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Mercredi 16 septembre 2015

**Standing Committee on
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Ministry of Health
and Long-Term Care

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 16 September 2015

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The committee met at 1233 in room 151, following a closed session.

2014 ANNUAL REPORT, AUDITOR GENERAL MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 4.01, cancer screening programs.

The Chair (Mr. Ernie Hardeman): Thank you all very much. I thank everyone for being here. The committee is meeting this afternoon for consideration of section 4.01, cancer screening programs, of the 2014 annual report of the Auditor General.

We have with us this afternoon, from the Ministry of Health and Long-Term Care, Bob Bell, the deputy minister. Welcome. And from Cancer Care Ontario, we have Michael Sherar, president and chief executive officer; Linda Rabeneck, vice-president of prevention and cancer control; and Elham Roushani, vice-president and chief financial officer. Thank you all very much for being here to help us with this review.

We will have a 20-minute session of your presentation to talk about the report and your comments on it. Then we will divide the time equally between the three caucuses for questions about your presentation to help us along. The questions will start with the third party this afternoon.

With that, the floor is yours. If you would introduce yourselves as you start speaking for Hansard so we'll know who's who.

Dr. Bob Bell: Thank you, Chair. My name is Bob Bell. I'm the Deputy Minister of Health for the Ministry of Health and Long-Term Care. We're delighted to have the opportunity to address the standing committee and thank the Auditor General of Ontario for her report and her recommendations to strengthen cancer screening programs in Ontario.

I'd like to introduce my colleagues. Dr. Michael Sherar is president and chief executive officer of Cancer Care Ontario. In addition to this role, Dr. Sherar is also a professor of medical biophysics at the University of Toronto and a senior scientist at the Ontario Cancer Institute at Princess Margaret hospital. Dr. Linda Rabeneck, vice-president, prevention and cancer control: Dr. Rabeneck oversees CCO's prevention screening,

research and surveillance programs and is a professor at the University of Toronto, a senior scientist at the Institute for Clinical Evaluative Sciences in Toronto, and an esteemed international expert on the issue of integrated cancer screening programs. Thanks to both Dr. Sherar and Dr. Rabeneck for their leadership and commitment to continually improving the quality of integrated, organized cancer screening in this province.

With respect to the audit, the Auditor General's report laid out five key recommendations, with an emphasis on the quality and accessibility of integrated cancer screening services in Ontario. Dr. Rabeneck, when I'm finished, will actually respond to the recommendations.

Together, the ministry and CCO have made significant progress, we feel, in addressing each of the five recommendations and we remain committed to collaboration and ensuring that Ontarians have access to high-quality cancer screening services.

As you know, cancer is the second leading cause of death in Canada. In Ontario, 45% of men and 41% of women will develop cancer in their lifetimes. The number of new cancer cases is projected to rise by 40% in the next 15 years. Breast, cervical and colorectal cancer, the subjects of our integrated provincial cancer screening program, account for nearly 30% of newly diagnosed cases.

Early detection of these cancers through—and this is important—organized population-based screening can save lives and reduce the burden on individuals in the health care system. I can say for sure, as a cancer surgeon who practised in this province for 25 years, that despite the expertise of our excellent care providers in Ontario, the excellence of our cancer system, we'd all rather see a case of cancer prevented rather than treated.

Some cancers are indeed preventable. For example, screening is the only way to detect the early changes that might lead to cervical cancer. Up to 93% of cervical cancers are preventable through regular screening. The Integrated Cancer Screening Strategy led to the implementation of a coordinated provincial program administered by CCO for breast, cervical and colorectal cancer screening services in this province.

The Integrated Cancer Screening Strategy aligns with the minister's Patients First action plan, the next phase of Ontario's plan for transforming Ontario's health system. This strategy exemplifies the commitment to put people at the centre of the system by focusing on improved access to screening services and providing them with the

information they need to make the right decisions about caring for their health.

The primary goal of the strategy is to increase cancer screening rates, to detect pre-cancerous changes or cancer at an early stage, when there's a better chance for treating it successfully, and to establish the information management and information technology infrastructure that inevitably enables performance improvement.

In terms of our progress on audit recommendations, which Dr. Rabeneck is going to detail, the ministry takes seriously our commitment to safety and the delivery of high-quality, evidence-based cancer screening services in the province and works in collaboration with CCO to ensure that the Ontario Auditor General's recommendations are addressed and that all eligible Ontarians have access to high-quality screening.

We thought that the Auditor General's report was very positive, but there is still work to be done in addressing some of the recommendations that are more complex and require time to implement. We're confident that the ministry and its valued partners will build on the capacity created through the ICS strategy to ensure that Ontarians have access to the highest-quality screening services now and in the future.

I now would like to hand your attention over to Dr. Rabeneck, who will speak to the specifics of the Auditor General's recommendations.

Dr. Rabeneck.

Dr. Linda Rabeneck: Thank you, Dr. Bell.

Good afternoon, everyone. I wanted to start by saying that Cancer Care Ontario—and in particular, the screening program—we welcome the audit. We had a very collegial set of interactions as we were preparing the materials for the Auditor General's team. We felt it was a very productive exercise, and we're very proud to be able to summarize for you the tremendous progress that we are making in cancer screening in the province, and our responses to the report.

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I want to make two comments just before we go into the details of the report. First, as we all know—just to make sure that we're all on the same page—cancer screening is doing the test when you feel fine: no symptoms, no problems. If I'm a woman considering having breast screening—there's nothing wrong with my breasts; I haven't found a lump; there's no discharge; I'm not concerned about anything; I am fine. It's the same thing with cervical and colorectal screening. Screening is doing the test when everything is fine, and a potential participant is not aware of any issues with respect to the colon, rectum, breast or cervix. That's the first thing I wanted to say.

The second thing is that I wanted to underscore a point that Dr. Bell made: What we have here in the province for breast, cervix and colorectal—or the large bowel—are three organized screening programs. We make a tremendous distinction—and this distinction is made in all jurisdictions around the world—of the difference between organized screening, which requires significant

infrastructure, and there are important reasons for that, and opportunistic or ad hoc screening.

Ad hoc screening is when you go to your doctor—you're going in for a blood pressure check or a prescription renewal—and you bring it up or your doctor notes that you haven't been screened and makes the recommendation then. That conversation may occur; it may not occur. So it's opportunistic. If you don't see your doctor, you may not get the recommendation about screening.

Organized screening is defined by the World Health Organization. It has several key components. The first one is a very clear target age group—for each of the three screening programs, we have that—a very clear test to be used; and the intervals at which the test is to be repeated if it's negative. Mammography is every two years for a woman at average risk, for example. Mammography is for women at average risk of 50 to 74 years of age. I'm a woman of that age group; I'm to have mammography every two years. So: a clear target age group, a clear test, and a clear recommendation about the interval for repeats.

Furthermore—and this is crucial—in any organized screening program, there needs to be assurance that the person with the abnormal screen gets helped and navigated and moved to the diagnostic test that's recommended. If I'm a woman and have a mammogram and there's an abnormality found, the Ontario Breast Screening Program navigates me to the further imaging and the biopsy that are recommended. I get navigated to that next stage. In ad hoc screening, that doesn't occur.

Finally, there needs to be a way of measuring the impact of the screening program in the population. For that, we're blessed; we have the Ontario Cancer Registry. We register every Ontarian who has a new diagnosis of cancer. We know exactly how many people are diagnosed with the disease.

The whole point of organized screening is that quality is assured at every step of the way, whether it's the mammogram, the follow-up after the mammogram, if needed, or into the treatment phase, if needed—quality every single step of the way. The quality of the screening program is only as good as the quality of every single step. Screening is not a test; it's a process.

Finally, there are invitations sent to potential participants. In the case of breast screening, women in the province receive a letter of invitation to participate in breast screening; the same thing for cervical screening in the relevant age group: women 21 to 69 years of age; and the same thing with colorectal: men and women 50 to 74 years of age. Invitations to screen to a clear targeted age group—there's a clear test, with recommended intervals, a follow-up with those with an abnormal screen, and measurement and public reporting of quality every step of the way.

I'm making a big point of this because we have these three terrific organized screening programs in the province that we have implemented and are continuing to implement—as opposed to ad hoc screening. There's a consensus around the world that organized screening is

the way to go to ensure the highest-quality screening in any given jurisdictions.

Turning to the report: As Dr. Bell mentioned, there were five recommendations from the audit team, and within those recommendations there were two or three sub-recommendations, so there were a total of 10 altogether. I'm very pleased that we've been able to fully implement seven of these since 2012, which was the time of the audit. We have a terrific team working on this and we've done, I think, some terrific work.

What I would propose to do is to quickly go through each of these, highlight for you what we have achieved and indicate those areas in which we have work under way.

The first three recommendations were on the three screening programs themselves. The first one is breast screening. Two items were noted: to periodically evaluate the wait times at the screening facilities and to take measures to increase our capacity for genetic assessments. This is particularly for women at high risk in our High-Risk Ontario Breast Screening Program. I'm pleased to say that we've fully implemented both of these.

I should have noted in the beginning that with the Ontario Breast Screening Program, for women at average risk, aged 50 to 74, it's a mammogram every two years. For women who are at high risk, we launched in July 2011 the high-risk breast screening program. We were the first and only province to launch a high-risk screening program and, to our knowledge, to this day we're the only jurisdiction in the world that we're aware of that has an organized screening program for women at high risk of breast cancer. We're very proud of that launch, and we are measuring our wait times and our cancer detection rates for those women at high risk.

Who are they? They're women aged 30 to 69. There are four categories that we invite into the program, but the main one is women who are known to be gene mutation carriers or a woman who is a first-degree relative—a close relative of someone who is a proven gene mutation carrier. If I had a sister who's a proven BRCA1 or 2 carrier, I don't need to be tested; I'm considered at high risk and I can enter our high-risk screening program.

The OBSP high-risk screening program is annual mammography—it's not every two years; it's every year—and it's also annual MRI, magnetic resonance imaging, another type of imaging. We have terrific high-quality screening for women at average risk and women at high risk for breast cancer in our province, and we have fully implemented those first two recommendations that mainly relate to our high-risk program.

The second recommendation related to our colorectal screening program, which is called ColonCancerCheck. Here, there were two recommendations. The first one was to address concerns that doctors have around the stool test that we currently use, which is the fecal occult blood test, or FOBT for short. The second one was to explore ways of improving wait times for colonoscopy.

With respect to the fecal occult blood test, we are working towards replacing that with another stool test called the fecal immunochemical test, or FIT, which is a superior test. We will have that fully implemented by 2016-17. That is the first recommendation of the ones we have talked about so far where work is under way but it's not fully implemented. So we're switching out the current one, the FOBT, which was launched in 2008, for a better test, the fecal immunochemical test.

The second recommendation for colorectal screening relates to the wait times for colonoscopy. Those are improved and we have completed that undertaking.

The third recommendation relates to cervical screening, and there were three recommendations. I won't go into detail here. This one is fully implemented. It relates to targeting promotional and educational efforts to increase participation among women in the province. We have a set of measures that we've taken there. The second one was educating the public and health care providers on appropriate cervical screening intervals—I'll talk to that in a moment—and thirdly, monitoring wait times for colposcopy. Colposcopy is the test where, if I have a highly abnormal PAP, I'm recommended to colposcopy, where the gynecologist does a pelvic exam, but looks directly at my cervix with a magnifying glass to see abnormalities. We are now measuring the wait times for a colposcopy and beginning to collect data from colposcopy sites in the province. That one is implemented.

Around the education, we've done abundant education around cervical screening. We updated our cervical screening guidelines in the spring of 2014 and disseminated them widely around the province. We changed the age at initiation of Pap testing and have disseminated that widely. It has had quite a significant impact. So those recommendations around better communicating the Ontario Cervical Screening Program to the public and to physicians, we have fully implemented.

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The fourth recommendation was addressing initiatives to improve participation in our three screening programs. We have fully implemented this. We have a suite of measures that we have put in place, since the original audit, addressing participation. But the most important one that I wanted to highlight was that, at the time of the audit in 2012, we did not send out correspondence—that is, letters of invitation—to all those three target age groups for each of the screening programs I mentioned. We had some correspondence, but it wasn't fully implemented. Today, and as of March 2015, in a terrific piece of work by our team, we've fully implemented correspondence—that is, letters of invitation—to the target age group for each of the three screening programs. We don't yet know the impact of that tremendous implementation of correspondence, letters to invite people to participate. It's too early yet to know the impact of that, but that was quite a significant undertaking and achievement. We have no doubt that that will have an impact on our screening participation rates. We have a

number of other measures that we've implemented to raise participation, but that really is the main one. So that one is implemented.

Then, the final recommendation is not fully implemented, but the work is under way. We have a tremendous team on this. This is to ensure that Ontarians are receiving high-quality cancer screening services whether they are provided under our screening programs that I just described to you or whether they are receiving the services from other providers outside the program. So you might say, well, what the heck is that? I described to you the Ontario Breast Screening Program. Today in this province, of the women who undergo screening mammography, 75% receive their mammograms within the Ontario Breast Screening Program and therefore benefit from all of the quality measures that we've described, and many others. Twenty-five per cent of women who have mammograms for breast cancer screening are screened outside the Ontario Breast Screening Program today. We haven't fully completed the work to transition all the non-OBSP mammography into the Ontario Breast Screening Program. That is a piece of work that's under way. We've begun to transition, but we're not fully implemented. That will be implemented fully at the end of the next fiscal year. So we have a team on that.

We also have a team on—there are individuals whose information is not fully captured for the Pap testing, for the cervical screening program. You might say that they are screened outside of our Ontario Cervical Screening Program. Who are they? Well, it turns out that the information that we receive at Cancer Care Ontario—we have tremendous data holdings. For women who have their Pap test done at a hospital, we don't have that result information. For all the other women who get their Pap test done not at hospital sites, we have the information. So we're missing about 15% of Pap tests currently in our data holdings at Cancer Care Ontario. Again, we have a team on this, working to bring all the information about all the Pap tests—regardless of where they're done, whether in hospitals or not in hospitals—into the cervical screening program. So that is a second piece of work that's under way.

Just in summary I would say that of the 10 recommendations, we have fully implemented seven of them and we have teams with a great deal of active work under way to complete the remaining three.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will now start with the questions, starting with the third party.

M^{me} France Gélinas: Chair, could you tell me how much time I will have in my first rotation, just so that I use my time wisely?

The Chair (Mr. Ernie Hardeman): It will be 20 minutes in the first.

M^{me} France Gélinas: How many rotations do you figure we'll get?

The Chair (Mr. Ernie Hardeman): Well, we have two hours.

M^{me} France Gélinas: So I'll get two 20-minute rotations.

The Chair (Mr. Ernie Hardeman): Yes. The second one may not be quite a full 20 minutes.

M^{me} France Gélinas: Eighteen?

The Chair (Mr. Ernie Hardeman): Something of that nature.

M^{me} France Gélinas: All right, then. I'm 30 seconds late, so I'll have to speak fast. Nothing good comes when I speak fast.

I don't know if you guys have chapter 4 of the audit—what we're talking about. Because in my first 20 minutes, I will go through the report and ask odds and ends questions that came up with the report.

If you have any interest, I'm on page 437, way at the bottom. That was part of the background, and it reads: "Mammography screening wait times for women with average risk for breast cancer ranged from just ... two weeks to 10½ months; and Cancer Care Ontario found that for women considered at high risk for breast cancer, wait times for genetic assessments of screening eligibility averaged 84 days."

It surprised me. Two weeks to 10½ months: This is a big range. Are there patterns? Are we quicker in small, rural hospitals and there's a big backlog at UHN? How does that divide up geographically or by size of facilities or whatever else?

Dr. Linda Rabeneck: Thank you for your question. In fact, we had quite a discussion with the auditor team around this wait-time estimate, which was not a figure that we provided based on information that was provincial in scope. I believe that it was obtained from either one large hospital, or from a review of charts at one or two facilities. It's just not the case that women wait 10½ months for their mammography, for breast screening. There may have been some charts that were reviewed in which this appeared to be the case, but we don't have wait times of 10½ months for screening mammography.

M^{me} France Gélinas: What would you say it is, then?

Dr. Linda Rabeneck: Well, it's probably on the order of—it would be better if I actually got the number for you. I'd be happy to do that.

M^{me} France Gélinas: Okay. But you know that it's not 10½ months?

Dr. Linda Rabeneck: I do.

M^{me} France Gélinas: Would it be 9½ or—

Dr. Linda Rabeneck: No, no. A matter of weeks.

M^{me} France Gélinas: A matter of weeks?

Dr. Linda Rabeneck: Yes.

M^{me} France Gélinas: Okay. Does the team from the auditor—I can ask them later as to where the 10½ comes from.

The next odds and ends question that I have is on the following page. It starts with "Cancer Screening Programs ... Recommendation 1," and it ends with, "Cancer Care Ontario should periodically evaluate the wait times at each of its screening facilities." You told us that it was fully implemented. Is this information that is easily available publicly, or is this information that is

available to you and the hospital in question, but nobody else?

Dr. Linda Rabeneck: I'd just say that in terms of the information, we have a system whereby in each of the LHINs, or regions, we have a regional vice-president, and the screening program provides support for a screening team in each of the LHINs. We have regular calls, monthly, with our screening team and the team in each region and provide for them detailed information on how many people have been screened, how many people have been navigated and all this detail. So we have exquisite detail in these regional calls, with the regional cancer screening teams.

In addition, we roll up, if you will—this is at individual facilities—at the regional level—

M^{me} France Gélinas: Which is at the LHIN level?

Dr. Linda Rabeneck: At the LHIN level—every quarter. We have good information. I'll give you a good example for the Ontario Breast Screening Program. One of the wait times that we do track, which is a very important one, is for when a woman has an abnormal mammogram and she requires a biopsy to determine whether or not she has cancer. For every single woman in the Ontario Breast Screening Program, we measure the time from the mammogram to when she gets that tissue biopsy. The target—it's a national target, actually—is seven weeks, and we measure provincially what our achievement is, and we measure for each region exactly what that achievement is. I actually can show you in one moment, if I look through my papers, exactly what it is region by region. That information is reported in the quarterly meetings with the LHIN-based cancer team. That's the kind of systematic approach we have to measuring access to biopsies.

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Dr. Bob Bell: If I could just fill in one other detail, you'll see reference in many of the materials to CSQI, the Cancer System Quality Index, which is the product of North America's first systematically established quality council. It began in 2002. It publishes an annual survey of cancer system performance, looking at Cancer Care Ontario's data, in a very publicly accessible website, www.csqi.ca. That's one of the indicators that is included: time from abnormal mammogram to biopsy or evaluation.

M^{me} France Gélinas: My question was: How public is that information?

Dr. Linda Rabeneck: That one's publicly available.

M^{me} France Gélinas: So the area where that becomes public is through the CSQI website?

Dr. Linda Rabeneck: Yes.

M^{me} France Gélinas: They may be quarterly, but before this data gets rolled up, years go by.

Dr. Linda Rabeneck: I would say, as Dr. Bell has pointed out, if you go on the Cancer Care Ontario website and you look for Cancer System Quality Index and click on it, and then click on breast screening, then you can open the graph up and you can see exactly this

indicator again: What the national target is, what we're achieving provincially, and each LHIN—how it's doing.

Dr. Bob Bell: That's reported annually, and it's frequently reported in the local press as to how one region is doing with respect to provincial performance.

M^{me} France Gélinas: It is made public, but the quarterly information is made public how far down the road? If we click all of this right now on your website, we're not going to see the data from June 2015; we're going to see data that dates from 2013-14.

Dr. Linda Rabeneck: That's correct. The more recent information, to your point, is the basis of these regular calls with the regional cancer screening team in each of the LHINs.

M^{me} France Gélinas: So I guess my question is a bit like—why the delay? I understand that you have a team that keeps track of it in a serious manner and an effective manner, and you are open to making that information public—obviously, I can click—but why is there a lapse in time in between your keeping close tabs of it monthly, and the website being 2013-14? I'm in September 2015.

Dr. Linda Rabeneck: The main point of providing it—it's not just us keeping close tabs on it—and having a discussion with the regional cancer screening team is so that they can take action. It gives them an early indication if their performance was exceeding our target—80% of biopsies done within seven weeks for women with abnormal mammograms, which we do meet on the provincial average—but if they're in a LHIN or a region that's not quite meeting the 80%, then they'll know within three months, without waiting for a year, whether they're meeting that target or not, and then they can take action. So it allows them to adjust their own work in the region or the LHIN.

M^{me} France Gélinas: I'm now on page 439, and I'm still on the details of recommendation number 1, and they say: "The changes"—I'm in the middle of the first paragraph—"The changes included moving from funding nurses who help clients navigate the system on a rate-per-case basis to funding an allocated position," which I completely support. Is this common within Cancer Care Ontario that screening would be paid by case rather than by position? Give me a sense as to the payment structure of all our screening programs.

Dr. Linda Rabeneck: On this one with respect to page 439, your question relates to, I think, the high-risk Ontario Breast Screening Program.

M^{me} France Gélinas: It does, but my question expands beyond this. It just flagged for me that I was surprised that—well, first of all, that came as a surprise. I always thought that nursing positions were funded as 0.5 or 0.7 or full-time positions. I was surprised that Cancer Care Ontario would fund nursing positions per case. I'm just wondering, is the per case payment common within the screening programs at Cancer Care Ontario?

Dr. Linda Rabeneck: The short answer is, "Not so common," but I'll explain this one. As I mentioned, the high-risk Ontario Breast Screening Program, the high-risk OBSP, is one of our most recent achievements. It

was launched in July 2011, so it was new. At the end of our first year of implementation, we had an evaluation. We conducted an evaluation of the performance, and we learned some things.

One of the opportunities that we learned about was—we did have an opportunity to adjust the funding model for navigation of women in that program, so adjustments were made to the funding model specifically for the high-risk OBSP.

It's a new program, and it's fair to say we felt that in retrospect, when we first set forward, we didn't have the funding component set at what it should be, so we made these changes. But that piece there reflects the changes that we made to the high-risk OBSP.

M^{me} France Gélinas: Maybe I will ask—I forgot your name, but I know that you're in charge of the financial aspect at Cancer Care Ontario.

Interjection.

M^{me} France Gélinas: The microphone will come on. They control them.

Mr. Elham Roushani: Okay. Elham Roushani. We at Cancer Care Ontario do not directly employ nurses, as your question, I think, was referring to. But when we do formulate the funding models, we account for, basically, the nurses' time with respect to navigating these cases. That's what this is about. This is not about paying nurses on a per procedure basis, but at Cancer Care Ontario, we do pay for certain procedures to providers on a per episode of care basis.

M^{me} France Gélinas: Could you name me some?

Mr. Elham Roushani: For example, in 2014-15, we implemented—for chemotherapy there are various bundles of care; for GI endoscopy, there are various bundles of care, which incorporate all the care providers in different—it's a complex funding formula. Nurses are included; their time is included in there.

Based on that, we're not paying the nurses directly in this case. We're paying the providers. But in order to capture the entire episode of care, and price it and cost it, we need to be able to calculate all the contributors to that episode of care and price it. That's how this is done.

Dr. Bob Bell: I can speak as someone who used to be in charge of the biggest cancer centre in the province. This method for providing funding ensures both quality and also efficiency, in that you're being paid not a global fund but, rather, you're being paid on the basis of the work that's done. There are always quality parameters associated with the work that's done, so it's not just a question of you have to put a patient through; you have to measure the quality elements attached.

There has been a tremendous difference to the quality of cancer care in the province as this pay-for-performance approach has permeated virtually all the cancer system.

M^{me} France Gélinas: Okay. I'm moving on. Still on page 439—that's for the FOBT being transitioned to FIT. From 2008 to 2017, we will have used the FOBT, and then we will transition. If it's a better test, it seems like it's a little bit slow, but I'm sure there's lots to be done.

So give me an idea as to why is it that we're not happy with FOBT, why is it that we will be happier with FIT, and why is it that it will take us two and a half years to get there.

Dr. Linda Rabeneck: Good question. I'll back us up. Minister Smitherman made the announcement of funding for ColonCancerCheck in January 2007. The public launch was actually in April 2008, but 2005 was when we submitted the actual detailed plan around the colorectal cancer screening program, what became ColonCancerCheck, that was to be provincial in scope.

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The recommendations we made in there were based on evidence available at that time, the best evidence, and the best evidence supported by evidence-based guidelines around the world, including our own Canadian Task Force on Preventive Health Care, which is a blue-ribbon panel. The Canadian Task Force on Preventive Health Care had an existing recommendation that said every Canadian province should, at a minimum, implement the fecal occult blood test, or FOBT, at a minimum done every two years. That was the existing evidence-based recommendation.

We always knew that there was more evidence to come for other tests, and we had our eye on the fecal immunochemical test, but no jurisdiction went with the fecal immunochemical test in those days because the evidence wasn't sufficient to support it.

I should say that we were the first Canadian province to launch an organized screening program for colorectal cancer, and we're very proud of that.

England launched in 2006, two years before us, and they went with the fecal occult blood test. They're still using the fecal occult blood test, but they're also planning a transition. The Netherlands, which just launched one year ago, launched with the fecal immunochemical test, but prior to that, they didn't have any screening program.

What I'm describing is the acquisition of evidence—

M^{me} France Gélinas: It led to the change.

Dr. Linda Rabeneck: —from high-quality trials that basically did head-to-head comparisons with the fecal immunochemical test and the fecal occult blood test. We learned that the fecal immunochemical test did a better job at detecting cancers and did a better job at detecting the high-risk polyps, the precursor, the pre-malignant.

M^{me} France Gélinas: So my next question goes back to the other end of the table. Is there a difference in cost between those two tests, and what does that represent?

Mr. Elham Roushani: We're still in the pilot phase because these are kits that need to be developed and tested. I don't have that information for you right now, because we're still in the pilot phase with respect to the FIT test. There has to be laboratory testing to ensure the quality of the test. Once our pilot is done and this can be provided to all the primary care providers, then we can be able to cost it. But I don't have that information—

M^{me} France Gélinas: So any idea if, per test, it's different in price?

Dr. Linda Rabeneck: I can make a comment about that.

The actual kit itself is a little more expensive. Now, as Mr. Roushani has indicated, what we end up paying for it will depend on when we procure it, and that will be a competitive process. The actual kit is more expensive than the fecal occult blood test, which has been around for a long time, but there are some very good cost-effectiveness studies that have shown that it is a more cost-effective test to use. Why? Because the kit may cost a little more, but you're detecting more cancers early—

M^{me} France Gélinas: —that you don't have to treat afterward.

Dr. Linda Rabeneck: Yes.

Dr. Bob Bell: If I could also comment—as Dr. Rabeneck said earlier, this is not just a test; it's a process. We expect, for example, with the use of FIT tests, the positive predictive value will be higher. We'll identify more complex patients, and we'll have to have colonoscopy services available for dealing with larger polyps, more positive cases. So it's not just a question of planning for the FIT test, I think it's fair to say, Linda. We also have to plan the next downstream step, which is more effective colonoscopy services than the current simple screening services, for more complex polyps.

M^{me} France Gélinas: Okay, got you. My next question—I'm on the next page—should be a very short one. As of March 25, 2014, Cancer Care Ontario had recruited nine of the planned 13 regional colorectal screening/gastrointestinal endoscopy leads. Why 13 leads for 14 LHINs?

Dr. Michael Sherar: Maybe I can answer that. We have a little bit of a difference with respect to the LHIN structure for our regional cancer program structure, in that we have one regional cancer program that covers two LHINs, one regional vice-president—I don't want to go back to all the reasons, although I can happily give you that information as to why we set out on that course.

The Mississauga Halton and Central West LHINs have one regional vice-president and really one mechanism of accountability for performance back to Cancer Care Ontario and provincially with respect to all cancer services across those two LHINs. The regional vice-president there, who is located at Trillium Health Partners, works with all of the providers across those two LHINs. So in some of our accountability mechanisms across the province in terms of clinical leadership, which falls under the regional vice-president in terms of working with the providers, we have 13 in quite a few of the areas of care because of that particular circumstance.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the first 20 minutes.

The government side: Mr. Potts.

Mr. Arthur Potts: Thank you, doctors, for being here, and Mr. Roushani. Delighted to have you here. In many respects, I think what we're talking about here is an extremely-good-news story. Much of what we see in the public accounts committee are agencies which we need to do some serious work on to improve performance, and

what we're experiencing in the auditor's report and what we're hearing today in some of your follow-ups is that Cancer Care Ontario is a leading jurisdiction in the world and certainly in Canada for screening for these kinds of cancers, and the response that you've done to the recommendations and the speed with which you've been able to implement that is most admirable and much appreciated.

You're a data-driven organization providing social services and following up on outcomes which allow you to measure so that you can go back and improve. At the heart of this, of course, are people's lives and families and how that impacts. So I think this is a great-news story and we're delighted to see the work that you've done and how you've responded.

Dr. Bell, you talked about prevention, that regular screening prevents. In layman's, we would think that you were screening to identify and then to treat, and much of the fear of people getting into the system relates to the fact that, "Oh, if I go there, they're going to find something and I'm going to be under care." So maybe you could expand on this whole notion and the examples of where the prevention is, the early precancerous conditions you mentioned and such, and maybe that's part of the public outreach that you're doing or you can explain how it helps drive more people into the screening program, that they're not so terrified of what the outcomes might be.

Dr. Bob Bell: Thanks, Mr. Potts. The answer to your question is so compelling that even an orthopaedic surgeon can talk about this issue with some degree of understanding.

Probably the best example is the progression of polypoid changes in the colon to become a full-blown cancer. There are absolutely well-understood—there's some research done in Toronto, some research done around the world, that demonstrates that there's a well-ordered progression of mutations that occur in the cells of the lining of the colon that result, first of all, in the development of a benign polyp, and then, with further mutations within that polyp, premalignant changes, malignant changes, and then, at that point, invasion of cancer cells down the stalk of that polyp into the wall of the colon.

With screening, if you have a fairly substantial polyp, or even a small polyp potentially with the immunochemical test, blood in your stool reflects the presence of this polyp. The polyp tends to shed blood. So if you have an FOBT-positive test, you're referred for colonoscopy, the polyp is identified, and the polyp then gets removed. The polyp is then evaluated under the microscope by a pathologist. I believe, Linda, if there are cancerous changes on the top that don't invade the stalk, you then have a very high percentage chance—

Dr. Linda Rabeneck: That's right.

Dr. Bob Bell: —of being cured. So how good is that?

In the old days, you would have presented three or four years later with an obstructed colon, terrible pain, because this thing would have invaded the bowel and you

would now have a full-blown cancer. With this program, we're able to remove these things at a time where—if any of you have had a colonoscopy, you know it's not the procedure you want done once a week, but certainly investing in that kind of procedure on a couple-of-yearly basis with this kind of anticipation is something that is a wonderful improvement in our health care system.

Mr. Arthur Potts: Great. And staying on the colonoscopy aspect, are the FIT test and the FOB test a pre-screening to a colonoscopy? Because, in my experience, it's colonoscopy first. I don't think I've ever had those screenings, but I have had the others.

Dr. Linda Rabeneck: Right.

Mr. Arthur Potts: Is that too much information, Chair?

Interjections.

Dr. Linda Rabeneck: The design of the ColonCancerCheck program is for people at average risk, so no symptoms, no family history. It's the stool test, the fecal occult blood test, or it will be the fecal immunochemical test or the FIT, as we've been talking. But for people with a family history of one or more first-degree relatives, so a parent, a brother or sister or, much less likely, a child—for people with that kind of family history, it's direct to colonoscopy. So we actually have two streams in ColonCancerCheck itself.

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Mr. Arthur Potts: I guess I have no history in my family, but that wasn't an option. But that's fine, and I maybe know going forward.

You talked about the three streams of organized province-wide testing, which is fantastic. Those are the three streams we're doing, and opportunistic testing in a whole bunch of other areas. Is that part of the review that we're doing, these other areas as well, or was it just on these three?

Dr. Linda Rabeneck: Thank you for your question. The review is just on our three organized screening programs that we've been talking about. What I would say is that we have a very active team of scientists who monitor the evidence all the time. We participate in the International Cancer Screening Network, which has a meeting every two years. We just had a meeting in June in Rotterdam. There, all the international experts come and we learn about any new evidence that's emerging regarding screening for any other cancer besides the three that we screen for. We learn what other jurisdictions are doing, how they're coping with the new evidence. We learn what trials are under way and where we're anticipating new results. So we keep on top of the evidence like hawks, frankly.

About the evidence: It needs to be of very high quality. There are certain ways of measuring the quality of evidence. We have our own program in evidence-based care based at McMaster University, where all of the existing evidence is pulled together and synthesized in a very rigorous way. That helps us assess whether the weight of the evidence favours moving forward to screening or whether the evidence is insufficient. So

we're very much evidence-based and evidence-driven. Why we have these three screening programs is they're bullet-proof evidence that organized screening for these three cancers makes a difference and reduces deaths from these three cancers.

When it comes to other cancers that we're not currently screening for, the evidence is insufficient or incomplete.

I would make one further comment. We now have evidence around high-risk lung screening, a very high-quality body of evidence, and we have started the planning work to move us forward to high-risk lung screening—a pilot to test the feasibility of high-risk lung screening. When the evidence reaches a certain strength and rigour, then we will start to advise the ministry that it's time to start planning. That's how the process basically starts.

Dr. Bob Bell: The strength of this process is evident. Within the context of scarce resources being applied to the right areas, and considering the example of prostate-specific antigen, or PSA screening for prostate cancer, the CCO has looked at that multiple times and has found that it's not a good screening test for population-based screening. We don't provide that test in our publicly funded health system.

Mr. Arthur Potts: Right, okay. Now we talked a bit about the new program for high-risk breast cancer screening. How have the wait times changed since the auditor's report or how do we move forward on improving on wait times for MRIs, particularly for women who have had positive results through their mammogram?

Dr. Linda Rabeneck: Yes, thank you. We do measure the wait times. What we mention with the high-risk OBSP is a woman has two screening images; one is a mammogram and the other one is an MRI, another type of imaging. Those need to be done within a month, or it's optimal if they're done within a month, of each other. They can't be too far apart. We're very pleased that in 2012-13, about 90% of women in the high-risk breast screening program had their two imaging tests done within 30 days. Now, in 2014-15, we're up to 93% of women getting their images done within that 30-day window, because if the time between the mammogram and the second imaging test, the MRI, is too long, it's very difficult to interpret. Then the whole set of images would have to be repeated. So we're very keen to keep those very tight, and I think we're achieving that.

Mr. Arthur Potts: Right. We talked about a backlog of maybe 900 case logs. Maybe you could explain—I believe a radiologist left or something, and it seemed like one person backlogging a system. Can you maybe explain that dynamic and how it's improved and where we are there?

Dr. Linda Rabeneck: Yes. I'm pleased to say that one is fixed. It's been fixed for some time. That's our interval cancer rate. Again, one of the quality measures in the Ontario Breast Screening Program is that we report to individual reading radiologists—individual radiolog-

ists—their cancer detection rates and their recall rates—how many women they bring back for further imaging—and we report to them on interval cancer rates. That is an individual physician performance measure. The assessment of whether a cancer has been detected by a mammogram or is an interval one that occurs subsequently: That assessment requires a great deal of expertise. You have to bring radiologists together; they have to read a panel of X-rays; it's a lot of effort that we put into that.

Earlier on, at the time of the audit, our provincial leadership, who's our radiologist-in-chief—had stepped down, and we were in the process of recruiting a radiologist-in-chief to lead this interval cancer review. During that time, we had a backlog of interval cancer cases to be read. That has now been fully dealt with. We have a spectacular radiologist-in-chief and we're all on top of that.

Mr. Arthur Potts: Great. Thank you very much.

The Chair (Mr. Ernie Hardeman): You have 10 minutes left. Mr. Fraser?

Mr. John Fraser: Ten minutes? Great. Thanks, Mr. Chair.

Thank you very much for being here today. I appreciate very much all the information that you've given us. I do want to ask some questions around colorectal cancer, initially just around the screening in terms of the uptake. There's a challenge around screening programs, as we discussed earlier today: people fearing the outcome. Then what happens is, you don't get great pickup or utilization, simply because—it's not for fear of outcome but I know I've got my second notice in the mail—too much information. Hopefully, I'll get that before I get a third.

What has CCO done in terms of—I shouldn't say that out loud, but I just did—targeting that perception that some people have? I'm sure it's across the screening world, but there seems to be a big difference between the uptake on colorectal cancer—

Dr. Linda Rabeneck: Yes. It's a good question. I'll talk about the uptake in a minute, for the ColonCancer-Check program. With respect to colon cancer screening, just to go back and put this in perspective: The Ontario Breast Screening Program was launched in 1990. All women know they need to get screened for breast cancer, and men know that women need to get screened for breast cancer. You can talk about it at a cocktail party. It's not, anymore—there's not social discomfort about talking about breast cancer and breast cancer screening, I would say.

With respect to colon and rectum, you won't find people talking about it as openly. It's a newer screening program. The evidence is more recent. We launched in 2008; that was seven years ago. But you're right: Across all jurisdictions, there is a challenge for all screening programs to educate the public about the importance of colon cancer screening. How to bring that to people's attention—what kind of campaign and how it should be presented—is often debated. But there is a discomfort in our society about talking about that part of the body. You

don't go to a cocktail party and hear people talking about their colon or rectum very much.

What we've done, together with our partners in the ministry, is embark on various campaigns to bring the message. Some of them are provincial in scope and some of them are just within our LHINs, within the regions: customized messages to help people learn that it's not to be feared and to help them get over the awkwardness about talking about and thinking about that part of the body.

Mr. John Fraser: Thanks. Another question that we had this morning—

Interjection.

Mr. John Fraser: Did you want—

Dr. Michael Sherar: I was just going to make one further comment, if I could, just to add to Dr. Rabeneck's comments. One of the other challenges that we face, and all screening programs face, is that that uptake challenge is variable. We have a very diverse population in Ontario, and we see variation in uptake across the regions and across our communities. We have very good information in terms of what that picture looks like. We can provide information to communities and providers around their specific populations, looking at those reasons for how we might develop targeted approaches that are going to help specific communities and populations overcome those barriers to participating in screening programs. So we have a whole set of efforts to try to make sure that this is equitable across the province, and "equitable" means sometimes very targeted approaches to support specific communities and populations overcoming those barriers.

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Mr. John Fraser: Therefore, you're able to identify whether there's a certain group of the population, whether it's geographical, rural—

Dr. Michael Sherar: Yes.

Mr. John Fraser: —or it's in one part of the province or the other, so you have that information and you're able to share that information with—

Dr. Michael Sherar: We do—with communities, with family practice providers, in terms of their populations and how we might support them with specific messaging that helps those communities engage with them in terms of a conversation about participating in screening.

Dr. Bob Bell: Four years ago, the Cancer Quality Council of Ontario challenged CCO to focus on health equity. One of the areas they identified was that it's difficult to screen aboriginal populations and some monicultural populations, and they've really put energy and work into it.

To the best of my knowledge, to this point they haven't considered parliamentarians to be a difficult-to-screen population, but perhaps with these comments—

Mr. John Fraser: Maybe I'm the outlier.

Just a technical question—we discussed this this morning. The screening tests are available through your pharmacist or with Telehealth Ontario. How does that work?

Dr. Linda Rabeneck: For people who have a family physician, they receive a letter from me saying that

they're in the target age group and inviting them to talk to their family doctor about getting screened. You don't get the kit in the mail currently. You get the letter, and you're encouraged to talk to your family physician.

Mr. John Fraser: You know I got the kit already, right? So that's—

Dr. Linda Rabeneck: Step two.

So that's how it works if you have a family physician.

We estimate that maybe 5% of people in this target age group—50 to 74—don't have a family physician. We call them “unattached patients.” There, they can call 1-800 Telehealth, and they'll quiz them to make sure they don't have a family physician. If they don't have a family physician and they're in the target age group etc. and satisfy the eligibility, they will receive a kit. Since there isn't a family doctor to send that test result to, the result gets couriered to the participant, and it also goes to Cancer Care Ontario. Then we have a system of attaching people to primary care providers and family physicians. In that process, we do attach people to family physicians.

Mr. John Fraser: I was talking, actually, to the president of the Canadian Cancer Survivor Network, not on the screening end of things but on when people are in care post-diagnosis and treatment.

Are those attachments done regionally? What's the mechanism? I'm just asking you a little bit more about those attachments, what the vehicle is to do that.

Dr. Linda Rabeneck: At Cancer Care Ontario, we have a contact centre, and you see on your letter that if you have questions, you can call the number. We have a group of trained individuals answering questions in our contact centre. LHIN by LHIN or region by region, they have a list of family physicians who've agreed to take on additional patients if asked; they're happy to add patients to their practices. The people in our contact centre can give them the name of a family physician who would be happy to accept them as a patient. We actually do that attaching, and we follow up to make sure it happens.

Mr. John Fraser: That's great. That's good to know.

How much?

The Chair (Mr. Ernie Hardeman): About a minute and a half.

Mr. John Fraser: Just a quick question. I'm from Ottawa. A number of years ago we had some challenges around a colonoscopy clinic in Ottawa. I just want to know what CCO has done in terms of—I know that public health did the inspection. But what have we done to ensure quality and safety at colonoscopy clinics?

Dr. Linda Rabeneck: We have a very important initiative, as we speak, that launched about two years ago, which is a partnership with the College of Physicians and Surgeons of Ontario, the CPSO. It's a CCO-CPSO partnership. We call it the QMP, the Quality Management Partnership, and we are focusing on colonoscopy, mammography and pathology. We have put together an expert panel and they have devised quality indicators, or quality measures: “Here's what high-quality colonoscopy looks like. This is what you need to achieve.” And we are in the process of designing a

method for collecting data from every site, hospital or clinic, wherever it occurs—a method of collecting this information from each of these sites and assessing the quality. Led by the regional leads that we have—and we have a provincial lead—there will be oversight of the measures of quality for colonoscopy regardless of the facilities in which they occur.

It's a very active piece of work as we speak, and we have a tremendous set of quality indicators already devised. Actually, this fall we'll be presenting our inaugural report for these three health services, which is the first report of our Quality Management Partnership.

Mr. John Fraser: Thank you very much. I guess I'm out of time.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll go to the official opposition. Mr. Yurek?

Mr. Jeff Yurek: Thanks, Chair. Thanks very much for coming in today. It has been a very informative day for me. Thanks to the Auditor General for briefing us this morning.

I do have quite a few questions, and it's generating more interest as we go along so I'm sure the second round might be a little more intensive, I would say.

I'll start where I was going to start, but I want to go back into Mr. Fraser's questions because he raised a couple of points with me, and then we'll carry on.

With the colon check program that's ongoing, do you collect numbers of how many turn out to be false positives and what's the percentage, and is that one of the reasons why you're changing the test to the FIT?

Dr. Linda Rabeneck: With the colon check, we track monthly the volume of kits processed in the lab. We track the percentage of those kits—what the positivity rate is. It tracks around 4.7% or just under 5%, right now. We track, of those who have a positive test, how many go on to have a colonoscopy, and we track, for those who have a colonoscopy, who have a cancer diagnosed. So we actually measure and track every step of that way.

Mr. Jeff Yurek: Okay. Leading to the next question with regard to tracking how many go to get a colonoscopy, maybe we can be provided those numbers when you get an opportunity.

Dr. Linda Rabeneck: Yes.

Mr. Jeff Yurek: You don't have to do it today.

Do you track failed tests? I just comment on that—everyone is getting personal. My mother had a test—she'll probably shoot me for saying this. She got a letter back from Cancer Care Ontario saying it was insufficient—they couldn't get a result; “please resubmit.” She said, “Forget about it. It's too much hassle. I'll just forget about it.”

Do you track how many failures you have in that respect and adjust your education program to ensure that the test is done properly? I'm sure there's a certain segment of society, of the community, that would have a hard time doing the test properly, especially those without a family doctor who—luckily my mom does, so she just goes and talks to him and lets him do the testing going further, but those that fall outside the screening—

Dr. Linda Rabeneck: Yes. We do track this—again, monthly. We track the number of kits received in the lab, the number that were suitable for processing, and we also know the number that are sent back, as you described with your mother. We also know the reasons that these are sent back, and in the letter it indicates what the issue was. We call them kit rejections, and we track it monthly.

Sometimes kit rejections occur because the labelling of the requisition and on the kit is not aligned. Sometimes there's not a label on it. Sometimes the way the kit has been completed isn't suitable, and sometimes the kit is outdated—in 21 days, the fecal occult blood test kit outdates. So there are several reasons why a kit can be rejected by the lab for processing, and then the person does receive a letter back, just as you describe.

One comment I would make: The fecal occult blood test, or the FOBT, that we've been talking about—as your mother would know, there are these three windows, so it's three separate specimens from three separate stool samples. When we move to the fecal immunochemical test, it's a single specimen and easier for a person to complete. That's one of the reasons why the uptake is higher and the number of kit rejections is lower with the fecal immunochemical test. It's just a simpler test for a person to complete.

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Mr. Jeff Yurek: Sure. That drives home the point that the member from the third party was making, which is it has taken two years to transfer to that. I mean, you'd think a simpler test to reach out to more people would be a quicker switchover.

Dr. Linda Rabeneck: Yes. The only short answer I would give is, as Dr. Bell was mentioning, screening is a process, not just a kit or a test. There are many aspects of the process that need to be changed or adjusted when we do something that seems as simple as swapping out a kit. It has to be procured; we have to ensure colonoscopy resources are there, and so on. There are many moving parts to the transition to FIT.

Mr. Jeff Yurek: Okay. Now, I'm just going to refer back to a response you gave to Mr. Fraser: 5% of patients, you figure, don't have a family doctor.

Dr. Linda Rabeneck: Right.

Mr. Jeff Yurek: Is that a provincial 5% you're figuring? Is it urban? Is it rural? Is it northern Ontario? Because I know the availability of family doctors varies throughout the province. I just want to know how those numbers jibe.

Dr. Linda Rabeneck: Maybe the deputy minister—

Dr. Bob Bell: We know pretty much that consistent responses to provincial telephone surveys suggest that 94% of Ontarians have access to a primary care physician. We also know there is a proportion of folks who just won't make themselves available to primary care. Young males, for example, tend not to have primary care doctors.

You're right: That rate does vary across the province. What we also hear is that availability of primary care providers, when patients want them, is probably as big a

problem as the issue of actually having a primary care physician.

Mr. Jeff Yurek: That just dovetails into recommendation number 4: "The Ministry of Health and Long-Term Care should monitor and assess current Cancer Care Ontario initiatives designed to improve participation in screening programs among people who do not have family physicians...."

The response I'm reading here: "When registered, participants who have abnormal screening test results are identified by Health Care Connect as a priority for referral to a family physician accepting patients within their local community."

I know in my community, especially in the far rural parts of my community, down in the Dutton area or West Lorne, which have been short of doctors—they don't have doctors available. Our one poor doctor, Dr. Peter, is overworked. He has to somehow utilize locums when he can, to get a two-week holiday over a 52-week year. I think he does a tremendous job for our community. But they don't have doctors. You're saying the LHIN has the list. If the LHIN has the list, it's not working, because I have pocketfuls of patients without a doctor. So I just want to know what happens. How can you ensure that they get into treatment? What if it's just not happening? Do you send them to the hospital then, to go further, or do they just sit and wait or get forgotten?

Dr. Linda Rabeneck: I would say, in answer to your question, that what I described—the work of our contact centre—is for those who have a positive fecal occult blood test. There, the recommendation is that they should have a colonoscopy. We're very keen to make sure that they have that colonoscopy.

For that group of people, men and women who have a positive fecal occult blood test, we not only have the list, LHIN by LHIN, of family physicians accepting new patients; we provide them with information about physicians accepting new patients. We follow up to make sure that they've been connected, because we want to ensure that those with a positive FOBT do go on and see a family physician about the recommendation for colonoscopy.

Dr. Bob Bell: Maybe I could just speak to the issue of ClinicalConnect, the concept of connecting patients to primary care physicians. That entity has been successful in placing more than 500,000 Ontarians with primary care providers. Currently, we have about 400 net new primary care physicians entering the province annually.

The issue, of course, is one of distribution, as you've described. It's important for rural areas to have the same kinds of access to primary care as urban areas. A couple of initiatives have been focused on rural areas. One, of course, is the Northern Ontario School of Medicine. This made a tremendous difference to access to primary care in the north.

The second one is the new program that we've introduced for managed entry to rostered models of care for physicians. We've made it possible for physicians to enter into rostered practices—which is the way that

physicians are trained and want to practice now—only if they're entering into high-needs areas, areas which have a measured deficiency in primary care. We're hoping that's going to result in more areas that you are describing having populations with access to primary care.

Mr. Jeff Yurek: I'm glad that my area was included in that. It was kind of concerning that it may not have occurred because my area is not an under-serviced area, but it's allowed to bring in the newer doctors that roster patients. In my area I think the average age of our family doctors is probably in the mid- to high sixties. Over the next few years, I'm sure they're going to want to retire and enjoy a little bit of the money and life they want to spend going forward.

But I do know that even in the urban areas—I've had comments from London, home of Deb, that they're in need of bringing in doctors and certain family health teams, but they can't because of that rule that has been stated. It will be interesting to see, going forward, how that works its way out.

You made mention here too, and I think it's an interesting idea, of where you've brought the mobile units up in the northern area to help with screening. The question was participation: Has it been well-utilized? Is the utilization rate showing the same type of numbers as would other parts of the province? To what would you attribute a lack of usage of that screening opportunity? And again, relate back to the lack of family doctors, because I'm pretty sure northern Ontario has a tougher time than my area of the province, which is having a terrible time attracting and keeping doctors.

Dr. Linda Rabeneck: Yes, I could answer your question about the mobile coach in the northwest. We've had a mobile coach in the northwest since 1992. The focus has been on breast screening, particularly women in the remote communities. In the summer of 2013, we added cervical screening to the coach, so women can receive Pap testing on the coach as well.

The coach travels quite a geography: over 30 communities and the annual mileage surpasses 17,600 miles a year. I can tell you that in calendar year 2014, nearly 6,000 women were screened with mammography in the coach, which is a terrific achievement for women in those remote areas.

We've added a coach in the Hamilton area more recently, but our longest experience is with the coach in the northwest.

Mr. Jeff Yurek: Is having a coach in the Hamilton region the best utilization of that tool? I would think there would be other regions in Ontario that would probably be more of a priority to getting that out there than, say, a large urban area like Hamilton that probably has more opportunity for the people in that area to access the screening.

Dr. Linda Rabeneck: One of the approaches that we wanted to test is—getting back to the earlier discussion we had about improving participation and reaching people—in the Hamilton area, we wanted to test, first of

all, the opportunity to bring it to large sites of employment so that women could, for example, have their mammogram during the day when they're at a large work site, for example, in an effort to improve and encourage participation. We have also started to plan the use of that coach for the First Nations communities, and we're beginning to discuss with them which communities might be most amenable to that.

Mr. Jeff Yurek: Just going back more to Cancer Care's colonoscopy standards: Your recommendation is to perform 100, minimal, new and follow-up colonoscopies each year to be competent and 25 new cases a year. Is that number a standardized number nationally or globally, or is that just a number that you thought would be good?

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Dr. Linda Rabeneck: Yes. This relates to the important observation, for which there's good evidence, that there is a volume-outcome relationship with the performance of colonoscopy. It's well-known in surgery, and Dr. Bell, I'm sure, could comment, that there are some cancer operations whereby the outcome of the cancer surgery is better if the surgeon does a large number of these procedures. The same thing is true of colonoscopy. It's not a cancer operation, for sure, but there's no question that if an endoscopist is doing a small number of procedures a year, on average the quality is not as good as if an individual is doing more than 200 a year—on average, if you aggregate. I'm not saying that there aren't individuals doing spectacular colonoscopy that are doing less than 200 a year, but if you add it all up and aggregate, we know that in this province, because we've assessed it, the quality is higher amongst those endoscopists that do at least 200 a year. We've measured it, and that's why we've set that as a quality indicator in place.

We were talking earlier about the quality management program and the indicators. We're going to be reporting publicly, region by region, on the proportion of colonoscopies that are done by someone, an endoscopist, who's doing at least 200 a year. So there's good evidence to support the 200.

Mr. Jeff Yurek: Now, in low-population-density areas throughout Ontario—northern, eastern and south-western parts—are the doctors able to reach the number to maintain their competency? Are there problems occurring with that? How do you work that out?

Dr. Linda Rabeneck: One of the pieces of work that we need to do is look within region, within LHIN, at the number of colonoscopies that are done, the number of endoscopists and how many each are doing in terms of capacity planning. So we have not said that if you're doing less than 200 you have to stop. We have not said that. We're beginning to measure it and report on it.

We do know that there's going to be a need to individualize this somewhat, because we don't want to implement something that's going to disadvantage people's access to the procedure. At the same time, we have to assure high quality. So we do believe we're going

to need to go work with our partners in the LHINs and in the regional cancer programs to make judgments and recommendations about the volumes for individual endoscopists.

Mr. Jeff Yurek: Okay. How many more minutes do I have?

The Chair (Mr. Ernie Hardeman): About three minutes.

Mr. Jeff Yurek: I'm just going to give you a three-minute question instead of continuing on. It was brought up about getting the colon kits from pharmacists and Telehealth.

Dr. Linda Rabeneck: Yes.

Mr. Jeff Yurek: Have you looked at utilizing other health care professionals to handle the kits? I know there's a strong number of people who go to chiropractors, or older people going to physiotherapists. Is there a way to utilize the other health care professionals or bring them in? Would that help, or have you looked at that and thought it was a waste of time and money?

Dr. Bob Bell: Just a comment in general: About 8% to 10% of Ontario's primary care providers are not physicians; they're advanced practice nurses, for example. So certainly they're strongly engaged in the integrated cancer screening program. As you've mentioned, pharmacists also have the ability to provide advice and screening materials. We haven't looked beyond that to this point. I don't know, Linda, whether you've looked at other providers?

Dr. Linda Rabeneck: We haven't. It's what we've called multiple distribution points, besides the primary care provider or the pharmacist. We haven't looked closely at it. Because, with organized screening, you need to be able to track how many kits are given out. You need to be able to follow them and find out what the results are. You need to attach people to family physicians if they don't have one—all those pieces. We thought that if we stick with primary care providers and pharmacists and did that well, that was how we were going to start. So we were hesitant to spread it, at the beginning, more broadly than that, because we do need to track every single kit that's disbursed.

Mr. Jeff Yurek: Just quickly on Telehealth—we were talking about it this morning. How does that function to give out the kit? Because in my history with Telehealth, whenever I've called, I've always been told, "We can't give you any advice. You should contact your primary care physician." If someone calls up with some sort of protocol that says they should get this kit, does that actually happen, or do they say, "Contact your doctor and go talk about the kit"? I just wonder how that works with Telehealth.

Dr. Linda Rabeneck: It actually happens. There's a script that they follow. They make sure you're in the right age group, they make sure you do not have a family physician, they make sure you don't have a symptom, like rectal bleeding—which means you shouldn't get the kit; you should go for a colonoscopy—and they make sure you don't have a family history of the disease. Once

those criteria and others are satisfied, then they will arrange to have a kit mailed. But they have a strict protocol that they follow to make sure that the right people are receiving the kits.

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the first round. We now have 16 minutes for each caucus. We'll go to the third party.

M^{me} France Gélinas: I'll use them wisely.

I wanted to correct my record but make a point at the same time. I have the CSQI data right now from breast cancer screening participation as well as colorectal. The data for breast cancer is 2012-13 and the data for colorectal is 2011-12. So there is data available online, but it is very old. Compared to what you're talking about, that you do the work, you collect the data, but it is not made accessible—that was the point I was trying to drive. I'll put that aside.

Some of the comments that you made, Deputy, about entering roster practice and a lot of new family physicians are interested in rostered practices and we now have areas of the province that are high-needs—I get all of that; I support all of that. The part I don't get is: Why do we only have so few a month? If we already know that Nickel Belt—because I have a soft spot for the vacancies in Nickel Belt. We already know that there are high-needs areas in Nickel Belt: 30,000 people without a primary care provider. We are in an area. We have requests for setting up rostered practices. Why is it that they have to wait in line and we don't know when they're going to get there?

Dr. Bob Bell: The number now is about 20 a month, and it doesn't stop physicians from going into practice. For example, physicians graduating today know that they could go into practice in Nickel Belt. They could certainly start practice as either a locum physician or a fee-for-service physician with a group that's practising within a family health organization, family health group, family health team etc. It's just a matter of going through the administrative steps of being able to join a rostered group and having a managed entry to practice. We administratively take about 20 a month to put them on that protocol, but it doesn't stop them from arriving and practising.

M^{me} France Gélinas: It does for \$1 million a reason, but that has nothing to do with what those good people are here for.

Why 20? Can I convince you that 25 would be a better number? How about 30?

Dr. Bob Bell: As I say, 50 can actually go to Nickel Belt and start practising. They will come on to the rostered model within a reasonably short period of time. I don't think at this point, if they knew they're going to be moved into a family health organization model within a period of time, it would stop people from actually going there.

M^{me} France Gélinas: What is that period of time?

Dr. Bob Bell: We work on a first-come, first-served basis, essentially. So it depends on where they are in terms of asking for registration within the full model.

M^{me} France Gélinas: So are we talking days, weeks, months?

Dr. Bob Bell: If they're at the front of the line, faster than if they're late in registering or later in registering. Once they've got a licence from the College of Physicians and Surgeons, they can move into a practice immediately.

M^{me} France Gélinas: And bill OHIP, but we'll leave that aside.

I love the idea that you get the result. Those 30,000 without a family physician in Nickel Belt? They do get those little letters, and we all have the 1-800 number to call. They call, and then it falls apart.

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There are no primary care physicians who will take them. They have a full-blown diagnostic of cancer. They're being followed by an oncologist, and the oncologist begs anybody and everybody to provide them with primary care, because at the cancer treatment centre they end up providing them with primary care because there's nobody to attach them to. To me, when you say things like this, it seems completely detached from my reality.

Dr. Linda Rabeneck: I hear what you're saying. I would just make sure that we all understand that when we talked about what we have with the contact centre, it's within the cancer screening program at Cancer Care Ontario. It is designed to assist those who have a positive screening test who need to go on to get a colonoscopy, the recommended next step. It's designed to attach those people because of the need, frankly. They're at higher risk of having cancer because they've got a positive stool test. So it's designed specifically for that population, wherever they are in the province. We do a very good job there and follow up to make sure the attachment happens.

M^{me} France Gélinas: Okay. So who do I call to give you examples of where this doesn't work? Because I have Mr. G right now who was in my office last week and followed exactly what you just said and it did not work. He still doesn't have a primary care physician who will take him on. He managed to go through a walk-in. The walk-in referred him for a colonoscopy. He got his colonoscopy. He went into the cancer treatment centre. He has an oncologist and he has no primary care provider.

Dr. Linda Rabeneck: So he has already had his colonoscopy?

M^{me} France Gélinas: Yes.

Dr. Linda Rabeneck: Correct. I see. So he's receiving cancer treatment from an oncology team, but he doesn't have a family physician in his situation.

M^{me} France Gélinas: Correct, but he went exactly through the process at the point where he needed a colonoscopy—

Dr. Linda Rabeneck: That was done.

M^{me} France Gélinas: No, you did not provide him with a family physician. He ended up going into a walk-in clinic with all of this. A physician who doesn't know him from a hole in the ground and certainly does not ever

want to see him again gave him a referral to go have a colonoscopy so that this colonoscopy got done, but you certainly were not there to provide him with a primary care provider, and he still doesn't have one.

Dr. Linda Rabeneck: I'm happy to receive the details and I'm happy to work on that one.

M^{me} France Gélinas: Okay. But I don't want everybody to come through their MPP office to have that done.

Dr. Bob Bell: Has he experienced ClinicalConnect at this point?

M^{me} France Gélinas: I have those kinds of cases in my office all the time, people who are very sick, who are under the care of a specialist and who don't have a primary care provider. The specialist doesn't want to be the primary care provider, for good reason. I must say, the cancer treatment centre is phenomenal with their nurses. Their primary care nurse does a very nice job. But the system you're describing does not work. It does not work in my riding, and I'm sure I'm not the only riding where it doesn't work.

Dr. Linda Rabeneck: Thank you for the point you're making. I'll make one other comment to describe another set of initiatives that we have around the unattached patient. I described the contact centre helping those with a positive FOBT make sure they have a colonoscopy. We also have a provincial primary care lead—a terrific doctor, Suzanne Strasberg—and we have a regional primary care lead in all of our LHINs. What that team has done is they've prepared a list of primary care physicians in the region who are happy to and can take on more patients. I know that Dr. Strasberg and her team have worked on these lists LHIN by LHIN, and that's another effort that we have under way at Cancer Care Ontario to address the issue that you're speaking about.

M^{me} France Gélinas: I'll put that aside. How long?

The Chair (Mr. Ernie Hardeman): You're halfway.

M^{me} France Gélinas: Okay. I get the process. You get a positive test, you send for a colonoscopy, the colonoscopy is done and then the diagnostic is done, if so.

I was surprised to see that if you look at the payment under OHIP for colorectal cancer screening, it has been going steadily down. I would have expected it to go up. In 2011, \$95 million; 2012, \$90 million; 2013, \$85 million; 2014, \$75 million; 2015, \$46 million—you can all see that it goes down. I'm just curious to understand how come the payment is going down. I guess this is to the deputy.

Dr. Linda Rabeneck: Just a point of clarification: Is that the total OHIP reimbursements across the province that you're referring to?

M^{me} France Gélinas: The deputy will know what I'm talking about. It basically comes from the estimates book, as to how much the province has spent on their colorectal cancer screening under OHIP.

Dr. Bob Bell: There are a number of different reasons that people have colonoscopies. Part of it is screening colonoscopies, part of it treats symptoms, and part of it treats people for surveillance after they have had a cancer diagnosis. I'll have to check on what the actual vote is,

but I can't imagine that the total billings for colonoscopy have actually decreased by that amount. I'll have to give you an answer on that.

M^{me} France Gélinas: Okay. It's basically in the estimates book, and there's a line in the estimates under OHIP that's called "Colorectal cancer screening," so it's solely for screening, and those are the numbers that I read to you. It's going down every year.

Dr. Bob Bell: I just don't know what the distribution of funding is to Cancer Care Ontario and what the distribution is to—actually, this may be an example of what Dr. Rabeneck has called "ad hoc" screening. Outside the actual population-based integrated cancer screening program, there may be other bills that are submitted for ad hoc screening, and that has potentially gone down as integrated screening has gone up, but I'll have to get back to you on that.

M^{me} France Gélinas: No problem.

I've talked a lot about the North, but there are other regions in Ontario where things don't perform as well. I'm now talking about Windsor, where they say, "By the time patients seek treatment at Windsor's cancer centre, their cancer is more advanced—and more deadly—than it is in patients elsewhere in the province.

"It's a dreadful phenomenon, say local cancer experts who cite it as one of the reasons this area has lower-than-average survival rates" for the more deadly cancers, and he names breast and colorectal.

He then goes on to say, "The participation rate for colorectal cancer screening is 58 per cent, which means 42 per cent of people" etc. How can we explain differences like what I just read about Windsor compared to the rest of the province?

Dr. Michael Sherar: Maybe I could respond to that, because I think it speaks to our general approach and accountability to the Ministry of Health and to the public in terms of our role, which is to advance a quality agenda in the cancer system, recognizing that, overall, we're continuing to improve and put efforts into improving the quality of the cancer system in the province and recognizing that, across the province, that is variable. It's of course variable to some degree in all aspects of the cancer system, and it's why we've put in place a performance management approach through regional vice-presidents, clinical leads, in these areas, as we do with all areas of the cancer system.

Part of that approach is dealing with this issue of variability where it occurs. The reasons for that variability can be quite complex with respect to why that's occurring, and part of the role of our interaction as a provincial agency with those local leaders—the regional vice-president and the organizational leaders, as well as the clinical leaders and the clinical leadership—is understanding what the reasons are, whether it's screening participation, quality of cancer surgery or any other aspect. We go through that process, based on data, to understand what those are and to support those regions and the local communities with respect to performance improvement.

Sometimes that involves targeted support from a provincial perspective, things like the under/never-screened initiatives, to help those communities and those regions bring that performance up. All of our approaches are aimed at improving that overall performance and when we look at the best to the worst of getting that, so it's narrower, I'm not sure we'll ever get it right to the line, but it's certainly that two-pronged approach of addressing the variation and the overall.

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We use all of our tools to do that, including the operational data driving performance management, as well as the public reporting with respect to that variation which we're committed to as well. In that case, we would work with the regional vice-president and the leads in the Windsor area, as we do on a regular basis and formally on a quarterly basis to really understand these issues and support them in bringing the performance up.

M^{me} France Gélinas: I remember when you and I last met. You gave me the think tank summary, Cancer Care Ontario's Enhancing the Delivery of Take-Home Cancer Therapies in Ontario. You gave me a copy of that, which I did read. I guess it would be to you, Deputy: Right in the executive summary, it goes, "Ontario is facing some formidable challenges, most notably"—that comes from Cancer Care Ontario—in quality, in patient safety, in equitable access and system integration. In quality, it goes on to say, "The system lacks oversight and comprehensive data collection to inform quality improvement processes." We have seen, through the review that the auditor has done, some of that in motion. Bringing it back to you: What are your ministry's overarching tasks, actions and goals regarding this?

Dr. Bob Bell: Thanks. Certainly, the agenda for transforming health care in the province really focuses on improving the quality of the care, measured in a variety of ways, as well as the customer experience, the client experience with accessing the health system. We'd agree that certainly we need to travel in terms of improving the quality of access to the health system and other things that the Patients First plan is focused on.

I think when it comes to actually measuring the quality of care and improving the quality of care, Cancer Care Ontario has set an international standard in terms of third-party measurement of the outcomes that patients achieve. Probably the thing that Ontarians care about most when it comes to the quality of cancer care is—bottom line—"What's the likelihood of surviving the type of cancer that my family member or myself is suffering from?" International comparisons of five- and 10-year cancer survival rates for the most common cancers have been published in the respected international journal, the *Lancet*, and demonstrate that rates in Ontario for common cancer survival are amongst the highest in the world—I think it's fair to say, Michael—and I think we continue to monitor that very carefully.

If you look at a base summary indicator of how well we're doing when we look at stage-specific five-year survival and overall survival from cancer diagnosis, that

speaks to the earliness of cancer detection, the effectiveness of screening programs, as well as the systematic application of best practices at every step along the cancer journey. I think that Ontarians feel that they're getting the highest-quality cancer care.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for that questioner.

The government side: Mr. Rinaldi.

Mr. Lou Rinaldi: Thank you, Chair. I apologize for being a bit late.

I don't have a question. I just want to make, I guess, a statement from my own perspective, putting more of a touch, as Madame Gélinas did within her riding. In the close to 10 years that I've spent here now—I stand to be corrected because my staff does most of the front-line work, as they should. The issue about access to cancer treatment or screening of any type hasn't really been an issue, because normally they flag for me what I need to raise. Maybe somebody did call at one time or another, but certainly, the process kicked in.

From some experience, both with family and with some very, very close friends who are now survivors—and we don't get too many compliments as MPPs, many times. Normally we get the complaints. But I must tell you that our area is serviced by Kingston, Belleville, Peterborough and the Durham area, and there's some treatment at the Cobourg Northumberland Hills Hospital, though as a satellite of Peterborough, I believe. It's never pleasant, but I guess the end result is that we have survivors, and I've had some people appreciate on that piece what you do. I won't take the credit—what you folks do.

I just wanted to highlight that. Things are not always perfect and I think you recognize that, but the fact is that we have some other train wrecks that call my office with issues. As sad as it is when somebody is touched by some type of cancer—it's normally not a very pleasant circumstance—at the end of the day, and I'm only reflecting on very close friends and family that have been impacted, I just want to say thank you.

Dr. Michael Sherar: Maybe I could just respond. I appreciate the remarks. All of us, I'm sure, have had family members who have gone through this journey. I just wanted to make the statement back that, although I think we have made very good progress with respect to the cancer system in Ontario—that's measured publicly by a quasi-independent group, the Cancer Quality Council of Ontario—certainly we as an organization are never satisfied with that. We're continually looking for opportunities for improvement, not only in what we're doing now, but reviewing the evidence that's changing that picture with respect to what's best practice for the future. We're motivated to do that with, of course, our own personal stories, but also our interactions with patients and families across the province.

We've just launched the newest Ontario Cancer Plan for the province. It's our fourth Ontario Cancer Plan. It was co-led by a patient representative as well as one of our vice-presidents. It's a renewal of that commitment:

We're not satisfied in terms of that quality; we continually think there are opportunities for improvement and we're looking for those and we want to act upon them. I appreciate your comments, but also reflect that this is continual work. It's never done.

Mr. Lou Rinaldi: This is in no way meant in any partisan way. From the little interaction that I've had with your agency, I think some other government agencies should take a close look at how you operate and learn from that.

The Acting Chair (Mr. Ernie Hardeman): Thank you. Mr. Potts?

Mr. Arthur Potts: I want to build on what Lou is saying because we take Ms. Gélinas's concerns very seriously. Different parts and regions may have different experiences. Certainly there's the experience in downtown Toronto, where we're extremely well-served by agencies, and our family members and friends who have gone through that process have had the experience they've had. They've said they've been well attended to and had the availability of doctors.

As an agency, do you track concerns, complaints, patient satisfaction surveys? We talk about it in that sense, but do you track people who are concerned and have those experiences, the negatives against positives? And are you then able to deal with action plans to address—maybe it's the geographic areas?

Dr. Linda Rabeneck: I can speak first for cancer screening and let you know what we do. We have a team. We log every piece of feedback we get, whether it's a letter—sometimes they're addressed to me and sometimes they come to the CEO—or whether they're in an email. Sometimes they come to me, the CEO's office, or sometimes to the public affairs and communications team. Sometimes they call the contact centre. Sometimes they email Screen for Life.

We track and log all of them and we respond to a large number, depending on the nature of the issue. In cases where action is needed, we take action. We're very good at circling back with people, I would say, with respect to cancer screening and the feedback that we receive.

Dr. Michael Sherar: More generally, if I may, we're continuing to strengthen our commitment to engaging patients and families in all aspects of the work that we do. That includes more and more gathering data from patients as a set of data that's very powerful for helping us drive performance improvement of the cancer system, as well as technical data, like kit rejection or quality of a particular procedure that we might measure with hospitals and providers.

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We are more and more gathering data sets in surveying patients in cancer centres. We now routinely invite patients to fill out surveys with respect to their symptoms and what is being done about those symptoms as they go through cancer treatment at a population level, and using that as a key set of information that helps us drive performance improvement.

So I think that evolution is continuing. It's certainly in the cancer system and I think more generally in the

health system, accessing patient information to help us improve the system for patients and families across the province.

Mr. Arthur Potts: Excellent.

Dr. Bob Bell: One of the major advances in clinical cancer care in Ontario's cancer clinics is the presence in cancer centres of symptom assessment scores that are routinely connected. So when the clinician actually sees the patient, you've got a sheet that talks about emotional distress; it talks about various symptoms in response to treatment. You can't forget to ask these questions. They are provided to you, and that's been a big piece of making sure that you're not just talking about the physical aspect of cancer treatment. It's also the emotional and symptomatic aspects of cancer treatment that our clinicians are treating.

Mr. Arthur Potts: Great. Thank you.

The Chair (Mr. Ernie Hardeman): Mr. Fraser?

Mr. John Fraser: Thank you very much. I want to ask a question in regard to public awareness and education around cancer screening. I know that you've done some things since 2012, so can you talk a bit about that? Then as a second part to that, I just want to know how you measure success, because you're in the business of measuring success.

Dr. Linda Rabeneck: Thank you for that. We partner with our communications team and also with the ministry to help devise province-wide campaigns, or even campaigns that are targeted at a specific group within the target population. That can be measured in two ways. The communications team will measure the number of Twitters and all the media metrics that they use. Yes, they measure that. I can't tell you all the indicators that they measure, but there are all these measures that they use. But we also measure uptake, participation rate in response to the campaign.

For example, we know whether the number of FOBT kits goes up because we measure it monthly. We know when the campaign was and we know whether that goes up, and we know whether there was an impact on overall screening participation in the target age group.

So we measure screening participation as an outcome. The communications team measures the actual response in terms of their media indicators.

Mr. John Fraser: For instance, you identified the aboriginal population.

Dr. Linda Rabeneck: Yes.

Mr. John Fraser: Did you have a specific awareness campaign or a public campaign of a type for that population?

Dr. Linda Rabeneck: Yes. One of our tremendous units within Cancer Care Ontario is the Aboriginal Cancer Control Unit that's led by a remarkable woman, Alethea Kewayosh. She's the director. She is a First Nation woman herself. She and her team help lead our efforts in terms of working with partners, working with the First Nations, Inuit and Métis communities to help devise the materials. Some of our materials are actually translated into Oji-Cree because in some remote

communities English is not the first language. We have a tremendous set of materials there that have been co-designed and developed with the First Nations, Inuit or Métis.

In addition, for one remote community—and that is the Sandy Lake community up in the northwest—at the request of their chief and council and with a great deal of work, we were able to provide them with a list of all the members of their community—there are approximately 3,500 people in this remote community—who were not up to date with screening. That was what they wanted, and we were able to provide it to them. And then the nurse in the nursing station can work with the community to encourage them to get screened. We call that our Sandy Lake screening activity report, or S-SAR.

Now that we've worked out how to do it—the technical and privacy parts of it—we're looking to do it for other communities that request it.

Mr. John Fraser: It's interesting when you look at the security and privacy end of it: It's something you want to disseminate publicly, you have to target a population and you've got to follow some rules and some basic principles around—

Dr. Michael Sherar: Maybe I can comment on that. Dr. Rabeneck has mentioned our aboriginal cancer control unit and this strategy of working with aboriginal communities, getting the best data we can to support that, but also working on all the privacy and legal issues that are very specific to aboriginal communities that might not be there for the work we do in the general population. We have a whole strategy targeted toward that work. It's a lot of work, but it's very worthwhile if we are able—and I'm confident we will be able—to work more effectively with aboriginal communities in providing the data and information and the tools that are going to be useful to them in their communities in reducing the burden of cancer and preventing cancer in those communities.

We feel this is a very worthwhile investment. A lot of work is going on now with those partnerships, with the information and all the technical work—privacy, legal—to start to provide this type of information in a useful form to communities in a way that's acceptable to them. In fact, just the other night, we launched a third aboriginal cancer strategy. We had leaders from First Nations, Inuit and Métis communities from Ontario in the room together committing to the implementation of this plan.

It's a very important part of our approach with respect to equity of top cancer services for everyone in the province no matter who they are or where they live in the province, but a very specific targeted effort to our First Nations, Inuit and Métis communities.

Mr. John Fraser: It is—I respect this—a big undertaking because of the duty to consult.

How much time do I have?

The Chair (Mr. Ernie Hardeman): Two minutes.

Mr. John Fraser: Great. I'll use all two minutes.

We heard, a little bit earlier, about new technologies and new screening. How do you actually keep up with

the change in technologies and the change in data around studies on new technologies for screening in these three areas or any other area? How do you do that?

Dr. Linda Rabeneck: We have multiple ways of doing this. We have a program in evidence-based care, that I mentioned earlier, based at McMaster University. It's supported by Cancer Care Ontario. We have superb experts in methods for retrieving evidence from published literature and unpublished literature and from other jurisdictions. So we can go to them and say, "We want you to critically appraise the evidence for organized prostate cancer screening; we want you to critically appraise the evidence for high-risk lung cancer screening." Then they pull the evidence together, pull together a group of expert scientists and provide a report to us that will let us know whether the evidence is strong enough or insufficient to begin to consider moving forward with screening for that particular cancer. That's one very important resource we have, and we make a lot of use of our program in evidence-based care.

In addition, we have individual scientists at Cancer Care Ontario who have their own areas of expertise in each of these screening areas and others, and they track the field. They go to scientific meetings; they know what's going on in the field because that's their life's work.

Also, as I mentioned, we're part of the International Cancer Screening Network, which is an international consortium of jurisdictions that have organized screening programs. We get together every two years and have superb presentations, panel discussions and debates. You learn there how other jurisdictions are grappling with new evidence or what new evidence is being anticipated, and we bring all this home to Cancer Care Ontario and to Ontario, and it helps us in our planning. Eventually, if we do take a decision to move forward, then we begin to work with the ministry on the steps we need to take together. But it's all rooted in the evidence.

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The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time there.

To the official opposition, Mr. Yurek.

Mr. Jeff Yurek: Are you guys tired yet?

Dr. Linda Rabeneck: Not yet.

Mr. Jeff Yurek: I think we could put a motion to carry on for an extra couple of hours.

I just want to go back to patients in my area and just flag something for you to maybe do some research or look on. In my region, in the St. Thomas area in particular, we have a high number of mental health patients. Many of those patients end up having their psychiatrist acting as their primary care physician, just because of the lack of family physicians in the area at the time.

Through this process—you end up with a positive screen to go further to testing—I just wonder if you know how often that falls back on a psychiatrist, who probably doesn't want to do much primary care—I know from my experience, they don't—for the fact to carry that forward.

That's just a comment; you don't have to respond. I thought I'd just make a note.

The other one is reaching out to cultural communities throughout the province. In my area again, the east part of it has a high Low-German-speaking population. I don't know if you've ever thought of ever reaching out to the public health units throughout the province who have probably already developed programs of outreach to these communities. It might save you some money down the road to utilize them as something going forward to promote and increase your uptake of this screening tool. Those are just two quick comments.

Just to get into my further question: Prostate cancer was mentioned earlier, and I think that's something that hopefully we can come to some sort of consensus to get that screening tool out there because I know, for someone in their eighties or nineties who gets diagnosed with prostate cancer, it's probably not likely going to be their detriment at the end of the day; however, someone in their mid- to late forties or early fifties who picks up prostate cancer—early detection is obviously key to maintaining survival. I know the PSA test has recently gone through some studies saying it's just not as effective, but I know Prostate Cancer Canada is thinking otherwise in their promotion.

Where do you hold that balance where you are getting the literature saying it's not 100% effective; however we are going to save some lives with this testing? Is it just the dollars and cents or is there scientific evidence behind that saying it's just not worth it?

Dr. Linda Rabeneck: The prostate cancer screening question comes up not infrequently, and it's always a challenge to reconcile an example of an individual person. Let's say a man with no history, no increased risk—let's say he's 40 years old—and he has a PSA and a cancer is found and he receives treatment. He will say, "I benefited from that screening," and he will make the case for all men being screened with a PSA because of his experience.

On the other hand, if you take tens of thousands of men in that age group and randomly assign them to routine PSA testing versus no screening, follow them over a decade and measure the deaths from prostate cancer in the two comparison groups—a big randomized trial in other words—you find they're not significantly different—there is no statistically significant difference in the deaths from prostate cancer in the one arm that was PSA-tested routinely and the other arm that was not in tens of thousands of men. This is what is being done.

There was a big trial in Europe and there was a big trial in the US. When those results were pooled, so now we're talking even more tens of thousands of men, the judgment of the Canadian Task Force on Preventive Health Care—a blue ribbon panel—is that the benefits do not outweigh the harms. So there are harms of PSA testing that we could talk about, but that's a recommendation of the Canadian Task Force on Preventive Health Care, and they published this in 2014.

The US Preventive Services Task Force, a separate blue ribbon panel in the US, did a similar kind of

exercise. Rigorous critical appraisal of the existing published evidence from these trials came to the same conclusion. Neither the task force in the US nor the Canadian task force recommends routine screening with a PSA test in men at average risk. I'm not talking about men with a family history or men who might be of African ancestry. We're talking about men at average risk.

That's why we at Cancer Care Ontario have not recommended to the ministry that we invest in an organized screening program, the way we have for the other three cancers, with PSA testing for prostate cancer, because the weight of the evidence does not support it. That is true in England, the Netherlands, the US and Canada. All of these expert panels have weighed the evidence, and this is the conclusion they have come to.

It's always a challenge, though, when an individual man comes forward with the description of an experience; it's very hard to explain that. But what we're talking about is that, in the population, there is insufficient evidence to move forward with an organized, population-based screening program across the whole of the province. And it is evidence based; it is not based on cost.

Mr. Jeff Yurek: Okay. Good to hear. I'm going to ask one more, and then Ms. Munro is going to ask a question.

I know your mandate right now is screening for cancers. I know I see a big push for chronic disease management, and I know Dr. Bell there is trying to maintain a budget. I can see the government going after chronic disease management.

I'd hate to see us reinvent the wheel. You have the basis and the structure in place. Are you able to switch over and include the mandate of chronic disease screening? Is it possible that we could expand that provincially? I think it would save a heck of a lot of money if we could catch people with diabetes and other chronic diseases far earlier than they are being caught right now. Is there a possibility that that could change in your mandate? Would you be able to handle it?

Dr. Bob Bell: One of the things that we base our investment in the integrated cancer screening program on is exactly what Dr. Rabeneck was just talking about; that is, the evidence that demonstrates that you can actually save lives and improve health by investing these funds in early detection.

I'm not sure that there's the same information there on a population basis that if you were to test everybody in a certain interval of time, you would actually save lives by picking up fasting glucoses that were abnormal at an earlier date. I'm not aware that that information exists. I don't know if you are, Linda.

Dr. Linda Rabeneck: No.

Dr. Bob Bell: Now, where you are absolutely right is that many of the risk factors for chronic diseases are the same risk factors for the development of cancers. Certainly the most worrisome one is the prevalence of smoking; eating fruits and vegetables, meaningful physical

activity—these are all risk factors for the chronic diseases of diabetes, congestive heart failure, chronic obstructive pulmonary disease and hypertension, and they are also risk factors for the development of cancer.

That is where behaviour modifications in the general population that would lead to better health is an area that we are emphasizing, as you know, and that is certainly something that Public Health Ontario and Cancer Care Ontario have come together to say: "These are changes in behaviour that can substantially improve health." I think that combined effort, as opposed to a combined screening effort, is probably where we need to put our investment in improving health.

Dr. Michael Sherar: Maybe if I could just add to that: In terms of our assets or infrastructure that we have at Cancer Care Ontario, where we see that issue as broader than a cancer issue—and Dr. Bell has alluded to one of those—which is all of the risk factors for chronic diseases. We look at that issue from a chronic disease perspective, so the advice that we provide to the Ministry of Health is not restricted to cancer. In the context of chronic disease prevention and what might be done in Ontario with respect to risk factors for cancer, we've provided advice with respect to all of the chronic diseases in the context that those risk factors are the same.

We do look for opportunities with the Ministry of Health as to where our expertise, assets, infrastructure or data could support improvement with respect to a broader effort. That isn't only cancer; as you're probably aware, we also manage issues with respect to quality for chronic kidney disease in the province in the context of trying to leverage on a set of infrastructure that can support that type of approach.

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Mr. Jeff Yurek: Okay. Julia?

The Chair (Mr. Ernie Hardeman): Ms. Munro?

Mrs. Julia Munro: Thank you very much. First of all, since we've had other personal disclosures, I would begin by saying that I'm a product of the process you represent and I'm here today thanks to the research and the money that's been put into cancer care, so thank you, personally.

Many of the things that have crossed my mind in the last couple of hours obviously have come up, but there's one which you might feel is appropriate from me, and that is that in the testing there is always—I think the highest age is 69 or 74 in the various screening initiatives that you have. With increased longevity, I wondered whether or not there is any kind of inkling or any kind of thought, any kind of evidence that would suggest that that might become something that you would want to revisit.

Dr. Linda Rabeneck: Yes, it's a good question. The question often comes up: Does your screening program stop at age 74 for breast cancer screening, for example, or colorectal screening? And the answer is: We don't routinely invite people aged 75, for example, but what we do encourage is a discussion with the person and their family physician to make a shared decision around whether screening is appropriate for them. But they won't receive a letter of invitation. The reason is that as

we get older there may be other health issues that need to be taken into account in terms of the decision. We're not saying, "Don't get screened"; we're just encouraging people to have a discussion.

The Canadian Task Force on Preventive Health Care: When we talk about them and the target age groups that we're talking about, what they would say, like for breast screening, is a good example: that the evidence is insufficient to support organized screening in those older than 74. It doesn't mean that it can't occur. It does occur, and that's appropriate when there's a good discussion.

Mrs. Julia Munro: I just thought people would begin to start thinking in those numbers as more people are living longer lives.

Dr. Michael Sherar: It's an important question, if I may, because of the issue that you've brought up, which is the demographics; that the population is getting older. But practice is changing too in terms of the evidence around the benefit of different parts of the process for the cancer system, whether it's screening, diagnosis or treatment with respect to older people. It's one of the things that we continually look at in terms of access to services for people of different ages.

Part of the equity issue: Are older people accessing the cancer system in as effective a way as younger people?—and the evidence around changes. So we would continually look at that. It is moving, certainly in treatment in terms of the effectiveness and safety, for example, of treatments for older people. We continue to look at that and advance the indications in Ontario, where there's evidence of more and more benefit for older people. We would look at that in the screening context as well.

This is a moving picture with respect to demographics, particularly in the western world, and it's something that we're certainly very much aware of and keep an eye on in terms of making sure that our system is there for everybody no matter what their age.

Mrs. Julia Munro: One other point that you raised earlier was the importance of the messaging, of being able to go with the broader public. Certainly, that's my concern as an MPP: I see people who don't want to know. There's a factor, I think, playing into their decisions that, "If it doesn't hurt, don't bother," sort of thing. So it seemed to me that I would encourage, as you indicated, the importance of screening as prevention, and I would add: and peace of mind is priceless. Anyway, thank you very much.

Dr. Linda Rabeneck: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time for this afternoon, so thank you very much for—

Mr. Arthur Potts: Mr. Chair, did you want to ask a question? I know that you had that experience in Winnipeg.

The Chair (Mr. Ernie Hardeman): No, I just want to thank you—all the questions have been asked—for being here this afternoon and to say: It's one of the times when, in fact, all the presentations and the answers to questions were more good news than bad news.

So we thank you very much for the work that you do and the advances that you're making in meeting the requirements of the Auditor General's department. We look forward that the next time, all the little things that were suggested today will be corrected, too. Thank you very much for being here this afternoon.

Dr. Bob Bell: Thank you, Chair. We'll endeavour to follow up on some of the issues that were raised. Thanks to the Auditor General for the excellent recommendations and the opportunity to respond. We appreciate it.

The Chair (Mr. Ernie Hardeman): Thank you very much. If you will just clear the room—hopefully the members of the committee, if they want to speak to the deputants, will speak outside so that we can carry on with the meeting.

The committee continued in closed session at 1446.

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