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Jeudi 13 décembre 2001

Standing committee on public accounts

Special audit of
Cancer Care Ontario,
Provincial Auditor

Comité permanent des comptes publics

Vérification particulière,
Action Cancer Ontario,
Vérificateur provincial

Chair: John Gerretsen
Clerk: Tonia Grannum

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 13 December 2001

Jeudi 13 décembre 2001

The committee met at 1005 in committee room 1.

COMMITTEE BUSINESS

The Acting Chair (Mr Richard Patten): I'm going to call the meeting to order. The first order of business is the Vice-Chair.

Mr Bruce Crozier (Essex): Before we get into the regular business, and maybe even into the closed session, I wanted to propose a motion. With your permission, I move that the Provincial Auditor, under section 17 of the Audit Act, conduct a value-for-money audit on all past and present contracts between the provincial government and MFP Financial Services Ltd and between the provincial government and MFP Technologies Ltd and report back to the public accounts committee as soon as possible.

As some preliminary discussion, much of what I have to say has already been said in the Legislature, but I would point out to the committee that since 1995—and the source of this information is the public accounts—in excess of $425 million has been paid to these companies for services provided, which is just fine; that's a matter of record and I just bring that to your attention.

The reason I bring this motion is that any of us who have been following the MFP stories in the media—and they were reporting on the actions of municipalities, mainly, around the province. I point out that Brock University had contracts with MFP that they found not to be just exactly what they thought they were and they negotiated a revision, the region of Waterloo is presently involved in a suit with MFP over contract discrepancies, the city of Windsor had a $2-million leasing agreement with MFP that they withdrew from and at the present time the city of Windsor is conducting a forensic audit of all MFP contracts. I understand that report will be given toward the end of the year. The Essex-Windsor Solid Waste Authority in my riding is conducting a forensic audit of its contracts with MFP. The Union Water System is conducting a forensic audit of its contract with MFP. More recently, the city of Toronto has entered into a suit with MFP over its contracts. All of this is ongoing, and I think it is prudent that the province of Ontario conduct an audit of these contracts.

I have asked questions of Minister Tsubouchi in the Legislature. He has given assurance that these contracts are in order, but each time he used the term "at this time." I will reiterate that I just think, considering all that's involved, it's prudent that this committee direct the Provincial Auditor to conduct such an audit. One might say, "What benefit will this have if the contracts have all been signed?" The auditor in his regular duties carries out these kinds of audits and they are essentially after the fact, and it always seems to be that we can learn from them and that if there are problems we can tighten up the way we do business in the province. I believe that's all I need say at this time, Chair.

Mr Steve Gilchrist (Scarborough East): I would just respond to Mr Crozier by saying that this is not the first time this sort of motion has been brought forward. Our concern would be that the Provincial Auditor is already charged with the responsibility of identifying appropriate areas of government operations to deal with and to perform audits on. When you come up with a new project like this there is an issue of allocation of resources. Mr Peters and I and the other members of the Board of Internal Economy had a lovely discussion on that very subject not that long ago. While I think it was resolved to the satisfaction of Mr Peters, a motion like this would certainly cause similar concerns, I imagine. Accordingly, I would far rather leave it up to the Provincial Auditor to continue to determine what is and is not appropriate subject matter for his audit.

1010

Ms Shelley Martel (Nickel Belt): We do know that under the Audit Act individual members and in fact the committee as a whole does have the ability under the provisions to request that the auditor conduct special audits. The audit that we are dealing with today and the audit on Bruce nuclear-OPG, which I referred through this committee, are both audits that the auditor is undertaking under that section. I see no reason why we shouldn't actually pass the motion and allow the auditor then to determine what resources will be required to undertake this audit and when he can have it accomplished, in the same way that he has done the two special audits we are going to be dealing with in this committee.

Mr Bert Johnson (Perth-Middlesex): I just wanted to add a few because I have heard the member for Essex speak in the House on this very issue. One of the contracts that is in dispute is either in his riding or in his own hometown or something. It seems to me that Leamington had a problem. I don't remember all of his comments, but it seems to me that Brock University and the city of

Waterloo and maybe the county of Essex as well. It certainly is an issue that's in the forefront and on the front page of some of the papers.

I have a little bit of a problem with the value-for-money audit. It would seem to me that audit would find out what it is that we're getting for the dollars that are being paid, and those, I think somebody mentioned, are signed contracts. So I don't know that that would delve into what really would concern me. What would concern me is whether they are interpreted the way they—it seems to me from what I've read, particularly in the city of Waterloo, as that's where I'm a fairly close neighbour, and in my interpretation of it, it isn't a matter of value for money anyway; it's how the contract is interpreted. So I'm not sure that we would get what we want out of this audit.

The other thing I wanted to say is that I'd be very concerned, yes, if we found that there were dollars that shouldn't have been paid and so on, but I guess I'm a little concerned too about the cost and the value: what resources do we have to put to Mr Peters? I assume that when he came to work today he had nearly enough to do to keep him until tomorrow night anyway. I assume that it takes extra staff and resources and either putting something else off or delaying it or hiring more people to do it. Those are a few of the questions and comments that I would like to put on the record today.

Mr Erik Peters: I would like to make a number of comments, if I may. The value-for-money audit would, among other things—you're quite right, Mr Johnson—refer to whether we're getting value for money from the work that is being conducted. But, more importantly, we would focus on how the contracts are being managed by the province. In other words, how do the ministries that give the contracts actually ensure that we are getting value for money and, specifically, whether all arrangements with these organizations are made in compliance with the Management Board of Cabinet directives that cover this particular area. That's one thing we would look at.

The other point is that as a matter of course we would not look at past contracts. The interesting feature of this motion is looking at past contracts. Normally, because our audits are principally geared to the current year's activities, we would not look at the past. From that perspective, it would be totally within the purview of this committee to decide that we should as a special assignment look into past contracts.

The last comment is the resource comment. As Mr Gilchrist referred to, there are continuous debates with the Board of Internal Economy because in relation to the other audit offices across the land we are significantly underfunded, so we always have to make a trade-off. Some trade-offs are necessary when we accept special assignments. But maybe I can put on the record that we are continually looking. As you know from our 2001 report, we looked at how the Ministry of Transportation was managing the consulting contracts and we found this significantly wanting and reported on that. I presume this committee will hear talk about that later on. So one way or the other, we will try to take action on this.

Mr Bart Maves (Niagara Falls): Chair, as a member of this committee, you and I have been on this committee since 1999 together, and several times since 1999, members come forward with pet issues that they would like the Provincial Auditor to do value-for-money audits of. We usually have very fulsome discussions on those issues. We've traditionally been a very non-partisan committee. Each time members bring forward an idea for an audit for the auditor, I have raised the problem that I get nervous that in this very effective non-partisan committee, the attempt is being made to utilize it and change this committee and the Provincial Auditor's office into a political vehicle where parties are picking pet projects that they want to have audits done on.

The problems we've talked about in the past—and anyone can go back in the Hansard and look at the debates that this committee has had when we talked about asking the auditor to do supplementary audits, for example, of Cancer Care Ontario and the OPG contract. The dilemma we have is that the auditor already has value-for-money audits he has chosen to undertake. The auditor has his resources out in the field already allocated to different audits that he's doing. We always get into the discussion about what audits will the auditor stand down in order to do this audit. The auditor typically doesn't want to stand down audits; his preference would be to get more resources in order to get staff to undertake another audit. So there are a variety of issues that come up over this.

In the past, the regular members of the committee, when we've discussed these things, have had discussions around the fact that we could as a committee start coming to the table with all kinds of ideas of audits that we want the Provincial Auditor to undertake and ask the Provincial Auditor, without any new resources, to undertake those. The government has available to it the ability of ministers to request that the Provincial Auditor do certain value-for-money audits in certain fields. That is not something ministers do that often. Again, I think the concern of having ministers, members of committees and individual members continually making requests about audits they wish the Provincial Auditor to undertake is that it politicizes the Provincial Auditor's office and it becomes one where people's political agendas take over the non-partisan, really people's agenda that the Provincial Auditor's office oversees.

1020

Some members who aren't on the committee on a full-time basis may think I'm positioning. But I know, Chair, that you've been on this committee and you've heard these debates. I think they have been fair, non-partisan, very rational debates. When we have gone the step of requesting that the auditor do an audit—for instance, the Cancer Care Ontario audit that's in front of us today and the OPG audit—we've usually taken the time to thoroughly flush out that audit and the reason for it, and the government has voted at least twice in favour of such

motions. But each time we have done that we have stated that we are getting more and more concerned about the frequency of requests coming from the committee to direct the auditor to do certain audits.

Once again I come in this morning and, without advance notice I might add, we have this request. I'm concerned. For all I know, I may indeed want to vote in favour of a motion like this. I think the motion needs to be fleshed out a little bit. I have no idea how many contracts we're talking about. I have no idea about the extent and scope of the audits. There are so many questions in front of us. In the past when we've requested the auditor to do these other audits we've had rather fulsome discussions and we have let the Provincial Auditor come back and talk about what audits he might not do in order to do this audit, and a variety of other things. So I'm hesitant to either vote on this motion or pass this motion this morning. The member may want to withdraw it and bring it forward at another time to let a little more research be done. I also would urge the member to think about some of the comments I made. Again, I think we've had the discussion several times about the committee directing the auditor to do certain audits, and we all agreed that it was a slippery slope.

A cell phone rang.

Mr Maves: On that, I'm going to turn my phone off, Chair, and let you go to somebody else.

Ms Martel: If I might in reply, I don't think there was general agreement that this was a slippery slope. On the contrary—and I'm going to raise two points again. I've been on this committee since the fall of 1995. It's now the fall of 2001. In the six years I have been on the committee we have made a request for two special audits over that time: the CCO special audit, which we are dealing with today, and the OPG-Bruce nuclear special audit, which the auditor will come back with. This would be the third in six years and I hardly think that qualifies, by any shape or form or stretch of the imagination, as an abuse of members on this committee trying to get the auditor to do political things.

Secondly, with respect to politicization of the auditor's office, the only way the auditor's office is going to be politicized is if the auditor lets that happen, and I have the greatest confidence in Mr Peters that that is not going to happen. We can bring forward whatever motions we want to. He, for his part, with the professional staff in his office, can conduct value-for-money audits. I don't question those audits or the professionalism attached to them and I certainly don't think they've been politicized. So I disagree entirely with the suggestion or the notion that because opposition members bring forward special audits—this would be three in the last six years—that somehow we are politicizing the auditor's office. Frankly, I think that's an insult to the auditor.

Finally, I see no reason for us as opposition members, or indeed as government members, not to bring forward special audits. There is a specific provision under the Audit Act that allows us to do so. In fact, the whole committee can do that unanimously as a committee under a specific section in the Audit Act as well. That is a right we have as members. It is not a right that has been abused and it is not a right that has been used too frequently in this committee. Frankly, I think it's a right that should be respected today and I think we should vote in favour of this motion.

Mr Crozier: Just a few closing remarks. I appreciate what my fellow members are saying. To Mr Maves directly, just for his information—Mr Maves? I'll wait until Mr Maves is finished. Just for your information, Mr Maves, I don't know what you refer to when you say "part-time members of the committee." I was a full-time member of the public accounts committee before you came to Queen's Park. I just want to clarify that: I don't consider myself a part-time member.

I take just a minor exception to the term "pet project." It does happen, and it's a fact, that the Essex-Windsor Waste Management Committee and the Union Water System are investigating contracts with MFP. But the region of Waterloo started all this when they realized that there was a problem. It seems to be festering around everyone but the province, to the point that the minister says there's no problem with the contracts.

The motion is purposely non-partisan. It's very straightforward. I merely brought to the committee this morning facts that are public knowledge: the amount of money that's been spent by the province with these firms, and what's going on in the province.

Finally, Chair, and I thank you for your indulgence, two things: I think it's the duty of this committee on occasion to look at something that is special. From a personal standpoint, if there was a scale on each of us in this Legislature from one to 10 on partisanship and those who are non-partisan, I would consider myself one of the ones who, most of the time—we all get partisan; we have to, from time to time—and particularly at this committee, want to be as non-partisan as I can possibly be. I assure you of that. This motion was only brought because of what's going on in the province at the present time with this company.

Mr Maves: Just in response, Mr Crozier, Ms Marland was a member of this committee since before I was born. She says she can one-up you.

The Acting Chair: You're going to be in trouble for that.

Mrs Margaret Marland (Mississauga South): I just told him that.

Mr Maves: To Ms Martel, if indeed there's been three requests made since 1995, all three have come in the past year, because this is at least the third. The government side approved of two that we've spoken of. For some reason in my recollection, I think there was another one that didn't go forward, where there was a motion made. So I think that this is the fourth this year.

So indeed it was something, by your own accounts, that was never done up until this year. Now we've had at least three requests made before. So that is the concern that I talked about before. Your comments just reiterate my concern that now this could be the third or fourth

request in a year by the committee to direct the auditor on what audit to do. That's exactly my point.

The Acting Chair: We have a motion on the table. Mr Crozier, Mr Maves suggested that we can call for a vote on it, because we have the motion, or you might withdraw it and consider that being an item for elaboration and further discussion at the committee. Do you choose to keep it on the table for a vote?

Mr Crozier: The motion was presented in good faith, and I would prefer that it stand.

The Acting Chair: All right, a motion by Mr Crozier. He has read it into the record.

Mr Crozier: A recorded vote, please.

The Acting Chair: A recorded vote.

Ayes

Crozier, Martel, Pupatello.

Nays

Gilchrist, Johnson, Marland, Maves.

The Acting Chair: The motion is defeated.

We now move into an open session.

Clerk of the Committee (Ms Tonia Grannum): You were in open session.

The Acting Chair: We're in open session? Yes, but for the purpose of dealing with the Cancer Care Ontario value-for-money audit, Mr Crozier, will you take the Chair?

1030

SPECIAL AUDIT OF CANCER CARE ONTARIO, PROVINCIAL AUDITOR

The Vice-Chair (Mr Bruce Crozier): I'm pleased to take the Chair this morning. I just point out to the members of the committee that our colleague, Mr Gerretsen, is on an assignment given to him by the Speaker. So he regrets his absence from the committee this morning.

So we will begin with the Provincial Auditor's report to the committee on the Cancer Care Ontario value-for-money audit.

Mr Peters: I'd like to open up by saying that of course I'm fully aware that you have only received the report just now, which was the earliest we could. Quite frankly, we had a last-minute snag. We had an intervention from the outside that delayed us. We had planned to report it on December 6 and we had a request made to interview one more person. We acceded to that request and interviewed that additional person, and that caused the one-week delay.

Mrs Marland: Was that at their request, Erik?

Mr Peters: Yes.

Mrs Marland: It was the party's request to be interviewed, was it?

Mr Peters: Somebody from the outside requested that they had information that they felt would be pertinent to our audit and requested that we meet with that particular individual. We decided to accede to that request because we never close the door on fact-finding. So if they had something significant to add, we were willing to listen to them.

The overall conclusion that we reached in this audit is found on page 2. There are a few words there. Maybe I will just read them into the record and then make some comments on them and walk you through some of the detail.

"The private after-hours clinic, operated by Canadian Radiation Oncology Services Ltd (CROS), which is controlled by CCO's former executive vice-president and coordinator of the radiation treatment program, has enabled Cancer Care Ontario to treat more patients close to home. In addition, the cost of radiation treatment at the after-hours clinic is approximately $14,000 lower per patient than treatment in the US. The referrals of breast and prostate cancer patients to the US ended in March and May 2001, respectively. However, we found little evidence to indicate that CCO had considered all reasonable options for providing these services itself before proposing the establishment of a private after-hours clinic.

"In addition, when awarding the contract to CROS, CCO did not follow the government's policy requiring a fair, open, and transparent competitive process and, therefore, did not ensure that it was acquiring the services at the best price."

In other words, it's good news and bad news. We have indeed reduced the cost to the program by stemming the flow of patients that had to seek treatment in the United States, but the bad news is that Cancer Care Ontario did not follow a sufficient process to ensure that those services are actually acquired at the best possible price. Particularly, it did not use an open and competitive process when it awarded this contract to Canadian Radiation Oncology Services Ltd, which is controlled by its former executive vice-president and coordinator of the radiation treatment program.

We provide quite a bit of detail in this relatively short report. Our main concern is found on page 4, where we talk about compliance with Management Board of Cabinet directives. They seem to have found some difficulty in interpreting these. In fact, it required, as you will see from the detail once you get around to having time to read it, that legal counsel was engaged by Cancer Care Ontario. We, because we are dealing with legal opinions, engaged legal assistance of our own and ended up presenting both views to you, and then formed our conclusion.

One of the concerns was, for example, that they did not have to follow the Management Board of Cabinet directives directly because they felt this was "an unforeseeable situation of urgency…and the procurement cannot be concluded in time to meet requirements." We are expressing concern about that assumption, largely be-

cause the fact that we had to send cancer patients to the United States was known for a long time. It was known to the ministry. In fact, the ministry instructions to Cancer Care Ontario are very clear. The ministry instructed Cancer Care Ontario to find ways of providing the treatment in the province as opposed to having to send patients to the United States. And that is clearly represented.

The other one is that they argued "only 'one supplier is able to meet the requirements of a procurement.'" Well, the problem was that they invited three organizations to make proposals; two did, and then they dropped to one. But we felt the evaluations could have been more thorough, under the circumstances, to determine what was happening there.

The other area of concern was whether Cancer Care Ontario had applied the Management Board of Cabinet's directive on conflict of interest appropriately. We concluded that we were not satisfied that Cancer Care Ontario took the necessary action to prevent the perception of a conflict of interest. This perception arises from the fact that Cancer Care Ontario allowed its executive vice-president and coordinator of the radiation treatment to remain in its employment throughout the procurement process. They did not ask for his resignation until after they awarded him the contract. The executive resigned on January 12.

Secondly, Cancer Care Ontario "permitted the manager of its central referral office to be involved in the proposal by the executive vice-president and coordinator of the radiation treatment program."

I should add on all these points that we have presented our draft report to both the Ministry of Health and Cancer Care Ontario and that we have had lengthy discussions with them. There were very minor changes made as a result of those discussions. They were largely more of a fact clearing—what are the facts that we presented. We made those adjustments. So there is agreement with both the Ministry of Health and Cancer Care Ontario that we are factual in our observations.

We talk about the cost of the treatment. We provided a little chart that indicates what the cost was of referring patients to the United States. That's on page 8. We're talking about what Cancer Care Ontario is paying for treatment at a regional cancer centre and what payments they are making to the CROS organization.

The audit certainly did not extend, and could not extend, into whether or not CROS is making a profit on this. We did not have a right of access, nor did we want to have right of access, to accounting records of CROS itself. We consider them a service provider like any other service provider to the government. Normally we don't delve into the costing and other information and profitability of service providers to the government. That is their business, and that forms the basis on which they presumably tendered for the services.

The last point that I would like to draw to your attention is that we also have on page 9 a comment on the waiting times. As we state, "there has not been a significant change in the overall waiting times at the regional cancer centres since CROS began providing treatment.

"The Canadian Association of Radiation Oncologists recommends that the time between patient referral to a regional cancer centre and initiation of radiation treatment not exceed four weeks. CCO's current target is that 50% of cases move from referral to treatment within four weeks and 90% within eight weeks. However, for the month of August ... CCO's statistics indicated that only 31% of patients were moving from referral to treatment within four weeks and 60% within eight weeks." There were also "no significant differences between the waiting times at CROS and for breast and prostate cancer patients being treated at regional cancer centres."

That concludes my comments, and I open it up.

1040

The Vice-Chair: Questions and comments? Since the motion was originally made by the official opposition, we'll begin a round of questions and comments with Ms Pupatello.

Mrs Sandra Pupatello (Windsor West): Are you doing timed rounds?

The Vice-Chair: I don't know whether they need be timed or not.

Mrs Pupatello: They should.

The Vice-Chair: They should?

Mrs Pupatello: Yes, just to make it easier. What, 10 minutes?

The Vice-Chair: Let's start out with 10 minutes.

Mrs Pupatello: I just want to ask them all up front, or I'll wait and time them.

There are two elements I wanted to ask the auditor about. One is around the wait times and the other is around the set-up of the agreement and how typical the agreement is with CROS. Specifically, there was some information provided via the media that there was start-up funding provided to the company as well. I don't see that listed in the agreement on page 7, or what you detailed.

My understanding was that not only were they given a number of elements in terms of, I guess, safety nets to start up this private firm, one of them that was so incredible to me was that they were handed about $3 million to cover their start-up costs. I don't know if that's factual, if it was erroneously reported in the media, but it just seemed that when you describe the right of refusal, it is an absolutely fabulous contract.

I don't know if you want to address that first. First of all, the right of refusal. It is completely unencumbered as a company to accept any and all cases outside of Cancer Care Ontario. There isn't a way that any other company would ever have an opportunity to enter into it because the first right of refusal is on every single measure. If the contract is changed, CROS has the opportunity to have it at the new terms, and they always have a right of refusal for all cases outside of CCO.

So are the start-up costs legitimate, or was it simply that they would just expense all of their costs?

Mr Peters: There was no additional money over and above the contract flow to CROS for the start-up costs. What did happen was that a certain amount of money was pre-flowed and then deducted from the services that were provided.

Mrs Pupatello: That's a fairly great deal; would you agree?

Mr Peters: I understand it's not that much money.

Mrs Pupatello: There's absolutely no risk, though. The point is that anyone could walk in and they have absolutely no financial risk. Any expenses incurred to start it up they were reimbursed, and then they were guaranteed revenue based on the guarantee of cases they were going to be sent. So this was absolutely a no-risk start-up for this private firm.

Mr Peters: What we found is there were no additional funds provided for start-up. The concern was of course whether they would be able to provide the services that Cancer Care Ontario needed to provide; in other words, could they handle the number of patients that they should handle? It was for that reason that there was some pre-flowing of funds. But the amount they are being paid per patient we outlined, and they did not exceed that. They were getting the agreed terms.

Mrs Pupatello: In terms of being guaranteed. I guess the questions we raised in the House at that time were that of every element that a private company would normally have to deal with in terms of risk to enter into business in general, the medical equipment was guaranteed, because they were using the hospital's; the personnel services were guaranteed, because they were using CCO's or the hospital's; any start-up cost was reimbursed; and they were guaranteed to be sent cases. So absolutely every element of the business deal was guaranteed to them. I don't know of any company on the planet that has such a wonderful offering, and your auditor has confirmed that.

The other element I guess that was important was the minister's responses in the House at the time. He continued to support this based on the fact that there was such a tremendous wait time. I guess the most interesting to me of your entire report is on page 9 around the wait times. There hasn't been significant change. I'm finding there's something that is not adding up.

If CROS was indeed given that many patients, then it can only be because of two things that the waiting times have not changed. They haven't changed because the demand is gone, so that in fact by starting up CROS, they've eliminated lists. There are no more people to send. The other element is that personnel have been taken from the public system and are now working in the private system so that the public system isn't able to work through their caseload.

There needs to be a reason why the wait times haven't changed, despite having an overflow clinic, which is essentially what the excuse was for the private clinic—this overflow. But it's impossible that the wait times have not changed. Either there has been this massive increase in total, but the numbers look like they're still the same in terms of the year-to-year, or the personnel is not working as much in the public setting. What would ever explain that lack of change in wait times?

Mr Peters: Nick, you can make comments. I'll just deal with the first part of it. In the principal objective, there was not even a statement of reducing wait times. The principal objective was to deal with treatment provided in the United States, that that was to be stemmed.

Mrs Pupatello: But a minister is responsible for this.

Mr Peters: I see. That's fair enough, but I'm responding to what we found, that the proposal to the ministry by Cancer Care Ontario dealt only with having treatment provided by an external service provider who would provide service that would otherwise have to be financed by the province by travelling to the United States.

Mrs Pupatello: Just explain why the wait times haven't changed. It's impossible for an overflow clinic to meet their objectives, and in fact be bonused based on meeting their objectives of caseload, and the overall wait times not to have changed.

Mr Peters: I think in all fairness that may be a question better directed at Cancer Care Ontario itself. We just noticed the fact that the wait times have not been reduced. What steps are being taken to address the potential reduction of waiting time etc was not within the direct purview of this audit. That's why, for example, you don't find our comments in the overall conclusion. We just thought we'd bring it to your attention. It is something that should be discussed further, and information should be obtained from both Cancer Care Ontario and maybe the Minister of Health as to what is being done about reducing wait times.

Mrs Pupatello: OK. I guess I need to put on record that it is an incredible outcome that we have gone through the institution of a private clinic completely outside of the conflict of interest guidelines, outside of the service-delivery models that are mandated by the government itself and, despite breaking all the rules in setting it up in this manner, they haven't even affected the wait times.

I don't know what the rationalization is for its existence. It hasn't improved wait times, we've sent monies into the private sector and we can't find an answer in the audit that says one of two things: either in the 12 months that it has been operating the demand on these types of treatments has increased exponentially or the personnel has been pulled from the public system and is working in the private system, so we've actually sucked the staffing availability out of the public sector and put it into the private clinic, all of which we had predicted initially. I don't know if you have a comment on that.

Mr Peters: We did find that the demand has increased. That is factual.

Mrs Pupatello: Can you tell me if ever in the history of Ontario business there has been any such breach of government policy in requiring a fair, open and transparent competitive process? Have we had this before in Ontario?

Mr Peters: I'm afraid that our reports are peppered with instances where the Management Board of Cabinet directive is not followed.

Mrs Pupatello: Can you tell me what happens once you've identified that this breach has been made? What have the steps been as the outcome?

Mr Peters: The fact is that the directives are administrative directives, so sanctions or penalties that can result are not actually provided for under directors directly. There is no direct relationship between what happens, if you breach the Management Board of Cabinet directive.

Mrs Pupatello: So historically every time we breach every rule the government creates, they just shrug their shoulders—that's been the history?

Mr Peters: No, the history has been somewhat more positive than that. At least in all the cases we noted, where we made recommendations that the directives be fully applied, the ministries have indicated that they will do so in the future.

Mrs Pupatello: Given the outcome, if you say administrative changes—and that's been the history—then what is your recommendation in terms of improving this, given the agreement that was signed with the company? No one else is going to be able to have such a contract. Would that also include the non-profit industry and/or the current cancer treatment centres? Would they not be able to increase their caseload based on the agreement with the private company?

1050

Mr Peters: The regional centres can increase the caseload during the day, but they can't go into overtime.

Mrs Pupatello: So just to confirm: given the agreement they've signed with CROS—and this is my last comment, Chair—even in light of what you've discovered, the government is unable to rectify it because they are beholden to the contract they signed with CROS. They can't extend into evening hours to recoup the caseloads, given the breach that you've identified?

Mr Nick Mishchenko: There is nothing to prevent Cancer Care Ontario from extending the hours of their existing clinics at the regional cancer centres. That's the case now and was the case previously. What this provision does prevent, though, is the establishment of a private after-hours clinic in any other centre without first giving right of refusal to this company.

Mrs Pupatello: OK, thank you.

Ms Martel: For how long is this contract in effect?

Mr Peters: For two years, and it provides for an automatic renewal.

Ms Martel: Automatic renewal for another two years?

Mr Peters: No, for the second year.

Ms Martel: OK. Let me start first on page 2, at the bottom: "We would have expected CCO to have prepared a business case that thoroughly analyzed options for providing the services internally before it approached private-sector service providers."

Can you tell the committee what business case—I use that term loosely—was actually provided or given to you to describe why they needed to do this in the first place, in terms of going to the private sector?

Mr Peters: There really was not an extensive business case. There was a lot of internal discussion taking place according to Cancer Care Ontario, but there was not a comprehensive business case that they could present to us.

Ms Martel: Would you describe the November 3, 2000, proposal to the ministry as their interpretation of a business case?

Mr Peters: I think they would have to answer that one. They made the proposal. I think they called it, "A New Approach to the Delivery of Radiation Treatment in Ontario," and that was the case they put forward to the ministry.

Ms Martel: That was the sole document that went to the ministry for approval of the funding of this contract?

Mr Peters: Approval of the concept, not the contract. The ministry was very clear that it gave approval to the concept of developing an after-hours clinic, particularly for the purpose of reducing the travel costs of people going to the United States. But the ministry was also very careful in saying to Cancer Care Ontario, "When you do this, please follow the Management Board of Cabinet directives."

They let Cancer Care Ontario proceed. There's always some concern, and I won't get into that in detail, but Cancer Care Ontario is a so-called schedule 3 agency and there's always some debate as to how autonomous a schedule 3 agency is from the government. That's why in the memorandum of understanding between Cancer Care Ontario and the Minister of Health there is an indication that Cancer Care Ontario should follow these Management Board of Cabinet directives. Certainly we also found sufficient evidence in correspondence by the Minister of Health that they asked Cancer Care Ontario to apply these directives.

Ms Martel: But it appears that they asked them after they had already given the approval. If I look on page 4 at the top, on January 11 the deputy writes to CCO approving one-time funding for the cost of treating patients in the after-hours clinic. Then on March 15 the ministry writes to CCO asking for assurance that it had complied with Management Board of Cabinet directives—two months later. What triggered the ministry's sudden concern and why wasn't that done at the time the money was actually approved?

Mr Mishchenko: It was. In the January 11 letter, if you read on, it does say, "The letter also stated that any contractual arrangement reached by CCO must comply with all relevant policies, directives and guidelines on procurement"—

Ms Martel: In the same letter of January 11?

Mr Mishchenko: The January 11 letter—"and conflict of interest of Management Board of Cabinet and of CCO."

Ms Martel: And you can confirm that letter also said that the funding was based on $3,500 per case?

Mr Mishchenko: Yes.

Mr Peters: Yes, I think that's what we're saying.

Ms Martel: OK, I'll return to that issue later.

Mr Peters: Can I just go back to an additional point that we're making?

Ms Martel: Yes.

Mr Peters: We also found that in March, the ministry said they would establish whether requirements in the deputy minister's letter of January 11—that's later on that page—were met, "based on the information supplied by Cancer Care Ontario, advice internal to the ministry, and the value-for-money audit ...." So the ministry effectively used the audit to determine whether there had been compliance.

Ms Martel: The ministry used your audit to determine if there had—

Mr Peters: That's right.

Ms Martel: So the ministry itself did not determine if CCO was in compliance?

Mr Peters: No. In March, they wrote that they would rely on our audit.

Ms Martel: I see what you're saying. The ministry also stated that it would establish whether the requirements in the deputy minister's letter were met, "based on the information supplied by CCO."

Mr Peters: Right.

Ms Martel: It sounds to me like the ministry itself gave an undertaking and then never followed up.

Mr Peters: I apologize. The letter was dated in May, way after. It was not March; it was in May that the ministry wrote that letter in which they say they would rely on the value-for-money audit being conducted by the Provincial Auditor at the request of PAC.

Ms Martel: So just to confirm, they never followed up themselves, despite what they said in January that they should comply. They relied on you to determine if compliance with Management Board guidelines had been met?

Mr Peters: Yes. Actually, they did receive a letter, at their request, from Cancer Care Ontario, that they had engaged legal counsel and legal counsel had advised them that they had been following. That's why, later on, we are challenging that to some extent, because they got into the situation where legal counsel made certain assumptions. We found it necessary to engage our own legal counsel, and our own legal counsel certainly felt that there was a problem.

Ms Martel: OK. Let me back up to the public sector. Our argument has always been that this could have been done in the public sector, had people wanted it to be done in the public sector. So that I'm clear, you're saying, "We found no indication that CCO pursued a similar arrangement internally whereby CCO would operate an after-hours clinic utilizing staff from" Sunnybrook, Hamilton and Princess Margaret. So in your opinion there was no effort made by CCO to determine if this could be done in the public sector?

Mr Peters: Yes, it is true that there was no effort made to involve people from other centres. There was certainly some effort made to involve staff from Sunnybrook, but there was not an effort made to see if staff could be drawn from other centres.

Ms Martel: OK. You also said on the same page that "CCO had drafted a letter in November 2000 to be sent to CCO's radiation oncologists across the province to determine whether any of them were interested in establishing a"—here's the "private"—"after-hours clinic, this letter was never sent." Do you have any indication why that was not undertaken? That would have at least covered CCO a little bit in terms of actually saying they had tendered this.

Mr Peters: You're quite right, but they will have to answer why they didn't send it. It's a factual observation, and they agreed with the observation that the letter was not sent.

Ms Martel: So there was no indication at all that they looked at how to do it in the public sector and, secondly, no indication at all that when they made the decision, which was frankly made in August 2000, they were going to make this in the private sector. The only people they were interested in were their own staff and Sunnybrook. That was it.

Mr Peters: That's what our report says.

Ms Martel: The decision was made. There was not even a point to—

Mr Peters: Well, I'm not sure whether the decision was made in August. Certainly in August we were told consideration was to be given as to how to establish it. I don't think the decision was made that early. The decision seems to have been made more in the November 3 document.

Ms Martel: I was interested, though, that you said, "We were advised"—your office—"that, in August 2000, CCO senior management asked the then executive vice-president and coordinator of the ... program whether he would be interested in establishing a private after-hours radiation clinic." It was pretty clear where they were going.

Mr Peters: It's certainly an indication of direction.

Ms Martel: Yes, OK. Next page, top of the paragraph. I was interested in your comments that there was a meeting of CCO radiation treatment advisory committee—the heads of all of the cancer centres—asking why there had been no advice sought from them about the establishment of this private sector clinic. You are saying that according to the minutes, "the establishment of the clinic was kept as confidential as possible to prevent the media from making it a political issue and therefore putting stress on finalizing the arrangements for the clinic." Can you tell this committee what was in the minutes that led to you writing that?

1100

Mr Peters: What you find is what you get. That's what the minutes said and that's why we reproduced it.

Ms Martel: Can you table those minutes for this committee?

Mr Peters: Again, I'm somewhat prevented by section 19 from preparing that for the committee. However,

there's no reason why you should not be able to make a request of Cancer Care Ontario to table its minutes.

Ms Martel: But let me ask if it was clear to you, upon reading the minutes, that there was a very definite concrete effort to keep this issue under wraps so that there would be no media scrutiny and then, I assume, no public scrutiny of what CCO was up to in establishing this private after-hours clinic. Would I be correct in making that assumption?

Mr Peters: That's not my impression; that is what the minutes said.

Ms Martel: It used the words "political issue"?

Mr Peters: Yes, they were used.

Ms Martel: That's lovely. Let me go back to the deputy minister's letter. Was there any indication, when you talked to the Ministry of Health, that they were aware that CCO was trying to do this under wraps in such a way as to avoid its becoming a political issue? Had they seen the minutes? Was there a ministry representative at that meeting who would have seen those minutes?

Mr Peters: I have verbal information that this was not so; they were not informed of this.

Ms Martel: They did not know. And there was no ministry staff person at that meeting?

Mr Peters: No.

Ms Martel: Fine, thanks.

The Vice-Chair: We have to move on to the government caucus.

Mr Maves: Auditor, on page 2 at the bottom, there's indication that "'CCO has many agreements with its various professional groups, which do not permit the very rapid adjustments required to eliminate out-of-province referrals this year.'" The contracts that staff had with CCO—and my understanding is that the employees who are in the after-hours clinic are also people who, in the daytime, are employed by regional cancer centres. They haven't brought in new employees?

Mr Peters: To the best of my knowledge, yes.

Mr Maves: So the contracts they currently have wouldn't allow them to work expanded hours and after hours at CCO, and therefore CCO said, "We need another alternative." So somebody came around with an unsolicited proposal to say, "Look, I'll run an after-hours clinic and I'll offer positions to those staff who are currently working," because those staff wanted to work, and that's what's happening here. So they're not detracting from their existing hours of work. They're doing their normal hours of work, and then after hours they're working at this clinic.

Mr Peters: There's some arrangement. I would just like to comment on the word "unsolicited." As we were advised, as we state, the people who did it were actually approached by Cancer Care Ontario to consider making a proposal. So Cancer Care Ontario asked for that.

We deliberately put this in quotations because that was exactly what Cancer Care Ontario stated under the circumstances and they concluded that this did not permit the very rapid adjustments required to eliminate out-of-province referrals, and that seems to have been the main objective of this exercise.

Interjection.

Mr Peters: I'm just advised that Cancer Care Ontario does have after-hours clinics of its own.

Mr Maves: In layman's terms, though—and I've actually just flown through this report—Cancer Care Ontario is requested by the government to find a way to stop sending patients out of the country at $18,000 a pop for cancer treatment. When they're discussing this, one of the members of the Cancer Care Ontario board—Mr McGowan, I think it was—decides that he's going to come forward with a proposal to create an after-hours clinic. He thinks he'll be able to utilize existing staff and the additional hours of treatment that will be available will eliminate the practice of sending people to the United States. Is that basically how that rolled out?

Mr Peters: He didn't approach them; they approached him. But essentially, the main thrust was to avoid the $18,000 average cost of sending a patient to the United States, to find another less expensive way to the taxpayer to do that.

Mr Maves: So Cancer Care Ontario is in a rush to stop this expensive practice of sending people out of Ontario for treatment. They get this idea, they get this proposal in, they decide to go in this direction but they don't take the time to go out and do proper tenders and all of that. The result is positive: people are no longer being sent out of the country for cancer care, they're being treated at home and they're being treated for $14,000 less. It's a good result. So in effect their heart was in the right place and the result was excellent as far as cancer patients are concerned. They really went about it a very poor manner as far as a business case is concerned.

Mr Peters: That's true. You're also quite right on the point, which I should have raised before, that it certainly is far better for the patients to have the treatment closer to home, and it is in there. What we point out is, they didn't know as a result of this exercise, and we don't know, whether they could have saved the taxpayer even more money and achieved the same objective.

Mr Maves: In your investigation, were there other agencies that would have bid on such a tender?

Mr Peters: There was one proposal made, as we point out in this letter that they drafted, which they didn't send. That could have potentially, I guess, involved other heads of radiation clinics or led other people to make proposals as well. Again, that's one part we don't know because the letter was never sent. They just approached one person, when in fact they could have approached other people, and they weren't approached.

Mr Maves: Who else—other companies outside of Ontario to come here and provide a service?

Mr Peters: Yes, other companies that are in the business of providing professional services, because that's ultimately what it was: how to provide these professional services that were required, and the question was raised as to who else could have done it. What we found is that

they did not go as far afield as they probably should have to determine if those service providers were out there.

Mr Maves: Normally in your reports, you have very clearly set out recommendations for going forward. I don't see them here. Obviously, your recommendation is you should follow Management Board's practice of doing proper tenders, but you don't set out any recommendations.

Mr Peters: No, this was really because it was a special assignment requested by the committee and we felt that the committee's decision was that we just do a value-for-money audit. So we decided in this case to bring the facts before the committee for a proposed action. If the committee decided to make recommendations as a result of this report, it was really the committee's prerogative in this particular assignment.

Mr Maves: Going forward, as a committee member, if I wanted to make a recommendation on the practice and what they've done, since the result has been so successful for so many people and has saved money, we could safely recommend that the concept and the practice of these after-hours clinics is the right one as far as patients are concerned, but they need to do a better job of the tendering process to make sure that more people have an opportunity to tender to provide such services.

Mr Peters: It goes a little bit beyond that. I think it will be, for example, within the purview of the committee to deal with the recommendation that we already made in 1999, which is, for example, to make additional efforts to reduce waiting times through other arrangements. It would also go into the fact that, in general terms, Cancer Care Ontario should follow the Management Board directives in all its activities. A third area of concern—and that is why we brought it out—is that the contract does have this unusual clause in it that virtually gives the first right of refusal of anybody else's service, and that is not very sound contracting in our opinion.

If it is the committee's wish that there be an open and fair tendering process, that contracts be drawn up in such a manner that adjustments can ultimately be made as to how the service is delivered, those are the kind of recommendations the committee might want to consider.

1110

Mr Maves: On the waiting time, I recall when Cancer Care Ontario was here that the four-week waiting time standard was one they set for themselves.

Mr Peters: No, it was set by the outside. That's the Canadian Association of Radiologists.

Mr Maves: No, but they adopted that standard, right?

Mr Peters: Yes, that's fair.

Mr Maves: At the time, as I recall, Ontario was the only province to have accepted that as their standard and their goal to achieve.

Mr Peters: No, there are others. Also, Cancer Care Ontario did modify the standards, as we point out on page 9. They said the current target is that 50% of the cases be done in four weeks. In other words, the overall extent is that the radiation oncologists said everybody should get it within four weeks, and they decided our target is 50% and the eight-week target is 90%. Both of those targets are currently not met.

Mr Maves: Is that an adjustment they made since they were here? I don't recall that being the case when they presented before us.

Mr Peters: I'm not 100% sure, but it's likely.

The Vice-Chair: Any further questions or comments?

Mrs Lyn McLeod (Thunder Bay-Atikokan): I apologize for having been out for a period of time. I'll try not to duplicate questions that may have been asked. I did want to come back and just clarify the wait-time issue, as I understand it. In your 1999 report, 32% of patients who required radiation therapy were receiving that treatment within four weeks. That was prior to there being any alternative measures like sending people to northern Ontario or out of province for radiation treatment. So it was 32% prior to any alternative measures being put in place.

In August, you said it was now 31% within four weeks. So whether we're talking about the re-referral program or the repatriation to the extended hours clinic, the wait times have only been reduced within that four-week period by 1%. Have I accurately stated that?

Mr Peters: It's 1% worse.

Mrs McLeod: I'm sorry, it's 1% worse?

Mr Peters: Yes. They were at 32% and they're now at 31%.

Mrs McLeod: Oh right, of course. I'm thinking of people getting treatment. Thank you for that clarification.

I understand that one of the arguments in favour of the extended hours clinics is that they have been able to repatriate patients so patients don't have to be sent out of province. We would all agree it's a good thing to have patients treated at home, but I think the thing that shocked me in this was to realize that the actual increased measures, whether it was in the repatriation or in the extended hours clinics, have not made a difference in terms of wait times. I understand you've been asked that question and aren't in a position to give any answers as to why that could be.

Mr Peters: The objective was clearly to stem the flow to the United States and provide a more convenient service, but that was a known population. They just redirected the same people to go somewhere else for the treatment, so there is no direct correlation to waiting times in this activity.

Mrs McLeod: But the re-referral program itself didn't change the wait times. The wait times are worse than they were before the re-referral program.

Mr Peters: That's what we found.

Mrs McLeod: So logically, that same population being brought back is better for the patients but it hasn't changed the wait time.

Mr Peters: That's right.

Mrs McLeod: The central question I was concerned about when I requested that the committee ask for a value-for-money audit was whether or not the private clinic was able to treat patients in a more cost-effective way, for whatever reasons, than could be done under the

publicly run system. First of all, I would say that the cost comparison between the re-referral program and the extended program is not the comparison I was looking for, and I think you would acknowledge that. It's a question of, if you're going to do this at home, if you're going to run this new program, if you're going to use your resources in a different way, can it be done in a more cost-effective way in a private clinic? That would be the only justification for continuing to look at these clinics being run privately as opposed to being run by Cancer Care Ontario's regional centres. Your response to that following the audit is that there is no evidence one way or the other because it has never been looked at. Is that a fair interpretation?

Mr Peters: There was an insufficient business case to determine whether the services could be provided internally.

Mrs McLeod: So it still remains, for me at least, a central question that hasn't been answered.

Mr Peters: Yes, it remains a question. The real cost comparison between the two services remains, but we did provide the table on page 8 in which we indicate that the regional cancer care centres are receiving up to $3,079 per patient and the CROS is receiving up to $3,500.

Mrs McLeod: Modified in some cases by $200-plus that they would not receive, so on a per-case basis the private clinic is still getting more. So on the surface of it alone, you might say, it's more expensive than a private clinic.

Mr Peters: That was one of the things we considered in this, whether to go into the costing of the services, but we didn't do that, nor did we cost out additional incentives that Cancer Care Ontario may have provided to its regional centres to provide the additional work. These were the obvious ones that we relate there.

Mrs McLeod: I appreciate the fact that you probably wouldn't have been in a position to ask the questions or get the information as to why the added cost per case appeared to be warranted, whether it was because people working in the extended hours clinic are actually personnel working in other clinics during the daytime in some cases, whether there are overtime costs or bonus salaries being paid and whether those costs would be incurred if you tried to set up the same thing in the publicly run centres.

Mr Peters: Maybe in a sense I can answer in this way: we didn't necessarily consider this as a scope limitation, but one of the facts that had to be considered was that there was a risk. At that time, Cancer Care Ontario had determined on its own that it had some difficulties providing these services internally. It was going external, and probably one of the major risks that the CROS faced was whether they would be able to get staff to do the number of cases they wanted to do. I presume—and this would not be an unreasonable assumption—that some premium was paid to make sure that there was some capability of providing these services.

Mrs McLeod: I guess for me it comes back to this frustration of really wanting to get the facts out as to whether or not running this service—and I don't want to argue with the value of finding ways of treating patients close to home so that the re-referral program can be ended. That's a goal I share completely. It concerns me that extended-hours clinics or re-referral have not reduced the waiting times, but at least the goal of trying to do it at home is one I support. What frustrates me is I still don't know whether or not there is any benefit for patients in doing it in a privately run centre as opposed to doing it under the auspices of Cancer Care Ontario.

Mr Peters: There are really two ways of answering your question. If we had made a recommendation, it would really be to treat this as a pilot arrangement and then do a very careful evaluation of whether it not only achieves this objective of having patients who were sent to the United States now treated in Ontario, and all the benefits that arise from that, but to take the next step and see whether, for the overall system, that is the best way to proceed with how these services are supposed to be delivered.

That's why we also raised the concern of the clause in the contract that virtually gives the right of first refusal and seems to have put the CROS into a fairly unique position of influencing the decision-making in that regard. That is certainly a concern, for that very reason.

1120

Mrs McLeod: I appreciate that, because that was going to be my last question. I noticed you used the term, in referring to Mr Maves, that it was an "unusual" clause. Would it be unusual in any kind of private concern?

Mr Peters: I would think so. I would consider it highly unusual that a contract was granted on the basis that the contractor or the supplier of the services virtually can influence future decision-making by Cancer Care Ontario as to how services are being provided.

Mrs McLeod: Thank you. Maybe that's the recommendation the committee should be looking at, that this private clinic be considered a pilot project and that there be a full evaluation with your assistance prior to there being any further request for proposal made.

Mrs Pupatello: I just have a comment in terms of the unusual content of the agreement. The January 11 letter from the deputy minister writes to CCO approving one-time funding of $4 million to CCO for the private, after-hours clinic. Your colleague also mentioned that was reimbursement costs, as opposed to start-up. I guess that's where the $4 million came from. How typical would it be for the government to hand a private company $4 million up front? What would the purpose of that be?

Mr Peters: The amount shows not the $4 million they were paid. They were paid some amount to set up the clinic, but as you pointed out in your previous question, a lot of equipment and everything was in place at Sunnybrook.

Mrs Pupatello: So what's the $4 million for? Did you discern that?

Mr Peters: That's why the amount was minimal, but afterwards—the $4 million was really to pay for the cases

they treated. That was the service provider payment for the cases they—

Mrs Pupatello: Agreed, but the unusual matter, in my view, is that we are assisting with those reimbursements of start-up costs. How typical is that in an agreement? You don't go to ABC Photocopy and give them money to buy or lease their photocopier.

Mr Peters: It's not that unusual, remembering that the objective, under the circumstances, was to stem the flow of patients going to the United States as fast as possible. If they pre-flowed some of the funds before they actually had patients, in a small amount, I think that would not have been an unusual business arrangement.

Mrs Pupatello: So it wouldn't have been—

The Vice-Chair: I'm sorry, that section's time is up. Any further comments or questions?

Ms Martel: Erik, you said that it was unusual to have a right-of-first-refusal clause in there. Can you tell me if the Ministry of Health was aware of this clause?

Mr Peters: They indicated to us they were not aware.

Ms Martel: So they are providing 100% of the funding and they were not aware of the details of the agreement between CCO and the private clinic?

Mr Peters: That is our understanding of the situation.

Ms Martel: They were not interested in understanding the terms and conditions of a contract that they were paying for 100%?

Mr Peters: Again, that would be ascribing some attitude as to why they were not. Their objective—and they stated that very clearly to us—was to ask Cancer Care Ontario to provide this service, stemming the flow of patients going to the United States, and that was their principal concern.

It is also clear that they decided not to get into the details of the arrangement, to the extent of afterwards relying on our audit as to whether, for example, the management directive had been followed.

Ms Martel: Don't you find that a little bizarre? There's a question of accountability here, and there's also the question that every dollar that's paying for this is a public dollar.

Mr Peters: It does get into the area of the working relationship between the ministry and their schedule 3 agency, and to what extent they want to control the agency and to what extent ministries, they would argue, micromanage agencies of the crown.

Ms Martel: Let me deal with page 8, because you have provided us with a chart which frankly is very valuable; most valuable because it completely contradicts testimony that was given to us by the Ministry of Health in the health estimates on October 9. On that day there were questions raised about what amount of money was being paid to the private clinic on a per-case basis.

Mr King, who is the ADM, said in response to this question—and I'm just going to quote this for you: "In answer to your question, the intent of the contract was such that if the after-hours clinic reached 1,000 cases, they would be paid $3,500 per case. So in that situation, if there were 1,001 cases that did occur, then they would be paid $3,500 for each of the 1,001 cases." The conclusion is that they have to do 1,001 cases and then they will receive $3,500 per case. Your chart, however, makes two things clear: one, that at 500 or more cases, in fact, they are paid $3,200 and, second, that the private clinic was guaranteed, as part of the contract, that they would receive 500 cases.

Right off the top, they were paid $3,250 per case at 501 cases, not $3,500 per case after 1,000. You've made that clear in your chart. In fact, they started to get $3,500 after 750 cases according to your chart. They had two chances at a bonus, or they are having two chances at a bonus, as far as I can read your chart. Would that be correct?

Mr Peters: You are correct. Not only that, but the chart we have presented was agreed to with the Ministry of Health. Our report received factual clearance from them, so they agreed that's the correct information.

Ms Martel: Did they have the information when you spoke to them?

Mr Peters: I'm not sure what steps they actually took to verify the information. We sent the contract over in draft in good time and said, "Are we factually correct?" They came back to us, we had a meeting with them and they said, "Yes, what we have here is factually correct."

Ms Martel: I want to be clear; it was the Ministry of Health that confirmed the numbers you have on this chart, the figures, the premiums. The Ministry of health confirmed these numbers.

Mr Peters: Yes. I can give you negative assurance. In other words, they didn't say it was wrong.

Ms Martel: OK, but they gave us a completely different set of numbers at the Ministry of Health estimates on October 9.

Mr Peters: Yes. I don't know how that occurred. One possibility—and maybe I shouldn't speculate, but I will anyway—is that they did not have the contract when they provided the committee with that information.

Ms Martel: Well, they provided it to us both in writing and verbally, in responses to committee questions, to mine and Mrs McLeod's questions.

Mr Peters: I won't go there as to what they had or what they didn't have.

Ms Martel: No, that's not your fault, I know that. It was only because I read into the record later on that day Ms Lankin's comments, because she had actually seen the contract. Ms Lankin's numbers are the same as appear on the chart.

Mr Peters: Right.

Ms Martel: The point I want to make is this: after 500 cases, these folks are getting $3,250. They're getting that right off the top because they were guaranteed 500. After 750, they start to get $3,500 for every case, and that's retroactive to case number one. If you compare that to what is being paid by the government in the public sector, which is $3,000 per case, it is clear that they are making quite a bit of money per case. They are being paid significantly more per case than the government is actually paying in the public sector. Is that correct?

Mr Peters: With one possible proviso: we don't comment on the overtime arrangement for the regional cancer clinics so we don't know how much premium they get if they work overtime and how much more money they get for that.

Ms Martel: Did you ask for that information?

Mr Peters: That is the case information. We did analyze the situation, but there are a variety of payments made to the regional cancer centres. How many of them directly relate to the treatment of these particular patients and to other incentives that are offered to the regional cancer centres is very difficult to sort out, so we didn't do a particular allocation.

1130

Ms Martel: But if you go to the paragraph above, you say, "The ministry has agreed to pay CCO a one-time performance bonus of $1.8 million if CCO's regional cancer centres provide radiation therapy to 7% more cases than in the previous year." I understand that 7% is close to 1,500 cases. We were given that in committee that day. Would that be the performance bonus you would be interested in in determining if more money is provided per case?

Mr Peters: That would be one element, but there are a number of other elements, such as overtime payments and incentive bonuses that are being paid.

Ms Martel: The ministry provided us with this, and this was the written response in committee. "A 7% increase in new cases would mean that the CCO target for a performance bonus is 1,499. This means that each of the cases beyond the threshold of 21,409 would receive retroactive funding of $1,200 per case in addition to the base rate of $3,000 per case." Would that be the information you would be looking for to make an adequate comparison?

Mr Peters: Yes, that works mathematically. In other words, if you take the $1.8 million and relate it to the number of cases that represent 7%, then you come to the number you've just cited.

Ms Martel: I go back to my original question, which is that it seems to me the government is paying significantly more per case for radiation treatment in the private sector clinic than they are in the public. The bonus in the public system is $200 after they reach 1,500 new cases. The bonus at the private sector clinic appears to be $250 right from the start because they were guaranteed 500 cases right at the beginning of operation.

Mr Peters: That is prima facie, but there are other payments made by Cancer Care Ontario that we couldn't directly relate to this comparison, like incentives or overtime premiums that are paid by Cancer Care Ontario. This is what the ministry decided to pay.

Ms Martel: You're saying there could be a separate arrangement between Cancer Care Ontario and the private clinic that you were unaware of?

Mr Peters: No, not with the private clinic, but there could be separate arrangements with its own regional cancer care centres where they provide some incentives or bonuses or other payments to make their regional cancer care centres more effective.

Ms Martel: Do you know that is the case?

Mr Peters: Yes, there are some.

Ms Martel: But you don't know what the nature of them is, what the payments are?

Mr Mishchenko: We know there are incentive bonuses paid to radiation oncologists for exceeding a threshold number of cases per year, but we weren't in a position to analyze that and apply it to the total cost of services being delivered at the regional cancer centres. As well, there are a lot of other costs that may be incurred by Cancer Care Ontario in regional cancer centres that won't necessarily be incurred by the private sector provider. It's hard to analyze those and come up with an apples-and-apples comparison between the two amounts that are being paid for the services being delivered.

The Vice-Chair: Further questions and comments?

Mr Johnson: I had a couple of things I just wanted to clarify. If we're making a comparison between the cost in US before to what this Sunnybrook clinic was supposed to accomplish, in the paragraph on page 8 you have described the cost and the number of patients and they have gotten a per patient cost of about $18,000 based on roughly 825 a year for those two years. What I wanted to be sure of was, were your costs on that expenditures by the province or on costs for treatment in the States? My reasoning is, I want to know if that $18,000 is all pure Canadian dollars or if there is a degree of exchange that should be added on to that.

Mr Peters: Yes, it's of course included.

Mr Johnson: I'm sorry?

Mr Peters: What you see is Canadian dollars, so it includes exchange rates for US dollars.

Mr Johnson: It is based on expenditures by the province?

Mr Peters: That's right. It's extra cash flow.

Mr Johnson: OK. The other point I just wanted to clarify—because particularly with mathematics and our English language, they don't always coincide—was in regard to the member for Thunder Bay-Atikokan. When we use the term "the reduction" was going from 32%, I believe, to 31%, I believe someone said that was a reduction of 1%.

Mr Peters: Yes.

Mr Johnson: There are two ways of interpreting that. One can say that a reduction from 32% to 31% is 1%, but indeed a few years ago there was a mechanism designed to increase the provincial sales tax and it was changed from 7% to 8%. The story was that this was an increase of 1% and, indeed, that increase was designed to increase the provincial part of provincial sales tax by about 14.3%. My point is that when we reduce from 32% to 31%, that is closer to a 3% reduction than 1%, depending if it's a percentage of what's reduced or if you just look at the difference.

Mr Peters: No, it's the decrease. It's not quite comparable if you compare it to a tax increase. If you take 1% over 7%, you get a different percentage of course, but

that's not what we're talking about here. We're talking about Cancer Care Ontario having set a target for itself, to have 50% of the patients treated in the four-week period. When we first reported, we reported that 32% were not treated in that period, and now it's 31%. Actually if we were to use your statistics, we would say the 1% is a 3% reduction.

Mr Johnson: My point was, I can take your answer to Mrs McLeod in two different ways, and I just wanted to clarify the way you were using it.

Mr Peters: Mrs McLeod had gone off in one way, and we pointed out that it was a reduction. If we used your statistics, we would have actually a worse reduction—I shouldn't say that.

Mr Johnson: I would argue it's not my statistic. It's a problem we have between the mathematics and the English language.

Mr Peters: I think that's fair enough. I apologize if I made it a personal comment.

Mr Johnson: Thank you. Those are all the questions I have.

Mr Gilchrist: I have a couple of questions. First off, I know they're going to look for every little salacious tidbit they can here, but is it typical that you would have every detail of every contract in every schedule 3 agency?

Mr Peters: That we would have access to?

Mr Gilchrist: Access to.

Mr Peters: Of course.

Mr Gilchrist: You would have right now?

Mr Peters: We would have access to schedule 3—

Mr Gilchrist: Access to, but you wouldn't have. So the suggestion that the ministry would know the details at any given point in time, not if you went in to get it, that the government would have knowledge of every employment contract with every hospital employee, every university professor and somehow this is just a terrible thing that the Ministry of Health didn't know in advance some of these details—would the ministry not be accorded some slack given that on March 15 they wrote and asked specifically, "Have you complied with the Management Board directives?" and not CCO. CCO, relating the comments of their legal counsel, writes back and says, "Yes, we did comply." We can all sit here today with the benefit of 20-20 hindsight and say maybe they shouldn't have trusted CCO. But would it not be fair to at least concede that they did take the steps to verify that the directives had been followed and they were told on what one would hope would be a pretty reliable basis that in fact they had been?

1140

Mr Peters: There appears to have been some skepticism on the ministry's part, because otherwise one would raise the question as to why they wrote a letter in May saying, "We will rely on the Provincial Auditor taking a look at it." There's certainly some question why they would do that. The other one is yes, you're quite right, in the working relationship between a schedule 3 agency, it depends very much on the interest a ministry takes in the particular operation or the concern. One of the concerns, and that's what we are raising, is that this was certainly an unusual situation. It was the first time that this sort of arrangement was being made and maybe some expectation of more involvement would be warranted.

Mr Gilchrist: My final question relates to the very title of what you're doing, "value for money," and I want to make sure I've gotten this very clearly from you, because you make some reference in here to barriers that CCO thought existed to their being able to provide—on the bottom of page 2 you cite, "CCO has many agreements with various professional groups, which do not permit the very rapid adjustments required to eliminate out-of-province referrals this year." Facing impediments elsewhere, they went off and found a solution that costs somewhere between $3,000 and $3,500. The offset for that was $18,000 in out-of-province care.

Leaving aside whether they could have done it better—and we applaud your critical comments, and we of course would love to see every dollar spent as wisely as possible. But leaving aside how much better we could have done, would it not be your conclusion that in going from $18,000 per patient to even the high end, $3,500, the taxpayers are getting better value today with this clinic than they were by sending people out of the province?

Mr Peters: We did so conclude. Right away, we said the cost is $14,000 lower per patient, and we did state that in our conclusion.

Mr Gilchrist: You did that on the record too because we clearly have it in your evidence here, and even in Ms Martel's questioning of you, that there would have been overtime payments. Whether it's $3,000 or $3,500, we have no evidence that even at the higher end the public sector could necessarily match that price, because we don't know what overtime premiums, we don't know what other overhead costs Sunnybrook would have to take on. At this stage right now, we don't even know whether or not this is the best possible deal relative to the public sector either.

Mr Peters: That's right. That's the point we're raising: CCO didn't know and therefore we don't know—

Mr Gilchrist: That's right. So it would not be fair to conclude that necessarily $3,500 is a higher cost per patient than if the public sector delivered it?

Mrs McLeod: We all agree.

Mr Gilchrist: Fine.

Mrs McLeod: But the central question stays.

Mr Gilchrist: Fine.

The Vice-Chair: There's a minute left on your time.

Mr Richard Patten (Ottawa Centre): I'd like to move a recommendation for the committee. There are copies for every member. It's in light of the report and the comments of the auditor and our discussion.

The Vice-Chair: Would you read the motion, please?

Mr Patten: Yes. It's a recommendation to the committee:

That this private after-hours clinic (CROS) be considered a pilot project and following evaluation which would include: the effectiveness in meeting the stated goals of (1) waiting times; and (2) cost-effectiveness.

That this be done prior to any further expansion or addition of private clinics.

Mrs Marland: I have one question. Richard, I think you probably want to put a word here—

Mr Patten: Any grammatical recommendations are fine.

Mrs Marland: Where you say "meeting the stated goals of waiting times," I think you want to say "of improving or reducing waiting times," don't you?

Mr Patten: Yes, fine. I'll accept that.

The Vice-Chair: A friendly amendment?

Mr Patten: Yes.

Mrs Marland: Their waiting times isn't a goal.

Mr Patten: You're correct, yes. "Of reducing waiting times," yes.

Mr Maves: I'm sorry. I'm having trouble having this flow. " ... following evaluation which would include: the effectiveness in meeting the stated goals of—"

Mr Patten: "Reducing waiting times and cost-effectiveness."

Mr Maves: What about the original stated goal of making services available closer to home? That's got to be in there. That was the purpose for the whole thing.

Mr Patten: OK.

Mrs McLeod: If I may, Mr Chair, the providing of services closer to home is reducing waiting times. The whole notion is to reduce waiting times. The question of whether or not you reduce the waiting times for services provided close to home versus re-referral is not the question here. The goal of the alternative programs was to reduce waiting times. The first alternative program that was put in place with the goal of reducing waiting times was the re-referral program. The private, extended-hours clinic was established in order to end re-referral. Nobody wants to see the re-referral program back in place—God forbid. But the original goal of having a re-referral program was to have a reduced waiting time. So there is still a goal of alternative programs reducing waiting times.

The other part, the cost-effectiveness, is to address the central question, which I think Mr Gilchrist agrees has not been addressed, and that is, is this the most cost-effective way of providing alternative programs that reduce waiting times?

The Vice-Chair: Before we get into too much debate, we're still trying to sort out the wording of the motion, I believe.

Mr Maves: Yes.

Mrs Marland: With respect, Bart's comments are to get the right wording.

The Vice-Chair: I didn't hear any wording suggestion come out of it. I just want to avoid getting into a debate—

Mrs Marland: I don't think he's debating it.

The Vice-Chair: Ms Marland, I just want to avoid getting into a debate on the motion before we know what's before us.

Mrs Marland: I didn't actually hear a debate.

The Vice-Chair: I'm on your side too.

Mr Maves: Is this your handwriting, Richard?

Mrs Marland: Yes, but he's an artist, you see.

Mr Patten: Listen, I could have been a doctor and then you wouldn't read it at all.

The Vice-Chair: The Provincial Auditor might be able to help us.

Mr Peters: If you'd permit me, I know it's on the record—

The Vice-Chair: I'll permit you.

Mr Peters: Thank you, Chair. I just have some concern about "further expansion or addition" because one of the areas you may want to address is the unusual clause in the contract which allows them the right to first refusal. I'm not sure whether this would possibly defeat the motion, but it strikes me that some consideration should be given whether their contract should actually be renewed on the same terms. In other words, does the government want Cancer Care Ontario to continue a contract which essentially restricts its ability to find alternative solutions to this particular project? I'm not sure whether you want to address this—

Mrs Pupatello: So that's just recommending—

Mrs McLeod: We thought this was addressing that very issue. That's why it's here.

Mr Peters: It's prior to renewal or further expansion etc.

Mr Patten: Actually what you've flagged for me is "any further private expansion"—no, that's correct. That's all right, it's covered.

Interjections.

Mrs McLeod: Mr Chair, I would have a problem with the auditor's recommendation. Even though the resolution was intended to try and address the whole issue of further cancer clinics being established with right of first refusal to get at that clause, my concern with putting "or renewal" in is that the renewal period, I believe, is January 1 coming up. If it said there had to be an evaluation before renewal of a contract, that could mean the existing clinic would be shut down. One thing I would hope we would all want to avoid is to shut down a clinic that is providing treatment to patients now. Whatever the effectiveness of alternate programs is in reducing waiting times, whatever the reason the waiting times haven't gone down, we don't want to take away any treatment that's currently being offered close to home.

Mr Johnson: It's meant in a friendly way, if I could. I wonder, if we left the last sentence off, would that help us a little bit in that very thing, Ms McLeod?

Mrs McLeod: It wouldn't. We were picking up from the auditor's statement that the right of first refusal to this particular clinic is a very unusual clause and his comment was, and I'm paraphrasing, that it would have been preferable from being able to do a value-for-money kind of thing to have seen this as a pilot project where a full evaluation would be done before there would be any further offerings. I think the auditor's quite appropriately said in theory that should also mean before this contract is renewed. My concern with putting "renewal" in is I don't want to see the current clinic shut down and patients on a waiting list who are now being treated.

1150

Mr Johnson: My point is, if that's covered in the contract, then we don't have to worry about any other expansion of the—

Mrs McLeod: No, the contract actually would allow expansion on exactly the same terms and to the same provider.

Mr Gilchrist: I'm not unsympathetic with the point Mr Patten's trying to make here. I would have thought, though, that perhaps a more appropriate use of the auditor's time would be to request a subsequent audit to determine the actual cost of providing radiation services in the public sector on a per-case basis.

We now know everything we need to know about this contract. There seems to be no debate about the number of dollars, the number of patients. We know what the overhead costs were. We know all of those things. What we don't have, to deal with the very question, the member opposite agreed, are the comparators. What are the overhead costs divided by the number of patients? What is the cost of the administrator divided by all the patients? What's the cost of the janitorial service divided by those patients? You know how long that list could be. We could talk out the clock here, just going through the things the auditor would have to consider.

If the members opposite want to get to the bottom of whether or not this was a good decision or a bad decision—and quite frankly I would think if the auditor wanted to have the best possible comparator to determine—again, leaving aside the competitiveness in the tendering, which we absolutely agree with his conclusions on, I don't see how anything else moves us along in this debate. I wouldn't want to tie it to holding up expansion of any service, private or public. The auditor's timetable may be very different than the timetable of the contract for CCO's needs, but the bottom line is that until we have that as the benchmark, we'll never know whether or not this is as good a deal as CCO obviously believed it was when they signed the contract.

Mrs Pupatello: I guess I'm asking the auditor; if the motion were to pass that includes the more fulsome audit, I don't know that there's any precedent in terms of a private company walking in and using all of the equipment of an existing public body. When you are looking at the cost-effectiveness of it, you need to weigh use of equipment, wear and tear on equipment, depreciation of equipment, all of those things. The notion that Cancer Care Ontario agreed to pay $3,500—all they based it on was that it was $500 more than what Cancer Care Ontario was being paid to serve each patient. It wasn't determined by the estimation of the cost of the private company providing the service. It was simply based on what the government and CCO was agreeing to pay. So the cart's before the horse in terms of your calculations of what the true cost is and then doing a comparison.

In the private sector, a company standard is going to determine that it's cost plus 10% margin, however a private company determines what the price points are. They might have agreed to charge $3,200, but they're going to estimate their cost based on equipment, all personnel etc. How do you make a full determination of what it costs to purchase the equipment and/or lease back the equipment in the evenings, their assumption of cost of depreciation of the items? There's no precedent I'm aware of in government that is going to give an appropriate evaluation that takes into account all of those factors.

Just on the motion, I wanted to—

The Vice-Chair: Let's get back to the motion. That's what we're trying to work on here.

Mrs Pupatello: On the motion, I do think Ms McLeod's comments are important in that we can't allow any delay or anything that's going to make the wait times longer by taking away a potential service that's currently available through this contract. What language can we use that's going to give us the time frame, not to simply stop services as of January 1?

Mr Peters: May I answer the question?

The Vice-Chair: Yes.

Mr Peters: Just very quickly, maybe taking into consideration your question and combining that with Mr Gilchrist's comments, would it not be within the purview—rather than relying on an audit by my office, you just ask Cancer Care Ontario to come forward to this committee with its evaluation into cost-effectiveness and then make a decision whether my office should do further work on it. But at the beginning, the issue you're raising is really covered in cost-effectiveness because the unusual feature of this contract is that we're dealing with incremental costs at this particular time. In other words, there's a clinic in the daytime and there's a private after-hours clinic. That could be evaluated and could be reported back to the committee, if you so wished, so that at the end you would make your recommendation that they report back to you on this evaluation.

Mrs Pupatello: What language would you suggest as opposed to "renewal" that isn't going to put it in a crisis come January 1, that the services will stop being delivered by the clinic?

Mr Peters: I think you have persuaded me that that would probably be a showstopper if we put "renewal" in. "Further expansion or addition to private clinics" would probably cover the point made.

Mrs McLeod: My understanding of what you have just recommended is that we would ask for Cancer Care Ontario to bring forward its evaluation prior to there being any further expansion, because the crux is, we have to have something in this resolution that says that some kind of evaluation has to be done before there are new clinics using this clause of right of first refusal under existing terms and conditions. I'm more than happy to have wording that talks about the comparator prices with the publicly run clinics. The wording of my original resolution was that there be a value-for-money audit that would look at the cost-effectiveness of the privately run clinic versus the publicly run clinic. The problem is it's been very difficult to get at that information.

I think the comparators need to be there. I guess my only concern about having Cancer Care Ontario come forward with an evaluation is that they might not be asked to make the comparator with the publicly run centres, and I think that's a very fair comparator. We didn't start out to make the judgment of one versus the other. We just wanted to get the facts out.

Mr Peters: At the time we did the audit, of course they were in operation only for a very few months, as you know, so this evaluation couldn't take place. But I thought you had covered it with the word "cost-effectiveness." I would expect this analysis to include for cost-effectiveness a clear analysis as to what it does cost to provide the services in-house versus by the outside clinic, the private sector clinic.

Ms Martel: I'm not sure we should worry whether or not people will continue to get service. CCO has a contract with Sunnybrook. They're not going to stop that based on whatever motion comes from this committee. They have an ongoing obligation and they will commit to that. I'm not worried about wording from this committee that might have them shut this down.

Secondly, I'm not very interested in having CCO come before us, frankly. Your comments on page 4 that they were trying to keep this as confidential as possible so it wouldn't become a political issue doesn't give me much confidence any more in terms of their providing upfront direct information to this committee, either about this contract or other things they might be up to. I would much prefer to have you do the investigation because you're an independent body and you're not party to the contract. It is not a conflict of interest for you one way or the other to report on the actual details of all of these things.

I would be very happy for you to look at the comparator because I also thought that was what the point of the exercise was. The question for me has never been: are we getting value for money from stopping people from going here because we're having them in the private clinic? I had always assumed we could do this and should be doing this in the public sector. I think the performance bonus you've provided us makes it clear they are being paid more in terms of performance bonus per case than we are in the public.

I'd be very happy for you to make that comparison. The only thing I would ask is, and I'm sure this will be part of your evaluation, that some credit be given where it is due. The public sector owns those assets. I'd be interested to know if, as part of all of this, the private company is paying for use of these assets, because that will change the cost per case, given who owns the assets and who is paying for operating costs and who may not be. If they're getting $3,500 merely for staff to do the work, which may be the case, and that doesn't include a payment that cancer centres would have to assume themselves in operating in the public sector, we need to know that.

Mr Peters: The answer is, they don't pay for that, but then the regional cancer centres also don't pay for that.

1200

Ms Martel: It would be part of their operating budget, wouldn't it?

Mr Peters: That's right; they are part of the operating budget. That's fair enough; that's in there.

The other brief concern that I have on this is whether the committee wishes to give some direction as to whether they should comply in future with Management Board of Cabinet directives.

Ms Martel: That's a given.

The Vice-Chair: Is that OK, Ms Martel?

Ms Martel: Yes.

Mrs Marland: I think there are some aspects of this that we really do need to discuss. I don't think, however, we want to go down the road about the question of private use versus public use of public assets, because we can go into that tremendous debate about physicians who have hospital privileges having their income relative to the fact they have those privileges. Indeed there are lots of physicians who don't even operate their own offices because they use that public asset, which gives them somewhere to see patients in a hospital, even if they're not full-time physicians in emergency, which is a situation that's always intrigued me: that physicians could have their income without having an office somewhere else. They just bill OHIP, whether they're full-time emergency or they go and see their patients at emergency. So there are a lot of examples where the public assets are used for "private income." If I'm a doctor in those circumstances, it is my private income that I earn as a professional by using the public asset, ie, the building; that is, the hospital.

I just wanted to confirm, Mr Peters, I think you said that at the time you did this—

Mr Gilchrist: Mr Levac?

Mrs Marland: No.

Mr Gilchrist: Oh, sorry.

Mrs Marland: Excuse me, I know whom I'm asking the question.

Mr Gilchrist: I'm watching Steve Peters up there.

Mrs Marland: This contract had only been in effect two months, did you say?

Mr Peters: A little longer than that. It came into being in about February. At the end of February they started operations, so I would say a good six months.

Mrs Marland: OK, I thought I heard you say two; that's fine.

Your reference to the aspect of in-house: there obviously isn't a hospital in Toronto or in the GTA that doesn't understand that there had to be other alternatives found to try to deal with the waiting list. The obvious place to go to try to find those alternatives would be the hospitals themselves that provided those services during the day. Did your staff ask any of those hospitals, and in this case particularly Sunnybrook—

The Vice-Chair: Ms Marland, does this relate to the motion that we're trying to resolve, or are you going back to the committee report? I tell you, the problem is this—

Mrs Marland: No, it relates to the motion, because what I'm coming to, Mr Chair, is the fact that the motion is saying that we're going to now consider this a pilot project. I'm wondering whether, first of all, it would be legal to change the status—I haven't seen the contract so I don't know the wording—with this private clinic. I think actually legally we might be on slippery ground, but I have no idea of the answer to that.

I have some other concerns. We're suggesting that Sunnybrook didn't look for a solution themselves. They've got the equipment; they've got the trained staff. Why didn't they look at evening hours or off-hours, the way this particular private clinic operated after hours?

The Vice-Chair: Well, since there's a pause, I'm in the hands of the committee, but we're all aware of the fact that even though it isn't 12 o'clock somewhere, the House has adjourned and we're going past 12 o'clock. We have to get this resolved very quickly.

Mr Gilchrist: Or defer it to the next meeting.

The Vice-Chair: That's right. It just stays on the table and we pick it up at the next meeting. I'm just saying—

Mr Patten: We could do that. If we want to discuss it more, that's all right.

Mrs Marland: I think we do need some other answers to the questions.

Mr Peters: Just very quickly, the pilot project would not be of concern, because that would be the approach that Cancer Care Ontario takes. There's nothing in the contract that says it is or it isn't.

The Vice-Chair: It's just a recommendation.

Mr Maves: I would also prefer that in the sense that I'd like an opportunity to have a more thorough reading of the report which I received this morning. With Ms Munro, Mr Gill and Mr Hastings, we're the regular members on the government side of the committee and we have been part of the entire Cancer Care Ontario process. I know that they'll want to read this and be part of the recommendations that the committee makes. So I'd be happy to carry it over.

The Vice-Chair: OK, wrap-up comments?

Ms Martel: Very quickly, this committee in all likelihood is not going to sit again till—

The Vice-Chair: January.

Ms Martel: —April, May.

The Vice-Chair: No, no, in January.

Ms Martel: Are we going to deal with it, then, when we sit in the intersession as the first order of business?

Clerk of the Committee: We would have to.

The Vice-Chair: It's on the floor.

Mrs McLeod: The next date of the committee, then?

The Vice-Chair: Those are kind of being determined.

Clerk of the Committee: We're waiting for the House to pass a motion. We've requested in February and March. So if the motion passes by the House, then it's the days that we select.

The Vice-Chair: Thanks for your co-operation. We're adjourned.

The committee adjourned at 1206.

CONTENTS

Thursday 13 December 2001

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Chair / Président
Mr John Gerretsen (Kingston and the Islands / Kingston et les îles L)

Vice-Chair / Vice-Président
Mr Bruce Crozier (Essex L)

Mr Bruce Crozier (Essex L)
Mr John Gerretsen (Kingston and the Islands / Kingston et les îles L)
Mr Raminder Gill (Bramalea-Gore-Malton-Springdale PC)
Mr John Hastings (Etobicoke North / -Nord PC)
Ms Shelley Martel (Nickel Belt ND)
Mr Bart Maves (Niagara Falls PC)
Mrs Julia Munro (York North / -Nord PC)
Mr Richard Patten (Ottawa Centre / -Centre L)

Substitutions / Membres remplaçants
Mr Steve Gilchrist (Scarborough East / -Est PC)
Mr Bert Johnson (Perth-Middlesex PC)
Mrs Margaret Marland (Mississauga South / -Sud PC)
Mrs Lyn McLeod (Thunder Bay-Atikokan L)
Mrs Sandra Pupatello (Windsor West / -Ouest L)

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Mr Erik Peters, Provincial Auditor
Mr Nick Mishchenko, director, health and long-term care audit portfolio,
Office of the Provincial Auditor

Clerk / Greffière
Ms Tonia Grannum

Staff / Personnel
Mr Ray McLellan, research officer,
Research and Information Services