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Jeudi 23 février 2006

Standing committee on public accounts

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Ministry of Health
and Long-Term Care

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Thursday 23 February 2006

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Jeudi 23 février 2006

The committee met at 0948 in committee room 1, following a closed session.

2005 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.01, ambulance services—air.

The Chair (Mr. Norman W. Sterling): Good morning. My name is Norm Sterling. I am the Chair of the public accounts committee. This morning, we are going to be dealing with section 3.01 of the auditor's report, dealing with air ambulance services. I'd like to welcome Mr. Sapsford, the deputy minister, to our hearing. I understand that not only you, Mr. Sapsford, but some of your other people with you also have some opening remarks. Can I ask you to proceed.

Mr. Ron Sapsford: Mr. Chair and honourable members of the Legislature, it's my pleasure to be here today in response to the annual report of the Auditor General of Ontario on the air ambulance program.

Joining with me today are a number of my ministry colleagues, each of whom has considerable and detailed knowledge about the air ambulance program. Mary Kardos Burton, to my left, is assistant deputy minister of the acute services division. To my right is Malcolm Bates, who is the director of the division's emergency service branch. This is the branch responsible for the air ambulance program. Mary Kardos Burton will present a prepared statement in a few moments. As well, she and her staff will make every effort to answer any further questions you might have concerning the air ambulance program.

I speak for my colleagues here today, and the many other people who are responsible for delivering air ambulance services across the province, when I say that we welcome the findings of the Auditor General. I'm pleased to say that appropriate action has already been taken in response to most of the recommendations, while work continues on the others. These efforts illustrate the ministry's continued commitment to ensure excellent air ambulance services to the people of this province, and recent changes to the air ambulance program will further improve these services.

As you may know, in January of this year, all operational functions of the air ambulance program that were provided or contracted by the Ministry of Health and the base hospital program were consolidated under the Ontario Air Ambulance Services Corp. These services include all organ recovery flight services, air ambulance dispatch functions, air ambulance service provision contracting, accounts payable and receivable, and base hospital functions. The latter, base hospital functions, include medical direction and medical quality assurance, as well as flight paramedic training.

This new corporation has the ability to enhance and improve the provision of air ambulance services in Ontario to a level that will contribute significantly to the health and preservation of life of the people in this province. The establishment of the corporation and the consolidation of the various elements of the air ambulance program will improve the ministry's ability to improve access to health services, ensure quality health services, and contribute to the alignment of health resources and the integration of health services.

This corporation will be fully accountable to the provincial government, to the patients who make use of its services and to the broader health community. However, while the corporation will manage and operate the air ambulance system under a performance agreement with the ministry, the ministry will continue to consult with all stakeholders to set and ensure that policy and standards are current. And the ministry will continue to certify and inspect air ambulance operators and conduct any investigations. The end result will be improved care, improved access to service, increasing effectiveness and efficiency of the delivery of service, and the assurance of greater fiscal and medical accountability.

These results are particularly relevant in light of the overarching theme of the Auditor General's report that identifies the need for more rigorous management to ensure services are delivered economically, efficiently and effectively.

I want to note that this recent consolidation of Ontario's air ambulance services is an important step for the ministry to move away from direct operational service delivery and towards the role of being a strategic manager and steward of this vital health care program. This new role of stewardship for the ministry—planning for, and making wise use of, our resources—represents the future overall role and function of the Ministry of Health and Long-Term Care.

In its new stewardship role, the ministry will be responsible for:

—establishing overall strategic directions and provincial priorities for the health care system;

—developing legislation, regulations, standards, policies and directives to support these directions;

—monitoring and reporting on the performance of the health care system and the health of Ontarians; and finally

—planning for, and establishing, the funding models and levels of funding for the health care system.

In essence, what this means is that the ministry itself will be less involved in the day-to-day actual service delivery and more involved in establishing overall direction on policy, priorities and investments.

The consolidation of air ambulance services in the Ontario Air Ambulance Services Corp. illustrates and exemplifies this new ministry's stewardship role. It means that we'll be setting standards, monitoring service delivery, and ensuring compliance with the legislative and performance contract requirements regarding the delivery of air ambulance services.

In closing, I want to stress that this will not change the ministry's uninterrupted commitment to a level of service that stands up favourably to any question and all scrutiny.

Now I am pleased to introduce Mary Kardos Burton, who will address directly the Auditor General's recommendations.

Ms. Mary Kardos Burton: It's my pleasure to join you today and to answer questions that committee members may have concerning our province's air ambulance program, its operation and its expenditures.

First, I would like to provide you with a brief background about the air ambulance program. Clearly, Ontario's air ambulance services play a critical role in providing people, particularly those living in the remote northern areas of our vast province, with quick access to specialized medical services.

Air ambulance services are available to all Ontario residents and cover the entire one million square kilometres of the province. As such, they're vital in overcoming the barriers of distance, geography and time for patients needing urgent or prompt access to vital diagnostic and specialist medical services. Air ambulance services are available around the clock to respond to emergencies where patients need immediate evacuation to specialized levels of care.

The fundamental purpose of the program is to provide rapid, efficient and safe transport of seriously ill or injured patients over long distances from accident scenes, from areas inaccessible by land ambulance or from community hospitals and health centres to locations where the needed health care services can be obtained.

These urgent transports include daily responses to interfacility transfer requests, as well as transporting victims of automobile, industrial and other types of accidents to the closest trauma centre. They also include rapid transport of specialized medical teams, such as neonatal or cardiac teams, and are vital to our organ recovery and implantation services, with almost 400 flights annually for these purposes.

Air ambulance services play a key role in the ministry's contingency planning and response components of the province's disaster and emergency response system. The air ambulance program, the first of its kind in Canada, was established in 1977 to transport critically ill patients to hospital. Today, it's one of the largest and most active air ambulance programs in North America. What's more, I'm proud to say that it's a world leader in handling the transportation of some 18,000 patients annually.

Often described as the glue that connects the components of the health system across the province, the air ambulance program is becoming increasingly important to health care providers and to patients who need its services. Now, as the deputy has noted, the various components of the air ambulance program have been consolidated into the not-for-profit Ontario Air Ambulance Services Corp. The primary objective of the consolidation is to streamline processes and improve service coordination.

The creation of this service is yet another example of the ministry's responsiveness to a need for innovation and for changing the status quo when such change is advocated by professionals, experts and stakeholders. This initiative is not only the latest development in the history of air ambulance services in this province but also an extremely meaningful development in the advancement of pre-hospital care.

This new organization, as the entity responsible for the overall management and operation of the air ambulance program, is now positioned to work with the ministry and all system stakeholders to determine how to best respond and react to the auditor's recommendations on air ambulance service in Ontario.

Let me now address the auditor's specific comments and outline the ministry response to each.

Reaction times: The auditor recommends that the ministry more closely monitor and improve reaction times.

This is one example of where the OAA comes into play. Last July, the government announced that the OAA will have responsibility for all air ambulance operations, including the medical oversight of paramedics and air dispatch. The OAA commenced operations last month. Under the terms of the performance agreement between the ministry and the OAA, which was signed last December, the OAA will implement new computer-aided dispatch communications system technology innovations which will encompass and improve many aspects of air ambulance dispatch.

The ministry agrees to work with the OAA to have reaction-time fields built into the new air ambulance software system to monitor performance for emergency calls. In this way, the new system will enable closer monitoring of actual reaction times and will also facilitate development by the OAA of a strategy to improve reaction times.

Decision to Dispatch: The auditor recommends that the ministry document the reasons for air ambulance use and the selection of particular aircraft.

The existing communication system does not allow for automated documentation regarding decisions on aircraft selection and deployment. In concert with the OAA, the ministry will undertake to have additional decision-making documentation in the new computer-aided dispatch systems software that will be used to assist in the dispatching of air ambulances, as long as use does not impair timely air ambulance operational response capability or safety. The ministry will also undertake to periodically have the OAA conduct a review of the decision-making information used for this purpose and to provide the director of the emergency health services branch with the results of the review and a plan for remedial action, if necessary and/or appropriate.

Cancelled calls: The auditor recommends the periodic review of cancelled calls, with particular attention to where there is a high number of such calls and with action taken to minimize the unnecessary dispatch of air ambulances.

Given all of the variables, such as weather and runway conditions, and the impact on aviation services, including air ambulance services, cancellations can be accepted as being systemic within the air ambulance program, and are not normally caused by staff performance, improper procedures or operational inefficiencies, nor can they be significantly mitigated without imposing significant time delays to secure more detailed patient data prior to responding to actual or potentially life-threatening emergency calls.

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All of this notwithstanding, there is a need and an opportunity for implementation of a better method for monitoring and recording cancellations. The ministry will work with the OAA to include call cancellation statistics and rationale information fields in the new air ambulance database that's being developed. The ministry will ask the OAA to have the call cancellation information analyzed on a regular basis and reported to the emergency health services branch.

Operator service reviews: The auditor recommends that any deficiencies identified in operator service reviews be corrected quickly, with attention paid to circumstances under which the ministry would apply sanctions or consider revoking an operator's certification.

The service review requirement for air ambulance service certification came into effect May 1, 2000, and is a total quality management process designed to have operators achieve full compliance with both legislated requirements and best industry practices. As with any new concept, a transition period is necessary, and it has taken both the ministry and the operators some time to implement and refine the process and to achieve a meaningful level of success. Review reports have been finalized and distributed, and revisits and follow-ups are being completed. The purpose of conducting these reviews is not only to identify deficiencies in meeting standards, but also to allow an opportunity for operators to correct those deficiencies. Sanctions and the revocation of certificates are considered as last resorts when all other reasonable efforts to resolve operator deficiencies have failed.

The ministry will work with the OAA in regard to ongoing service reviews to further clarify when or if financial sanctions or certification revocation options should be considered for an air ambulance service operator.

Location of air bases and aircraft: The Auditor General recommended the assessment of the number and type of air ambulances needed, the hours of their operational availability and the optimal locations for aircraft bases and landing areas, including helipads.

The ministry informally assessed this information each time it contemplated awarding a contract to an air ambulance operator. The ministry will now discuss the need to formalize such assessments with the OAA prior to initiating future contracts.

Lines of authority: The Auditor General recommended that lines of authority be clarified among air ambulance dispatch, base hospital and operators to enable the effective coordination and delivery of services.

The new service delivery model provided by the OAA will clarify these lines of authority. It will also address the Commission on Accreditation of Medical Transport Systems recommendations. This is a meaningful accomplishment since CAMTS is widely recognized as the body that sets the standards of excellence in the international aero-medical transportation industry. It is a not-for-profit organization dedicated to improving the quality and safety of medical transport services. In an audit of the previous structure of the air ambulance program, CAMTS had identified various opportunities for improving the program.

Acquisition of operator services: The Auditor General recommended the evaluation of risks posed by the dependence on one preferred service provider and the development of a long-term strategy to encourage a more competitive environment. The performance agreement between the ministry and the OAA will require a competitive procurement environment consistent with government requirements.

Patient billings: To help ensure that costs of air ambulance services are recovered where appropriate, the Auditor General recommended that the ministry consider billing such costs similarly to other health program billing practices.

Patients who are billed for air ambulance costs are patients not covered by OHIP, such as patients who reside out of province. Of the more than 18,000 patients transported by air ambulance in 2004-05, fewer than 1% were billable for actual costs. In essence, this recommendation is calling for those patients to be charged for all the repositioning costs of the air ambulances used in servicing these patients. Also, implementing this recommendation would mean charging these air ambulance users for not only picking up the patient but also returning the aircraft to its home base.

In concert with the OAA, the ministry will review whether it is reasonable to charge these system costs to

patients not covered by the Ontario health insurance plan and/or to establish a maximum recoverable amount.

Integrated air information system project: The Auditor General recommended better integration of air ambulance information systems, as well as balanced communication between air and land dispatch systems.

The ministry will work with the OAA to assist it to establish a substantially improved air ambulance dispatch information system.

That concludes my review of the Auditor General's recommendations and the ministry responses concerning Ontario's air ambulance program. Since the OAA is now responsible for all of the operational facets of the air ambulance program, it is a matter of appropriateness and necessity for the ministry to request that the OAA review all of the auditor's recommendations to determine, in consultation with the ministry, how best to react to each one.

I appreciate your kind attention today. And now, with my colleagues, I would be pleased to answer your questions either today or in written form.

The Chair: Mr. Zimmer.

Mr. David Zimmer (Willowdale): I have a theme I want to explore that arises from pages 7 and 9 of the auditor's report—page 7, operator service reviews, and page 8, acquisition of operator services. I'm sorry, it's 5, operator service reviews, and 8, acquisition of operator services.

When I read through 5, the operator service reviews, without getting into the detail, it's clear to me that in about 70% of the service review files there is no supporting evidence and so forth and so on and various things didn't happen. But the point is that I get the sense that there was no central management oversight, governance or quality control of what the service operators were doing. There was no provision for penalties if they were doing things that they shouldn't be doing or if the service standards weren't up to snuff and so forth. So that's the service review situation: There essentially was none.

Then I go to 8, the acquisition of service standards, and we have this thing of the preferred provider operators. It looks like they got the contract, so they're a preferred provider but they're operating without a lot of service oversight. After a couple of years of their contract and—I should say, presumably they got the contract with an RFP, so there would have presumably been standards and all that sort of stuff in their proposal. Then the contract sort of comes to an end and they announce that health structures are such and so on, and they're going to terminate the contract. The ministry's internal audit service had great difficulty—perhaps it was even impossible—determining the validity of the provider's claims that they couldn't service the contract at the prices. Then of course, there were very few providers out there in the marketplace, so the contract was not re-tendered and it was extended, and it looks like they caved in to the additional fees and so on.

So it seems to me that what we have here is effectively, not to put too find a point on it, an ambulance service that's really operating as a fiefdom, if not its own monopoly, because there's not a lot of oversight and when the contract was up they essentially rewrote it on their own terms. I know that's the challenge that you face. It's one of accountability, governance, oversight by central management and so on. My question then is, given that scenario, how are you going to break down that monopoly or fiefdom? Once you break it down, how are you going to govern it, keep an eye on it on a going-forward basis? What's the plan on the going-forward basis? How are we going to crack this nut of what amounts to a de facto fiefdom or monopoly out there?

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Interjection.

Mr. Zimmer: My question is to the deputy and staff.

Ms. Kardos Burton: I'll start, and then I'll turn it over to my colleague Malcolm Bates. I think I mentioned in my comments that we are going with the air ambulance organization. One of the things that we are requiring is that there be a more competitive procurement environment. Our performance agreement with them will also ensure that we do monitor. They will have reports back to us and there will be a responsibility on their part. Part of the problem, as you correctly identified, is the availability in terms of the expertise and experience in this business. Certainly, our expectation is, with the air ambulance authority running this, that we will have a higher competitive environment. Malcolm?

Mr. Malcolm Bates: Good morning. I think one of the first questions you had though that we should address is your question of certification and quality, if you don't mind. We have a certification process under the legislation where an operator is required to certify prior to becoming an air ambulance operator. You cannot be an operator unless you're certified. That certification process is a very involved, comprehensive process that every operator must go through. Every air ambulance operator, and every land, for that matter, has to go through a certification process. That certification process involves an interview and a review of the qualifications of any operator who wishes to become an ambulance operator. So you have to pre-qualify to go through a certification interview and review of your qualifications with respect to how you can operate and your financial stability and your patient care plans and everything else before you can even step foot in the ambulance operation side of things. Then you must undergo an on-site review by a group of people who are very knowledgeable—paramedics, base hospital staff and our certification people—within a set number of days under the legislation to ensure that, in fact, you are performing in the way you have said you would perform.

There's a certification review process consisting of upwards of about 400 items that are looked at during a certification review. You must score 90% on that particular review. There are about 12 ambulance operators at this point in time; eight underwent review last year. All of them were certified eventually. Two had to undergo a review follow-up process. One of the things

that the auditor was concerned about was a follow-up process, and that has been addressed. In the beginning of the certification process—as the ADM mentioned previously, there was a transitional period. It's new, it's something that not only we have to get accustomed to, to make sure that we're doing it properly, but the operators also have to get accustomed to, to make sure they understand what this is all about. That process now, I believe, can assure the operator is totally in place at this point in time and the follow-up is done and the reviews are done properly.

Now, there are sanctions, because I think you're concerned about whether or not an operator is performing properly. There are sanctions, with respect. I do have some charts. They may be a bit difficult to read with respect to—but I'll point it out to you, if you don't mind.

Mr. Zimmer: If I may, I'm not so much interested—I expect that there are sanctions there and all of that stuff and I accept everything you've said and I think that's the way it should be. My question is more how the ministry is organizing itself so it carries out its oversight functions, so that it properly manages the contract. You can have the finest and most elaborate contract, with all the protections built in and so on, but if someone is not overseeing or managing the contract, bringing down the hammer at the appropriate time, the word gets out there, and the service will soon realize that the teacher's not there to keep an eye on them and they can pretty well do what they want. The situation is even more difficult because, as I understand it, practically speaking, there are not a lot of other viable competitors out there to compete with.

Mr. Gilles Bisson (Timmins–James Bay): It's a highly specialized business.

Mr. Zimmer: Just a second. I'm interested in the answer here.

Mr. Sapsford: Maybe I can start with the question about the ministry's role. Up until the creation of this new organization, the ministry, as you're aware, was involved both in the delivery as well as in the policy and monitoring. I think the comments were made first by the accreditation council as well as the auditor about lines of authority and who's responsible.

So this change in the basic organization of how the program operates using a non-profit transfer payment agency and accountability agreement clarifies who is responsible for the service performance. The ministry's role in the future, as the program, is really to take a much larger role in the oversight and the monitoring that the auditor and his staff are referring to.

With the clarification of the role of the ministry and the role of the service provider, consolidating all the elements—dispatch, providing the fixed and helicopter services, as well as the medical supervision and the training of paramedics—under one governance authority is, in my view, a better organization of responsibilities and, hence, each one of us will be able to focus on our own roles and perform those roles much better than they have been in the past.

Mr. Zimmer: I'm happy to hear that. My last question is, how will you adjust for or compensate for or take into account the lack of viable competitors out there? If you're unhappy or if there are problems with the service these folks are providing and they know there isn't really, practically speaking, anywhere else the ministry can go for the provision of the service, how will you sort out that tension? It seems that they've got a slight advantage there.

Mr. Bates: If I can have a chance at that one, there are two types of air ambulance operators. The ones you're referring to there are the rotary wing, I believe. There are also fixed-wing operators who function throughout the province. There are eight fixed-wing operators at the present time under a standing offer agreement that we utilize across the province, primarily in the north, of course. There's also a fixed-wing dedicated operator. The fixed-wing is a competitive process, and some of them are coming in and out of the business regularly, depending upon the need for that type of business. So that's competitive at its utmost, if you will.

The rotary wing, which is what you're talking about, I think, is indeed a very specialized business and a very expensive business to get into. In fact, there was competition at the last RFPs. We had, I believe, three or four competitors who put in proposals on the RFP. So there are people and companies that can indeed present themselves as potential operators, and did in the last RFP that went through.

Although we only have one particular company that is now providing rotary wing services—you're quite right, and the perception is that maybe it is a bit of a monopoly, if you will—there were competitors, and I'm sure there are competitors. That's my understanding in discussing this with the Ontario air ambulance service. It's one of their concerns as well.

Let's face it: They have to, from this point forward, be concerned about it and operate. They have indicated they will look elsewhere—"elsewhere" meaning across North America, if you will—for potential operators for rotary-wing services. So I think they're under control of that particular aspect of it, and will be using different methods of procurement to try and solicit additional competitors.

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Having said that, the one we have is very good; I don't want to say anything about that. You also mentioned, though—and I want to go back to quality assurance, because it's a very important part of air ambulance, a very important part of safety, to make sure that patients and crews are protected. It's a multi-faceted approach, not just through our certification through the ministry, which is a very important process, but also through the Ministry of Natural Resources, which looks after the safety aspects, and through Transport Canada, which also looks after the safety aspects of all the aircraft. We also do unannounced inspections, and we do investigations of any complaints. I can tell you, as far as history goes, that in the last two months we issued two suspensions of

standing agreement operators for things like not having a properly qualified paramedic on board, for not having oxygen on board. So we are watching that on a very close basis.

The Chair: Mrs. Munro.

Mrs. Julia Munro (York North): Thank you very much for coming today. I want to ask a couple of questions, at this point, just to understand a little bit more in terms of how this system works. You made reference, in response to Mr. Zimmer's questions, to the need for rotary-wing units as well as fixed-wing and the question of competition. We also have a map here that gives us a sense of the air ambulance system. I wonder if you could tell us how many rotary-wing units we are talking about here, particularly in light of the sensitivity around basically one provider.

Mr. Bates: Looking at this particular chart may help as well. If you don't mind, I'll stand up and explain this.

Interjection.

Mr. Bates: I have to stay at this desk? All right, I'll move it over.

Mrs. Munro: It's easier than moving the sound system.

Mr. Bates: Rotary-wing: There are 11 helicopters in the system at the present time. We have rotary-wing bases in Toronto, where we have two helicopters based. We have one in Sudbury and one in Thunder Bay, and those are the dedicated critical care transfer services, as we call them; they provide critical care paramedical services in those particular locations. We also have preferred provider, which I believe Mr. Zimmer mentioned a moment ago. They are located in London, Ottawa, Moosonee and Kenora. London and Ottawa also provide critical care paramedic services. Kenora and Moosonee are advanced care paramedic services. That is the rotary-wing system in the province.

The fixed-wing service in the province: The dedicated are based in Timmins—there are two aircraft there—and Sioux Lookout—there are two aircraft available there.

Having said that, there are a number of standing offer agreement carriers. I think there are about eight of those online right now, and they might provide 25 aircraft to utilize for air ambulance services at any point in time.

Organ retrieval: There are about 80 aircraft available at any point in time for that particular service.

Mrs. Munro: Thank you. I just felt it was important for us to get a sense of the numbers when we talk about this service.

With the creation of Ontario Air Ambulance, does this mean there is one location?

Mr. Bates: The number of bases and the number of aircraft will remain the same, with one exception. There's one additional rotary-wing coming on in September as part of the agreement with the carrier we have at the present time. That will be an additional spare, if you will, for maintenance purposes, because helicopters require significant downtime for maintenance, as I'm sure you know. It's very important to make sure that maintenance is provided and that the aircraft are kept online. That additional spare will assist in that.

No change will take place initially with respect to the number of aircraft and the number of bases. OAA has already assumed responsibility, by the way, and is in fact responsible for the air ambulance system and functioning within that air ambulance system.

Mrs. Munro: I guess my question had to do with simply the physical entity of Ontario Air Ambulance. For instance, we know that a lot of it was previously centralized at Sunnybrook. What I wanted to know was whether that was changing in any way. Is there still basically one location that is serving across the province in terms of its oversight responsibilities?

Mr. Bates: Yes, there's one dispatch centre, the Ontario Air Ambulance dispatch centre, which is the same. They have simply assumed our air dispatch centre, and the staff associated with it are providing that service. There is a base hospital, and in fact the OAA is now the base hospital. The staff at the Sunnybrook base hospital function for the OAA and provide aero-medical direction in the system.

Mrs. Munro: We can safely assume, then, that this has simply been superimposed on those existing features?

Mr. Bates: Yes.

Mrs. Munro: One of the areas that received some comment in the auditor's report dealt with the inclusion of software and the importance of creating the appropriate technology and software. I wondered if you could give us an idea about the extent to which that has already taken place and what we can expect in the future under the new leadership.

Mr. Bates: The current system—this is basically just an illustration of the current system—is patient-focused. The name of the game is to provide to the patient in the province the type of service that is necessary through the air ambulance system. This screen will reflect that. This is the sort of screen they utilize at the present time when a call comes in that requests air ambulance service. For instance, a request for a helicopter on-scene will provide—you've often heard of a helicopter responding, as an example, to a very significant motor vehicle collision on the 401 and the transport of the patient to Sunnybrook. About 15% of rotary-wing calls across the province are on-scene calls. You'll see that there's a medical transfer request, a trauma request, obstetrical, neurological.

These are all the types of things that are utilized when a call comes in to determine what type of service should be provided. That sort of system is what we call DFAFS, dispatched flight assistance following service, and that is currently in use at the medical air transport centre as it now exists. OAA, under its performance agreement with the ministry, has indicated that it will make some changes to the software system that is now in effect. Much of those will improve what we're doing and make it a better system for the dispatcher, the medical analyst and the flight followers, and provide the type of information the Auditor General is looking for. This system provides some of it. This system is patient-

focused. This system provides the medical analysts with what they and the flight follower need to do the job of getting the aircraft dispatched. It does not provide the type of backup information, the stewardship we require, as Mary indicated previously, that we will be getting from the OAA, and it doesn't provide what the Auditor General has recommended, but it will. The performance agreement has called for a change in the system within two years.

Mrs. Munro: Just a couple of other questions. With regard to the ambulance—that is, the provincial system and the bases—would they be subject to any kind of scrutiny with regard to usage and therefore flexibility in terms of moving? Are you in a position to analyze usage in a particular area and say, "We should actually have a base somewhere else. This base is not as effective as it could be." Is there a mechanism to make those kinds of judgments?

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Mr. Bates: Yes, there is a mechanism for making that sort of judgment. If you go back in history, the air ambulance system—and I think it's important to look at the historical perspective—started back in 1977 when the province first started providing air ambulance service. There was a major report done by an outside consultant at that particular time recommending where the bases for dedicated helicopters and fixed wings should be. Then there was a follow-up in 1994. Another outside consultant at that particular time looked at all aspects of the air ambulance system, including the bases, and indicated where those bases should be located. It said there were things you should look at. Obviously, medical hubs are important things. You must be close to hubs, particularly with a dedicated aircraft. You have to have the right type of airport facilities and you have to have hangars, so you have to be in a particular area where there are hangars available. You have to have fuelling for the organ retrieval aircraft. You have to have a longer, 5,000-foot runway, as an example. With respect to the remote areas, we're talking about heliports or helipads, and we have 230 of those spread throughout the province.

These things were looked at, and there was a follow-up report in 1996 that looked, area by area, throughout the province as to where service should be and where it should be changed. The Auditor General mentioned that nothing has been done since that point in time, or at least nothing to any great extent. Well, we have looked at bases, and what happens is the standing agreement operators, the fixed-wing people that I mentioned previously, are constantly looking at demand, because they have to be in the business. If they don't secure business from the air ambulance system, then they're not going to be there to provide service. So they're constantly looking at where we should best put our bases. And they move them around. Twice a year, they present proposals to us, and they may have different bases that they work out of. There are about 25 of those bases that they utilize, the eight carriers, primarily throughout the north.

Several years ago, we looked at cottage country and the fact that during the summertime, obviously there's an increased need for additional resources on the air ambulance side in cottage country. Now we move one of our helicopters from Toronto Island to Muskoka every summer. It's put there for three or four months each summer to better service cottage country. So we've looked at air ambulance bases.

But the fact of life is that you've got to be where the demand is. We can show you pickup locations as well. These are pickup locations across the province. It's difficult to see at this particular point in time, but the fact of the matter is, if you overlaid them with our heliports and our bases, it would look very similar. For instance, demand across the north—helipads match where the demand is, obviously. There's a big concentration of calls in Thunder Bay and obviously in southern Ontario. And we're throughout southern Ontario, so are meeting these particular ones.

Could it be better? Perhaps, and that's what the OAA will be looking at, I'm sure. But at this point in time, I'm satisfied that the bases are adequately located in proximity and meeting the needs of the operators, which is important.

Mrs. Munro: My final question at this point deals with the issue raised in the submission by the assistant deputy minister on patient billings. The information here is that less than 1% fell into that category for billing actual costs. I wanted to ask you about a potential comparison with the use of land ambulances, where people are asked to provide a relatively modest sum in relation to the actual cost of land ambulance service. I wondered if you have considered making a similar kind of process for people who use the service.

Mr. Bates: The charges for residents of Ontario with health insurance coverage are the same, whether it be air or land. What is contained in the Auditor General's report is reference to out-of-province or people who do not have OHIP coverage.

First of all, we'll put up here the number of patients transported so you'll get an indication of the volume of the types of movement that we're talking about here. We've got each province indicated down here. For instance, in 2004-05, which is all we have, this is the number of patients who were transported by air ambulance: out of Saskatchewan, 6; people from Quebec, 44; Prince Edward Island, 1; Nova Scotia, 2; Newfoundland and Labrador, 4; New Brunswick, 6; Manitoba, 50; British Columbia, 14; Alberta, 16. And there were about 75 more, I believe, transported from other places, primarily the United States, of course.

That gives you an idea of the volume that we're talking about and, as Mary indicated, 1%, because we transport 18,000 overall. That's what we're looking at with respect to the cost elements associated with this and the additional billing associated with out-of-province patients.

I'll give you an example as well of the billing, if you don't mind, as it may take place. This is a hypothetical movement. As I indicated, we have aircraft based in Thunder Bay. Just take as an example an aircraft based in

Thunder Bay that is dispatched empty to Kenora to pick up a patient who is non-billable, as we call it, or OHIP-covered, and take them to Winnipeg. That happens every single day of the week, multiple times. We're moving from Kenora to Winnipeg, because that's the tertiary care centre. That particular aircraft is in Winnipeg at this particular point in time. A call comes in for a patient who happens to be in Moosonee. Maybe it's a hunter from the United States. We heard of an accident last week. These things happen. So this is an out-of-province patient—

Interjections.

Mr. Bisson: That was absolutely hilarious. Good thing the mike was off.

Mr. Bates: So we're in Moosonee with a patient there—it could a hunter, it could be whatever—and whatever happened to that particular patient, he's billable. He's from out of the province. He's transported, under the direction of the base hospital, to Sudbury, and the aircraft goes back to Thunder Bay empty. According to an actual cost of billing, which the Auditor General is looking at—and that's a fair way of looking at it—what do you actually charge? It's difficult, because what would you actually charge a patient on that particular movement? Would you charge him from here to here to here and back to Thunder Bay? If you did, your cost would be $12,300. That's what happens in numerous other provinces and jurisdictions; there's no question about it.

I just had an incident of someone in the Yukon—that happened there—a $15,000 bill for that particular individual; transportation for a resident of Ontario. Our current billing practice—because we feel this is reasonable. We feel it's reasonable to charge this particular patient for the cost of the air, which is a standing-offer agreement, so much a statute mile, from Moosonee to Sudbury. We also add on a small amount for repositioning, a 0.5 factor. So that patient is billed $3,300 at this particular point in time. Mind you, there's—what?—200 and something of these particular patients a year. That's the type of billing that is now in effect.

This is the type of billing that you will incur if you utilize actual billing. That's the situation, and that's what we feel is the right way to do things, to recognize the cost of the movement, to recognize the need, because we have to move the patient. No matter what, that patient must be moved to the care that's required for him or her.

The Chair: I think Mr. Bisson is next.

Mr. Bisson: Just on that particular case, because I get the phone calls in northeastern Ontario, in my riding, from people who are Ontario residents and end up in a car accident in Quebec. Then I call the dispatch centre to get the ambulance to pick them up and bring them back to Ontario. In a particular case like that—let's say it's a Quebec citizen—would they then just bill their provincial health system and recoup the cost? Is that what would happen?

1040

Mr. Bates: Perhaps you can repeat your question?

Mr. Bisson: First of all, you wouldn't dispatch that, would you, because you've got planes at Hearst, Kapuskasing and Timmins, so that's probably not a very good example. But let's say that you have a Quebec patient in Moosonee who ends up at the Weeneebayko hospital, and you've got to transport that person to Timmins, let's say. You're then just going to charge them the actual miles flown. In other words, you're not going to charge the patient for the trip from Kapuskasing to Moosonee to pick up and come back down.

Mr. Bates: But there's a factor.

Mr. Bisson: I understand. I'm going somewhere else. My question is, this person gets a bill. They then take the bill, go to their provincial health system and recoup it?

Mr. Sapsford: Depending upon the policy of that provincial government. Each province would have an independent policy on ambulance services and what portion the patients pay. But yes, they would submit it as part of their plan.

Mr. Bisson: That being the case, why wouldn't we actually charge them the full cost and have the other province pick up the bill?

Mr. Bates: Generally—let's look at Ontario.

Mr. Bisson: I can understand it if a person is uninsured, but if they're insured through another provincial health system, we—Ontario—are subsidizing Quebec, Manitoba or whoever.

Mr. Bates: Generally, out-of-province ambulance service is not insured. I gave you an example of someone from the west. A person from Ontario utilizing an air ambulance in another province is not insured.

Mr. Bisson: What happens if you pick up an Ontario patient who was in a car accident, let's say, in Val d'Or, and you send the air ambulance to pick them up and bring them back to an Ontario hospital? Who picks up the bill?

Mr. Bates: That is picked up only if it's cleared ahead of time; we provide our services and we're told to go and pick up an out-of-province patient. Otherwise, we do not go out of the province to pick up.

Mr. Bisson: I don't know if you get the same thing, Richard, out in eastern Ontario, but once a year, I'll get a call from somebody who will say, "My father had a heart attack," or a car accident or whatever it might be. They happened to be somewhere in Quebec. The Quebec system says, "If you stay here, we're going to have to charge you, because you're not insured in Quebec." That's the argument that I'm given, anyway. So they have to get the patient back. Now, more times than not, you can do it by land ambulance if the person is stable, but every now and then, they have to do it by air. In a case like that, would it be the OHIP system or the Ministry of Health that would actually absorb the cost of transferring the patient back?

Mr. Bates: No. In 1995, ambulance transportation out of the province was removed from the Health Insurance Act.

Mr. Sapsford: The point you made, though, about Quebec saying that Ontarians aren't insured for health services in Quebec—

Mr. Bisson: Well, they try to get them out, is what happens. The hospitals will push them. They're going to

pay, obviously, but they're going to push the patient out because it's a cost to them. They want them back in Ontario.

Mr. Sapsford: Right, but I guess the point is, to answer your question, ambulance services to transport back are not part of what we would pick up normally.

Mr. Bisson: Well, we can get into a whole discussion about why I think it should be, but that's for another time. Anyway, I've got a couple of other questions, actually, in another direction, but I thought that was interesting.

First of all, let me explain. I'm from Timmins–James Bay, so I service the James Bay coast and Timmins. I'm also a pilot, so I get to talk to a lot of the guys and women who are flying either the fixed-wing or the rotary-wing air ambulance units up in Moosonee, Timmins or wherever they might be. There are a number of things I've observed over the years, and this just gives me a chance to raise them with you.

One of the complaints I get from the land paramedics is that often there is a change in order from doctors when it comes to transferring the patient, far too many times because the land ambulance system on the James Bay is controlled by the land ambulance system out of Timmins. So you have a base doctor at the Timmins hospital who's giving the paramedic information about what he or she should be doing with the patient.

Here's a scenario: You have Attawapiskat. A person has a heart attack and ends up at the hospital. The Weeneebayko hospital, through telemedicine, will basically triage the patient with the nurses there. An order will be given by the doctor that X medication has to be taken, whatever IV drugs have to be pushed. Now that is an order that is basically being followed by the hospital. The patient then falls into the land ambulance system to be transported to the airport to be put in the air ambulance system. Now you've got a base doctor in Timmins who has responsibility for the patient on that trip from the hospital in Attawapiskat to the airport, which is a transportation total of around four minutes. What that means is that the doctor in Timmins at the base hospital is now in charge of the patient, looks at the thing and says, "Change the medications, change the IVs," whatever they have to do. The paramedics are now under the direction of the base hospital out of Timmins, so they've got to change medication. They get the person into the air ambulance. Now they fall under the base ambulance of the base system out of Sunnybrook, so the doctor in Sunnybrook says, "No, no, no. Now we need you to change the medication again."

The complaint I get from the paramedics is, we should have a more streamlined approach as to who is in charge of the patient. One of the suggestions I've been given—I don't know if this is feasible; I've never looked at it in any detail—is that maybe one of the things that we need to do is take the land ambulance services on the James Bay and put in part of the air ambulance system so that at the very least it's the attending doctor in Moose Factory, out of Weeneebayko hospital, who would do the initial order, but then they'd be under supervision of the base hospital out of Sunnybrook for both the land and the air ambulance, so you wouldn't have this confusion of what to do with the patient. Your comments?

Mr. Bates: That's a very valid question and probably a very valid answer, in the sense of what is under way right now in the base hospital system is a consolidation of base hospitals. That was recognized, as 19 or 21 base hospitals probably isn't the way it should be done. There's a consolidation now taking place down to six, I believe. One of those, perhaps—and your recommendation for Sunnybrook is something we should carry back to the air ambulance system to have a review of, because I think that's a very good point that you've made and something that should be followed up.

Mr. Bisson: If you can give me your card before you leave, I'll put it down in writing. But I'd ask, don't take my word for it. I'm not the paramedic, I'm not the doctor. So there may be some reasons they're doing it this way. All I know is that the paramedics often, when I see them on the ground, are saying, "Oh, there we go again." It's a bit of a trauma for the patients as well, because they're confused, they don't know what's happening and all of a sudden there's all kinds of confusion as to what drugs to push and what to do when it comes to the treatment. So if you give me your card, I'll give you that. I'd ask you to consult with the James Bay and the Weeneebayko hospital and the base hospitals to see if that makes sense.

On to another issue: Again from a pilot's perspective, I notice in the annual report, the auditor, rightfully so, says there is an increasing number of cancelled calls. As a pilot, we listen to 126.7 as we're flying around and we hear air ambulances talking back to flight centre, either if you're out of Toronto Centre control or you're just on class G airspace. Often you'll hear a cancellation while up in the air. I hear that probably more often than I should, as you pointed out in your report. One of the suggestions I would make—and it's just an observation that I make and again needs to be looked into—part of the problem is that as you looked across—can you put the chart of the northern bases up there for both the Kenora and the Timmins–James Bay area? I'll explain what part of the problem is. I don't know if this is going to solve your problem, but I think it will solve part of it. All of these communities up here, which we're not seeing—Moosonee, Attawapiskat, Big Bear Lake and all those places—have no weather reporting system. So as a pilot, you get in your plane, you get a flight briefing out of London, and London will say, "Here are basically the flight conditions." The pilot needs to make a decision—"Do I or do I not fly?"—based on the information they get. If they're within the minimums, the pilot will take off IFR and they'll fly up to Attawapiskat. They get to Attawapiskat and it's below flight minimums, right? So they end up flying all the way back, and then you have to pay the bill, because the person has been dispatched.

One of the simple solutions, it seems to me, is to do what they do in Moosonee and probably a few other

communities like Sioux Lookout or whatever, and put in what they call AWASs, which are the automatic weather aviation reporting systems. When I fly up to Moosonee, I can tune in to their frequency and it'll say, "Moosonee automated system. Flight conditions now are ceiling such and such, wind such and such, altimeter such and such," so that you can actually make a decision if you press on. If you had that, the pilots would be, at the very least, able to get that information because it would be all relayed back into London and you'd be able to make a decision on the ground before you go.

I know this is federal jurisdiction, is what you're going to tell me. I'm not a big fan of federal governments, for all kinds of reasons, but it seems to me that one of the things the Ministry of Health has got to do is become a partner in trying to broker a solution. It seems to me one way that you can reduce a lot of aborted flights, or cancelled flights, would be to try to pressure the federal government to put AWAS systems in those communities where we need to fly into. Your comments?

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Mr. Bates: Again, I'm sure it's a very valid comment. Not being a pilot, but recognizing your ability, qualifications and experience, it's a very valid comment that we'll carry back to the Ontario Air Ambulance Services.

Mr. Bisson: How many of your cancellations are en route? Do you know?

Mr. Bates: Yes, we know that perfectly.

Mr. Bisson: I didn't know what the numbers were.

Mr. Bates: No, I know. It was a little difficult. The concern of the Auditor General was the rotary-wing, not the fixed-wing, because that was down around 6%, and, as Mary said in her presentation, you can't avoid some cancellation.

Mr. Bisson: I'll explain why that is, but go ahead.

Mr. Bates: All right. As far as rotary-wing flights go, we have to be aware of the fact that there are many legs to rotary-wing flights. A flight always consists of more than one leg, at least two, and sometimes five or 10 legs. We'll give you an example here as background.

Mr. Bisson: What they're getting at is you dispatch from Sudbury and you've got to pick up fuel on the way up.

Mr. Bates: This is not Sudbury, but this is Toronto, one helicopter in Toronto, what we call 799. We selected a week, because we're concerned about cancellations too, rightly so; the Auditor General is concerned about that sort of thing.

So we went through a week of calls for this particular aircraft, and it gives you the legs we dispatch from Toronto airport, where it's based: Toronto to Buttonville, Buttonville to CHEO in Ottawa, CHEO to Ottawa International Airport, Ottawa back to Toronto. Of all of these particular legs—there were 46 legs associated with 15 flights in that particular week for that particular rotary wing helicopter—we had five legs cancelled. That's 11% of the legs.

In our experience, you have to look at the legs as cancellations. The auditor looked at flights and didn't take into consideration the legs. Of those flights that the auditor looked at, 6,100-something flights indicated that 27%, I think, were cancelled. That's what the report indicated at a particular time. We looked at that particular instance as well. Of those 6,000 flights that the auditor looked at, 1,432 were cancelled before they left the ground.

Mr. Bisson: Most of them are, yes.

Mr. Bates: I mean, that happens, because for various reasons it happens. There's no question about it. The patient expired before the aircraft got off the ground, or there's an air problem, just as you indicated, Mr. Bisson. That happens on a regular basis as well. Flights are cancelled before we get off the ground.

One thousand fifty-two legs were cancelled in that particular area that the Auditor General was looking at. That equates to 6% of legs, similar to this, where we came up with 11%. That, to us, is expected and reasonable, and you have to look at the legs. We had 17,000 legs in that particular time for 6,000 flights. So although it looked as if 27% were cancelled, the actual fact is 1,000 were done before we even took off. So they weren't even flights, if you will, and 6% of the legs were cancelled.

Mr. Bisson: So in flight, how many, roughly?

Mr. Bates: In flight: 1,052.

Mr. Bisson: Just again, on the difference between the fixed- and the rotary-wing, the big difference—I've still got time, or on to someone else? Okay.

On the fixed-wing, there's obviously a little bit of a different situation. The pilot gets a briefing, and away they go. The flight minimums are much lower for a rotary-wing than a fixed-wing. So your minimums going in to Attawapiskat, if I remember—I think it's 300-and-some-odd feet; for the choppers it's probably somewhere around 70 feet.

The problem for the choppers—I'm talking to the pilots up in Moosonee, where they're based—is they have no way of knowing what the weather is where they're going. Far too often they are dispatched, they get to Albany, or wherever they might be going, and they're not able to land because the minimums are below what they're able to land. But they had no way of knowing that before they left. All you can do is, somebody at the other end of the phone is saying, "Yes, I see cloud." Well, that doesn't tell you anything, as a pilot. So again, it would be a good idea to talk to the feds and get them to do something for a change, like help the province deal with this particular issue.

You had a slide that you wanted to show, but I'm sure I can look at it after.

The other thing I want to just raise: Do you have problems with uninsured patients? I'm not talking about out-of-province, but people who don't have health cards whom you have to transfer, specifically out of the northwest and northeast part, First Nations people who don't have health cards. Is that an issue for you, the uninsured?

Mr. Bates: No, because there is a method—and I'm not totally sure of the process for charging back. The federal government—

Mr. Bisson: Yes. There's the uninsured health program out of the feds.

Mr. Bates: Yes.

Mr. Bisson: Is that how you recoup?

Mr. Bates: Some of it, yes. It's not a major—

Mr. Sapsford: It would be through federal-provincial agreement, but access to the Trillium fund would—

Mr. Bisson: Let me say this, not only for your benefit but for the benefit of my friends, and I've been trying to convince people of this: A big part of the problem is that there is no method to register births in many of the northern communities. There's no office to go to, there's no provincial or federal infrastructure as far as being able to go to your nearest whatever office to get a birth certificate. The easy solution would be to do it online, but 90% of those communities don't have the Internet and most families don't have enough money to buy a computer. So that's the basic situation.

What we found is that with the base hospital, the Weeneebayko General, and the federal hospital, the James Bay General, the biggest complaint they have is that about 30% of the patients they treat are uninsured because they don't have a birth certificate and, thus, don't have a health card. One of the things we need to do—I've talked to Minister Phillips about that, and thank God he wants to work with us in trying to find a solution. Currently, my federal counterpart, Charlie Angus, and I do birth registration clinics. We'll go up at a significant cost through charter and go to all of the communities and say, "We're in the community for a day or two. If you need a birth certificate, come and see us." We do the processing of birth certificates. For example, in one clinic in Attawapiskat for one day we'll probably do 120, 140, which is a significant amount of work for my staff, as you can well imagine.

One of the things that I'm trying—not to convince you—to convince my friends of across the way: We need to find a permanent solution to registering births in those communities because it means that not only don't they get a health card, they don't get a status card. If they don't have a status card, the band doesn't get money. If they don't have a health card, it means the hospital runs a deficit because an uninsured program doesn't always pay if there isn't a status card. Do you follow? So you're in a Catch-22.

I was at a meeting with Health Canada a week ago over Weeneebayko. Their deficit on that issue last year was just over $1 million worth of services that they couldn't recoup under the federal uninsured services program. So what we need to do provincially—and hopefully we'll get this done—is to get the province to work with the feds and to establish a mechanism at the hospitals so that, when a patient comes into the hospital uninsured because they don't have a health card because they don't have a birth certificate, there's a retroactive way of making the application happen.

I'm just looking for your support and I want to thank you from the bottom of my little heart and on behalf of all of the great people of the James Bay. That was just me doing my thing for my community.

The Chair: Thank you for your speech.

Mr. Bisson: You're welcome. It was so much fun.

The Chair: Mr. Milloy.

Mr. John Milloy (Kitchener Centre): I learned a lot too from Mr. Bisson.

Thank you very much for the presentation today. I'm the rookie on the committee and I'm sitting here trying to think like an auditor. Can you help me just understand a little bit of the background of the sort of public-private of this organization? We're told that you spend about $93 million a year. What is under the control of the Ministry of Health and then what is contracted out? The more we talk, the more confused I'm getting—if we start there. Are all the aircraft contracted out, and what's the basis for that?

Mr. Sapsford: The relationship between the new corporation and the ministry is what I would call a transfer payment relationship. We've agreed that it will be the service provider for air ambulance service and they have an agreement with the ministry in terms of the total dollars involved, the standards of performance and some of the indicators that you've heard about this morning. They are responsible, as a corporation, to provide the service. Some of it they provide directly with their own employees, such as the dispatch centre. What was formerly a ministry service that we provided directly, as government, was transferred to them so that they now provide it as part of their service. Then the actual delivery of the aircraft is done by external contract. So the corporation is now responsible for issuing the RFPs, developing the contracts and making the decisions about how those contracts will be structured. They're responsible for the delivery of the service, first of all; the overall management of it, the coordination of dispatch with the actual operators of fixed-wing and rotary aircraft, as well as coordinating the medical oversight part of it, which speaks to the paramedics, the training, some of the issues that Monsieur Bisson raised around coordination of medical decision-making.

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Mr. Milloy: So obviously the dispatchers are employees of the corporation. How are the paramedics and other medical personnel categorized? Do they work for the—who pays for the paramedics?

Mr. Sapsford: They work for the corporation. Essentially, the corporation is renting the aircraft, if you want to put it that way. But taking care of the patients, doing the dispatch and managing the actual process of transport is being done by the corporation.

Mr. Milloy: But if I'm struck ill somewhere, I'm in an air ambulance, and there's a paramedic beside me, who is paying that paramedic's paycheque? Is it the corporation?

Mr. Sapsford: Yes.

Mr. Milloy: So they're devoted entirely—they're basically in an on-call situation at one of the bases, sitting—

Mr. Sapsford: Absolutely. It's a 24-hour—yes, that's right.

Mr. Milloy: So in terms of the aircraft—and this is going back to both the helicopters and the airplanes. I'm just trying to follow up on what Mr. Zimmer was asking, maybe from a slightly different angle. Those aircraft, presumably more the helicopters than the airplanes, have to basically be on call 24 hours a day. They are of no other use to the owners of them, in a sense?

Mr. Sapsford: Correct.

Mr. Milloy: So they can't be used for any other purpose.

Mr. Sapsford: They're dedicated aircraft, and that was the difference between what is dedicated and what isn't, and what's on standby. So there are various arrangements based on the requirements that the corporation decides.

Mr. Milloy: Looking at what Mr. Zimmer was raising about competitiveness, I'm going to ask—well, I'll ask the stupid question. Why don't we own them? I'm trying to look at the competitiveness and think, where is the value added in having it contracted out? Where would potential savings be in terms of—I mean, the auditor's report talks about costs going up by $500,000. Why has this really evolved so that we're contracting them out? I realize there are different categories. There's an airplane that might be transporting an organ. But I'm talking about a helicopter that's sitting there 24 hours a day, on call, doing the work.

Mr. Sapsford: I think Mr. Bates talked a little bit about that, but it has to do with the specialty and who is in the business of providing what service. I guess the argument I would make is that the Ministry of Health isn't in the business of flying helicopters, maintaining them and so forth. It's a specialized business that others can provide on a contract basis, I would argue, more effectively and more efficiently than we could ourselves. But there is a requirement that some of the aircraft are devoted 24/7 to this specific purpose, whereas a larger number are not. They're on standby relationships.

Mr. Milloy: I'm just going to pursue this. We don't do that with fire trucks. The Ministry of Natural Resources owns airplanes that fly around. As I say, I'm trying to come to Mr. Zimmer's question or the question raised by the auditor about competitiveness and going outside, going to different companies. I'm sort of thinking, where could an increased competitive atmosphere—where are the savings going to be? Fuel costs are fixed and transport costs. What are the different categories that are going to go? But then the obvious question is, what sort of value is it to third parties to have these companies doing the work as opposed to our just purchasing whatever it would be—the top-end helicopters that we need to have 24 hours a day?

Mr. Sapsford: I guess I repeat myself. The ownership and operational function owned and operated by the ministry is not a model that we've pursued in the delivery of air ambulance. The ministry has been trying to identify what business it is in, and has pursued a strategy over a number of years to move away from direct service delivery into these transfer payment arrangements. I suppose it would be a point to discuss with the new corporation, whether over time a different business decision could be made about whether they own the hardware of the helicopters, as opposed to doing this contracting relationship. One could contemplate that, but that's not currently the way it's structured.

Mr. Milloy: But you can see my point. If this was a case where you had a helicopter that you needed three hours a month—

Mr. Sapsford: I agree, it's a make-or-buy decision. For this particular service, given the high speciality of aviation—the helicopters and the hardware and the standards involved—the decision, to this point, has been that it's a buy decision and not make.

Mr. Milloy: What are some of the categories of costs? Again, the auditor has raised concerns about competitiveness and other issues. Is this a situation where a provider would be paid a lump sum and then so much per call in the sense of cancellations? Are cancellations an issue where there would be significant cost savings in that if you get the call and then it's cancelled, say, on the ground, they're going to bill you?

Mr. Bates: Good question there. Again, I say there are two types of systems. One is a fixed-wing standing agreement, which is, as the deputy said, on call, waiting for a call to come in. We don't pay them unless we utilize those particular aircraft operators. The rotary-wing, on the other hand, and the fixed-wings in Timmins and Sioux Lookout, are on dedicated contract to the Ministry of Health, or at least to the OAA at this particular point in time; the contracts were assigned to the OAA. Those are costs for the provision of the aircraft and the aircraft crews associated with it around the clock, 365 days of the year. It's up to us to ensure that we can utilize those aircraft properly and that they are positioned in the places where we can effectively utilize those particular aircraft.

There are additional costs. But when one of these dedicated aircraft flies, there is no additional cost other than things like landing fees, or if they have to weather over somewhere or their hours are over and above the maximum, we have to pay for their accommodation costs. Other than that, all costs of providing service are included in that annual contract.

Mr. Milloy: That's for the aircraft?

Mr. Bates: Aircraft and the paramedics.

Mr. Milloy: But not for the helicopters?

Mr. Bates: For the helicopters, yes, certainly.

Mr. Milloy: Oh, okay. I thought you said there were two.

Mr. Bates: There are two types. There are the fixed-wing standing agreement operators, which are basically in the north, and we use those as necessary. The balance of them are dedicated aircraft, as we call them. The preferred and critical care and the fixed-wings in Sioux Lookout and Timmins are under contract to us. Those aircraft are there for us to utilize, including the spares, to make sure that the service is available when the patient needs it, around the clock, as the deputy said.

Mr. Milloy: So cancellations, then, don't affect—

Mr. Sapsford: Not very much.

Mr. Milloy: Are there any categories of cancellations that would affect the costs?

Mr. Bates: On the standing agreement, if we send a standing agreement aircraft operator out, we pay per mile, and if it's cancelled, for whatever reason, we pay.

Mr. Milloy: Just to my initial question, where are some of the areas where we'd see competition? Are there areas where there are potential savings, where one carrier is going to say, "We can do this cheaper" or "We could have a different type of arrangement"? I know I'm arguing all sides of it, but I'm just trying to explore this whole issue.

Mr. Bates: When the contract is finished there's a request for proposals. The OAA also has to follow, as the ADM indicated previously, government procurement requirements. So it does happen at that particular point in time that there are in fact competitive processes to secure the procurement of air ambulance services.

Mr. Milloy: What would be the categories where you'd see different bids coming in? The cost of fuel is going to be the same. Just in general—maybe it's an unfair question. I'm just wondering, is there any flexibility in the system?

Mr. Bates: There is, because another competitor may have additional aircraft, better aircraft or whatever, that they can possibly submit as a proposal. They may be able to do things more economically from the viewpoint of maintenance. That's a competitive factor in the private enterprise business as far as provision of air ambulance services is concerned.

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As Mr. Bisson said, and quite rightly, it's a very specialized business. There are limited companies that can provide this particular type of service and they have to be knowledgeable, experienced and have the aircraft available to provide the service. These are very expensive aircraft, as I'm sure you can imagine, that we're talking about here. It's an expensive business to get into and an expensive business to maintain. But there are opportunities when the contracts come up for bids to be submitted, and they were submitted, from other contractors.

Ms. Kardos Burton: If I could just add to that, I think your question was extremely interesting and a very good question, as Malcolm Bates has mentioned. In terms of looking at why wouldn't we have purchased the equipment ourselves, I think it's the cost. The capital costs, rightly or wrongly, have been what has prohibited us from actually purchasing the equipment, or at least that's how we've operated.

The other point that I want to raise, and it's also in relation to the contracts when the proposals come forward, is the availability of medical personnel and the companies' ability to have that. So while some paramedics have moved and are in the process of moving over to the OAA, the operators also had some responsibility for medical personnel, and how they were going to do their business factored into it as well.

It's a good question you raised. I haven't done a study and I haven't seen a study on whether MNR's purchasing the equipment itself is cost-effective. I'm assuming if they've kept it that way it must be, but I don't know that. I think it's a really good question that you raise and it's something that we should always be conscious of in terms of our move forward in working with the OAA.

Mr. Milloy: So you're saying that in the past medical personnel have in a sense worked for the companies and been contracted. My understanding is that that's being changed now?

Ms. Kardos Burton: Yes.

Mr. Milloy: What's the process of that? Has that been changed 100% or is that—

Ms. Kardos Burton: No. My understanding is that it hasn't been 100%.

Mr. Bates: It's in process.

Ms. Kardos Burton: It's in process.

Mr. Bates: The OAA has taken over the services of the paramedics and the critical-care aircraft in Toronto, Sudbury and Thunder Bay. The preferred, I believe, are in process and they do have plans for looking at the standing-agreement paramedics.

Mr. Milloy: But is that a commitment, then, that over time that 100% of the medical personnel will work for the—

Mr. Bates: Yes.

Mrs. Liz Sandals (Guelph–Wellington): Just to follow up on that, I get how the 24-hour dedicated fixed-wing and rotary-wing would work in terms of a private aircraft owner having a contract to have this many aircraft in these places 24 hours a day, and it's going to evolve so that the OAA employs paramedics. I presume the paramedics the OAA employs will be based in the same community as those 24-hour dedicated aircraft are based.

What I don't get is the standby. If you have a standby contract for a fixed-wing airplane, I assume that one day you're doing a medical transfer and the next day you're transporting flour or food into the grocery store or something; right? Yes. So you're doing different things each day, depending on where you're called. How do the paramedics work in those cases where you never know whether today you're shipping flour or patients?

Mr. Bates: That's a good question. Some of these standing offer agreement—and that's what you're referring to—operators in fact provide aircraft around the clock, because it's good business for them. They stay on air ambulance. But there are some that do exactly as you say. From day to day they change the type of business that they're in sort of thing.

Mr. Bisson: Mostly doing federal transfers.

Mr. Bates: Yes. They have a number of aircraft. They may devote a portion of their fleet to medevacs, as we call them; okay?

Mrs. Sandals: When we talk about medical transfers we're talking about scheduled medical transfers. So you say today, Wednesday or Thursday or whatever today is, "Next Friday this patient needs to be transferred to

Thunder Bay because they're having an operation." So you're booking a charter a week in advance, which means that there is a paramedic required to go with the person. Do you book that a week in advance, too? Or a nurse or something?

Mr. Bates: There's some of that, but most of it is in fact on an emergency basis or at least on an urgent basis, if you will: if they require, within four or five hours, assistance and movement of the patient. You're asking, I think—correct me if I'm wrong—about the paramedics working for those particular companies because they're not guaranteed a job the way the dedicated paramedics are. Is that correct?

Mrs. Sandals: Yes, and particularly if, as you're telling me now, it fills the gaps in emergency, everything that's dedicated is out. Now we have to call one of these to go in for an emergency.

Mr. Bates: There are paramedics in every one of these towns, cities and villages working for the land ambulance system. Some of them in fact are working in hospitals and they can be utilized on board those types of aircraft. Those companies may have some dedicated staff because they have sufficient business to utilize those paramedics on a very regular basis and thereby efficiently pay their wages. But there are on-call paramedics, a roster, if you want to call it that, similar to what a hospital would have; a roster of individuals who they can call in when the need is there. That's what happens: They will have that type of availability of people who they know, and they will call when a flight is requested by our air ambulance dispatch centre. They will call those paramedics in to work on that particular flight.

Mrs. Sandals: So as the OAA takes over the responsibility for paramedics on this standby, will they have the flexibility to say, "In this location, standby is used frequently, so we'll have somebody that we pay to be the standby paramedic, but in other locations the standby is used infrequently, so we'll contract with some other organization to borrow a paramedic as required"? Will the OAA have the flexibility to come to different sorts of arrangements depending on the—

Mr. Bates: This would be up to them, to develop their plans. But having employed all these other paramedics in the same organization, this is an advantage that they have over other entities. They already have a basis in the sense that they've got paramedics in, if you look at the map again, Moosonee, Kenora and so on. Wherever the dedicated bases will be, they will have paramedics there, a number of them; 12 to 14 paramedics will be available in each one of those places

Mrs. Sandals: So they could take somebody who's posted in Kenora and say, "We're going to have to pull in the standby aircraft, but we can also pull in one of the paramedics that we're already employing anyway to go on the standby aircraft," and we're already paying them anyway.

Mr. Bates: Yes. That's one of the advantages of the OAA. I'm sure they will still maintain a roster because that's a good way of doing it, but they also have this extra flexibility.

Mrs. Sandals: Okay. Because as you showed flight plan, the rotary-wing thing up in Gilles's riding, but we've still got a paramedic to spare in Kenora.

Mr. Bates: That's right. They're based there.

Mrs. Sandals: Okay. I get it now, finally. Can we go back—

The Chair: Could I just ask a supplementary? We're going to a more expensive, costly system by doing this, in terms of the paramedics. Is that correct? Basically you're going to have new contracts, more full-time paramedics rather than part-time paramedics filling in these particular roles and people having dual roles in terms of the hospital. It's going to be more expensive. Is that correct?

Mr. Bates: The agreement with the OAA calls for the same funding that we have in the base at the Ministry of Health and Long-Term Care for air ambulance. It will be no more expensive for the government to provide that type of service.

What you're saying is quite valid in the sense that the OAA will have to look at those particular aspects and make decisions internally as to what is the best, most efficient and, as you indicate, the least costly method for providing the service.

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The Chair: As well, are we going to get some kind of break on the existing contracts we have with the providers because they are no longer responsible for this function? In other words, you're taking a huge burden off the backs of the contractees with regard to their responsibility to provide the paramedics.

Mr. Bates: Yes.

The Chair: The government is now taking this on their shoulders.

Mr. Bates: In essence, prior to the OAA, prior to January, the government was funding the carriers dedicated both for the provision of aircraft and paramedics. Subsequent to the OAA assuming responsibility last month, the government is paying the OAA the total cost of it. The OAA, of course, is paying less, as you indicate, to the aircraft provider and they're assuming the cost directly of paying the paramedics.

The Chair: Yes, but the payment for the paramedics is one thing. The administration and the headaches of getting the paramedics in place and being ready to be in place is also a huge burden to take off the shoulders of the private providers. What kind of compensation is the government getting for that? Are we getting a break on that in addition to the actual cost?

Interjections.

The Chair: Just let me ask my question and see if we can get the answer.

Mr. Bates: The cost to the government remains the same. There is a cost associated with providing paramedics, you're absolutely right. You're right, there are difficulties associated with it and, you're right, it's being removed from the dedicated operator and given over to the OAA who now must incur those costs and, as you

said, those headaches. The cost to the government does not change.

The Chair: I don't believe that, because I know what's going to happen. As with CHC in terms of their ability to meet whatever it is now, these people who are getting on the plane are the responsibility of somebody other than the actual company that's running the plane so there are going to be conflicts associated with getting the paramedics to the plane. The plane provider is saying, "I've got my pilot there. I've got my plane there and there aren't any paramedics," or they say to the OAA, "You make certain that these people are here," and they just wash their hands of it.

This is a beautiful set-up for the providers of the planes. This is a beautiful set-up. I disagree with you totally. I think the person who is contracting to provide the service should be providing the plane, the pilot and the paramedics, and it's their responsibility to ensure the people are there. You're letting them off the hook and the government is going to get nailed with a lot of costs because you just can't do it as well as they can. You will not be able to provide it. The OAA, which is a non-profit organization—we've seen what a boondoggle non-profit organizations are when you look at the GTAA, the Ontario—

Mr. Bisson: I strongly disagree.

The Chair: That's fine, but I'll tell you, this is the wrong direction to take.

Mrs. Sandals: As I understand it, however, no matter who pays for it, if you've got a plane that's sitting in the middle of a remote community, there's going to be challenges around paramedics. However, if you've got three different services all operating out of one location—for example, Thunder Bay—and you've got three different kinds of services—you've got the dedicated fixed-wing, the dedicated rotary and the standby—and formerly there were three different pools of paramedics, all three having to be maintained individually, the government was in essence by contract paying for three different pools, now we're consolidating into one pool of paramedics, which can be sent with whichever plane is going where. While we're never going to solve the challenges of paramedics that have to be picked up in remote communities, that's going to be a challenge of remote communities, just like professionalized service in remote communities is always a challenge. It doesn't matter how you model it. In the larger communities, where we've got larger dispatch centres, there may be some efficiencies by consolidating the pools of professionals. Am I getting the drift here?

Mr. Sapsford: Yes, you're understanding. The other point I'd ask you to consider just in this business about having the plane but not paramedics, remember that it's the responsibility of the corporation itself that's doing the dispatching. As they do the dispatch, they have to have the paramedics available to complete the call. You can't do one without the other. So the idea that you're going to dispatch and not have paramedics available but have a plane sitting empty all has to be taken together as part of that overall responsibility of the corporation.

Mrs. Sandals: Do I have one more question, Norm?

The Chair: Yes, sure.

Mrs. Sandals: This ties in to the dispatch. So everybody is being centrally dispatched from the base hospital in Sunnybrook for the whole province. Is that correct?

Mr. Sapsford: Well, from the dispatch centre, yes.

Mrs. Sandals: So there's one central dispatch system for the whole province. The auditor has raised some issues around dispatch times. I take it that there's a tie-in with the software here in terms of the ability to look at what the response times actually are. When I looked at that mock-up you had of the screen, it seemed to me that there were different types of transfers there but it didn't identify the urgency. I'm assuming that you, having identified the type of transfer, then have to fill in some additional information somewhere else about urgency.

Mr. Sapsford: Yes, behind each one of those screens is then the clinical information that's required to complete the transfer, and urgency is one of them.

Mrs. Sandals: Because the medical transfer could be anywhere from "We need this instantly" to "We need this two weeks from now."

Mr. Sapsford: Yes.

Mrs. Sandals: In terms of the software, are you going to be able to break that down into different standards for different types of responses and then look at that reaction more accurately in the future, so that we're actually looking at whether we do emergencies quickly and some of the other things that may take longer to arrange?

Mr. Sapsford: Yes. The idea here is that the standards themselves will be built into the software itself, so that as the dispatcher goes about their business of gathering the information and doing the dispatch, when the orders are issued, that will automatically flag the clock so that you'll be able to automatically calculate these sets of management reporting, which would address some of the issues. The difficulty in gathering this information by hand is that you have to keep watching a clock for all of this, whereas the idea here is to build this right into the software.

Mrs. Sandals: So what the software will do is say, "Here's the start of the transaction; here's the time at the end of the transaction." That will be logged, which will automatically give you a response time. Then somewhere, as part of the process of that transaction, you'll have codified it level 1, 2, 3, 4, so you'll then be able to analyze and monitor properly what you're getting in terms of different types of service.

Mr. Sapsford: That's correct. Part of the accountability agreement between the ministry and the corporation is the specification of the standards and the reporting that we would require in order to monitor that appropriately.

Mrs. Sandals: So as we go to that new software, then, that's one specific thing that has been addressed in the new software. What other opportunities are there to address some of the other issues with the new software?

Mr. Sapsford: Well, other issues we've talked about here: Reasons for cancellation is another obvious one;

response times is another one; compliance with other types of operational standards. There's quite a wide variety of things that you could build in to the measurement system, but you have to decide what it is upfront, and that's the discussion that we're undertaking now.

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Mrs. Sandals: Thank you very much.

The Chair: In terms of the OAA, who appoints the board of the OAA corporation? How is the board formed?

Mr. Sapsford: It's an incorporation under the Corporations Act. So they would be responsible for finding their membership and electing their board from the membership.

The Chair: Who's a member?

Mr. Bates: We can get that for you.

Mr. Sapsford: There would have been a starting list of membership. I don't know that as I speak, so we'll find that for you.

The Chair: So the government is not appointing this board?

Mr. Sapsford: No. It's a voluntary, non-profit corporation. It would be similar to a hospital board corporation or a hospital corporation.

The Chair: What does the CAO get paid a year? What is the salary?

Mr. Sapsford: That, I don't know. We can find that information as well.

The Chair: Could you provide me with how many positions are in excess of $100,000 a year?

Mr. Sapsford: That would be reported, yes.

The Chair: Thank you. Mrs. Munro.

Mrs. Munro: I wanted to ask a couple of questions. It's sort of following along the most recent theme on paramedics. Is there a difference in the training between that of someone who's serving in the land ambulance service and someone who's serving in the air ambulance service?

Mr. Bates: We have another chart, of course. This outlines the difference between paramedics: the primary care paramedic, the advanced care paramedic and the critical care paramedic.

The primary care paramedic is, if you will, the primary person on the land system. There are perhaps three or four times as many primary care paramedics in the system as any other type of paramedic. They provide, obviously, the basic care that a patient needs, including symptom relief, as we call it, semi-automated defibrillation, intravenous access and maintenance. So those are the skills of a primary care paramedic—two years through a community college to graduate as a primary care paramedic, certified by the ministry as an EMCA. That's the primary care person within the system.

Then there are advanced care paramedics. I think there are maybe 1,500 of those in the province out of 6,000 paramedics. They have not only the primary care, but built upon that are other skills, like medication, IV therapy, blood product, pulse oximetry, endotracheal intubation and all these other types of skills that they provide. They require an additional training period of about six months through a base hospital or a community college that happens to be able to provide that type of system. Most of the air ambulance system provides advanced care and/or critical care. Primary care is the standing agreement in some instances, but the bulk of the paramedics in the air ambulance are advanced care or critical care.

All of the paramedics in a dedicated aircraft, as I mentioned before, are critical care, and they must be for the type of patient care that's required. Medications, pacing, maintenance of arterial CBP and catheters, lab, management of chest tubes and balloon pump utilization—all of these are very high skills that must be provided. They're basically trained through Sunnybrook to come up to that particular skill.

We have another chart indicating how many calls are handled by each one of the flights. In 2004-05, primary care was 34%, advanced care was 21%, and critical care was 45% of the flights that were undertaken.

Mrs. Munro: The reason I asked was simply because of the conversation we had a few moments ago about the fact that these people would then be moving from being part of the provider, whether it's fixed-wing or rotary, to now being part of the overall OAA. So my question really has to do with the methods the OAA is going to use to be able to demonstrate the kinds of efficiencies that come with having brought everybody into that same framework.

My concern is that, obviously, looking at the maps you showed earlier—the paramedics who would be on-site at all of these various places and the kinds of costs that would be associated with, as you showed us, for instance, going from Winnipeg to Moosonee and things like that—these people are going to be, I would assume in a fairly regular way, outside their own home base, like nightly, so there would be a lot of costs associated with the fact that to get back to their base may be overnight, may be an extended period of time. I'm not sure.

I'm wondering if you are looking at the methods by which you can create those efficiencies through deployment, and if this new organization then will be able to demonstrate that that kind of analysis of deployment—because to me that's the only purpose of changing from the relationship with a service provider to providing the staff now in the form of the paramedics. I'm looking for some evidence of that kind of analysis of deployment that would demonstrate those kinds of efficiencies.

Mr. Bates: Most of the critical care paramedics, as we said before, are on the rotary-wing services. That's London, Toronto, Ottawa, Sudbury, Thunder Bay, Kenora, Moosonee. Those aircraft have a range—I'm sure Mr. Bisson would be able to confirm—of maybe 300 kilometres. So they go out from Toronto up to the Bruce Peninsula and back. Generally, they're back from that flight. They don't overnight unless there's a problem with the aircraft or weather. Those particular paramedics are always back to the base, and if their time is up, there's another crew waiting to take over from them.

There is very little of that sort of accommodation cost associated with the rotary-wing, simply because it can only fly so many kilometres and they must get back. They have to get back because they're carrying urgent patients anyhow, so the idea is to get back as quickly as they can to the tertiary care centre.

Having said that, the fixed-wing critical care in Timmins and Sioux Lookout is what you're talking about. They make the longer trips, perhaps from Sioux Lookout to Toronto or whatever the case may be, and they do incur those particular overnight costs because they run out of flying time or they simply have to overnight. But it's not a large cost associated with it. I don't think that will change, because that's based upon the demand and the need in the hospital system in the province. We can expect that to basically remain the same no matter what the system is.

We also have a slide, if you wish, on the benefits of the new system, which might give you some insights into what we see as anticipated benefits from the consolidation within the OAA. Of course, the basic thing is the patients, because they're the ones we must focus in on; they're the reason that there is an air ambulance system. So it's improved patient care because they become the sole employer of paramedics, and rightly so. We've discussed that previously. The benefit is greater flexibility to ensure the right care is available on all flights. Patients receive the right paramedic level of care and the right aircraft because it's being analyzed at all times. When the call comes in, the medical analyst has to take all the information. It takes five minutes.

You'll see, again, "Reaction Times" listed in the Auditor General's report. There's a reaction time for the medical analyst to assess what is the need of a patient, what type of paramedic we need and what type of aircraft we need, and then it's given over to the flight planner as to where it is the aircraft will be sent from. So there's improved patient care from the right paramedics, the right aircraft and the medical oversight, because now it's all consolidated together. The doctors are in the same area, working for the same organization as the paramedics, as the dispatchers. It's consolidated, and there's obviously going to be a better opportunity to provide better oversight and better care as far as that goes.

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Public—there are all sorts of benefits for the public as well, and we've talked about some of these: improved service delivery, new medical dispatch protocol, greater access to air ambulances in the north. We are integrating air ambulance services and resources more effectively in the northern communities, as we discussed.

Air ambulance service providers: continuation of existing contracts, and the ministry retains control of the hangars. While it's an aside, that is another aspect of competition that will be assisted. If it is another competitor that, in fact, receives a contract in the future, the ministry has control of the hangars for the rotary wing and the fixed wing in each location. So, whoever the contractor who comes in might be, we know the hangars are there. That's an integral part of a provision of air ambulance services. You must have the right type of hangars.

There are benefits for the health care system, part of which the deputy outlined previously: clinical expertise; operation responsibility. This all relates to what was recommended by the Commission on Accreditation of Medical Transport Services when they looked into the air ambulance system in the province and recommended the type of consolidation that the OAA provides to the province. This is an internationally known organization that looks at air ambulance providers across the world, and at this particular time there are only two that are, in fact, accredited by this organization: one in Alberta and us in Ontario.

Greater opportunity for research, because, obviously, the doctors now have the opportunity to look at things. The doctors at Sunnybrook are very organized towards looking at the research side of things and doing studies there on medicine for evidence-based health care decision-making, which is, again, part of the ministry's viewpoint: evidence-based decision-making for health care. That's very important.

Clarified lines of authority and responsibility through this new system: Again, I think the deputy alluded to most of these for the Ministry of Health and Long-Term Care. That allows the ministry, for instance, to focus on stewardship and oversight of air ambulance systems, such as setting air ambulance policy and standards, certifying and monitoring, inspecting air ambulance operators and paramedics, investigating incidents and complaints, and ensuring accountability objectives and a stable funding program. We have a stable funding program in the agreement with the OAA.

Paramedics—big advantages for the paramedics. Some of that, again, was alluded to by Ms. Sandals. That is, they have a training plan which focuses not only on clinical competencies but also on career. They can move up in the organization, they can move throughout the organization and across the province. They're not restricted to one operator. The whole province is there. They're setting up educational programs, programs to allow paramedics to pursue studies at work and programs that meet or achieve the competencies required for Canadian Medical Association accreditation. Of course, there are benefits for the Ontario Air Ambulance Services Corp., because they have an agreement to fulfill under a ministry agreement, and they employ the paramedics to provide greater flexibility to deploy paramedics where and when needed.

So you can see it's an advantage for all parts of the system to go with the consolidation of air ambulance under the Ontario Air Ambulance Services.

The Chair: Mr. Bates, could you provide the committee with the benchmarks and the measurements that are going to be necessary for us to evaluate whether or not this move was, in fact, successful, over the next few years?

Mr. Bates: Yes.

The Chair: So you'll give us, in writing, the benchmarks and the measurements that you will be using as we go forward?

Mr. Bates: Of course.

The Chair: Did you have any more?

Mrs. Munro: No, that's fine.

The Chair: I think Mr. Patten had one short question as a supplementary to one of the questions I asked.

Mr. Richard Patten (Ottawa Centre): My question is, does the government appoint any members at all to the board?

Mr. Bates: No.

Mr. Patten: Why not? We appoint people to hospitals, hospital boards and all kinds of things.

Mr. Sapsford: Only on very rare occasions are there provincial appointees on hospital boards. Those hospital boards are non-profit, private corporations under part IV of the Business Corporations Act.

Mr. Patten: They don't feel that way any more, believe me.

Mr. Sapsford: Well, legally, that's how they're constituted. As I say, there are a few hospitals in the province that have provisions for provincial appointees in their constitutions, but they're viewed as arm's-length organizations. This Ontario ambulance corporation has been structured in a similar way. But as I said before, we'll provide the details to the committee.

The Chair: Mr. Bisson. I'd say to the other members that we do have sandwiches next door, if you want to grab those as we finish up. I think you'll probably be the last questioner.

Mr. Bisson: Just a couple of quick questions; I don't have a lot of time.

I've got a particular individual who contacted me in my constituency who's in a bit of an odd position. In the transfer from the previous operator to the new operator, there seems to be some kind of a glitch in getting him transferred over. That is, he is a flight paramedic, he's been doing it for years, but he doesn't have a driver's licence. Because he doesn't have a driver's licence, there is apparently a rule that you guys have that you can't be a flight paramedic. I assume he doesn't need the driver's licence to pilot the airplane and I assume he's not going to be driving an ambulance. Why would you have that requirement?

Mr. Bates: It is in the legislation for a paramedic to have an F licence: He's right and you're right. There are occasions—it has happened and I'm sure it will happen in the future—in which the paramedic must in fact be available to drive a land ambulance, because at each end of a flight by an air ambulance, there is a land ambulance.

Mr. Bisson: Waiting, with a driver.

Mr. Bates: There have been circumstances in which a flight paramedic has been required—and in fact in some instances in the past, we had domiciled an ambulance at a hangar, for instance, for a dedicated aircraft, and utilized that, because sometimes there are delays in moving patients from the airport to the hospital. So you have to be considerate of that.

Mr. Bisson: I know that talking to the flight paramedics—the ones I've talked to, because I checked this out when I was out at the airport one day when the guy raised it with me, and I said, "How many times have you had to drive an ambulance as an air paramedic?" The answer was, "Never." The people I've talked to—and it's obviously not a conclusive survey. Of the two or three paramedics I've talked to—I'm talking flight paramedics—they have never had to do it, and they have 15, 10, 20 years of service. So what can we do for this guy? He's lost his livelihood, for God's sake. Are you going to fix it for me? Just say, "Yes."

Mr. Sapsford: We would rather say, "We'll go back and look at it." But if it's a legislated requirement, then—

Mr. Bisson: You're going to throw it back at me, is what you're going to do.

Mr. Sapsford: Let us go back and look at the requirement.

Mr. Bisson: There must be something under the regs. Again, I've got your card and I'm going to give you a letter on that. We've actually corresponded with the ministry, but I think my staff sent it to the minister's office when it probably should have been sent to you directly. Anyways, I just thought that was kind of interesting.

There is another thing that I ran across. It was a bit troubling, and I didn't get a chance to talk about it earlier. Again, this was just in meeting fellow pilots around the province. I was in Sudbury a while back, and there was a very frustrated air ambulance pilot who felt he was being pushed, a couple of days previously, to make a choice to fly when he thought the conditions were not conducive to flying. He was quite angry about it because he was saying, "The rule is, the pilot's in command." You make the decision: go, no go. It's not a dispatcher, it's not the chief pilot of the airline, it's you, as the pilot, in command of the aircraft.

I was just listening in to talk; I was getting some fuel there, maybe about a month ago. This particular guy was talking to his co-pilot. They were having quite an animated discussion about this, so I decided to find out more about it. It seems that, for some reason—and I don't know if it's particular dispatchers or there was some change within the operation of your organization. It's not a prevalent thing, but it's happened a couple of times. That troubles me both as a potential patient who may need to be transferred and for the safety of the crews.

Mr. Bates: You're absolutely right. It should not happen. The pilot has control over the aircraft and makes the decisions. In fact, if it happens, we should investigate, because it's not something that we can condone in any way.

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Mr. Bisson: We all know, as pilots, we're really macho; right? We like to show that we can fly in the worst of conditions and get from point A to point B. We can't put people in a position of forcing—what I thought

was interesting with this one is that because this particular pilot had refused, the dispatch centre had called the chief pilot of the airline in order to say, "Your pilot made a bad decision." These guys get licences, these women get licences because they make good decisions. They do check rides. You watch them. So please talk to your dispatchers, if you could.

Mr. Bates: Yes.

Mr. Bisson: The other thing I wanted—I've got six minutes; I can probably do this. Have you ever tried to do this without your glasses, Chair? I've written little notes here, and I just can't see a thing without my glasses.

Mrs. Sandals: Would you like me to come and help you?

Mr. Bisson: I probably can't read through your glasses, either.

Yes, there was the pilot issue, and I've got another one here. One of you had raised the question—it might have been you, Norm; I forget who it was—of having different service providers. You have dedicated providers who basically do the traumas. They're the people who are paid to be on call 100% of the time and fly people from point A to point B. You then have others who do air ambulance transfers, which is quite a different part of the business. You call those—what's the term for those, again?

Mr. Bates: Standing agreement.

Mr. Bisson: Yes, they have standing agreements; that's right. One of the odd things in the standing agreements is that it's much more lucrative for the aircraft operator to say no to a transfer if they have a charter, because a charter, quite frankly, pays more in some cases, depending on what the charter is, than they would get through the standing agreement with the Ministry of Health. I know it's a source of a bit of frustration because I've talked to some of your operators out of Timmins and Thunder Bay about this particular issue. I'm one who charters quite extensively on the James Bay coast, and I know that Howard does the same up in the northwest, so I've had a chance to talk to different operators. I've just asked them that, because it seems to me that somehow or other it's a bit of a disservice to the transfers. The doctors at the hospitals then are a bit frustrated because they can't move the patients out when they'd like to transfer them out.

They thought they had an airplane, but they lose the use of the airplane. There's nothing in the contract to say that if Richard Patten has an airline company and you're on a standing agreement with the Ministry of Health and they call you to say, "You're going to have a transfer at 5 o'clock this afternoon from the Ottawa hospital" to wherever—if you get a call for a charter that pays more money, nothing beholds you to do their flight. It just seems to me an odd way to put an agreement in. It seems to me that you should have something in the agreement that basically makes sure that the plane is reserved for the use of the transfer.

Mr. Bates: I understand your point of view, but there are two other points of view. One is the competitive nature that we've already heard about. That is a very competitive segment. As I indicated before, they all submit their bids twice a year. They decide what they need to make money on that particular work that they have. If it is indeed producing more revenue for them on the charter, as you call it, flying you to Moosonee or whatever the case may be, then obviously they're going to take the more lucrative work.

On the other hand, we have, as we discussed as well, a system of dedicated, and we try to make sure that there are sufficient aircraft available to handle the most urgent needs.

Mr. Bisson: I hear you. Just because we're running out of time, I don't want to monopolize whatever time we have left, but I'll probably do a good job of it nonetheless.

The Chair: I'm going to cut you off in about a minute.

Mr. Bisson: That's what I figured. I felt the gavel of the Chair coming.

My point is that for those with a standing agreement, it seems to me that you should reflect on finding some mechanism in your standing agreements to basically say to those people who are doing the medevacs that there's a disincentive for them to say no to you. I've seen, especially up on James Bay, where there's some frustrated hospital doctor—Dr. Trussler or whoever I might be dealing with—who all of sudden says, "Jeez, I was hoping to get this patient out, but I lost my airplane."

Mr. Bates: I understand that, and you're totally right. But they have the option of bidding a higher amount for another aircraft, for instance, that we could utilize if they felt that was in their best interest to do that.

Mr. Bisson: But in their submission to get the work, obviously they've got to be the lowest bidder to get the job.

Mr. Sapsford: Or some thought around things like if your refusal rate goes over a certain rate, then there's another consequence.

Mr. Bisson: That's what I'm getting at. I understand the financial side of it. All I'm saying is that we need to think, within the agreement, of some mechanism.

Mr. Sapsford: In terms of the service.

Mr. Bisson: That's all I'm saying. Thank you, Chair.

Mr. Sapsford: I understand.

The Chair: On behalf of the committee, I'd like to thank Deputy Sapsford, Mr. Bates and Ms. Burton. You'll be forwarding the requested information to the committee. We would like to get that—within a month or so is probably fine in terms of the time.

Mr. Sapsford: Yes, I think that's acceptable.

The Chair: For members of the committee, we'll grab a sandwich, come back and then just discuss our thoughts with the researcher.

The committee adjourned at 1157.

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