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Thursday 21 February 2008

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Jeudi 21 février 2008

Standing committee on public accounts

2007 Report, Auditor General:
Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

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Chair: Norman W. Sterling
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Thursday 21 February 2008

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Jeudi 21 février 2008

The committee met at 0941 in room 151, following a closed session.

SUBCOMMITTEE REPORT

The Chair (Mr. Norman W. Sterling): Before we begin this particular consideration of section 3.09, we have a small matter to deal with in terms of the organiation of the committee, so I would ask Mrs. Van Bommel to put forward a motion with regard to that report.

Mrs. Maria Van Bommel: I would move the adoption of the report of the subcommittee as follows:

Your subcommittee on committee business met on Thursday, December 13, 2007, and recommends the folowing:

(1) That the committee table the report on section 3.07 of the 2006 annual report of the Auditor General on Hydro One Inc.—acquisition of goods and services.

(2) That the reports on section 3.03 of the 2006 annual report of the Auditor General on community colleges—acquisition of goods and services, and on section 3.10 of the 2006 annual report of the Auditor General on the Ontario Realty Corp.—real estate and accommodation services, be printed and that the committee table both reports.

(3) That the report on section 3.11 of the 2006 annual report of the Auditor General on school boards—acquisition of goods and services, be signed off by the subcommittee, translated and printed, and that the committee table the report.

(4) That the following documents received by the clerk during the intersession be distributed to the committee:

—Ministry of Transportation responses on section 3.05 of the 2005 annual report of the Auditor General;

—Ministry of Education response on section 3.11 of the 2006 annual report of the Auditor General;

—Ministry of Health and Long-Term Care response on section 3.08 of the 2006 annual report of the Auditor General;

—Ministry of Citizenship and Immigration response to the committee motion.

(5) That the committee request authorization from the House to sit up to three days during the winter adjournment to consider the 2007 annual report of the Auditor General on February 20, 21 and 22, 2008.

(6) That the committee consider section 3.09 of the 2007 annual report of the Auditor General on hospitals—management and use of surgical facilities on February 21, 2008.

(7) That the other selection for consideration by the committee from the 2007 annual report of the Auditor General be section 3.12 on outbreak preparedness and management.

(8) That the government and the official opposition be allowed to provide their two selections to the committee at a later time.

(9) That the committee begin the review of each selected section with a closed session briefing by the Auditor General and the research officer, and the deputy minister, ministry staff and other relevant witnesses be asked to attend the committee following the closed session briefing to provide a response to the auditor's report and to answer any questions.

(10) That the clerk of the committee, in consultation with the Chair, be authorized, prior to the adoption of the report of the subcommittee, to commence making any preliminary arrangements to facilitate the committee's proceedings.

The Chair (Mr. Norman W. Sterling): Any discussion? Shall the motion to adopt the report be carried? Carried.

2007 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.09, hospitals—management and use of surgical facilities.

The Chair (Mr. Norman W. Sterling): Thank you very much for your patience, Mr. Sapsford and other guests.

As I mentioned to the committee in our closed session—which is basically a briefing session, for those of you who are visiting with us today—the Ontario Hospital Association asked for an opportunity to make a statement here this morning, and the committee agreed that that would be likely.

Mr. Sapsford, perhaps you wanted to lead off.

Mr. Ron Sapsford: Thank you, Mr. Chair. I'm pleased to be here today on behalf of the Ministry of Health and Long-Term Care, and I want to thank the

standing committee on public accounts for providing the ministry an opportunity this morning to address some of the issues in the Auditor General's 2007 report on hospitals—management and use of surgical facilities.

Let me state at the outset that the ministry fully supports and appreciates the work of the Auditor General to complete this important value-for-money audit. This audit constitutes the second year of the value-for-money audits of the broader public sector, including the hospital sector. The ministry supports this report and is pleased to update you today on its progress since the audit was conducted.

Before I begin to address the specifics of the report, I think it's important to review the roles and responsibilities of the various players within the province's health care system. Under Ontario's legislation, accountability for each entity is clearly set out.

The Ministry of Health and Long-Term Care Act establishes the duties and functions of the minister, and through him the ministry, to oversee and promote the health and physical and mental well-being of the people of Ontario, and to be responsible for the development, co-ordination and maintenance of comprehensive health services. This includes a balanced and integrated system of hospitals, long-term care, family health and primary health care, laboratories, ambulances and other health care providers in Ontario, all engaged in providing timely and equitable access to health services to all the residents of Ontario. To move forward with the government's agenda to put patients at the centre of the health care system, the ministry recognizes the need to work closely with all of the health care partners.

The Local Health System Integration Act, a new piece of legislation, is designed to improve the provision of health care for Ontarians. It is about building a health care system around the needs of patients and communities, and, most importantly, defines the mandate and role of local health integration networks.

The Public Hospitals Act sets out the responsibilities of the province's hospital boards of directors and, importantly, the medical advisory committees that report to the boards. The board of the hospital is ultimately accountable for the quality of patient care provided in the hospital.

Recognizing that physicians have the expertise to supervise and assess the quality of care being provided to patients, every board is required to establish a medical advisory committee, which is responsible for recommendations to the board concerning the quality of care provided in the hospital by the medical staff and specified other health professionals.

Each of the regulated health professions, including the profession of medicine, is governed by the Regulated Health Professions Act, 1991, and a specific profession act. Under these acts, each of the professions has a college that is the self-regulating body for its members. The colleges are to protect the public through the regulation of practice of the profession and its members.

As I have said, the ministry takes its role and responsibility seriously in setting the system's strategic direction and administering the province's health system, but, importantly, we cannot overstep legislated boundaries. As a ministry, we must work within the legislative framework and, at the same time, in collaboration with our partners, deliver the best possible care to patients.

0950

You will see that the activities that the ministry has undertaken fall within its mandate and have been implemented in conjunction with our partners within the legislative framework that I set out earlier. We appreciate, as a ministry, that the Auditor General is also cognizant of the responsibilities of all of our partners, as demonstrated in his recommendations.

Let me turn now to where we are now in relation to the Auditor General's report on hospitals—management and use of surgical facilities, as outlined in the table that was provided to you. The ministry is encouraged by the Auditor General's references to the many projects currently under way within Ontario to improve the use of operating rooms. In particular, I would thank the auditor for acknowledging and highlighting the good work of the surgical process analysis and improvement expert panel, the perioperative improvement coaching teams, the surgical efficiency targets program, the new models of care being developed, the anaesthesia care teams and the wait time information system.

Overall, the report is valuable to the ministry as it provides guidance and information on areas for continuous program improvement, and the specific recommendations will be taken into consideration for future program development. I am pleased to report to you today that many of the Auditor General's recommendations have been implemented since the review of these three hospitals last March, and significant changes have taken place to improve the management of surgical facilities within hospitals.

For this presentation this morning, I will focus primarily on recommendation 7, which reads: "To monitor and manage patient wait lists more efficiently, the Ministry of Health and Long-Term Care and hospitals should continue to jointly develop more standardized reports, utilizing data from the new wait time information system that would readily provide hospitals and surgeons with useful and comparative information on patient wait times. As well, hospitals should periodically test the accuracy of their key data elements in the system."

In order to reduce wait times, the ministry has committed to providing timely and appropriate access to key services in five areas under the provincial wait time strategy: cancer surgery, total hip and knee joint replacements, select cardiac procedures, cataract surgery, and MRI and CT scans. To measure the province's wait times, the ministry implemented the wait time information system, which is a Web-based tool used to track and monitor provincial wait times at all hospitals participating in the wait time strategy.

The wait time information system works like this: Hospitals and surgeons submit data to the system that is then consolidated at the wait time information office. This information is then posted on the ministry's website at www.ontariowaittimes.ca. The wait time information system was fully implemented in all wait time strategy hospitals as of July 2007, after the Auditor General completed his audit of the three hospitals. At present, the system is deployed in 82 hospitals across the province. Participating hospitals are those who have elected to take part in the wait time strategy by agreeing to complete additional surgical cases, which is part of their funding agreement. Approximately 86% of all cases completed for these five key services are completed at the hospitals who participate in the wait time strategy.

Currently, the wait time information system tracks the procedures in these five areas, and at present, this represents about 14% of all surgical volume of all hospitals in the province. By summer 2008, the ministry and the hospitals will have implemented the system for all general surgery, all ophthalmology and all orthopaedics, which will represent over 50% of all surgeries in the province. By summer 2009, all surgical procedures at wait-time-strategy-funded hospitals will be captured and reported publicly on the ministry's website. As well, by 2009, the information system will also include pediatric surgical cases at both academic and community hospitals.

While hospitals currently have the capacity to generate patient-priority-level reports, as was referred to in the auditor's report, from the wait times system, by summer of 2008, this information will also be publicly available.

This information system is changing the way hospitals manage their wait times. This particular information system was recognized nationally last year when the project won the 2007 Diamond Award from the Canadian Information Productivity Awards for excellence in the non-profit sector. CIPA is one of the largest business awards programs in Canada and a CIPA award recognizes excellence in information technology and innovation.

In March 2007, significant changes were made to the website, which address recommendations of both the Auditor General and Senator Kirby. There is now a section for patients and a separate section for health care providers. This is to provide more relevant information to better meet the decision-making needs of the specific users. And to improve the public's and providers' ability to use the website, the site has been modified to improve its functionality.

Beginning last November, the patient section is refreshed monthly rather than bimonthly as was previously the case, and reports on the most recent data of the previous three months are also available.

MRI and CT scan information is reported differently on the public and provider sections as recommended in 2006 by the Auditor General. On the patient section of the website, wait time information for in-patients and urgent outpatients has been removed from the wait time calculation. The information now being reported represents elective patients waiting for scans only.

On the health care provider section of the website for MRI and CT scan information, it is now possible to view in-patients, outpatients, or all patients waiting times. This gives providers the ability to see the differences in wait times of these two patient groupings.

All of these new enhancements make it easier for hospitals to compare their wait time performance with other hospitals. The enhancements also enable hospitals to generate reports to help them understand wait time performance within their hospital and make adjustments as necessary. In addition, to assist hospitals to use the wait time information, the ministry has provided all hospitals with extensive training for all users of the information system. Users at each hospital are also supported by their respective wait time information system coordinators who ensure data quality and submission compliance and extract hospital-level reports for performance management purposes.

And so today, wait time hospitals are regularly using the system to review their data and their ability to meet targets.

Finally, I want to inform the standing committee that the ministry established an independent data certification council in February 2007 to review and approve how Ontario's wait time information is collected and reported on the wait time website, to ensure fair and accurate representation of the information.

As stated before, standardized reports are available on the wait time information system, and the information office is in the process of developing a decision support tool to assist hospitals in using this information. The tool will be provided to all wait time hospitals in the spring of 2008.

Again, as I stated, the system is moving to report all surgeries in wait time hospitals. This is a system in evolution and enhancements will be made as time goes on and as needs arise.

In reference to the recommendations related to surgical efficiencies, as noted in the Auditor General's report, the ministry is implementing the surgical process analysis and improvement—or SPAI—expert panel's report recommendations. This panel was established in October 2004 to assess the patient's journey from the decision for surgery through the perioperative stage and to identify areas that could be improved to increase surgical efficiencies in order to provide a seamless flow for the surgical patient.

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One recommendation of the SPAI expert panel was that the ministry implement perioperative improvement coaching teams. This program was started in the winter of 2005-06. These coaching teams, composed of clinical and administrative experts in surgical practice, help hospitals to improve their operating performance by assisting hospitals to address many of the efficiency issues identified in the Auditor General's report. The teams are made up of peers with experience in the effective management of operating rooms. They assist hospitals with planning, mapping their processes, analyzing results,

identifying areas for improvement, and determining optimal human resources and scheduling of surgery. The coaching program started in December 2005, and to date the coaching teams have visited 46 sites.

An additional recommendation of the SPAI expert panel was to develop a surgical efficiency targets program to track and monitor predetermined operating room key performance indicators. The surgical efficiency targets program, or SET, is a Web-based tool, again, where participating hospitals enter operating room data into the system. Although the system is still in its implementation phase, all wait-times-strategy-funded hospitals are involved with the program and are tracking phase 1 key performance indicators, which include prime-time operating room utilization, start time accuracy and scheduling accuracy.

Additionally, in order to calculate utilization, the program requires operating room information. To date, there are 676 operating rooms currently in use among the 82 hospitals participating in the wait times strategy. Phase 2 of the program will capture unused capacity in these hospitals as well.

The data that is collected on the SET program provides decision-makers at the participating hospitals, the LHINs and the ministry with current and reliable information regarding operating room performance. This system will provide local health integration networks with accurate data to work with their hospitals and community stakeholders to more efficiently allocate resources, optimize surgical throughput, reduce wait times and improve the patient experience.

It will be the role of the local health integration networks to work with the hospitals, using this data, to develop work plans to achieve target improvements. Once performance targets are set, LHINs will be able to ensure that hospitals are managing in accordance with the best practices developed by the expert panel.

Next, let me turn to recommendation 9 in the report regarding patients who no longer require hospital care.

As you are aware, the ministry has put into effect a number of strategies to improve the flow of patients through the health care system. This includes investments in alternate levels of care, which were announced on February 16, 2007, and the aging-at-home strategy, which was announced by the government on August 28, 2007. The local health integration networks are primarily responsible for the implementation of the aging-at-home strategy, to be done over a three-year period. The focus of both of these strategies is on improving health programs for seniors at home; preventing senior admissions in hospital emergency departments; building appropriate community settings and seniors' programs within those settings; improving care delivery; and improving hospital performance related to seniors' care.

The last item I'd like to address is the Auditor General's recommendation related to flash sterilization. I thank the Auditor General for raising this particular issue.

On receiving the draft report, the ministry, in conjunction with the Ontario Hospital Association, forwarded a letter to all hospitals asking them to review their sterilization procedures in relation to the Provincial Infectious Diseases Advisory Committee, or PIDAC, guidelines entitled Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings.

The OHA, as you will hear shortly, convened a conference and held a webcast on their website on flash sterilization. Recently, the Ontario Hospital Association distributed a flash sterilization fact sheet developed by PIDAC to all hospitals.

This work with the Ontario Hospital Association is the best example, in my view, of the new approach that the ministry is taking to its role. I would like to thank and compliment the Ontario Hospital Association and its staff for their collaborative efforts to inform providers of this matter. The ministry is committed to working with its partners and to ensuring that Ontarians receive high-quality, timely and appropriate care.

Once again, Chair, I wish to thank the public accounts committee for this opportunity today to discuss how we are managing in these areas and how we intend to work harder in the future to ensure Ontario's health care system will continue to provide the best possible health care for all Ontarians.

Again, the ministry is grateful for the Auditor General's report. Productive feedback is an important part of any efficient system. Continuous improvement is the key to every successful activity, and effective improvement depends upon useful feedback. The Auditor General's report is indeed an invaluable report card that tells us what, where and how we can improve Ontario's health care system. Thank you, Chair.

The Chair (Mr. Norman W. Sterling): Thank you very much.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Norman W. Sterling): Next, for members of the committee, we're going to hear from Mr. Closson, who is the newly appointed president and chief executive officer of the Ontario Hospital Association. On behalf of the committee, I want to congratulate you on your new appointment.

After Mr. Closson's presentation, we'll call forward the representatives of the three hospitals. They are going to respond to questions from the committee as well as Mr. Sapsford and Mr. Closson.

So, Mr. Closson, if you would go ahead.

Mr. Tom Closson: Thank you, Mr. Chair, and good morning, everyone. On behalf of my—

Mr. David Zimmer: Could we have a copy of the remarks?

The Chair (Mr. Norman W. Sterling): No, we don't have a copy of the remarks.

Interjections.

Mr. Tom Closson: On behalf of my colleagues behind me—Kevin Smith, who is the president and CEO of St. Joseph's Healthcare in Hamilton; Joe Pilon, who is the vice-president of Sudbury Regional Hospital; and

Rob Devitt, who is the president and CEO of Toronto East General Hospital—I'd like to thank the members of this committee for inviting us to speak and answer questions about the management and use of operating rooms. I should say that the CEO of the Sudbury Regional Hospital is ill today, and that's why Mr. Pilon is here on her behalf.

Because we embrace accountability and transparency, Ontario's hospitals are always interested in the opportunity to speak publicly about our many successes and also about the steps we're taking to do even better. This is one of those opportunities. So, again, thank you.

As you know, we're here to respond to the observations and recommendations regarding hospital operating room efficiency made in the Auditor General's annual report, to outline progress we've made since the audits were conducted, and to answer questions you may have.

The Auditor General found that audited hospitals were, in his words, "managing ... their surgical facilities well in some areas" and were working with the Ministry of Health and Long-Term Care on "several encouraging initiatives in connection with its wait-time strategy designed to help hospitals improve their surgical processes"—on page 206 of his report.

I would like to note that the Auditor General's observations with respect to sound management in hospitals are consistent with other independently produced evidence that suggests Ontario hospitals are among the most efficiently operated in Canada.

The last few years have been a time of continuous change for Ontario's hospitals. In 2004, the government of Ontario created the wait time strategy. I'm proud to say that the OHA and its members supported the wait time strategy from the outset and we continue to support it. The creation of a wait time strategy was revolutionary in terms of how wait lists were managed in hospitals. An inefficient, largely paper-based approach to wait list management was replaced by one that is digital, centralized and systematized. The introduction of a new and welcome volume-based funding approach, when coupled with surgical process and standardization improvements, has allowed hospitals to complete more surgeries more efficiently. The new and improved techniques are being shared across the hospital sector through conferences and training sessions such as those sponsored by the Ontario Hospital Association, and also by ministry-led expert perioperative coaching teams.

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Anyone with a computer can now go online and, with a few keystrokes, access information about wait times in hospitals, in LHINs, and across the province. This kind of information can help patients and their health care team to determine the best course of action.

Finally, and most importantly, the length of time that Ontarians are waiting for a number of very important procedures has shortened significantly at many hospitals. These are successes that hospitals are rightly proud of.

That said, it is no secret, and should be no surprise, that the full potential of the wait times strategy has not yet been reached. The introduction of any revolutionary tool requires users to rethink every aspect of how they do things and what they do in order to make full use of that tool.

As noted in the Auditor General's report, hospitals must absolutely make better use of the data that they are collecting. More must be done to improve the scheduling of procedures in ways that allow hospitals to maintain the integrity of their surgical staffs and reduce the number of delays or patient cancellations. We must also ensure that surgical instruments are available and ready to be used every time they are needed. These are relatively straightforward improvements that most hospitals can make. The OHA will continue sponsoring training opportunities where our members can both learn and share how they are successfully implementing these improvements.

We must also remember that as a public policy instrument, the wait times strategy is relatively young and has not been perfected. It is also fair to say that the wait times strategy has put new pressures on hospitals. Some pressures, like ensuring the right mix of health professionals is available at Ontario hospitals, were anticipated. Others, such as the extent to which the demand for surgical instruments would increase, were not. Further, the increasing levels of alternate-level-of-care patients in our hospitals, if left unaddressed, could make additional progress more difficult. However, we are working with our partners in hospitals, in the wait times strategy office at the ministry and at the HealthForceOntario group, to make sure these challenges are met head-on. I believe very strongly that we can resolve these challenges and do more for patients.

I will now turn briefly to the use of the procedure known as flash sterilization.

Flash sterilization is meant to be used when the rapid turnaround of instruments is required. The Auditor General found that flash sterilization was being used at some audited hospitals with higher than appropriate frequency. I would like to stress that I am not an infection control expert, so I'm not in a position to answer all the technical questions about surgical instrument sterilization techniques, or flash sterilization specifically. As you know, the OHA is a member-oriented advocacy organization; we're not a regulatory or scientific body. For that reason, we defer to the expertise of the Provincial Infectious Diseases Advisory Committee, or PIDAC. PIDAC has stated that flash sterilization is an acceptable practice in certain circumstances. For example, a situation could arise in an operating room where an important instrument is contaminated and there's not enough time to subject it to the regular sterilization process. In such circumstances, the risk to the patient of having to wait for a reprocessed device is greater than the risk of flash sterilizing the instrument. I'd also like to reassure the members of the committee and Ontarians who may be watching or listening that these experts believe the use of flash steri-

lization in these circumstances poses a low risk to the patient.

As noted by Deputy Minister Sapsford, in November 2007 the OHA and the ministry distributed PIDAC's advice on the appropriate use of flash sterilization in a letter to every hospital in Ontario. We followed that letter with a videoconference viewed by 274 individuals from OHA member hospitals, during which PIDAC's experts discussed the appropriate use and methods of flash sterilization. That videoconference was archived on the OHA's website and has since been viewed by an additional 186 individuals. We have also distributed to hospitals a flash sterilization fact sheet to reinforce the advice and are examining additional opportunities, such as educational conferences, to reinforce best practices.

I would also like to note that the OHA has worked with the Ontario Buys Ministry of Finance broader public sector supply chain secretariat to create and launch the operating room supply chain project. The objective of this program is to assist hospitals to make targeted improvements that would ensure sufficient instrumentation and supplies to support operating room schedules, separate physical supports from clean and soiled instrumentation and supplies, and standardize instrument supplies and vendors.

Each of these process enhancements would promote specific leading practices as identified in the Ministry of Health and Long-Term Care's surgical process analysis and improvement expert panel report. A number of hospitals have expressed their interest in this project, and we expect to begin evaluating its success beginning in April 2009.

I would like to conclude my remarks the way I began them, with our thanks. I would like to thank the Auditor General for his report. I can assure him and members of this committee that the OHA and its members will take the recommendations very seriously. As you've heard, a number of the initiatives have already been undertaken to respond positively to the Auditor General's recommendations, and our work, both at the OHA and the audited hospitals, continues.

Through you, Mr. Chair, I would like to thank the committee again for allowing us the opportunity to appear here and discuss the Auditor General's recommendations and observations. We look forward to answering any questions that you might have. Thank you.

The Chair (Mr. Norman W. Sterling): Thank you very much. I'll call forward now Mr. Smith, Mr. Pilon and Mr. Devitt. Perhaps each of you could identify yourselves, which hospital you come from and approximately its size. Mr. Devitt, who I am very well aware of from my long political career, used to be at the Queensway Carleton Hospital. He won't go away, and I won't either.

Mr. Robert Devitt: Thank you, Mr. Sterling. I'm Rob Devitt. I'm CEO of Toronto East General Hospital. Toronto East General is about a 500-bed community teaching hospital, so that means we offer a full range of acute care, rehabilitation and mental health services, and we're also very active in teaching the full range of health professionals: nurses, physios, pharmacists, physicians.

Dr. Kevin Smith: Good morning. I'm Kevin Smith from St. Joseph's Healthcare in Hamilton. We are an academic health science centre affiliated with McMaster University. Approximately 5,000 people make up the organization, with a budget of approximately half a billion dollars.

Mr. Joe Pilon: I'm Joe Pilon. I'm the senior vice-president at Sudbury Regional Hospital. We're also an academic hospital, fairly large. Our budget is about $300 million and we have about 525 beds.

The Chair (Mr. Norman W. Sterling): Thank you very much. Mr. Hardeman, you had some questions?

Mr. Ernie Hardeman: Thank you very much for your presentation.

First of all, I want to say thank you on behalf of all the people I represent for the good job the hospitals do in providing health care to them. I was talking to a professional in the health care field not too long ago and we were talking about the challenges and the things we hear in the media from day to day about how bad it is. He said, "You know, the largest complaints come from people who have never been involved in the health care system, who likely haven't even been to the hospital." So I want to say that it's not often enough, when we have the opportunity to talk to the people who administer health care in hospitals, that we say thank you for doing the work that you do.

Having said that, I just want to start off with the discussion I had with the Auditor General this morning, to make sure that we—

Mr. David Zimmer: Excuse me, Chair. Just before we start, what is the rotation plan?

The Chair (Mr. Norman W. Sterling): Mr. Hardeman caught my attention first. We give parties usually about 15 minutes each, and we rotate around.

Mr. David Zimmer: Okay. Thank you, Chair.

Mr. Ernie Hardeman: The discussion I had with the Auditor General this morning—and I appreciate the hospital association being here this morning. The question and the concern I have is that as we have the Auditor General look at the operation of three hospitals and we hear from the presenters how invaluable that tool is to find the things that can be improved upon, how do we proceed to get that message out to all the other hospitals, that we want to make those improvements even though they weren't the lucky ones to get audited?

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Mr. Ron Sapsford: The process that we use—certainly, we view the Auditor General's report as part of what I would call quality improvement. Continuous quality improvement in the health care sector is a way of operation that's quite common. So we use the auditor's report as identifying areas for improvement, as you've heard this morning and as we'll talk about. The ministry and the OHA and hospitals have followed up to try to build those improvements into the system. But that's only the first step, because we're using the wait list strategy as an

example of how to improve the system and then take the next steps to expand that across all hospitals.

So it's an ongoing process, and we're using the wait list hospitals; I should say that there are 86 of them, I think, but they do represent a huge amount of the surgical care that is offered in this province. While we're focused on certain procedures, inside the hospitals they're looking at these improvements and applying them to all of their surgical cases; then beyond that, as we gain experience, moving it through teaching and updates and the coaching teams as well to all hospitals across the province.

Mr. Ernie Hardeman: On that same issue, the flash sterilization would come into question. In your presentation you said that we immediately sent out letters to every hospital stating to look at the protocol, to make sure they adhere to the protocol. I guess this would be the hospital association, because they sent out the letter. How do we deal with the fact that now that we've told them what they should do—what assurances do we have that that's what's happening in every hospital? It appears the only reason that they were using flash sterilization is because of the lack of resources to buy the equipment—we want quicker turnaround for the same equipment so we do it that way. What is going to prompt them to change just because we told them to look at the protocol?

Mr. Tom Closson: You have to start from the premise that hospitals are independent corporations. They have their own boards, they have their own medical advisory committees, and they have to manage the trade-offs in terms of how they allocate their resources to best serve the patients that they serve. The Ontario Hospital Association, as I indicated earlier, is not a regulatory organization. We're there to support our members, providing them with information on best practices, providing education on best practices and videoconferences, and we really encourage all our members to participate. But in the end, the individual hospitals will have to make their own choices.

If we look at flash sterilization as an example, in preparing for today—because, as I said, I'm not an expert in infection control—I had a discussion with Dr. Michael Gardam. I used to be the CEO of the University Health Network; he's the head of infection control there and somebody I have a very high regard for, having gone through SARS with him a few years ago. When you look at infection control in general in hospitals, there are actually a lot bigger issues than flash sterilization. Probably the biggest issue—I'm sure you've read about this in the papers—is whether the providers wash their hands, and having campaigns to do that.

Another very important thing, very expensive to do but they're doing it at UHN at the moment, is testing every patient who comes in for MRSA, VRE and C. difficile. It's very expensive to do. I'm sure you've read in the paper about the issues associated with outbreaks related to those in hospitals, not only causing inefficiency but also in the end actually having some people die as a result of contracting these bugs. These are real, serious issues that cost a lot of money to address.

If we take that in comparison—this is why I say that I think each hospital board needs to make its own decision. This is best practice in terms of flash sterilizing only in emergency situations, but for some hospitals, being able to do that would require hundreds of thousands—in fact maybe millions—of dollars' worth of investments in additional instruments.

Just to give you an example, for heart bypass surgery, the instruments to do a case cost about $80,000. Obviously, you reuse the instruments and don't throw them away, but if you were increasing your volumes and therefore had to have more sets of instruments, they're very expensive, and it adds up because we're increasing the volumes of surgeries to reduce wait times in the province. So a board would be faced with the situation, "Okay, we want to improve infection control here. Would we be better off spending our money on buying more surgical instruments so we reduce the amount of flash sterilization, or would we be better spending our money on testing of people for MRSA or VRE, or having a major handwashing campaign and monitoring what's going on?" These are the kinds of challenges.

We're not telling them exactly what they should do; we're giving them best practices and trying to engage them on that. What we're getting back from our members is, they want to move towards best practice in this area, they want to be using flash sterilization only to a minimal extent, but the risk is a theoretical risk. There are no studies out there you could find that say that people are dying because of the extent of flash sterilization. It's a totally theoretical risk, whereas some of these other risks I mentioned aren't theoretical. There's good evidence from research that would suggest that they're very serious. So we provide the information, as I say, and the education, and then each hospital board needs to make their own decisions.

The Chair (Mr. Norman W. Sterling): Dr. Smith, did you want to add to that?

Dr. Kevin Smith: There's one other issue to Mr. Hardeman's question. We also have a national accreditation body, the Canadian Council on Health Services Accreditation. One of the standards that our accreditation body looks at would include issues of infection control. So in addition to the very helpful work of Mr. McCarter and Ms. Klein, we also have regular updates to our accreditation council, and that would be carefully observed.

Mr. Ernie Hardeman: I guess my concern, as was mentioned earlier, is that we have to weigh the cost-benefit for all procedures in order to make the budget stretch. So I think when the auditor says that this is not the safest way to do it, and we tell all the hospitals that this is not the safest way to do it, somebody has to stand up to the plate and say, "Okay, here's the funding to change what you're doing." There has to be a connection between expecting something and allowing hospitals to be able to do it.

Mr. Tom Closson: There's only limited money in the health care system, and that's one of the reasons having hospital boards makes a lot of sense, so somebody locally, with the advice of experts, can be making these trade-off decisions in the best interests of patients.

Mr. Ernie Hardeman: Getting to the point of there being only so much money, in my community and in a lot of smaller towns in rural Ontario, utilization of hospital operating rooms is strictly based on their ability to pay for them to be open. In fact, operating rooms are sitting idle because they can't afford to keep them open or have them utilized. If you look around in my community, the hospital with the most balanced budget is likely the one that performs the least operations, because the operating room isn't open. Doctors call my office and say, "We could reduce the waiting time if we could get more operating room time." The room is there—it's not functioning—but they can't get time because they're only allocated as much as the hospital can afford.

Do you have any idea, representing the hospital association, how big a problem that is, that operating rooms are just not operating because it was decided that the budget money would go somewhere else?

Mr. Tom Closson: First of all, you only need to do as many surgical procedures as need to be done. I don't think we'd want to fill all of our operating rooms with surgical procedures. There's only so many that need to be done. The wait time strategy is trying to determine whether people are getting timely access to surgery. We're still not at the targets of the wait time strategy; this is work in progress. We're moving towards it, so it would suggest at the moment that there's still a need for more surgery to be done. So I'll say that.

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Then you come to the issue of where that surgery should be done. The Ontario Hospital Association believes strongly that each of our local health integration networks needs to develop a regional service plan of the various mix of capacities: acute beds, the amount of surgery, the number of operating rooms, the number of nursing home beds, the amount of home care—you name it, the whole gamut. There needs to be a standardized approach to that in the province.

That sort of work was actually done 10 years ago at the time of the restructuring commission, but that work hasn't really been done in a very formal way across the province in the last 10 years. We believe strongly that it should be done. Then you could try to determine where and what kinds of procedures should be done.

For small hospitals—I know that in some cases in the north there are orthopaedic surgeons going from, for example, Thunder Bay out to the smaller communities so many days a month to do surgical procedures in those facilities. So you need the surgeons, you need the nurses, you need the anaesthesiologists; you have to have the right mix of staff. As you know, that's another issue in the health system. It's challenging to get the staff we need to actually do the procedures. Sometimes, procedures tend to be more consolidated just because you can't get access to that kind of staff in the smaller communities. But, as I said, there are good examples of surgeons going out and doing the procedures in local hospitals, which has the benefit for the people in those local communities that they don't have to go long distances to get the procedures done.

Mr. Ernie Hardeman: One of the things that the association has suggested is that there's 18% occupancy of beds in the hospitals that would be better served in another location, another way of service. That's holding up the process of surgery, particularly in the wait time strategy priority areas.

I guess the question is, which is the problem—the beds that are not available at the end of the surgery, or our ability to do the surgery if we found a place to put that 18% of our population in each hospital?

Mr. Tom Closson: Let me speak about it, first, a little bit more broadly, because you've raised the issue of alternative level of care, which, of course, is in our documents and in the auditor's report as well.

We have a growing issue around alternative-level-of-care patients. These are patients who have finished their acute care episode and they're still in the hospital. It gets back to my earlier point. If we had the right mix of capacities out in the community for home care, assisted living, nursing homes, we could move them out.

The major impact of ALC is not on surgery, although there are some minor—I'll come back to that. The major impact of ALC is you've got all these medical patients—they tend to be medical patients, not surgical patients who are ALC—in medical beds, and all the medical beds are full and people need to be admitted out of the emergency department into the acute care beds, and they can't get out. So actually the big impact is on emergency ward wait times.

However, having said that, there certainly are examples from time to time in different hospitals of medical patients actually having to be cared for in surgical beds because all the medical beds are full. What do you do? You're trying to get people out of the emergency department, so the medical patients are put into surgical beds. Now you're faced with the situation where surgery is to be done and the concern is that there is not going to be a bed to put the patient in after the surgery is finished, so the surgery has to be cancelled. This is not a huge issue, but it is an important issue because, if you're a patient, you wouldn't want your surgery to be cancelled.

I need to say one other thing, though, just to put this in context. For about 70% of surgery that is done in Ontario hospitals, people don't go into in-patient beds; it's day surgery. They go to the hospital, there is day surgery and they leave. It's not impacted by ALC at all. It's that 30% where people would need a bed. Sometimes they are having to cancel those cases because the beds are full of medical patients.

Mr. Ernie Hardeman: The reason I asked that question is that it's part of the auditor's report. He drew a connection. He was looking at the utilization of our emergency facilities and he came up with the conclusion

that there was a roadblock in the way—beds occupied by people who shouldn't be there—so surgeries were being cancelled, just as you mentioned.

Mr. Tom Closson: Yes.

Mr. Ernie Hardeman: I guess my question is, if we found a way to get those beds vacant, how much impact would that have on our wait time for surgery?

Mr. Tom Closson: Hospitals do not like to put medical patients in surgical beds. It's not the best care, right? The nurses are used to dealing with surgical patients; particularly in the bigger hospitals, you have to have certain doctors go to those units where they don't normally go to take care of that medical patient. So it's not the best care. If the ALC numbers dropped, the first benefit would be to keep the medical patients out of the surgical beds; that would be the first priority. That would mean that surgical cases wouldn't be cancelled because there was no bed. But the reason surgical cases get cancelled isn't just because there is no bed. It could be because there are no nurses. It could be that they need to go to the intensive care unit, and the intensive care unit is full. It could be because they're short of anaesthesiologists. It could be because somebody got sick—

Mr. Ernie Hardeman: No, I'm not suggesting it is, but my question really is, what part of the problem belongs to that? If you're going to solve a problem, you have to look at what needs to be solved.

Mr. Tom Closson: Right.

Mr. Ernie Hardeman: How much would we improve the process for the emergency department if that was done, if we had more long-term-care beds or more people in their home?

Mr. Tom Closson: For the emergency department it would be night and day, if we didn't have the ALC patients. Right now, we have about, by my latest numbers—it's actually grown a bit, but the last numbers we've been using are 680 people who are in emergency departments, admitted, who can't get into acute care beds, and 680 patients is a lot of patients. It's bigger than most hospitals are in this province. In fact, it's as big as a couple of hospitals or maybe three hospitals, so it's a big number. So that would really help with the emergency department access issue. On the surgery issue, it would be a small part of reducing the likelihood of the cancellation of a case, but it's not a major contributor to case cancellation.

The Chair (Mr. Norman W. Sterling): Thank you. Ms. Horwath.

Ms. Andrea Horwath: One of the things I was curious about is that the auditor's report mentions that the internal audit service of the ministry hasn't been used to determine any of the surgical issues. So I was just curious, and it's a really small issue: Is there an internal audit service that the ministry has, and what are its priorities at this point? Then, to follow up with that, the auditor's report also suggests that perhaps individual hospitals should have internal audit functions, and apparently many of them don't, or all of them don't. So a little bit of conversation about that, just a curiosity issue.

Mr. Ron Sapsford: Yes, the ministry does have an internal audit function. They're generally directed to auditing of provincial health programs to ensure that we're in compliance with government standards, transfer payment rules and so forth. So they act as a resource to the ministry at large for our own management of the broad range of programs and services that we have. They will also function in urgent situations, going out into the field where a specific problem is identified, a financial problem, and then we would dispatch our internal resources out to a facility or a specific problem where we had concerns about the financial health, perhaps, of an organization.

In this particular case, the whole wait times strategy is a project in and of itself, and we've organized and devoted substantial ministry resources to developing the project, working with the hospitals, implementing the project, developing and implementing the information system, and working with them that way. Occasionally, as we go through the program implementation, we'll ask our internal audit team to go in and monitor as we go to make sure that as we develop and implement the program, it's being done with best practices in mind.

Ms. Andrea Horwath: Okay, excellent. And just from some of the hospitals maybe, do you have internal audit functions, and do you find them useful?

Mr. Joe Pilon: We certainly do. It goes to organizations trying to measure their performance, and one of the ways we do that is benchmarking. We do that internally at Sudbury Regional Hospital with decision support, and occasionally we take outside consultants, third party, who have objective means of auditing our processes. We've done that in the OR with some outside consultants. We were fortunate enough to have the auditor come in as well. It is important, in the new days of strong accountability, for organizations to audit their processes.

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Dr. Kevin Smith: We too can offer a number of internal processes. What we haven't offered, and what I think the Auditor General's process allows us to look at, is a value-for-money audit. I think that is a new approach for us, and it's been a very helpful one.

Mr. Robert Devitt: We don't have a formal internal audit process along the lines that Kevin just spoke of. We've actually looked at it and the cost to put it up and running, and we've made the decision to invest that money in direct patient care. But we do regular benchmarking annually as we do the budget development process. Our board gets a quarterly report of performance indicators, measured against provincial benchmarks. We've been able to balance our budget in each of the last four years; in fact, to turn a surplus.

Mr. Tom Closson: Almost all of the medium and larger hospitals in the province participate in a benchmarking exercise that the Canadian Institute for Health Information and the Hay Group manage to measure clinical and operational efficiency and compare one hospital to another. That's a national benchmarking, so that

means we can actually benchmark Ontario hospitals against hospitals in other provinces. You may have noticed that I slipped into my remarks how Ontario hospitals are the most efficient hospitals in Canada. This comes from that benchmarking, the CIHI/Hay. It shows that we admit fewer people per capita, we keep them for a shorter length of stay, and we staff at lower levels than at other provinces. So Ontario hospitals are quite remarkable. In fact—I said this to SCFEA and I see a few similar faces—we actually spend $100 per capital less on hospitals in Ontario than the other provinces do. One hundred dollars doesn't sound like much until you multiply it by the number of people in Ontario: It comes to $1.2 billion less that we spend on hospitals. So I'd never suggest that there isn't room to improve our processes or to improve efficiency in Ontario hospitals, but we're starting from a very solid base of efficiency in this province.

Just to be a bit more specific about internal audits, I was fortunate enough to work at both Sunnybrook and the University Health Network. In both cases, we discussed the idea of having an internal audit group and decided against it at the board level because of the challenge, given the size of the organizations, of recruiting and retaining really good people to perform that function. I expect the Auditor General would say that he has difficulty doing that, even for the whole Ontario government. So what we did instead at both of those organizations, and a number of larger hospitals do this, is they have their own auditor who audits their financial statements, but they'll use a different auditor, an external auditor, to be their internal auditor. There are a couple of external auditors who have sort of specialized in this, and they're doing it for several hospitals. That has the advantage, then, that they can compare what they're seeing in one hospital to another and to provide some real value-added to the organization. So you can do it that way.

As was mentioned, at Sudbury they tend to use management consultants. Certainly almost all hospitals use management consultants to a greater or lesser degree, to maybe give them a sense of the value for money that they're achieving. But because of the financial pressures, every year we're constantly looking to become more efficient. We have no choice. The focus on patient safety, which has become enormous in the last few years—hospitals are putting lots of energy into looking at how they measure whether they're safe and how they change their processes to be safer for patients. The environment imposes a real requirement that we be accountable, but I think—and I've been in the industry a long time—the people who work in the industry at the moment are really grabbing hold of trying to work on improving how they function.

Ms. Andrea Horwath: Thanks very much.

I'm going to switch gears a little bit, because one of the issues that came up in the report and piqued my interest—and maybe a little discussion about this would be helpful. I know that the purpose of the wait list strategy and a lot of the work that's being done by the ministry is really all about improving access of patients to docs, to surgeons, to nurses, to the whole medical system. But one of the things that came up in the process of the auditor's work and is identified in his report is the idea of making public the individual surgeon wait lists. I know that there is some resistance to that by the ministry. I know there are other jurisdictions, as the Auditor General reported, that have that in place already. I just want to get a perspective from the ministry as to why the ministry is resistant to that or doesn't believe that's a good thing to do, and then maybe some comments from some of the others as to making public the surgeon-by-surgeon wait list.

I guess part of the reason I raise it is because if the stated goal is to reduce wait times and provide greater access, then, in theory anyway, you would think that family physicians and patients could perhaps have more choice if they knew which surgeons had a lower wait list and could perhaps make decisions based on that, as well as the website and the other information that's out there. So maybe, Ron, if you wanted to start with that.

Mr. Ron Sapsford: I'd be happy to. You're correct in your assumption: This is about accessibility. You've heard from my colleagues some of the issues surrounding access to surgical services. The points of access or the issues that have to be addressed are frankly not at the level of a surgeon but rather at the level of the institution. So how surgeons get access to operating rooms is a decision in the hands of the hospital, not an individual surgeon. The referrals to surgeons are done doctor to doctor; the access to surgery is a partnership between the surgeons of the hospital and the hospital in terms of allocation of time in the OR, numbers of days a week and so forth.

So as the ministry looks at where we focus our attention, the most success comes from focusing the attention and having the agreements and understandings and accountabilities not with individual surgeons but with the hospital itself. Then the hospital in its role of managing the resources of the hospital works out with its surgical staff questions of access to operating room time. For that reason, reporting an individual surgeon's wait list isn't necessarily going to tell you how that plays out at the level of the hospital. Our agreements are with the hospitals and there's an understanding in those agreements that issues of access and allocation of operating room time is an active discussion that goes on between the hospital and its medical staff.

I think the other important consideration is that one of the solutions that we've been looking at to begin to solve the question of access is the very point you've raised about individual physician referral mechanisms. Traditionally, you would go to your family practitioner: "Oh, you need to see a surgeon. Go see this surgeon or go and see that surgeon." It's handled by the physicians referring among themselves, quite independently of where those particular specialists practised.

We've been looking at options, rather than people gaining access to certain procedures physician to phy-

sician, simply making the referral to an institution or a program. Who actually performs the surgery is not as important as getting accessibility. In one particular new model that we're trying now at the Kensington unit here in Toronto for cataract surgery, patients are referred to that surgical facility and the surgeon who performs is based on who comes to the front of the line—the next surgeon in line, the patient and surgeon are matched up. Of course, if there are objections to that by an individual patient, those accommodations are made.

That kind of organizational model is more effective at bringing the patient to surgery much more quickly because you're not having to worry about which surgeon has access to how many rooms and on what day of the week. That's a second major reason that surgeon by surgeon, in our view, is less important than coming to agreements on accessibility with the organizations that are offering the services.

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Ms. Andrea Horwath: Thanks. Kevin?

Dr. Kevin Smith: Let me supplement what Ron has had to say. I totally agree with the issue of a systems capacity, that looking at referral to individual physicians perhaps is a model of the past. In the future, we really need to look at—we have capacity. How does one push as much volume as possible through that with high-quality outcomes?

The other is some perverse incentives in systems, and it would be the impact of long or short wait lists. Some academic literature has looked at this in the United States. Interestingly, patients have occasionally said, "I'm not sure I want to go to the physician with the shortest wait list. I think I want to go to the physician with the longest wait list," and perhaps incorrectly concluded from that that a wait list is equated with quality. It might simply be equated with time in practice or movement in the area or what have you. So again, there are some challenges around that.

The other is a bit of short-term impact based on measurements. We know the Hawthorne effect or other effects can have a short-term rebound when we start measuring things at units too small to have statistical significance. I suspect that is the case with most surgical procedures.

Lastly, in some more private sector endeavours than Ontario, thank goodness, we have an approach that would say, "I'm going to do things that are particularly quick to push through," as opposed to looking at a balanced contribution of everyone carrying some of the heavy work and some of the lighter work. So collectively, I think we've found, and our surgical teams have found, it's better that we should look at that.

What we can and should do as individual hospitals, I would say, is make sure that surgeons and surgical teams are provided that data, so that I could look and say, "Well, if everyone is around the mean but I'm way out here, maybe I want to understand that or at least have access to that data." There may be very good reasons for it. If I'm an orthopaedic surgeon, perhaps my wait list is very long because I have a patient roster of "re-dos": people who've all had a hip before or are getting another hip. Maybe it's a very focused practice and it takes a long time to get to that super-specialist. But the data has often been unreliable; aggregate data has been much more helpful.

Ms. Andrea Horwath: Thanks very much. You raise an issue that I find curious in terms of the wait list strategy. One of the things that you mentioned was the way that patients might determine, "Gee, that one's got a short wait list; I don't want that guy because he's obviously not very good." But what is the mechanism for quality outcomes? How do you measure the outcomes of the quality of the surgeries that are being done in hospitals? Where is the feedback loop in terms of—there's the wait list strategy and those things are in place, but at what point are you measuring or looking at the quality of the procedures being done and the quality control mechanism? Is that something that's part of the information collection strategy that you have now? Is it something to be added in? Is there anything at all that feeds back the quality piece or the outcome piece of surgery?

Mr. Ron Sapsford: The wait list information system is an administrative process. It's about how to monitor patients through the surgical procedure and focused on how we improve accessibility. The questions of quality of surgery are an ongoing responsibility of public hospital boards through the Public Hospitals Act. We've developed the system with the assumption that the quality reviews and quality monitoring is an ongoing part of what hospitals do, and I know any one of these people could speak to that.

Ms. Andrea Horwath: And do those boards then report back to the LHIN or to the community in any way around those quality issues?

Dr. Kevin Smith: Many of us are now posting that information on our website. In Hamilton, our hospitals have put—we have balance score cards for each of our major programs and they're available on the website for whomever would like to look at them.

The Auditor General might comment on this one: Some people would say that we measure too many things in hospitals. There's an awful lot of data out there, but I would suggest that any area of drill down around aggregate quality outcomes is available. I think there is variation across hospitals about how easily accessible it is, but our industry is moving much more toward open access of information.

Mr. Tom Closson: Can I just add that this is something certainly the Ontario Hospital Association encourages its members to do, to be as transparent as possible, to post information on their websites in an understandable way, which is actually quite a challenge when you survey patients about their—how you put something in such a way that they can actually benefit from seeing it. We need to keep working on that.

Kevin mentioned the accreditation council earlier. All hospitals in Canada voluntarily are accredited once every three years. Now they're moving to a new process that

collects certain information on a continuous basis in terms of quality indicators in hospitals. Accreditation is one way of trying to take best practice around measurement within a hospital and share that information with the hospital board, and then ultimately with the community, and really trying to promote that in a standardized way across the system.

I don't know if you're really asking this, but at the individual surgeon level—because I would agree entirely with what Ron said about the importance of trying to focus on hospitals rather than individual surgeons for wait lists. If you look at the past, which we're trying to get away from, the surgeons were the only people who knew how long wait lists were. The hospital didn't know, the ministry didn't know; only the surgeon knew. We're trying to move to a process here which is more standardized and centralized and makes it better for patients so that they can see what's going on.

We want to encourage surgeons to share cases in a hospital. In the past, the old world was almost like market share: "That's my patient." We want them to share patients. We want them to work together. We have a good example over the history in Ontario of cardiac surgery, where cardiac surgeons have been very good at sharing their cases. But that hasn't been the case in all other kinds of surgery. So, we want to encourage it. I think that reporting information by hospital is a better way to make that happen so that we can get our minds around it.

On the issue of quality, it's really important in each hospital that they also measure the quality of the service; not just of the group, but also of the individual surgeons. Hospitals are divided into medical departments under the Public Hospitals Act. It's the responsibility of the head of each department—the head of surgery, the head of medicine, and the bigger hospitals break it down: neurosurgery, general surgery, cardiac surgery etc.—to be doing those kinds of reviews of each individual and analyzing the data to see which individuals are having good outcomes, looking at infection rates, things like that, and making sure that where there are issues, those get addressed, some of which may be individual surgeon-related, some of which may be case-mix related, and trying to understand why they're getting different outcomes.

Hospitals are working on that. Again, the accreditation council really encourages that. Of course, the legislation—I forget the name of it—that was passed a couple of years ago, I guess while I was out in British Columbia—

Interjection: QCIPA.

Mr. Tom Closson: —QCIPA, which protects the discussion of this from litigation so that it's encouraging doctors to actually sit down and look at each other's cases and understand where there are quality problems and then deal with those quality problems, was really helpful legislation. They had that in British Columbia when I worked there in the late 1990s, and I know it really facilitated getting doctors involved in that kind of dialogue without fear of litigation because there was discussion of outcomes. I think we're making real progress in that area, at the individual hospital level.

The Chair (Mr. Norman W. Sterling): Mr. Zimmer.

Mr. David Zimmer: I have two questions, and they're very general questions, just to help me understand this whole issue of wait times. In the auditor's report, between pages 206 and 208, is the following statement regarding pre-operative patient testing: The auditor's report also noted a significant variance in the rate of pre-operative electrocardiogram and chest X-rays among medically stable patients undergoing low-risk procedures in Ontario hospitals, despite clinical guidelines indicating patients usually do not even require an ECG.

So my general question is: What's the difference between a guideline for a hospital or a doctor to do something vis-à-vis a requirement to do it? I get the impression from reading that comment that some things that emanate from the ministry or whoever issues the guidelines are guidelines, but my question is: When is a guideline an imperative? What discretion is there if it's not an imperative? What is the discretion to follow or not follow the guideline, and how are those discretions exercised? It seems to me that's one of the aspects of whether things get done as we wish things to be done, via the issuance of guidelines.

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Mr. Ron Sapsford: Maybe I'll start with the general, and some of my colleagues may talk more specifically about in the hospital. The Ministry of Health does not practise medicine, physicians do, and so when there are questions about orders for diagnostic work or treatment orders, that is the exclusive domain of the physician. The regulation of the practice of medicine falls to the College of Physicians and Surgeons of Ontario, as I mentioned in my opening remarks.

However, anyone who is in a practice needs to practise according to the standards. So often over time, as different issues come up, guidelines are developed for use by clinicians to assist them in their actual practice. At no time would the ministry regulate, by fiat or by order, or dictate a particular medical practice or part thereof. These issues are usually handled, in hospital practice, by the medical staff of that individual institution through the work of their medical advisory committee. So every hospital is permitted, through their own bylaws for the medical staff, to establish rules that govern the practice of medicine in that particular hospital. I'm not so sure about this particular area, but in many areas of practice, based on their own review, their clinical opinion, the review of guidelines, medical advisories with the support of their board will establish rules of practice that govern these sorts of issues, which is to say, "In this hospital, this group of medical staff practise according to this rule." So they adopt it as their own practice standard for that particular institution.

When we talk about setting guidelines, it's really to draw to the attention of, initially, the hospital and then subsequently their medical staff that perhaps there needs

to be a more formal establishment of a rule or a rule of practice in that facility to remove the variation of every single physician independently making those judgments. These are the mechanisms generally that are used to establish best practice, and the PIDAC guideline we talked about for flash, for instance, comes from that specialty group. Then the decision to be made whether it is a rule or not is left to that organization. That's the general approach that is used for clinical guideline development and how they're brought into practice.

Mr. Tom Closson: At a hospital level, under the Public Hospitals Act, every hospital has a medical advisory committee, and the medical advisory committee can establish guidelines or rules for the medical staff that work in that organization. We have 157 hospital corporations in Ontario, so therefore we have 157 medical advisory committees.

The guidelines would be set out, and the medical advisory committee, working with hospital management, would have to work on what to do with them. If we take the example we're talking about here, these are not dangerous tests that are being done; these are resource-using tests. You're not going to die from having an EKG, and the amount of radiation from a single X-ray is pretty minor, so I don't think these are dangerous tests. If there was something that was a danger, the MAC would put a rule in place, or they'd make it pretty well impossible. Say it was a particular drug that shouldn't be used for certain conditions; that would be the rule, and the doctors wouldn't be able to order that drug for those kinds of conditions.

I'd say this is more a management-of-resource issue, and I think the MAC could ask, in each and every hospital, if they wanted to—and I think senior management needs to work this through with them—for what kind of conditions would you do these, or for what kinds of surgeries would you do—and patients, because it's sort of a mix of the surgery and the patient condition—these tests? Which ones wouldn't you do? Then that could be tracked and monitored, as to whether each of the surgeons was actually following it. It goes back to the surgical department head, as I mentioned before. If they see that certain surgeons aren't really following the rules, or the guidelines—because there's a little bit of discretion here, right? Patients aren't black and white; they're sort of grey in a lot of cases. So it's a doctor practice. They have to make a decision. But if they look out of whack in terms of how they're practising, then there would be some pressure put on them, I'm sure, by the head of surgery to get more in line.

Those sorts of processes need to be in place. In some hospitals, I expect they're more in place than they are in others.

Dr. Kevin Smith: There is a challenge in this area, though. Your question raises an important issue, and that is that there are times when the management of the system and the management of resources are not as well aligned as we might like them to be with clinical opinion—

Interjection.

Dr. Kevin Smith: Yes—and, frankly, clinical income.

One other vehicle that we have through the deputy minister's aegis is our negotiation with the Ontario Medical Association as the sole bargainer. We have evolved some new models, and in the case of this audit, I think we looked at areas where more approaches to group practice and more approaches to wait times reveal some questions about how appropriate or how useful some pre-operative screening might be. So in addition to, as Tom has mentioned, the MAC being able to comment on it from a quality perspective—and I'd agree completely with Tom that probably most of what we're talking about has no negative impact on quality—the challenge is, at times of shortages of docs, nurses and others, how does one push that pattern of practice in a way that, frankly, may not be to the economic advantage of the practitioner whose income is completely separate from that of hospital funding?

But I do believe that this audit has kicked open the door on those initiatives, has allowed us as hospitals and medical staff to talk to one another. I think it's another tremendous benefit of the exercise. It has allowed us also to talk with the ministry, as we embark on a new OMA negotiation, about how we work together to identify the best use of scarce resources.

Mr. Robert Devitt: I guess there's just one thing I'd add to Kevin's comments. We also have to acknowledge that there may well be at the local level factors or history that impact why a group of physicians at an MAC choose to exceed a guideline. So in the case of this one, where exceeding it has no negative quality consequences—and in fact one might argue it had positive ones, but it is a resource allocation decision—if a hospital has had a case at some point in the past where people regretted that they didn't do the tests and there was an outcome, that will create a different tolerance level in terms of the willingness to perhaps follow a guideline and not do these tests. One has to acknowledge that part of what a group of physicians at the local level decides is clearly shaped by literature and best practice, but part of it is also shaped by experience at the local level.

The Chair (Mr. Norman W. Sterling): Could I just ask a supplementary? How would this committee garner a better response to this issue? In other words, what would go down with the hospitals and the physicians in terms of making this a better resource-based function? The auditor has identified that in one hospital, in low-risk cases, it's 1% of the cases that they do it, and in another it's 98%. It's too wide a spread. I think that our committee would like to assist you and assist the deputy in trying to drive a more reasonable use of this diagnosis.

Dr. Kevin Smith: I'm sure we could all offer you observations. My personal observation would be that I really do believe the upcoming round of OMA negotiations offers an opportunity to look at how we're advancing the approach to practice in this regard; similarly—and I'll let the deputy minister comment on this—if there was perhaps some focus or working groups

through OHA and the ministry to look at whether there are some common approaches to areas of standardization.

Mr. Joe Pilon: There's another mechanism that hospitals have as well, and most MACs—I think all MACs—have a utilization review committee. That committee's responsibility is to look at the utilization of resources. This would probably not typically go to them because of the magnitude of the resources being used, but that avenue is there for hospitals to look at how physicians are utilizing the resources, and if this became a significant issue—there are probably other priorities they're dealing with—it would be appropriate to send it to that committee for review.

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Mr. Tom Closson: I think that's part of the challenge. In the broad scheme of things, this is small for a hospital in terms of its costs. How long it takes to get people out of the hospital or whether they come in in the first place are probably the two main ways to save money. But I think this is a management issue too. The fact that one hospital could be so different than another suggests to me that attention has been put to it in one hospital and not as much in another, and I think by highlighting it, it actually helps. As an association, I think we need to be showing those differences across the system.

I'll give you an example that is actually a lot bigger than this one. Back in the early 1990s—this might amaze you; it amazes me just how things have changed in the last 18 years. First of all, probably over 50% of surgery in the early 1990s was done on an in-patient basis; very little was done on an outpatient basis. But for those people who were being done on an in-patient basis, they would be admitted to the hospital for one, two or sometimes three days before they actually had their surgery, and the tests would all be done while they were in the hospital. So it's sort of related to this issue. Of course, I'm sure they did it on everybody back then too. By the end of the 1990s, we were doing the majority on an outpatient basis. Today, if you are going to have surgery and you're going to be admitted—we talked about cancellations. One of the reasons people get cancelled is because there are no beds. They don't admit you at all before you have the surgery. They have you come in early, you have the surgery, and then they put you in a bed, but they don't want to do the surgery until they're sure there's a bed for you to go into.

Just compare that to the way it was 18 years ago. It started maybe with one or two hospitals seeing that they could do that, and other hospitals looked at it. Of course, the cost pressures cause hospitals to really try and learn from each other. It's gradually spread that that's the standard of practice. Nobody would admit patients for multiple days before doing surgery anymore.

But it's useful that it was highlighted. It's something that as an association maybe we could be doing a little bit more in terms of highlighting among our members the variation that's occurring, and maybe they could work on it themselves.

The Chair (Mr. Norman W. Sterling): Mrs. Van Bommel.

Mrs. Maria Van Bommel: I have three rural hospitals in my riding, all three under 100 beds each—one actually with only 16 beds, so they are quite small. We talked about surgeons being able to move out and do surgeries for maybe one or two days in a smaller hospital, but you also mentioned the issue of staffing and the surgical team. Could the surgical team move with the surgeon for that day or two days or whatever that they do in the small hospital?

Dr. Kevin Smith: I could give you an example of where it's a challenge. If the surgical team moved on those days, then there wouldn't be a surgical team where they moved from. The challenge really comes back to capacity, as Deputy Minister Sapsford and Mr. Closson have said. In the old days, we used to make the assumption that there were nurses hanging on clotheslines, that you could just go out and pick a bunch and bring them in and do the work. That's a flawed assumption. We no longer live in a world of oversupply.

Secondly, I think there is some patient-safety literature around not simply putting together unlike teams in unfamiliar environments. But I don't think that's insurmountable, if the team did enough prep work. The real issue, I think, is that it may bring some service closer to home, but overall it won't expand system capacity. If you're operating in hospital A, you're not operating in hospital B. So I think therein lies the challenge.

Where there may be really unique opportunities, and Mr. Sapsford and his colleagues have championed this and advanced this, is looking at broader scopes of practice for other professionals. We're looking at physician assistant training programs, as an example, at McMaster; we're looking at extended rural nursing, anaesthesia extenders. So in addition to training more docs and nurses, we're also starting to say, "What other professions, supervised by regulated health professionals, could expand that capacity?" But of course, that will be a few years away because of a four- to five-year training cycle.

Mr. Robert Devitt: I'd also add to what Kevin said, because he's right: The literature on the challenges that putting teams in different physical settings creates points to some concern. The other one is being careful on the complexity of the surgery. The literature is clear that quality is affected not just by the frequency with which the surgeon and the OR team do the procedure, but the staff who care for the patient afterwards, if it's an in-patient surgery, is just as important. The more of that type of case they see, the better the quality, the better the outcomes. We've seen in a number of specialties over the last few years—vascular surgery, thoracic surgery—a real move to consolidate that work because the literature is clear that if you do a lot of it as an organization, not as a surgeon, outcomes are much better—survival rate, complications etc.

Mr. Tom Closson: You have to look at what kind of procedure it is. The example I was using is in northwestern Ontario, where an orthopaedic surgeon is going

out and doing day-surgery cases in other centres with the staff. First of all, the cases aren't that complex, but secondly, they can follow up on people, they can do their clinics there. It's working quite well. I think so long as you are selective about what kind of cases you're talking about, it can work.

I think the creation of local health integration networks is a huge plus here because it will start, over time, making physicians feel that they don't serve just their patients at a hospital but they actually serve the population of a region. This will help in terms of on call—making sure there is access to doctors 24/7 in different communities and access to specialists. I think it could potentially enable some minor procedures to be done in the smaller community hospitals closer to where people live.

Dr. Kevin Smith: This is an opportunity for us to think about whether we need to do all the surgery we do at some of those sites. Just as an example of things we've applied in the province, in a lower-acuity site that perhaps doesn't have the same capacity for admission, what if one took all of the activity—in our community, we've done this with eye work—and centralized it in one place? It's actually not an in-patient facility; it's an ambulatory facility. Rather than seeing a surgical team go out to do the work of that individual hospital, might it be an option to group all of the activity of a particular discipline or specialty for that geographic region and see patients served in a very high-through-put model—a very good use of capital dollars as well.

Mrs. Maria Van Bommel: You also mentioned the issue of surgery beds and medical beds and the availability of those and that impact on wait times, with the possibility of having, say, a surgery in one centre and then repatriating the patient to a rural hospital. The questions are, is that done frequently; how does the funding follow the patient; is it worthwhile for the repatriating hospital to do that business?

Mr. Tom Closson: The idea of people convalescing back in their home community makes an awful lot of sense because that's where their relatives are, that's where their supports are. I was the CEO of the Capital Health Region in Victoria, and the idea of people having to go to Vancouver to get care—I didn't realize how big a deal this was. It's not just a big deal for the patient, it's a huge deal for the family, because they all have to go over to Vancouver, they have to take away time from their jobs, to be close with the family member. So the idea of convalescing close to home makes a lot of sense.

Hospitals each have their own budgets which are allocated—it was through the government; directly now, it's through the LHINs. Their budgets would relate to the volume of work they do and the level of efficiency they have. It would be our hope over time that we make that clearer and clearer. I don't think, from a funding point of view, there's any problem with what you've said. The money should be there if the workload is there, from a convalescent point of view.

The other thing is that now we have clinical telemedicine capability. Ontario probably has the biggest clinical telemedicine system in the world. It's world-class. It provides the capacity for the smaller hospital to be able to have two-way video with the surgeon who did the original procedure. Let's say it was orthopaedic: The patient could get up and walk and the surgeon could view their gait through the two-way video, so they wouldn't even need to go back to the surgeon for a follow-up visit. It could be done just by staying in their home community, which saves money. It means their life is less disrupted, and it's just great for everyone.

The OHA has a small, rural northern hospital group that's been working on strategies to better understand how we enhance and maintain the viability of health services in local communities.

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It's not just about hospitals; it's about family health teams, the hospital, nursing homes and home care. It's the whole package of services to try to ensure that people can get reasonable access to care in smaller communities. It's something we're working closely with the government on in terms of trying to understand what makes sense, and it's obviously differently for remote communities like Red Lake than it is for a small community like Lincoln, close to Hamilton. So we have to look at it in that way as well. Anyway, I can assure you that we're not forgetting the small communities and the importance of maintaining the viability of health services in them.

The Chair (Mr. Norman W. Sterling): I know Mr. Sousa has some questions, but we'll catch him on the next go-around.

Mr. Jerry J. Ouellette: Thank you for your presentation, Mr. Sapsford. On page 3 of your presentation you specifically state, "The Public Hospitals Act sets out the responsibilities for the hospital boards of directors and the medical advisory committee. The board is ultimately accountable for the quality of patient care provided to each hospital." As elected officials, I would say that at least in our ridings and with anyone I've come in contact with, in excess of 95% of the populace at large have no idea of the boards or their responsibilities. What onus is on the boards to deal with the public and what abilities do they have to deal with the public?

Mr. Ron Sapsford: The history of hospitals in this province—and it's a long history—has always been based on the notion of local voluntary governance. That's the way our hospital system started. In my experience in health care, there's a fierce loyalty, community by community by community, to their hospital. The history of funding, the investment in creating many of our hospitals started in communities, in local hospital groups, and then in latter times was funded and supported directly by the provincial government.

There's a clause in the legislation that says that the board is responsible for the quality of care and management of the hospital. As a ministry, we rely on that particular provision as being where the responsibility and accountability lies.

In my experience, hospitals are in most cases very engaged with their communities. From the perspective of fundraising, from the perspective of knowledge about services and programs, families are in contact with hospitals all the time simply because of the services they offer. That people are less aware of the board—I understand the point you're making, but I think over the years many hospitals have made greater efforts to speak to their communities more directly.

Could boards do more? Yes, I believe they could in terms of speaking about services and some of the issues they face, but also the success stories. Because in the public domain, oftentimes we're focused on what's wrong and what can be made better, and that's a legitimate exercise that we're all engaged in, but the success stories and the amount of successful care that goes on in Ontario's health care system every single day is frankly astounding.

Mr. Jerry J. Ouellette: Most of the time we hear about the complaints and the negative aspects within the health care system. As MPPs, we usually funnel them to the ministry, as opposed to going directly through a board.

Mr. Ron Sapsford: Yes.

Mr. Jerry J. Ouellette: Would they have any training or know how to handle the process if the complaint process were to be funnelled through a board? As elected officials, do we want to start having the board dealing with issues like that, that our offices normally account for?

Mr. Ron Sapsford: Every hospital I know has a process to handle complaints, be they from individual patients or families or from members of the general public. So if it's a very specific complaint about a hospital service or outcome, then I would encourage any member of the public to contact the hospital directly and to work with their local hospital.

Without satisfaction, there are other avenues, depending upon the nature of the complaint. If it's about the medical care or concern of the patient or family about the quality of the medical care, then my advice would be to begin to turn to things like the college of physicians, who govern the practice of medicine. If it's more of a system problem, then the administrator or chief executive officer of the hospital is there for that. If it's more of a coordination effort, then we have local health integration networks, another local source where people can raise concerns. So this is a system built not to rely only on the ministry to respond to every complaint—although we do our fair share—but also to encourage people to try to get satisfaction at their local level.

Mr. Jerry J. Ouellette: Ideas on structural changes to boards: I know that each of the disciplines that work in the college system have voting seats on the board. In the hospital system, I don't believe they have the ability, whether it's the nurses or whether it's the CUPE workers or the OPSEU workers, to have voting positions on that board. There's an internal complaints process, and there's an external one for patients. I hear regularly from a lot of the individuals who work in the hospitals that they'd like to have a larger voice. What's your opinion about restructuring a board to account for that internal complaints process?

Mr. Ron Sapsford: You're talking about the composition of the board and participation?

Mr. Jerry J. Ouellette: Yes.

Mr. Ron Sapsford: The composition of the board is generally governed by the hospital's bylaws. In most standard bylaws, there's an exclusion that's usually written in that employees of the corporation are excluded from membership on the governing board of the hospital. In our system, most professionals who work in hospitals are employees of the hospital. The exceptional group is our physicians, who are not employees of the hospital board but are independent agents who are granted privileges to practise inside. The Public Hospitals Act specifies that members of the medical staff are full voting members of the hospital board—the president, the vice-president and the chief of the medical staff are generally the three. So, of the board, three are reserved for medical participation, to advise and assist the board in its decision-making. That's the general structure. Over time, there have been various models proposed, but at this moment in time, that's the current structure of hospital boards.

Dr. Kevin Smith: Just for clarity, few of us would encourage a model that the board be anything but skills-based. All of the literature on governance, be it hospitals or other endeavours, really looks to say these are very complex organizations—some would suggest some of our most complex social organizations—and governance is about quality of individuals comprehensively.

To the deputy minister's comments about complaints, I think another important endeavour is making sure the board focuses on governance, not on individual management issues. Most hospitals, I believe, have a very clear complaints process, and that would be rolled up aggregately as a governance issue to the board. But the board wouldn't deal with an individual complaint, nor, in my opinion, should it.

Mr. Tom Closson: I think we're coming at this from the perspective of quality. As Ron said, the board, in legislation, has the responsibility to ensure the quality of care; therefore, they have to have good mechanisms to be able to do that. Most hospital boards have quality committees, including board members and others, to receive information on indicators of quality within the organization. The issues related to how staff feel about working in the organization—whether it's a positive or negative experience—are often things that come up directly to the board as an indication of whether there are issues in the organization about how staff feel, whether they feel engaged or empowered working in the organization. The quality of care—not just medical care, but all aspects of care—is something that should be flowing through. I think the vast majority of boards do an extremely good job in ensuring that they do get good information on quality of care.

Mr. Jerry J. Ouellette: When I look at the presentations in here, we talk about the non-utilized time, where it's 12% in some cases and 60% in others. I know when we were on the college board, different perspectives were brought forward from the disciplines working there. So if it's suddenly 60%, and we're trying to do staffing, where we can staff the surgeons okay—the surgeons will be there, but the rest of the support staff are not there—the ability to sit down at the table and say, "This is part of our perspective on the problem and how we can come forward and assist on it." That might be one of the ways that the board can address certain things such as that—by having an inclusive area right at the board level. At the college level, we had that regularly come forward, where the teaching staff would say, "That's a great idea, but this is how it's going to impact us and this is how we would probably respond." It changed the dynamics on how it worked as a functioning operation.

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Mr. Tom Closson: Saying again what Kevin said, the modern literature about governance says that best practice is a skills-based board, not a representative board. We feel strongly that that's the direction we should be heading in: towards a totally skills-based board, having the right mix of skills and trying to make sure you get those people in place to perform their fiduciary responsibility to run a highly complex organization.

Having said that, you need to have the right inputs at the right level. If you're looking at how the operating room is run, for example, it's really important to have a good operating room management committee that has representatives from nursing, anaesthesia, surgery and others to look at the measurement of the performance of the operating room and to discuss how the operating room management processes can be improved. That's true in every aspect of running a hospital. It's so important—I'm agreeing with you—to make sure that the staff are there and involved in giving their views on how to make things work better, because they are the ones who will have to do it every day. They understand better than anyone else what the issues are.

Mr. Robert Devitt: Just adding to that in terms of what the literature and experience are telling us is best practice, if I use that example, you're absolutely right: We need to make sure that all our stakeholders have processes and forms where they can raise their concerns, raise their ideas and feel they've been effectively heard. It's not the board's role to actually do that. In a best-practice organization, the board demands of its leadership that that be done and they have regular reporting mechanisms to validate that it has been done. So what that might look like is regular reporting on staff satisfaction, and a requirement in proposals that come forward that there be a description of the consultative process that the hospital went through, not only with staff but perhaps with the community. That's how you get to outstanding governance, and that's what the literature says is the board's best role, because there are so many issues. If the board started delving into many of these, the organization would get mired. There's just too much for it to do.

Mr. Jerry J. Ouellette: Also, to move on, in the presentation you speak on page 8 about the 82 hospitals throughout the province that are participating. Is there a reason that there's not full participation, and do you have a breakdown of the areas? Is it rural Ontario that's not participating? Is it northern Ontario? What are some of the reasons for that?

Mr. Ron Sapsford: The wait times strategy started with a federal-provincial agreement. The first ministers agreed to implement this strategy, and it was limited to the five procedures that I've talked about in the report. That was the initial target grouping: cancer, heart procedures, hip and knee replacement, cataract replacement, MRI and CT. When you look at the hospital population that is actually providing that range of surgery, it tends to cluster certainly in the academic centres and generally large community hospitals, which have full orthopaedic programs, cardiac programs and so forth. So, by definition, the number of hospitals that would participate was limited, frankly, by the federal-provincial agreement on where the initial focus was. That's the largest reason why all hospitals don't participate. It's the type and technical difficulty of the surgeries involved.

As far as distribution in the province, I can get the detailed information as to which are the 82. I can tell you that all local health integration networks have hospitals that are participating, so the coverage is north, south, east and west. There are some smaller centres that, for instance, do cataracts and are participating in that particular part of it. While they may not have cardiac surgery, they are getting some benefit in terms of improving accessibility.

The approach that was taken on this was that we also wanted to increase capacity. This was to pay additional amounts of money for additional amounts of surgery; it wasn't simply to give hospitals money and say, "Do your best." As Tom mentioned, this was a volume payment system. So over the course of the strategy, the ministry has spent almost an additional $900 million to generate the extra cases that have been provided. But, because capacity was an issue, some hospitals did not have sufficient capacity to expand the volumes beyond their current capacities. For some of those reasons, certain hospitals decided not to participate, or they only had two surgeons who were available, they were at full capacity, and the notion that they could take on more volume was beyond the human resource capacity of the hospital.

It wasn't any single reason, but rather focusing on the five, who's available to do it, who has the capacity, or who can purchase more capacity with the additional revenues that were provided?

Mr. Jerry J. Ouellette: When you're dealing with wait times, is it possible that a single individual can be on more than one wait time list, and do you have any tracking to find out? So, one individual could apply for knee surgery in three different sites and now we have

three cases of one individual. Is there any tracking to determine if that's taking place and how broad it is?

Mr. Ron Sapsford: Yes. It's an excellent question because it assumes it didn't happen before, and we don't really have any direct evidence of that. I suppose it was possible to be on three surgeons' waiting lists, but because of the medical referral system, I tend to be doubtful of that. However, in the new system we've created it's not possible that you're on different lists because, as the names go in, patients are identified individually with their own characteristics. The way the system is set up is that we can identify individuals and where they're waiting. So that notion of waiting in three different places is trackable in the system that we have.

The Chair (Mr. Norman W. Sterling): Ms. Horwath.

Ms. Andrea Horwath: Thank you, Mr. Chair.

Could I just follow up on the previous question around the access to surgeries that are of the five priority areas? My question is around the extent to which all patients are equally able to access the five priority areas. For example, you spoke about the volume pay system and the extra $900 million put into the system to pump up the volume. Sorry about the pun; I couldn't resist. But the issue then becomes, what about patients who are presenting with more complex medical situations—they need cataract surgery but they also have other complicating factors? Are they equally able to access the priority areas as someone who presents with fewer medical problems?

Mr. Ron Sapsford: Outside the five you're referring to now?

Ms. Andrea Horwath: Yes; they're needing cataract surgery, but they also have all kinds of other medical problems. Is it just as easy for them to access the services as others?

Mr. Ron Sapsford: Yes. If they're entered into the wait time system, they're not differentiated apart because they may have other problems. In terms of the clinical management of that particular patient, that might be an issue for the surgeon involved, or there may be multiple consultations, or it would require a different approach when the care is actually being provided. But those particular clinical issues for an individual patient would be monitored by the medical team involved. Unless there was an overriding medical reason why cataract surgery shouldn't be given—because you do have other problems and they're concerned about risk, and, as a result of that, surgery is deferred longer—that kind of clinical situation would not contribute to the length of time waiting.

Ms. Andrea Horwath: But is there not a disincentive built in, that the more complicated, difficult-to-serve patient or potential patient would be taking more of that surgery time, so therefore not as many of those surgeries will take place if the more complicated patient were to be seen?

Mr. Ron Sapsford: No. Those would be questions of medical judgment. Our system wouldn't discriminate: "You've got three problems, so we're going to shunt you off to the side." It simply doesn't work that way.

Ms. Andrea Horwath: From the hospital's perspective, is—

Mr. Ron Sapsford: That would be the physician's judgment.

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Dr. Kevin Smith: It might actually be more advantageous, frankly, to the hospital, not necessarily to the surgeon, but when we look at the complexity of our patients and something in case-mix groups and a whole bunch of other mumbo jumbo, that would end up really saying sicker patients have a higher waiting time, and each hospital would be looked at relative to the complexity and waiting of its patients. So I think the nature of the system today wouldn't discriminate, although, as the deputy minister has said, if there were clinical indications—for example, if you had very unstable diabetes and it was unwise for you to go to a surgical situation—that obviously would factor in. But I don't believe we'd see complexity pushing a patient back.

Mr. Tom Closson: Some hospitals, of course, specialize in doing the more complex cases, particularly the major academic centres. They thrive on getting access to patients who are complicated because that's the business they're in.

The other thing I wanted to mention, though, about this was that for some of these procedures we have the priority rating system. So if their complexity sort of linked to whether they would fit into one of those priority levels, we'd be able to see by priority level whether the targets for wait times were being achieved for those kinds of cases. As you know, the higher the priority, the shorter the wait time target is, so in fact you could say it would be the reverse: They'd be more likely to get their care faster.

I think Ron indicated that by the spring or early summer, the intention is to start making information by priority level public. Ron also mentioned the Data Certification Council, and in my role as CEO of the Ontario Hospital Association, I'm one of the three people on the Data Certification Council. I know they're at the point right now of being able to show that information to the providers by priority ranking. The reason they want to show it to the providers first is a data quality issue. We want to make sure, before we show it to the public, that if the providers say there is something wrong with that data, it just doesn't look right—let's be assured that the data is high quality before it's posted for the public later this year.

Ms. Andrea Horwath: On that issue of the priority areas and the wait times that are supposed to be the benchmark, if you want to call it that, the auditor's report indicated that if the 10 months go by, there's no reassessment. So there's no closing of that loop where if the wait time has gone beyond what it's supposed to be, then there's supposed to be a reassessment of that patient, because theoretically, some of them could be moving up

the priority list based on the wait time. I guess that's not happening, or at least the auditor's report identifies that that hasn't been happening. How do we get that loop closed? I think the responsibility is at the hospital level, if I'm not mistaken, to have the physician or someone go back to that patient who's been waiting. I think there were some significant examples of waits that were quite surprising that were identified in the report. Can I get some understanding of how we fix that or how we make that a better system?

Mr. Ron Sapsford: Well, we took note of the observation, recommendation, and certainly the expectation that that reassessment will occur. That's part of the expectation. How you do it and how it's flagged was a question for the information system. I think that as we've gone on, those flags will come up in the system. As you've suggested, it's then the responsibility of the local team to ensure that the reassessment is done. So since the time of the audit, we've started to move forward to implement that particular part of it.

Ms. Andrea Horwath: Kevin?

Dr. Kevin Smith: All priority *[inaudible]* are reviewed when they wait longer than the benchmark as well, so all patients pop up on your list and you say, "Would we like to reallocate? Might we go back to other surgeons or other physicians involved in their care?" So there is a closing of the loop at the local level.

Ms. Andrea Horwath: Okay, thanks. Mr. Ouellette was talking about how the wait list system came into place. One of the things that I was interested in is the cost of the implementation of the system. I look at the operating and capital summary from the briefing books from the last budget cycle, and there are two parts on table 2 of that document, the second and third lines down, under operating and capital, "Health Policy and Research" and "Smart Systems and Knowledge Management." The increases are about 20% in each of those categories. Is that where the costs of these programs are being identified in the budget for the ministry?

Mr. Ron Sapsford: You're looking at the estimates from last year?

Ms. Andrea Horwath: Yes.

Mr. Ron Sapsford: Without seeing it, I can't be absolutely sure, but my sense is they're not included in those numbers. Smart Systems would be the external agency that is developing some of our networking. The costing would have been under something. The cost of the information systems would have been internal to the ministry's accounts, but I can certainly verify that for you.

Ms. Andrea Horwath: What would the cost be to the ministry thus far, all in, in terms of the implementation of the wait list system?

Mr. Ron Sapsford: The cost of the procedures alone, which were transferred to hospitals, as I said, is approaching $900 million over the two or three years.

Ms. Andrea Horwath: I'm thinking more of the information system.

Mr. Ron Sapsford: I will get the exact numbers for you, but my memory would tell me we're probably in the neighbourhood of $30 million, several tens of millions.

Ms. Andrea Horwath: Can I just ask one of the other—I'm just jumping all over, because I recognize that we're running out of time.

The Chair (Mr. Norman W. Sterling): No, we'll continue on. There are still questions that the Liberals and the Conservatives want to ask.

Ms. Andrea Horwath: Okay, that's great.

The issues that the auditor's report raised around the anaesthesiology teams and the inherent barriers that prevent or dissuade hospitals from adopting that model—I'm sure the ministry has seen the report and acknowledges that there's an issue there. My question would be, is the ministry looking at ways of changing that historical way of funding, or is this something that the LHIN is now charged with? Who's responsible for it, and is it possible to start on a new path when it comes to this kind of funding for the team approach that seems to be much more valuable in terms of getting the work done?

Mr. Ron Sapsford: The anaesthesia care team project is something that we're pursuing quite actively. There seem to be quite large benefits in spreading the expertise of anaesthesiologists across a broader group of people. Again, one of the key limiting factors in some hospitals for surgical procedures is anaesthesia—we don't have enough of them and so forth—so when you return to the question of access, this was a key point of which we had to undertake a review. There were extensive discussions with the Ontario Medical Association on the point, and after those discussions there was an agreement that we would start some demonstration projects around these care teams. Currently, we have nine hospitals—four of them are community hospitals; five of them are teaching hospitals—and seven local health integration networks that are involved in those demonstration teams. Currently, it's confined to cataract surgery. Two trained staff will operate, one in each, with a supervising anaesthesiologist. So we have one anaesthesiologist who's really supervising two operating rooms.

You can't just throw people into the rooms, so there was a training component which was developed with the Michener Institute. So people were trained and are now staffing these demonstration projects.

On the question of who pays: As Deputy Minister of Health, I say it will always be the Ministry of Health who pays.

Ms. Andrea Horwath: One way or another.

Mr. Ron Sapsford: Yes.

Who gets paid and how they get paid, I think, are some of the questions that the Auditor General was asked to reflect on when he was looking at these issues. That's part of the consideration of these demonstrations. Do we pay the hospital a lump amount for the project, managing it this way—and the more ORs you put in, the more clumping—or as we traditionally pay anaesthesiologists, on a fee-for-service basis through OHIP? Do we pay for the assistant's services as an adjunct to the anaes-

thesiologist's service, or do we pay it through the institution? This is part of the discussion in developing some policy around that. But we're relying on these demonstration models to give us the information that will inform that decision.

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Ms. Andrea Horwath: What's the timeline of these?

Mr. Ron Sapsford: I think it's some time during this year that we get the preliminary evaluation. They need to be up and running for a certain period of time before you can really do a thorough evaluation, but over the course of this year. I think they only started in November 2007, late fall 2007.

Ms. Andrea Horwath: Thanks. Kevin?

Dr. Kevin Smith: We are one of the sites and I have to comment that, although we wait for the evaluation proper, despite initial bumps and grinds that one expects—introducing a new profession, getting people used to a new team model, some degree of potential threat around income, to be frank—after those things moving to the side, which they did very quickly, we frankly would not be able to meet the demand in our wait times without this new model of anaesthesia care extenders.

It's been a remarkably good addition. It really worked well for clients; it's been very positive for the learners. In this model we've also adopted something that didn't take nurses away from nursing, but expanded the use of respiratory therapists so that we didn't compound an already great shortage, although there are many models out there and they're all good ones. But full marks by observation for this initiative on our experience.

Mr. Robert Devitt: I would echo that. We are also a demonstration site. The one other added value that this has, which I think is terrific, is it has really created a conversation among an entire care team—anaesthesia, ophthalmology, nursing, respiratory therapy. So we're really moving toward that integrated team approach to care, which is a better approach.

Ms. Andrea Horwath: Thanks. A big part of—from what I could read, anyway, through both the auditor's report and the follow-up summary, the implementation of the perioperative coaching site, the coaching teams—the site visits started in December 2005, I think, something like that, 2006.

Mr. Ron Sapsford: It was 2005; you're right.

Ms. Andrea Horwath: You mentioned in your remarks, actually, 2005-06. The winter of 2005-06 I think is what you said.

When I was reading some of the background material that legislative research provided for us, one of things that I wasn't sure about comes from a document that was published—the Trypuc, Hudson and MacLeod study. I don't know if you've seen that study. So there you go—you have seen it, or not? Yes?

Mr. Ron Sapsford: Undoubtedly, I've seen it.

Ms. Andrea Horwath: Okay. One of the things that they talk about in that study is the issue around the evaluation that comes afterwards. So the team goes in, issues are identified and implemented, and then at some point there is an evaluation. I guess my question is, some of the initial ones that were undertaken—have the evaluations taken place and what has been found in terms of the value of the model coming full circle? It's lauded by yourself and others, and I think that's positive, but one of the issues is the extent to which the final evaluations have taken place. What I'm getting at is, are the results in? It's called the Pivotal Role of Critical Care and Surgical Efficiencies in Supporting Ontario's Wait Time Strategy.

Mr. Ron Sapsford: I don't know the answer to that question. I'll certainly find that out. I know that most of the energy at this point has been put into actually doing the coaching teams; I think there are 46 that have been done. I'll respond to the question more formally, unless there are others who know.

Ms. Andrea Horwath: Sure.

Mr. Joe Pilon: We've taken advantage of perioperative and critical care coaching. They've both been very valuable exercises. They help the organization look at what they're doing from an improvement perspective, and it's nice that they're funded. So it has been great for our organization.

Dr. Kevin Smith: We've also had a follow-up visit and I think that's a really important ingredient in this. All too often we do a study, we table the study and maybe some of the results of the study get implemented. We have had the care team come back, or leaders of the care team come back, and ask us what we have done and why we haven't done some of the things they recommended and done some reconciliation around them.

Ms. Andrea Horwath: Good. So the loop is closing.

Dr. Kevin Smith: The loop is closing in our example, absolutely.

Ms. Andrea Horwath: Excellent. So if I could get it, that would be helpful.

Mr. Ron Sapsford: I'll check and find out for you how many, so that you have a sense of—

Ms. Andrea Horwath: Yes, and how many are closing the loop. That would be helpful, because the documents indicate, and I think you mentioned it in your opening remarks as well, that the expectation is that this will cycle through all of the wait times strategy hospital sites by 2009. Is there a plan, then, to expand these kinds of teams to the rest of the hospitals in Ontario if it's found to be beneficial to these particular sites? Is that part of what the ministry's looking at? I don't necessarily see why the wait times strategy hospitals would be the only ones to benefit from these kinds of teams.

Mr. Ron Sapsford: It's an excellent question. As you can tell from the presentations and how we're managing this particular project, it's in a stepwise fashion. The primary goal was improving accessibility, to bring the wait times for these five areas of practice down to the goals. As has been said, I think we still have some work to do. The benefit of approaching it this way has led to the information system, the coaching teams, the efficiency work, now beginning to set actual operational

benchmarks and targets that hospitals will use in the future.

My view is, we're focused on completing the whole model to get the maximum benefit to improve accessibility—and then questions about how far out. Do we put this kind of a system into a 24-bed hospital that has several hundred surgical procedures a year? Honestly, I think not, because the benefit of extending this kind of a system isn't going to yield the improvements in accessibility that you would in a 500-bed hospital that's got a significant surgical load. There's a question of prudence here, I think, in terms of how far do you expand what in a sense is quite an expensive measurement system to get the kind of benefit that you would want. We haven't come to a decision about how far we expand it. Our first priority is to get the model fully operational, get the maximum benefit on the target hospitals, and then subsequently make decisions about the benefit of extending it further.

Mr. Charles Sousa: Thank you for all the good work you've done, especially given the limited resources, and the opportunity that you've taken to improve efficiencies.

I'd like to readdress the issues of overcrowding and surgery cancellations. In my riding—I'm in Mississauga, Peel region, more specifically in the south, where we have a very mature community with a rising seniors' population—the in-patient bed issue is becoming a problem. Notwithstanding some of the new build that's going on with some of our hospitals to alleviate some of those issues, there are concerns. We have taken on some ambulatory care centres that have been separated from the hospitals, and some others, I think, want to also do the same. It has improved the ability, especially for the outpatient issues.

My question, then, more specifically to the ministry, is, how do we plan to ensure that those surgery cancellations due to hospital overcrowding are kept at an absolute minimum?

Mr. Ron Sapsford: I think we've all talked about the issue of capacity. As has been acknowledged sometimes, capacity on the medical side of the hospital spills over into the surgical. Every hospital that I know manages in a way to keep those situations to an absolute minimum. The more common phenomenon is patients in emergency departments and the problems of alternate level of care, as Tom Closson has talked about.

The government has moved in several ways to address this particular issue. There were investments made in alternate level of care as part of the emergency strategy that was put forward last year. There were some adjustments community by community, but most of that additional revenue went to increasing home care services, to looking at alternate placement such as supportive housing. In a few communities, there were actual additional beds opened to accommodate the problem.

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The government has, as well, announced its aging-at-home strategy, which is a $700-million program over the next three fiscal years, starting in April of this year. Again, to begin to supplement resources at the local level, each of the LHINs in the province has been working on those plans over the past several months, and at the end of February are due to present them, working within envelopes of funding and making local decisions about where those resources should be applied. There's a timing issue here, I know, because the hospitals are under severe pressure right now, as would be the case in your particular riding.

So we started, early in the new year, an active discussion with local health integration networks as well as with the Ontario Hospital Association about some short-term things that could be done to begin to relieve the pressure as quickly as we can. Some of it deals with best practice questions. Some of it deals with how the hospital is managing its emergency room problem. Some of it deals with long-term-care homes. About the frequency, we did an analysis, for instance, on a LHIN basis. The rate of residents from long-term-care homes moving to hospitals varied at a level of five times. There was a five-time difference in the variance of referral to hospitals from long-term-care homes. Something is going on there, so we've had resources put at doing that kind of analysis. In some parts of the province there have been specialty nurses hired by hospitals, so that when a long-term-care home runs into a problem with a patient the nurse will go out and visit the home as opposed to sending the resident into the hospital.

So there are a number of initiatives that have been started across the province, and this recent discussion is to see whether we can come to a quick consensus about what specific interventions are needed in the near future. Given the resources that have been allocated by the government, we would then begin to map resources to relieve the pressure that has been identified.

I would hasten to add that this isn't a new problem. This is a problem that is a part of the health care system. As Tom said, it's an issue of balancing resources of acute hospital against long-term-care placement against home care, and having enough capacity in each of those areas, so that as patients move through the system you can move them relatively effectively. This is part of the mandate of local health integration networks. I know they're working on these issues as we speak so that new investments, as they come along, could be used to address those.

We're actively pursuing this. In fact, in some of the discussion there have been suggestions for some regulatory amendment in terms of the levels of care; other suggestions about, on a LHIN-by-LHIN basis, actually identifying specific groups of patients and getting clinicians together in teams to come up with specific care plans so that people aren't bouncing through the system but that there's a more effective plan of care to keep them stabilized in the community as opposed to constantly bouncing into the hospital and then having difficulty in finding placement when they're through their period of care. We're working on this quite diligently. I know the

OHA is engaged in that, and they may have some comments to add.

Mr. Joe Pilon: There's a surgical cancellation impact of not having any beds because of ALC. But there's also a limitation, and it's relatively small, I think, because hospitals are not booking surgeries when they don't have beds so they can't cancel them. But the other impact that ALC has is the inability for us to expand our hip and knee procedures because we don't have beds to open. When the ALC beds are resolved, it will allow hospitals to open more beds, which they can fill with the additional funding that the ministry provides for us.

It's particularly good that our LHIN has accepted accountability and has even made a commitment to reduce our ALC problems by 25% per year. That will allow us to open beds that have been previously occupied, to still run those beds, and therefore add more hip and knee procedures. I think we need to distinguish that we're not cancelling surgeries because we don't have beds, but we could do more surgeries if we had more beds.

Mr. Robert Devitt: Back to the comments made earlier when the ALC issue was raised, the bigger outcome of ALC patients is delays in the ER and admitted patients in the ER not getting up to a bed. Some hospitals have different tolerance levels or different capacities in their ER to carry extra patients, which may impact the quickness with which they may cancel electives as another option to create capacity. But the biggest impact—certainly in the east Toronto context, our ALC problem really shows up in terms of long, long waits in the ER. We've made it a point of policy to not cancel electives, because once you start down that slippery slope it becomes too easy to use that as your answer, as opposed to trying to find other workarounds.

Mr. Tom Closson: I'd like to just say a couple of words, as well.

The ALC problem has been a problem for a long time, but it's a growing problem, and it's becoming quite urgent, actually. A way of looking at this is, if you think of some stores, if you're lining up at the cash register and the line gets too long, they add another cash register, right? Then, when people come, the lineup doesn't just keep getting longer. If you only kept with the one cash register, the line would get longer and longer if people were coming in faster than they were going through the cash register. I think that's what's happening at the moment: People are coming in to hospital, particularly in medical beds, at a faster rate than we're able to get them out of the hospital. That's why the ALC problem in hospitals is growing. So we possibly need some changes in regulation that would enable people to get into various settings, whether it be home care, assisted living, retirement homes with supports, whatever it might be—ways of getting them out fairly quickly to be able to take the pressure off the system, because the data that we've been collecting is showing that it's an increasing problem.

Having said that, we're working really closely with the ministry—they understand how significant this issue is—and we're working closely with the local health integration networks to try to come up with the best solutions that you could do in the short term. The aging-at-home strategy, the $700 million over four years—it'll take a while to do some of those things. If a solution in a local community was to build another nursing home, you don't build a nursing home overnight. But if we can do something on the home care side to support people and divert them from going into nursing homes, that's terrific.

I'll give you a statistic. One of the heads of the community care access centres—these are the organizations that do the assessments to figure out whether people should go into home care or go into nursing homes—told me that they did an assessment of all the people who are in nursing homes in their particular LHIN, because now they have the same boundaries as the LHINs, and found that 25% of the people in the nursing homes didn't need nursing home care. They could have been cared for at home or in an assisted living environment. There are almost 80,000 nursing home beds in this province, so that's potentially 20,000 people, if I just do the math, who could be somewhere else.

Once people get into nursing homes, it's really hard to get them out because sometimes their home situations change—their homes are sold in a lot of cases—and there is the issue of, do they have the right home environment, with a spouse or family member to keep them supported there? But there are assisted living options, where people live in more congregate arrangements.

So I think the solutions are there. I think this is clearly a solvable problem, and I think if we all work together on it, we'll get it solved.

Mr. Phil McNeely: I first came here in 2003, and I think it was about a year later when the ICES report had the wait times across the province. I had one of my staff plot them up. Ottawa came out 14th out of 14 at that time on the wait times for about 12 or 14 procedures and 14 geographic areas in the province. But we've had a lot of good investments in Ottawa over the past three years. We just did a groundbreaking last Friday for the cancer treatment centre at the Queensway Carleton Hospital. In my own community of 100,000 people, we had an MRI come in in 2004. So these things really helped. I can see that as the wait time controls are going to come in and we have the facts for proper management, they're going to be getting better and better. You'll be covering more procedures in 2008; I see good work being done there. Are they going to be used across the province to make sure there's equity in delivery and availability of services? Will this be part of the wait time information as well, that you'll be looking to provide equity across the province?

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Mr. Ron Sapsford: Yes.

Mr. Phil McNeely: Could you speak more loudly? I'm having difficulty hearing you.

Mr. Ron Sapsford: Equitable access is, I suppose, the best way to describe the principle. So as the ministry has looked at how we allocate the resources that have been

provided across the province, ensuring that there's equitable access has been a constant challenge for us.

First of all, capacity is an issue. I know initially in Ottawa, capacity was an issue. We wanted to allocate resources to increase the caseloads, but the hospitals were unable to absorb the volumes. I think initially in Ottawa it was a question of anaesthesiologists, actually. But over time, people have worked through those issues and we try to allocate the money based on an equitable formula across the province, so that we have a hospital in every part of the province; the volumes that are allocated are done based on notions of differential waiting across the provinces, and sometimes a little more is provided in one category than another. So each year we monitor the results from the previous year, how much the wait time has gone down in terms of days, how many cases are still waiting, from the information system, and then make an allocation on that basis.

The Chair (Mr. Norman W. Sterling): Mr. Lalonde has one question for you.

Mr. Jean-Marc Lalonde: It's about waiting times in emergency rooms at the present time. I just came in not long ago, at about 11:30—but my question is: Does the ministry intend to do something to reduce the waiting time in emergency wards?

When I say "emergency ward"—at the present time the way it's working is that for family doctors we have clinics that anybody can go to. But if you're caught going to a clinic, the doctor is telling the patient, "You can't be my patient anymore because you stopped at the clinic." It's to the emergency you have to go for colds. Let's say you have a bruise at a hockey game; you cannot go to the clinic on the way up. In Orléans, for example, we have a good clinic: You could get even better service than the emergency sometimes.

For a good example, I happened to be told one night: "Jean-Marc, I hope you're going to reduce the health budget." I said, "How can we do that? At the present time, everybody's asking for more services in health care." He said: "Just go down to the emergency tonight." It was 8:15. I jumped in the car and went to the Ottawa General. There were 12 people waiting there, of whom six were from the same family. I went to the counter and asked, "You're not busy tonight?" and she said, "It's dead." I went to the Montfort: Four people, two from the same family. The nurse is eating an apple, watching the game on television. I've said it before: If you have a good program on television, you won't have anyone at the emergency. It's just to show you that a lot of people are going to the emergency who shouldn't be there. Those people who really need care at the emergency have to wait seven or eight hours. I had to wait nine hours myself one time, and the next time, just for curiosity, I sat there for seven hours.

The hospital administrators are saying, "Don't ever cut that; it's our bread and butter," because the people who are registering at the emergency, after a while, decide to leave. The hospital gets paid just the same, even though they haven't served the patient. So really, there is something to be done there to eliminate the waiting time and serve the people who are really in need at the emergency.

I just wonder if you people are planning to do something—first of all, that the doctors are not getting penalized because the patient happened to be stopping at the clinic, and secondly, something has to be done at the emergency.

Mr. Ron Sapsford: Thank you for your question. The short answer is, yes, we are looking quite aggressively at emergency departments. The government and my minister clearly have stated a goal to address the issue of emergency department waiting times and crowding, and the subsequent ALC question, as a matter of some priority. So we've started work on that now.

If I could say it to you this way, the work that we've done so far on the waiting list strategy—what are the issues, what are we trying to solve, how do we measure it, what investments do we make, how do we monitor it, the use of expert teams, coaching teams and internal reassessment—these are all the characteristics that we're intending to replicate, but now focused on emergency departments. It's an issue that the ministry has raised as well with the Ontario Medical Association. So some of the issues that you talk about—disincentives or incentives to use or not use emergency departments is one of the issues that we want to work on.

First of all, with the information system in emergency departments, we're not exactly starting from nothing. We do have the beginnings of an emergency department information system. It needs some upgrading, it needs some better definitions, but the measurement of the waiting times in emergency we are a bit further ahead on than we were for the surgical waiting lists.

We've also already established 14 physician leads in each of our LHIN areas who are expert in emergency services, and they are gathering together working teams at the level of the LHINs to begin to pull together ideas and plans and to start to identify the issues community by community, because they are different. Each community is slightly different in its ability to cope with emergency service and capacity issues.

There are a number of factors that affect emergency department utilization. With the one I hear you referring to, people who come to emergency with a sore throat, as an example, many hospitals now are streamlining those patient groups and dealing with them out of emergency room clinics, asking them to come back tomorrow for follow-up in primary care clinics. I know in the work we've done with family health teams, there's a requirement now for family health teams to provide expanded-hours coverage, so if people are linked up with family health teams, the notion that they are being told to go to hospital for a cold—maybe after we finish today you can take me aside and tell me who is telling you that. That's not consistent with the policy framework that we're trying to develop as we look at family health care and providing more of that service outside of the hospital.

The problem for the hospitals in emergency room crowding is not that group of patients who come and go,

who come in with a sore throat and leave; it's the people who need the services of the hospital and need to be admitted. This is the core group that we have to focus on in terms of the emergency department. So it very much depends upon what group of patients you are talking about, why they are there, what services they need from the hospital, if any, and then coming up with very specific strategies for each one of those issues and knitting them together as part of an overall plan.

That's the work the ministry has now embarked upon. We're moving forward with creating the working groups and the expert advice that we need from both hospitals and the physician community. Over the course of the next year, we'll begin the implementation work to address it.

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The Chair (Mr. Norman W. Sterling): Thank you very much. We're going to try to wrap this up in the next 20 to 30 minutes. I understand Mr. Hardeman has a few questions, and Ms. Horwath has some. I don't think there's any indication from the Liberal caucus that they have more, but if you do, we'll extend it.

Mr. Ernie Hardeman: I suppose the reason for being here is to review the auditor's report on the management and use of our surgical facilities. There are two areas of questioning I just want to cover very quickly. On page 226, there's an issue with the operation of the surgical facilities. It says: "For example, the best start-time-accuracy rate for the first case of the day was 95%, while the lowest rate was 17%. Similarly, start-time-accuracy rates for subsequent cases" ranged from 98% to 25%.

This is to the hospital people: If I was running a business and only 17% of the employees showed up on time, I wouldn't be in business long.

I just want to go a little further. On that same page, there's an issue of time of day of the operation of surgical rooms. It says here:

"(1) 'Planned use' is based on the number of hours operating rooms are staffed Monday to Friday," so we have all our staff there; and

"(2) 'Total availability' is based on the maximum number of hours operating rooms could be available if all of the hospital's operating rooms were used Monday to Friday."

From 8 a.m. till 11:59 a.m., the planned use is 85% and the total availability is 77%. From 5 p.m. till 8 p.m., we are staffed full-time for 82%, and we have 14% for actual use. What kind of a business are we running with our surgical rooms? That's where I think the auditor points out that we have a problem with delivering services with the money we're spending on operating the surgical rooms. What can be done to solve that problem?

Mr. Tom Closson: Maybe I can start off. One of the challenges always in hospital operating rooms historically has been getting them to start on time. You may think that sounds easy, but you have surgeons and you have anaesthesiologists, both of whom are not employees of the hospital, like in the example that you just gave—they have privileges under the Public Hospitals Act—then you have your nursing staff. The challenge is to get all three of them into the room on time. And of course you have to get the patient into the room on time, so I guess there are four groups you have to deal with. It's almost like if one person doesn't come in on time, then other people say, "Well, why should I show up on time?" This is an issue of effective management of an operating room and making it clear that everybody shows up on time. I think that's why you'll see variation from one hospital to another. It's like I said to you before about the importance of good local management of the operating room resource. It's like a factory: You wouldn't start the machines at 10:30 when really the shift started at 9. But it's really important to focus.

As you get through the day—patients are all different. How long it takes to do a procedure is sometimes hard to predict. They predict how long they think it will take, but there is variation based on the condition of the patient, their weight, their condition when they open them up and have a look at the situation, the skill of the surgeon—there are all sorts of things that could impact on how long a procedure takes. So as the day goes on, it's actually a little bit harder to stay on schedule.

Then in the afternoon—I don't know how you could ever get that 14%; that's a little hard for me to fathom—if the workload is done, of course, the day ends. It may well be, let's say, that there were some cancellations. Maybe patients cancelled at the last minute. Sometimes patients get sick the day before. They get a cold, so they cancel; there's a reason why the case is cancelled. Then they may try to move up other cases, and it's hard to bring another patient in. It's not like you have them sitting over there waiting just in case they can get in that day for elective procedures.

It is a very complex environment. But the fact that one organization can do better than another suggests the value, I suppose, of having these peer teams that go out and look at the processes and see how the best practices in one hospital can be applied to another hospital.

Mr. Ernie Hardeman: I appreciate that and, really, the reason I bring it up is because I think that's the area where one has to look if you're trying to improve the efficient operation. I appreciate your explanation. What really bothered me as I read the numbers was that the actual rate of being on time, the spread between the starting and the finishing, is better as the day goes on. The lowest rate for the starting time is only 17%; the low for the day time is 27%. So in fact, the problem that I would see immediately is that as an operation takes longer, you have a tendency through the day to lose time. But starting time—there is no excuse for it except people didn't show up. So I would think management—

Mr. Tom Closson: And that's exactly what the issue is.

Mr. Ernie Hardeman: So I think management has a responsibility to find out why.

I had the privilege of serving on a hospital board and I know doctors get privileges, but the hospital board decides whether to give them or not.

Mr. Tom Closson: Exactly.

Mr. Ernie Hardeman: I think there needs to be some pressure put on so people show up for work.

Mr. Tom Closson: I agree with you. Again, this is something that can be solved and can be addressed in a hospital. There's no reason why you can't create an environment where there's that expectation.

Mr. Ernie Hardeman: The other question is somewhat in the same vein, and it's to the deputy minister. We're going back to the 13% or 18% of the beds that are occupied, depending on which report, by people who should be in other facilities. The government has made announcements in recent months or years about spending more and keeping people in their homes instead of long-term-care beds, taking them into homes. The question is two-fold. Obviously we've known this problem has existed for some time. How many more beds have been created in the last—since sitting on this side of the table—four years? How many new beds have been created and how many of the people that we're talking about could and should be cared for in their homes, as opposed to even the ones who are in beds now? As we're proceeding with putting more care in homes, on a percentage basis, how much of that problem could be solved by providing more care in the home?

Mr. Ron Sapsford: The precise numbers of beds I can't tell off the top of my head. I know in planning there are a few thousand more hospital beds that are associated with construction that's moving forward. In long-term care, I believe there were between 1,000 and 2,000 new beds moving forward as well. I think the basis of your question is right. I think where we want to put our next level of energy is in the home care environment, being the next expedient place to do that.

What percentage? You will get different estimates based on the level of care that we're prepared to support through the policy framework. So as I've said already, there are regulated limits to the number of hours of home care for an individual person, and we're now actively looking at whether we should increase that. Presumably, if you increase those hours of care, it would allow you to place more patients at home than would have been the case. We're actually doing that analysis right now. Local health integration networks have been looking at those questions as well in conjunction with their local CCACs.

I think apart from home care, the next area where there seems to be a growing consensus is this notion of supportive housing. It's something short of long-term care, where they need assisted living on a daily basis and a little more attention than is the case with home care, but less than a long-term-care facility where the care requirements are much higher. So that's another area that we're looking at and targeting for additional investment.

I know people tend to gravitate toward the question of how many more beds, but I think we've had experience in the province over the last 10 years where there were substantial increases in the capacity of beds, and here we are, not too many years later and we're essentially back in the same position. We're using this opportunity in looking at alternative ways of providing services that keep people as independent as possible for as long as possible, while still at the same time respecting the quality of care and the quality of life that the individual people enjoy.

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Mr. Ernie Hardeman: And just on that, first of all, I want to be of assistance to you. I have a constituent who is in charge of a non-profit organization and is interested in building that supportive housing for seniors as opposed to long-term-care beds, so we'll be contacting your ministry to see if we can help you with that.

Mr. Ron Sapsford: Thank you, Mr. Hardeman.

Mr. Tom Closson: Can I just say one thing about supportive housing? The issue really is subsidy, because if you have money you can get access to assisted living in a housing environment very easily, but the challenge is subsidy. There are subsidies provided in some LHINs but not in others at the moment, and that's an area that needs to be really worked on to get some equity in and make it available, because a small subsidy can make a big difference in people's ability to actually get to live in those environments.

Mr. Ernie Hardeman: Thank you. I just wanted to go on to the program of more in-home care to keep people in that home longer and the present funding that has gone out with that. Is it going to be or is it directed to deal with some of the people who are presently in long-term-care beds and in hospitals, or is that more futuristic to just increase home care for future use and not needing more beds? Are we looking at trying to solve our wait time problems by actually bringing some of the people who are presently occupying the beds back home instead of just waiting for it to evolve in the future?

Mr. Ron Sapsford: Most of the additional resource is to increase the number of people receiving it, so identifying patients in hospital and providing service at home. It really is directed to resolving the waiting issue. One of the questions before us is, how restrictive do we become in that? In other words, a priority should be given to hospital patients coming out; similarly, with access to long-term-care homes. Do we focus the access to long-term-care-home beds in the short term to only those patients who are currently in ALC designation in an acute care hospital? These are some of the ideas that are being put forward, but you don't move in that particular direction. There's consequence to that, because if you restrict access to only hospital patients, then you end up with people who legitimately are living in the community and are at the point where they need higher levels of care. So we're going to have to look at that quite closely.

The newer idea that's coming is that, rather than simply taking more patients out of hospital and giving them home care, we also, at the same time, need to increase the amount of home care that's given to a single person, to take a new group of patients out of hospital and bring them home. We're looking also at that question. It's, yes, more patients but more intensive care provided at home,

and those two pieces are being looked at as part of the policy work that's going on now.

Just for clarity, since fiscal 2003 there have been 7,712 new long-term-care beds, and 2,412 new beds are under construction; those would be acute care beds. So those are the numbers.

The Chair (Mr. Norman W. Sterling): Ms. Horwath.

Ms. Andrea Horwath: I don't want to continue on the same issue over and over again, but an interesting fact was brought up by Mr. Closson about one particular CCAC identifying 25% of the people who are in long-term care maybe don't belong there and could be living at home with supports. I think that's the one thing we should keep our eye on in terms of where to go forward with providing supports.

Mr. Tom Closson: Right. Can I say, just so there's clarity on that, that they were looking at them from a physical and a cognitive perspective, but they probably didn't look at their home environment. So the question of, "Would there have been a home environment for them actually to go back to with a spouse or with a child?" is probably something they didn't do. But we're still talking 20,000. If even 10% of the 20,000 did have a home environment to go back to, that's 2,000. That's almost the same size as our ALC problem at the moment.

Ms. Andrea Horwath: Right, and it is kind of extrapolating the numbers. Does the ministry track any of this? Has the ministry asked CCACs to look at this issue at all? Is there any kind of more formal gathering of this information, or is it just by informal discussion that this comes up?

Mr. Ron Sapsford: Not on a province-wide basis. Their reassessment of patient care levels in long-term-care homes is done on an annual basis because that's factored into the funding methodology, as well.

Ms. Andrea Horwath: I was just curious.

One of the things that I don't know that we've actually touched on—there are actually two that I'm interested in—started to come up with Mr. Hardeman's questions around the utilization of operating rooms. I think what follows from that is the allocation of surgical time, and I'm not sure that we really explored that a great deal, in terms of the barriers to changing the way surgical time is allocated vis-à-vis the needs of the patients who are presenting. I wanted to get a little bit of a perspective on that issue, in terms of the historical method of allocation versus something that's more reflective of the needs of the patients coming to hospital. That was the one thing.

Next—and this is a different issue, but I figure I'll throw it on the table anyway—is the issue of tracking wait times from the point at which the surgeon is seen, as opposed to from the time at which the family physician refers. Is there any tracking of that time? Why wasn't that included as part of the wait times strategy? How variable is that? If the family physician of a patient in this city or that town or with this issue says, "Okay, you have to see a surgeon," and then, who knows, three months later the appointment is set up for surgery, that's when the clock starts ticking. Why is that, and what do you think of changing that around and timing from the day the family physician says, "You need to see a surgeon"? How would that affect the numbers?

Mr. Tom Closson: I think I'm going to answer the first one, or at least take a stab at it, and Ron is going to answer the second one.

Surgeons are paid on a fee-for-service basis. They make their money working in the operating room, so the number of procedures and the complexity of the procedures is how they make a living. There's a shortage of surgeons. When a hospital has good surgeons, they like to hold on to their surgeons. It would be like if, in an organization, we started selling X as opposed to Y, and we said to the people who are on the Y side, "Well, you're now going to go from full-time to part-time." It's the same kind of thing: "We're going to cut your income in half because the demand for service has changed." With an employee it might be a little bit easier, in the sense that maybe you could retrain them. With a surgeon, it's often pretty difficult because they do a certain kind of surgery. So the real challenge is that if you're going to change surgeons' availability of time, you'd have to do it fairly gradually, and I suppose that if you were going to change it very much, they would look for another job. They'd just move on and go somewhere else.

In the best world, you'd say, "Well, we should be focusing totally on the patient and the patient demand." But you have to balance that off with being able to retain surgeons. This is how they get paid. Actually, it's not a bad way to pay them, because they're being paid for the volume of work that they do, and that provides an incentive for them to want to do more work.

Ms. Andrea Horwath: But if it's that closed of a shop in terms of access to surgery, then how do you recruit new surgeons?

Mr. Tom Closson: This is a challenge in hospitals. I wouldn't call it a closed shop. It does relate, as well, to how much money the hospital has to provide the nurses and the instruments and everything else to support the surgeons in doing their work. It's been a huge benefit, obviously, with this increasing volume. If you aren't increasing the volume of surgery in a particular hospital, and a surgeon is getting older and older and older and you know they're going to be leaving in a year but they still want their OR time, the challenge is how to make room for the new surgeon coming in. It's a real juggling act.

Fortunately, for the moment at least, because we have the increasing volume, it actually makes it a little bit easier to create some space, which is paid for—it's volume-funded—for new surgeons to come in. But this is something that hospital management and the surgeons in every organization have to work through. I'd say it's a little bit of an easier thing to deal with in large organizations, but in smaller organizations it's a particularly difficult challenge. I think we're dealing with the patients and their needs, though, through the wait times strategy. We're trying to identify how long they're having to wait;

we're trying to give them that information. Obviously, we do need to bear in mind what the patient needs are in a particular committee in terms of recruitment of new surgeons. Sometimes surgeons leave on their own, and you can say, "Okay, we don't need to replace that surgeon. Let's recruit a different kind of surgeon for the needs that we have." That is sort of the conceptual model that we have to work within in trying to retain surgeons.

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Dr. Kevin Smith: Most of us, Andrea, use history but also priority, and I think wait time funding has also allowed us to look at not only priority of all surgical cases, but priority of wait time. So the push forward has been getting surgical colleagues or perioperative programs to look collectively at all patient populations and then prioritize those. But unquestionably, wait time volume has dramatically expanded capacity, and the majority of hospitals have ensured that it truly created new volume—didn't scale back on other things, but actually created new volume.

I would suggest the greater challenge at the moment is finding adequate staff rather than adequate surgical time, more money. I know the deputy minister is always grateful when we tell him it isn't about money. So the outcome really is, do we have enough nurses and docs? These are long-training professionals. To complete a surgical rotation or surgical training is five postgraduate years, often, plus fellowship, so six years beyond medical school.

Mr. Robert Devitt: And can we guarantee that volume over the long term so we can actually attract the doctor to stay for the long term, rather than knowing they've only got it for a year?

Interjection.

Mr. Ron Sapsford: Yes. We call it wait time one, I think. You have to watch the patient move through the system, so the first contact is generally the family physician, then a referral, the wait for that visit, the assessment by the specialist, a decision, maybe some diagnostic tests, a decision then for surgery, then book the case—wait, wait, wait. The wait times strategy has been focused on that second point. From the point where the surgeon decides, yes, surgery is to be performed, how long does it take to get access to surgical facilities? That approach was taken mostly for reasons that I've talked about before this morning, focusing on the capacity of the hospital, making sure that the hospital system itself is able to respond to the increasing volumes that would be necessary to reduce the wait times.

The creation of the information system in and of itself has been quite a monumental undertaking, and when you look at the first wait time, because physicians are an independent practice, how do we intervene in a way to reduce that wait time? It's easier, frankly, for the ministry to work with hospitals than it would be with 7,000 or 8,000 specialists in how they manage their office and to get into the detail of, "Why does it take so long?" I think it's ironic in a sense because, particularly for surgeons, we want them in the operating room, operating. That's where we need them to reduce the waiting lists, which leaves them perhaps sometimes less time to be in their office seeing the patients who are being referred. So even when you start to look at wait time one, there is a constellation of reasons that are going to contribute to that length of waiting time.

However, it has not been forgotten about, and the Toronto Central LHIN is currently doing a pilot project looking specifically at the wait times for hip and knee patients, the length of time it takes to get from family physician to that decision for surgery. I think I mentioned earlier the model that's being used here in Toronto for cataracts, where the referral is to the centre and not to a physician—actually, in Hamilton, I think, too, with the hip and joint replacement program. Now the initial referrals are not picked up by the specialist but by other staff to begin the assessment process, quite independent of the surgeon, and then the surgeon is brought in at the end to make the final decision.

So again, there are other models that we are beginning to experiment with that will help to reduce that time one by creating different access points for patients to get that initial assessment—is surgery needed or not?—and then to move them in a more streamlined way through the system. The results of this project in Toronto Central will be finished sometime this year.

Ms. Andrea Horwath: Thanks very much.

The Chair (Mr. Norman W. Sterling): Thank you very much. The auditor asked to say a few words.

Mr. Jim McCarter: Yes. Something I said in camera I wanted to say publicly. We had excellent co-operation from the three hospitals, so I would like to thank you, Rob, Kevin and Joe, for the co-operation. We talked to a number of surgeons, anaesthesiologists and nursing staff. I think the tone for that co-operation is set at the top, so thanks very much.

The Chair (Mr. Norman W. Sterling): And thank you all on behalf of the committee, particularly you, Joe, coming from the far north. It's probably a lot warmer down here, though.

As the delegation is moving out, what I suggest we do is, I've ordered some sandwiches, which are down in committee room 1. I suggest we adjourn for approximately 25 minutes, till a quarter after 1. Then we will have Hansard return and we will deal with Ms. Horwath's motion at that time. I think you can bring your sandwiches back here if that's your desire. After that, we will try to instruct the researcher as to the direction she might take in preparing the report for the committee while it's still fresh in our minds.

We'll reconvene at a quarter past 1.

The committee recessed from 1248 to 1319.

The Chair (Mr. Norman W. Sterling): Okay. I call the meeting to order. Ms. Horwath, you have a motion?

Ms. Andrea Horwath: Yes, I do, Mr. Chairman. Thank you very much. What I'll do is first give you a little bit of perspective on why I'm bringing the motion forward—or do you want me to just move it?

The Chair (Mr. Norman W. Sterling): I think you should move the motion first.

Ms. Andrea Horwath: Okay, then I'll start by moving the motion, which should be in front of everyone, I believe, thanks to Katch.

I move that the public accounts committee recommends that the Provincial Auditor conduct an investigation into all aspects of the North Bay Regional Health Centre expansion project, and in particular:

(1) Carefully assess the inputs into the assessment that the NBRHC project demonstrates projected value-for-money savings of $56.7 million (or 8.7%) under the AFP approach compared to the traditional approach; and

(2) Examine those aspects of the North Bay General Hospital contract with Plenary Health-North Bay that determine the employment relationships of various medical and non-medical hospital personnel with the two corporate entities, as well as those penalties and incentives related to the performance of contracted obligations by the two entities.

If I could speak to it, Mr. Chairman?

The Chair (Mr. Norman W. Sterling): Yes.

Ms. Andrea Horwath: The motion arises as a result of significant concerns that we have about the lack of transparency of the new financing model that the government is using for a number of hospital projects. In an attempt to try to understand with some clarity the assumptions underlying that model, we have been attempting to obtain information that would help us understand where some of the government's assertions come from.

Unfortunately, we are getting nowhere fast when it comes to that kind of information, and we have ended up in a situation where in order to try to understand the details behind the model, we've asked for financial documents, and we've basically received documents that look like this. These are the kinds of documents we're receiving back. They have no numbers on them whatsoever. The government's model speaks particularly to this idea of risk and the extent to which the mitigation of risk makes their model valuable or in some way money-saving. Unfortunately, there's no evidence at all, no indication at all, because the documents showing that these assumptions are based on any fact are kept under wraps. We simply can't get the facts to back up the government's assertion. When we have some 30 projects on the drawing board that the government's putting forward, with the intent of funding these projects through this model, it raises considerable concerns for us.

I know that we'll hear from the Auditor General in regard to the project that has been in the news, which is the Brampton hospital, but we all know that that was funded under a different model. That was not the same financing model that is being used to fund the hospital that I'm referring to. I think it's incumbent upon this committee to ask the questions that need to be asked to have the auditor review these assumptions.

The Infrastructure Ontario website says that there has been a PricewaterhouseCoopers assessment. But take a look at that assessment. In fact, PricewaterhouseCoopers has a little paragraph at the bottom of their documentation that says, "We did not audit or attempt to independently verify the accuracy or completeness of the information or assumptions underlying the PSC which were provided by Infrastructure Ontario"—so the very figures that were provided for Infrastructure Ontario have not in any way been given rigorous review or any kind of assessment—"and/or the successful proponent's final offer." The government is hanging its hat on this idea that PricewaterhouseCoopers has provided a value-for-money assessment where they actually have not, where actually they are distancing themselves from taking any responsibility for the efficacy of the numbers that are in this model. The burden of proof is still wanting. There's no evidence whatsoever that indicates that the $56.7 million in savings actually exists, so the idea of this motion is to say, "We have these 30 projects on the drawing board, apparently, that are going to be funded under this model." We know that the auditor's looking at the previous model that resulted in the Brampton cost overruns, if you want to call them that, and I think that's an excellent initiative that's being undertaken, but really, isn't it incumbent upon us as a committee to identify these issues of accountability and of transparency that the government likes to talk about but we really have the responsibility of getting to the meat of? And I think that the only one that can really get to the meat of these issues, quite frankly, is the Auditor General, and so I put this motion forward because I really hope that members of the committee see our important role in terms of the accountability of the financial model that the government's going forward with on so many projects in the health care sector here in the province.

It's a huge, huge contract that we're talking about in North Bay, but it's one small piece of an even broader number of projects. I think, because this one has gotten to the point that it has, it's not about what the actual costs are at the end of the day, once construction is complete. It's about the assumptions that are built into the model, that we simply cannot get independent verification that those assumptions are actually true or based on any kinds of facts.

The government wants to say this model is about risk. Well, that's fine, but give us the numbers on which you're basing that analysis. Unfortunately, those numbers aren't coming forward, and so really the whole house of cards falls down in terms of the accountability of this model and the efficacy of it. At this point I would just ask the members of committee to seriously consider the extent to which we have an obligation to ask the Auditor General to look at this model and to provide a report back, whether it's in the context of the work he's already doing in Brampton or whether it's simply independent. The bottom line is that there's absolutely no access or availability to any of the key financial information that should be made public in regards to the financing of the North Bay hospital project.

The other issue, of course, is the extent to which the costs over time are being used for things other than the

provision of health care. We all know that's a different issue. New Democrats believe that we need to be spending those dollars on actual health care and not on private financing.

Again, what we're really focusing on in this motion is the fact that the financial model being used by the government needs to have some review, and it's not a matter of waiting until the construction's complete because we already know that contracts have been signed, the model has been ingrained, and the government's moving forward on this project and many others. Now is the time to make sure that all of the assumptions and all of the pieces that are identified as the risk factors that generate the savings actually exist, and they exist in a way that can be verified by the auditor. That's my motion and the reason for it. Thank you.

The Chair (Mr. Norman W. Sterling): Discussion?

Mr. Ernie Hardeman: I will be supporting this resolution, for slightly different reasons than the mover of the motion. I think it's important to recognize the chain of events. In 2003, the present government said that they would not be building any P3 partnerships if they were elected. Then, when the first one came along, they said, "Well, we have changed it, so what we're doing we call alternative financing and procurement." AFP I think is the right acronym. My concern is that the change, they said, was a major change in the package that they were going to have on hospital funding and hospital building now but no one has explained what the difference is, except that I was told that under a P3 arrangement, in simple terms, it was called a lease with ownership at the end of the lease, that at the end of a long-term lease the public would own the hospital. The government said, "What we're changing is, it's not a lease, it's a mortgage. The public will own the building the day it's built and we will pay it over that period of 30 years and then it will become a fully owned public institution again."

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But I'm concerned, and I share this concern with the New Democrats, that they changed more than that, that they changed the fact that the liability, the cost overruns—the problems that we've had in building hospitals for years in Ontario is that we price it at one price and we end up paying a whole different price when the building goes up. As an example, the last fully funded public hospital built in Great Britain was 42% over budget when it was finished. The hospital identical to that, a few hundred kilometres up the street, was the first public-private partnership one that was built. They opened in the same month, one at 42% over and two years past its due date; the public-private partnership one opened on time, on budget.

The only reason I mention that is the way the P3 contract was written was that if they didn't meet their obligations, it was a penalty to the people who were building it, not to the public which was going to use it. I'm not sure that the contracts and the way the government has changed them does that. No one seems to be willing to stand up and give us the information to make sure that all cost overruns—that the end result is a signed deal, a committed price of how much per year the government will pay to the consortium that now owns—or has built the hospital. I was going to say "owns the hospital." In fact, they do. If you have a 30-year mortgage, the mortgage holder still owns it until it's paid for. I mean, we can call it what we like, but it's the same deal. So if that didn't change, I have real concerns that in order to get the letters changed they gave up the security of no cost overruns. I think it's appropriate that we as a committee ask for that to be looked into, to make sure that the public is protected.

Having said that, I disagree with the mover of the motion that this is the appropriate time to do it. I have real concerns about trying to do a value-for-money audit on the building and operation of a building when only the footings have yet been poured. There's a lot going to happen. My concern in this contract, as I mentioned, is cost overruns. Those cost overruns haven't yet happened. So I would hate to see a report coming back from our Auditor General stating, "With what I could see, everything seems to be going okay." My only concern was the cost overruns, and they wouldn't be there yet.

I will be supporting the motion, but I would hope that maybe we could get some comments from our Auditor General about the timing of the actual investigation and the audit that he does on this particular contract, I think to deal with his workload but, more importantly, to deal with the project being in such a state that we could actually tell the cost benefits and the approach.

At the end of it, I'm not as skeptical or as concerned about the end result as the mover of the motion. I think a public-private partnership properly done is a good thing. I want to make sure that this is properly done. That's why I support the motion.

Maybe, if I could, Mr. Chairman, ask the Auditor General whether he could speak a little bit to the timing and when would be the most cost-effective and appropriate time to do the audit.

The Chair (Mr. Norman W. Sterling): Perhaps I should give Mr. Zimmer the opportunity to speak before that, or would you prefer the Auditor General to speak?

Mr. David Zimmer: I'll make my remarks now, thank you.

The Chair (Mr. Norman W. Sterling): Later or now?

Mr. David Zimmer: Now.

The Chair (Mr. Norman W. Sterling): Okay, go ahead.

Mr. David Zimmer: Thank you very much.

I just want to pick up on part two of Mr. Hardeman's remarks, where essentially what he is saying is that he agrees that to do a value-for-money audit on this hospital in North Bay is in effect premature. The Auditor General has already committed—he made this commitment on February 11, as reported in the Toronto Sun. I'm quoting from the Tuesday, February 12, 2008, Toronto Sun article, among other things:

"Auditor General Jim McCarter told the Sun yesterday a value-for-money audit of Ontario's first public-private partnership hospital—or P3 hospital—will be part of his annual report at the end of this year," that is, 2008.

"'We are primarily looking at the Brampton deal because it was one of the first ones out of the box,' McCarter said."

That story was picked up by the North Bay Nugget on Wednesday, February 13, 2008. The North Bay Nugget says: "Jim McCarter tells the Toronto Sun a value-for-money audit of Ontario's first public-private partnership hospital will be part of his annual report at the end of this year."

Mr. Chair, I think that what we should do is allow the Auditor General to get on with the task that he's undertaken in reviewing the first P3 partnership hospital in the context of the Brampton model, and we'll see what information comes forth as a result of that analysis. As Mr. Hardeman has said, the hospital in North Bay has just got the cement foundations in. So in our view, it's not necessary. We should see what the Auditor General is going to do with the task that he's already undertaken and committed to doing before the end of the year, and for those reasons, we are unable to support this motion brought by Ms. Horwath.

The Chair (Mr. Norman W. Sterling): In fairness to the mover of the motion, Mr. McCarter can't really enter into the debate on the motion. If there were points of clarification, that would be fine, but I don't know whether what he would say would colour the debate, and that isn't perhaps fair in terms of either side. We know, as Mr. Zimmer said, he is undertaking a value-for-money audit in Brampton. Perhaps, with permission of all members of the committee, he could make comment with regard to that. What is your desire?

Ms. Andrea Horwath: Certainly, Mr. Chair. There are a couple questions of clarification that perhaps could be asked to help get through the discussion, if that would be helpful.

The Chair (Mr. Norman W. Sterling): Sorry?

Ms. Andrea Horwath: I said that there are probably some questions that we could ask the auditor that would help with the discussion, if that's useful.

Mr. David Zimmer: If I may, just before we get into that, the Auditor General has undertaken a value-for-money audit at a hospital in the Brampton area. This motion asks that he undertake a second or further value-for-money audit on a hospital that is yet to be built and up and running. I think for this committee to ask questions of the Auditor General about a project that he is about to undertake—the P3 audit in the Brampton hospital, which he will do and has to do and is required to do. It's an independent audit without influence, if you will, from this committee. To ask the Auditor General questions about how he would approach—I don't know what the questions are, but to get him involved in a question-and-answer exchange about an audit that he's already undertaken and other potential audits that he may do, is compromising the independence of the Auditor General.

The Chair (Mr. Norman W. Sterling): Mr. Hardeman.

Mr. Ernie Hardeman: I appreciate the comment about not putting the Auditor General in a compromising position on an audit he's presently been instructed or asked to do. I would point out that the Auditor General is a man of great substance, and if the question is inappropriate to answer, I'm sure that he would say, "No thank you, that's not something I want to talk about," or "That's not something I want to answer." I have every confidence that he would do that.

I don't see any reason why it would be inappropriate as we're discussing this motion, since we have an arm's length, independent auditor here who does auditing and does this type of work, to help us understand the principles that we're talking about in this motion. If I might, Mr. Chair—and you can rule the question out of order—I would like to demonstrate my position by just asking the auditor what is the most appropriate time to audit a project and a value-for-money audit.

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The Chair (Mr. Norman W. Sterling): No. Then you're asking him to basically rule whether this is a premature motion or not. I think that's probably the thing that I would want to avoid more than anything else because that's one of the arguments that is put forward in this debate.

I think the committee should wind up its discussion amongst the members and we should vote on the motion as put.

Ms. Andrea Horwath: I just want to make one last comment before the vote is taken. That is, if you read the motion carefully, the motion asks specifically for the auditor to conduct an investigation into the aspects of the North Bay Regional Hospital Centre expansion project to assess the inputs into the assessment that the North Bay Regional Hospital Centre project demonstrates projected value-for-money savings.

Again, I'm not saying this is a value-for-money audit of the project at the end of the day, but what we're saying is that there needs to be an independent look at the assumptions of the model that's being used. Unfortunately, there is no independent review of that, notwithstanding the fact that the government claims there is. Even PricewaterhouseCoopers, the people that they are saying have done that, haven't actually done that. They say quite clearly, "We haven't done that." So we're going forward with this model where the people of Ontario, let alone the people around this table and the people who are responsible, are blindfolded in terms of what is supposed to be happening here. I think it is totally inappropriate and wrong for us to simply go blindly forward on a model where there is no evidence whatsoever as to—and there's no access to the evidence, which is why we're asking the auditor to investigate those pieces of the model that we can't seem to get any information on.

So it's a not an actual end-of-the-day, value-for-money audit. How could it be? As people have mentioned, the project is not done. But we'd like the Auditor General to investigate what the assumptions of this model are, because we cannot get that information, and it's so important, particularly when this is the exact model that the government is going to be using over the next several years on multibillions of dollars of projects.

It's our responsibility. It's incumbent upon us. It's incumbent upon the government, I would say, to make that information public. If it's not public, then it is the public accounts committee, I would say, that has a role to play in asking the Auditor General, as a third party totally at arm's length and independent, to have that review. Thank you.

The Chair (Mr. Norman W. Sterling): Mr. Zimmer?

Mr. David Zimmer: With the greatest respect to my colleague opposite, you confuse the function of an auditor. An auditor's role, broadly speaking, is to determine how money has been spent. It's from a historical perspective. It's not an audit of a plan that's about to unfold in the future. We have no idea of the various contingencies that might arise in the future, so it's impossible for the auditor to get in and have a look at things that haven't happened yet. An audit is, essentially, a historical review of what's gone on in a financial exercise.

The Chair (Mr. Norman W. Sterling): Further discussion?

Ms. Andrea Horwath: Just on that point, the reality is that the contracts have been let. There is an historic thing that has happened, which is that the model has been approved for use and the contracts flowing from that have been let. The project is under construction. So I would disagree that this is something that doesn't have any historical context to be looked at. I actually believe it does.

The Chair (Mr. Norman W. Sterling): Just before we have the vote, I will say, as the Chair of this committee for some period of time, that notwithstanding the fact that we don't normally direct the Auditor General—we have on one instance in my recent memory over the last four years—the Auditor General does listen to what members of this committee say or don't say. His freedom to do whatever he wants to do in terms of what he investigates going forward is entirely within his decision to do so.

Having said that, all those in favour of the motion put forward—

Ms. Andrea Horwath: Can I ask for a recorded vote, Mr. Chairman?

The Chair (Mr. Norman W. Sterling): Yes.

Ayes

Hardeman, Horwath, Ouellette.

Nays

Albanese, Lalonde, Sousa, Van Bommel, Zimmer.

The Chair (Mr. Norman W. Sterling): I declare the motion lost.

That wraps up the formal part of today's hearings. We will now have a brief discussion in camera with our researcher about some direction with regard to her report, which she is about to engage herself in writing.

The committee continued in closed session at 1346.

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