario programs but were practicing in Ontario 2 years later we get a measure of PG migration. On average over the years mentioned above, Ontario lost 16 anaesthesiologists per year which is very high. (CAPER)



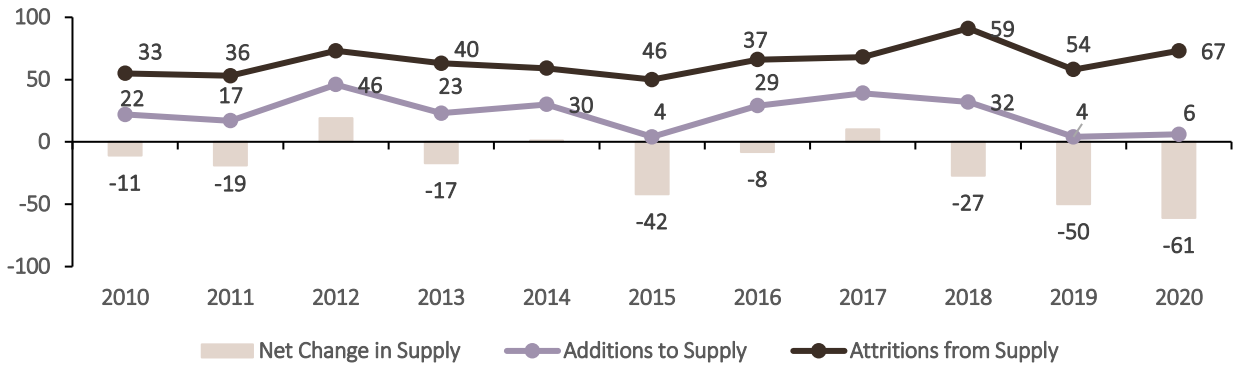
Anaesthesia

In Practice Attrition

From 2010 to 2020, attrition has outpaced additions to anaesthesiology supply.

- Between 2010 and 2020, the number of attritions increased by 103.2% (from 33 to 67).
- Between 2019 and 2020, the number of attritions increased by 24% (from 54 to 67). Between 2017 and 2018 there was a significant increase in attrition, 131% from 29 to 67.
- In 2020, attrition was 4.8% of the 2019 supply. In 2010, the attrition was 2.8% of the 2009 supply. (OPHRDC)

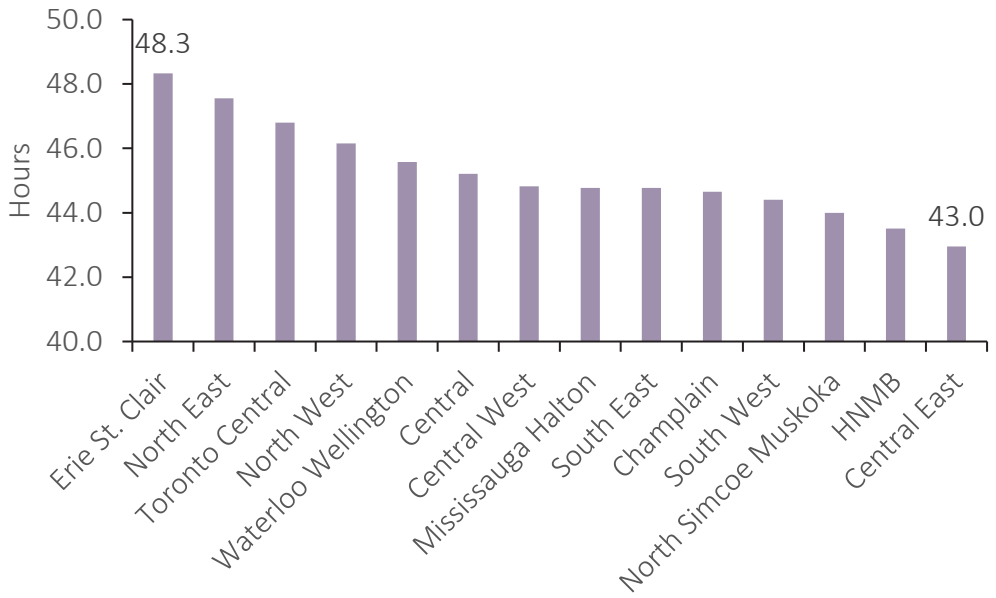
Annual Additions, Attritions, and Net Change in ON Anesthesiology Supply, 2010-2020



Hours in Practice

The average hours worked per week by an anesthesiologists is 44.5 hours. Most anesthesiologists (79.1%) work between 31 to 50 hours per week. Anesthesiologists in the Erie St. Clair LHIN worked the highest average hours in practice per week (48.3). (OPHRDC)

Average Hours Per Week Per LHIN, 2020



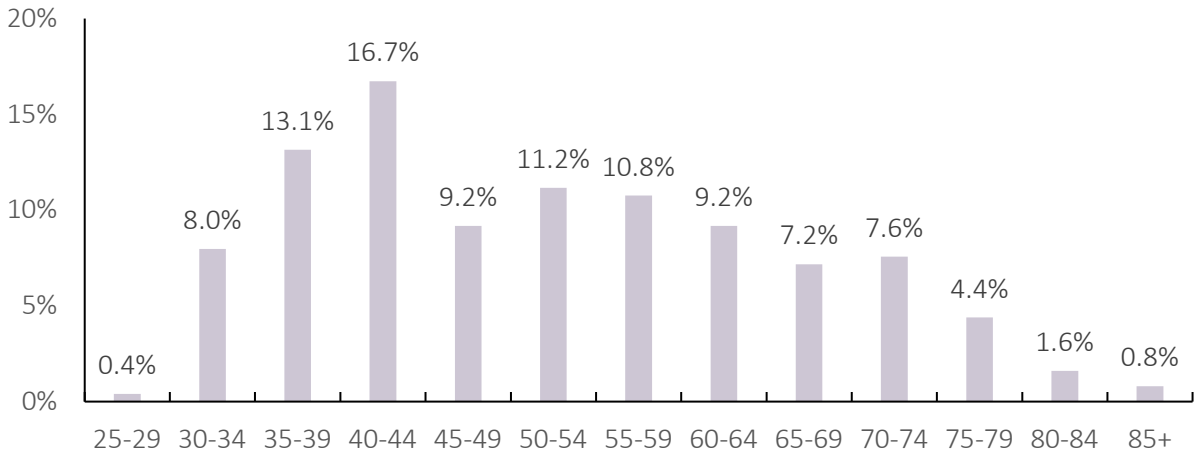
Ontario

Dermatology

Supply

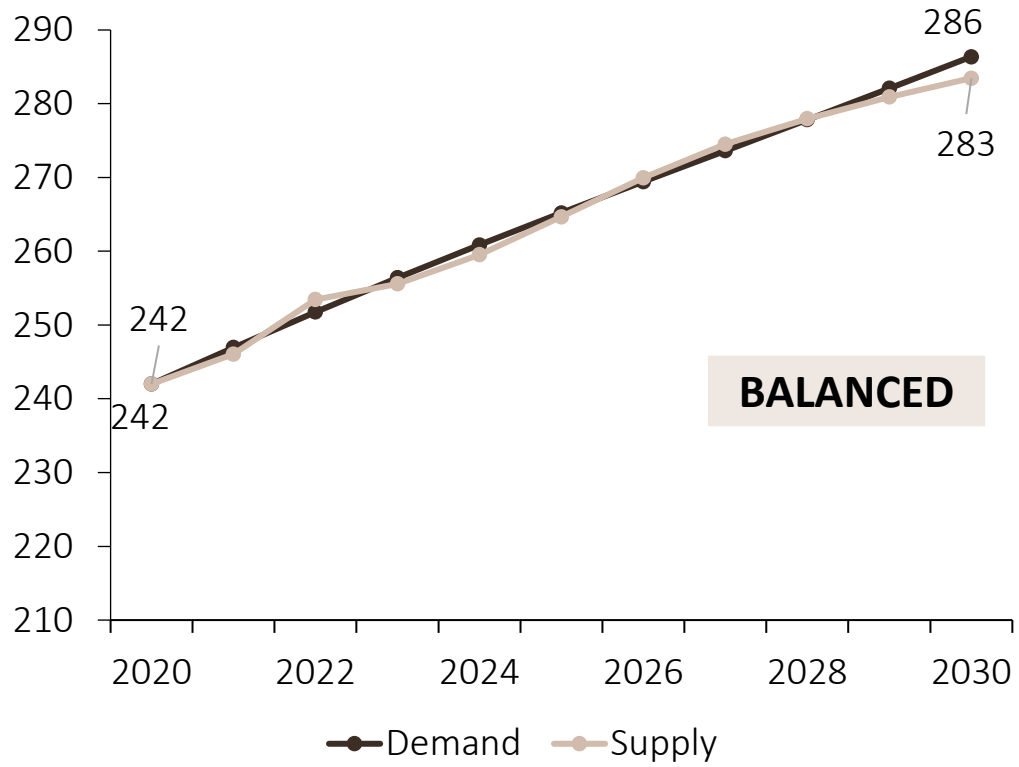
In 2021 there were 251 dermatologists practising in Ontario, up 3.7% from 2020 (242) and up 29.4% from 2011 (194). (OPHRDC)

Age



In 2020, the average age of a dermatologist in Ontario was 52.0 and 14.8% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

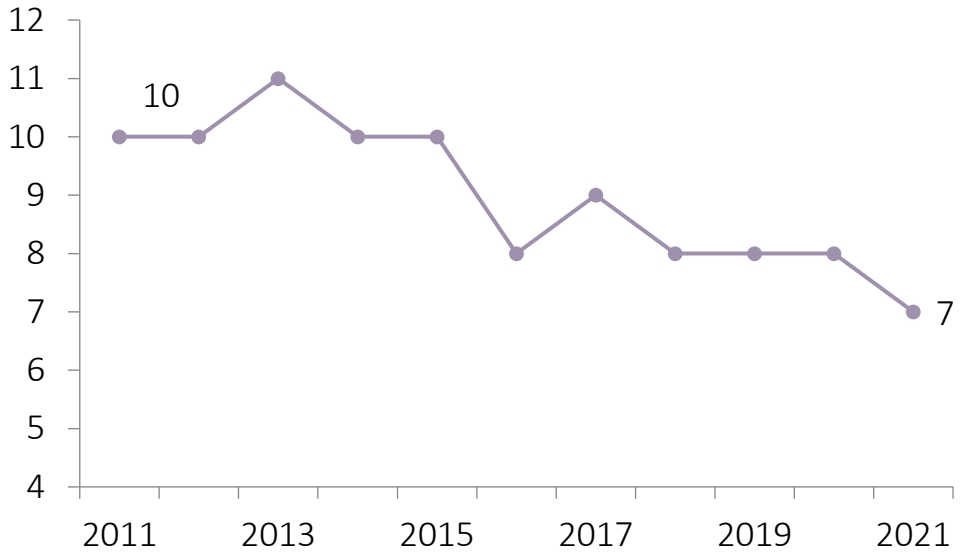


Our modelling predicts supply and demand to be well balanced. (ADIN/UM)

Ontario

Dermatology

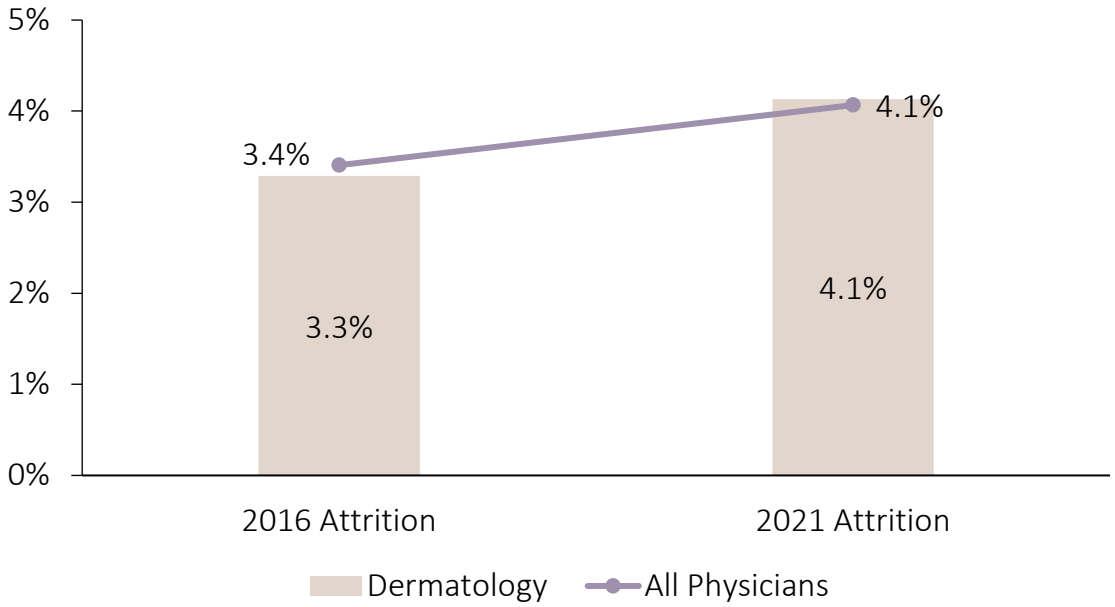
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 30.0% (from 10 to 7). (OPHRDC)

In Practice Attrition

In 2021 the attrition rate for dermatologists matched the average attrition rate of all physicians, while in 2016 it was slightly below. (OPHRDC)



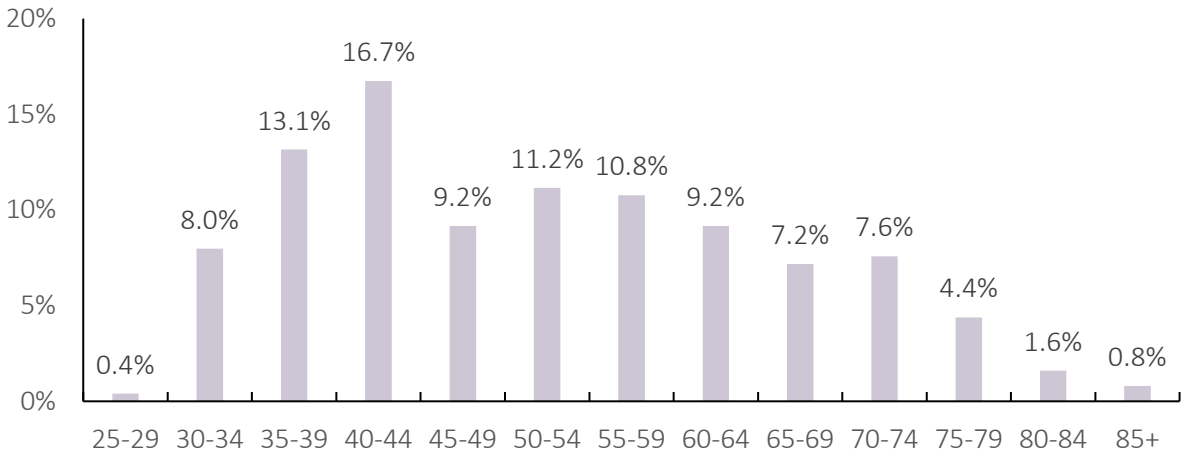
Ontario

Diagnostic Radiology

Supply

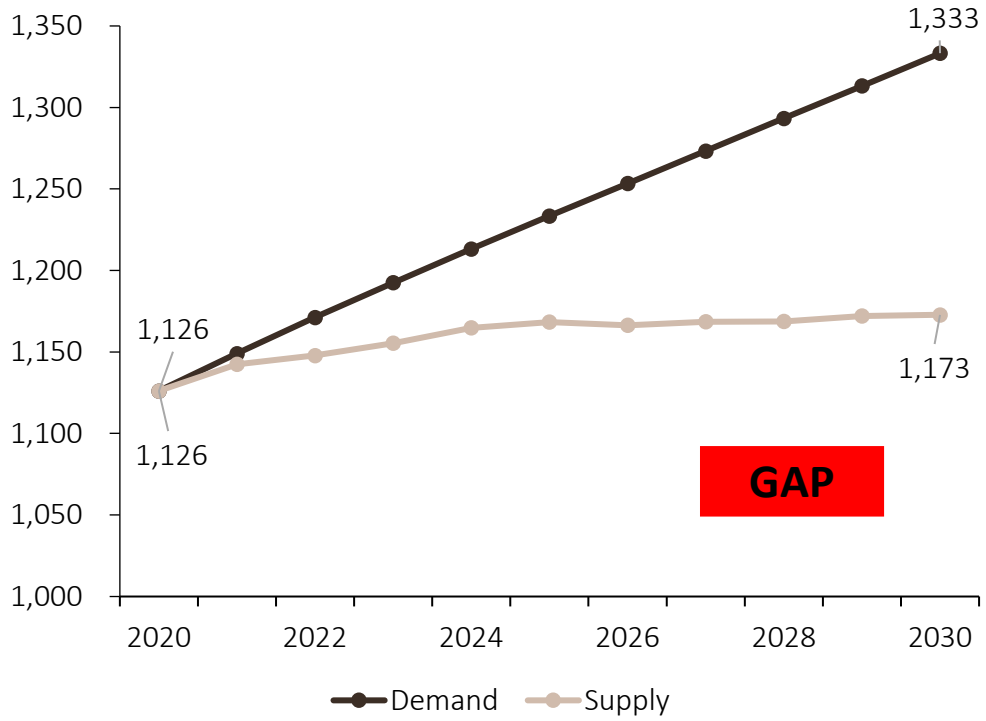
In 2021 there were 1,141 diagnostic radiologists practising in Ontario, this is up 2.6% from 2020 (1,112) and 22.4% from 2011 (932). (OPHRDC)

Age



In 2021, the average age of a diagnostic radiology in Ontario was 51.3 and 12.3% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030



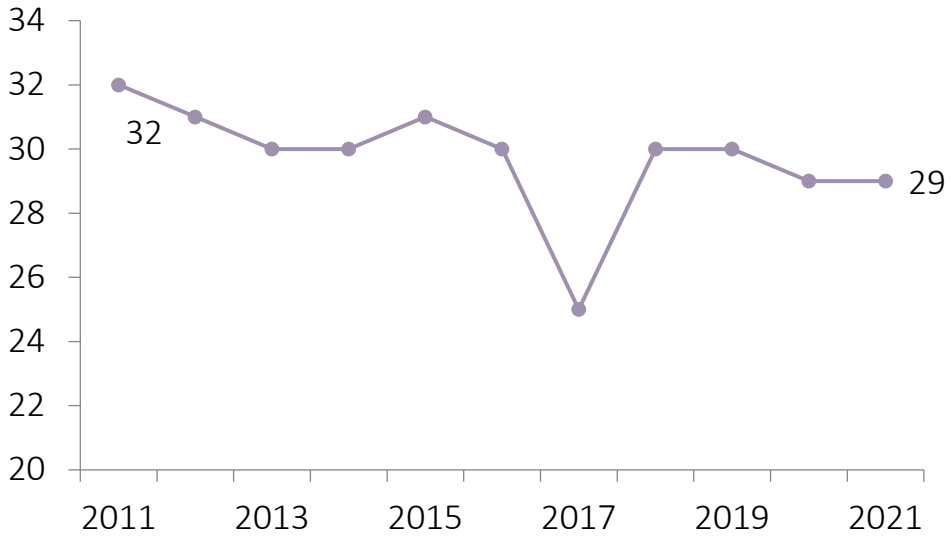
Our modelling is predicting a gap of 160 diagnostic radiologists by 2030, if nothing is done. (ADIN/UM)

Notes: Includes Diagnostic Radiology, Radiology – Pediatric, and Neuroradiology

Ontario

Diagnostic Radiology

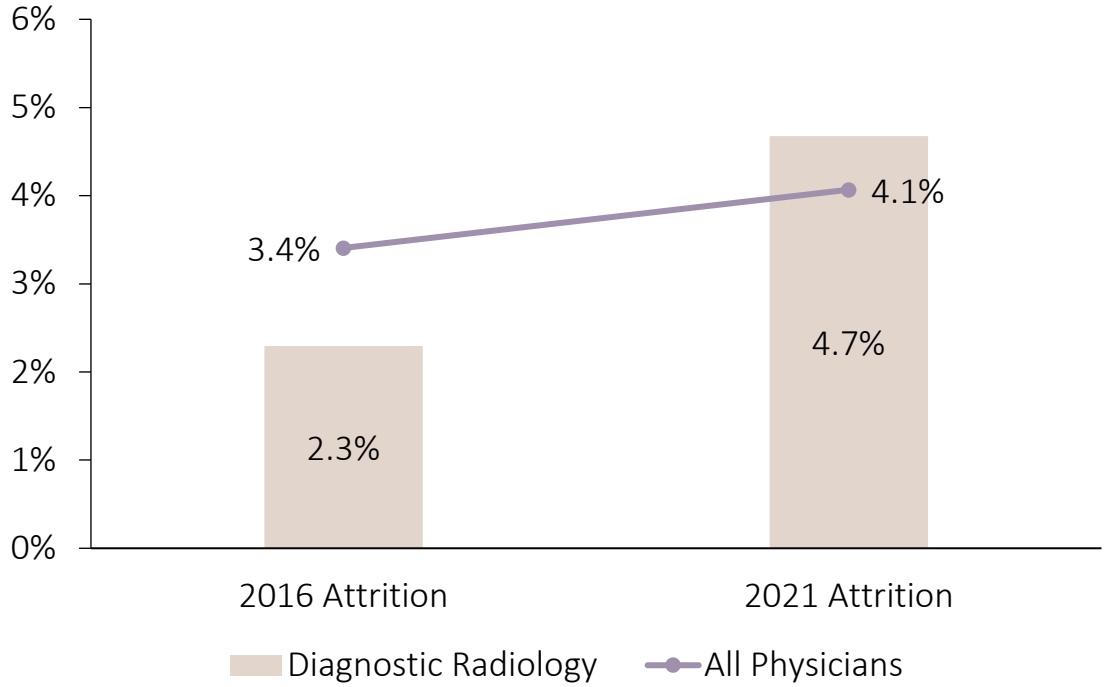
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 9.4% (from 32 to 29). (OPHRDC)

In Practice Attrition

In 2021 the attrition rate for diagnostic radiologists was higher than the average physician, this was not the case in 2016.(OPHRDC)



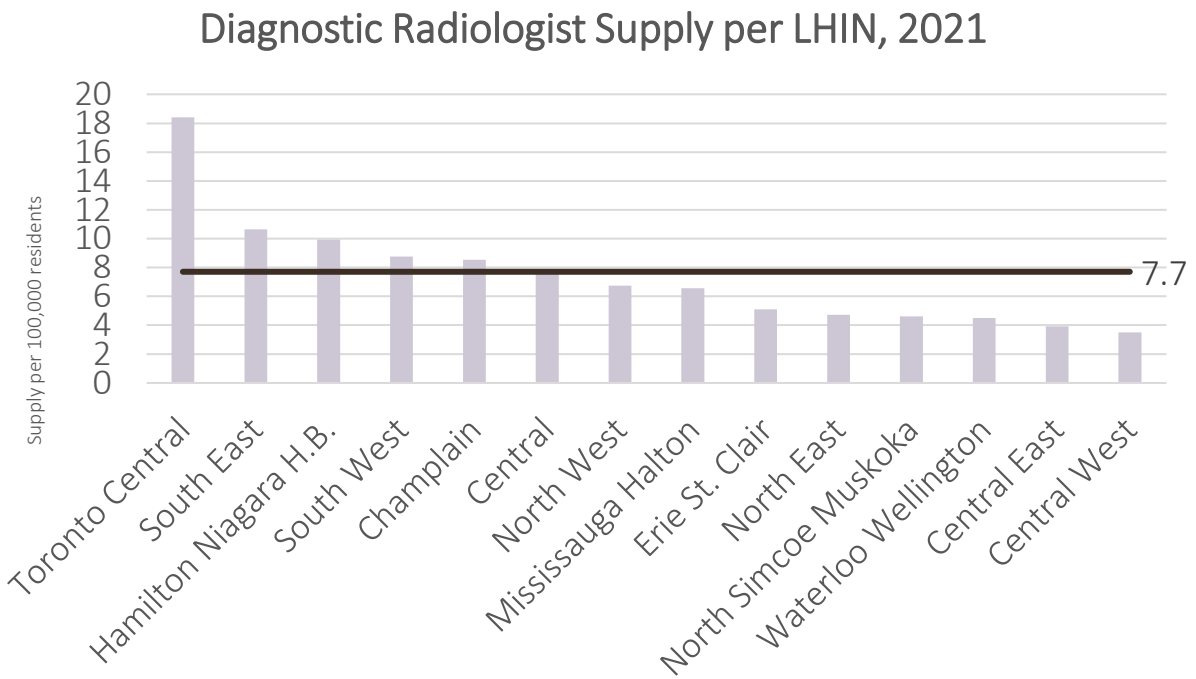
Ontario

Diagnostic Radiology

Distribution

In 2021, there were 1,141 diagnostic radiologists practising in Ontario; up 2.6% from 2020 (1,112) and 8.9% from 2016 (1,042)

Ontario had 7.7 diagnostic radiologists per 100,000 population, with high variation across LHINs. (OPHRDC)



Ontario

Emergency Medicine

Emergency Department Coverage

Ontario is experiencing service disruptions in emergency departments. The primary reason for HHR related disruptions was lack of nursing staff (80% of service disruptions were reported to be a nursing issue), however lack of physician staffing is also a key issue.

What types of hospitals are experiencing ED service disruptions?

72% of hospitals who experienced a service disruption were small hospitals, 9% were medium sized hospitals, and 19% were teaching or large community hospitals.

What Types of Physicians Staff Emergency Departments?

Based on a 2015 survey from HealthForceOntario Marketing and Recruitment Agency (HFO MRA):

- **Emergency Medicine Physicians (RCPSC):** 83% work in academic centres, 5% work in large high-volume community hospitals, Remaining 12% work across all remaining hospital categories, irrespective of size or volume.
- **Family Medicine-Emergency Medicine Physicians (CFPC):** 48% work in large high volume community hospitals, 21% work in academic centres, 6% work in sites with less than 20,000 visits per year
- **Family Physicians with No Formal EM Training (CFPC):** Covering northern, rural, small, low-volume ED sites

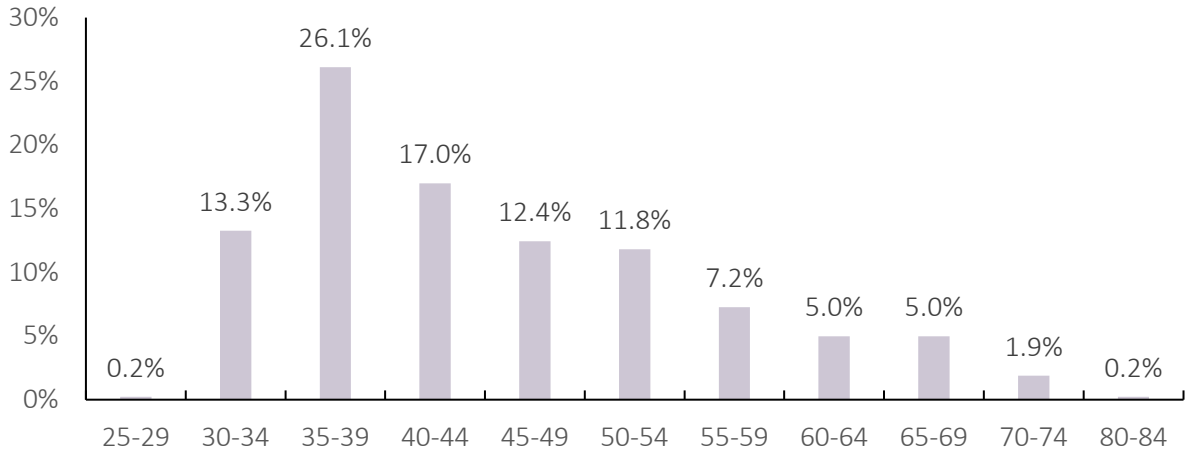
Based on the above the focus should be on training family physicians interested in providing ED coverage in northern, rural and small, low-volume ED sits.

Emergency Medicine (RCPSC)

Supply

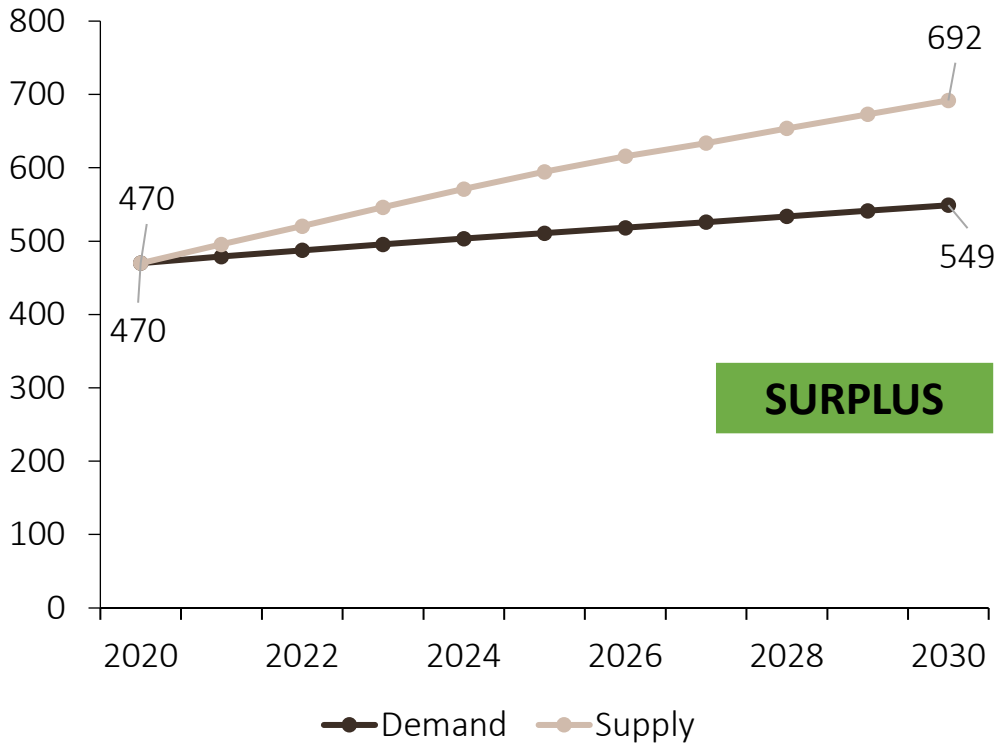
In 2021 there were 483 EM physicians practising in Ontario, this is up 2.8% from 2020 (470) and 102.9% from 2011 (238). (OPHRDC)

Age



In 2021, the average age of a EM physician in Ontario was 45.3 and only 6.9% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

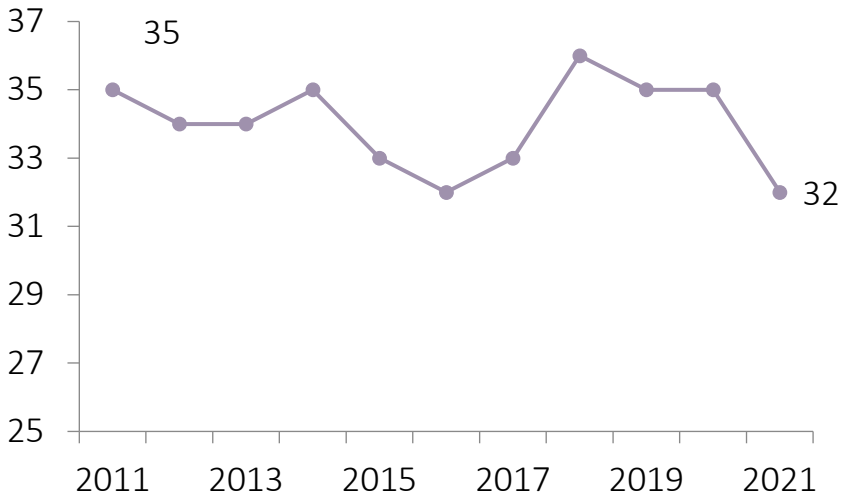


Supply is projected to significantly outpace demand throughout the projection period. (ADIN/UM)

Ontario

Emergency Medicine (RCPSC)

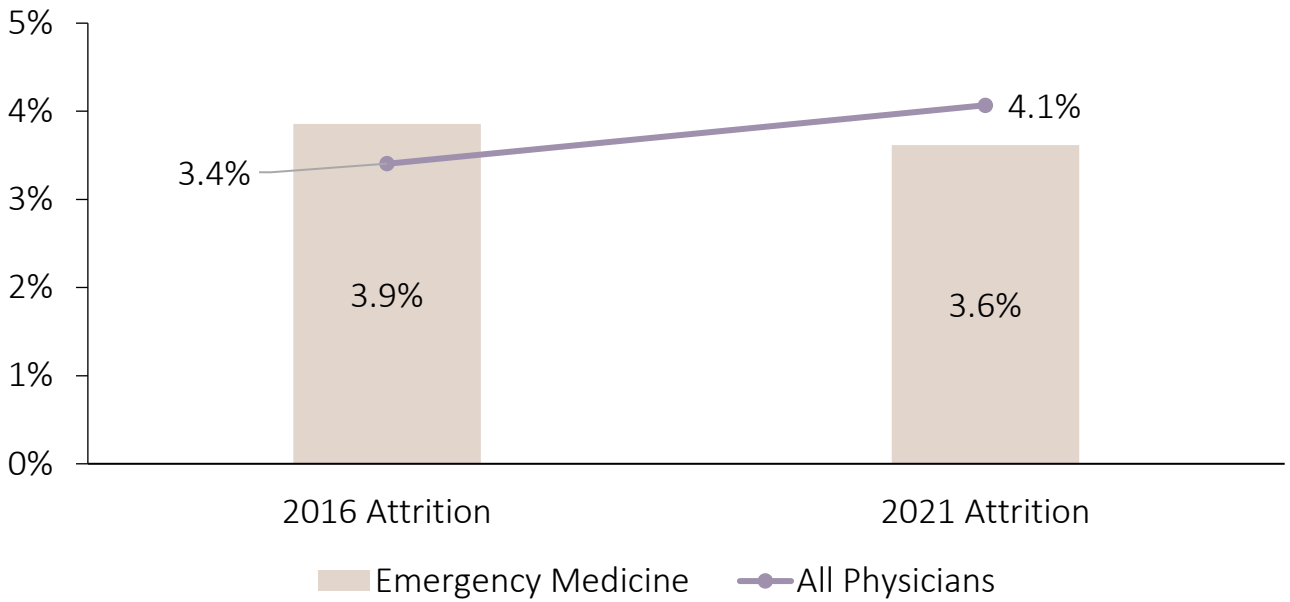
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 8.6% (from 34 to 32). (OPHRDC)

In Practice Attrition

In 2021, the attrition rate for emergency medicine physicians was lower than the average attrition rate for all physicians. The opposite trend was seen in 2016. (OPHRDC)



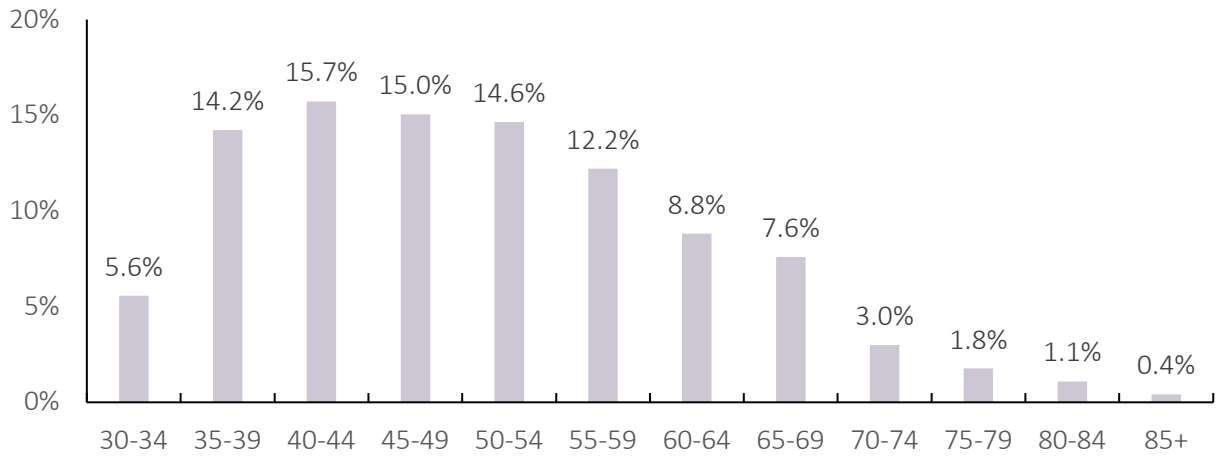
Ontario

General Surgery

Supply

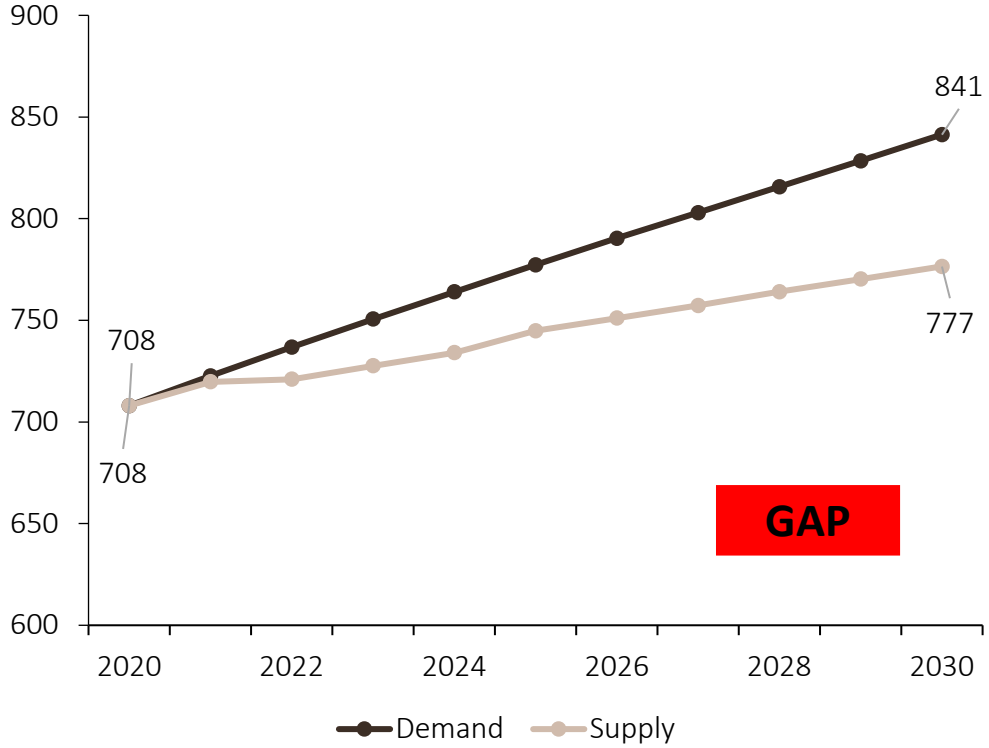
In 2021 there were 738 general surgeons practising in Ontario, up 4.2% from 2020 (708) and up 23.4% from 2011 (598). (OPHRDC)

Age



In 2021, the average age of a general surgeon in Ontario was 50.5 and 10.6% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

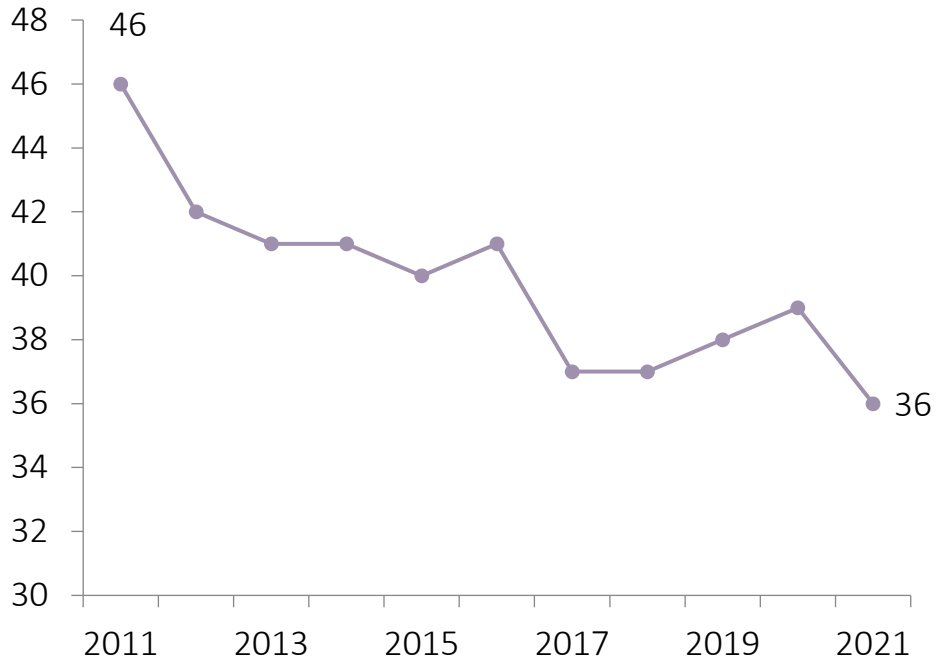


Our modelling is predicting a gap of 64 general surgeons by 2030, if nothing is done.(ADIN/UM)

Ontario

General Surgery

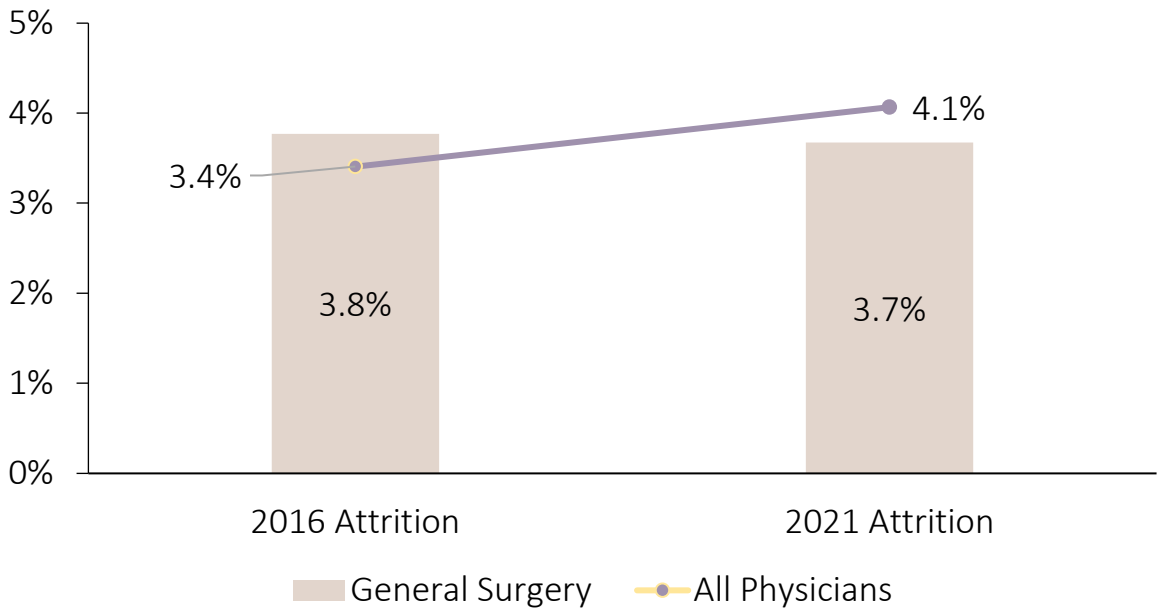
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 21.7% (from 46 to 36). (OPHRDC)

In Practice Attrition

In 2021 general surgeons had a lower than average attrition rate, while the opposite trend was seen in 2016. (OPHRDC)



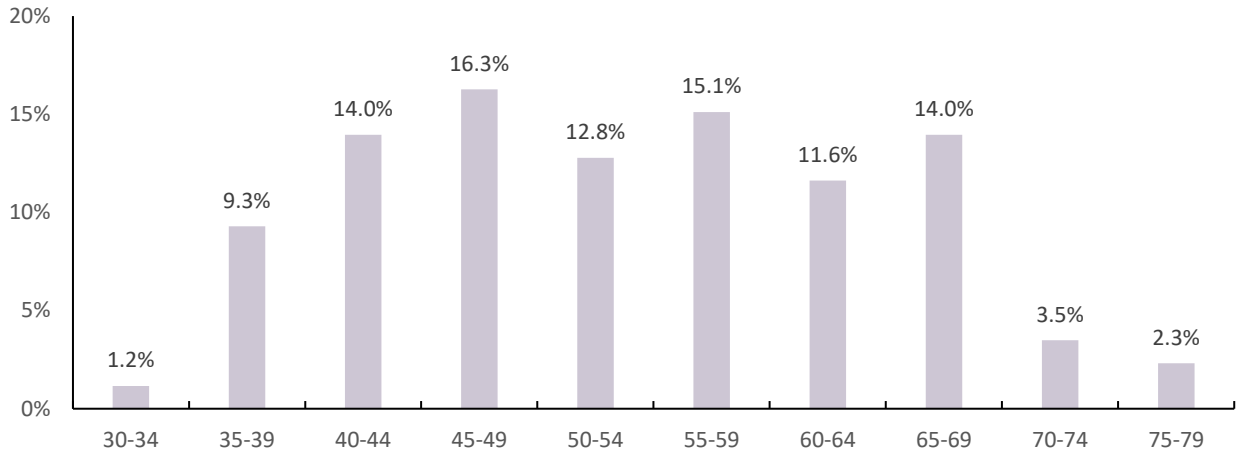
Ontario

Cardiac Surgery

Supply

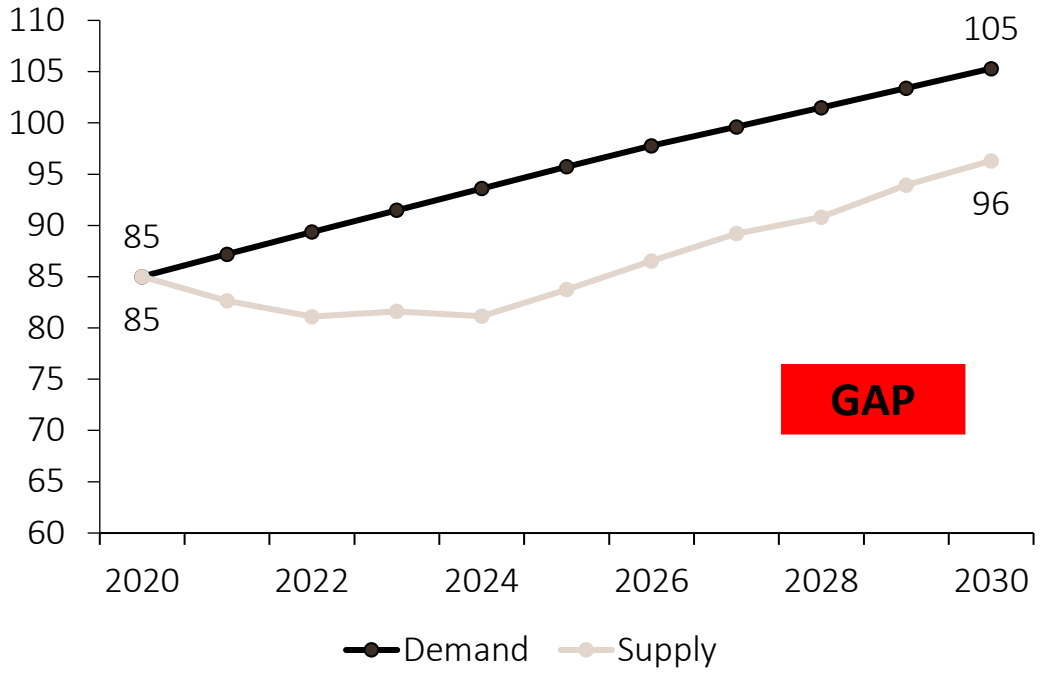
In 2021 there were 86 practising in Ontario, up 1.2% from 2020 (85) and down 3.4% from 2011 (89). (OPHRDC)

Age



In 2021, the average age of a cardiac surgeon in Ontario was 53.7 and 17.5% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

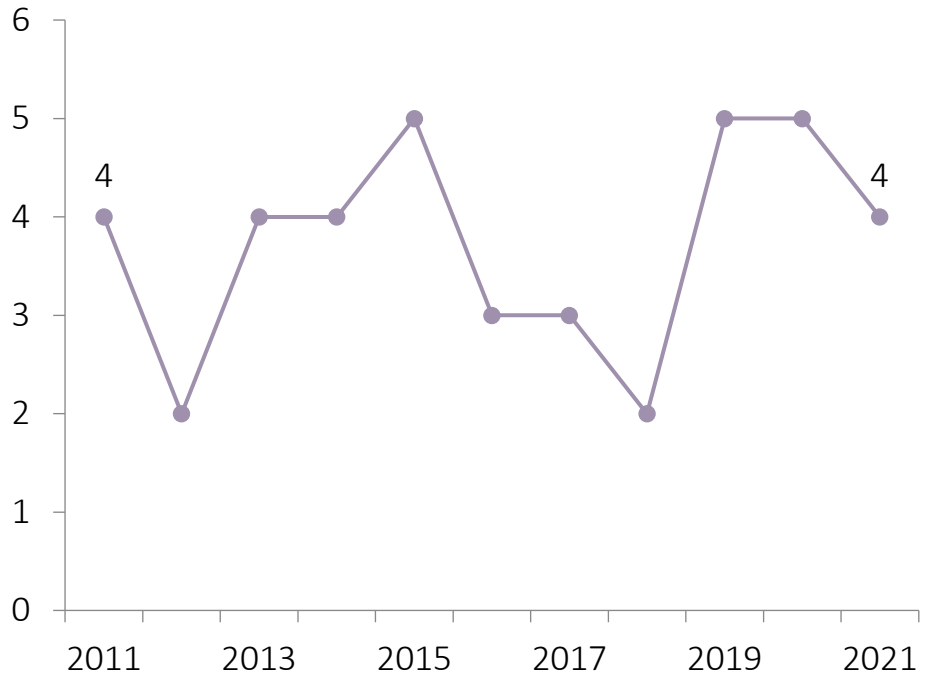


Our modelling is predicting a gap by 2030, with demand outpacing supply. (ADIN/UM)

Ontario

Cardiac Surgery

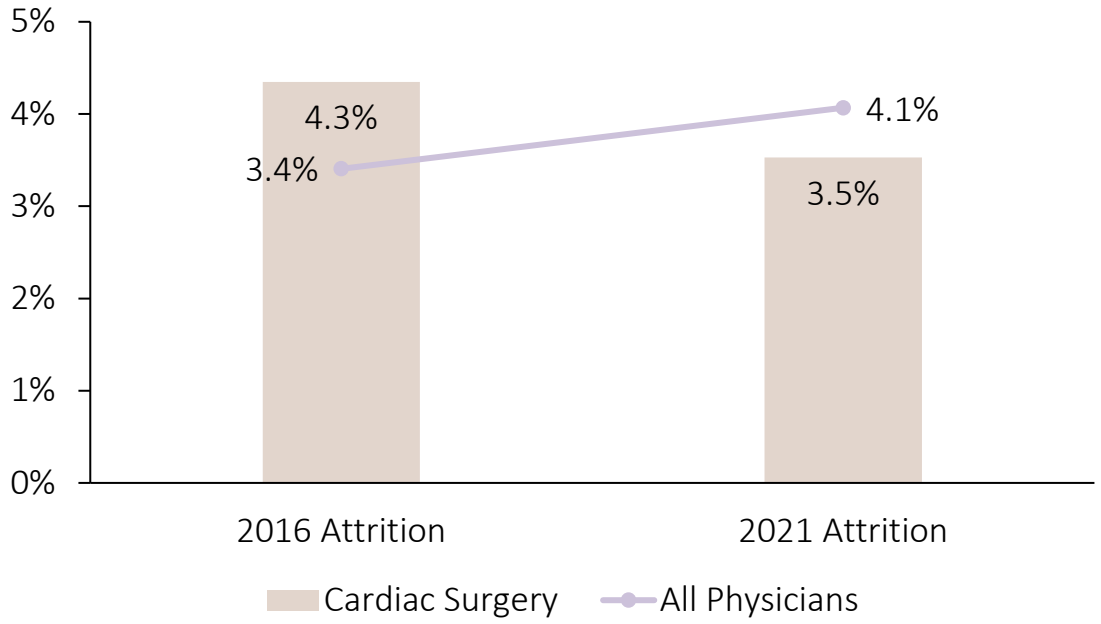
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 0% (from 4 to 4). (OPHRDC)

In Practice Attrition

In 2021, the attrition rate of cardiac surgeons was lower than that of all physicians, while the opposite trend was seen in 2016. (OPHRDC)



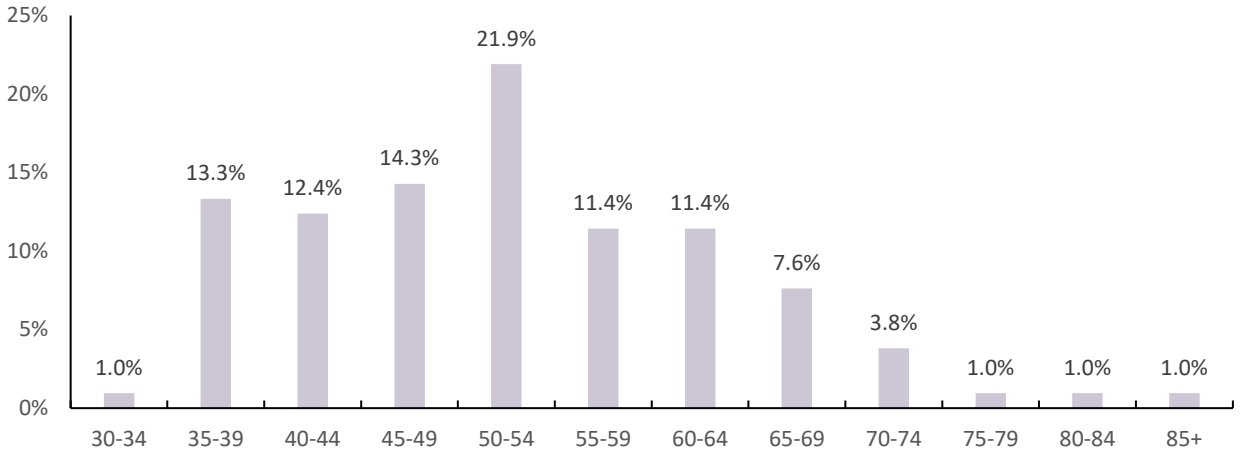
Ontario

Neurosurgery

Supply

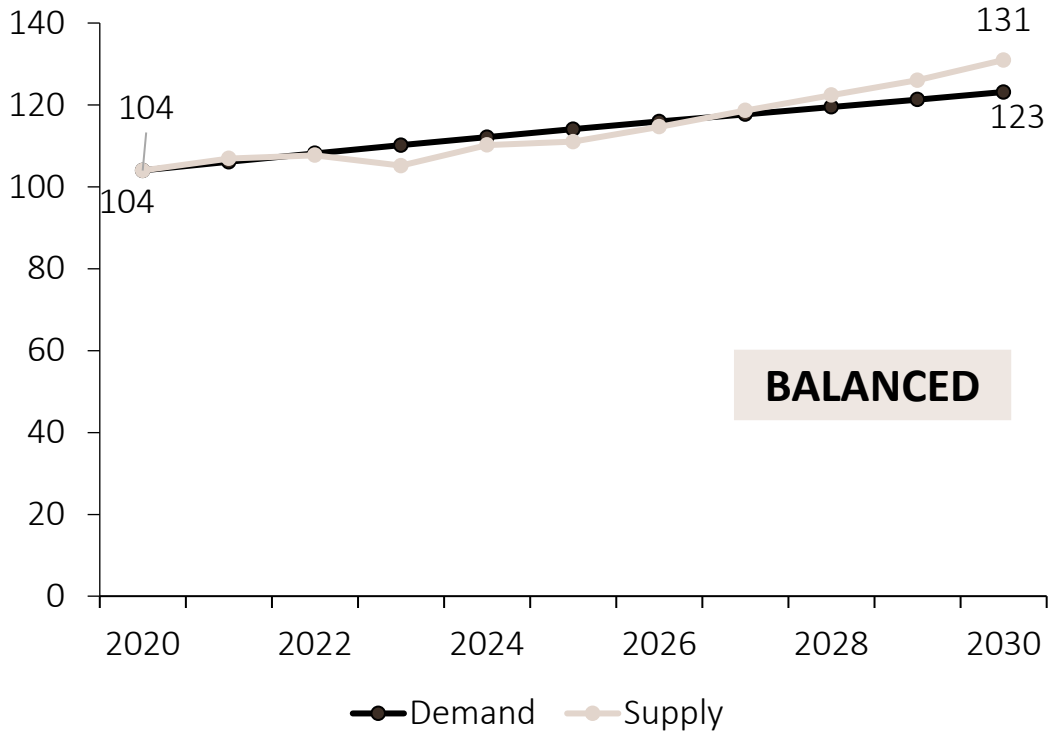
In 2021 there were 105 neurosurgeons practising in Ontario, up 1.0% from 2020 (104) and up 14.1% from 2011 (92). (OPHRDC)

Age



In 2021, the average age of an neurosurgeon in Ontario was 52.3 and 11.4% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

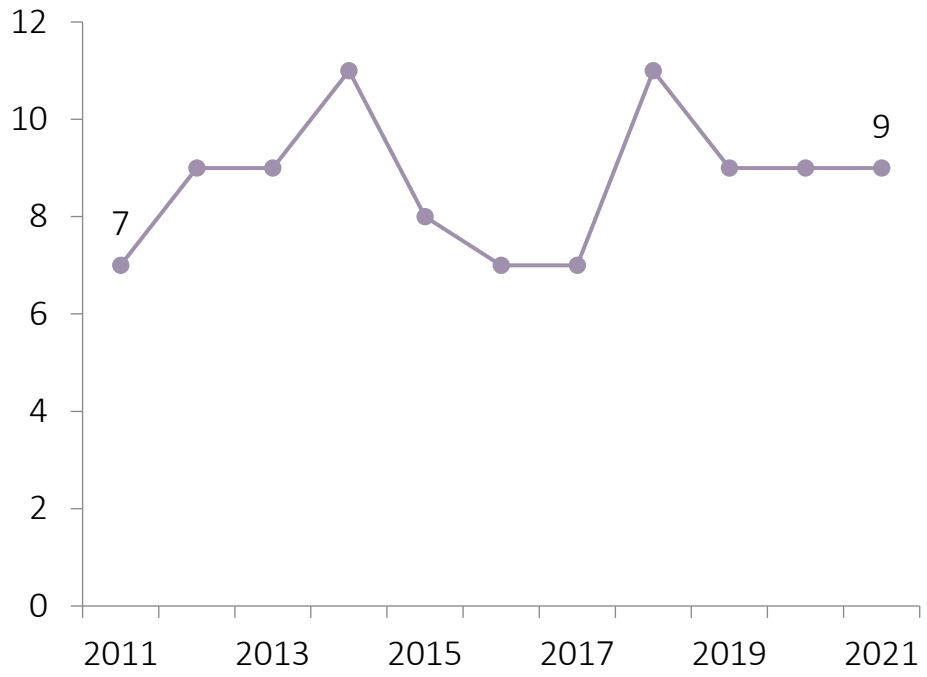


Our modelling predicts supply and demand to be balanced throughout the projection period. (ADIN/UM)

Ontario

Neurosurgery

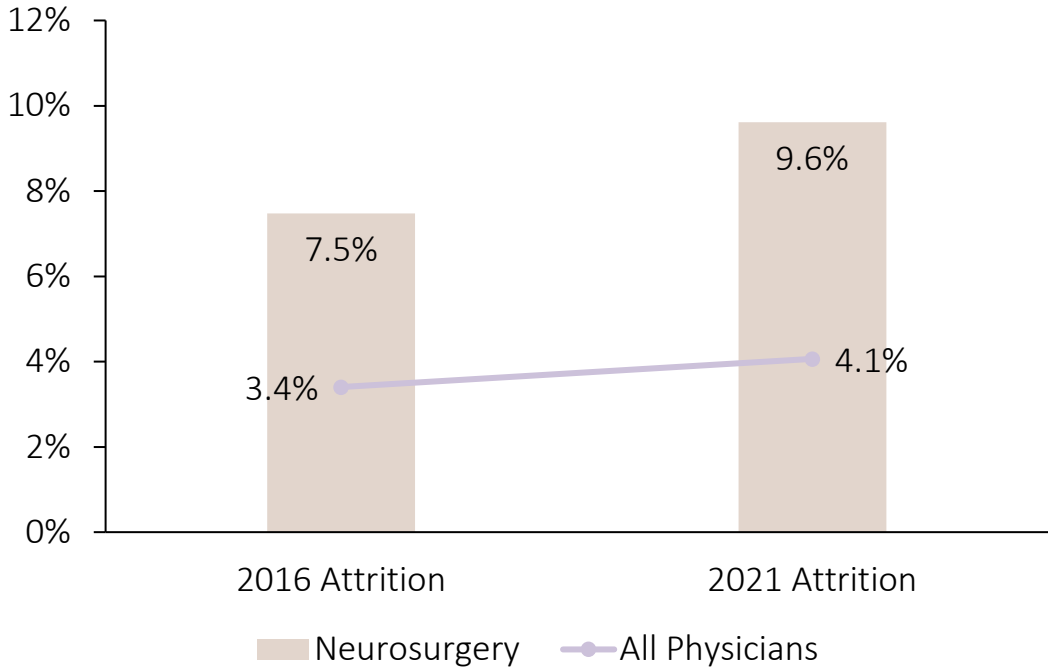
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 28.6% (from 7 to 9). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, the attrition rate of neurosurgeons was higher than that of all physicians. (OPHRDC)



Ontario

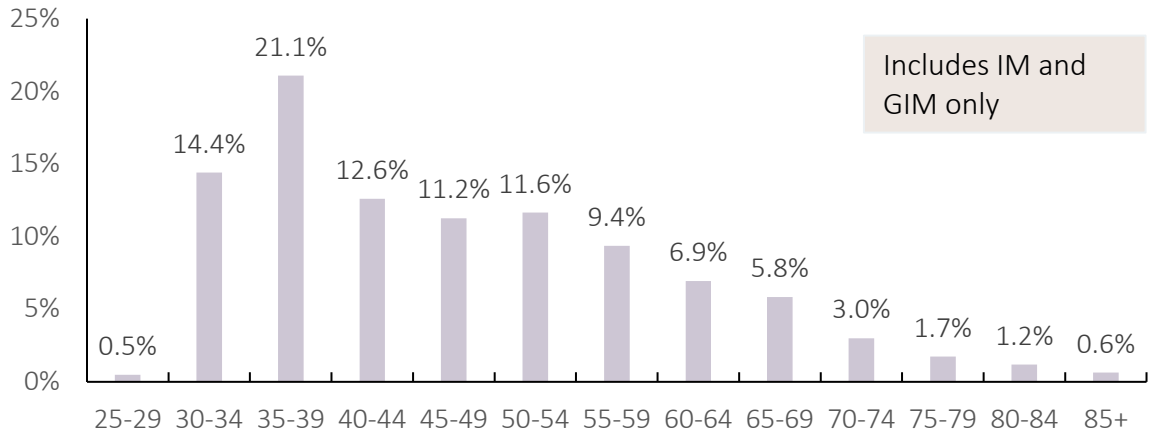
Internal Medicine

Supply

In 2021 there were 1,272 internists practising in Ontario, up 7.8% from 2020 (1,180) and up 93.6% from 2010 (657). (OPHRDC)

Includes IM and GIM only

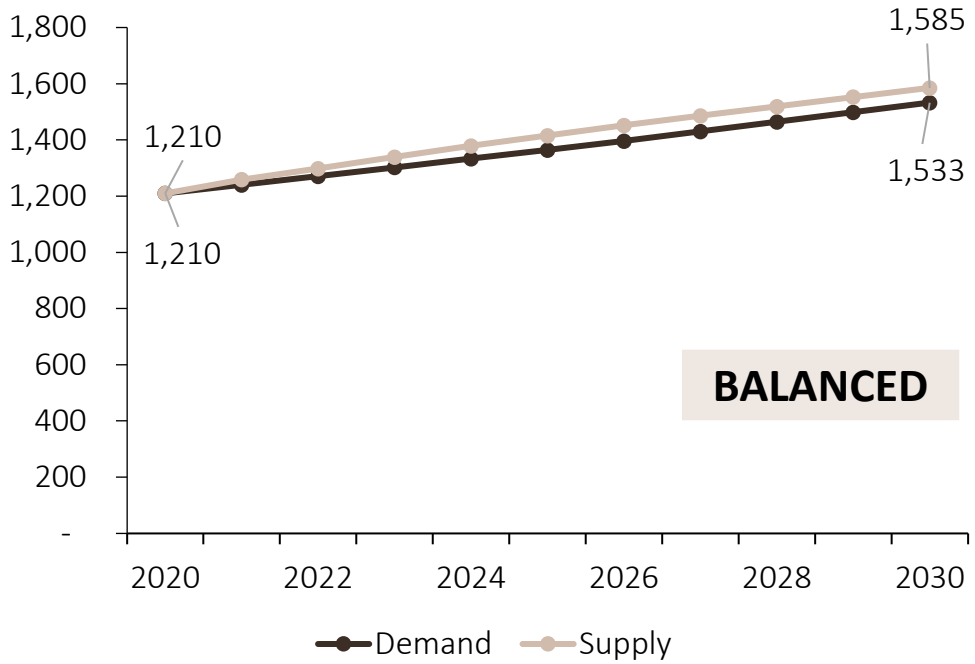
Age



Includes IM and GIM only

In 2020, the average age of an internist in Ontario was 47.7 and 8.8% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030



BALANCED

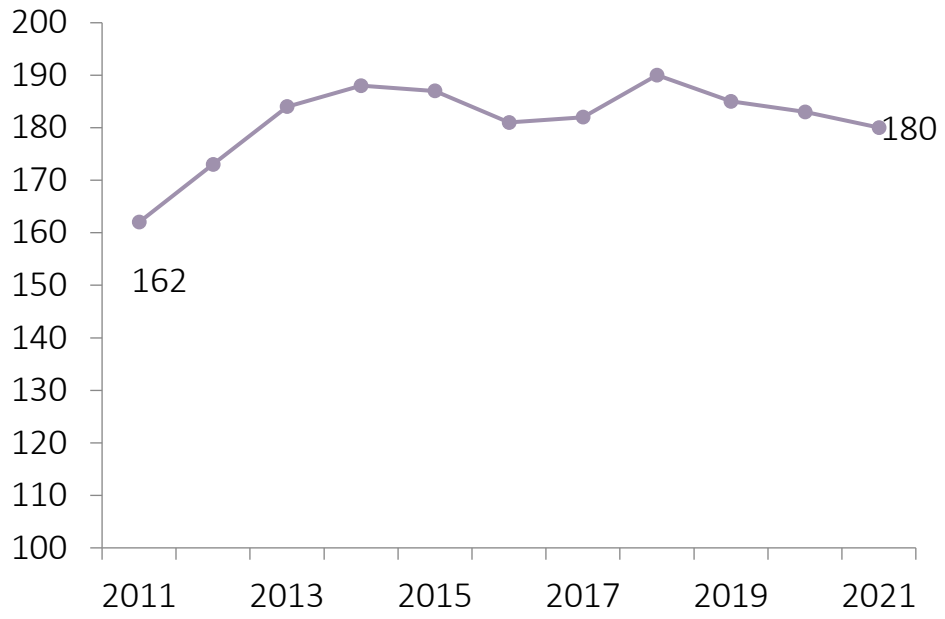
*Includes IM, GIM, Clinical Pharmacology & Toxicology, Occupational Medicine, Palliative Medicine

Our modelling predicts supply and demand to be balanced throughout the projection period. (ADIN/UM)

Ontario

Internal Medicine

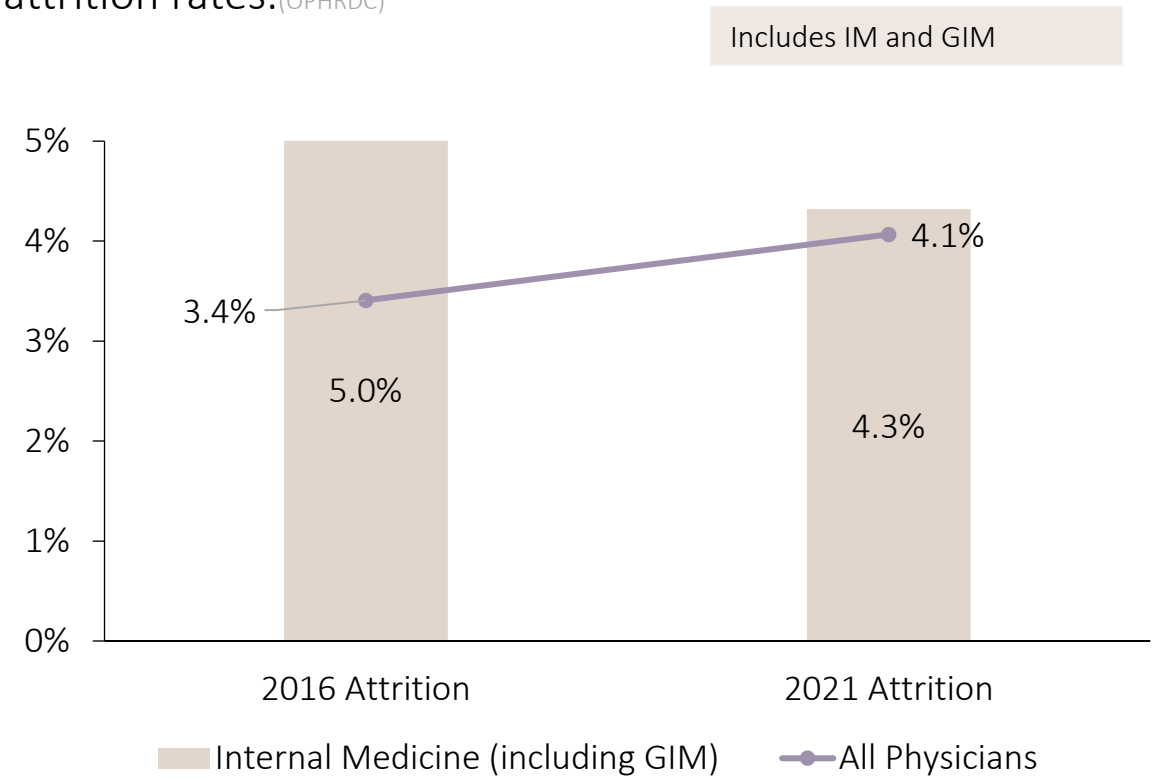
PGY1s



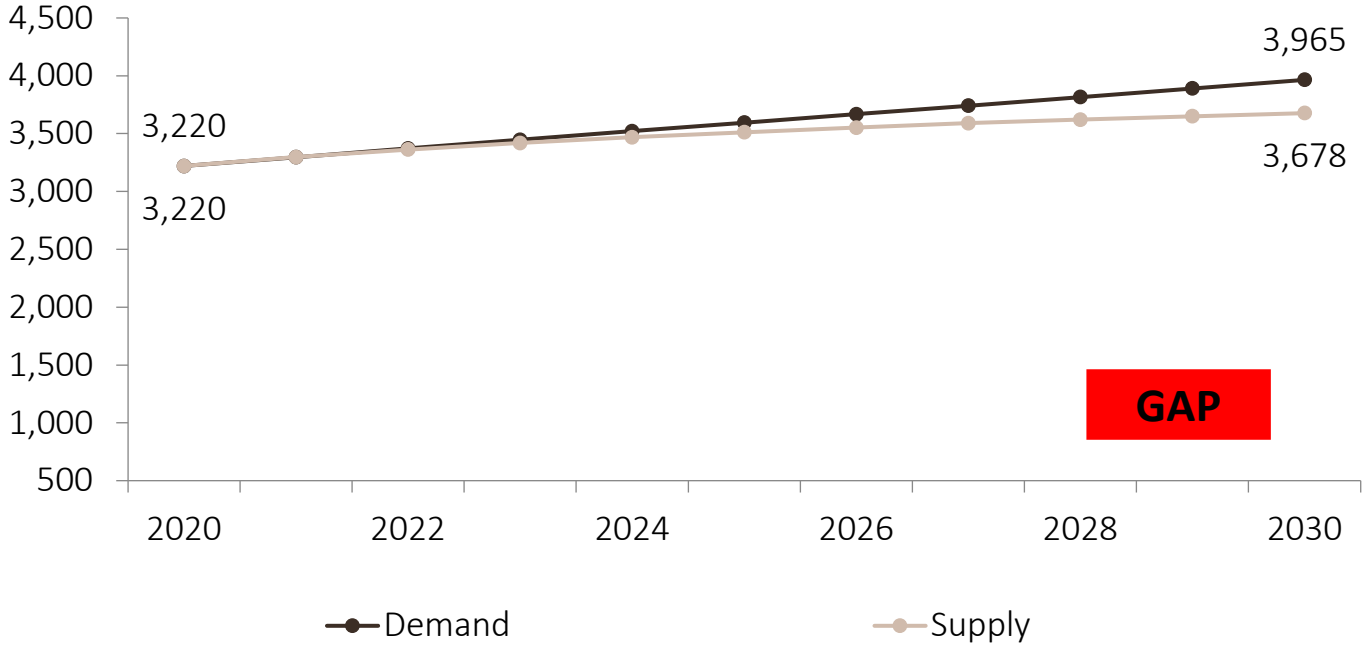
Between 2011 and 2021, the number of PGY1s increased by 11.1% (from 162 to 180). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, internists had higher than average attrition rates.(OPHRDC)



Internal Medicine: Subspecialties



In 2021 there were 3,335 IM specialists practising in Ontario, up 3.6% from 2020 (3,220) and up 33.2% from 2011 (2,503). (OPHRDC)

In 2021, the average age of an IM specialist was 49.6 and 12.0% were between the ages of 65 and 74. (OPHRDC)

Our modelling predicts demand to outpace supply. (ADIN/UM)

*Includes the following IM subspecialties: Cardiology, Clinical Immunology & Allergy, Critical Care Medicine, Endocrinology & Metabolism, Gastroenterology, Geriatric Medicine, Haematology, Infectious Diseases, Medical Oncology, Nephrology, Respirology, and Rheumatology.

Ontario

Internal Medicine: Larger Subspecialties

Cardiology

Supply (2021)	720 up 24.1% from 2011 (580)
Average Age (2021)	52.4
% Between 65 & 74 (2021)	16.9%
Modelling (2020 to 2030)	ADIN: Undersupply

Gastroenterology

Supply (2021)	346 up 15.3% from 2011 (300)
Average Age (2021)	50.3
% Between 65 & 74 (2021)	12.4%
Modelling (2020 to 2030)	ADIN/UM: Balanced until 2025 then undersupply

Respirology

Supply (2021)	333 up 34.3% from 2011 (248)
Average Age (2021)	48.7
% Between 65 & 74 (2021)	10.8%
Modelling (2020 to 2030)	ADIN: Undersupply

Medical Oncology

Supply (2021)	293 up 32.0% from 2011 (222)
Average Age (2021)	48.9
% Between 65 & 74 (2021)	11.3%
Modelling (2020 to 2030)	ADIN: Oversupply

Internal Medicine: Larger Subspecialties

Nephrology

Supply (2021)	268 up 23.5% from 2011 (217)
Average Age (2021)	50.0
% Between 65 & 74 (2021)	9.0%
Modelling (2020 to 2030)	ADIN/UM: Balanced

Endocrinology & Metabolism

Supply (2021)	289 up 60.6% from 2011 (180)
Average Age (2021)	48.7
% Between 65 & 74 (2021)	12.8%
Modelling (2020 to 2030)	Oversupply

Rheumatology

Supply (2021)	242 up 37.5% from 2011 (176)
Average Age (2021)	49.6
% Between 65 & 74 (2021)	15.3%
Modelling (2020 to 2030)	ADIN/UM: Oversupply

Hematology

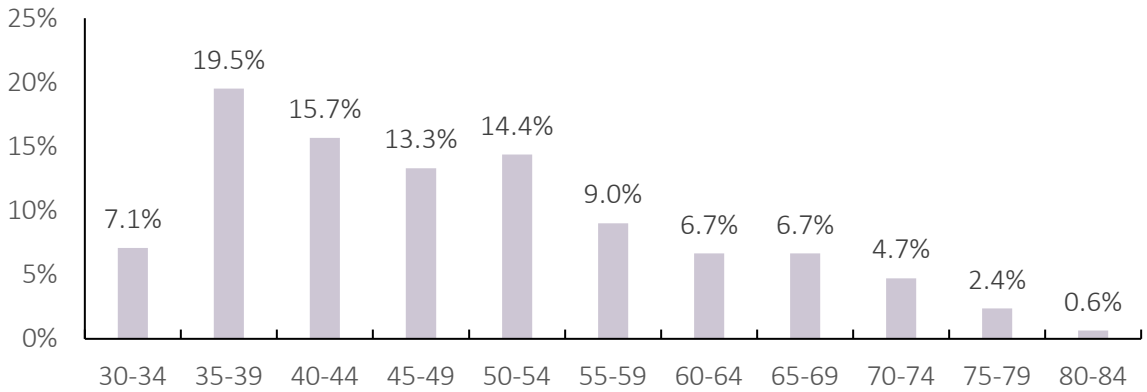
Supply (2021)	240 up 42.9% from 2011 (168)
Average Age (2021)	49.4
% Between 65 & 74 (2021)	9.6%
Modelling (2020 to 2030)	Oversupply

Neurology

Supply

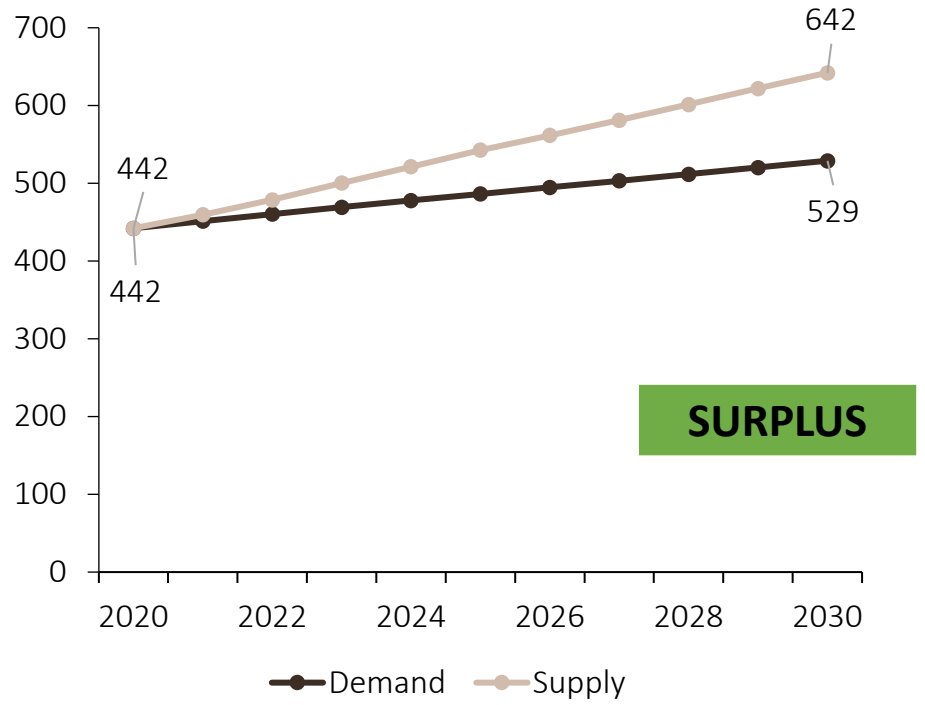
In 2021 there were 466 neurologists practising in Ontario, up 5.4% from 2020 (442) and up 61.2% from 2010 (289). (OPHRDC)

Age



In 2021, the average age of a neurologist in Ontario was 49.2 and 11.4% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

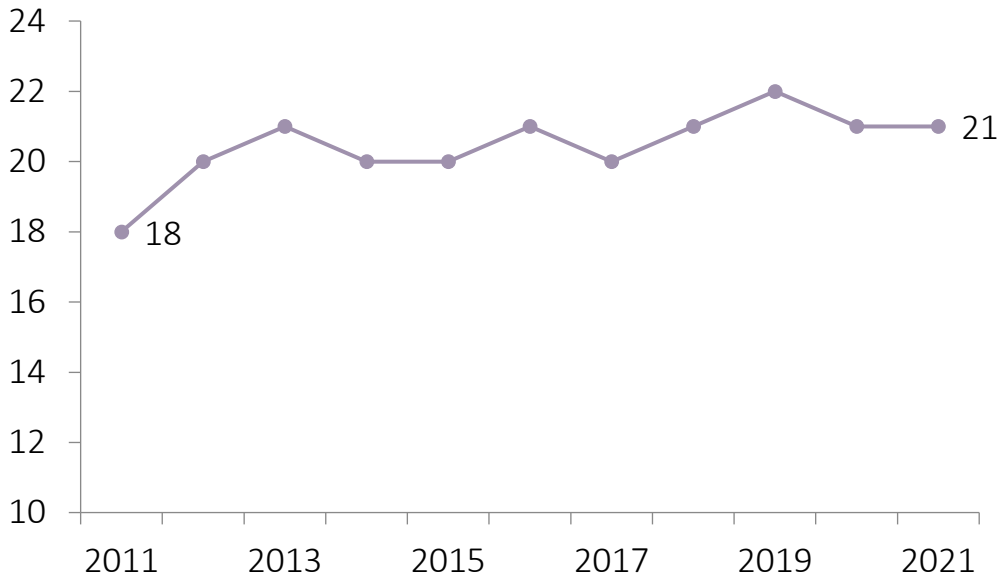


Supply is outpacing demand throughout the projection period. (ADIN/UM)

Ontario

Neurology

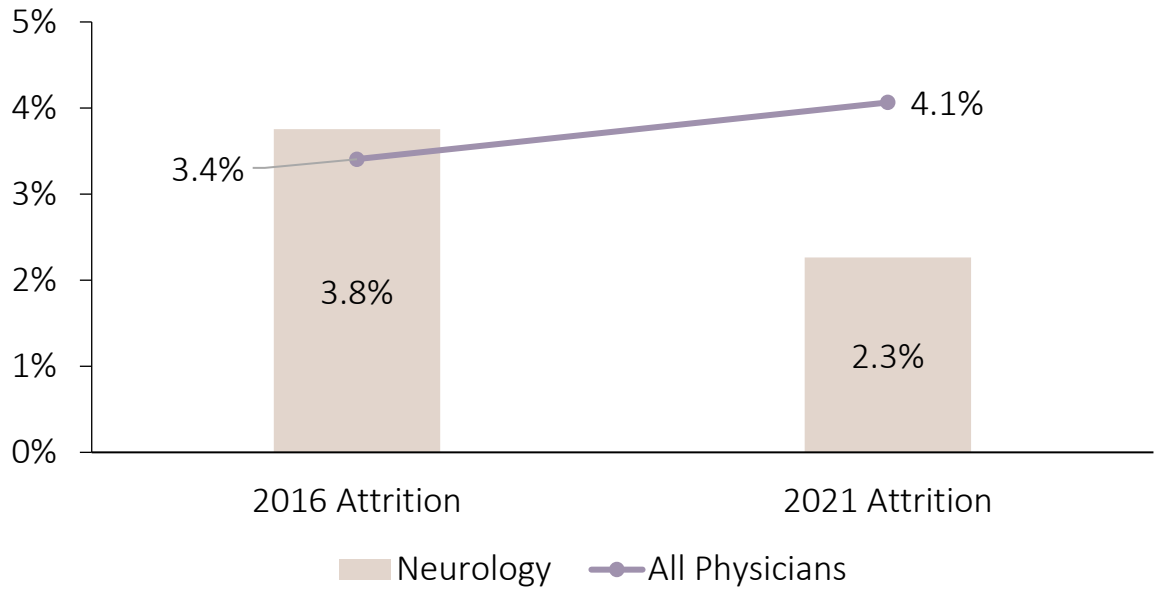
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 16.7% (from 18 to 21). (OPHRDC)

In Practice Attrition

In 2021 neurologists had a much lower attrition rate than the average across all physicians, while in 2016 the opposite trend was seen.(OPHRDC)



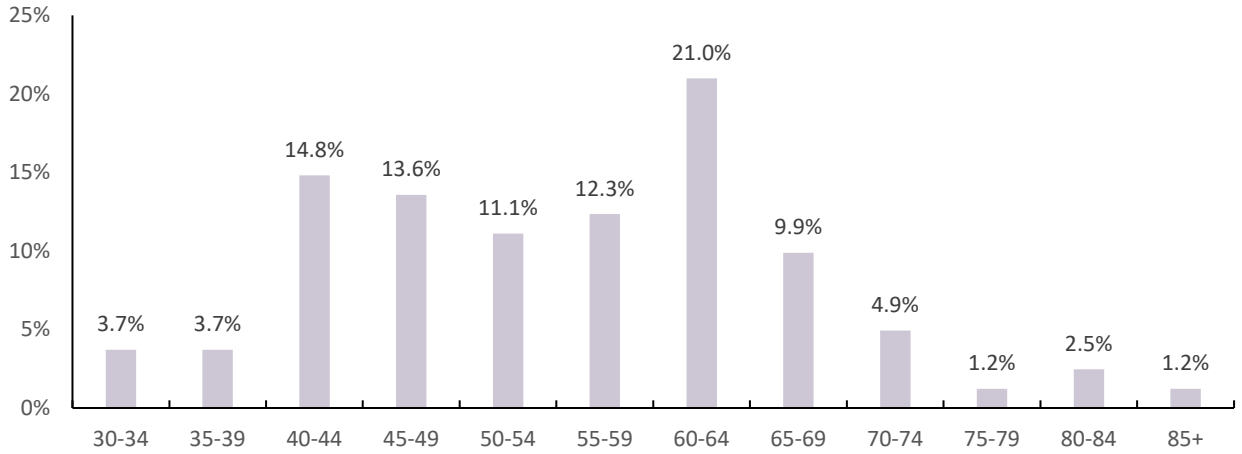
Ontario

Nuclear Medicine

Supply

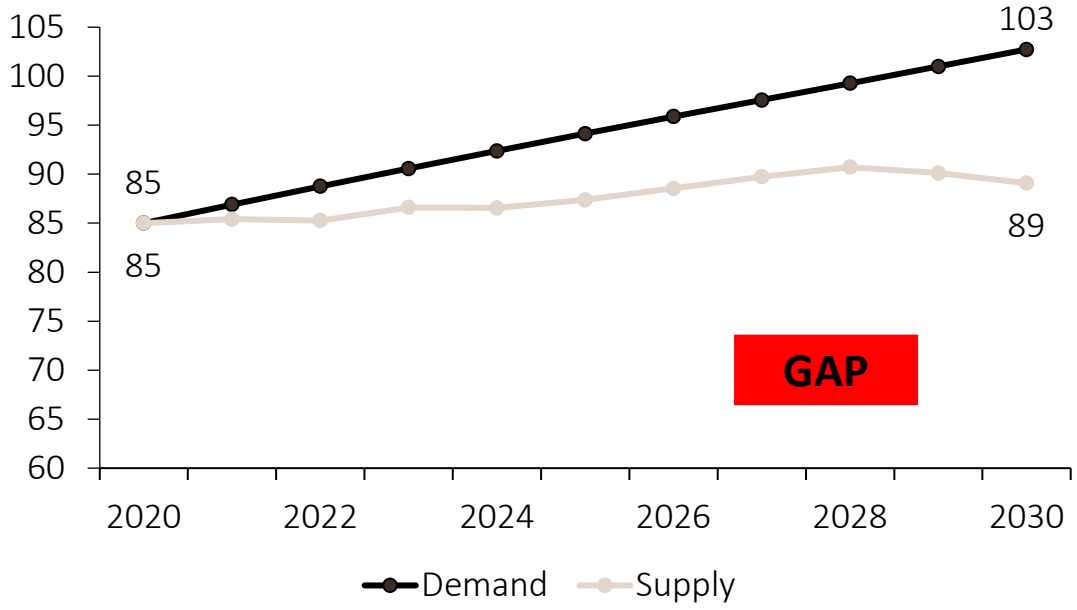
In 2021 there were 81 nuclear medicine physicians practising in Ontario, down 4.7% from 2020 (85) and up 3.6% from 2011 (84). (OPHRDC)

Age



In 2021, the average age of a nuclear medicine physician in Ontario was 55.1 and 14.8% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

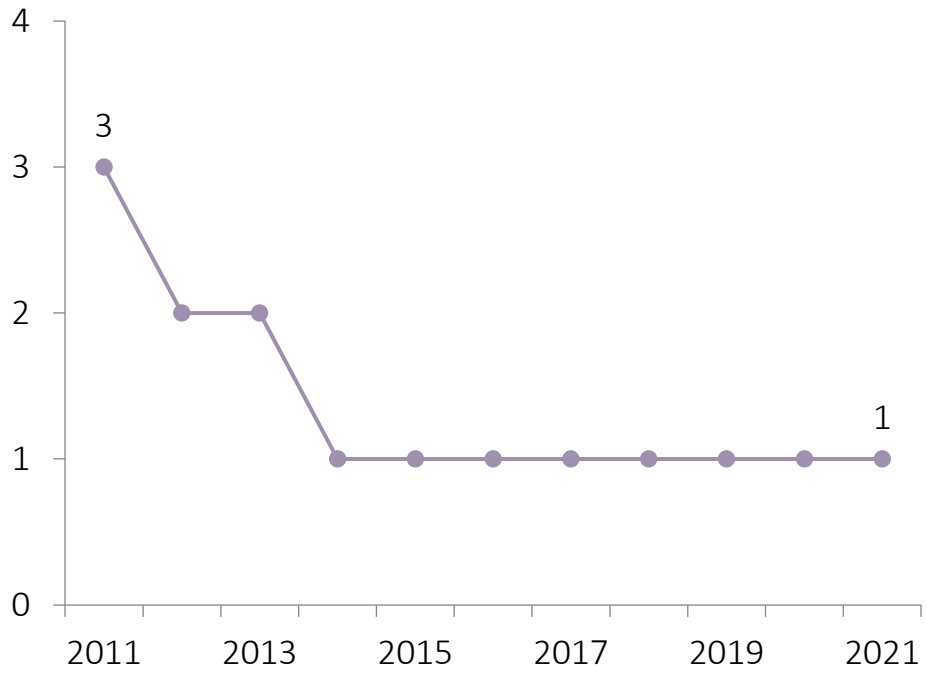


Our modelling is predicting a gap by 2030, with demand outpacing supply. (ADIN/UM)

Ontario

Nuclear Medicine

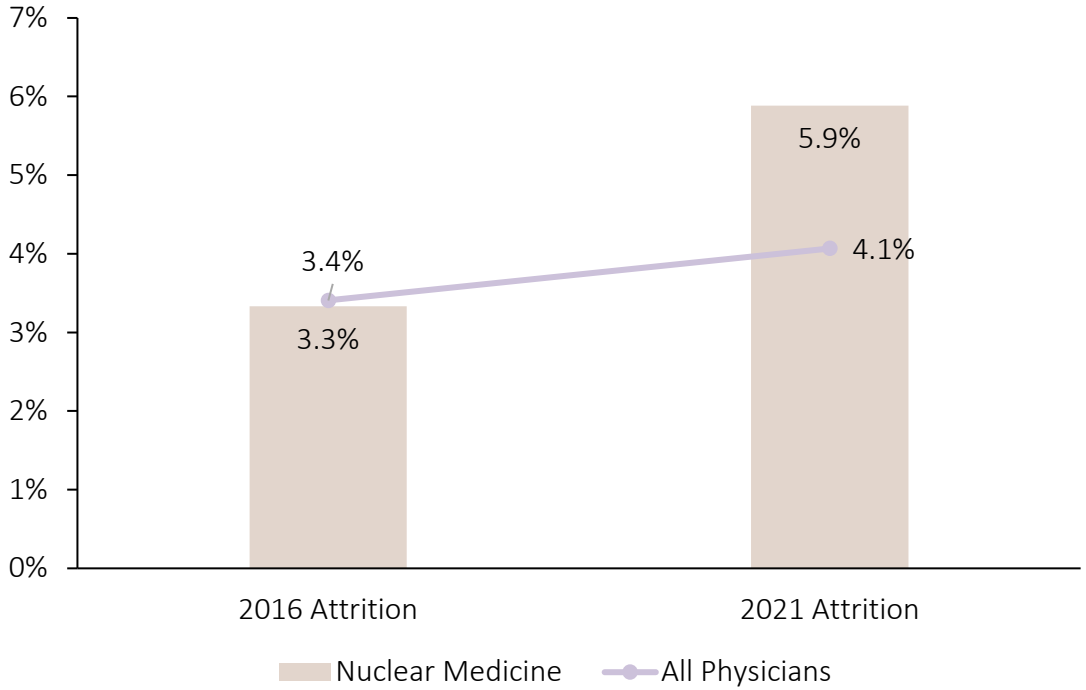
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 66.7% (from 3 to 1). (OPHRDC)

In Practice Attrition

In 2021, the attrition rate of nuclear medicine physicians was higher than that of all physicians, while the opposite trend was seen in 2016. (OPHRDC)



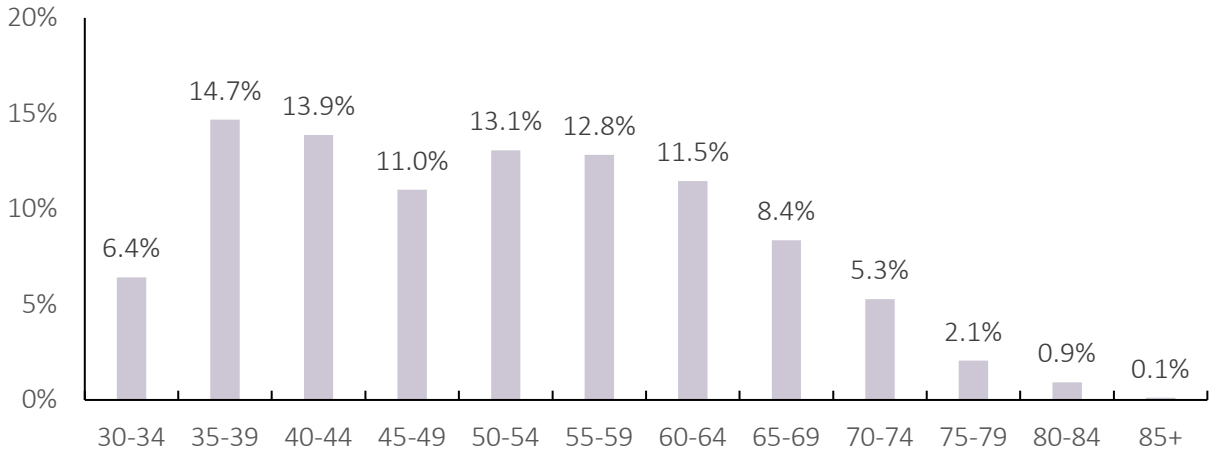
Ontario

Obstetrics & Gynaecology

Supply

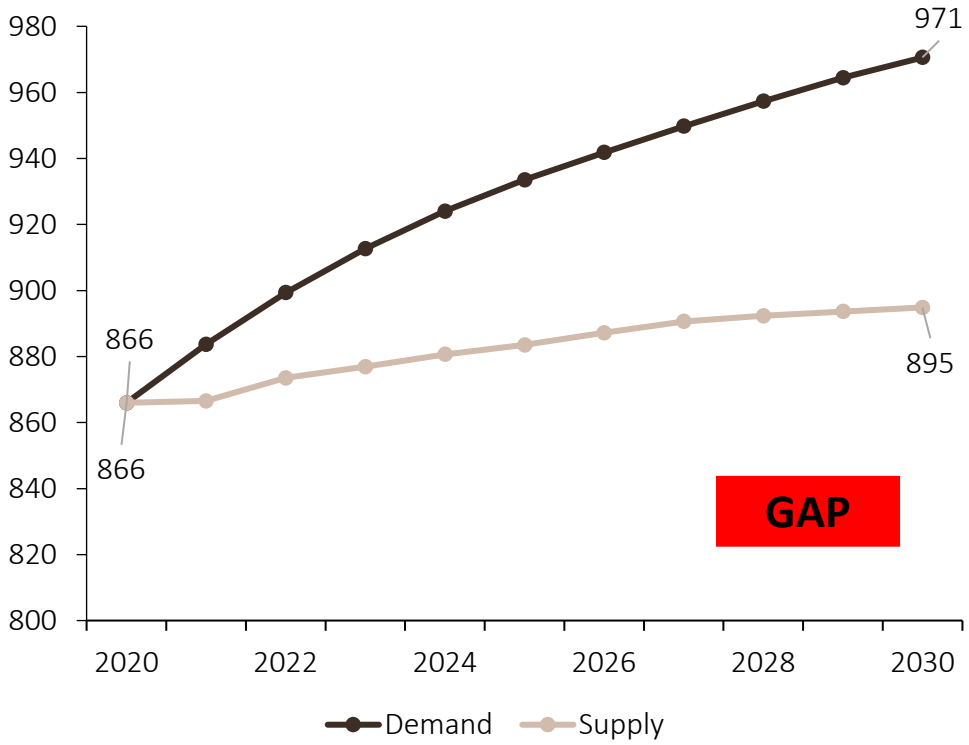
In 2021 there were 873 obstetricians/gynaecologists practising in Ontario, up 0.8% from 2020 (866) and up 23.0% from 2011 (710). (OPHRDC)

Age



In 2021, the average age of an obstetrician/gynaecologist in Ontario was 51.5 and 13.6% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

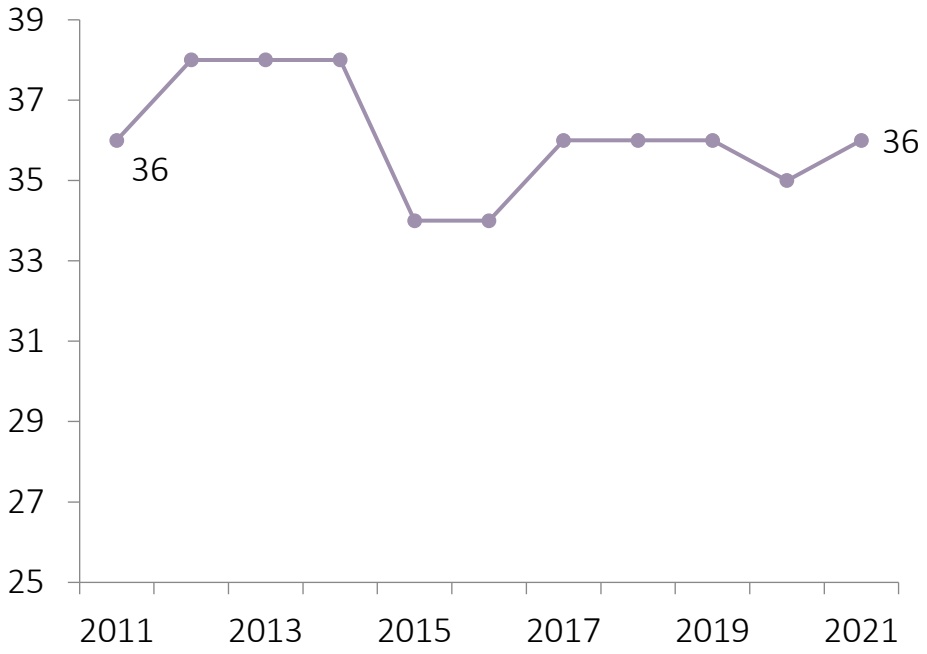


Our modelling is predicting a modest gap of 76 obstetricians/ gynaecologists by 2030, if nothing is done. (ADIN/UM)

Ontario

Obstetrics & Gynaecology

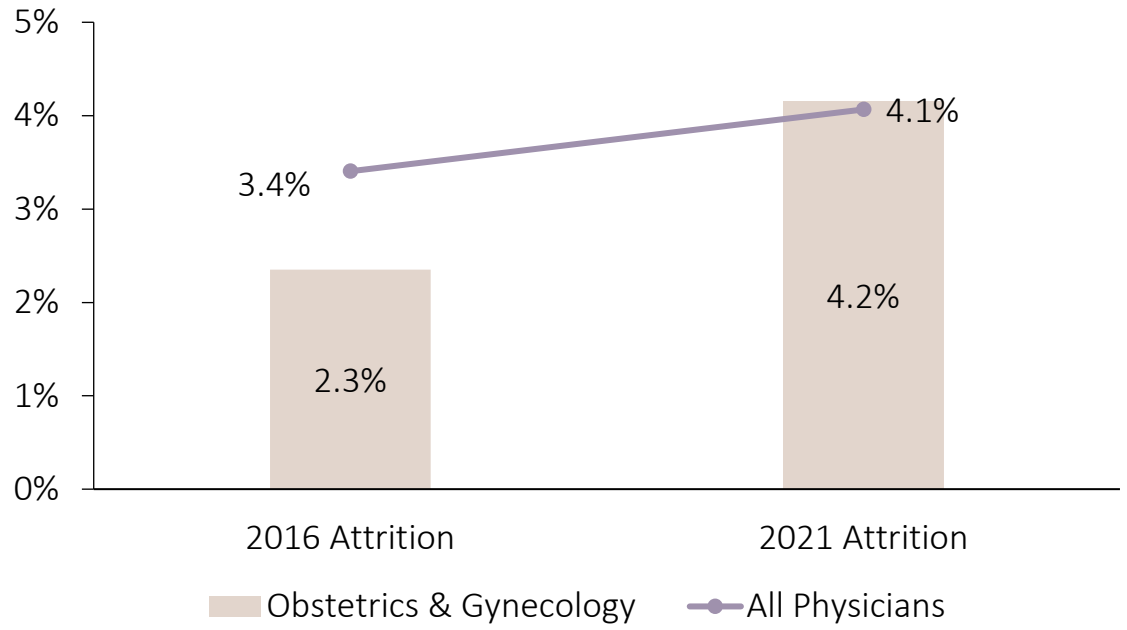
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 0% (from 36 to 36). (OPHRDC)

In Practice Attrition

In 2021 obstetricians/gynaecologists had a higher attrition rate than the average across all physicians. While in 2016, they had a much lower than average attrition rate. (OPHRDC)



Ontario

Obstetrics & Gynaecology

BORN Data Summary

Overall Ontario Pregnancy and Birth Data:

- Only minor changes/fluctuations in Ontario 'pregnancies with a birth' from 2012 (139,782 births) to 2019 (139,489 births).
  - There was a substantial decrease in births in 2020 (134,754). Anecdotal evidence suggests this was probably related to the COVID-19 pandemic, and a quick rebound was anticipated.
  - Ministry of Finance population projections (Summer 2022) a projecting a rebound in births over the next 10 years (from ~144K to ~169K).

OBGYN Data (Deliveries and Supply):

- From 2012 to 2020, the number of 'pregnancies with a birth' that were 'delivered' by an OBGYN has decreased, from 114,214 in 2012 to 98,434 in 2020 (-13.8%).
  - This represented around **73.0% of total 'pregnancies with a birth'** in 2020, down from 81.7% in 2012.
- The number of 'pregnancies with a birth' that were 'delivered' by a midwife increased substantially, from 11,893 in 2012 to 15,240 in 2020 (+28.1%).
  - This represented around **11.3% of total 'pregnancies with a birth'** in 2020, up from 8.5% in 2012.
  - Midwife 'deliveries' (+28.1%) have not increased nearly as much as 'clients' (49.6%).

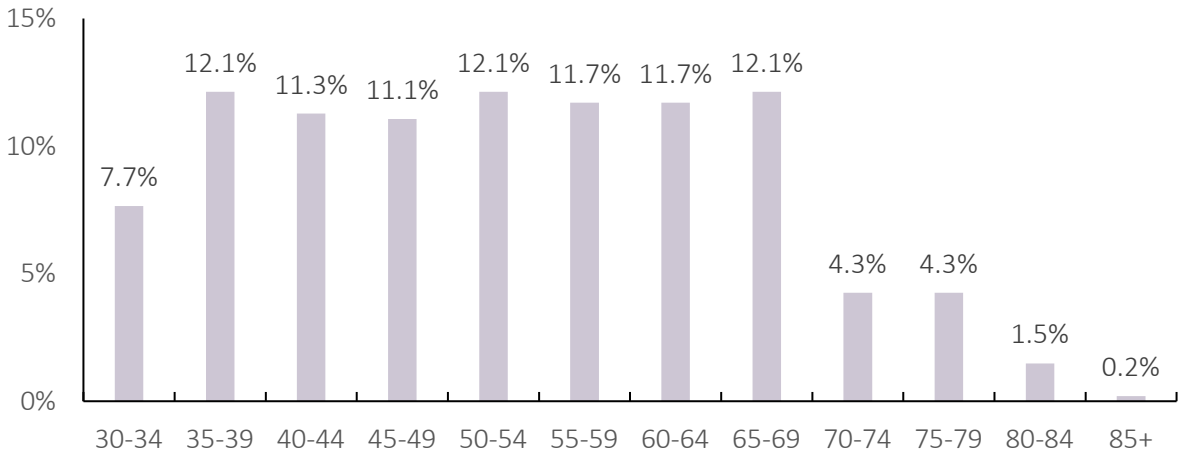
<u>Based on the above any increases to OBYGN supply should be done with caution and with an understanding of regional variance.</u>

Ophthalmology

Supply

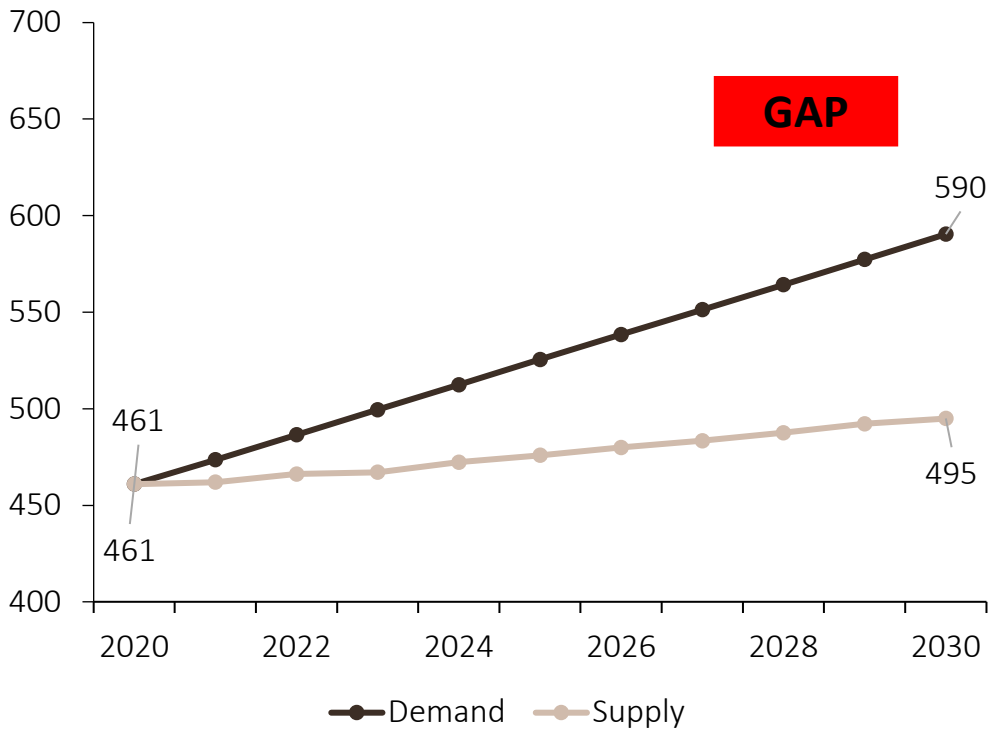
In 2021 there were 470 ophthalmologists practising in Ontario, up 2.0% from 2019 (461) and up 10.3% from 2011 (426). (OPHRDC)

Age



In 2021, the average age of an ophthalmologist in Ontario was 53.0 and 16.4% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

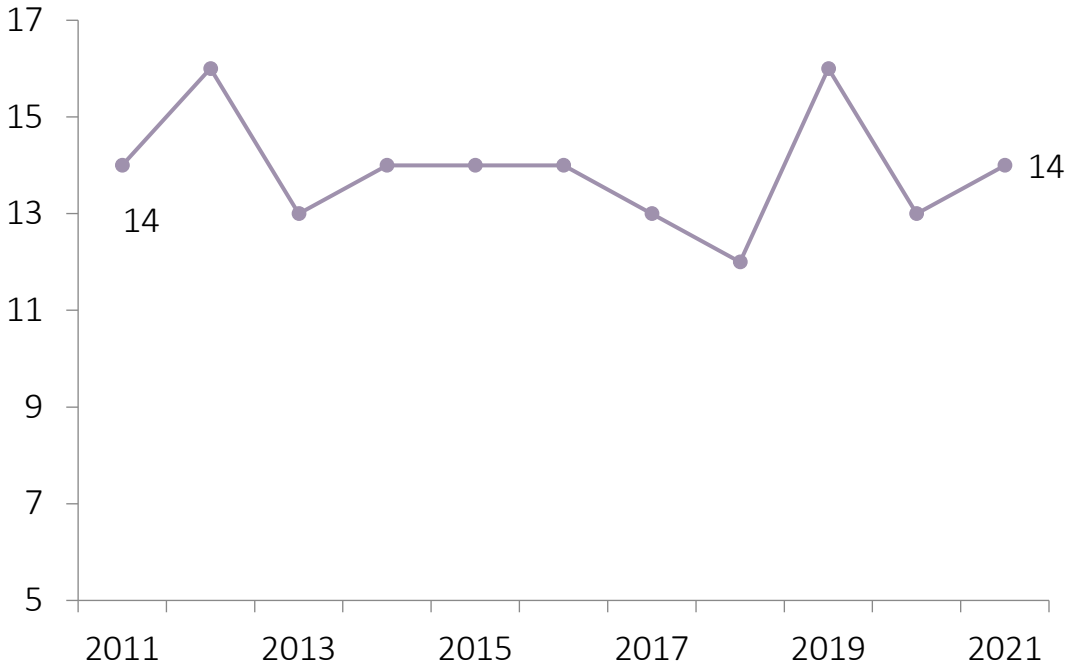


Our modelling is predicting a gap of 95 ophthalmologists by 2030, if nothing is done. (ADIN/UM)

Ontario

Ophthalmology

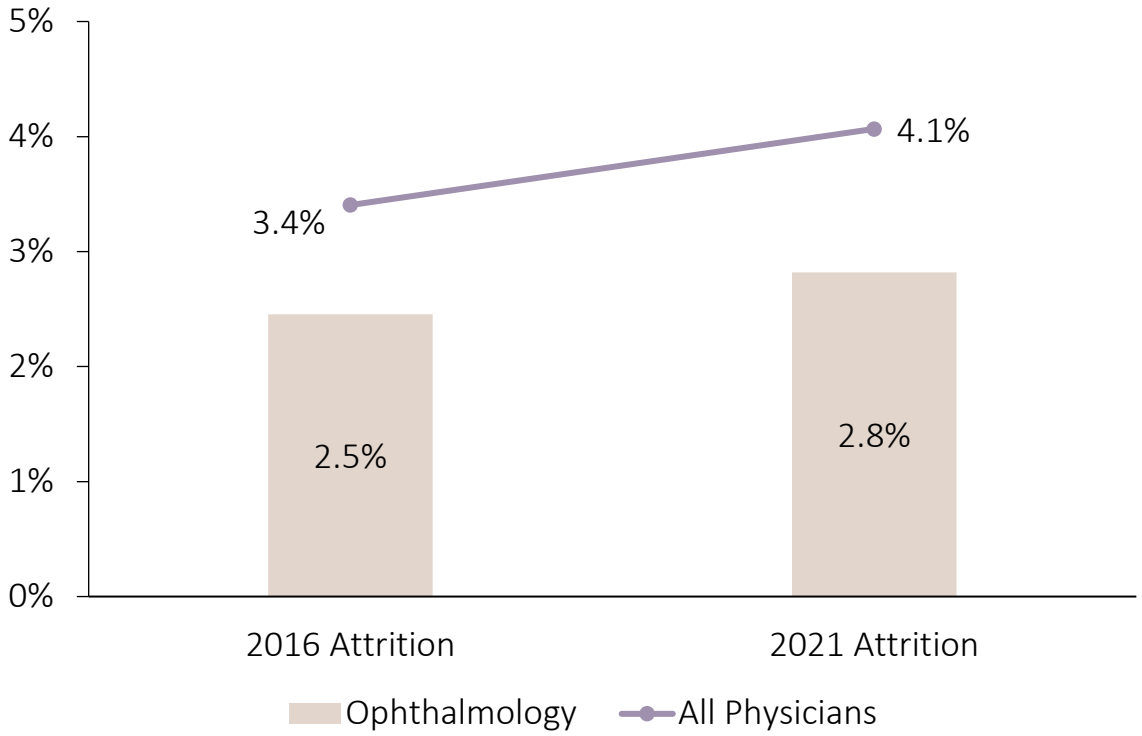
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 0% (from 14 to 14). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, ophthalmologists had much lower than average attrition rates.(OPHRDC)



Ophthalmology

Conflicting Ophthalmologist Data

Our modelling is indicated a need for ophthalmologists but Ontario Health has previously indicated that there are few vacancies for ophthalmologists.

The number of seniors is growing. Disease prevalence and incidence are increasing with longer life expectancies.

At the time of the analysis, demand for cataract surgery (as one of the leading causes of blindness) was increasing, but the number of medical only (non surgical) new ophthalmologists was increasing while a group of high performing cataract surgeons (usually older in age) was emerging.

Research and analysis suggest that the conflicting data indicated the following:

- Road blocks with respect to training ophthalmologists in surgical procedures are related to lack supply and funding for supporting staff (e.g. surgical nurse) and access to OR time.
- The ministry increased Health System Funding Reform funding for cataract surgeries for hospitals (e.g. funding for support staff) in May 2018. However, hospitals did not fulfill the additional cataract surgeries funded in 2018-19, but it was thought that it was because hospitals were not ready to achieve these new volumes so quickly but would be ready in subsequent years. In 2020-21 and 2021-22, cataract surgery volumes were less than the funded amount but this procedure was greatly impacted by COVID—19.

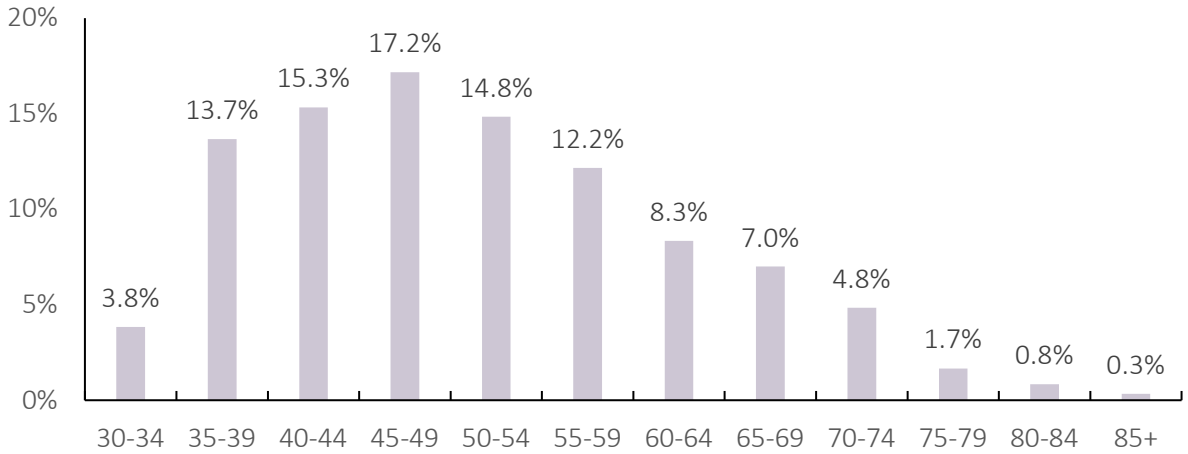
Based on the above information, it is recommended that any increases to ophthalmologist supply be measured and in line with funding reform and supports in hospitals.

Orthopaedic Surgery

Supply

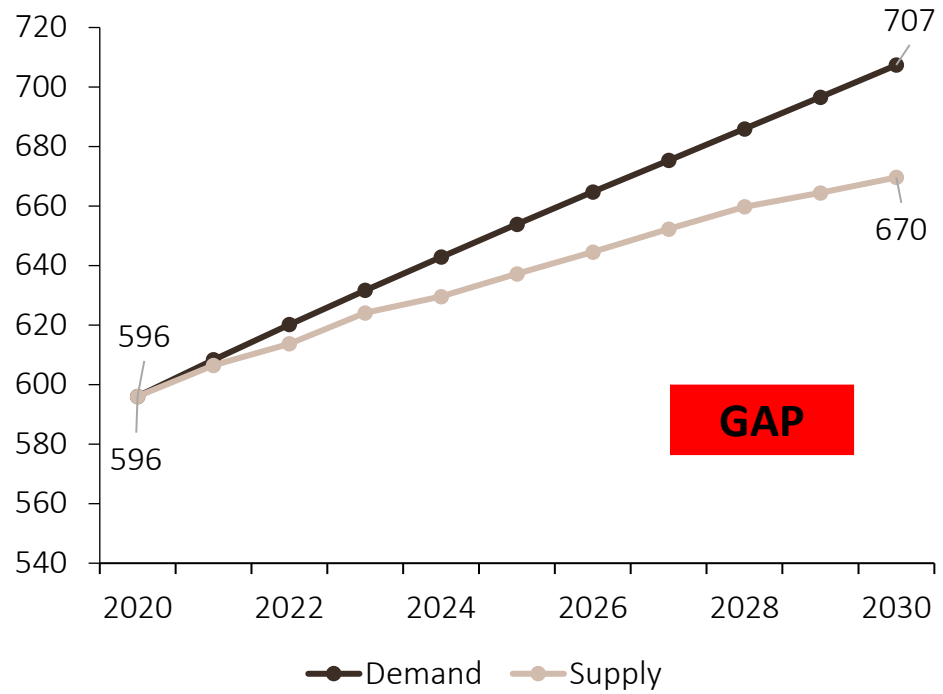
In 2021 there were 600 orthopaedic surgeons practising in Ontario, up 0.7% from 2020 (596) and up 26.3% from 2011 (475). (OPHRDC)

Age



In 2021, the average age of an orthopaedic surgeon in Ontario was 51.0 and 11.8% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

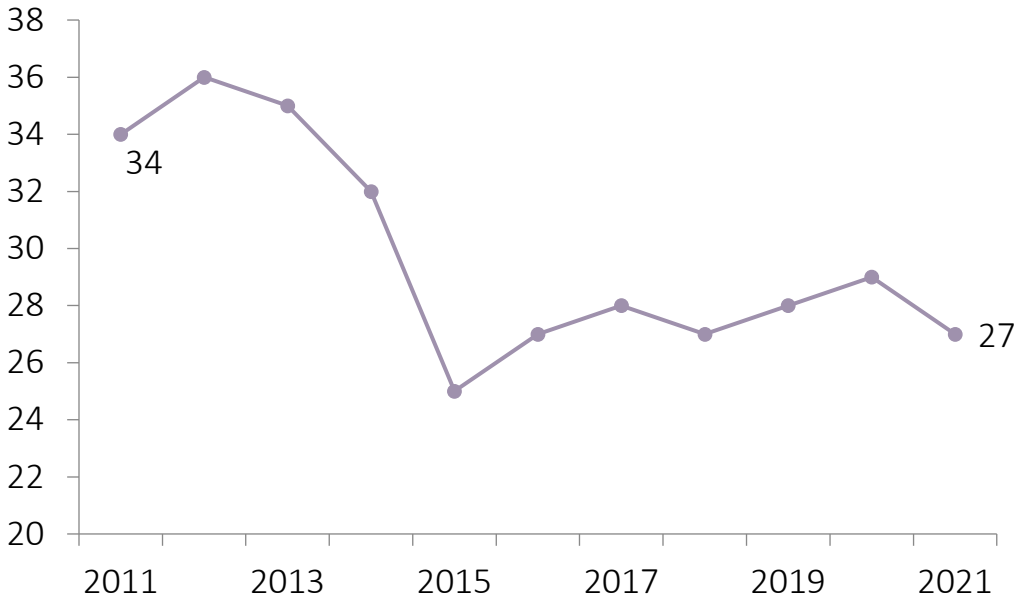


Our modelling is predicting a gap of 37 orthopaedic surgeons by 2030, if nothing is done. (ADIN/UM)

Ontario

Orthopaedic Surgery

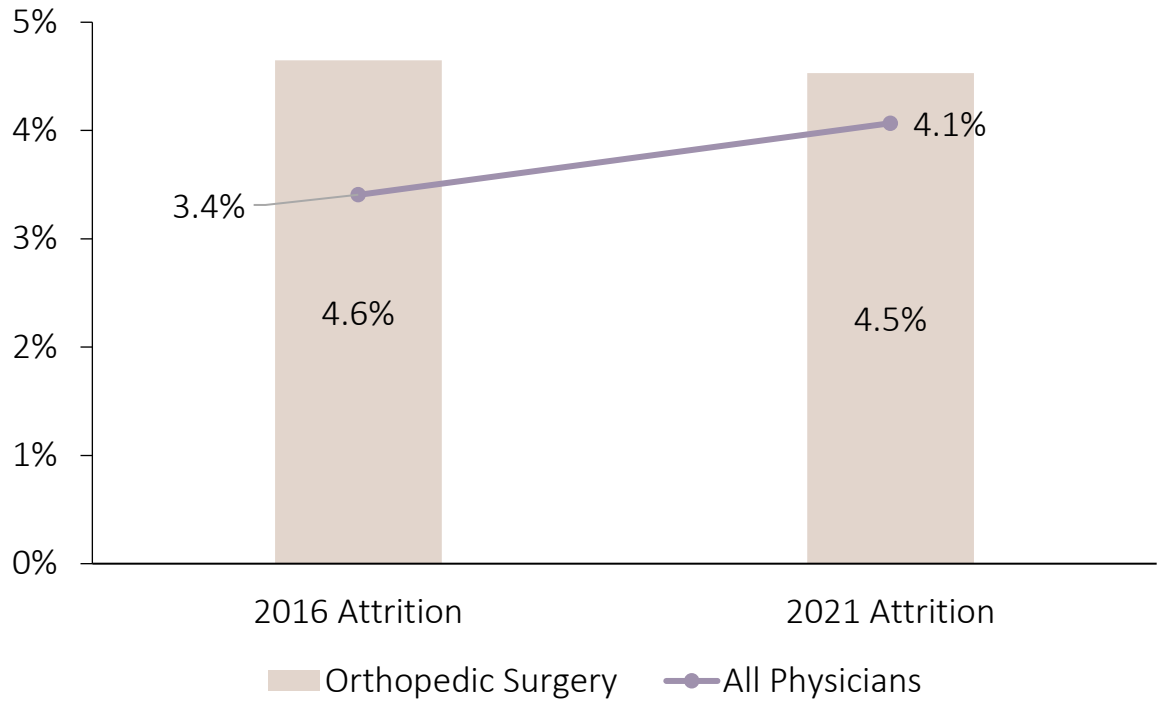
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 20.6% (from 34 to 27). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, orthopaedic surgeons had a higher than average attrition rate. (OPHRDC)

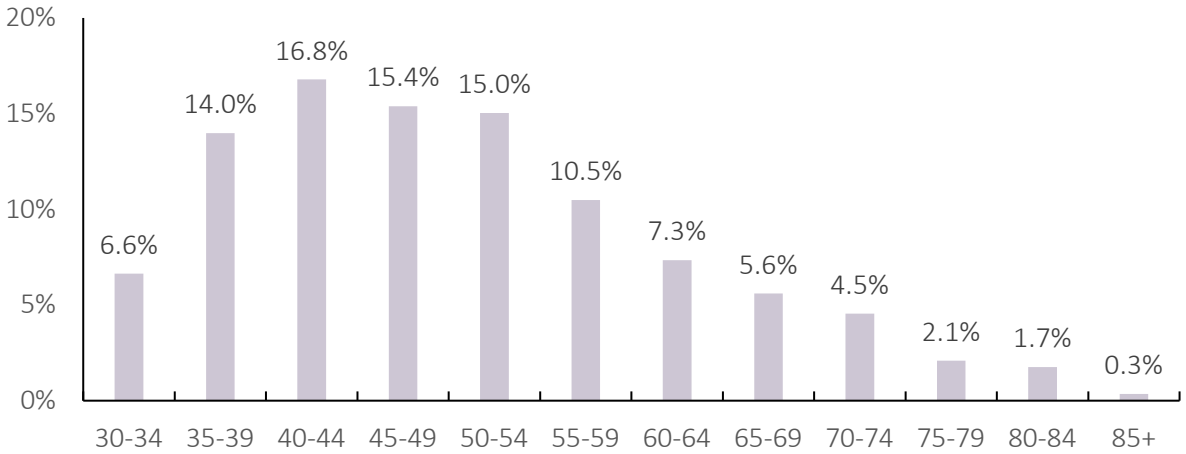


Otolaryngology

Supply

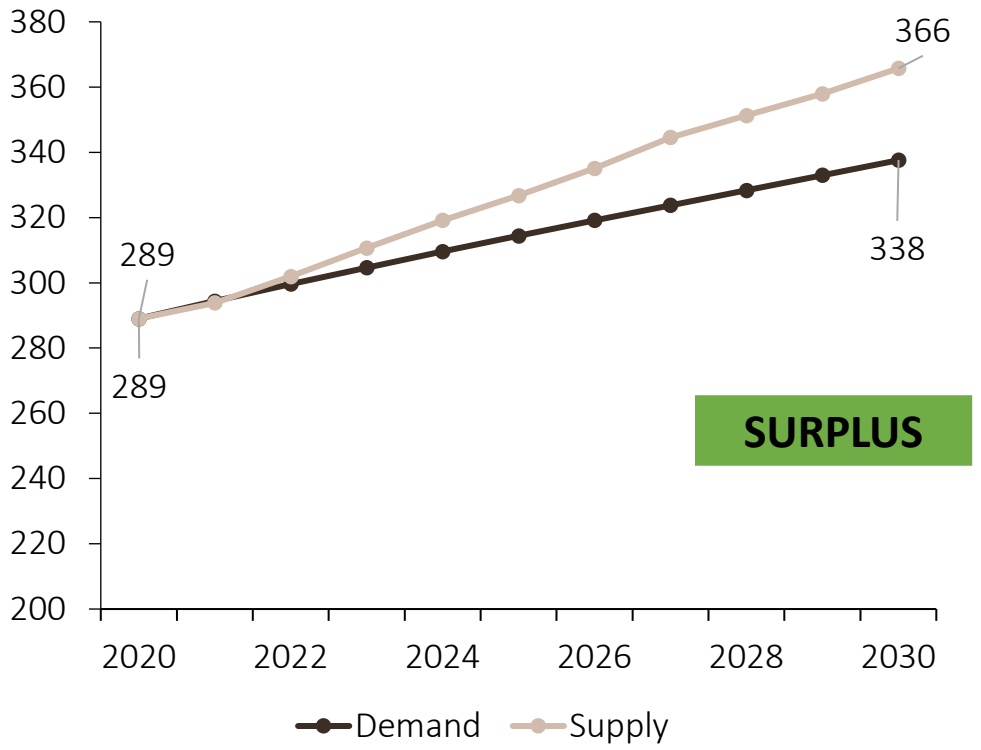
In 2021 there were 286 otolaryngologists practising in Ontario, down 1.0% from 2020 (289) and up 19.7% from 2011 (239). (OPHRDC)

Age



In 2021, the average age of an otolaryngologist in Ontario was 50.4 and 10.1% were between the ages of 65 and 74. (OPHRDC)

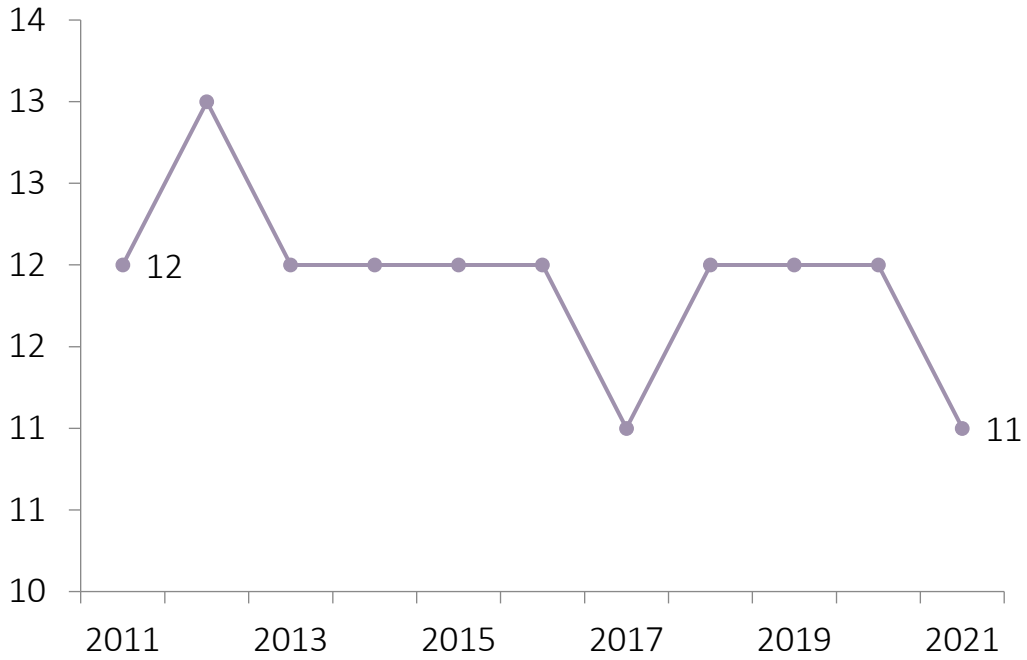
Modelling: 2020 to 2030



Our modeling projects supply will outpace demand during the forecasted period. (ADIN/UM)

Otolaryngology

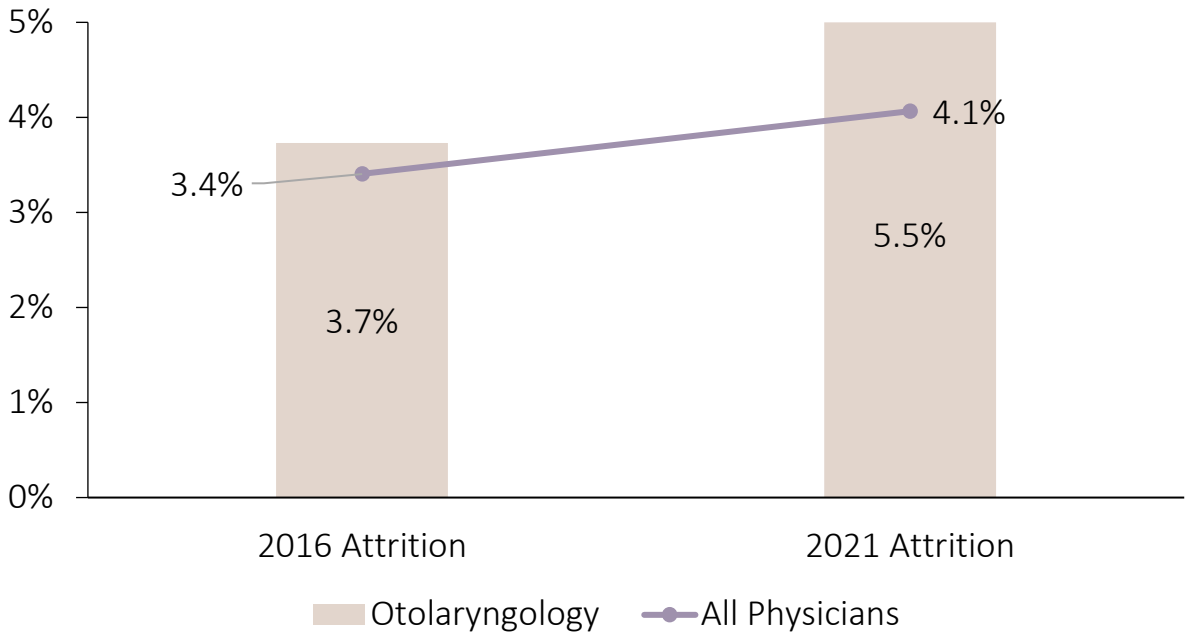
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 8.3% (from 12 to 11). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, otolaryngologists had higher than average attrition rates. (OPHRDC)



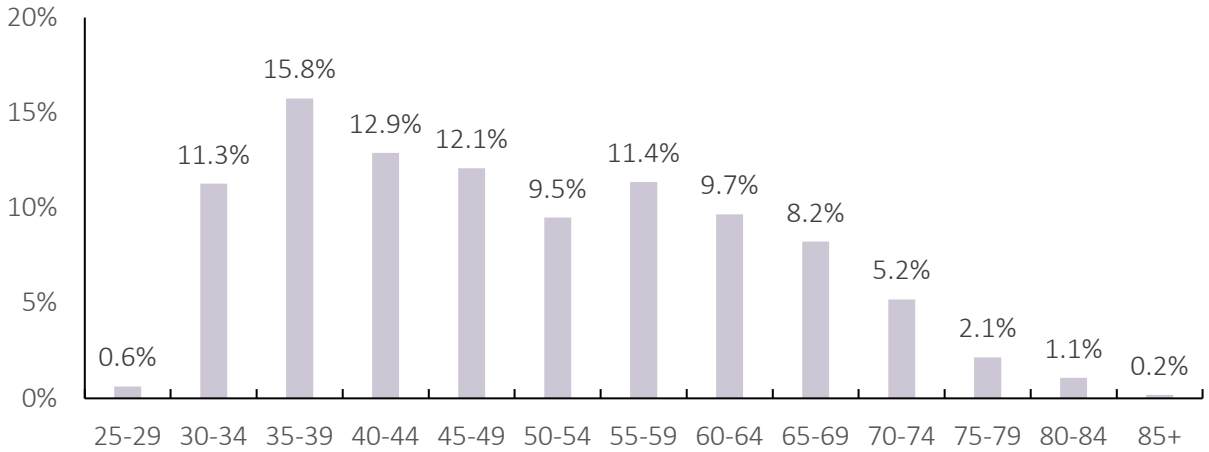
Ontario

Paediatrics

Supply

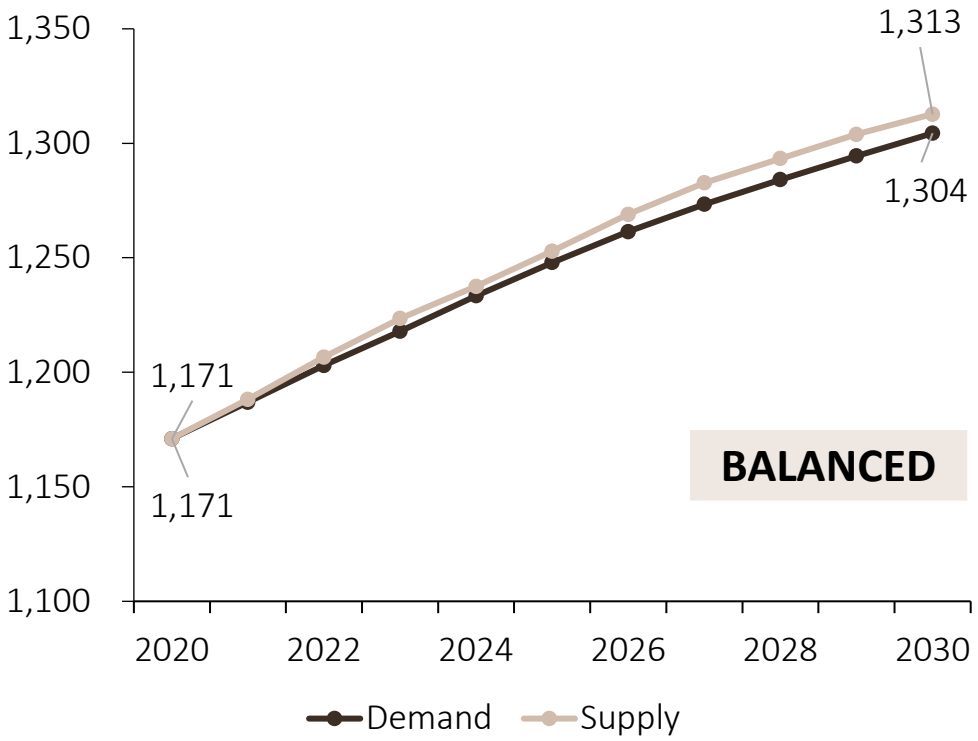
In 2021 there were 1,117 paediatricians practising in Ontario, down 1.7% from 2020 (1,136) and up 31.6% from 2011 (849). (OPHRDC)

Age



In 2021, the average age of a paediatrician in Ontario was 50.0 and 13.4% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030[1]



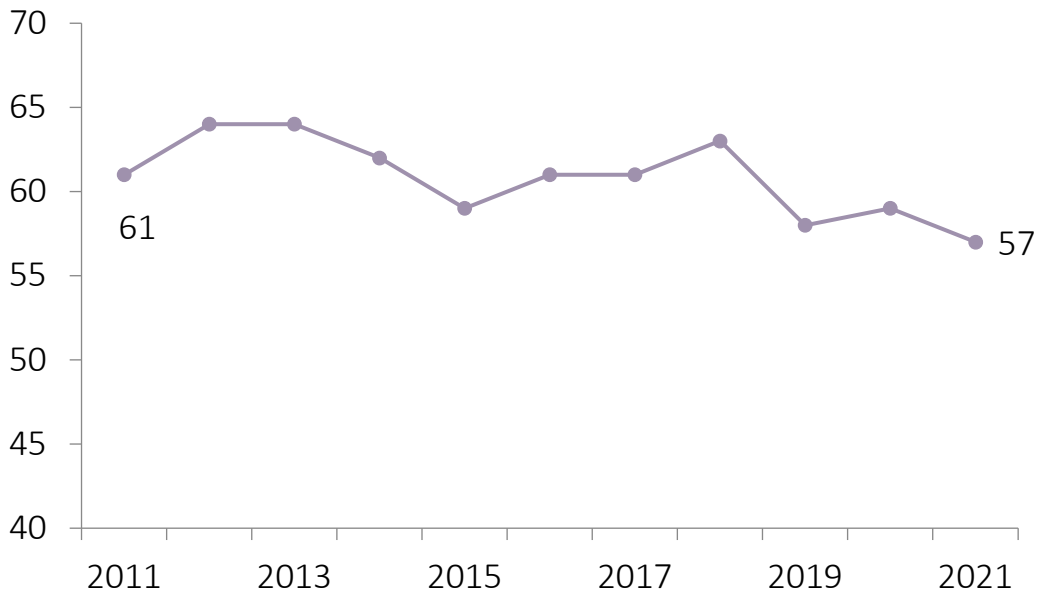
Supply and demand are well balanced throughout the timeframe. (ADIN/UM)

[1] Includes Pediatrics, Developmental Pediatrics, and Adolescent Medicine

Ontario

Paediatrics

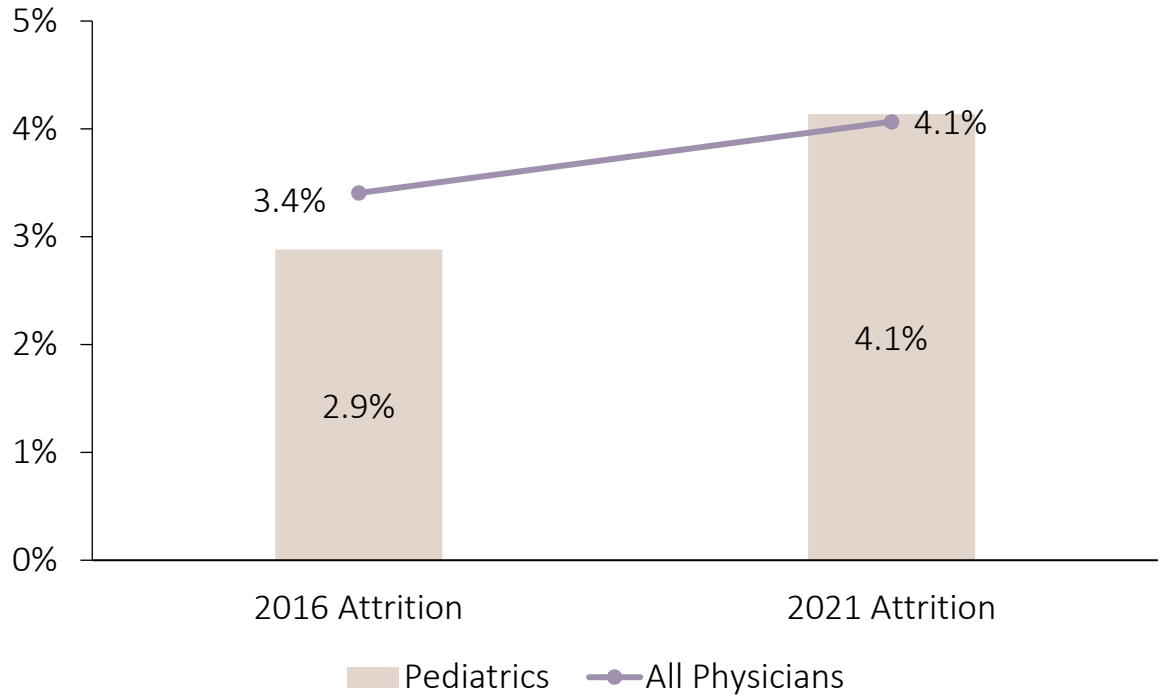
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 6.6% (from 61 to 57). (OPHRDC)

In Practice Attrition

In 2021 paediatricians' attrition rate matched the average, while in 2016 their attrition rate was lower than average. (OPHRDC)



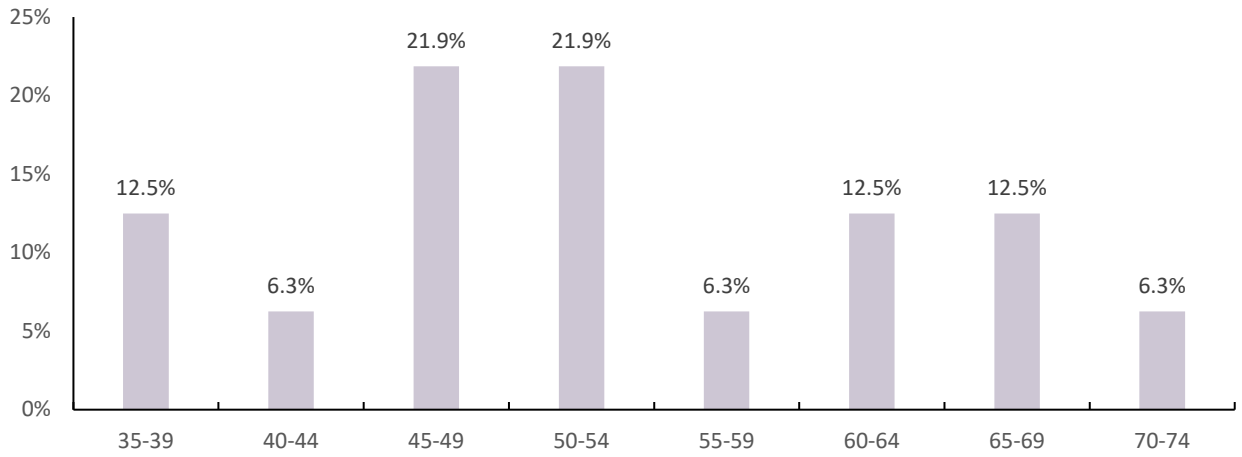
Ontario

Paediatric Neurology

Supply

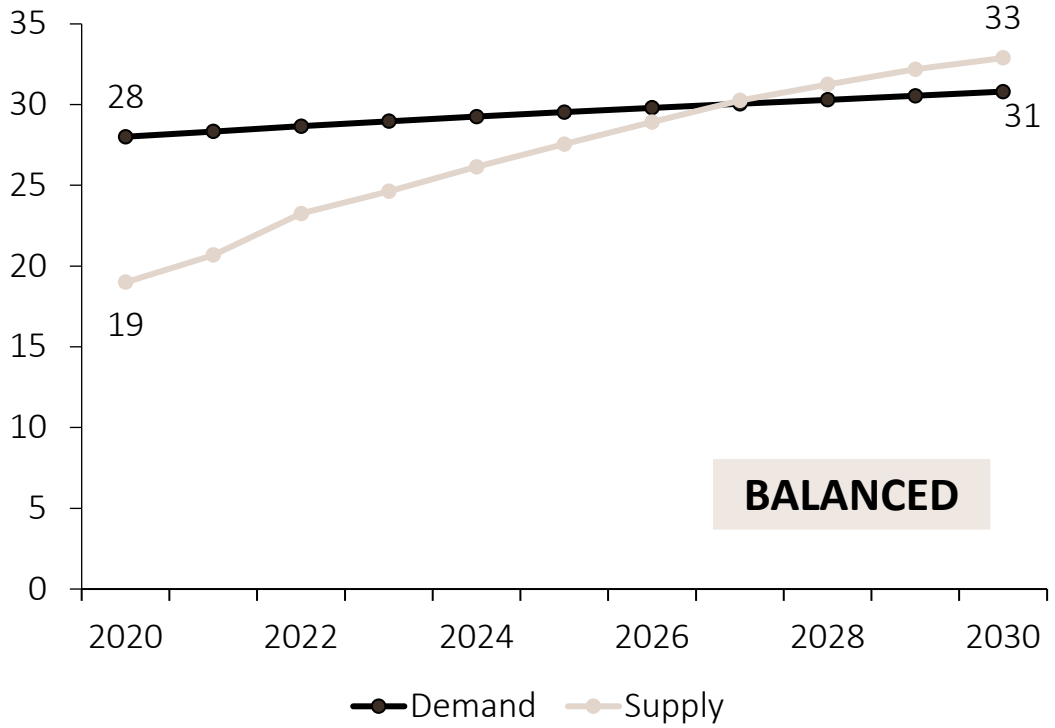
In 2021 there were 32 paediatric neurologists practising in Ontario, down 14.3% from 2020 (28) and down 5.9% from 2011 (34). (OPHRDC)

Age



In 2021, the average age of a paediatric neurologist in Ontario was 53.2 and 18.8% were between the ages of 65 and 74. (OPHRDC)

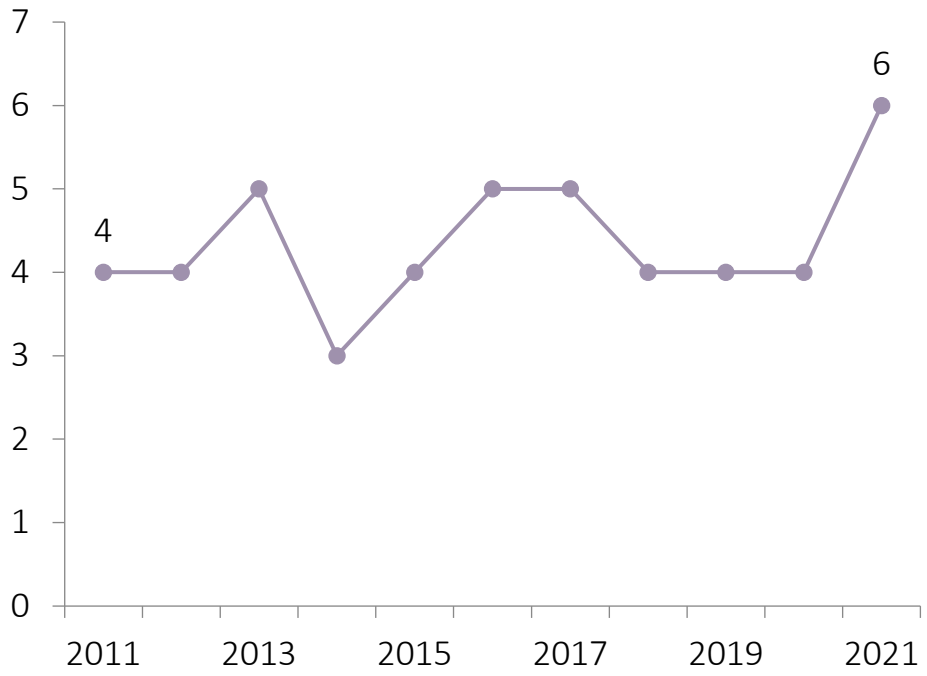
Modelling: 2020 to 2030



Supply and demand are well balanced by the end of the projection period. (ADIN/UM)

Paediatric Neurology

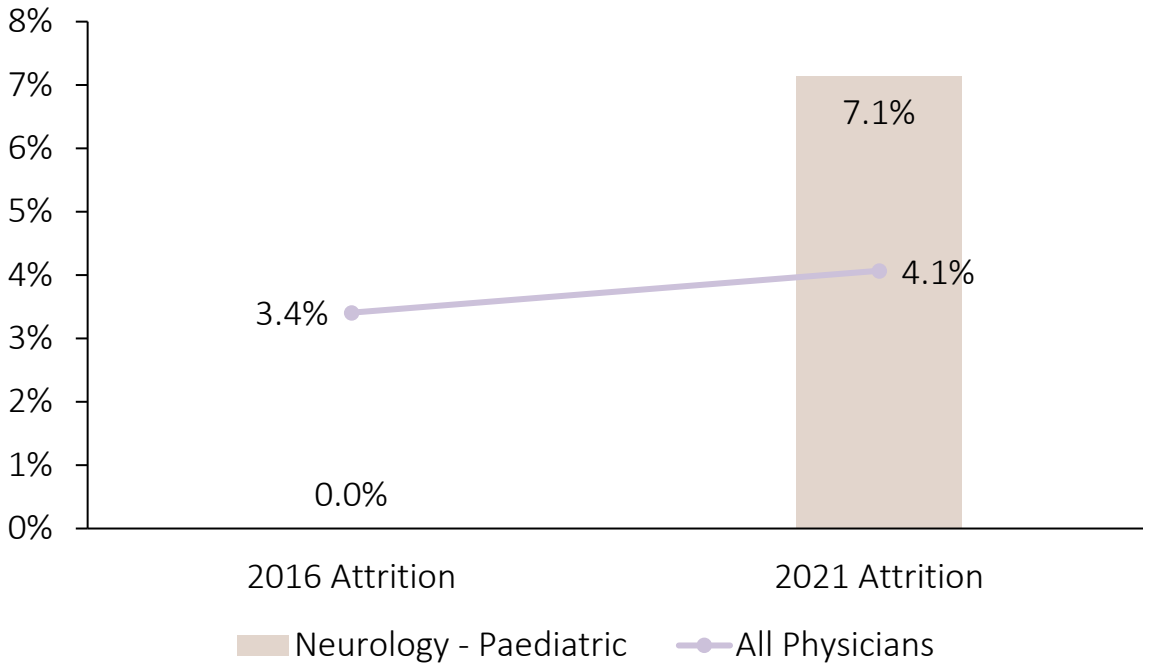
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 50% (from 4 to 6). (OPHRDC)

In Practice Attrition

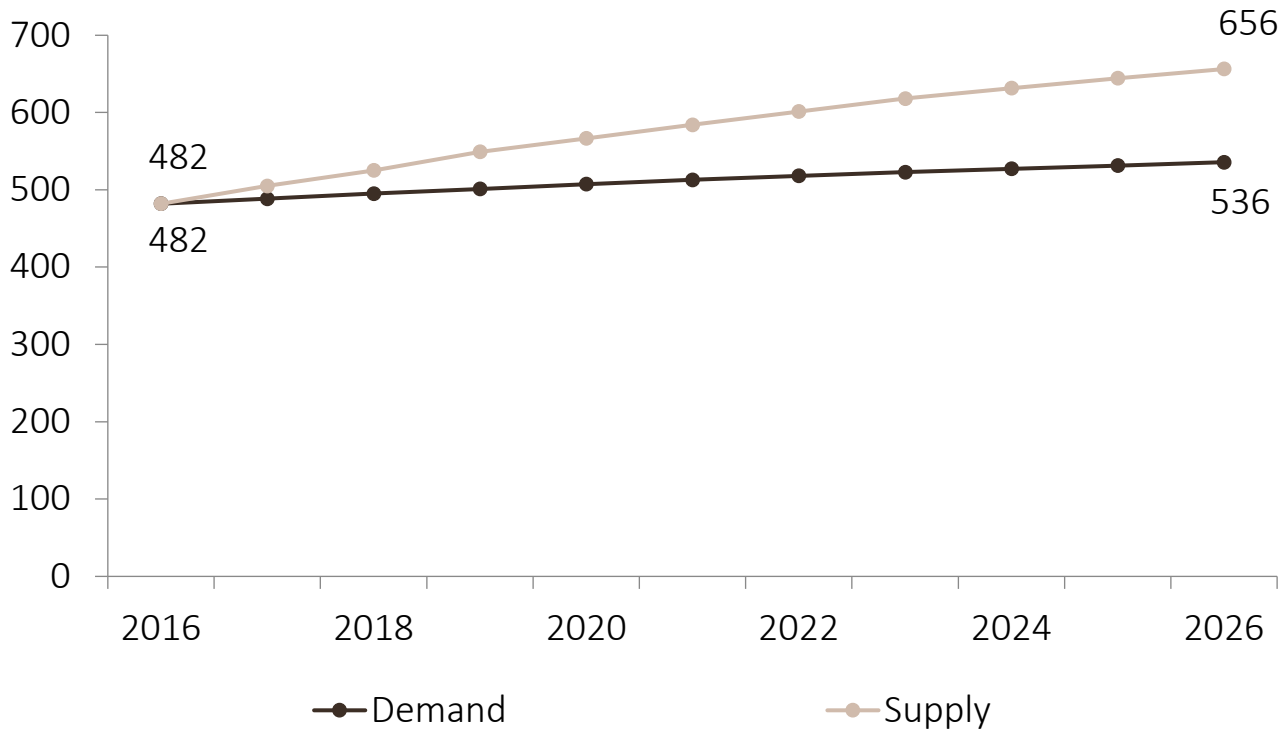
In 2021 paediatric neurologists' attrition rate was much higher than the average attrition rate, while in 2016 their attrition rate was lower than average. (OPHRDC)



Ontario

Paediatric Subspecialties

Modelling: 2020 to 2030



In 2021 there were 447 paediatric specialists practising in Ontario, up 11.2% from 2020 (402) and up 63.1% from 2011 (274). (OPHRDC)

In 2021, the average age of paediatric specialists was 48.7 and 8.9% were between the ages of 65 and 74. (OPHRDC)

Supply outpaces demand throughout the projection period. (ADIN/UM)

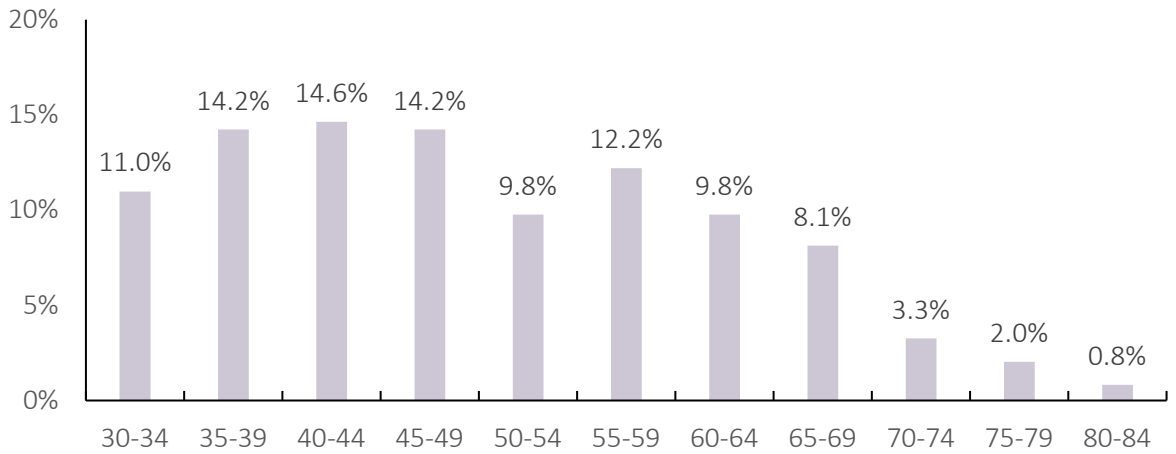
*Includes the following paediatric subspecialties: Paediatric Cardiology, Paediatric Clinical Immunology & Allergy, Paediatric Critical Care Medicine, Paediatric Emergency Medicine, Paediatric Endocrinology & Metabolism, Paediatric Gastroenterology, Paediatric Haematology, Paediatric Infectious Diseases, Paediatric Respirology & Paediatric Rheumatology

Physical Medicine & Rehabilitation

Supply

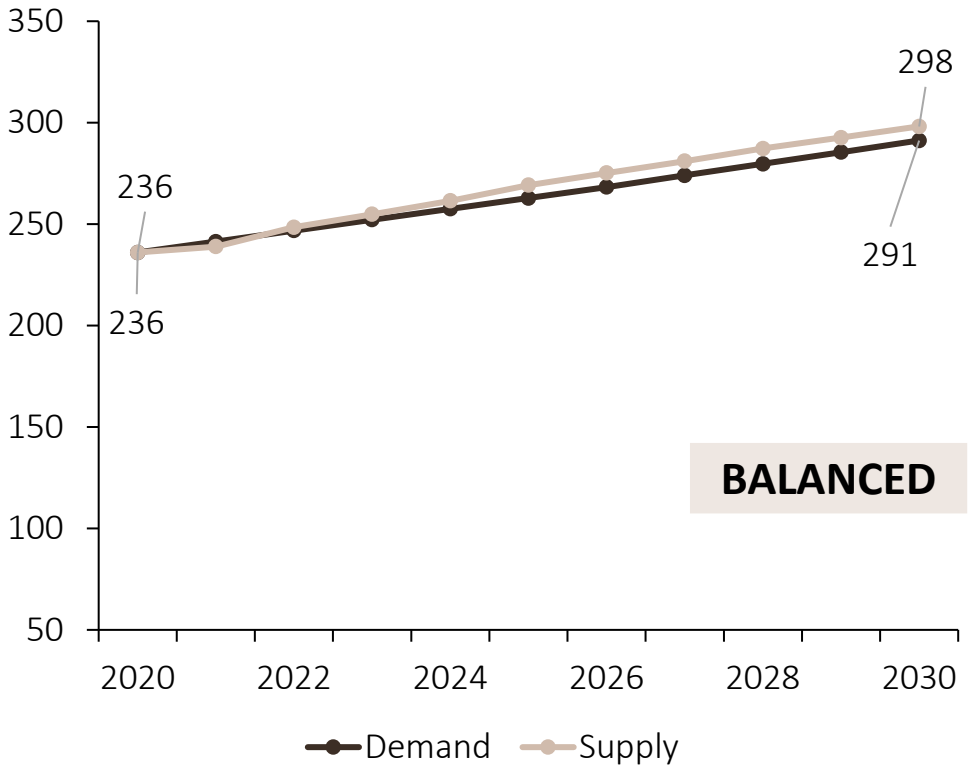
In 2021 there were 246 physical medicine & rehabilitation specialists practising in Ontario, up 4.2% from 2020 (246) and up 43.0% from 2011 (172). (OPHRDC)

Age



In 2021, the average age of a physician medicine & rehabilitation specialist in Ontario was 49.8 and 11.4% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

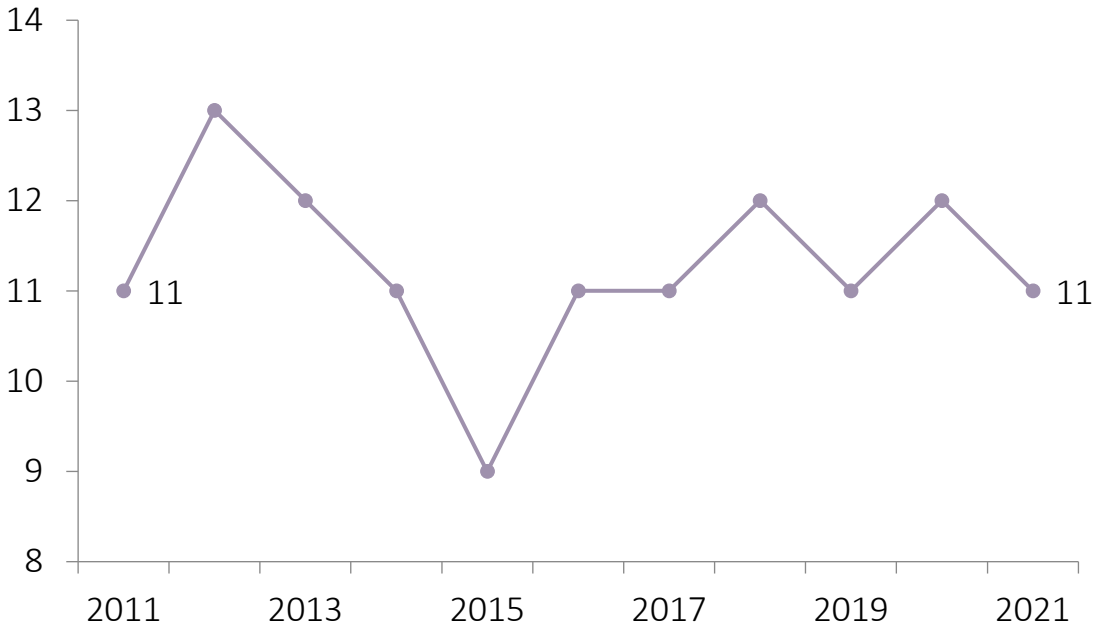


Our modelling projects supply and demand to be balanced. (ADIN/UM)

Ontario

Physical Medicine & Rehabilitation

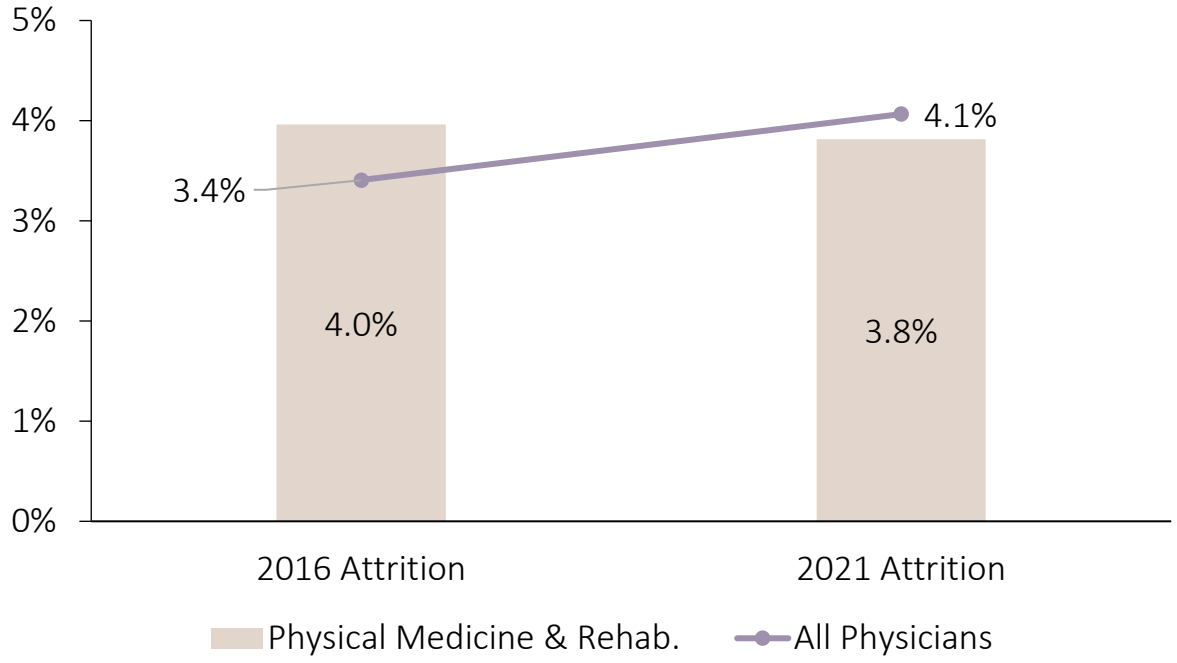
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 0% (from 11 to 11). (OPHRDC)

In Practice Attrition

In 2021 physical medicine & rehabilitation specialists had a lower than average attrition rate while in 2016 they had a higher than average attrition rate. (OPHRDC)



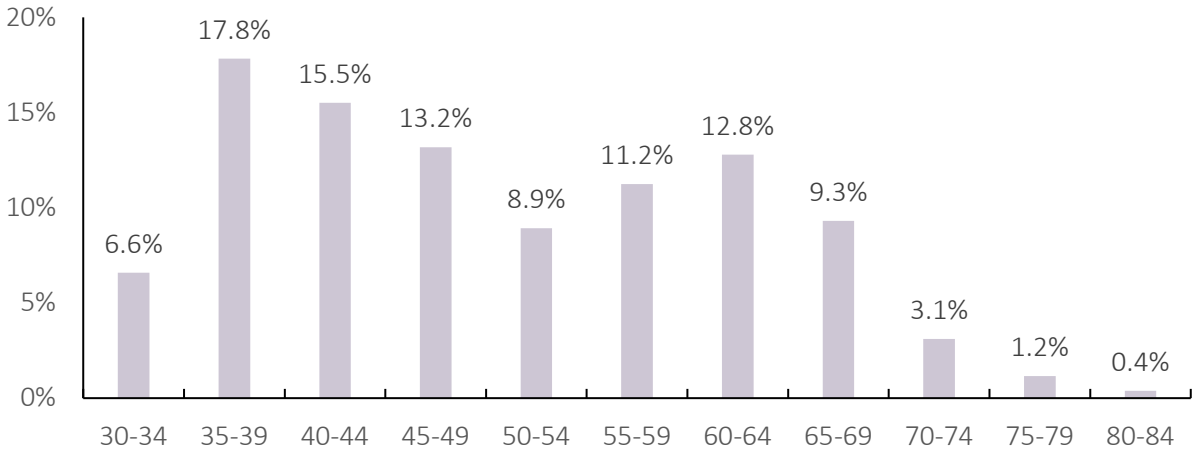
Ontario

Plastic Surgery

Supply

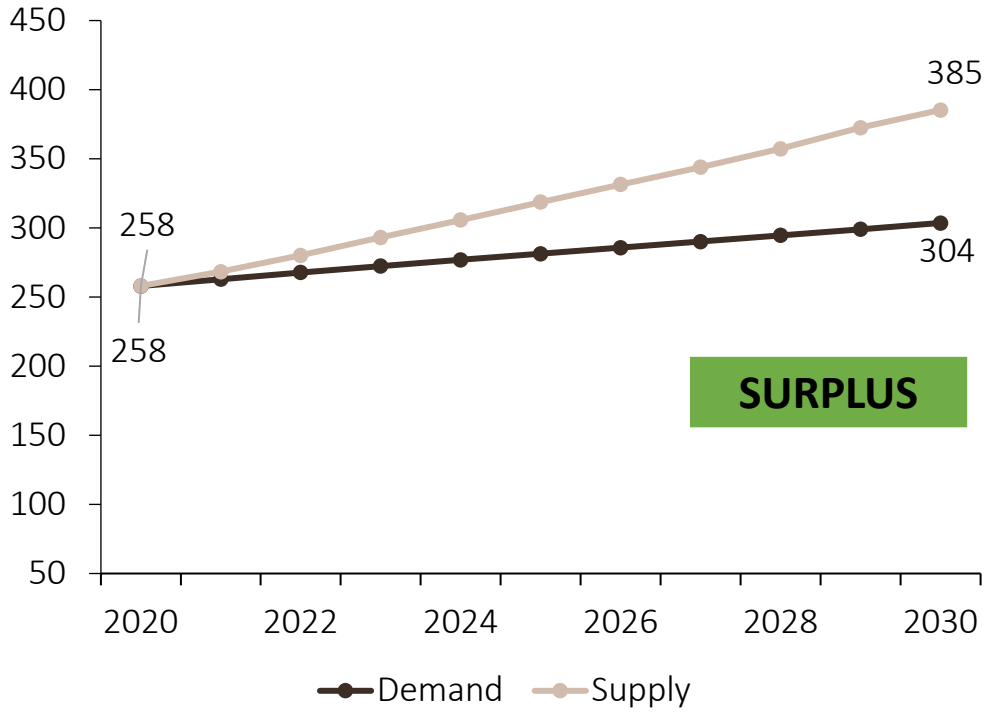
In 2021 there were 258 plastic surgeons practising in Ontario, no change from 2019 (251) and up 25.9% from 2011 (205). (OPHRDC)

Age



In 2020, the average age of a plastic surgeon in Ontario was 49.9 and 12.4% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

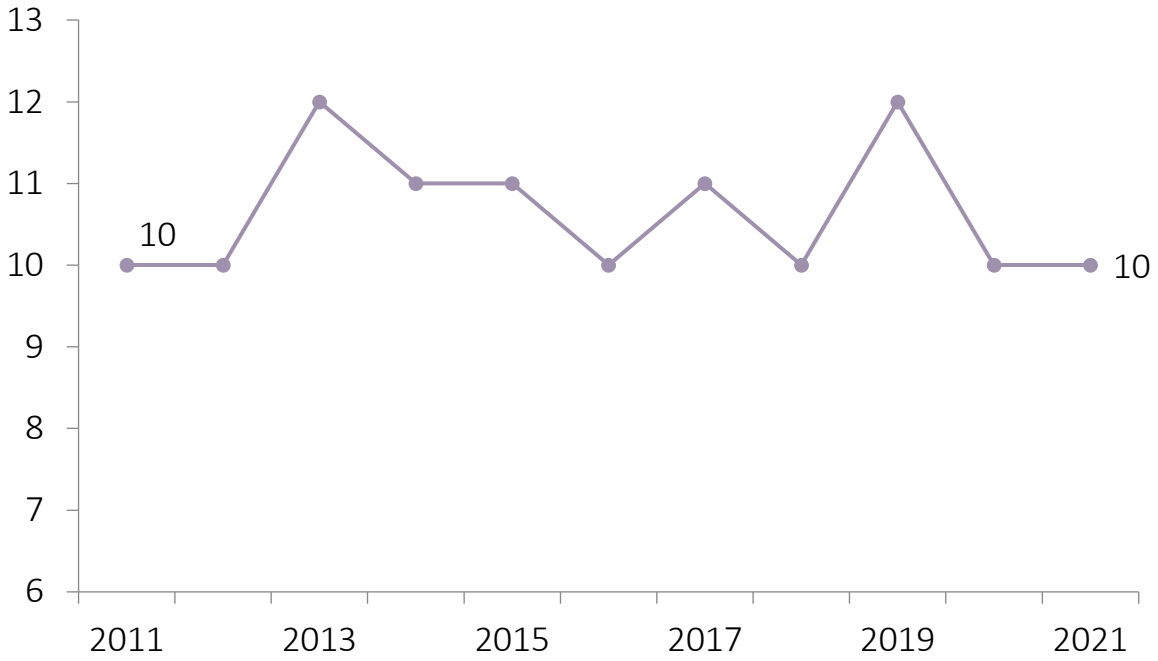


Supply outpaces demand throughout the projection period. (ADIN/UM)

Ontario

Plastic Surgery

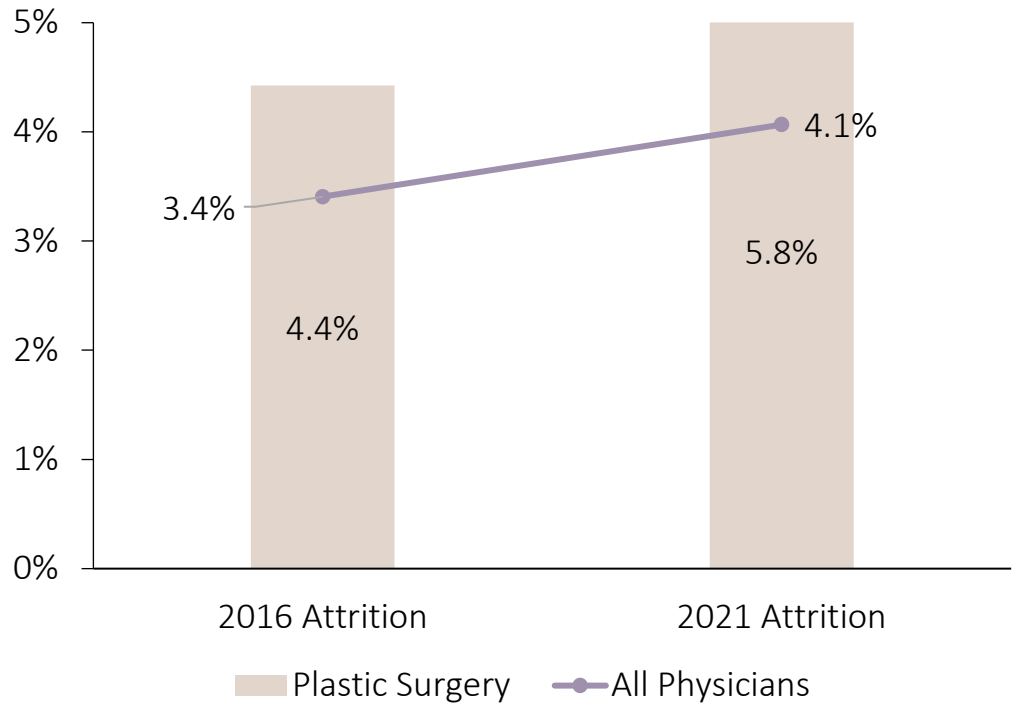
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 0% (from 10 to 10). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, plastic surgeons had higher than average attrition rates. (OPHRDC)



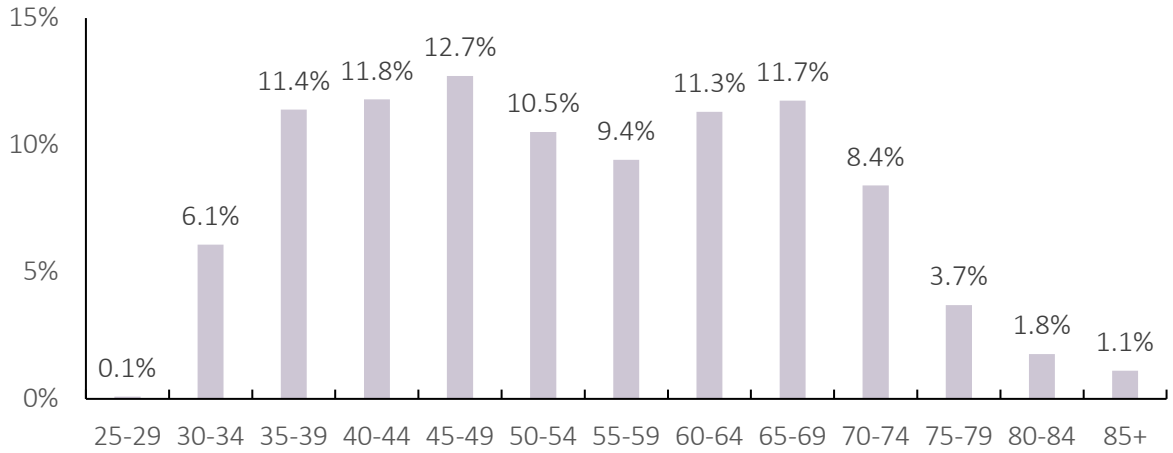
Ontario

Psychiatry

Supply

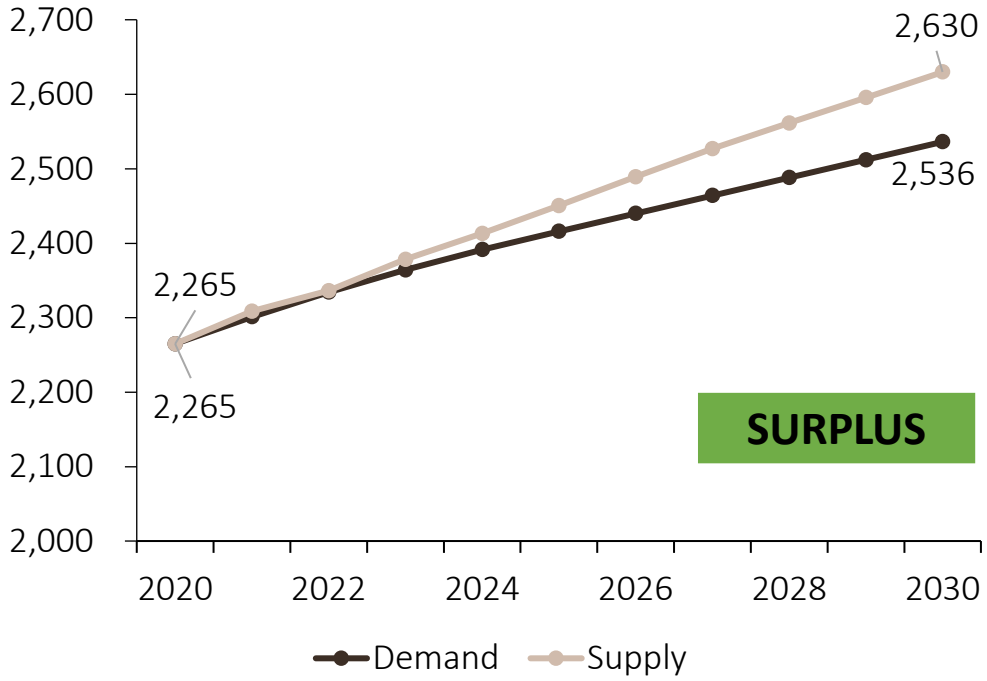
In 2021 there were 2,273 psychiatrists practising in Ontario, this is up 0.4% from 2020 (2,265) and 15.5% from 2011 (1,968). (OPHRDC)

Age



In 2021, the average age of a psychiatrist in Ontario was 53.7 and a high 20.1% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030



Our modelling is projecting supply to outpace demand. (ADIN/UM)

Notes: 1) Does not include unmet need. 2) Includes Psychiatry, Psychiatry - Child & Adolescent, Psychiatry – Forensic, Psychiatry – Geriatric

Psychiatry

Assessment of Need

There is significant unmet need for psychiatrists and mental health services across Ontario.

It is for that reason that the forecasts in the previous page seem unreliable.

Distribution of psychiatrists continues to be an issue, however, demand for psychiatrists may be slowing due to the following:

Increase in PGY Seats

The number of PGY1s in psychiatry increased by 43.6% (from 55 to 79) between 2010 and 2020. By comparison:

- The number of Ontario PGY1s in other specialties increased by 4.0% (from 595 to 619) between 2010 and 2020. (OPHRDC)

Attrition

Past slow growth in psychiatrist supply was due to high attrition rates. For example, between 2018 and 2019 the number of psychiatrist attritions increased by 80.7% (see next slide).

It is anticipated that attrition will slow due to the large number of PGYs graduating and entering the system. (OPHRDC)

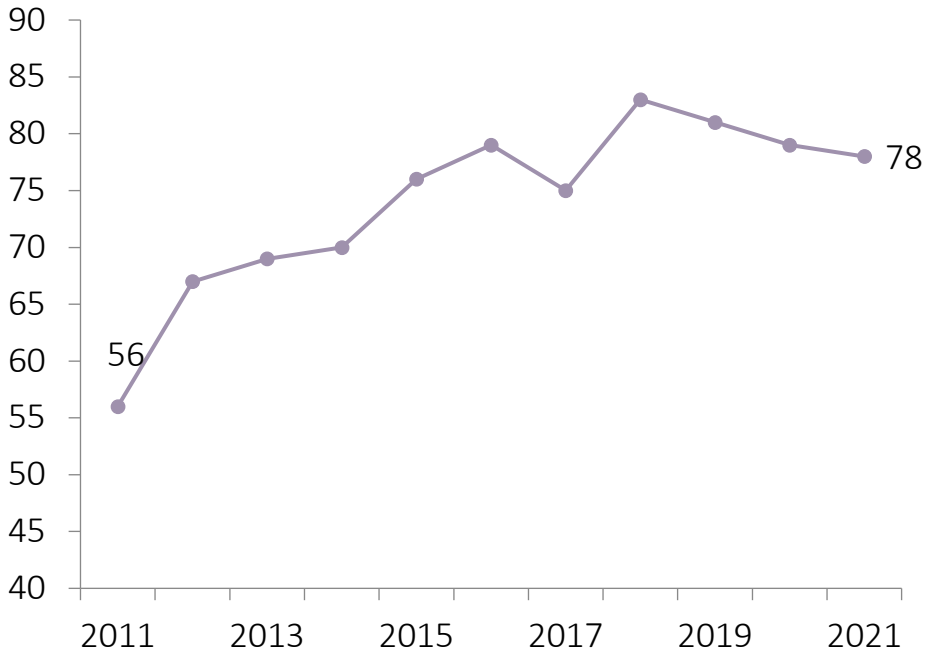
Psychiatrists in Practice

- In FY2020/21, psychiatrists saw on average 202 patients (visiting for a MH&A concern) each, accounting for 1,374 MH&A visits per doctor.
  - In FY2018/19, psychiatrists saw on average 218 patients (visiting for a MH&A concern) each, accounting for 1,367 MH&A visits per doctor.
  - In FY2016/17, psychiatrists saw on average 210 patients each, accounting for 1,396 MH&A visits per doctor. (Claims History Database, Registered Persons Database)

- Between 2020 and 2021, psychiatrists saw their MH&A patients 6.8 times (on average), which reflects typical continuing care or an episode of acute care with pharmacotherapy or evidence-based psychotherapy.
  - Between 2018 and 2019, psychiatrists saw their MH&A patients 6.3 times (on average).
  - Between 2016 and 2017, psychiatrists saw their MH&A patients 6.6 times (on average). (Claims History Database, Registered Persons Database)

Psychiatry

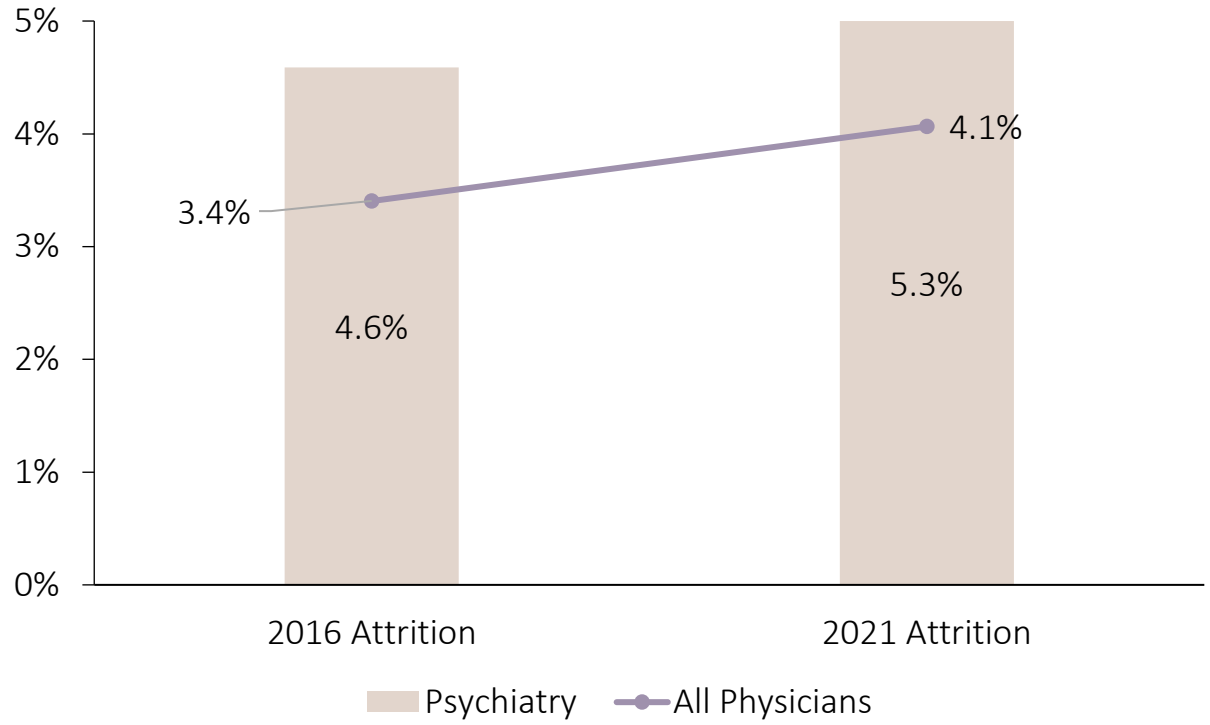
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 39.3% (from 56 to 78). (OPHRDC)

In Practice Attrition

Both in 2016 and in 2021 psychiatrists had a higher than average attrition rate. (OPHRDC)



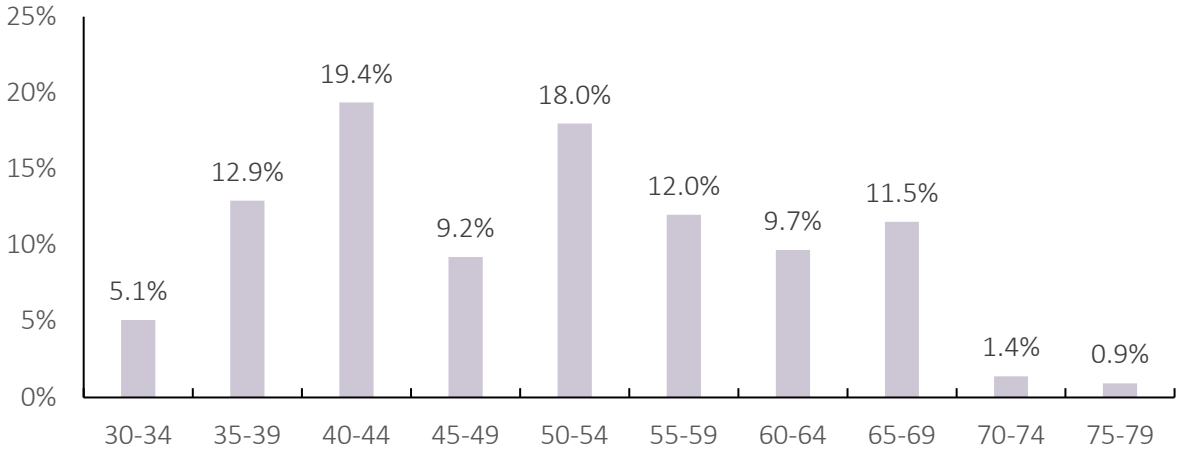
Ontario

Radiation Oncology

Supply

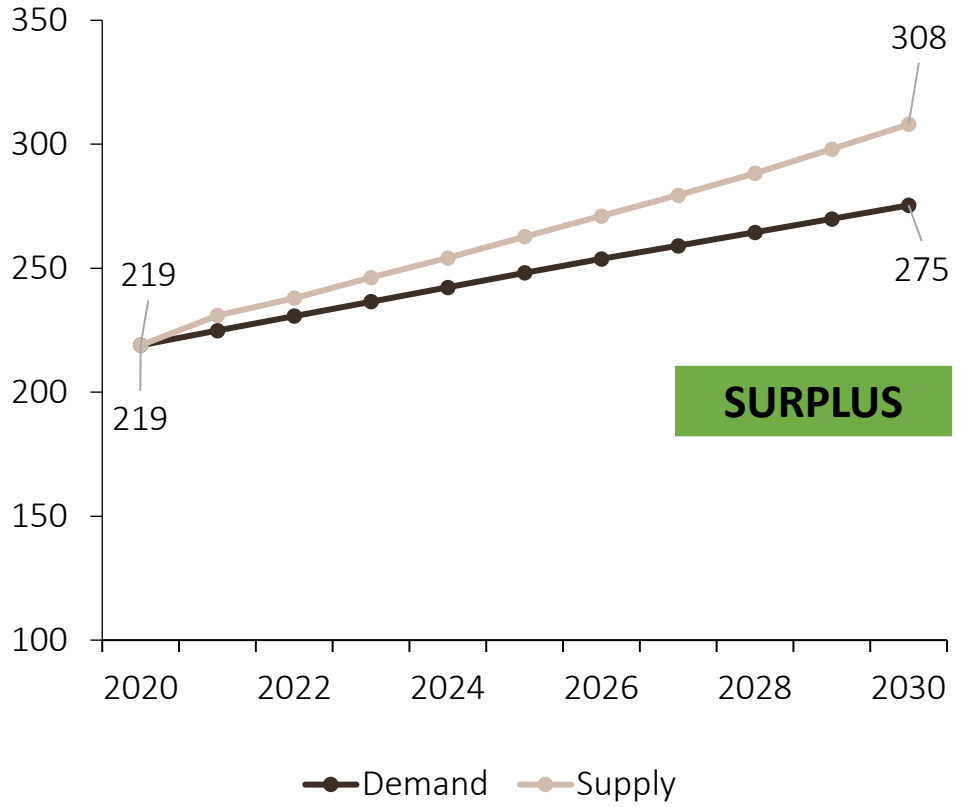
In 2021 there were 217 radiation oncologists practising in Ontario, down 0.9% from 2020 (219) and up 17.3% from 2011 (185). (OPHRDC)

Age



In 2021, the average age of a radiation oncologist in Ontario was 50.5 and 12.9% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

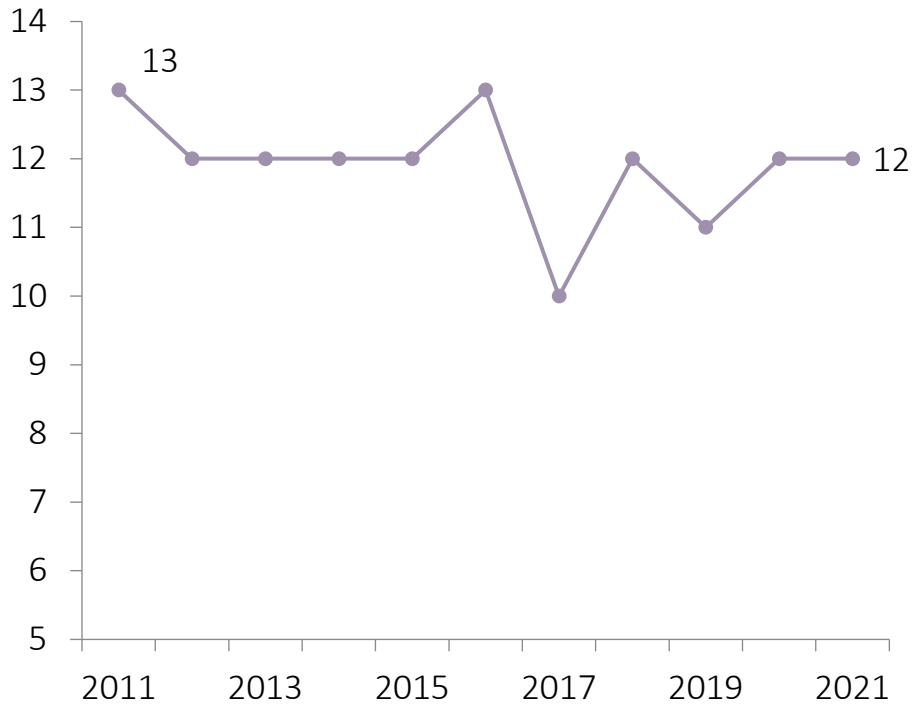


Supply is slightly outpacing demand throughout the projection period. (ADIN/UM)

Ontario

Radiation Oncology

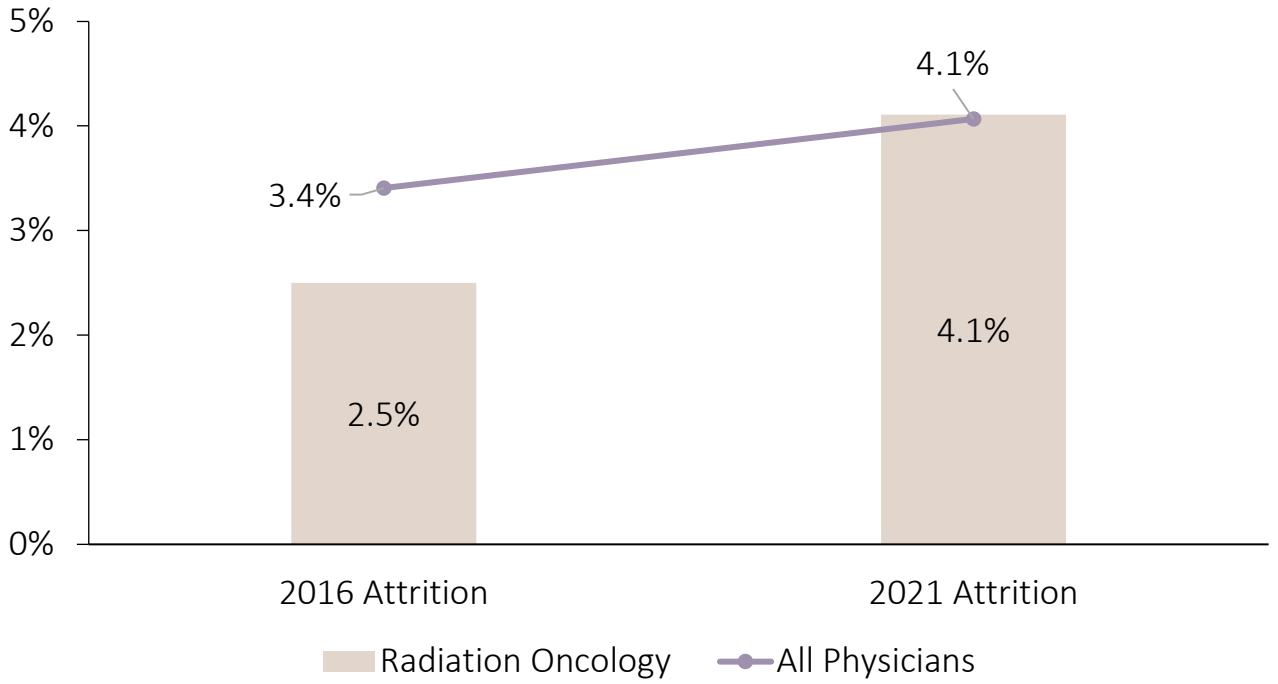
PGY1s



Between 2011 and 2021, the number of PGY1s decreased by 7.7% (from 13 to 12). (OPHRDC)

In Practice Attrition

In 2021 radiation oncologists' attrition rate matched the average across all physicians, while in 2016 they had a lower than average attrition rate. (OPHRDC)

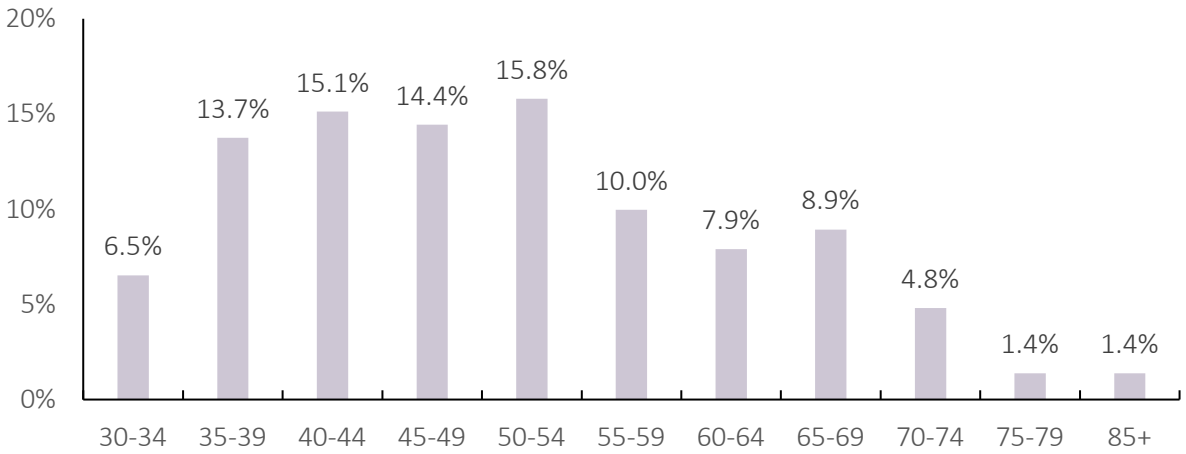


Urology

Supply

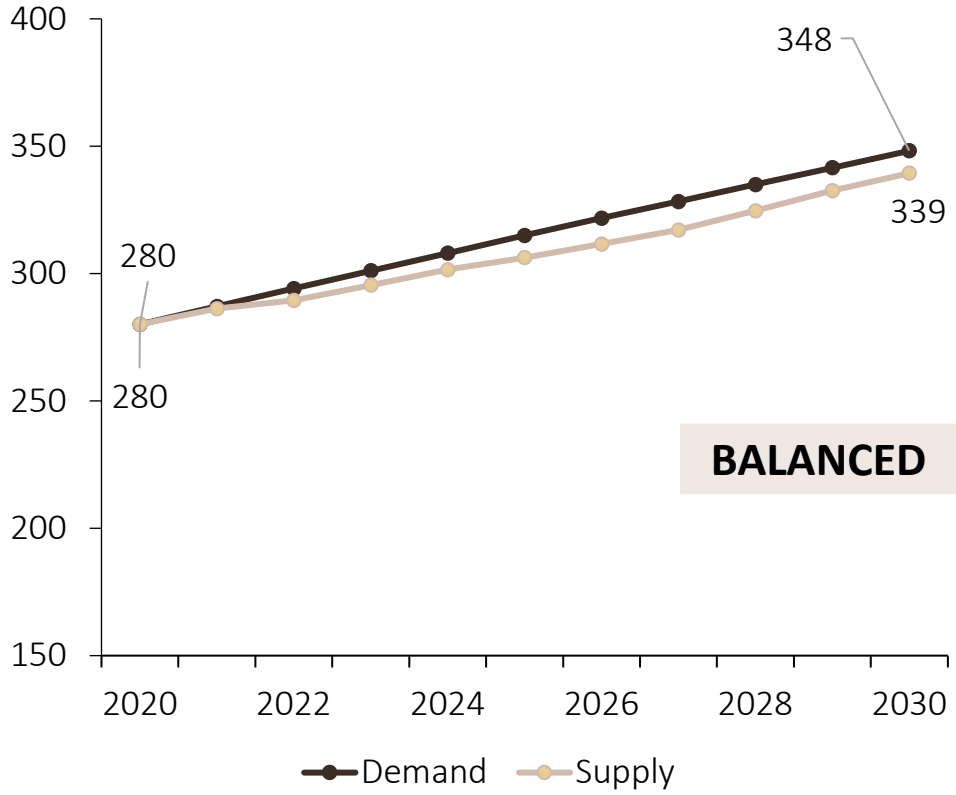
In 2021 there were 291 urologists practising in Ontario, up 3.9% from 2020 (280) and up 20.2% from 2011 (242). (OPHRDC)

Age



In 2021, the average age of a urologist in Ontario was 50.9 and 11.8% were between the ages of 65 and 74. (OPHRDC)

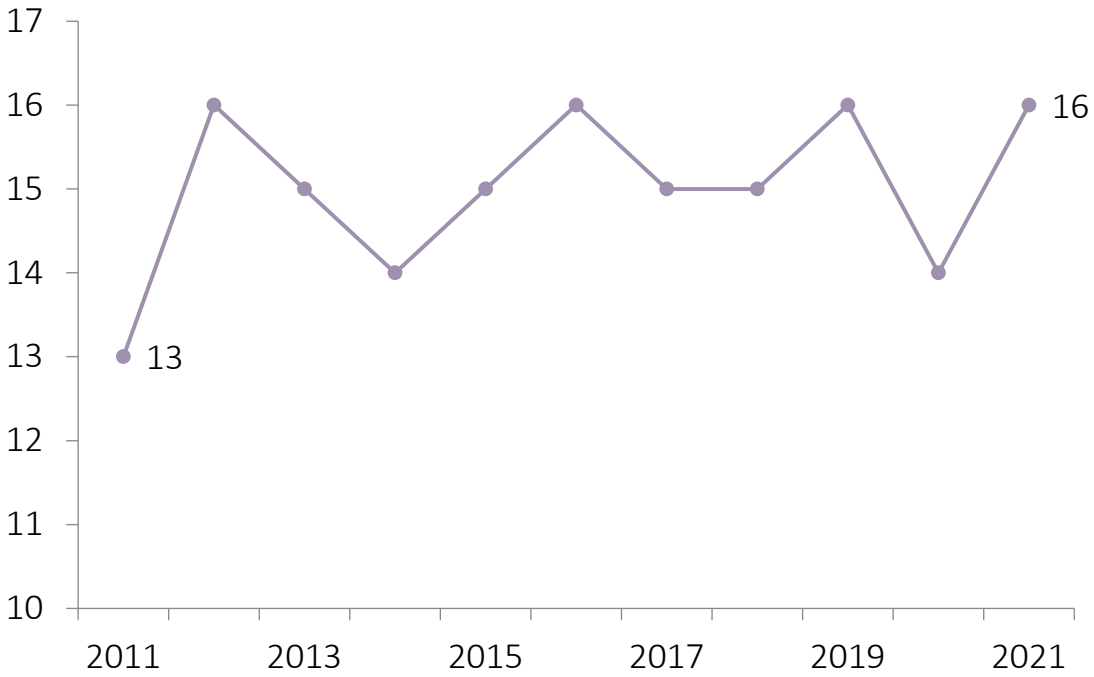
Modelling: 2020 to 2030



Supply and demand are well balanced throughout the projection period. (ADIN/UM)

Urology

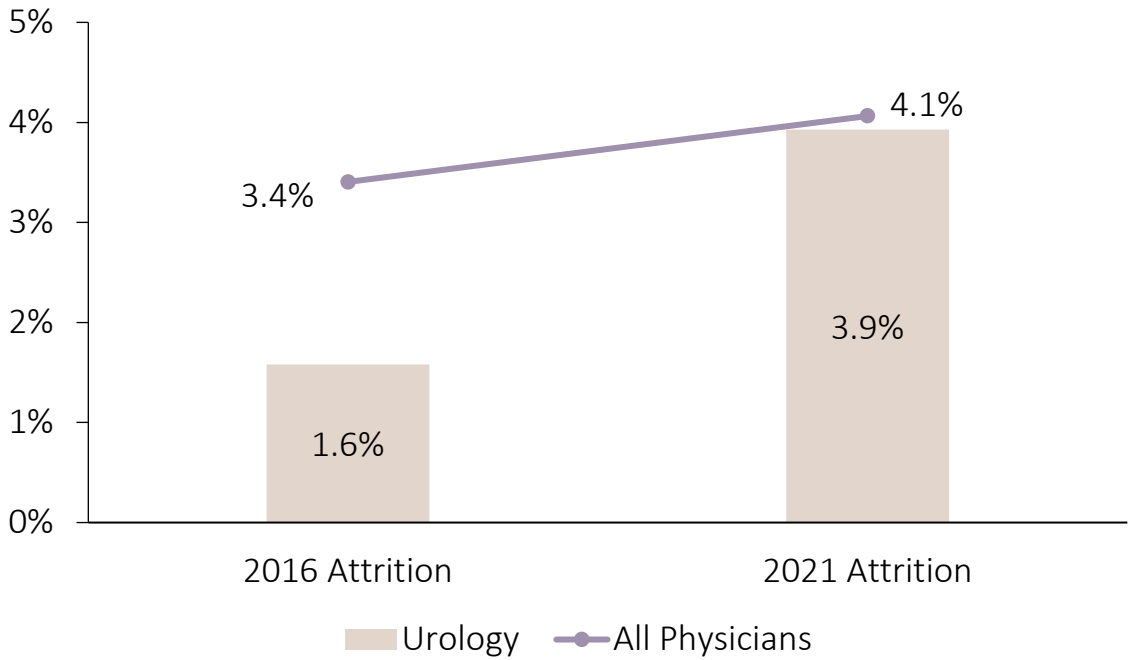
PGY1s



Between 2011 and 2021, the number of PGY1s increased by 23.1% (from 13 to 16). (OPHRDC)

In Practice Attrition

In both 2016 and 2021 urologists had a lower than average attrition rate. (OPHRDC)



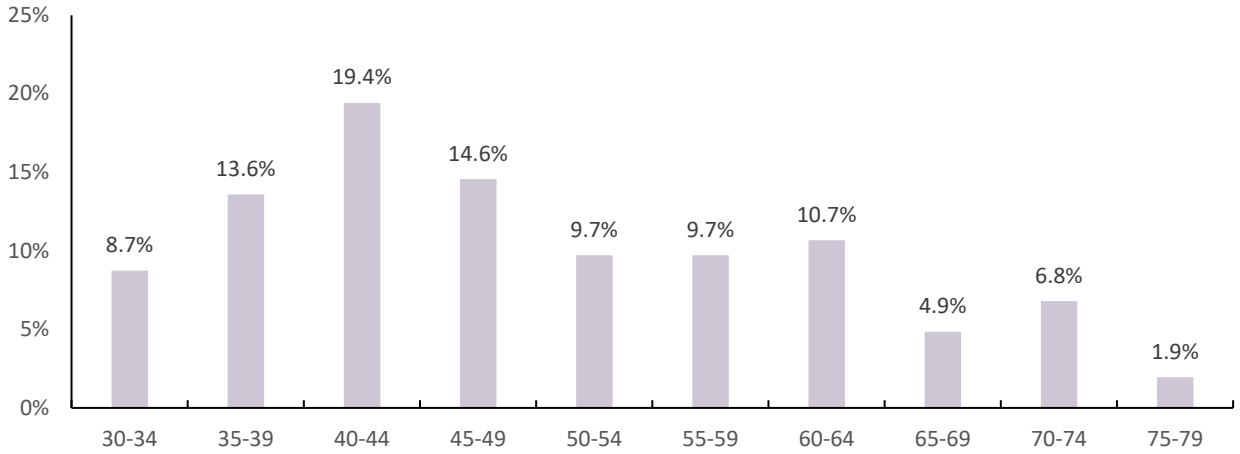
Ontario

Vascular Surgery

Supply

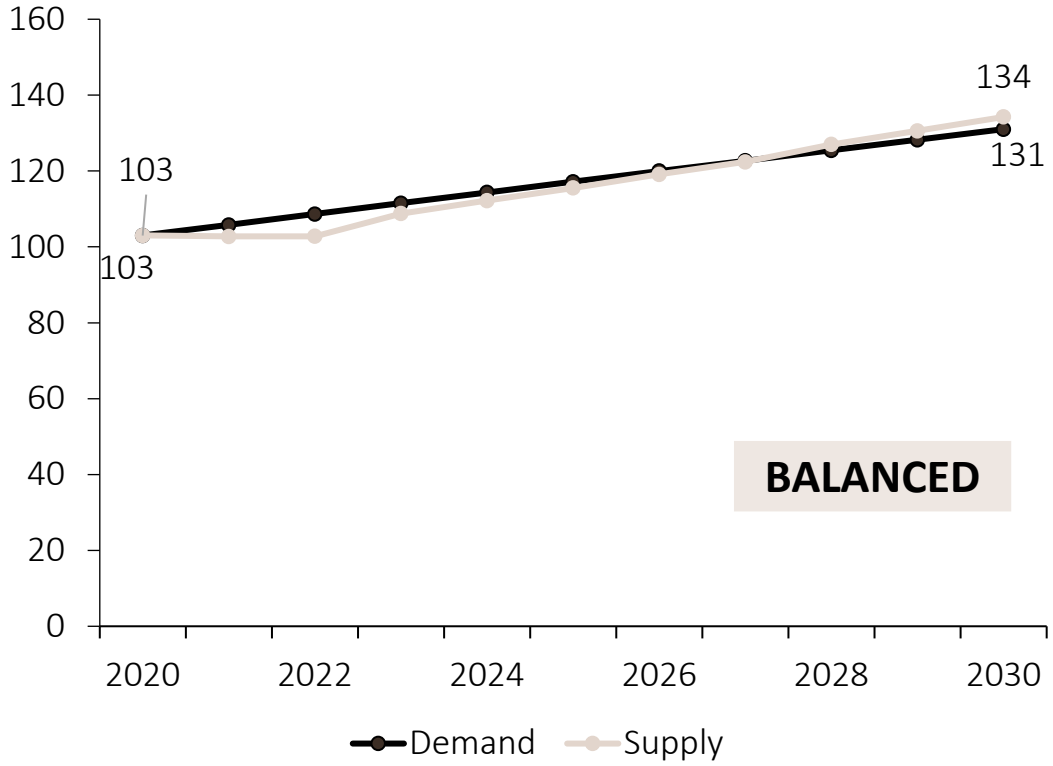
In 2021 there were 103 vascular surgeons practising in Ontario, up 0% from 2020 (103) and up 53.7% from 2011 (67). (OPHRDC)

Age



In 2021, the average age of a vascular surgeon in Ontario was 49.8 and 11.7% were between the ages of 65 and 74. (OPHRDC)

Modelling: 2020 to 2030

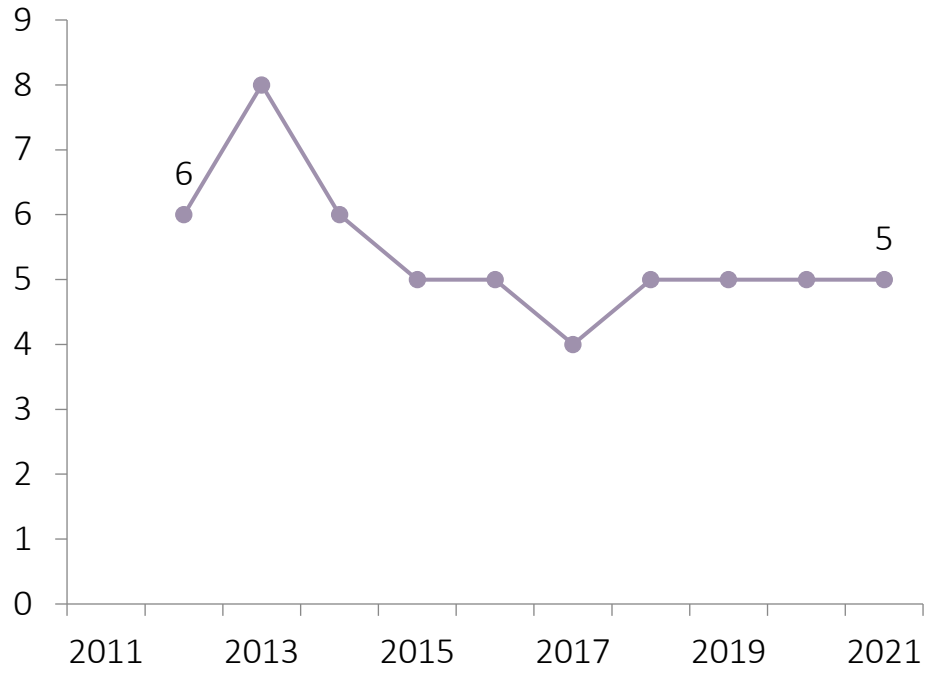


Our modelling projects supply and demand to be balanced. (ADIN/UM)

Ontario

Vascular Surgery

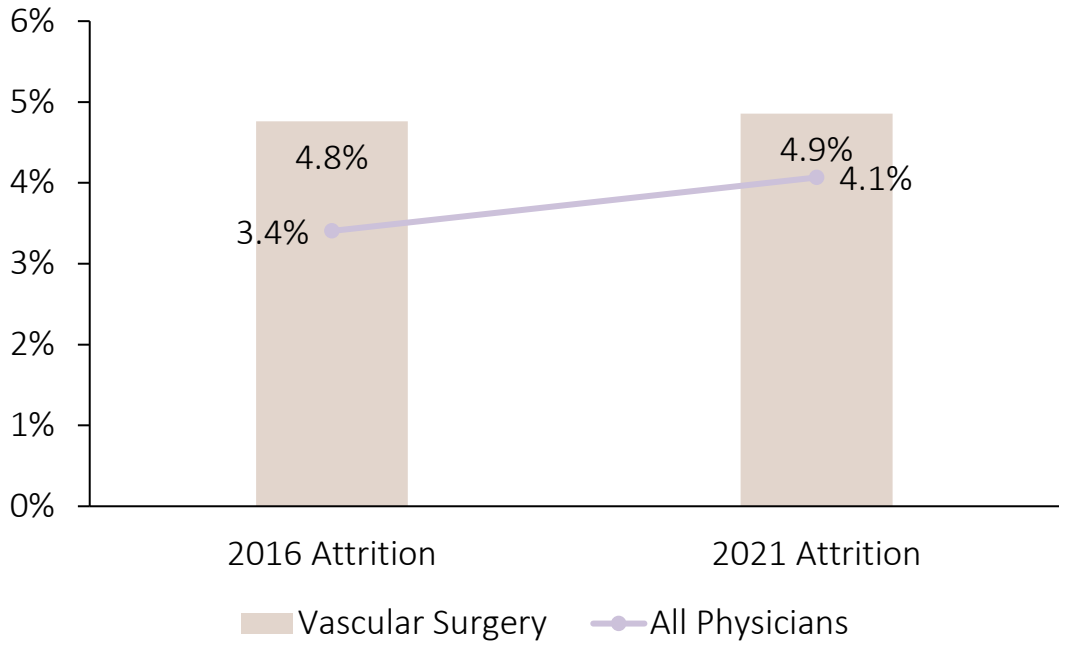
PGY1s



Between 2012 and 2021, the number of PGY1s decreased by 16.7% (from 6 to 5). (OPHRDC)

In Practice Attrition

In both 2016 and 2021, the attrition rate of vascular surgeons was higher than that of all physicians. (OPHRDC)



Ontario

Appendices

Appendix 1: Population Analysis

Between 2020 and 2030:

- Ontario population will increase by 13.2% from 14.8 million to 16.8 million
- 75+ population will increase by 54.3% from 1.1 million to 1.7 million
- Seniors aged 75+ and infants are the highest cost users of the Ontario health system. Therefore future pressures may occur:
    - In the Central West and Champlain LHINs with projected high percent increases in the 75+ population.
    - In the Central West, Mississauga-Halton, and Central LHINs with a high percent increase in the number of infants under the age of 1

Sources: 1) Ministry of Finance Population Estimates (2011-2016) and Projections (2017-2041) for Local Health Integration Networks (Updated June 2017), and 2)Health Analytics Branch, Health Care Users 2015/16 by Annual Cost Per Patient

Analysis of Health Conditions in Ontario

A review of the 2021 CIHI grouper data provided us with two types of analysis.

1) What are the conditions that are most prevalent (i.e., that people have most often) where they need to interact with the health system?

2) What are the conditions that use the most health system resources?

To the right you find the results of the analysis. Non-users/users without health conditions are the most common followed by individuals with neurotic/anxiety/obsessive compulsive orders.

"Dementia with Significant Comorbidities" is the population group that used the most resources, followed by "Palliative State" population group. In fact, those top two population groups used more resources each than the next 3 conditions combined (3. "Heart Failure", 4. "Skin Ulcer", 5. "Respiratory Failure without Heart Failure).

Health Profile Groups with the Highest # of Patients (2021)
Conditions
1. Non-users
2. Users without health conditions
3. Neurotic/anxiety/obsessive compulsive disorder
4. Minor acute respiratory condition (including cough, bronchitis)
5. Diabetes/hypoglycemia without chronic kidney disease or PVD/chronic vascular diagnosis without significant comorbidities
6. Minor acute skin condition (including dermatitis, cellulitis)
7. Minor GI acute condition (including GI symptom, ill-defined infection)
8. Other minor acute condition (including general symptoms)
9. Joint/tendon disorder and injury (including pain/sprain/strain)
10. Hypertension

Health Profile Groups with the highest total Resource Intensity Weight (2021)
Conditions
1. Dementia (including Alzheimer's disease) with significant comorbidities
2. Palliative state (acute)
3. Heart failure with CAD/arrhythmia with significant comorbidities
4. Skin ulcer (including decubitus) with significant comorbidities
5. Respiratory failure without heart failure
6. Obstetrics without significant comorbidities
7. Diabetes/hypoglycemia with PVD/other chronic vascular diagnosis with significant comorbidities
8. Respiratory failure with heart failure
9. CAD/arrhythmia without heart failure with significant comorbidities
10. Metastatic cancer with significant comorbidities

Utilization Model: DATA & METHODOLOGY

Ontario

Utilization-based model projects the future physician human resources (HR) need by combining OHIP claims data with existing supply-based physician HR modelling to estimate future physician gaps or surpluses for each physician specialty.
There are limits to utilization-based method of projection as it will not account for all factors regarding population needs but can still provide valuable data for trending and analysis as well as support ministry's health HR planning.

- The model uses OHIP claims data as a baseline to estimate the number of annual patient visits per five-year age range in the Ontario population and the number of annual patient visits per physician for each physician specialty.
- Patient visits per five-year age range are applied to Ministry of Finance population projections to estimate the future number of patient visits needed for each physician specialty.
- Patient visits per physician ratio is applied to future patient visit projections to estimate the future physician need for each physician specialty.

Note: The OHIP billing data will have greater number of entries than the Ontario Physician Reporting Centre, Physicians in Ontario (PIO) database of physicians in practice. During the OHIP and PIO data linking process, there were physicians with OHIP billing entries with CPSO numbers that were not found in the PIO database.

TAB 13

Canada faces critical anesthesiologist shortage, causing backlog of surgeries

CARLY WEEKS > HEALTH REPORTER
PUBLISHED AUGUST 23, 2023
UPDATED AUGUST 24, 2023

A surgery is performed in the operating room in Toronto's Hospital for Sick Children on Nov. 30, 2022.
CHRIS YOUNG/THE CANADIAN PRESS

A nationwide shortage of anesthesiologists is forcing patients to wait longer for surgery and putting hospitals in the increasingly difficult position of prioritizing cases, according to several practising anesthesiologists and a national professional association.

Canada is also facing critical shortages of a wide variety of health care workers, including nurses, family physicians and medical technologists, which are making it more difficult for patients to access timely, high-quality care.

But the shortage of anesthesiologists is being singled out because it can have an outsized impact on patients and the ability to delivery medical services.

It's a problem that medical leaders say is getting worse.

Last summer, Manitoba's health authority said it had to postpone 300 surgeries because of a lack of anesthesiologists.

This past February, Ontario's Niagara Health announced that a shortage of anesthesiologists was forcing it to move emergency after-hours surgeries to its Niagara Falls site from its Welland site.

In April, there were no anesthesiologists available for an entire week in Summerside, forcing patients to be diverted to Charlottetown for care.

Anesthesiologists work throughout hospitals to provide comprehensive sedation and pain management, including in surgical and critical care units, obstetrics and diagnostic imaging. Insufficient staffing means patients are waiting longer – a situation that could deteriorate further as the population ages.

"Access to surgeries in Canada will be impacted for years to come," said Lucie Filteau, president of the Canadian Anesthesiologists' Society.

Numbers provided by the association show there are 11 anesthesiologists in Canada for every 100,000 people, compared with 23 in Australia, 21 in the United States and 18 in Britain.

Dr. Filteau said the shortage is compounded by the fact the growing cohort of older Canadians increasingly needs surgery.

Many anesthesiologists are also nearing retirement age, according to the association. In 2018, 13 per cent of anesthesiologists in Canada were 65 or older, while 26 per cent were between 55 and 64.

The pandemic made the situation worse, with clinicians still trying to clear the backlog of patients awaiting surgery and lacking sufficient resources to do so, said Kevin Gregg, the president of the Alberta Medical Association's anesthesia section.

"The reality is we don't have enough providers to perform all of the surgeries that need to be done," Dr. Gregg said. "It's really tough when you're in a room with a patient one-on-one and you have to say, 'You're not a priority right now.' That's the reality of our system."

Ontario rolls out programs to boost health staffing

Rohit Kumar, a practising anesthesiologist and chair of Ontario's Anesthesiologists, said the good news is there are ways to address the current shortages. For instance, some hospitals may be understaffed while others have anesthesiologists who are available to work. Finding ways to address those gaps and ensure hospitals are able to work at full capacity would be an important change, Dr. Kumar said.

But if the shortages in anesthesiology aren't addressed in the near term, he sees it becoming a much more serious problem.

Dr. Filteau notes that anesthesiologists have long been calling attention to the issue, saying it was an entirely predictable problem.

And it can't be solved overnight. It can take anywhere from 13 to 15 years for an anesthesiologist to complete training, Dr. Gregg said. Other solutions are being looked at, such as using anesthesiology assistants – respiratory therapists who have completed additional training. While they can't replace anesthesiologists, in specific circumstances they may be one way to contend with the current shortage, Dr. Gregg said.

Other solutions being touted by the professional association include increasing the number of anesthesiology residency positions; greater use of family practice anesthetists – family physicians who have undergone an additional year of training, in order to fill gaps in rural or remote areas; and creating a national licence for physicians that would allow anesthesiologists to go to areas outside their home province that are facing a significant need.

TAB 14

Embargoed until May 5, 2023: ISSUE: To provide a summary of the results of the Canadian Medical Resident Matching Service (CaRMS) 2023 second iteration match

Key Messages

- **On April 27, 2023 (Match Day), The Canadian Resident Matching Service (CaRMS) concluded the 2023 CaRMS second iteration entry match.**
- **The results from the 2023 CaRMS match indicate that, on balance, this is a favourable match for Ontario.**

Ontario Results **EMBARGOED UNTIL MAY 5, 2023**

Filled Position (Seats)

- **Ontario had an extremely high fill rate. Filling 1,245 of the 1,248 offered positions, 99.8% filled. Ontario decreased the number of unfilled (vacant) positions from 15 in 2022 to just 3 in 2023.**
- **Nationally, there were 110 unfilled positions, only three were in Ontario.**
- **Ontario has been able to attract more international medical graduates (IMG) than in any previous match. It is anticipated that up to 280 of our funded positions have been filled by IMG's.**
- **Ontario filled more Family Medicine positions than in any previous match. Filling 523 in 2023 compared to 497 in 2022, 26 more F.M. residents than after last years match.**
- **As part of Ontario's multi-year medical education expansion plan, the ministry increased the number of available funded positions in 2023 by 60 (from 1,188 in 2022 to 1,248 in 2023) (see appendix A for details).**

Unmatched Ontario Graduates

- **Embargoed information indicates that the number of unmatched current year graduates from Ontario medical schools increased from 10 to 31 unmatched overall. (See appendix B for possible reason for being unmatched). This may give rise to some concern from the schools and from Ontario Graduates.**
- **Ontario has already taken action to support improved matching rates for Ontario graduates by offering positions exclusively dedicated to Ontario Medical Graduates.**

Recent Ministry Interventions:

- **To support Ontario's expansion and increase the role of IMGs in our training system, the ministry blended the 2nd iteration of the match. This opened more positions to IMG's.**
- **In March 2023 the ministry announced the expansion of an additional 154 resident training positions. 91 dedicated for Ontario graduates and 63 for IMGs.**

Public Information:

- **CaRMS will publicly release a small "snapshot" report on April 27. Privately to Schools around 11:00 and publicly around 5:00 p.m.**
- **A full data report from CaRMS will be publicly available on May 5, 2023**

Embargoed until May 5, 2023: ISSUE: To provide a summary of the results of the Canadian Medical Resident Matching Service (CaRMS) 2023 second iteration match

Table 1: Ontario unmatched

Unmatched Ontario Medical Graduates								
	UG to PG (MOH Funded)				2nd iteration			
Year	MCU Funded Seats (Ontario Medical UG)	Ontario CMG Resident Positions	# of Positions over 1 :1	Ontario UG to PG Ratio	Unmatched Current Year Graduates	Unmatched Previous Year Graduates	Total Unmatched After Second Iteration	Vacancies (unfilled) Ontario Positions
2023	952	1,038	86	1 : 1.09	15	16	**31**	3
2022	952	988	36	1 : 1.04	4	6	**10**	15
2021	952	988	36	1 : 1.04	10	5	**15**	4
2020	952	988	36	1 : 1.04	8	7	**15**	9
2019	952	988	36	1 : 1.04	7	2	**9**	5
2018	952	988	36	1 : 1.04	32	21	**53**	2
2017	952	988	36	1 : 1.04	35	18	**53**	2
2016	952	988	36	1 : 1.04	19	29	**48**	2
2015	952	1,009	57	1 : 1.06	17	21	**38**	1
2014	940	1,009	69	1 : 1.07	22	19	**41**	5
2013	888	1,011	123	1 : 1.14	11	19	**30**	1
2012	864	984	120	1 : 1.14	13	12	**25**	7
2011	845	947	102	1 : 1.12	6	9	**15**	11

- Ontario's 31 unmatched graduates does represent an increase from last year's 10. However, the announce creation of positions dedicated to Ontario graduates will address this issue in all future matches.

Unfilled by program and school

- Ontario has only 3 unfilled positions after the offering largest number of positions ever (1,248 positions).
- 3 Family Medicine positions were unfilled, two with NOSM and one with Western

Next Steps:

- The Capacity and Health Workforce Planning Branch (CHWPB) will meet with the Council of Ontario Faculties of Medicine (COFM) to hear any concerns with the match and to discuss the next phase of the expansion.
- CHWPB will continue to monitor any stakeholder reaction to these results.

Prepared by: Peter Rizzo, Sr. Planning and Programs Analyst, Health Workforce Planning and Programs Unit (HWPPU)
Branch: Capacity and Health Workforce Planning Branch (CHWPB)
Phone: (437) 219-8934
Originated: April 27, 2023
Approved by: Laura DesRoches, Manager, HWPPU
David Lamb, Director, CHWPB (416 453 4898)

Embargoed until May 5, 2023: ISSUE: To provide a summary of the results of the Canadian Medical Resident Matching Service (CaRMS) 2023 second iteration match

Appendix A – 2023 Expansion Position Table

PROGRAM	2023 Expansion
Family Medicine	**18**
Anesthesia	6
Emergency Medicine	6
General Surgery	4
Cardiac Surgery	2
Ophthalmology	2
Internal Medicine	8
Neurology	2
Obstetrics & Gyn North	2
Pediatrics	2
Phys Med & Rehab	3
Psychiatry	4
Total Spec Programs	**42**
Total All Programs	**60**

Note: 2024 Expansion will target Family Medicine

Embargoed until May 5, 2023: ISSUE: To provide a summary of the results of the Canadian Medical Resident Matching Service (CaRMS) 2023 second iteration match

Appendix B: **Possible Causes for Being Unmatched:**

A number of factors account for medical undergraduates to be unmatched.

- Unmatched factors that the applicants cannot address at the match time include:
    - Poor grades
    - Weak Medical School Performance Report (MSPR)
        - The Medical Student Performance Record (MSPR) is a comprehensive transcript of your performance throughout the four years of medical school. It is not a letter of recommendation but a more objective reporting of academic history, the evaluations received, and the faculty-sponsored activities in which the candidate has participated.

- Unmatched factors the applicants can address or modify at the time of the match include:
    - missing documentation
    - the quality of a personal letter
    - poor interpersonal skills or language issues

- Results for unmatched may include:
    - Applicants who did not complete a Rank Order List (ROL)
    - Applicants who were Ranked (selected) by a program, but did not Rank that program
    - Applicants who were not ranked by any program
    - Applicants who were ranked by the program, but the program filled before getting to their name; for example, a program has 10 positions and ranked the applicant as 14th choice and the program filled before getting to 14th choice.

TAB 15

	Ontario UG Graduating and PG CMG & IMG (MOH Funded)					Match Results			Ontario CMG Unmatched		
Year	MCU Funded Seats (Ontario Medical UG)	Ontario CMG Resident Positions	Ontario IMG Resident Positions	Total Positions Offered by Ontario	Ontario UG to PG Ratio	Filled by CMG	Filled by IMG	Vacancies (unfilled) Ontario Positions	Unmatched Current Year Graduates	Unmatched Previous Year Graduates (1)	Total Unmatched After Second Iteration
2023	952	1038	210	1248	1 : 1.09	962	286	0	15	16	**31**
2022	952	988	200	1188	1 : 1.04	973	200	15	4	6	**10**
2021	952	988	200	1188	1 : 1.04	984	200	4	10	5	**15**
2020	952	988	200	1188	1 : 1.04	978	201	9	8	7	**15**
2019	952	988	200	1188	1 : 1.04	983	200	5	7	2	**9**
2018	952	988	200	1188	1 : 1.04	986	200	2	32	21	**53**
2017	952	988	200	1188	1 : 1.04	975	211	2	35	18	**53**
2016	952	988	200	1188	1 : 1.04	984	202	2	19	29	**48**
2015	952	1,009	201	1210	1 : 1.06	1000	209	1	17	21	**38**

1034-
1087 CMG 237 IMG

Current + Proposed Entry Level Undergraduate (UG) & Postgraduate (PG) Positions											
Training Positions (All Schools)	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
UG Entry Level Positions											
Current UG Positions	952	952	952	952	952	952	952	952	952	952	952
160 Expansion of UG Positions	5	30	60	160	160	160	160	160	160	160	160
Total Entry Level UG Positions in Ontario	957	982	1012	1,112	1,112	1,112	1,112	1,112	1,112	1,112	1,112
PG Entry Level Positions											
Current PG Positions	1,188	1,188	1,188	1,188	1,188	1,188	1,188	1,188	1,188	1,188	1,188
295 Expansion of PG Positions	0	65	121	268	284	295	295	295	295	295	295
63 Proposed IMG PG Positions	0	0	18	35	46	63	63	63	63	63	63
91 Proposed OMG Positions	0	0	12	35	49	70	91	91	91	91	91
Total Entry Level PG Positions in Ontario	1,188	1,253	1,339	1,526	1,567	1,616	1,637	1,637	1,637	1,637	1,637

TAB 16

Canadian Institute for Health Information (CIHI) Release of Health Workforce in Canada 2021 Report

ISSUE: What does this report indicate about the health workforce in Ontario?

On November 17, 2022, CIHI released its report titled Health Workforce in Canada, 2021: In Focus (including [redacted] and physicians). This publication includes a data report that provides information on how the pandemic has impacted health care workers and health care delivery, and data tables that provide information on physicians, [redacted] in provinces and territories across Canada.

Ontario commends the CIHI for their collection and reporting of health workforce information to support federal, provincial and territorial workforce planning and policy development.

The ministry is in the process of reviewing this report and determining how this data will be used this data in conjunction with other key health workforce evidence to support robust policy and program development.

■

Canadian Institute for Health Information (CIHI) Release of Health Workforce in Canada 2021 Report

Overview

This release includes:

- **Data tables, 2012-2021**: provide information on supply, workforce, employment, education and demographic trends for physicians, [redacted], as well as physician service utilization data.
- **Health Workforce in Canada, 2021 - Quick Stats**: contains data on provincial and territorial trends in the supply, workforce, direct care, inflow/outflow, graduate migration data and select hospital staffing indicators for physicians, [redacted]
- **2021 methodology guides** for reported professions will also be released with the data tables. These documents summarize the basic concepts, methodologies, strengths and limitations of the data.

Key Results

- [redacted]
- Between 2017 and 2021, the ratio of all Ontario physicians per 100,000 population increased from 228 to 235 but was below the Canadian average of 246 in 2021.
- Provider to population ratios should only be used along with other factors to determine need for [redacted] and physician services. These ratios do not consider many important factors such as: the specific health needs of the population, the amount and types of services provided, and the geographic distribution of providers.

1. Data tables, 2012-2021 [1]

Report Description: These data tables highlight supply, workforce, employment, education and demographic trends for nurses, physiotherapists, occupational therapists and pharmacists (2012 - 2021), physicians (2017 – 2021) [2], and physician payment/utilization data (1996 - 2021) [3].

[1] Physician data tables have different sets of years
[2] Additional physician data tables with historical information are available for 1971-2021
[3] Years of data reports varied (starting with 1996 or 1999 depending on the data set)

Canadian Institute for Health Information (CIHI) Release of Health Workforce in Canada 2021 Report

Physicians:

- Between 2017-2021, the number of all physicians increased by 8.8% (from 32,055 to 34,860):
  - The number of family medicine physicians increased by 7.0% (from 16,088 to 17,220).
  - The number of specialist physicians increased by 10.5% (from 15,967 to 17,640).
  - In 2021, 25.5% (8,891) of all physicians were aged 60 years and older:
    - 24.4% (4,195) of family medicine physicians, and
    - 26.6% (4,696) of specialist physicians.
  - In 2021, 42.9% (14,951) of all physicians were female:
    - 47.3% (8,151) of family medicine physicians, and
    - 38.5% (6,800) of specialist physicians.
  - In 2021, 30.0% (10,457) of all Ontario physicians were internationally educated:
    - 34.3% (5,897) of family medicine physicians, and.
    - 25.9% (4,560) of specialist physicians.
- The ratio of all physicians per 100,000 population increased from 228 to 235 (in comparison, 246 in 2021 across Canada):
  - the ratio of family medicine physicians increased from 114 to 116 (in comparison, 124 in 2021 across Canada).
  - the ratio of specialist physicians increased from 113 to 119 (in comparison, 122 in 2021 across Canada).

Family Medicine Physicians per 100,000 population by LHIN, 2021

Ontario	**116**
Erie St. Clair LHIN	95
South West LHIN	115
Waterloo Wellington LHIN	100
Hamilton Niagara Haldimand Brant LHIN	103
Central West LHIN	77
Mississauga Halton LHIN	106
Toronto Central LHIN	196
Central LHIN	102

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Central East LHIN	89
South East LHIN	133
Champlain LHIN	145
North Simcoe Muskoka LHIN	113
North East LHIN	128
North West LHIN	162
Unknown	n/a

Specialist Physicians per 100,000 population by LHIN, 2021

Ontario	**119**
Erie St. Clair LHIN	68
South West LHIN	131
Waterloo Wellington LHIN	73
Hamilton Niagara Haldimand Brant LHIN	132
Central West LHIN	51
Mississauga Halton LHIN	90
Toronto Central LHIN	323
Central LHIN	92
Central East LHIN	70
South East LHIN	144
Champlain LHIN	154
North Simcoe Muskoka LHIN	75
North East LHIN	79
North West LHIN	87
Unknown	n/a

See Appendix A for more information on the number of physicians by specialty in Ontario in 2021.

2. Ministry Analysis

- [redacted]

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- MOH compared CIHI's 2021 data to the 2021 HPDB results, [redacted] (except physicians).
- [redacted]

Physicians

- MOH compared CIHI's 2021 data to the 2021 Ontario Physician Reporting Centre (OPRC) results. The ministry found that most numbers were comparable where applicable (i.e., within 5% of each other) (See Appendix C).

- Significant deviation was found for:
  - **Family medicine physician number:** OPRC data is 12.1% lower.
  - Please note explanations below.

- The Ontario Physician Reporting Centre (OPRC) is Ontario's primary source for physician supply and postgraduate medical trainee data for over 20 years. OPRC has maintained a registry of all practicing physicians in Ontario since 1992.

- The OPRC and CIHI have periodically reviewed/compared their methodologies and data sources to ensure the accuracy of each other's data. The OPRC's use and access to multiple data sources for Ontario has provided them with, what is generally agreed to be, a more accurate count of physicians in Ontario.

- There are several differences between CIHI's and the OPRC's methodologies for counting physicians:
  - In Ontario, physician supply is reported by OPRC. Their counts include only practicing licensed physicians, semi-retired and military physicians.
  - By comparison, CIHI's Scott's Medical Database includes non-registered physicians, excludes physicians who are semi-retired, in the military and those who request to be excluded from the publication (non-registered physicians only).
  - In recent years, CIHI's methodology includes a higher number of physicians than the OPRC.

- In 2017, CIHI's Scott's Medical Database was purchased by iMD Health Global Corp. In 2018, iMD undertook a significant cleaning/updating process intended to improve data quality. This resulted in a significant one-time change in the supply of some (sub)specialties.

- The ministry uses OPRC data whenever possible within its physician models and planning tools; however, Ontario relies on CIHI for data pertaining the migration of physicians in and out of Ontario.

3. Stakeholder Reaction

- There are several stakeholders who will have an interest in the results of this CIHI report. It is not anticipated that the report will be contentious and/or result in significant issues. Below is a chart that outlines the key stakeholders, their possible reactions to the report, and any mitigation strategies.

Stakeholder	Reaction to CIHI Data Report/Tables	Mitigation Strategy
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Ontario Medical Association (OMA)	The OMA may highlight that the Ontario physician-to-population ratios are below the Canadian average. OMA might interpret this to mean Ontario physicians work harder than physicians in other	Message that the ministry works with health system partners and uses research, data and analytical modelling to determine the number of physicians required to meet health

	provinces and should be compensated at a higher rate.	system demand. Further physician-to-population ratios do not consider many important factors such as: the specific health needs of the population, the amount and type of services provided, and the geographic distribution of providers and patients.
Ontario Medical Schools	May use the physician to population ratio to point to a need for more postgraduate training positions as a solution to access to care challenges in the province.	Continue to message that the ministry works with Ontario medical schools, uses research, data, and analytical modelling to determine the number and mix of postgraduate seats to best meet Ontario's population health needs.
Pan-Canadian Stakeholders	Data can be used to support pan-Canadian planning.	N/A – stakeholders will be pleased to receive this updated data to support national planning.

4. Background

- CIHI is an independent, not-for profit, federally incorporated organization. It was formed in 1994 with the mandate to lead the development of a comprehensive health information system in Canada. It provides a foundation for understanding some of the most critical and complex issues in health care.

Prepared by: Olha Shmanko
Health Workforce Evidence Unit (HWEU)

Approved by: Stephanie Akers, Manager, HWEU
David Lamb, Director, Capacity and Health Workforce Planning Branch

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Appendix A:
Number of Physicians by Specialty in Ontario, 2021

Source: Scott's Medical Database, Canadian Institute for Health Information.

Specialty	2021
1 Family medicine	**17,220**
General practice	4,205
Emergency family medicine	930
Family medicine	12,085
2 Specialists	**17,640**
2.1 Medical specialists	**13,459**
2.1.1 Clinical specialists	**12,808**
Anesthesiology	1,359
Dermatology	242
Diagnostic radiology	1,050
Neuroradiology	1
Pediatric radiology	0
Emergency medicine	475
Internal medicine	1,956
Cardiology	563
Clinical immunology and allergy	54
Clinical pharmacology and toxicology	0
Critical care medicine	202
Endocrinology and metabolism	217
Gastroenterology	290
General internal medicine	0
Geriatric medicine	128
Hematology	197
Infectious diseases	113
Medical oncology	223
Nephrology	246
Occupational medicine	22
Palliative medicine	0
Respirology	282
Rheumatology	209
Medical genetics and genomics	46
Neurology	459
Electroencephalography	1
Nuclear medicine	73
Pediatrics	1,291

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Adolescent medicine — Pediatrics	0
Cardiology — Pediatrics	33
Child and adolescent psychiatry — Pediatrics	3
Clinical immunology and allergy — Pediatrics	38
Clinical pharmacology and toxicology — Pediatrics	0
Critical care medicine — Pediatrics	14
Developmental — Pediatrics	0
Emergency medicine — Pediatrics	39
Endocrinology and metabolism — Pediatrics	33
Gastroenterology — Pediatrics	16
Hematology/oncology — Pediatrics	28
Infectious diseases — Pediatrics	30
Neonatal — Perinatal medicine	0
Nephrology — Pediatrics	21
Respirology — Pediatrics	27
Rheumatology — Pediatrics	20
Physical medicine and rehabilitation	236
Psychiatry	2,198
Forensic psychiatry	0
Geriatric psychiatry	1
Public health and preventive medicine	145
Radiation oncology	227
2.1.2 Laboratory specialists	**651**
Anatomical pathology	448
General pathology	87
Forensic pathology	0
Hematological pathology	30
Medical biochemistry	17
Medical microbiology	50
Neuropathology	19
2.2 Surgical specialists	**4,181**
Cardiac surgery	135
General surgery	826
Colorectal surgery	1
General surgical oncology	7
Pediatric surgery	18
Neurosurgery	112
Obstetrics and gynecology	981
Gynecologic oncology	10
Maternal–fetal medicine	0

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Ophthalmology	461
Orthopedic surgery	658
Otolaryngology — Head and neck surgery	290
Plastic surgery	261
Urology	317
Vascular surgery	104
2.3 Medical scientists	**0**
Total — All physicians	**34,860**

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Appendix C: 2021 Supply Count: OPRC Versus CIHI

Profession	CIHI	OPRC	Difference	% Difference
All Physicians	34,860	33,170	-1,690	-5.1%
Family Medicine	17,220	15,363	-1,857	-12.1%
Specialists	17,640	17,807	167	0.9%

TAB 17

Proof Point

Proof Point: Canada needs more doctors—and fast

- Canada will be short about 44,000 physicians by 2028, with family doctors accounting for 72% of the deficit.
- In addition to closing that gap, Canada will need to train or hire 30,000 more physicians by 2028 to match the average number of doctors per capita among OECD peers.
- Limited residency spots, a lack of professionals to evaluate prospective physicians, and funding shortfalls have created a chain of bottlenecks.
- And the shortages are adding pressure to an already strained healthcare system, as patients unable to find family doctors turn to emergency rooms instead.
- **The bottom line:** Hiring and training more doctors specializing in high-demand disciplines will help alleviate chronic shortages. Adding residency spots for fresh domestic and international medical graduates can help address some long-term challenges. And technology and policy that support the current workforce can improve efficiencies.

Ben Richardson and Yadullah Hussain
November 23, 2022

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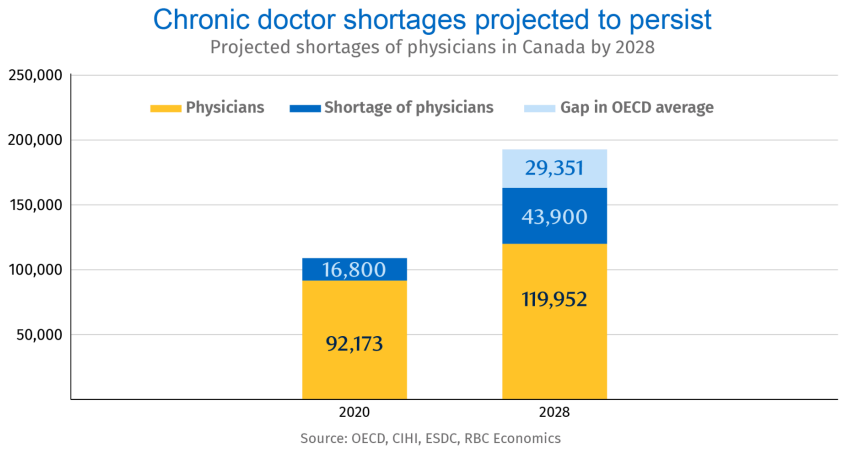
Topics

Proof Point

The doctor is out: a severe shortage of physicians is fast approaching

Finding a family doctor in Canada is getting harder. Roughly six million Canadian adults don't have access to a family doctor—up from 4.6 million in 2019. The situation is particularly alarming in rural communities where only 8% of physicians are serving nearly one-fifth of Canada's population. The pain of this shortfall is already being felt in the broader healthcare system. Family doctors are often the first stop for patients seeking medical attention. And without quick access to them, patients are turning to emergency departments already overwhelmed by the pandemic.

The crisis is set to deepen. Canada is estimated to be short nearly 44,000 physicians, including over 30,000 family doctors and general practitioners, before the end of the decade. Though 2,400 family physician positions were advertised on government websites by the end of 2021, just 1,496 family doctors exited residency training that year.



Canada's supply of doctors has fallen behind other major economies

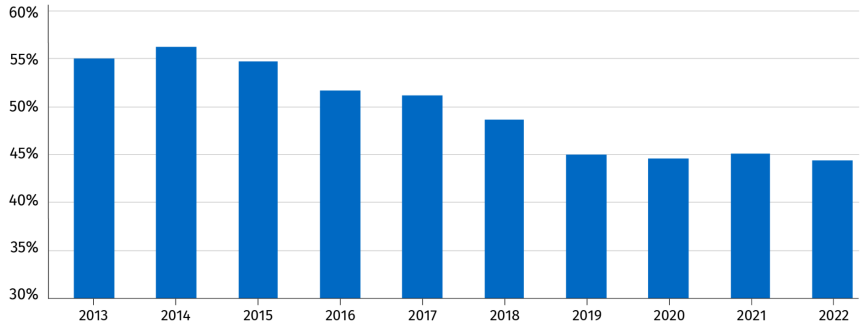
The number of doctors per capita in Canada is well behind that of peer countries like France and Germany, according to OECD data. What's more, due to data comparability issues, these figures paint a rosier picture for Canada by including non-practicing doctors (educators, researchers, managers, etc.) in overall physician

statistics. With Canada's population set to rise 7.7% by 2028, addressing this primary healthcare crunch is critical. But easing bottlenecks across the system is more complex than simply recruiting more domestic and international individuals to study medicine.

The first choke point is a quota system that all 17 Canadian medical schools are subject to, and that limits student admissions to just under 3,000 spots for prospective doctors each year. The second is the disproportionate number of graduates from international medical schools (both Canadian and foreign-born) who don't end up with residency positions. Over 90% of the roughly 2,100 applicants who went unmatched in the past three years were international medical graduates (IMGs). The third is the expansion of quotas for medical students without a commensurate increase in residency opportunities—a vital requirement to practice medicine.

The final bottleneck is the declining share of medical students choosing to study family medicine—the discipline most in demand in Canada. An incentive drive to encourage more people to pursue this career, and for medical practitioners to take trainees, is urgently needed.

Fewer residency candidates in Canada favour family medicine



Source: CaRMS

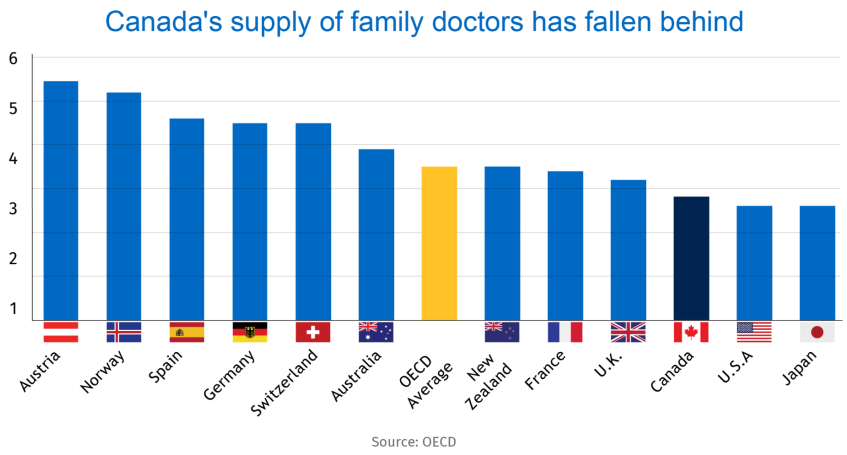
Streamlined credentialing, more funding needed to curb doctor shortage

Investment will be needed to expand the capacity of hospital and university networks, to add educators and assessors, and to increase residency spaces in the Canadian medical system. More

residency spaces are also needed to align with the increase in medical school student quotas. And streamlining credential recognition for internationally-trained physicians (ITPs) and international medical graduates (IMGs) will be crucial. Programs like Practice-Ready Assessment (PRA) can assess ITPs and IMGs in a clinical environment over a period of twelve weeks by evaluating candidates more practically and thoroughly while expediting their workforce integration. Currently, however, only seven of ten provinces employ PRA. Ontario, home to 39% of Canada's population, scrapped the PRA program in 2018. This has exacerbated the province's doctor shortage.

Many provinces are taking important steps to alleviate shortages. Ontario is making it easier for out-of-province physicians to temporarily practice in the province, while British Columbia is raising family doctors' earnings. But more should be done to attract internationally-trained physicians who can begin providing care to Canadians quickly.

As we work to attract more trainees to family medicine, we can unlock other efficiencies, including by encouraging family physicians to work collaboratively with other healthcare professionals to ensure timely patient care. Technology can help streamline the prescription process, and telehealth consultations can reduce administrative burdens.



Ben Richardson *Ben is responsible for researching pieces for RBC Economics and Thought Leadership. Prior to joining RBC, he obtained a Master's degree from the University of Toronto and worked in Washington, D.C., at the Woodrow Wilson Center, researching topics concerning Canada-US relations.*

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+ Disclaimer

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May 29, 2024

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May 24, 2024

The Tech Outlook: Bumpy Now, Bright Soon

May 21, 2024

Top

TAB 18

Physician Workforce Strategy

"We must eliminate the gaps in Northern Ontario health human resources in order to achieve equitable and sustainable access to quality health care."

Dr. Sarah Newbery
Associate Dean, Physician Workforce Strategy
physicianworkforce@nosm.ca
@NOSMMDworkforce

The health and wellbeing of Northern Ontarians depends on having timely access to physicians and other healthcare providers, to meet the diverse needs of the people.

In June of 2023, Northern Ontario was actively recruiting for 384 physicians. This was an increase from recruitment needs of 364 physicians in the year prior.

As with many places, the need for family physicians across our communities has increased.

At NOSM University we are working hard, alongside partners to reverse this trend and ensure that communities and citizens have the physicians that they need to improve care and health outcomes.

What do we know about our current needs? +

What is NOSM University's role in the development of physician resources for Northern Ontario? +

1. Education and training of future clinicians – both through NOSM University's programs and through elective and core rotation placements for learners from other schools
2. Facilitating the retention of skilled faculty through career and academic opportunities
3. Collaboration with health system partners for planning, advocacy and alignment

4. Collaboration through formal and informal agreements with other Ontario universities to increase clinical placements of core and elective learners in Northern Ontario

NOSM University offers several Family Medicine and Royal College Specialty Postgraduate Programs. **Learn more**.

Physician HHR Data for 2023 +

Physician HHR data – June 2022 +

Physician Human Health Resource Data – June 2021 +

For more information about working as a physician in N. Ontario +

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Ontario/Queensland Knowledge Transfer Project

Presentation: Building a Flourishing Physician Workforce

TAB 19

justanoldcountrydoctor

Medicine. Politics. Common Sense.

Perspectives on Ontario Health Care by a Recent Graduate

NB: My thanks to Dr. Tristan Brownrigg for guest blogging for me today. By his own admission, he never planned to be political, or seek out the limelight. But the situation in Ontario is such that he felt his perspective should be heard. I have a great deal of respect for people like Dr. Brownrigg, who are willing to step out of their comfort zone when necessary, and I commend him for doing so.

Dr. Tristan Brownrigg: I am a family physician, outdoorsman, and rural generalist currently working a mix of clinic, ER and inpatient care in the East Kootenays of British Columbia. I graduated from the University of Toronto Medical School, and did my Residency at Queen's University (Kawartha site).

I completed family medicine residency in Ontario in 2022 and worked there for 6 months. Prior to this I completed medical school in Ontario, completed my undergraduate in Ontario, and had called Ontario home. Over the years I had watched my goal of working as a comprehensive rural family physician slowly become unsustainable amidst a collapsing system, decades of funding stagnation and poor planning, with a patchwork of good people on the ground trying to do their best in a system that doesn't seem to value their input. Day after day the insidious march of the family medicine crisis grew closer to the forefront of peoples' lives and garnered wider media attention, while the government either denied its existence or made no substantive changes that would realistically address it. This has not been the time for band-aids, let alone denial.

Last year I moved to rural British Columbia to try something different for a year, cautiously optimistic about the significant changes to family practice on the back of the LFP model implementation in early 2023. The Longitudinal Family Physician (LFP) model significantly changed how family physicians billed and were compensated in BC, including the ability to bill for the many hours family physicians typically spend on previously unpaid administrative tasks.

My experience has been night and day. For the first time in my medical career I have felt hopeful about the future of family medicine and find my day to day life to be sustainable. These changes have been received positively amongst all other family physicians I have discussed it with. It is not perfect and there are still kinks to be ironed out, but I at least believe my provincial medical association and government are trying to improve things for family physicians. I am not left questioning if government actions are purely incompetent or malicious with the intent to drive privatization.

I had retained my Ontario medical license until now, awaiting the May 2024 renewal deadline unsure if I would return home after a year of trying on a different life out west. Reading the recent government positions and negotiation briefs has been the final nail in the coffin for me. The disdain the Ontario government shows towards the hardworking family physicians who hold up the medical system is nothing short of repugnant. After more than a decade of training and education here, I will now be relinquishing my license to practice medicine in Ontario and stay in British Columbia.

The minister of health thinks recruitment and retention is "not a major concern." That's the problem; it should be. If I am not a prime example of this, I don't know what is.

I wish all of my colleagues still in Ontario who do not have the luxury to vote with their feet the best of luck. If not this government, then I hope the next one learns to value your work and dedication.

Author: justanoldcountrydoctor

Dr. M. S. Gandhi, MD, CCFP. Practicing rural family medicine since 1992. I still have active privileges at the Collingwood Hospital. One Time President of the Ontario Medical Association. Follow me on Twitter: @drmsgandhi View all posts by justanoldcountrydoctor

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One thought on "Perspectives on Ontario Health Care by a Recent Graduate"