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Jeudi 24 février 2005

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Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2004,
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ministère de la Santé
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Chair: Norman W. Sterling
Clerk: Susan Sourial

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 24 February 2005

Jeudi 24 février 2005

The committee met at 0937 in committee room 1, following a closed session.

2004 ANNUAL REPORT, PROVINCIAL AUDITOR

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.08, independent health facilities.

The Chair (Mr. Norman W. Sterling): I think we're ready to begin. My name is Norman Sterling. I'm the Chair of the committee. You can see the names of the various members of the committee in front of their desk.

I believe, Ms. Rappolt, you are heading the delegation. I would ask you to introduce those people sitting with you. If you require other people to come forward, then perhaps you could introduce those people at that time. The microphones come on automatically, just so you know. Do you have any opening comments that you would like to make?

Ms. Marg Rappolt: Yes, I do, Mr. Chair. Thank you and good morning. I am Marg Rappolt, the Acting Deputy Minister of the Ministry of Health and Long-Term Care. To my right is Marsha Barnes, the director of the independent health facilities program at the time of the audit. Directly to my left is Jeff Morgenstern, who is the manager of the independent health facilities program, and to his left is Susan Fitzpatrick, the executive director of the health services division.

Mr. Chair, ladies and gentlemen and honourable members, it's an honour to be here today before the public accounts committee of the Legislature, more specifically, to make remarks and to answer your questions regarding the Ministry of Health and Long-Term Care and what is has done to respond the 2004 provincial Auditor General's report as it relates to independent health facilities.

As you know, the auditor's report provided advice and raised some concerns about independent health facilities in Ontario. It goes without saying that the ministry takes all comments made by the Auditor General very seriously, no matter which of our operations, programs or services they may impact.

I want to assure members of this committee that in the year since the Auditor General's report was released, the ministry has been moving forward with a plan to respond to the recommendations and the concerns. We welcome the findings, and we thank the Auditor General for his recommendations. They serve to shed more light on the path ahead.

Accountability in all of our operations is paramount. So if I can, I'd like, with our team, to be very specific about how the ministry has responded to these recommendations. Before moving into more detailed responses, though, I'll make some general comments about independent health facilities in Ontario.

Independent health facilities are needed community-based health care operations. As members of the committee know, they provide both diagnostic and surgical treatment. Some of them have a long history of working with Ontario patients.

There are a total of 955 independent health facilities in Ontario, with 924 diagnostic facilities providing important services such as radiology, nuclear medicine, ultrasound, and pulmonary function and sleep studies. Seven of these facilities provide MRIs and CTs. There are 24 licensed ambulatory facilities providing dialysis, plastic surgery, abortion, retinal and cataract surgery, vascular surgery, laser dermatology, and obstetrical and gynaecological surgery. An IHF may be established in a variety of settings; for example, completely free-standing, located on the site of an existing health facility or in a multi-office complex.

Their presence helps to reduce wait times, and reducing wait times for key services is one of the main planks in the government's broader strategy to transform Ontario's health care system. The ministry has committed to providing timely and appropriate access to health care services, including cancer surgery, hip and knee total joint replacements, cardiac surgery, cataract surgery and MRI/CTs. Significant investments have been made thus far, and the government has a plan to do more.

I'd also like to note that the Auditor General was categorical in stating that the ministry has "adequate procedures in place to ensure compliance with applicable legislation and policies for the licensing, funding, and monitoring of independent health facilities." But the auditor said that "if the program is to cost-effectively fulfill its mandate, action is still required" to address a number of issues.

Let me get to the specifics, line by line, so to speak.

The first recommendation of the Auditor General was:

"To help ensure that facility fees paid to independent health facilities are reasonable, the ministry should:

"objectively determine the current cost of providing each type of service; and

"examine the relationship between the volume of services provided and the costs of providing services."

I am pleased to report that our work on this very important and complex recommendation is in progress.

In order to address the issue of facility and technical fees, the ministry agreed, as part of the 2003 memorandum of agreement with the Ontario Medical Association, to establish the diagnostic services committee, or DSC. This committee will function as an advisory body to the minister for the purpose of planning and coordinating an efficient and effective diagnostic services system in Ontario. The DSC will also examine how the technical component of diagnostic services, currently described as technical fees, will be evaluated, compensated and administered. This includes establishing a costing methodology and an ongoing review process to reflect that reimbursement is based on actual costs and current service volumes.

In another recommendation, the Auditor General said:

"To help ensure that the services provided under the Independent Health Facilities Act are reasonably accessible to all Ontarians, the ministry should:

"assess the need for each service by region and determine what actions are required to meet its commitment to provide services where and when needed."

He also recommends that the ministry "assess the implications—from a financial and waiting list perspective—of licensing more than one independent health facility to provide cataract surgeries."

The diagnostic services committee will use a planning-based approach for the diagnostic services system, including making recommendations to address access and health care needs. This will include addressing issues such as access in underserved areas, new approaches to meet patient needs and capacity and wait-list issues.

The diagnostic services committee will provide advice and recommendations on the funding and structure of the province-wide diagnostic system, including the use of new funding for diagnostic services. Work on this recommendation is in progress, and the expected date of completion is the spring and summer of 2008.

On the question of assessing the implications of licensing more than one independent health facility to provide cataract surgery, the ministry has conducted a needs assessment to identify areas of the province in greatest need of additional cataract surgery services. As a result, we are looking at a range of options to meet community needs, including independent health facilities.

In yet another recommendation, the Auditor General said, "The ministry should also determine what legislative or other actions should be taken regarding unlicensed facilities" which offer "surgical and other procedures" generally undertaken "in hospitals or licensed independent health facilities."

Once again, work on this recommendation is in progress, with an expected completion date of the fall of next year.

The structure of the act is such that the definition of an independent health facility, and the problems and penalties associated with operating an unlicensed facility, all hinge on the charging of a facility fee as defined in the legislation. Facilities that forgo the charging of facility fees do not require licensing under the act and are not subject to its quality assurance provisions. The imposition of the quality assurance established under the act on facilities performing IHF-type services, yet not licensed, would require significant amendments to the legislation. The ministry fully supports the consideration of this issue under a policy review of the act.

Moving on to yet another of the recommendations, the auditor said:

"To help determine the severity of regional service-level fluctuations, the ministry should:

"develop and implement a waiting list management system; and

"monitor and analyze waiting times."

In an effort to manage wait-lists, the government has committed to provide timely and appropriate access to key services, including the five key service areas that I discussed earlier. Initial activities to address the length of time Ontarians wait for health care services, as part of our wait-time strategy, will include the development of a comprehensive information system so that the province has the capacity to compile, measure and evaluate wait times in all facilities providing key services. This includes independent health facilities. This information will be publicly reported so that patients and their providers can make informed decisions about their options and feel certain that their needs are being addressed. Work on this recommendation is also in progress.

The Auditor General also recommended that to "help ensure that independent health facilities are being appropriately used to meet ... health care needs ... the ministry should implement a process for determining whether particular services should be provided by hospitals or by licensed independent health facilities."

I'm pleased to report that this recommendation has been implemented. We believe the introduction of any service, either in a hospital or in an independent facility, should consider the best mechanism for delivering the service for the benefit of the patient. Senior officials at the ministry assess the best possible options and venues for providing patient care and optimizing available human and financial resources.

The process for the creation of new independent health facilities requires the minister to authorize the issuance of a request for proposals. In deciding whether to issue a request for proposals, the minister must consider the items set out in section 5 of the Independent Health Facilities Act, including current and future need for the service. The minister must also consider the extent to which the service is already available and, of course, the projected cost and availability of public funds.

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Our independent health facilities program currently includes an assessment and/or rationale for establishing

an independent health facility-based service, as opposed to a hospital-based service, as part of that material for the minister's consideration. This generally includes a cost comparison between hospital-based and independent health facility-based services, along with an assessment of the complexity of the service. It also includes quality assurance issues associated with providing the service in a non-hospital setting.

Continuing with other recommendations, the auditor also said, "To help ensure that the College of Physicians and Surgeons is meeting the ministry's expectations regarding the assessment process and the development of clinical practice parameters and facility standards, the ministry should regularly update its agreement with the college." It was suggested that this be done in a signed memorandum of understanding.

The ministry supports this recommendation as well, and I'm pleased to report that work on implementing it is in progress. The need for this memorandum was discussed with the college at the December management working group meeting. I should report, however, that it requires significant discussion with the college to resolve issues on program objectives, scope of activities and deliverables. Having said that, we are determined to move ahead, and the memorandum is to be developed and implemented for the 2005-06 fiscal year.

In another recommendation in his 2004 report, the Auditor General notes: "To help provide assurance that independent health facility services comply with clinical practice parameters and facility standards, some assessments should be performed without advance notice."

On this recommendation, we have also initiated discussion with the College of Physicians and Surgeons of Ontario. We hope to develop with them policies and procedures defining circumstances under which unannounced assessments will be conducted. Work on this recommendation is in progress, with an expected completion by either this year or next. The policy will be implemented upon receipt of necessary approvals.

Moving on, the auditor further recommends:

"To help improve the effectiveness of the assessment process, the ministry should establish time frames for:

"the submission of assessment reports by the college ... to the director of the independent health facilities program; and

"the forwarding of information from independent health facilities to the college that provides assurance that any required corrective action" be "taken on a timely basis."

Work on this recommendation is also in progress, with an expected completion date of this year or early next year. I should note that the College of Physicians and Surgeons has committed to a turnaround time under a new process of within 10 business days of receipt of the report. This is for facilities determined to be operating in a manner prejudicial to health and safety. Their turnaround time will be 72 hours for immediate health and safety risks. This will allow the ministry to respond to these important health and safety issues in a more timely fashion.

I should point out that current letters to the licensee include that the licensee must contact the CPSO within 15 days of receiving the report. For more serious concerns, but not requiring licensing action, the licensee is instructed to contact the college within 15 days and to submit a written plan addressing the recommendations within 30 days of receipt of the report.

The Auditor General further recommended:

"To help improve the effectiveness of the process for assessing independent health facilities and to help ensure that quality standards are met, the ministry should:

"have a formal policy on suspending facilities with serious quality assurance issues, especially when the same issues arise on reassessment; and

"consider charging facilities for reassessments."

The ministry supports the recommendation of a formal policy. The ministry will develop a policy establishing circumstances under which licensing action will be taken for repeat quality assurance problems where the deficiency, in itself, does not constitute a health and safety risk or an immediate threat. The ministry also supports that charges for reassessments be considered. The ministry will develop an options paper setting out the process for implementing this change and the advantages and disadvantages of charging the licensees costs for reassessments. Work on both aspects of this recommendation is in progress, and we're hoping to have an expected completion date of 2005-06.

To help protect the public, the Auditor General recommended: "The ministry should consider appropriate public disclosure of serious quality assurance problems at independent health facilities."

Let me say the ministry also supports the recommendation that this issue be considered. Work on it is in progress, also with an expected completion date of this year or early next.

Our ministry will also develop an options paper on this matter. A number of issues need to be considered in the development of a system for such public disclosure. These considerations include: the retention period for the information; the posting of proposed suspensions while under appeal; the impact of changes in ownership on posted information; as well as timing for the posting of information and so on.

The Auditor General further says: "To help ensure effective assessment of the quality of services provided by independent health facilities, the ministry should work with the College of Physicians and Surgeons of Ontario to ensure that:

"the sample of services to be assessed is sufficient to reach a conclusion and is selected from a complete listing of all services rendered to patients; and

"the sample is selected independently by the college or by the ministry."

This is another good recommendation and the ministry supports it. The issue will be discussed with CPSO, and requirements for review of files and sample selection will

be included in the memorandum of understanding between the college and the ministry.

Work on this recommendation is also in progress, with an expected completion date of 2005 or 2006.

We discussed the matter with the college of physicians at the December management working group meeting. Requirements for sample size and selection process were scheduled for discussion at this month's meeting of the group.

There are two more recommendations I'd just like to give you details on. The auditor said: "To help ensure the consistent quality of medical services in Ontario and to help minimize the risk to patients, the ministry should assess which diagnostic and surgical services performed outside of hospitals and licensed independent health facilities should be covered by the Independent Health Facilities Act."

I'm pleased to inform the committee that this recommendation has been implemented. Any decision to expand the independent health facilities program to include additional services must balance the cost of implementing a licensing and quality assurance program against the need for: enhanced quality assurance of services performed in community-based settings; and planning and utilization controls on the service achieved through the independent health facilities licensing scheme.

The ministry developed criteria in 1997 to evaluate proposals for expansion of the act to include additional services. These criteria were used to regulate sleep medicine facilities under the act and it led to the licensing of sleep medicine facilities through changes to the schedule of benefits in 1998.

These criteria should continue to be used to evaluate any proposals for expansion of the act to include additional services. Evaluation of proposals for new and/or expanded services under the IHFA will be conducted on a case-by-case basis.

Finally, the Auditor General recommended: "To help ensure that new facilities that are brought under the Independent Health Facilities Act in future meet quality standards, the ministry should:

"inspect all such facilities on a timely basis; and

"follow up on identified problems on a timely basis to verify that corrective action has been taken."

The ministry supports this recommendation. To ensure that any future grandfathering situation is resolved in a timely manner, the ministry recognizes the need to ensure that sufficient dedicated resources, both within the independent health facility program and in the college of physicians, are assigned to the inspection and licensing processes.

Work on this recommendation is in progress.

Once again, I'd like to thank the Auditor General for these very useful recommendations. As you can see, the ministry has taken the recommendations very seriously. We're working hard to address these concerns.

On behalf of the Ministry of Health and Long-Term Care, I'd like to thank the committee for this opportunity to provide a full response in answer to the issues raised in the Auditor General's report.

It goes without saying that we at the ministry respect and appreciate the process of the auditor's reporting and of this committee's work.

Our work at this time is so important to the people of Ontario, and no one knows it more than the dedicated staff of the ministry.

I thank you, Mr. Chair and committee members, and we're now available for questions.

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The Chair: Mrs. Munro, did you want to go first?

Mrs. Julia Munro (York North): It doesn't matter. No. That's quite all right.

The Chair: Go ahead, Bill.

Mr. Bill Mauro (Thunder Bay–Atikokan): Thank you for your remarks. I'm just wondering if you can speak to me a little bit about the RFP process that was undertaken with the issuing of the seven private MRI/CT scan facilities several years back.

Ms. Rappolt: Certainly. I'll begin with some remarks, and I may refer to Marsha Barnes, to my right.

There was an RFP issued in the fall of 2002 to proceed with seven MRI/CT services and clinics. As the members are aware, in relation to the commitment of this government to ensure that diagnostic services are provided in a way that best meets community need, the government proceeded with us pursuing what we call a conversion process for those clinics. That process has taken place successfully with regard to four of those clinics, and those clinics are now operating as non-profit clinics in four centres in the province. There are discussions and negotiations regarding the conversion of three remaining clinics ongoing.

Mr. Mauro: I'm sorry, to your right is Marsha, is it?

Ms. Rappolt: It is Marsha.

Mr. Mauro: Marsha, can you speak a little bit more about the details of the process? Was it a sole-source contract? Was it open to everybody to bid equally?

Ms. Marsha Barnes: It was a competitive bid process. Under the legislation, the minister can direct the director of independent health facilities to issue a competitive request-for-proposals process. In this instance, that's what he did. We provided information to him in making the decision on the need for the services and availability of funds and the future need of the services.

Based upon that information, the call for proposals was directed at specific geographic areas. It followed the normal procurement processes for government, where we had bidders' meetings and answers to questions that were provided in writing.

That was then followed up by a formal evaluation process, resulting in award of the licensees to the contractors and operators. There was one area where an award was not made, and that was in Brantford, because the results of the proposal request came in so that it would be more cost-efficient to provide the services in hospital than in an independent health facility. The de-

cision on that case was made by the minister to cancel that RFP.

Mr. Mauro: You spoke a bit about the audit that was first performed on IHFs in 1996. There were, I think, some recommendations or at least mention of challenges that the auditor felt were existing at that time, some of which don't seem to have been addressed. I'm more concerned about—and it sounds like you're saying they are being acted upon now.

Two points that were raised, actually, as a result of that audit: one was the appropriateness of the fees that were being charged in the independent IHFs at that time; and the second was the relationship between the volume of the work relative to the overall cost being submitted. So I'm wondering if you can speak to me a bit about that. What's happened since 1996 until now, and the work that's ongoing today to try and address it?

Ms. Rappolt: I'll begin, and I may ask my colleague Jeff Morgenstern, the manager of the program, to the left.

Yes, it is the case that, in the audit from 1996, there were questions raised or considerations given to the ministry to ensure that the services and the cost of the services did better reflect both in terms of volumes and the actual price. What we've proceeded with is an understanding through the diagnostic services committee that I referenced quite recently with the Ontario Medical Association as a result of an agreement with the medical association in 2003. We've agreed that the diagnostic services committee will play a significant advisory role with us in ensuring that in our assessment of need, we're taking appropriate care and paying attention to issues of price and volume.

Mr. Mauro: Yes, but it was recommended in 1996, and the DSC is now just beginning the work that you're speaking to. So I'm wondering if there's any substantive reason why something had not begun sooner.

Ms. Susan Fitzpatrick: I think there has been substantial work going on since the late 1990s. It's a complex area spanning several sectors. It's not just the independent health facilities; it's also hospitals that receive technical fee payments. There have been committees. There was a committee on technical fees, followed by a diagnostic services development team that actually did a lot of work on how we should plan and set these fees. So there are literally hundreds of fees that are set in a complex way, and they're billed in more than one sector. So out of that work, I think the OMA, the ministry and the OHA, as well as the independent health facilities, realized that that group has to work together to set the fees. We can't do it in isolation of that.

Mr. Mauro: Last question, Mr. Chair: Previous to the introduction of the Independent Health Facilities Act, is it fair to say that there was no governance structure, no regulation at all of these?

Ms. Barnes: I would say that it's partially correct. Most of the facilities, at that time, were funded through OHIP, so that their physicians were providing the services and billing through OHIP. There was no formal quality assurance program, and the services were perhaps not appropriately attributed to the operator of the facility, so that there was a use of a billing number that perhaps was less than appropriate at the time.

Mrs. Munro: My question really follows very much from the comments that have just been made on the diagnostic services committee. I think it's really important for us to understand why something that was identified several years ago appears only to be making its presence. I think it's really important for us to understand the complexity of the situation.

If you can, I'd like you to give us a picture, since on page 5 you talk about it functioning as an "advisory body to the minister for ... planning and coordinating ... efficient and effective diagnostic services...." In your best-case scenario, where would you like to be? Between the College of Physicians and Surgeons, the hospitals and the independent health facilities, what would be your ideal in their relationship and where this would take you then, in terms of the goals of this committee?

Ms. Fitzpatrick: I think the committee has a broad structure for planning and advisory, specifically on the issue that was raised previously. They also are very interested in the funding of the technical fees services, ideally, and that's very, very important to the committee, that they get that work underway. One of the ways of approaching it is to agree on a methodology for evaluating the fees. These are fees that are constructed, traditionally, through the Ontario Medical Association process. They have an evaluation form. I think it's 25 or 30 pages. They actually look at the inputs in coming up with a technical fee rate. They look at the cost of the equipment, the cost of paying the technician, the supplies. So I think one of the early deliverables of that committee would be to establish that process, look at all the fees and start recommending how those fees should be changed. It's not only that fees should go up; they may go down. So that is what they would look at.

Then there are broader activities they would also be undertaking: looking at underserviced areas, looking where there are distributions problems; looking where there are efficiencies. Again, that's why we said we have to work collectively: How are hospitals and independent health facilities exchanging information, patients and that type of thing?

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Mrs. Munro: Would the work also then include some comparisons, particularly when you're looking at underserviced, of how you address distance issues, and also the differences in terms of demand for these services? I can imagine that there are going to be those kinds of differences, just simply based on the geography. What kind of rationale are you using or would you want to project in terms of balancing off those kinds of issues, of creating efficiencies but obviously in situations where you don't really have a tremendous critical mass?

Ms. Rappolt: I'll just offer some high-level comments. This committee, which is a multipartite committee, is charged with getting to the right methodology, getting to the right formula to ensure that all the factors that should

be taken into consideration, such as those you've raised, are appropriate.

I would say the overriding principles for the government in coming up with the right formula would be a formula that appropriately balances and ensures quality with access and efficiency, and takes into consideration, of course, access in terms of the remoteness of some Ontarians in needing these services. That is a core task of this committee, to establish the right methodology, meeting those principles.

Mrs. Munro: Would you anticipate that there should be more independent health facilities or fewer?

Ms. Rappolt: I don't believe we can sit here and make that anticipation. We would need to make that determination and offer advice to government as a result of getting the information and data that this committee will be providing.

Mrs. Munro: Just on that, when you raise the issue, when you talk about the memorandum of agreement that was signed in 2003 and then list for us the initial focus of this group, when do you think you're going to have some answers?

Ms. Fitzpatrick: I think the three organizations are ready to proceed to set up that committee, I would say, hopefully, within the next month or so. The representatives are being nominated at this point. I would say that within the fiscal year there would be preliminary work back.

Mrs. Munro: Do they have an incentive to act expeditiously on this project?

Ms. Fitzpatrick: I think they do. Although this will be a new iteration of a committee, there has been significant work. I imagine the representatives will be people who have been previously involved. They are people who are working in the communities that are dealing with these issues every day. I think they're very impassioned and they want to see change. They really are very committed to it.

The Chair: Can I ask a supplementary here? One of the problems I have is that we don't seem to have data on who owns these independent health facilities and who benefits in the end. In terms of the 1,000 independent health facilities, how many are owned or have beneficial ownership in the hands of physicians themselves?

Ms. Rappolt: What I do know is there is a broad range of arrangement, of corporate structures, that make up these 1,000 independent health facilities. I'm going to ask that Jeff give a more detailed breakdown on that.

Mr. Jeff Morgenstern: The ownership structure of independent health facilities: Sole proprietors, corporate entities, publicly traded corporations and partnerships are all eligible to be licensees of the independent health facilities. We track details as to who the shareholders of the corporations are. The difficulty in identifying which are physician-based is that in many cases the shareholder in the corporation could be the spouse or child of the physician, or the shares could be held in trust through a foundation. So it's difficult to identify the actual number that are physician-based or physician-owned.

All of the facilities prior to licensing in 1990 were structured—the billing arrangements were through radiologists or physicians billing the services through to OHIP. Then, when the change was made to the schedule of benefits to delist the technical fee, to create an IHF licensing situation we licensed the structure that was actually the owner of the equipment and the person who hired the staff. That wasn't necessarily the physician who was billing; it could have been a corporation under their control. But it's difficult to actually identify the percentage that are held by physicians.

The Chair: Can we ask each one of these independent health facilities—do we have the power to ask them?—what the interests of physicians are in these particular facilities?

Mr. Morgenstern: We have the power to ask that. We do know the corporate shareholding of the facilities, so we know to a shareholder level who holds the shares in the corporations. But we do not know whether that individual who's a shareholder is a physician or not. We don't keep track of the professional capacity of the shareholder.

The Chair: I'm asking these questions because we're doing negotiations with the college of physicians. The OMA are involved in some of these negotiations. It seems to me that there could be self-interest in terms of where those negotiations go. We're in such a crunch on health care costs. It just strikes me that there doesn't seem to be a huge urgency to deal with accountability mechanisms in this regard. As Ms. Munro has said, in 1996 we were supposed to set this committee up. We're still talking about setting this committee up.

Would it make sense for Management Board to take over this function of the Ministry of Health? It seems to me that it's a financial matter, and you're put in a bit of a conundrum because you're negotiating with regard to other matters. Would they have cleaner hands and more ability to bring this thing to a conclusion?

Ms. Rappolt: Mr. Chair, if I may, I understand exactly your point about the critical nature of accountability on this, for many reasons: access, cost and so on. May I suggest that we take that suggestion under consideration. The model that is struck does engage the OMA and the OHA. My sense is that those parties are critical partners in this exercise, but I understand your point to be: Would the government benefit from having, in addition to the Ministry of Health, some other leaders partnering in this discussion or negotiation? If we may take that under consideration, I'd appreciate it.

The Chair: Perhaps the committee will have some comments on it as well. I'm not saying to partner; I'm saying to lead it. I mean somebody else outside of your ministry to lead it.

You mention that there's a whole host of services. There are 1,000 independent health facilities, and this project could be a long project when you consider all the services that are involved and all of that. Why would you not pursue the most expensive, the most-used service; deal with one at a time and not consider this as a whole

basket; that you consider each independent health facility or each service that is provided by a particular type of independent health facility and deal with one problem at a time, particularly those that are costing and continuing to increase in cost very rapidly in the province?

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Ms. Fitzpatrick: I think that's exactly what we have done in the past. The two that come to mind that were dealt with as a high priority were sleep studies and bone density testing. Those fees and the model for payments have changed over this period of time. The sleep study services were part of the physicians' schedule not required to be performed under an independent health facility. They can be performed now in an independent health facility or a hospital. So that was one measure that was taken. We've also tightened down the requirements on bone density testing, which is also part of the independent health facility services.

The Chair: Would it help you if the committee came forward with a recommendation that you bring back a completed set of negotiations within a period of time? Basically, I think your problem is that you get tremendous pushback from some of the people involved. As a member of this committee, I am quite willing to take the responsibility for you and have you tell your negotiating partners that a committee of the Legislature wants an answer.

Ms. Rappolt: My sense is that would be a helpful measure. Obviously, we'll have to see what kind of success we can lever with the parties to meet the target that is set, but I can't help but think that's a useful thing. In a results-oriented world, having a target to work to should be beneficial to everyone.

The Chair: It would be useful for us, then, to have some kind of idea as to the schedule in terms of which ones are part of your priority list.

Mr. Richard Patten (Ottawa Centre): Just building on your comments, Chair, it would be similar to talking to the Toronto police department and saying, "We're anxious to work with you to review the quality of services." Of course the chief can't say no, but he probably wouldn't be too keen on the idea. So here we are talking to the association that represents medical business people who have a responsibility for their union, and we've got this very nice memo of understanding with them, I gather, to set up this technical committee to take a look at the situation.

I think we should take a harder line. Either we say, "To hell with it, we're going to do this anyway. We're paying the fees. We'll set up our own if we can't get this thing moving." It's now been nine years since this was identified by the auditor, and it seems to me that either we're serious about it or something isn't being clarified in an honest fashion.

Ms. Rappolt: I appreciate those remarks. It is a long time. It was something that was worked on through the negotiation process with the OMA, and the success was achieved in the spring of 2003, so I certainly take your point.

As to the recommendation of the Chair to ensure that there's a target we're working toward, with an opportunity for us to come back perhaps and set out a sense of what's a priority and the timing associated with certain priorities, I think we would appreciate that.

Mr. Peter Fonseca (Mississauga East): I have a question, Chair. This goes to the growth rate of the independent health facilities. We heard that it was between 8% and 10%, but there are certain services like ultrasound, up 60%, and sleep disorder clinics, up 135%. Back to some of the comments that the Chair made, how are we reassured that there isn't unnecessary testing going on or a redundancy within the system that's costing all of us, and are we getting value for money?

I know there were questions in terms of if somebody were to own an independent health facility—let's take a situation like a sleep disorder clinic—and also have ownership over the products and services that come after that diagnostic—selling of the masks, the oxygen tanks etc.—would that not be a conflict of interest in a situation like that? And are those types of conflicts taken care of right now in the system or not? I'm talking about somebody who would do the diagnostic and then further provide products and services to the individual down the line.

Ms. Barnes: The majority of the licensed services are referred services. Most of the diagnostic services are referred to the clinics by other doctors, not the doctor who would benefit from the service provision itself. By and large, that's the vast majority.

With respect to the other conflict-of-interest provisions, the College of Physicians and Surgeons has fairly specific guidelines with respect to self-referral and the conduct of its members in terms of benefiting from that. That's not covered by the legislation itself, but it's covered by another piece of legislation. I'm sure counsel here could provide a bit more on that at another time, if you want.

Ms. Rappolt: Was there anything else you wanted to add, Jeff?

Mr. Morgenstern: No.

Mr Fonseca: How will this whole strategy work in terms of the local health integration networks? Will the independent health facilities find their way into the LHINs and how were they part of the LHINs?

Ms. Rappolt: As everyone knows, there's much planning and some good excitement out there regarding the implementation of our new local health integration networks, which is on the horizon. The networks will have a significant mandate to plan for and help integrate services within a local geography. Obviously they'll be working with a range of partners.

With regard to those services that are related to our hospital insurance program, I think the planning will be mindful of those services. But the hospital insurance programs are ones that likely won't be the first programs that will be directly managed or overseen in any way by our local health integration networks. They'll certainly be charged to work in partnership with the hospital system

and the physician community to ensure the appropriate planning for diagnostic services, but I don't believe we foresee any early change in oversight of the integrated health facility program.

Mrs. Munro: I'm interested in following up on Mr. Fonseca's question with regard to the LHINs. You mention the planning and the integration. I want to know what that really means. Does that mean there's going to be a computerized patient network that means somebody is actually going to be put into a plan, like a medical response appropriate to whatever their issue is? Is that going to be centrally organized through a LHIN? If a patient walks in a door and we know who this person is, have their OHIP card etc., where does the LHIN fit in for that person who walks in a door?

Ms. Rappolt: It's an excellent question for which there likely isn't an absolutely definitive answer yet, so I'm going to be very honest in that regard.

I think what you're talking about, which is integrated services to get better access for patients in their community, is the goal. I believe that the government truly sees in its vision better-connected information management and technology that would facilitate the appropriate tracking of that patient's needs across various elements of our system. That is our goal. The detail around how and when and through what phasing that will materialize at a local level is a very big question, and one that is being thought about as part of our overall electronic health strategy, but also, as you say, in relation to our consideration of the local mandate at the LHIN level versus the provincial mandate.

I want to say that all these things are under consideration. There is a great deal of ongoing planning regarding the implementation of our new network strategy, and this is a very critical element.

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Mrs. Munro: Can I just ask, how would it differ from what is currently available in terms of the coordination, for instance, between hospitals and CCACs? How would it be different?

Ms. Rappolt: I'm happy to answer the question. Mr. Chair, you'll let us know when we feel the questions are—how they will relate directly to the results of the Auditor General that are on hand today. I think what our vision will deliver is a focal point, a community leadership focal point, where, for the first time, there'll be a structure and leadership at the local level which will be charged with ensuring that the providers that we know are out there are doing their best to work together. But there'll be an entity there which is charged with that sole purpose, to ensure the right protocols, the right access points, that barriers are removed, so that Ontario patients don't face some of the hurdles they currently do in receiving integrated care in their communities and in their regional areas.

The Chair: I have a question with regard to the DSCs. The DSC, as it's now envisioned, is going to look at the costs of the services, the value of the services in terms of both the changing technology, which may have occurred over a long period of time, and also in terms of volume and those kinds of things, in particular to the IHFs. As well, according to your statement on page 7, the DSCs are envisaged to look at the needs of particular communities and the sharing of the services. So there are two functions that you view for the DSC: Is that correct?

Ms. Rappolt: I believe that is the case, yes.

The Chair: OK. With regard to the need for additional cataract surgery—I don't know whether you asked this, Mr. Mauro, or not—there was an RFP, or there is an RFP, to look at what additional services are needed in that area?

Ms. Rappolt: As part of the government's wait-time strategy to expand cataract services, the government most recently announced the expansion of 2,000 services already this year, and the intention is to achieve 9,000 new services throughout 2005-06.

The Chair: But in terms of the distribution of those additional services and the services we have, how are you establishing where they are most needed?

Ms. Rappolt: My understanding is that, as part of our wait-time strategy work, which is overseen by Dr. Hudson reporting within the ministry, there is a needs assessment process ongoing that is trying again to look at the principles of quality, access and efficiency. That process is going to assist in determining the right kind of delivery model for cataract services for the province.

The Chair: I guess I was referring to page 223 of the auditor's report, where it says you have "conducted a needs assessment to identify areas ... in greatest need for additional cataract surgery" and that you were seeking approval for RFPs for approval. I was asking you where that status was.

Ms. Rappolt: I believe it is the case that certainly the government with its wait time strategy will consider which locations are the appropriate locations—hospital-based, IHF-based—for expansion of cataract, and that work is ongoing right now.

The Chair: In terms of either an independent health facility or a hospital undertaking a diagnostic procedure, what kind of reporting do we demand back from both of those kinds of providers of service in terms of what they're doing with their equipment, their resources, and whether they're getting positive or negative results? In other words, in order for us to go forward and share the services we already have more equitably and make certain they're applied to the people who are most in need, my concern is that we don't have the information to make those kinds of decisions.

Ms. Rappolt: Mr. Chair, I understand your point. I think the government has understood the importance of ensuring access to the right data to build the right strategy. I'll comment just for a minute on Dr. Hudson's work and the fact that a critical element of that work is receiving the kind of inputs you're talking about regarding existing services—volumes, cost and so on—in order to build the plan to ensure that we are enhancing services in the appropriate way in the appropriate place. That is a critical element of his mandate. It's very active work right now.

With regard to diagnostic or surgical procedures in the IHF facility, Jeff, do you just want to comment on the response to the Chair's question on sort of quality assurance or follow-up regarding surgical procedures in the IHF venue?

Mr. Morgenstern: For diagnostic and surgical procedures performed in the IHF, the quality of care is ensured through a quality assurance mechanism where we contract with the College of Physicians and Surgeons to do on-site inspections of the facility. The ongoing status of the licence is dependent upon maintaining good-quality care and maintaining the appropriate equipment within the facility. Failure to do that—and if we get a report that there are deficiencies within the clinic, we can take licensing action to suspend the IHF licence until they make corrective action, and then we'll reinstate the licence.

The Chair: How many licences have you suspended in the last year?

Mr. Morgenstern: It's routinely around 10 to 15 licences, where there are deficiencies of a severe enough nature that result in a suspension of the licence. In all cases in the last year, the ones that were suspended took corrective action and have since been reinstated.

The Chair: Does that become public information as to who's been suspended?

Mr. Morgenstern: We don't report publicly the details. That's one of the recommendations within the audit report, that we consider a process for publicly reporting the results of the assessment.

The Chair: Is it FOI-able?

Mr. Morgenstern: There is an FOI case that has gone to appeal on that issue. At this point, I don't believe that's resolved.

The Chair: When is the decision expected on that?

Mr. Morgenstern: I'm not really sure on that.

Ms. Rappolt: We could get back to you with that information, Chair. I do understand this is one of the critical recommendations brought forward regarding disclosure of compliance behaviour, so it's something we've got to take into consideration.

Ms. Laurel C. Broten (Etobicoke–Lakeshore): I want to pick up on a couple of issues that have already been discussed. On the wait time strategy, I had the privilege to attend with the minister when the wait time strategy was announced in my local hospital, Trillium Health Centre. I have to say that I was very shocked when I learned of the real lack of information that did exist in the province prior to a decision being made that we absolutely needed to get a handle on what these waiting lists were.

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You made mention, Madam Deputy Minister, about the need to make decisions based on that information. The question one must pose then is, on what information were decisions being made before? Since we didn't have this information, how were good decisions, or likely not good decisions, being made and what criteria were being examined if there was no information available?

Ms. Rappolt: I appreciate that question. I'd like to begin the answer and then I will introduce a colleague to my right, Rachel Solomon, who is a project leader with Dr. Hudson's wait time strategy.

I'll begin by saying that it's not the case that funding allocations to hospitals were made in the past with no consideration of the need for placement and capacity for critical surgical procedures, such as cataract. But I think it is fair to say that these decisions were made likely in the context of looking more narrowly at data on an individual hospital basis—maybe hospitals within a region but not with the capacity to step back and look at the needs of a system or a broader geography. That's the approach and the tremendous value that our wait time strategy and Dr. Hudson's approach are bringing to this.

I'll just ask if Rachel wants to comment any further on the details behind that planning.

Ms. Rachel Solomon: In the past, estimations of geographic demand have been done on an individual hospital basis or on current rates of surgery per population and estimates of population growth in those areas. The work that the wait time strategy is doing in terms of getting a comprehensive wait time registry for the province will add to that as being able to look at both rates of population and population growth within a geographic region, such as the LHIN, as well as the wait times within those LHINs. Combining that information will give us the information we need to plan better.

I would say also that while there is a dearth of information on most of the services under the wait time strategy, we do currently have good wait time information on cardiac surgery and other cardiac services. So it's a bit of a mismatch. There are some services for which we have good data, some very limited and we hope to bring that all up to par.

Ms. Broten: OK. The other question I wanted to just go back to was coming directly out of your early statement, Madam Deputy Minister, about the "creation of new independent health facilities" and the requirement that "the minister authorize the issuance of a request for proposals." You go through how the system is now, as I understand it. Is this a new change or is this always the way it has been? What improvements have been made to respond to the criticism of the auditor?

Ms. Rappolt: I think our historical expert, Marsha, is someone I'll call on to answer this.

Ms. Barnes: I'm not quite sure which auditor recommendation you're referring to, but with respect to the request for proposals process, it's more or less the same as was set out in the legislation when it was proclaimed in 1990. It's only been used in a few number of instances, such as for the dialysis proposals, and then the MRI/CT most recently. The process in all instances was the same in terms of following government procurement guidelines and doing a competitive process. There has been a more recent amendment that allowed for a directed RFP during the time of restructuring to allow the minister to request a proposal from a specific individual facility and that has been used in two instances.

One was in the instance where a hospital was previously providing the services and did not want to continue in that way, and in order to maintain the services in that community there was a directed RFP to a group that was willing to take that on: the physicians who were providing the service.

In one more recent instance that Jeff is more familiar with than I am because it happened since I've left, there was a directed RFP where a facility operator no longer wanted to provide a service in a small community and, again, a group of physicians was willing to take on that responsibility and to maintain the service in that community.

Ms. Broten: Was a change required in the legislation to allow the directed to RFP?

Ms. Barnes: Yes.

Ms. Broten: When did that happen?

Ms. Barnes: That happened at the time of Bill 26, which was—

Mr. Morgenstern: In 1996, the Savings and Restructuring Act.

Ms. Broten: What are the dates of the times that that new change has been used? It's only been used on two occasions, you've indicated?

Ms. Barnes: That's correct.

Ms. Broten: When was that?

Ms. Barnes: The most recent one, Jeff, was within the last—

Mr. Morgenstern: The most recent one was October or November of last year when the RFP was issued. Prior to that, it was 1999 for the situation of the hospital closure.

Ms. Broten: Where was the 1999?

Mr. Morgenstern: Burlington.

Ms. Broten: You indicated that the dialysis, MRI and CTs have gone through the RFP process. What other process, then, is a process that issuance of other independent health facility licences are provided, if it's not through an RFP process?

Ms. Barnes: The other one is, if there's a change in the schedule of benefits, it brings the services under the ambit of the act. That was used in the instance of sleep studies that Ms. Fitzpatrick mentioned earlier, to designate the services, one that required licensing under the Independent Health Facilities Act.

Ms. Broten: OK. Thank you.

The Chair: Can I ask some questions about the wait list?

Ms. Rappolt: Yes. I'll ask Rachel Solomon to return.

The Chair: I want to convey to you a story that a constituent told me of going for a CT scan at the Ottawa Hospital, at the Riverside campus. He showed up at 8 o'clock in the morning. This was fairly recently, probably last fall. There were three people in the waiting room at 8 o'clock. He was the third to have his CT scan. He said he finished around 8:20 or 8:25. He came out into the waiting room and nobody was in the waiting room. He asked the administrator or whoever it was running the particular clinic, "It's funny. I mean people are lined up for CAT scans. How come there's nobody in the waiting room? When's your next appointment?" She said, "Around 10:20." He said, "Why's that?" She said, "Well, everybody else has cancelled."

I guess my concern in us talking about waiting times and waiting lists is how we are putting the heat on institutions like the Ottawa Hospital to readjust their lists and make certain that more people get in between 8:25 and 10:20 and that we provide the services and don't have people standing around doing nothing. Are we asking those questions of the providers of these diagnostic services, questions like how many cancellations there are? As I understand it, with MRIs, only about 35% of those ordered are actually done. Are these 60% of the time cancelled appointments and nobody showing up? We have to know that. We have to drive this system so that in fact if we have the capacity, the waiting times will become less.

The other question to you is, when you're developing these waiting lists and when you're developing the tracking of the system, do we know how many tests actually result in positive responses, or are we doing a lot of tests to comfort people when in fact there may be other diagnostic tools which are less expensive and less time-consuming that should be used?

Ms. Solomon: We actually think those are the most important questions under the wait time strategy, and while increasing volumes and capacity is very important, one of the big foci of the wait-time strategy has been and will continue to be efficiency, especially in the next year or so. We're working with hospitals to find out: Are they cancelling procedures because a physician doesn't show up on time? Are they failing to remind patients to come to appointments? Of the hours that you're operating, are you doing the number of procedures, surgical or diagnostic, that you should be? We're working on all those things. We actually have a working group looking at surgical process efficiency as well as diagnostic efficiency. So these are the very questions that we think are the most important.

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With respect to your comment about whether the procedures being done are appropriate and whether we know the outcomes, right now we don't. We have asked the Institute for Clinical Evaluative Sciences, ICES, to develop an access index that would look at the issue of access comprehensively; not just wait times, but also outcomes and what's appropriate and what's not.

The Chair: How long is that going to take to do?

Ms. Solomon: The first bit of work from ICES, which will be establishing our baseline of wait-time data—because we don't have a baseline—will be completed this spring. As to getting the piece on appropriateness and outcomes, I don't want to give a precise date, because I'm not entirely sure, but in the following year.

The Chair: Maybe it seems too simple to me, but I could think up probably in a week the reporting mechanisms that I'd like from my hospitals and my independent health facilities about how often the CT scanner is down.

Ms. Solomon: We have gathered that data in the last couple of months via survey, and that's part of what the recommendations will be based on.

The Chair: Is that published information?

Ms. Solomon: No.

The Chair: Why not?

Ms. Solomon: We've just collected it. We have to validate it.

The Chair: But if I asked you how busy the Ottawa Hospital's CT scanner was, could you provide that to me?

Ms. Solomon: I would have to go back and check that the data has been validated.

The Chair: OK. I guess what I'm saying is, I think the only way to bring these people into line is to publish this information so that when the public come and talk to us, it makes the hospitals start to seek efficiencies. Why do we need to wait much longer? You've got the information. Why don't we just put it on a Web site?

Ms. Rappolt: Mr. Chair, I'll just confirm that your objective is our objective. That's exactly it. I know you're pressing about time. My observation is—and Rachel will know this better than me—if there's someone who can press the Ministry of Health and that big, complex health system out there on driving toward results on this topic, it is likely Dr. Alan Hudson. I know it does sound like an overly complex process of involving ICES and developing the methodology and so on. I feel reassured. I really believe it is an aggressive plan, and it is absolutely the intention to be able to publish and make transparent this information for Ontarians.

Mr. Fonseca: Just a question about that, going on the Chair's questioning around the wait-time strategy: Would certain things come on-line before others? Would somebody waiting for an MRI be able to look at where they are in the queue, and if they are willing to drive two hours to a different MRI facility, would they be able to get that MRI at some other facility, because their list is a lot shorter? Could you just take us through how that would work?

Ms. Solomon: Once we have a fully comprehensive wait-time registry, the purpose of it is that it would be public. One of the objectives would be that when a family doctor is referring a patient for an MRI or for surgery, they could collectively look at giving the patient the choice. If there's a wait time that's much shorter two hours from here or if they want to wait for a particular surgeon or a local hospital, if they want to make the choice and travel, that would be open to them.

Mr. Fonseca: And that is not available at this time?

Ms. Solomon: No.

Mr. Fonseca: That is something we're working toward?

Ms. Solomon: Yes.

Mr. Fonseca: I brought up the MRI just because that's at the top of my mind, but would other services, other diagnostic work, also have that capability, where they can decide to travel a distance?

Ms. Solomon: The initial focus in terms of the information system under wait times includes MRI, CT, cataract, cardiac and cancer surgery, as well as hip, knee and total joint replacement. That's our initial focus, but the system will be built with the capability to expand in the future.

Mr. Fonseca: With the wait-time strategy, are we working toward a reasonable wait time? Do we know what a reasonable wait time is for these different procedures?

Ms. Solomon: We don't, and that's one of the things we're working on. It's also part of the federal commitment, so we're working with the other provinces.

Mr. Fonseca: So none of this information was available until this work that is being done at this time?

Ms. Rappolt: It is correct that Ontario is a jurisdiction where the wait-time strategy and transparency to Ontarians on their access and waits for services wasn't in the same spot as many of the other jurisdictions in the country. This is information, this is a result that Ontarians will have in the very near future that other Canadians have had access to, which I think we'll very much welcome.

The Chair: Can I ask a question? In terms of the inspection of the independent health facilities, is there any body other than the College of Physicians and Surgeons that could do this job?

Ms. Rappolt: I'm glad Marsha came back because I think she should deal with this question. When you say "this job," what you're looking at I think is the oversight or accountability of the corporations, of the entities.

The Chair: Or whether they live up to the act in terms of what they're doing: Is it healthy for our people to go into this particular clinic or facility?

Ms. Rappolt: In terms of the nature of services provided by the physician, obviously their own college does have an ongoing role in looking at any issue with respect to the service. With regard to the oversight of the IHF legislation and the role of the physician, I'm going to turn to Marsha.

Ms. Barnes: The Independent Health Facilities Act is very specific in that the College of Physicians and Surgeons is to be the body that would go in and do the assessments on behalf of the ministry. So to change that, there would need to be a change in the legislation.

The Chair: Perhaps the auditor wanted to follow up on that.

Mr. Jim McCarter: Just to follow up on that, how do you find the relationship with the college? I know in 1996 the act was changed. You could go in and do unannounced inspections, and that hasn't been done as yet. I noticed your comment saying, "We've initiated comments." When you go to the college and say, "We'd like to start this up," do you find the college is very receptive in the sense that, "This is a great idea, Minister. We're going to get this in place right away"? Or do you find that there's some resistance to something like that? What would the time frame be of getting that up and underway?

Mr. Morgenstern: On the unannounced visits this year, they were very receptive to that, because I believe they recognize the potential of problems in facilities.

With a scheduled date of inspection, you could correct it for that one day, and I think they recognize that that's a potential for problems. When we met with them in December to discuss this, they were very receptive to the plan.

Mrs. Munro: Actually, that's exactly where I wanted to go with a question on the unannounced assessments. As it seemed that that had been recommended some time ago and yet they hadn't started, and in your comments you said you expected some completion either this year or next, I took it that there was some reluctance, obviously, to take these on. I think it's important for us to understand the position in terms of the speed with which this hasn't been happening.

Secondly, I wondered, does it have anything to do with the complexity that would accompany any kind of assessment? I just wondered if that was an issue around the whole business of the reluctance and the slowness with unannounced assessment.

Mr. Morgenstern: There were a lot of issues around unannounced assessments, because one of the concerns was that we were sending in an assessment team to review, and that generally involves a physician and a medical radiation technologist in a diagnostic facility. In many cases, they're travelling quite a distance; it could be anywhere in the province. You don't want the assessment team to show up at the door unannounced and find it's closed that day or that they don't have any scheduled patients that day.

1100

So there are issues around how this unannounced assessment is going to work and to make sure that it's going to work effectively and that you're going to be able to go in and assess the facility. Ideally, when they go in and assess, there are actually patients being seen at the time of the assessment; that's part of the assessment process. It's easy to do that with an announced assessment, because you can ensure that the facility operator schedules a patient on that day and you can observe that patient being seen. So there are still issues around how it's going to work, and we have to make sure that it's going to be done effectively.

I think the delays were more around other priorities within the assessment process—getting the assessment reports in order, getting the structure back and forth between the college and the ministry on how we did our business—and those were the delays in not proceeding with unannounced assessments. We now are in a position where we think we can sit down and develop a procedure for doing it that will be effective and implement it fairly quickly.

Mrs. Munro: On a related issue, there was the question of those who have to respond to some of the issues that are raised. I'm not sure, in all this paper, exactly where it is, but it talks about the potential to assess a fee if you have to go back, so that this would be self-supporting. I just wondered where that stands in terms of the thinking on moving in that direction.

Mr. Morgenstern: Implementing charges for re-assessment would require a regulation change under the act, and it would likely involve maybe six to 10 facilities a year where we would go back and reassess and charge for a reassessment based on their not taking corrective action in a timely fashion. So, it's a question of priority because it's dealing with a small number of facilities—only six to 10. The cost recovery associated with it is not large.There is a certain amount of administrative work in preparing the proposal and getting it through regulations and proceeding to implement, for a fairly small return. To do it would be more an incentive for facility operators to take that corrective action, knowing that there was a financial penalty for not proceeding. So it's not really the amount of money that the ministry is going to collect in reassessment fees; it's an incentive for them to proceed with the corrections that we want them to do. So for that reason, we're viewing it as a positive step, but it still requires a regulation change to implement.

Mrs. Munro: I appreciate knowing that information. How often would an independent health facility expect to be assessed?

Mr. Morgenstern: They're on a schedule that they will be assessed once each during their five-year licence term. There are 1,000 facilities. We do approximately 200 assessments per year.

Mrs. Munro: I appreciate your comments earlier about whether the day happens not to be a good one in the sense of patients being there and so on and so forth, but obviously people recognize the fact that they're going to be assessed. A lot of the things that would make up that assessment would be there on an ongoing basis, regardless of the day on which you happen to visit.

I wanted to ask a question with regard to the kind of work that is being done on the wait times, and it's really a simple one that perhaps we don't have to ask you to get up and come over for. It was my understanding that one of the things that was done under the auspices of Cancer Care Ontario was to try to collect data and be able to provide opportunity for a greater coordination between facilities and patients. If I'm correct, is that a model for what you would be using in looking at wait times in other medical procedures?

Ms. Rappolt: I can answer that at a general level and suggest that, given Dr. Hudson's relationship with Cancer Care Ontario, it wouldn't be a surprise, I don't think, that the foundational work at Cancer Care is a model.

As Rachel mentioned earlier, there are other good practices regarding wait time planning in some areas of care. Cardiac is an area where the province has a relative foundation as well, so I would say: Absolutely, yes, some of the progress made in the cancer venue is progress that they're moving forward from, but also using some of the best practices from other areas.

The Chair: Can I ask you a question about unlicensed health facilities that are providing diagnostic care? I'm talking about another constituent of mine who went through a healthy pregnancy and had a healthy baby, but every time she went to the obstetrician, she was given an ultrasound. Not that she requested it, but it was suggested

to her by the obstetrician to have it. It was done in her office.

What would the obstetrician get paid for that particular service? I presume, because it would be an unlicensed facility, that there wouldn't be a technical fee, but there would be a fee that the obstetrician would gain from giving that particular test.

Ms. Rappolt: Jeff, do you want to go with that? Susan may supplement.

Mr. Morgenstern: On the first part, it's possible that the facility with that obstetrician is a licensed facility, because many obstetricians are licensed to perform obstetrical ultrasound as a component of their obstetrical care practice. It is possible that the facility is licensed and would be billing both the professional and technical fee associated with the service. There are limits on payments for obstetrical ultrasounds. Perhaps Susan could comment on that.

Ms. Fitzpatrick: Yes. I was going to say that if it is unlicensed, then the obstetrician would be able to bill the professional component of the fee, which is for the interpretation of the ultrasound. On pregnancy ultrasounds, I think the limit is two per pregnancy—there's a third, I think, in the early stages—so there is a limit on how often OHIP will pay for it.

The Chair: So the physician fee or the technical fee has a limit on it, or both?

Ms. Fitzpatrick: Both of them.

The Chair: OK. Do you have a question, Bill?

Mr. Mauro: I do. Actually, Mrs. Munro touched on the question, the last one I wanted to ask, and that is about cancer care. About two and a half years ago, a process began under the previous administration of taking the six or eight—I'll call them satellite cancer care facilities—that existed under Cancer Care Ontario and rolling them into the hospital structure.

A lot of people were very surprised and did not understand why the government of the day would undertake that initiative, given that, from all the information I have, that program was functioning incredibly well. At least, I can speak to the one in my home municipality, where it was a bit of a shining light as far as health care provision went. People were very concerned about it, insofar as they saw the budgets being rolled together—and that they might be diminished on the cancer side and used to prop up the hospital side and that sort of thing. Nobody really understood why it was happening.

We've talked a lot today about Dr. Alan Hudson; he was in charge of Cancer Care Ontario at the time. While we're talking about waiting times, I guess my question would be, is it not easier for us to track waiting times on specific procedures when they are actually in a stand-alone capacity, like Cancer Care Ontario was before, than it would be when they are rolled into the hospital sector or a larger conglomeration of service provision? Is it not easier? Is that an example of something that would have made it easier for us to track waiting times?

Ms. Rappolt: I think I understand your question. My colleagues and I likely don't have at the table right now deep expertise regarding cancer services and all the details around the integration.

Mr. Mauro: It's less about cancer; that's as an example.

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Ms. Rappolt: Right I just want to suggest that none of us here are experts. But I do understand your question, which is, might it not have been easier with a free-standing or satellite model to be capturing the data we need and ensuring that we get the right methodology?

Mr. Mauro: Yes.

Ms. Rappolt: My observation would be this: The provision of appropriate services to patients in Ontario requires such a degree of integration and seamlessness in access points that ensuring that the model we're using to collect the data and then use the data to inform decisions—that model has to be a model that can be and is applied across all the access points of service. So I would feel fairly strongly that it would be critical that the hospital setting, the free-standing setting and the clinic setting all have to be users of the same approach.

Mr. Mauro: Well, I'm not suggesting that they were using a different approach. I don't know that the approach or data collection or methodology changed once they were rolled into the hospital sector. I guess it would just seem to me that it would be easier to track when they were stand-alone. I guess I'm interpreting your answer to be that you don't think it changed anything.

Ms. Rappolt: I want to say that I understand, I hear your points about the reaction at a local level, a community level, regarding an integration such as this—

Mr. Mauro: It's not about that.

Ms. Rappolt: —but I want to say to you, I don't think that it would or should be an additional barrier.

Mr. Mauro: OK. We talked earlier about cataracts and that we think there's going to be a larger provision of cataracts. I think that the Chair raised it a little bit earlier. If that was going to be in a stand-alone facility, wouldn't it be easier to track the success of their ability to provide the service and to track those wait times that way than—

Ms. Fitzpatrick: I am somewhat involved with the wait time strategy. No matter where the services are provided, they're going to have to provide the same information. The hospitals and the independent health facilities will have to report. So I don't see it as a more difficult task.

The Chair: Mr. Levac?

Mr. Dave Levac (Brant): Thank you, Mr. Chairman. It will be a quick question, but I have a little bit of a preamble, first, to thank the Auditor General for his work in bringing focus to some of the things that you've accomplished. My compliments to you for dealing with it, because as I've heard your presentation and read it again, these are in progress and some of them have already been completed. My large "thank you" for that. You also answered, apparently, a question that I had earlier—I had to excuse myself; forgive me—about LHINs and the effect of LHINs in this. I do want to make sure that we get that part of the equation right. The

implementation of the LHIN will affect what the ministry does across the board when we start talking about regions etc.

That part of the preamble being said, going back to what Chair Sterling was talking about regarding the caps and certain procedures that are done: if you can reinforce what effect the response to the Auditor General would have or is already having on the concerns that get laid before us as the government, or specifically the ministry, to deal with duplication and to deal with unnecessary procedures inside of the specifics of this report. Because I know that the ministry is way more vast in its application. The independent part and how even the unlicensed part is getting addressed—I'd like you to reinforce how responding to the Auditor General is going to, in effect, provide us with that removal of the duplication and the concerns of caps and all of that kind of stuff. It's pretty generic, but it's an opportunity to reinforce what it is we're trying to accomplish.

Ms. Rappolt: I'll begin, and I think I might flip it then to Susan regarding the work on looking at volumes, price and fees, and that relationship. I would suggest that how the Auditor General's recommendations overall assist us in ensuring that we're continuing to improve access to care for Ontarians and reduce duplication—I think much of that is reflected in the conversation we've already had regarding the development of a really robust comprehensive wait strategy, for one.

It does also speak to the conversation we had more at the beginning of our session regarding the intended role of the diagnostic services committee. It has been noted and we acknowledge that the establishment of that committee has been taking a little long, but their work is intended to help ensure that we have the most effective approach to fee-setting reflecting community need and efficiency.

Susan, was there anything more you would want to elaborate on?

Ms. Fitzpatrick: Just in terms of the streamlining and the efficiency, and I think I did say that there has been committee work already done. There was a committee on technical fees and then a follow-up committee. They did do a lot of investigation and research.

One of the things the committee is very interested in is looking at transfers of patients between facilities or hospitals: how that happens and how they can streamline and make that the most efficient. One of the issues they've identified is that a patient may get multiple diagnostic tests for the same complaint because there isn't an efficient way of transferring that information. That is something they will look at quite early on. And they're not just looking at a systems way for doing that; it could be, in the short term, more of a manual process. So there is definitely a focus.

As I said, the people on the committee are people who are working in the sectors, and they see opportunity to try to generate some efficiencies and savings.

Mr. Levac: A quick supplementary, and that would be to ask the question, instead of using the word "assume," is it fair to predict that we don't have to wait for the Auditor General to guide us through that process in the rest of the ministry to look for what you're trying to accomplish as a result of the Auditor General's report?

Ms. Rappolt: Yes, I think it is fair that you can predict. We are taking that approach across the ministry. I think that speaks to the ministry's and this government's acknowledgement of the need for very strong accountability between the ministry and the parties we work with to deliver services to Ontarians and on behalf of Ontarians. I think the ethic of ensuring good accountability, quality, efficiency—that approach is being taken to our oversight of all the services we oversee in the Ministry of Health and Long-Term Care.

Mr. Levac: No disrespect to the Auditor General intended, of course. Please don't misinterpret that, but that's a culture and that's what I was asking about. So I would probably give the Auditor General an opportunity to explain his purposes—not what I've been asking—in clarification.

Mr. McCarter: The other thing maybe I could just add too is, I don't know if you're aware, but two years after we make our recommendations, we actually go back to the ministry. We will be following up on each of our recommendations. We report on the status of the action taken on those recommendations two years later. So in our 2006 annual report, we'll be asking the ministry where they stand on these. And especially where they say they've made substantial progress, our staff does go in and we do check to make sure that that progress has been made or has not been made, and we report on that in the follow-up section of our annual report.

Mr. Levac: Thank you.

Mr. Michael Prue (Beaches–East York): I'd just like to go back to the unannounced assessments. I heard the rationale: You want to make sure that everything is proceeding and that there are going to be patients there. But let me put it in another way. When you go in unannounced, you're going to find things, I would suggest, that you may not find on an announced visit. As an example, you may find unlicensed people on an unannounced day, whereas, I assure you, when they know you're coming, you're going to have a licensee there. You might find health and safety violations which would be cleared up well in advance. I give you the example of health inspectors going into restaurants in the city of Toronto. They find the violations when they go unannounced, not when they go announced. Isn't this the same rationale? What you're doing is servicing the facility, not the public, when you take the procedure you do. Could you comment on that?

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Mr. Morgenstern: The rationale you mention is the exact reason we are looking at introducing the unannounced visit: the fear that an operator changes their way of doing business on the day of the assessment to make it look as though they're operating well. That's the very reason that there's a need for a policy on doing unannounced visits, but you have to develop a process that's going to make it work. It's easy to go into a restaurant and do a restaurant assessment. It may not be

as easy to go into an independent health facility on any day and do a complete assessment. A process is going to have to be built that allows for a full assessment to be done, even if there are patients who aren't there on the day of that visit. But I agree that we clearly want to go in, without giving them the opportunity of making corrections, to see how they do business on a day-to-day basis.

Mr. Prue: What is stopping you now? Businesses are generally open Monday through Friday. Businesses have regular business hours, which they post. I don't see the rationale you gave earlier, that you have to send somebody off to a far place and not necessarily see it. I could make a phone call to any one of these licensed facilities and ask them what their business hours are. That wouldn't trigger anything to them.

Mr. Morgenstern: We can ask them their business hours. Many facilities are licensed for multiple modalities. They're doing X-ray, ultrasound, nuclear medicine procedures, fluoroscopy. When the assessment team goes in, you want to be able to view all modalities in operation. It may be that they run ultrasound one day a week, X-ray another. It may be that when you enter the facility, you're not getting a complete picture of what they do in that facility if you go in unannounced.

There are still ways to make it work. We're doing file reviews, so we pull actual records that were done in the facility and assess the quality of the image for past records. You lose a component of it, that is, viewing patient interaction, if there happens to be no patients that day. But the process can still work. It's a matter of working out how that process is going to work with the college, getting the assessment teams trained so they know what to do when they go in on an unannounced visit and making sure we're going to get an assessment report that adequately explains the quality of services within the facility.

Mr. Prue: Maybe I'm naïve, but I don't understand. What kind of training would be required? I was in the civil service myself for 21 years. When you went in unannounced, you knew what your job was. What kind of training would these people have to have to go in unannounced that they don't already have? I don't understand that.

Mr. Morgenstern: The assessors undergo training now. The college has a training program for the assessors that involves the standard process of what they do when they go in. You have to train them in what they do if there's no ultrasound technician on site that day: If you're going into assess a radiography and ultrasound clinic, but there is no ultrasound tech, who do you talk to? What's the process you follow? It's procedural issues on how they conduct the assessment in situations that are not routine. When we announce the assessment, the facility operator is instructed to be there, so the licensee is there, all his staff are there, all his records are there. If you go in unannounced, the facility operator might say, "My records are at home," in which case the assessor would need to know what to do in that situation, which would probably be instructing the operator to—

Mr. Prue: Go home and get them.

Mr. Morgenstern: But you need the processes written out. You need a process for them to follow. It's going to be detailed training, but it's a variation on what they do now when they assess a facility.

Mr. Patten: You might surmise that this arrangement with the college is too cozy for me. I think there's too much self-interest built into the whole structure of the relationship. It is limited by their perceptions of services, by and large. At any of these independent health facilities, do you have any proactive health advice advisors, nutrition, fitness, exploration of lifestyle or anything of a preventive fashion?

Mr. Morgenstern: The facilities that we have licensed for diagnostic services are specific for those diagnostic tests and it doesn't include other types of counselling services. We would expect a family physician to be involved in that type of thing.

Mr. Patten: My bias, frankly—and I've spent a lot of time on this, as you might imagine—is that we are locked into a treatment model, and the health ministry is locked into an illness model, treating people who are sick after the fact, which of course we would all want to support. But I don't see any end to this.

I was in Ottawa a couple of weeks ago to present, on behalf of the government, a cheque—not a cheque, but an announcement of funding of $11.4 million, something in that range. Part of the money was for the regional cancer centre. I have great respect for the doctor, by the way, who heads this up. It was directly related to a contribution to reduce waiting time, $6.6 million, I believe it was. The doctor said, "Thank you very much. I'll take this as a down payment. It isn't really going to do all that much related to the situation, because cancer is growing at 7% a year and our population in the area is growing at 2%." I did a quick calculation, and in about seven and a half to eight years, their treatment list will double. We're trying to eat into 15% to 20% of their list as it is now, and we can't keep up. If it had been a cheque, I would have just grabbed it out of his hands and said, "You know what? I'm taking this back to give to the Premier and tell him that we'd better do something in terms of prevention."

Anyway, that is an oblique reference to my bias. I get really worried. That little experience scared me, because when I hear them say that at the end of the decade, one out of every two people is going to have cancer, that's an epidemic. If 10% of our population gets the flu, we call it an epidemic, but half our population having cancer is not. It's in our very structure to accept that right now. We're all experiencing this, in our families, our staff; I just had an experience this week. This is extremely, extremely worrisome.

My point is that this particular area is on the diagnostic side, and that can play a role somewhat in early detection and prevention. May I ask you if you see any signs of expanding other practitioners? More and more people are losing faith in our system and are going to other practitioners—naturopaths, Chinese medicine, acupuncture, vitamin and mineral therapists, whatever it is—and finding great success. So when I look at

independent health facilities, maybe we need to revisit the act, because it's too limited. I guess you can't respond that way, because that has to be done by the government, but do you have any hopeful signs in any of this as you look at what's being done? You must be asked this a lot, in terms of what some of the other ways are—not the only way. We're locked into this allopathic approach, and if it's so great, how come we're losing the battle on more and more cancer every year?

Ms. Rappolt: I thank you very much for the comments. I'll just say a few things. First of all, with regard to cancer, as you know, these matters affect all our lives and we all wish for the right kind of investment at the front end in order to avoid what we find to be very tragic outcomes. Cancer Care Ontario does play a pivotal role in early intervention, screening, and research and prevention. I just want to say, in the context of the investment the province makes in cancer, part of that context is very much focusing on prevention and very early intervention. In addition, within the ministry, our public health division, led by Dr. Sheela Basrur, takes very seriously its mandate regarding healthy living, which of course covers a range of domains, whether that be nutrition or breast screening programs etc.

I just want to say that we do need to look at health care as a system. We're all committed to moving out of a framework of illness care, and we need to make sure that our investments are balanced to treat those who need it but also invest in research and early intervention to keep people healthy.

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Mr. Patten: If I might just respond to that, I was at a meeting in Ottawa at the Ottawa Hospital when the Cancer Care executive came and presented their strategic plan. They talked about outcomes, and that there's step 1, step 2 and this kind of thing. The preventive side of things was detection and screening. I didn't see anything that went beyond that. It just moves very quickly into treatment. "We're going to do early detection if we can": That refers to when people think something's wrong, but it is not preventive, in my opinion. I think part of our problem is that the people who sit on our advisory groups are all doctors and they don't have training in this area. They don't have much training in nutrition. They get half a day, or at least they used to—maybe they get a day now, I don't know—and it's only if they have a personal interest. That's not to say that all doctors are not aware, because I know that many are. But it doesn't take place through background or the kind of training that's in the medical schools.

Anyway, I'll leave it there. There may be opportunities down the line to broaden all this.

Mrs. Munro: I just have a quick question. It relates to the information you provided in your remarks this morning about the ability under the act to develop criteria to evaluate proposals for expansion to include additional services. Actually, I think there's a connection between my question and the comments of Mr. Patten. I wanted to ask whether you are seeing any proposals or any pressures with regard to expanding independent health services. Are people interested in providing different or augmented services through this approach?

Ms. Rappolt: I'm going to ask Marsha to respond.

Ms. Barnes: Yes, but there has always been interest expressed to us, particularly with respect to the opportunities presented to move services that traditionally had been hospital-based services into the community as the technology has advanced to make it safe to perform those services in the community. Things like colonoscopy and endoscopy come to mind, where there has been some interest expressed, largely by the providers, regarding an opportunity to move those services into the community.

Mrs. Munro: If you were evaluating those, I'm assuming you would be looking at whatever efficiencies might be addressed by doing that. Earlier, there were questions raised about whether services are in the hospital or in the community. Are there different kinds of services that really make more sense in one place than the other, so therefore you can consider greater numbers of services in independent health facilities?

Ms. Barnes: I would say it's probably not either-or. It tends to be a blend of both, because hospitals need to provide a full spectrum of services in order to do their role in treating the very sick people and the in-patients, and in some communities, there aren't enough people to warrant having the service in both settings. But there are opportunities to look at which services would be best performed in the community.

Then you also need to look at the quality issues. We have conversations, as part of those guidelines we developed with the College of Physicians and Surgeons, about the safety of providing those services there, and if they are provided there, do they need to be within a certain distance of the hospital in case a problem occurs?—those sorts of things. It does take a while to move through that process, and in some cases it's just more efficient, because of the volume of services, to have them within the hospital setting where they can do both types.

Mrs. Munro: I guess my question was, if we're sitting at about 1,000 right now, do you see pressures to increase the number, or is there a steady demand using the ones we already have? Do we have any sense of that?

Ms. Barnes: Off and on, there have been requests to increase the number of diagnostic services, perhaps largely related to relocation as the population changes, the high-growth areas around Toronto, for instance, where previously the population may have been more in Toronto and has been moving out of the Toronto centre. There have been requests around the redistribution of services, which I think the auditor also pointed out, in terms of the ability to do that. There's not a huge amount of pressure right now. There's certainly an interest in looking at the opportunities, but we may get a few requests a year.

The Chair: Thank you very much. I think that brings our questioning to an end. Do you have any closing comments at this time?

Ms. Rappolt: I don't believe I have anything more to add, other than to thank the committee very much for

their attention today. If there are matters on which we need to follow up, I know we will hear from research about that. We appreciate this opportunity today.

The Chair: Thank you and all of your assistants. I think you've been as direct as you possibly could. Committee will recess for five minutes and then reconvene to talk with our researcher about the direction of the report.

The committee recessed at 1138 and continued in closed session.

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