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Mercredi 3 mars 2010

Standing Committee on Public Accounts

2009 Annual Report,
Auditor General:
Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2009,
Vérificateur général :
ministère de la Santé
et des Soins de longue durée

Chair: Norman W. Sterling
Clerk: Katch Koch

Président : Norman W. Sterling
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 3 March 2010

Mercredi 3 mars 2010

The committee met at 1232 in committee room 1, following a closed session.

2009 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.01, assistive devices program.

The Chair (Mr. Norman W. Sterling): I'll call this meeting to order. My name is Norm Sterling, and I'm the Chair of the public accounts committee. We are today dealing with section 3.01 from the 2009 annual report of the Auditor General, which deals with the assistive devices program of the Ministry of Health.

Today we have with us David Hallett, the associate deputy minister; Ruth Hawkins, the assistant deputy minister; and Brenda Kritzer, director of the exceptional access program branch and director responsible for the assistive devices program.

Also, I believe there are additional people from the Ministry of Health here, who no doubt will be called forward to assist in answering questions, should they arise, involving their expertise.

I understand, Mr. Hallett, you have some opening remarks, and I would ask you to go ahead at this time with those.

Mr. David Hallett: Thank you, Mr. Chair. As mentioned, my name is David Hallett. I was appointed associate deputy minister on January 4 of this year. My accountabilities include direct services delivery, corporate services, legal services, information and information technology services, and health system information management and investment.

I have been with the Ontario government for 10 years. From July 2004 to December 2009, I was associate deputy minister, Ontario Shared Services, at the Ministry of Government Services. From July 2000 to June 2004, I was assistant deputy minister and chief information officer at the Ministry of Finance.

Prior to joining the Ontario public service, I had the privilege of spending 15 years in the private sector, holding senior and executive roles at Loblaw Companies Ltd. and the Oshawa Group Ltd.

I'd like to thank the Standing Committee on Public Accounts for this opportunity to address the Auditor General's report on Ontario's assistive devices program. I am keenly aware of the important work of the Standing Committee on Public Accounts and its vital function in our system of government. I look forward to providing you with an update on our actions to the Auditor General's recommendations, as well as addressing your questions related to the report's findings.

Let me state at the outset that the Ministry of Health and Long-Term Care greatly appreciates the thoughtful work of the Auditor General and his team. It is the intention of the ministry to address both the report's findings and its recommendations.

While I am pleased to note that the Auditor General has recognized that the ministry has improved its ability to monitor and enhance client service delivery and that it has implemented a number of initiatives to improve customer service in recent years, we recognize that our work is not complete and that more actions can be taken by the ministry to further strengthen service delivery, enhance controllership and achieve value for money.

As a result, the ministry is undertaking a comprehensive modernization of the assistive devices program. We are doing so not only to address the Auditor General's recommendations but also to enhance the transparency of the government's ADP process framework, to strengthen the accountability of how public funds are managed, and to ensure that the program is responsive to the changing assistive devices marketplace.

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Going forward, the ministry will continue its efforts to strengthen accountability, ensure the efficient use of resources and make certain clients continue to be provided with high-quality devices and services at reasonable prices.

I'll start by providing you with a brief overview of the assistive devices program, ADP for short. Then I'll move on to a focused overview of the audit findings and indicate our plan of action and the progress we've already made since the report was published.

The assistive devices program provides critical devices that enable people with disabilities and seniors who develop age-related disabilities to live with relative independence in their homes and participate in their communities. The program provides funding support to all Ontarians who are eligible under specific clinical and

program criteria. That funding support enables clients to obtain competitively priced and personalized assistive devices appropriate to their basic needs. ADP recipients are among Ontario's most vulnerable citizens. That's why the ministry's priority is focused on ensuring that people have affordable access in their communities, where possible, to dependable, high-quality devices, supported by qualified vendors and health care professionals.

At the same time, the ministry is committed to achieving value for money while administering a program that is open-ended and demand-driven. ADP and the home oxygen program serve a growing and aging Ontario population. What's more, with the right supports, seniors and people with long-term physical disabilities are able to and, indeed, prefer to live in their own homes instead of in institutional settings. The growing utilization of this program reflects these realities. That is the context I would ask you to bear in mind as you review the Auditor General's report.

The audit report includes nine recommendations that, in general terms, focus on pricing, claim verification and review, conflict of interest, recovery of overpayments, and authorizer registration. Rather than discussing each of these items in detail, I propose to focus on three specific areas where I acknowledge that the ministry needs to do better. The three areas are the pricing of home oxygen, the pricing of computers and peripherals, and the matter of potential conflict of interest among prescribers, authorizers and vendors.

With regard to home oxygen pricing, the Auditor General recommends that prices for home oxygen be competitive and that the ministry should perform a more rigorous analysis of the cost of delivering home oxygen under each of the three methods currently available. In response, I am pleased to inform this committee that the ministry is conducting an open and transparent procurement process for home oxygen services. A request for proposals to establish a vendor of record was released February 1, and the ministry expects to publish a vendor of record list by April 2010.

The ministry has conducted an extensive jurisdictional review of other home oxygen programs, completed an extensive literature review and analyzed several optional service models with respect to the administration of the home oxygen program. As a result of this work, the ministry has determined that establishing a vendor-of-record list for home oxygen services, along with modifications to the program's pricing structure, would be the most effective service model for Ontario at this time. This service model will be transparent, open and consistent with government guidelines, and has been determined to provide the best value for money to the taxpayer while ensuring continued continuity of care for vulnerable clients in their homes.

There are many benefits to the proposed vendor-of-record approach. It will ensure that clients will continue to have access to a multi-vendor market and exercise choice of vendor. Competition among vendors will be driven by quality of service and the type of oxygen delivery system that best meets the needs of clients. The ministry will set a fair price for home oxygen that supports a comprehensive service delivery model which includes in-home clinical assessment, training of the client and caregivers, 24/7 service by the vendor and ongoing follow-up.

The ministry has established a positive working relationship with the home oxygen industry that has resulted in more stringent service guidelines, a joint commitment to manage utilization, and a positive response to participate with the ministry in responding to such crises as SARS. This co-operative relationship will continue under this new model.

Clients are responsible for the selection of a vendor to provide services and may choose the vendor that best meets their needs. In establishing a VOR list from which they may choose their vendor, the ministry is also providing clients and their health care providers with the assurance that the registered vendors are meeting the service delivery requirements of the program.

Based on the ministry's research and recent experiences in the United States, where a tendering model was tried, the ministry is confident that the proposed service model which is being pursued will best meet the program objectives of the home oxygen program.

I'd like to take some time now to explain the rationale for our home oxygen program service model. The ADP's comprehensive service model enables clients for most devices to select from a number of qualified vendors in their area, to receive ongoing support from those vendors and to pay the same price everywhere in the province. This cost-sharing model guarantees fairness, equity and access.

Research indicates that a home oxygen program is an effective way to prevent and/or shorten hospital stays. The level of care and follow-up are also reported as critical factors to ensuring compliance with therapy, an improved quality of life and decreased visits to emergency departments and/or hospitalizations.

More than 80% of clients currently in the home oxygen program are over the age of 65. These elderly clients are frail and vulnerable. They have a strong trust relationship with the medical professionals and service providers involved in their therapy. It is critical that these patients have confidence in the continuity of their care and in their ability to change service providers, if unsatisfied.

The typical home oxygen therapy patient is a 73-year-old woman suffering from chronic obstructive pulmonary disease—COPD for short—which is the nation's fourth leading cause of death. COPD is a respiratory disease that obstructs airflow to the lungs, causing shortness of breath and a host of other ailments. Having ready access to oxygen therapy allows this individual to live in her own home, be mobile, and enjoy a relatively good quality of life.

Again, let me emphasize how important this program is in preventing and delaying clients from being directed to alternative care programs such as homes for special

care that come at a higher cost and are more intensive for people living with disabilities.

With regard to the pricing mark-up of computer systems and peripherals, the Auditor General recommends that the ministry ensure that the cost of the equipment paid for is competitively priced by conducting regular pricing reviews. In addition, he recommends that the ministry take into account volume discounts and price reductions related to technological advances.

Let me respond by first providing you with some background on the ADP visual aids category. This category provides funding assistance to eligible Ontario residents who have long-term low vision or blindness that cannot be corrected either medically or surgically. The types of visual aids covered under the program include optical aids, such as magnifiers, specialized glasses and telescopes; reading aids, such as closed circuit televisions, audio book playback machines and talking scanners; writing aids, such as Braillers and computer systems with screen reading/magnification software; and orientation and mobility aids, such as standard white canes.

The ADP funding contribution for all visual aids, except optical aids, is 75% of the ADP-approved price of the visual aid. The funding contribution for optical aids is 75% up to a maximum contribution. The ADP price or maximum contribution will vary depending on the type of visual aid or optical aid needed by a particular client.

Computers and peripherals used by the visually impaired and those with communications disorders must be able to run highly specialized software and hardware. The specialized computers provided to ADP clients run adaptive software and hardware technology that may require more resources than the average computer, such as faster computer chip processors, larger memory capacities, high-quality video cards for people with low vision, more powerful sound cards for people who rely on synthetic speech, scanners that handle legal-size paper, as well as larger, high-resolution monitors for people with low vision and so forth.

Since the ADP replacement period is five years, applicants may need to acquire a number of software and hardware upgrades on their own so that their computer systems last the full five years. For this reason, a number of vendors will offer clients a five-year extended warranty as part of their service offering. ADP vendors are responsible for installing any adaptive technology required, including the set-up and service of equipment in the client's home.

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Mainstream vendors who sell to the general public are not necessarily aware of various adaptive technologies or their technical requirements. As a result, it is unlikely that they are able to provide this service to ADP clients. Specialized computer and adaptive technology vendors are usually small to medium-sized businesses that have the requisite knowledge and experience to ensure ADP clients get the right equipment and ongoing support needed.

As is well known, technology prices do fluctuate at a much faster pace than most other products and services. Given this reality, the ministry conducts reviews generally every two years. A pricing review of all communication and visual aids, including computer equipment, commenced in May 2009. We are targeting to have this review completed by April 2010.

This is one area where the ministry agrees that it could do better. I'm therefore pleased to inform you that in response to the Auditor General's findings, the assistive devices program will review its pricing approach to ensure that resources are effectively and efficiently managed, and that appropriate devices are provided to qualified applicants at the best possible price.

The objectives of this review are to:

—assess the current pricing approach for all device categories in order to identify areas for improvement;

—review the ADP's current pricing framework with the intent of providing a set of recommendations to senior ministry officials by July 2010;

—incorporate a revised pricing framework into a proposed device listing and delisting policy by July 2010; and

—publish the ministry's strengthened approach to the setting of prices via the assistive devices program home page on the ministry's website by September 2010.

With regard to conflict of interest, the Auditor General has recommended that vendor billing patterns be monitored to deter potential conflict of interest, misuse and abuse of program funding.

The assistive devices program has a conflict-of-interest policy that includes statements regarding authorizer and vendor obligations in both authorizer and vendor agreements.

The following procedures have been put in place to guard against, detect and respond to conflict-of-interest situations:

We require registered health care and service providers to follow specific policies and procedures regarding confirmation of client eligibility for funding assistance;

When concerns arise regarding the practice of an authorizer or vendor, the ministry works closely with the individual or organization to gain compliance;

If an authorizer or vendor doesn't comply with the ministry's requirements and remains non-compliant, then their registration is terminated;

When the ministry becomes aware of questionable practices, we investigate and take corrective action, which may include referring the matter to the Ontario Provincial Police; and

Where there are clear instances of professional misconduct, these instances are referred to the appropriate governing college.

To further strengthen monitoring and enforcement oversight, the ministry is developing a new information system that will significantly enhance the ministry's oversight capabilities.

In addition, the ministry is providing enhanced education and training to all program staff in the area of risk management. The goal of this training is to enable staff to better recognize and follow up on abnormal claim and authorizer prescription patterns.

ADP staff will conduct a jurisdictional review to identify best practices. They will also conduct a review of the standards of practice and codes of conduct related to conflict of interest at regulatory colleges and professional associations. The program will also put in place strengthened protocols that will more quickly address conflict-of-interest situations when they occur.

To summarize, the ministry is committed to the fair and responsible delivery of the assistive devices program to ensure that ADP recipients, who are among Ontario's most vulnerable citizens, have access to assistive devices and supplies that they need. At the same time, the ministry is committed to obtaining value for money and to protecting the taxpayers' investment in the health care system.

The Ministry of Health and Long-Term Care also remains committed to continuously improving the assistive devices program it administers. We fully appreciate the Auditor General's recommendations and have begun taking concrete steps to act on those recommendations.

In closing, I would like to once again thank you for this opportunity to address you today. I'd now be pleased to respond to any questions.

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

M^me^ France Gélinas: I get to go first?

The Chair (Mr. Norman W. Sterling): Yes. It's the NDP's choice.

M^me^ France Gélinas: I want to thank you for coming here today.

I was very distraught when I read the auditor's report as to how many areas that he had looked into where it seemed obvious that improvements were needed. You picked three, and even in your answers to those three you still leave a lot of questions unanswered. If—how long do I have?

The Chair (Mr. Norman W. Sterling): Around 20 minutes for the first time.

M^me^ France Gélinas: Okay. If I follow what you've presented—I also have questions on parts that you have not presented, with oxygen therapy. How do you intend to address the issue that respiratory therapists right now are hired by the oxygen providers, therefore leaving the auditor and ourselves to wonder how much incentive there is for those respiratory therapists to report somebody who doesn't need oxygen anymore and take a client away from their employer?

Mr. David Hallett: I'll provide the initial part of the answer, and then maybe I'll pass it over to Brenda to provide some more information for you that would be helpful.

First off, unlike other provinces, my understanding is that many of the respiratory therapists are part of vendor groups within the province of Ontario, but they do fall under their college's responsibility and standards of conduct. We believe that they're holding to those standards, but nonetheless, there will be occasions where there could be abuse happening, and we are going to be looking in the coming months to figure out what more we can do, working with respective colleges and the therapists to help educate them to be more compliant with the policy of the program. We will also look at what we can do for further checks and controls to ensure their compliance.

Brenda, do you want to comment further?

Ms. Brenda Kritzer: Sure. The home oxygen program has been changing quite a bit over the last few years. Within the first 90 days, approximately 40% of clients who are referred for home oxygen are able to carry on without home oxygen. Those who are remaining on home oxygen generally are people who are suffering from chronic obstructive pulmonary disease or another serious lung disease from which they're unlikely to recover.

What we do is have three assessments initially in the first year. The patient is initially assessed in a clinic. The physician has determined that that assessment is required, and it's usually an arterial blood gas assessment for home oxygen. The physician also determines generally what is going to be the best mode of delivery for home oxygen.

Once the patient is referred to home oxygen, they are connected up with a vendor. They choose their own vendor; they may choose from a number of vendors in their community, or they may be referred to a particular vendor by their physician.

They are assessed again at 90 days to determine whether or not they continue to meet the clinical criteria that have been designed for this program. If they continue to require home oxygen—and that's the other 60% of people who are on home oxygen—they are assessed again at 12 months. So from zero to 12 they're assessed three times.

That assessment, currently, is an oximetry test. When our new vendor of record is in place, that assessment will have to be confirmed by a physician, and thereafter, the physician will confirm on an annual basis the requirement for continued home oxygen.

Currently, our average length of stay on the program has fallen to around 192 days, so we feel that we have very good control of the program. As David has indicated, respiratory therapists are members of a professional college and are required to adhere to the standards of that professional college.

M^me^ France Gélinas: I don't share your view that we have very good control of this program. The auditor has shown that in 30% of the cases where an audit had to be done after one year, it basically was not there—it showed that oxygen therapy did not need to continue, yet it continued. It also showed that it took months, after a patient became deceased, for the government to stop paying the bill. Deceased people don't need oxygen.

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Ms. Brenda Kritzer: Certainly, we do make recoveries for patients where we have made payments and the patient is deceased.

In terms of whether or not the client continues to require home oxygen, certainly when they are receiving therapy, we expect to see some improvement in their lung capacity, but that improvement is tied very much to the use of home oxygen. So someone who's suffering from this chronic disease is not getting better; they are in fact generally getting more ill. The disease is progressing. While test results may indicate some improvement, those improvements are tied specifically to the therapy. Without that therapy, they're not going to be improving, and in fact would quickly slide.

M^me^ France Gélinas: In your answer, you say we will now require physicians to confirm on an annual basis. We have this right now. Respiratory therapists have to do a yearly for the chronic oxygen user. They are not doing it. When they are doing it and showing that the patient doesn't need it, nothing happens. When the patient is deceased and we continue to pay for a service that is no longer needed, you talk to us about doing recovery, but here again, when the auditor looked at the recovery, it was a fraction of what is owed to the government that was actually recovered.

Mr. David Hallett: We recognize there are going to be situations of abuse, and we're committed to addressing what the Auditor General has found and aggressively getting a handle on any kind of abuse that would go on in the oxygen program.

M^me^ France Gélinas: How are you going to do this?

Mr. David Hallett: I don't want to give you a trite answer. I'm just new in the role. I have to look at this situation and get myself fully apprised of it. But consistent with what I've done over 25 years of trying to do these things, I understand what the problem is, I look for the opportunities, and I drive a program to achieve them. I can't articulate it for today. I've just been eight weeks into the job.

M^me^ France Gélinas: I understand. Good luck to you. In the entourage you have brought with you, is there anybody who can say why those recoveries were never sought before, why the yearly checks were never done before—and that's not to talk about the price we've been charged.

Mr. David Hallett: I don't think we can give you a totally solid answer.

Let me explain how the program has gone. From 2001-02, when the program was last audited, up until the end of 2008-09, the number of clients has grown from about 140,000 to 250,000. In 2008-09 alone, we had approximately 347,000 claims that were made for various categories of the assistive devices program.

We're now looking at the fact that the resource base we're using for that organization since 2001—we started off with 38 full-time individuals supporting that program. While it's grown by leaps and bounds in that whole period of time, we still have about 38 people supporting that program. The operating budget we used just to support that program was approximately $3 million back in 2002-03, and today it's $3 million. So while the program has gone up to 347,000 claims, our actual costs to support the program have been capped, both from a full-time equivalent basis and a funding basis on that side of it. So we also have to look at that.

We need to employ additional resources, what types of resources we need, so that we can make sure we are aggressively monitoring and following up on abuses for not only the oxygen program but all the other categories we support under the assistive devices program.

The Chair (Mr. Norman W. Sterling): Could I just ask a supplementary—because it's an important number. The national average: 60 out of 100,000 on oxygen. Ontario: 150 out of 100,000 on oxygen. Why is there a two-and-a-half-times difference between the national average and our average?

Mr. David Hallett: We couldn't answer that question. I'd be pleased to provide a follow-up written response to you on that.

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

M^me^ France Gélinas: The auditor is very good at picking out numbers that speak for themselves. Again, we're talking about oxygen concentrators, and 90% of the people on oxygen at home use those. They cost between $400 and $1,000, and they last five to seven years, according to the manufacturer. Yet the ministry pays $23,000 over five years for the difference. Let's say we bought the best one at a thousand bucks. We'll pay $23,000. That leaves $22,000 per client for that period of time. How can you reassure me that we are getting $22,000 worth of follow-up care for each and every one of those concentrators for each and every one of those patients? It doesn't seem reasonable to me.

Mr. David Hallett: I'll have Brenda take you through what encompasses that program, and then I'll provide you with some additional stats on the five years and $23,000—because I was asking the same question coming into this meeting today.

Ms. Brenda Kritzer: Within the home oxygen program, based on our research—we looked at this back in 1999, and we re-examined it very closely in 2009—the equipment actually represents something in the neighbourhood of 10% of the total cost of delivering home oxygen. The largest component, in terms of the cost of delivering home oxygen, is staff costs, and that's primarily the professional health care service provider, generally the respiratory therapist. In addition to that, there is servicing of the equipment, ensuring that it continues to be in good working order.

Initially, once the person has been referred for home oxygen, the respiratory therapist comes into the home, makes an assessment of what the individual's requirements will be, determines what the oxygen flow rate should be, for example, and examines the home and the ability of the person to operate home oxygen in a safe environment. For example, if there's a natural gas stove, that might not be the safest environment for home oxygen to be provided in. So they not only assess the client, they're assessing the home. They then provide training to the client on the use of home oxygen and the maintenance of their equipment in the home, and they

provide the same training, in terms of those components, to any other caregivers who are involved with the individual. Our average client in home oxygen is an elderly woman, probably in her early 70s, who is suffering from chronic obstructive pulmonary disorder, is frail and requires additional supports. So we are providing that training to others.

Our program requires that the service provider provide 24/7 response to the client if there's any change in the health condition, they have a failure in the equipment or whatever. If there's a failure in the equipment, the vendor will provide replacement equipment while the equipment is being repaired. So they are maintaining the equipment and they're maintaining the individual.

As the individual progresses in their disease, they will be providing ongoing follow-up to the patient, ensuring that assessments are done as required.

If the patient is leaving the province or leaving her or his home, they essentially provide what you might call a vacation planner, which describes what they need to do to ensure that they're travelling with oxygen in a safe way, and they assist the client to ensure that that's going to happen.

So these are the primary components.

If there is a change in condition—the patient is admitted to hospital for some reason, and they come back out—there's a set-up again, an assessment of what the patient's health requirements will be in terms of flow, whether they require the same equipment or whether they should be changing the modality of the equipment.

M^me^ France Gélinas: But all of those services are encompassed into the monthly fees that you pay. Here again, the auditor shows that for 30% of those people—they looked at 18 months—those people had not been assessed. So all of those services you're talking about, that I have no problem that we pay for—I think they're valuable services. But when the auditor looked, for a period of 18 months, none of those had been provided. Yet we are still paying the monthly fee that averages to $23,000. It doesn't feel like we're getting our money's worth here.

Ms. Brenda Kritzer: I think the other thing to factor in here is that $23,000 was a price that the auditor assessed in terms of how much we're paying for a piece of equipment. It's not actually a real number. That's not the cost of the equipment and it's not the cost of the service. Most of our clients are not on for five years. As I said, the average annual is now falling to about 190-some days. So you'd have to take that $23,000 and say, "Okay, over $23,000 in seven years, how many clients actually had to go through set-up, vacation planning, follow-up, change in their program etc., to the point where they no longer required the service?"

1310

Mr. David Hallett: If I may, I'd like to just build upon that, because the $23,000 did catch my eye. It is accurate, if it's $389 a month and the person is on it for 60 months, on that side of it. So I did ask some questions, and in recent days I was able to get some preliminary analysis on this program. In 2002-03, the average person was on the program for 616 days. By 2008-09, we were down to 193 days for the average person on that program. So it's roughly 69% over that long period of time.

More importantly, though, according to the information I've been able to gather in the last few days, the program currently averages about 7,200 clients on long-term funding of one-plus years—not as many would go to a full five years on that side of it. More importantly, of the clients that are on that home oxygen program, 82% are over 65 years of age, another 6% are between the ages of 61 and 64, and finally, another 7% are between the ages of 51 and 60. We're now looking at data to understand that. I'm interested in making sure that we're not paying more than we have to for the service being provided, or for months beyond what is needed. As I mentioned earlier, it's our full intention to get a handle on this, so that we aren't finding ourselves in a situation where we're paying for services that should no longer be provided.

M^me^ France Gélinas: I want to move to something other than oxygen, but I'm going to let it go around to see if other people have questions about the oxygen program before I move on.

The Chair (Mr. Norman W. Sterling): Okay. Mr. Shurman?

Mr. Peter Shurman: Thank you very much, Chair, and thank you very much, Ms. Hawkins, Ms. Kritzer and Mr. Hallett, for appearing here.

I have a list of possible questions for you, and I'll get to it. But before I do, I've got to tell you that I find the presentation very disappointing. It represents everything that the average guy out there, the average woman out there, believes is wrong with government-provided services. It doesn't take a genius to know that if you want to buy a computer monitor, they cost $200 or $300 and you can get them at Best Buy. I'm not suggesting that the government say, "Go out and buy your monitor at Best Buy," but I am saying that when the story got out that the Auditor General had talked about $1,000 and $1,200 monitors, it was the topic of conversation at the water cooler for the day.

I listened to your presentation, Mr. Hallett, and what you're giving us, even where you talk about modifications to programs, is a series of kind of government-speak or functionary-speak messages, and then we hear that you're new on the job. I don't mean to be vicious or venomous in any way with you; I understand that you're trying to do a job. But you represent the face of the Ministry of Health. This morning at a media availability, I stood and watched the Premier of the province say that we can expect health costs to rise to something like 70 cents on the dollar sometime in the next decade. I don't disbelieve him; I think he's right. But I think that if you take a look at the symptomatic elements of it, what you're talking about here today represents the worst of it.

What I want to know is that, in some general way, there's a recognition that it's not necessarily costly reviews that are going to fix things, which you've

addressed fairly well; it's getting the program completely rejigged, so that people get what they need—because they surely deserve that—at a price that all the people deserve to pay, in terms of its fairness. It sounds to me like everything has fallen between the cracks. We've got suppliers who are unscrupulous. I can even recall from my personal experience in dealing with several wheelchairs and a scooter for a late parent, what it costs and having people say to me, "Well, don't worry. The government pays. You're in for 25%, but we'll take care of that"—nudge, nudge, wink, wink.

To get down to the nuts and bolts, if you have revised your vendor process in the oxygen program—you talk about vendors of record, which I suppose represents a new list. Could I say that?

Mr. David Hallett: Uh-huh.

Mr. Peter Shurman: Is that a list that will be public and readily available to everybody?

Mr. David Hallett: For the vendors, yes.

Mr. Peter Shurman: Okay. If that's the case, what was the previous process for selecting vendors that caused so much difficulty?

Ms. Brenda Kritzer: In the past, home oxygen vendors have approached the ministry to indicate that they would like to become vendors with us and be registered. We have requirements of each vendor—they're fairly extensive—and we provide to them a registration package. So in order to register as a vendor, they would have to carry all of the varieties or modalities of oxygen and they'd have to meet certain requirements regarding insurance etc.—so business requirements.

Mr. Peter Shurman: But clearly they didn't. Something was wrong. I want to know what was wrong. I want to know what the criteria were for you to reject somebody from this list, because you've come up with a new process—we've just heard that—and there must be a reason for that.

Ms. Brenda Kritzer: The new process is to ensure that we are completely transparent in how vendors can become registered with us to provide home oxygen. In fact, we have not identified issues with our previous process, and vendors have met and continue to meet our requirements, but this will ensure that we've done a review of those requirements and that they are continuing to meet our business requirements.

Mr. Peter Shurman: What's going to happen as a result of this? Are we going to see a continuation or a proliferation of $23,000 price tags per patient, or are we going to see something competitive?

I have a little bit of experience, again, in the oxygen area, and I can't see—it reminds me of that famous report years ago from NASA in the United States where they were paying $20,000 for a hammer. And why was that happening? The same reason as here: because they could. That's the worst reason for anything. So I want to know that you've got a process and a new vendor list that's going to result in us seeing a big drop in the cost of this stuff.

Ms. Brenda Kritzer: Our research indicates that the fees that we're paying for home oxygen are not out of line with fees being paid in several other parts of Canada where they have a similar model of delivery.

Mr. Peter Shurman: What's wrong with looking at new models of delivery? It's kind of like saying, "You should give to this charity because your neighbour does." That's the worst reason in the world. You should do it because you have a feeling in your heart that you should. Not to go too far afield with my simile; my point is that just because Manitoba or Saskatchewan or BC pays these outrageous—and I think they are outrageous—fees for service delivery or for product delivery doesn't necessarily mean that Ontario should.

Mr. David Hallett: If I may, the intent of the vendor-of-record program is to put more rigour into the overall process, the management and oversight of that program, to drive pricing down; to put in tighter controls and accountabilities to hold the vendor community to what has been agreed to, and to put in the proper oversight to ensure we follow through.

Mr. Peter Shurman: So you're telling this committee that you're satisfied that the review that you've conducted and the rejigging of the process would mean that, if the auditor took a look at this again in, let's say, a year or two years and you were to come back before this committee, we wouldn't be listening to the same questions that my colleague was asking, because we all have these issues on our mind, and that we would be looking at two things: (1) a level of pricing that is consistent with what the market will bear as opposed to what the vendors can get, and (2) that we would have some accountability in this system? Because both of these things have been terribly lacking, and I think we're agreeing on that.

Mr. David Hallett: The bottom line is, if the Auditor General does his follow-up audit in a year or two years from now, I would hope that he would be able to proudly say that the ministry did respond to his audit findings and they did follow through. That's the intent.

Mr. Peter Shurman: Okay.

The Chair (Mr. Norman W. Sterling): Could I just ask a supplementary? It's on that exact point. Is it a competitive process? In other words, if vendor A comes in and says, "I can supply oxygen at $1 per unit," and another one comes in and says, "I can do it at 95 cents," do you exclude the $1 one or do you just fix the price?

Ms. Brenda Kritzer: We have set the price.

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

Ms. Brenda Kritzer: We felt that that was the best model. We took a look at what was happening in other jurisdictions. We took note, for example, that in jurisdictions in the US, they had a very negative experience with a process that was completely competitive.

The way that respiratory services—and I'm not talking just oxygen services—are currently provided in Ontario, we didn't feel we were at a point where we could move to a different model. We absolutely agree that there are other models that may be more appropriate for us as we move forward, and we will be looking very closely at

those models that would allow us to move to a competitive model.

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The Chair (Mr. Norman W. Sterling): Mr. Shurman? Sorry for the interruption.

Mr. Peter Shurman: Not a problem. Just a couple more questions: In your initial response, the ministry had outlined measures that included the implementation of a new computer system by the spring of 2011 to enhance your monitoring capacity. Could you tell us what that's going to cost?

Mr. David Hallett: I can't give you—

Mr. Peter Shurman: You don't have a rough idea?

Mr. David Hallett: I don't, but I'd be happy to do a follow-up response to you.

Mr. Peter Shurman: Okay. Maybe you could tell me what the previous monitoring process consisted of. Given that you have identified the need, you're replacing something that exists.

Mr. David Hallett: Yes.

Mr. Peter Shurman: What is it?

Mr. David Hallett: Brenda?

Ms. Brenda Kritzer: The current system has been in place since the program first began. The computer system that supports the program is more than 20 years old. Over the last 20 years, we've had various changes, but you reach a point in time where basically you can't put any more band-aids on; there's no way of continuing with this program.

It's a very basic system. We can generate reports. The program staff do not have the skill to pull those reports off this computer system, so we have to use our IT staff to pull those reports. Our new system will enable the program staff to pull reports and to carry out ongoing monitoring.

We have program staff who do monitoring. We also have staff who are part of the financial accounting policy and financial reporting branch. They are charged with the task of assisting us in monitoring the claims, so they do a continuous monitoring of claims.

Mr. Peter Shurman: Also in the initial response provided, the ministry had outlined a number of measures that it intended to implement "to more effectively"—and you've addressed some of this—"identify abuses, recover overpayments, and deter misconduct," which included training staff and liaising with appropriate regulatory colleges. I believe that was the wording.

Why were those measures not effective? You've mentioned what some of the deficiencies were with that computer system, and the lack of ability of staff to get the kinds of reports that they needed. That would be a partial answer. There must be more to it than that, because what I find frankly appalling is that it took an Auditor General's report to discover that this was a need and then address it.

Ms. Brenda Kritzer: I think part of the answer, sir, goes back to what Mr. Hallett was discussing when he talked about the number of staff we have in the program. We just haven't had the resources. Most of our staff have been focused very much on the processing of individual claims and meeting the needs of clients and their caregivers and helping them get the devices that they need. So we haven't had the resources to focus as much attention as we should have and need to—and will, in the future—on monitoring.

Mr. Peter Shurman: Had the ministry ever received—I know what the answer is—any complaints about abuse and misconduct in the program? I'm presuming the answer is yes. What was your process for dealing with those?

Ms. Brenda Kritzer: I can give you a specific example, off the top of my head. We did have a complaint. This was in the mobility category. The complaint came from someone who had noted that there seemed to be a lot of people in a particular area who were being prescribed and receiving scooters.

The ministry did undertake an investigation. First of all, we required another independent assessment of each of the clients over a period of time to determine what their needs actually were. We did find that there were some clients who did not meet the clinical criteria for the scooter; that was not the best device to meet their needs. In that case, the authorizer was deregistered from the program. In terms of whether or not we reported it to the college, the authorizer self-reported.

Mr. Peter Shurman: Overpayments: Do you have an answer to the question of how much globally you've been able to identify as overpayment? If so, is there a recovery process?

Ms. Brenda Kritzer: Are you asking about overpayments in relation to—

Mr. Peter Shurman: Oxygen. For now, oxygen.

Ms. Brenda Kritzer: Yes, we do. We check the registered persons database to determine whether a patient has passed away. Where we determine that a patient has passed away and no longer requires the service, then we do—

Mr. Peter Shurman: Wouldn't do much good, no.

Ms. Brenda Kritzer: No. Then we make a recovery.

Mr. Peter Shurman: Do you have a global amount that you think you could provide as an estimate for this committee? It can be whatever you have. If it's over the year 2008-09 or over five years, from 2005, I don't care. But I'd like to know roughly where we are in terms of what we've lost.

Mr. David Hallett: We're just taking a look to see if we can provide the answer.

I just want to go back to something Brenda touched on in terms of the phenomenal success of the program in anticipating the aging population. Again, you'll appreciate the fact that I'm trying to understand this and I need to have certain data points that can help me really start thinking where the problem might lie or where the opportunities are to address situations.

Back in 2001-02, there were approximately 163,000 clients on the program. Fast-forward to 2008-09: There are 257,800 people on the program—a 57% or 58% increase over that period of time. If you look at how

many people I said we had trying to administer the program: Back in 2001-02, we had 38 people. So if you look at the numbers of clients at that time, on a full-time-equivalent basis, for each employee we had in the program, they were servicing, on a notional basis, 4,300 clients. If you fast-forward to 2008-09, that has jumped to 6,875 clients per employee. So we've actually had a workload increase, on a notional basis, of roughly 60% on that side of it. Sometimes when you drive efficiencies, you might have gone too far, and we have to re-evaluate—

Mr. Peter Shurman: I'm not being argumentative in saying this. I understand that that is an issue. Having said that, we've also been talking about things like controls, accountability, and computer systems that will generate reports so you can follow up on the cheaters. That wasn't there before, and now, imminently, we're talking about it being there. So I think that there's some balance to arrive at.

I presume you now have some figures for us.

Ms. Brenda Kritzer: I do. Home oxygen: We have recovered $175,000. That's for the year 2008-09. That was recovered by February 2009. We are continuing our recoveries, and we'll continue the reporting—

Mr. Peter Shurman: That's the recovery, which is, in the overall scheme of things, a small amount of money. Do you have a figure that represents what you estimate the losses to have been?

Ms. Brenda Kritzer: At this point, we haven't written those off as losses. We are continuing to work toward recoveries.

Mr. Peter Shurman: Thank you very much.

The Chair (Mr. Norman W. Sterling): You said, in approximately the same time periods that you talked about caseload, that the length of duration had dramatically shrunk in terms of the time that people were receiving oxygen. So how do you add up the two, in terms of saying that the caseload has increased dramatically when, in fact, if you take the time that people were on, it's much shorter? On the one hand, you're using stats to justify one thing, and on the other, you're doing the reverse.

Mr. David Hallett: That's a fair comment you're making. The length of stay that a person is on the home oxygen program is one of 11 categories under the assistive devices program—a major one, but it's one of 11, approximately. When I was talking about the reduced time, from 616 days in 2001, for those who are using oxygen therapy, down to 193, that refers to the individual who is on the program. I'm talking about the resources that support the entire assistive devices program, all 11 categories of assistive devices. That's what I was referring to on that side of it. That's where the volume has gone up. The entire client base is in all 11 categories, not just on home oxygen.

The Chair (Mr. Norman W. Sterling): Okay. Ms. Sandals.

Mrs. Liz Sandals: We've talked a lot about oxygen, so let's talk about some of the other areas now.

When we look at some of the visual and audio devices and things like that, leaving aside the example you used with the monitor, the discussion we got into on, "What's the price at Best Buy, and is that really the same monitor?", because that's one issue, but the auditor seemed to be identifying a couple of other issues, which is that there would be an approved price for a device, and if you actually looked at the invoice the company had, there was a significant gap between the actual invoice—so: This is the price for this exact piece of equipment, not some imaginary piece of equipment at Best Buy; this is the same piece of equipment, and there's a large gap between the approved price and the invoice price.

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There have been a couple of different suggestions as to why that might be. One was around the issue that perhaps the approved price was the best price you would be able to get if you were in some little remote corner of the province and weren't taking into consideration all the regional variations where you could get volume discounts.

I guess the first question would be: If that's the reality that these pieces of equipment really do cost different amounts in different places in the province, what are we doing so that we're taking advantage of that as taxpayers and the volume discount advantage doesn't just go to the vendor? That's question one.

The second thing that isn't at all clear to me is: What else is in the approved price other than the actual device price, and how well it's laid out what the vendor is supposed to supply in terms of maintenance and service, and how do we evaluate how much that costs? You would think that our approved price should be a combination of whatever the cost of the required service is and the cost of the device. That would be reasonable, but do we have any way of evaluating what is the required service commitment for each device and how much that represents in terms of value?

Mr. David Hallett: I'll give part of the answer and then I'll ask Brenda maybe to explain the process of how we approach it.

We wouldn't argue with the fact that there are cases and situations where vendors are overcharging from what the program has prescribed, and we think that's not acceptable. When we find out about it, we do pursue it. We need to be more aggressive on that side of it.

We are undertaking a complete review of the current pricing structure. Again, we're looking at how we strengthen this process so that we don't fall into a trap when we set prices. There's an acceptable margin, I think, of around 33%, and we're making sure that the vendor community who's providing the services is adhering to it.

That's the fundamental principle for the ministry. We don't think it's acceptable to be having—if I can use the words—price gouging. It's not fair to the clients who are being served who are the most vulnerable in this province, and our intent is to address it on that side of it.

In terms of the process, maybe I can ask Brenda to talk to that.

Ms. Brenda Kritzer: In order to set the price, we contact manufacturers and ask them to provide to us what

their price is for a single unit to a vendor, as opposed to, "What price would you give us if we're buying 5,000 over the next two years?" So that's the price. We get all of those prices and then we do reference-based pricing, finding a price that's somewhere in there, or if the devices are actually different, then we may list all of those devices.

When we see an invoice that is substantially different from what is our approved price, there are a number of components that might make up that invoice price. Let's take CPAP, for example. Our review has indicated that a CPAP machine—would anyone like me to explain a CPAP machine?

Mrs. Liz Sandals: That's the breathing thing?

Ms. Brenda Kritzer: That's right. That's generally prescribed for people with sleep apnea. Currently, we're looking at a CPAP machine which, say, if you were to go on the Internet, might be around $700. So we've priced one at six hundred and ninety-some dollars. If you allow a markup on that, what's the markup? Within that price we require the provision of the tubing that's required, a basic mask that is required and a carrying case. The individual who's actually getting this device may say, "I don't really like that mask. I would prefer a different type of mask, something that doesn't cover so much of my face. This is too intrusive. I don't think I can sleep." So they can upgrade on the mask, they can upgrade on a number of things, or they can say, "I need two pieces of this." So they're paying for additional things.

Now, we estimate that a CPAP machine will last for X number of years. That warranty is part of the price. But the vendor may say, "This is the warranty period that the assistive devices program has approved." If your machine breaks down before that, they may say that they're not going to pay. So the vendor may essentially promote an extended warranty or a more comprehensive warranty package than what we have covered.

These are the types of things that end up getting added into an invoice. We, nonetheless, as a program pay only the base price.

Mrs. Liz Sandals: But what happens if the vendor is located next door to the sleep clinic and they don't sell one of these, they sell hundreds of these because of where they're located? How do we get the advantage on the volume discount instead of paying the one-off price that you've found for a one-off wherever?

Ms. Brenda Kritzer: Currently we're not taking advantage of that. We are taking a look at whether there's a business model or a different way to approach pricing that would enable us—and the client—to take advantage of those kinds of discounts. Our program has basically tried to ensure access and that the price paid in southern Ontario, in Toronto, is the same price that's going to be paid in Timiskaming, so that clients aren't seeing different prices just because of where they live. We realize that that may disadvantage us in terms of being able to take advantage of discounts—

Mrs. Liz Sandals: But surely another way of doing the math would be that every client gets, I don't know, $200 on the price of whatever it is, but how much we pay the vendor is more related to what the vendor actually paid as their cost of procuring the device.

Ms. Brenda Kritzer: Exactly. That is—

Mrs. Liz Sandals: So there are ways that we can be equitable to the consumer and still be getting our own price advantage.

Ms. Brenda Kritzer: You're exactly right; that is one model. That's the type of model we use, for example, in hearing aids. There we list at least several hundred types of hearing aids. We pay $500 to the client, and that's it, and they may make a selection.

Mrs. Liz Sandals: And then they can make their decision based on—okay. Let's look at the other thing, because on the sleep apnea device, it's pretty cut and dried: Here's the tubing; you need to physically maintain the machine. There's not a lot of training. But let's go back to some of the computer devices, where you're dealing with vision issues. You presumably have a whole lot of issues around what software that particular client needs to use, how you get software compatibility and how you get trained to use the software. Who's responsible for making sure that all those installation, software compatibility and training issues are dealt with? Is whoever prescribes this in the first place or the vendor going to be responsible for what are not just physical servicing issues, but more training and technical support issues?

Ms. Brenda Kritzer: It is the vendor. The types of equipment that you're discussing are very specialized. We are learning more as we're going through our pricing review now, and we're considering whether or not we have the right kind of business model for computers. We may come to a decision on pricing before we make a decision on the business model, so we may see considerable change in this device category over the next few months.

Mrs. Liz Sandals: So you might actually separate out the hardware from the technical support or something.

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Ms. Brenda Kritzer: Yes, or we might look at the model you talked about, which is where we provide a set amount based on our research and the client can sort of mix and match and deal with that as they choose.

For example, I did some research just this morning on the monitors, because everybody says, "I can get a monitor for $250." We looked at a couple of people in the Ontario public service who have low vision and what types of monitors they require. The monitors they have are going for around $1,100 as a list price. That's without any of the software that goes on in terms of any further magnification that the person may require, setting up the software, as you mentioned, and teaching the individual how to use that software. Currently, our vendors are required to provide that service to the individual in their home. So they get what they need, they get it set up and they get the training, and that service is provided by the vendor.

Mrs. Liz Sandals: Do you have a good way of costing that, or is that something that's part of the review?

Clearly, pricing the monitor is the easy part of what you're describing. Figuring out what the service is worth is a more complicated issue. Is that something you have really looked at in detail before, or is that new?

Ms. Brenda Kritzer: That is what has been encompassed in the 33% markup. So no, we haven't priced that individually. It would be difficult—not necessarily impossible; we can certainly take a look at that—but different have clients will have different needs, and as they progress, their level of expertise will change. So the next time they come in, they will have a new requirement, but they may already have a level of expertise that the vendor doesn't have to provide that kind of new user training.

Mrs. Liz Sandals: And depending on the device, one may have a 33% markup, where there's a lot of training and support involved, and for some of the things it's just, "Here's the device," and there really isn't much training and support required. It's going to vary dramatically, I would presume, from device to device.

Mr. David Hallett: Just as a point of clarification, in terms of the visual aids, the prescription of that authorizes that.

Ms. Brenda Kritzer: I'll have to get back to you on that, if you don't mind. I know that we use very specialized clinics and the CNIB to assist us in actually determining for people with visual aids, but they're not the only people who are using computers, monitors and this very complex software. People who have other communications needs also are assessed.

I know that we have used the CNIB, and there are a number of clinics around the province that we're using—I think it's about 12—but in terms of other areas, I'll provide that.

Mrs. Liz Sandals: Do I have any more time, Mr. Chairman?

The Vice-Chair (Mr. Peter Shurman): You have about two more minutes.

Mrs. Liz Sandals: Okay. Let me stay where I'm at, and then I'll come around the next time.

When you get to the issue of motorized wheelchairs, because again you get into this sort of service issue, the first piece that isn't clear is—and we got into a bit of a discussion about this with the auditor this morning—do people actually have any choice, or is there just one vendor and they have to go to that vendor?

Ms. Brenda Kritzer: If you're speaking of the power wheelchair, we did go through a competitive process to select a single vendor. So we have a single vendor for that high-powered wheelchair, and that includes adjustments in positioning; the wheelchair isn't just about mobility—moving forward—but also changing of position.

We have a centralized equipment pool. They manage that service for us. They do the recycling, which is actually a refurbishment. So when an individual no longer requires that wheelchair, the wheelchair is returned to the centralized equipment pool—I'll call it the CEP—and, depending on how long the wheelchair has been out, the client is provided with a rebate on the amount they have paid, and that varies.

Mrs. Liz Sandals: What I'm interested in again is really the service component of this. For example, I have a constituent who is in a very sophisticated wheelchair and who is almost a quadriplegic—a little bit of hand movement—but can do no positioning. What she tells me is that she needs frequent service, because as her condition changes, that chair may need different sorts of adjustments over time and different cushioning and things because of the degree of disability that she has. She finds it very difficult to get appropriate service from the one and only service provider.

In a case like that, when we've narrowed it down to one vendor—and the service is very critical to the use of the device—how do we assess whether that vendor is actually delivering service that meets the medical needs of the client, for quality of life in this case, quite frankly?

Ms. Brenda Kritzer: Generally, it's through a complaint mechanism. If someone's not getting the service they require, then we would hopefully hear about it. If your constituent is not happy with the service that she's getting, I'd be happy to follow up and ensure that she gets that.

Mrs. Liz Sandals: Have we ever thought about providing people with choice so that they have a little bit of flexibility, given the service issues?

Ms. Brenda Kritzer: Again, I could get back to you. This model has been in place since, I believe, 2001. We felt that this was a good business model, given the very high cost of this device. For example, the average powered wheelchair is about $20,000. That's pretty steep, especially for a client who then has to find 25% of that. We wanted to ensure that we were moving these through. Because many of these wheelchairs are not really required for a long period of time, we wanted to make sure that we had a good system in place to move these wheelchairs back into service—a competent vendor who can distribute appropriately, meet the client's needs for fitting and servicing and then retrieve and refurbish the wheelchair and put it back into service.

The Vice-Chair (Mr. Peter Shurman): Thank you, Ms. Sandals. Questioning to the NDP. Madame Gélinas.

M^me^ France Gélinas: I don't know where to start, but I'll start with this: Some of the comments that you make fly in the face of what the auditor's report says.

I'll start with saying that when a client goes and selects—we'll take a mobility device—he or she may select extra warranty or whatever. For all of this, ADP pays the base price plus 33%, but the auditor tells us that we pay up to 84%, 117% or 128% more than the manufacturing price. He has done an audit and shows that when people in your ministry review those invoices, they don't ask for the manufacturing price; therefore, they don't have a comparison to work with.

Then you go on to say that the vendor provides the service, and this is why we have a markup of 33%. The auditor says that it's way high. This is an insult to every therapist, every children's treatment centre communi-

cation therapist who spends weeks and months with those people to show them how to use their high-tech computer so that they can communicate. It's not the vendors who do this. If you're paying for that service, we're all getting ripped off, because they're not the ones who teach those people how to use it. It's the therapists in children's treatment centres and in rehab units and at the CNIB who do that work. You're leading us to believe that we're getting all of that work done within the 33% margin when the auditor has already told us that it's more in the range of 100% to 128%.

Then you go on to say that motorized wheelchairs are being recycled when, again, the auditor shows us that only 8% of electric wheelchairs actually get recycled, and none of the manual ones get recycled in Ontario. We ship them out to Third World countries.

What am I missing here? How come the story you're telling us is all good and a system that works well and that is compassionate, and we're getting value for money, when I have this book in front of me that tells me a completely different story with numbers that scare me?

Mr. David Hallett: I'll go back to my earlier comments to Madam Sandals, and those are that we agree. We wouldn't dispute that there are instances where vendors are overcharging. If you're going up to 84% or 114%, from my perspective, that would be price-gouging. We don't accept it. We don't think it's appropriate. We specifically don't think it's appropriate for the clients who are being looked after, the most vulnerable, on that side of it, and when we find out about it, we do pursue it.

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But we need to do more, and that's the intent of the program, going forward. How do we get a handle on this to make sure that we minimize—we'll never eliminate it totally—the amount of abuses in terms of markups for any of the categories of devices that clients are using out of this program?

You touched on the issue of wheelchairs being shipped to Third World countries. Again, we looked at that. I understand that Alberta and Quebec have a recycling program that they seem to be reasonably comfortable with. We've looked at it and decided to take a pass in past years. Going forward, in this year, I've already directed the team to say that we're going to look at it again, because what may not have been practical for recycling of wheelchairs is something that may be more appropriate now and that might actually drive better value for money, and it still might meet the needs of the clients that need them, on that side of it.

Brenda, do you want to add anything more?

Ms. Brenda Kritzer: I would like to comment on the recycling or refurbishing of the power wheelchairs. Of course, it's dependent on when the client returns it. The program has been operating. We feel that we are pretty much hitting the target, and would be discussing that further with the Auditor General. But if clients aren't returning them, if the wheelchair is still meeting their needs and the client is still there, then it's not returned. We can set a target for recycling, but that depends very much on the wheelchair coming back in and being in good enough shape that it can be refurbished and put back into service.

M^me^ France Gélinas: You had a target of 20% for the first year, rising up to 25%. We are at 8%. How can you say that we've met the targets? Why are you using this language when we are not?

Ms. Brenda Kritzer: I will send you the statistics on what the program has actually achieved in the last year.

M^me^ France Gélinas: Are you saying that the 8% that the auditor has put in his report is not true?

Ms. Brenda Kritzer: No, I'm not saying that it's not true; I'm saying that what we have to consider is the number of wheelchairs actually coming back in for recycling. I did not have an opportunity to hear from the auditor on what they actually examined in terms of the recycling rate and how they arrived at that percentage. But I'm quite happy to share with them the statistics that we have in terms of the wheelchairs that have been returned, how many of them were deemed suitable for refurbishing, and what the rate is.

M^me^ France Gélinas: I encourage you to read the auditor's report, because he mentions that you had a target of 20% the first year, 25% the second year, and that you have achieved 8%, and that the government never got any money back for the difference in the targets that were supposed to be met and what was actually delivered.

To fix the problem—I would like to hear from you an acknowledgement that we have one. The first step in moving forward is to acknowledge that something is wrong so that you can fix it. But all the answers I'm getting from you are that everything is just hunky-dory and we have those systems in place and it works and they bring it back. None of it is substantiated by what the auditor is saying.

My last point—and I hope I'm happier with this than the rest of it—is the reporting of registered health care professionals. The auditor says, "In cases where the ministry did find potential conflict of interest"—even when you did find misconduct, you did not report those professionals to their colleges. How come?

Ms. Brenda Kritzer: Our process has been to try to achieve compliance with our policies. So if we determine that there is potential for conflict of interest, our process is to identify that with the vendor, identify it with the authorizer, make sure that they clearly understand our policies, and follow up with them to achieve compliance. It's not to necessarily deregister them. So in terms of conflict of interest, generally we are getting our needs met.

We have very recently met with the colleges to talk to them about the comments of the Auditor General. We asked all of the colleges to read the report, and we are working with them to develop a process that will be more stringent and that we can report to them on the conflict of interest that we see.

M^me^ France Gélinas: The conflict of interest that you see leads me to believe—how come you don't see them?

How come the Auditor General goes in there for a couple of weeks and is able to give us pages of examples, and yet none of those were acted upon before? He gives examples of the same authorizer prescribing 80% of mobility aids or scooters or whatever else, and nothing was done.

Ms. Ruth Hawkins: I would like to add something further to that. That is an area in particular that we are very, very concerned about and it's an area as well in which we would fully acknowledge that we have a lot more to do. We have done some things, but there's much more. For example, in the policy and procedures manual, there is a very clear definition of what constitutes conflict of interest. That's all well and good; however, I think we have to continually remind the vendors and authorizers of their obligations. That's absolutely critical. That is something that we need to do, we need to do it more often and we need to reinforce that we're doing it more often so that people understand that there is some oversight related to that.

Further, we are also trying to spend a lot more time and diligence in terms of looking at the claims that come in such that we look at who the vendors are, who the authorizers are, and looking at claims patterns, for example, so that we can detect where there would be potential areas that we need to pay attention to.

Thirdly, in incidents where we see unusual patterns, we also need to—it's not only calling them up, per se, but also sending letters, asking for explanations, sending letters to clients and saying to them, "Is this the service that you received? Were you actually provided with a list of other vendors that could provide you with this equipment?" That, to me, where we have a lot more to do and are very committed to doing that.

Where we find that there are vendors and/or authorizers that are not adhering to those particular policies and procedures, they absolutely—this is where we would get into—and we have to be much better at this and will get better at this in terms of what I would call being more progressive in terms of—this is a pretty strong word—the discipline around that kind of behaviour.

M^me^ France Gélinas: I would say that you say all the right things, but the auditor shows us that over the last three years, there have been 128 investigations. That's it; that's all. So the follow-up with the letters and all this is all good practice and I encourage you to do this, but when the auditor goes in and checks—you've done 128 of them in three years. What's wrong? Where is the disconnect here? You know what to do. You're giving me the right answer—what I want to hear—but when we go and check if you do it, you're not doing it.

Ms. Ruth Hawkins: And that is absolutely why we accept the recommendations that the auditor has given us. We absolutely also accept the fact that we have not done a good job in that area, and that is an area where we have to do better at.

Mr. David Hallett: We have 38 full-time people to support that program across 11 categories, and the fact that it's $347 million in expenditures for all of those categories combined, given the hundreds of thousands of claims that are done—on average, 1,200 claims per day—we have to fundamentally rethink how we can better approach the investigation and the pursuing of inappropriate claims. Our intention is to do that.

Mr. Peter Shurman: Just thinking: If all you've got is 38 people, we'll get them to fire some of those 300 tobacco police who aren't doing anything and get you the money. You can get some more people. Bob's your uncle. I'm just kidding.

On a very serious note, some of the things that I'm hearing sound dangerously close to, if not indeed being, fraud. I'm not talking about on the part of the department; I'm talking about on the part of suppliers. In terms of enforcement, we'll drill down a little bit and see what you're doing with it.

1400

Let's deal for a moment with computer-type devices. The reason I want to talk about those is because they're somewhat of a different category than talking about mobility devices like wheelchairs, scooters and CPAP machines. Computer devices, monitors, scanners and those types of things are things that we all own. All Ontarians buy them. We just don't get assistance with them because we buy them for our own particular use—and somebody else who you're dealing with needs them. I understand that.

The average markup, according to the information that we've got, is 128% on devices like that. My friends in the computer industry tell me that we're probably looking at something more akin to 25% to 30% markup in a typical retail store. Is this still the case? And is the 128% average, the figure that I've supplied, a legitimate figure?

We're also being told, for example, on the high end of that—because that's an average figure—monitors, printers, scanners are being billed at an even higher markup.

Mr. David Hallett: I wouldn't disagree that there are exceptions where certain vendors may be, but I'd be cautious about saying that all vendors are doing that, in terms of price-gouging, in terms of the markup.

I'd also want to be a bit careful about the fact that going to my local Best Buy and buying a computer versus getting a computer that has the adaptive technologies for a person who has speech or vision problems—the technology components and the servicing around that is part of the whole package. It's different from going to a Best Buy, when they ask at the end of the bill for your computer, "Do you want a three-year warranty with that?", and then you can bring it in. This may involve the terms of the service package, where the client has chosen to have on-site service for all of the pieces of technology around it. It's more than just the operating system or the monitor itself; it's the inside hardware, and there's certain software. The example I would use is, I experiment with speech-recognition software to pronounce words. I'm pretty good at speaking the normal language, but that software still doesn't get 100% of what I need to do or the instructions. The software that may be

being used by the clients on that computer must be more robust, more premium than the normal consumer would use. All of that has to be considered.

So I want to be a little careful about trying to do an apples-to-apples comparison when I don't think that it may be appropriate.

Mr. Peter Shurman: I recognize what you're saying, and I recognize that there are some aspects of this that are particular to the user. I used to be involved in a business where we employed people who had to keyboard all day, and I remember employing people who didn't have the use of one arm. They'd get a special keyboard and could do it with one hand, faster than some people can do it with two. You don't buy those keyboards at Best Buy. So I get that.

I focused particularly on things like monitors, printers and scanners because those particular devices are pretty consistent regardless of who the user is. That's what we're talking about with regard to 128% average mark-up—higher on balance for those particular things. Where do we stand today with a procurement policy? After your explanation and my agreement that there are some specialty aspects of it, that's what we got from the auditor's report. Where do we stand as we speak?

Mr. David Hallett: In my opening comments, I said that we accept the findings and we currently have a review under way—I think we said we're going to complete it by April of this year—that's looking at entire computer components to see what the prices should be, so we can figure out how best to drive down those costs for the clients who use them.

Mr. Peter Shurman: Would you have in mind the same type of policy you've been referring to in other areas, like a single supplier based on a tendering process? Or would you put out an RFP that said, "We're looking for"—fill in the blank—"some markup and we're calling on submissions from people who are prepared to meet it"?

Mr. David Hallett: We would look at the model that's going to drive the best mixture of price and service.

Mr. Peter Shurman: Okay. We are told that vendors sometimes billed for two devices—for example, a scanner and a printer—in separate invoices, but what was discovered by the auditor was that a lot of these devices turned out to be one box. I think we all know that you can buy a scanner, printer and fax all in one. That is where I alluded to fraud, because that is fraud as far as I'm concerned. Would you agree with that characterization? And where that was discovered, what's the relationship between you and those suppliers now?

Mr. David Hallett: I'd have to know the particular vendor that was the cause of that. But the bottom line is that I concur fully with you. If a vendor is providing a bill that says, "Here's the price for a scanner and here's for the printer," but is actually providing all in one, it's not acceptable. When it is brought to our attention, we need to pursue it and pursue it correctly. It could be an innocent error; it could be a malicious error that was done to price-gouge. In each case, we'll look at it, and if the case is a fraud—

Mr. Peter Shurman: Well, I would have a problem—

Mr. David Hallett: When we suspect the case is a fraud or inappropriate behaviour, we have called in the Ontario Provincial Police to do investigations.

Mr. Peter Shurman: You have done that?

Mr. David Hallett: Yes, we have.

Mr. Peter Shurman: Good, and I encourage you to continue to do it.

I'm going to restate what my colleague to my left said earlier: You provide me, when I ask these questions, with perfect answers. That's exactly what I would expect and probably what I would say, were the roles reversed. However, "say" and "do" are two different things, and I will repeat for the record that I heard you say earlier that you're new on the job.

Mr. David Hallett: Yes.

Mr. Peter Shurman: I just don't want to be here in a year talking to somebody else who says, "I'm new on the job and yes, we have to correct those things." I'm not doubting your sincerity; I'm doubting your ability, within the context of the Ministry of Health and Long-Term Care, to actually effect these changes.

Mr. David Hallett: Well, I hope to prove you wrong.

Mr. Peter Shurman: Yes, I hope I'm wrong too.

Let's talk about volume discounts. How many monitors—

The Chair (Mr. Norman W. Sterling): Can I just ask a question?

Mr. Peter Shurman: Yes, of course.

The Chair (Mr. Norman W. Sterling): With regard to your referring it to the police, what do you do with the provider of those services? Do you cut them off immediately, and if not, why not?

Mr. David Hallett: That's an area where I don't have a perfect answer for you, but as we're reviewing it, the same thing: There's a problem regarding whether you automatically just terminate someone. In some cases—

The Chair (Mr. Norman W. Sterling): What's the problem?

Mr. David Hallett: Pardon me?

The Chair (Mr. Norman W. Sterling): What's the problem? They could sue you if you incorrectly did that?

Mr. David Hallett: Possibly, but that's not it.

The Chair (Mr. Norman W. Sterling): So what?

Mr. David Hallett: Possibly, but that shouldn't necessarily be the reason. The issue is that on a certain device as a category, depending on what category the person is getting, we want to be careful that we don't cut them off and actually inadvertently affect the health of the individual. So if someone has cystic fibrosis or emphysema, uses home oxygen and has a provider providing theirs, if we say, "You're now terminated," and the vendor takes a turn and says, "Okay, I'm not going to support that client," we could put that person at risk. That's not what we want to do.

It isn't necessarily about termination. When we suspect things, we're looking at—and I've asked the team to look at this—communicating ahead of time to advise the vendors that we will suspend them and follow

up with an investigation that we're going to have with them. So rather than just outright terminating them, we're looking at suspending them, and that means they can't do any business with the government until we complete our investigation. That will be an incentive for them to help us complete the investigation as quickly as possible.

The Chair (Mr. Norman W. Sterling): Would you provide us with statistics as to how many police investigations you have requested, as well as how many of those people's relationships, in terms of vending with the government, were cut off over the last 10 years?

Mr. David Hallett: Sure. I don't have that information, but we'll follow up and provide that to you.

The Chair (Mr. Norman W. Sterling): The other question I have: Both Alberta and Quebec have pretty successful recycling programs with regard to scooters, wheelchairs and that kind of thing. Has the ministry investigated those in terms of perhaps duplicating or imitating those programs? I understand they have much better results with regard to using these used devices.

Mr. David Hallett: The one major argument that I've heard since being briefed on the particular issue of recycling wheelchairs is the liability issue. Nonetheless, I've actually directed the organization that we need to now revisit and look at a recycling program that would be potentially similar and comparative to those of provinces like Quebec and Alberta. We need to fully understand the benefits of their programs and how they work and consider that for the province of Ontario.

The Chair (Mr. Norman W. Sterling): Well, as I understand, in Alberta what they do is that everything goes back into a controlled renovation. Then the party who renovates becomes responsible for those particular wheelchairs, scooters or whatever they are. So what's the liability concern?

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Ms. Brenda Kritzer: I believe there's a large hospital in Winnipeg that was operating a recycling program or refurbishing program for manual wheelchairs. They have withdrawn from that program due to concerns about liability.

As David indicated, we're taking a look at other programs that are operating across the country to determine, "Are there models there that would work for us?" With the Quebec model, for example, the Quebec government or the agent owns the wheelchairs, whereas in Ontario, the individual who is prescribed the wheelchair ends up owning it. In Quebec, they continually recycle them. Here, we don't own them; it's up to the individual what happens to that wheelchair when they're finished with it.

That doesn't mean that we don't think that it's an important thing to pursue. We've had queries from people who are saying, "My father no longer requires this wheelchair. What can I do with it?" So we know that it's an area that people are very interested in pursuing, and we're looking at these other models. The model in Alberta is somewhat similar to the model that's operating in Quebec. We understand from the Alberta government that they're actually having some difficulty in moving those recycled wheelchairs. So we're going to explore that further with them to find out what they are doing to solve that problem and what the cost of operating the program is in relation to what they are actually saving by using recycled wheelchairs.

The Chair (Mr. Norman W. Sterling): Under the present program, there's no requirement for somebody to return it?

Ms. Brenda Kritzer: Not a manual wheelchair.

The Chair (Mr. Norman W. Sterling): Why wouldn't we require that, if we pay 75% of the cost of the wheelchair or the scooter?

Ms. Brenda Kritzer: Our model is that they own it; they've paid 25%. Essentially, you're right. We have subsidized their purchase of the wheelchair by 75%. That wheelchair may be in operation for a short period of time or for several years. If the item costs $1,000 on day one—

The Chair (Mr. Norman W. Sterling): So there's no reason for us not owning it or not owning 75% of it. Okay; thank you very much.

Ms. Van Bommel.

Mrs. Maria Van Bommel: In your presentation, you talk about cost-sharing models, related in particular to the home oxygen program. At one point, to someone's question, you were talking about a centralized vendor system for motorized wheelchairs. I'm just wondering: What other assistive devices do you do in that way, that you cost-share for your clients?

Ms. Brenda Kritzer: The 75-25 model is in place for most of the devices that we're providing. Home oxygen is 75-25, but seniors receive home oxygen at 100%. For clients of the Ontario disability support program, that ministry pays their 25% and we're paying the 75% that the Ministry of Health pays.

As I indicated, hearing aids are still at a flat rate: $500 is what we're currently paying. There are a number of areas where we're providing supplies. We've determined an amount that we can support. It doesn't cover all of the supplies that a client may require. For example, we pay for ostomy supplies. We also pay for insulin pumps at 100%. That's the way the program was introduced and approved by cabinet. That's for both children and adults. Supplies: We pay $2,400 a year, and that's in quarterly payments. The client is required to reapply each year for those supplies.

Mrs. Maria Van Bommel: So if that's the case, and you're saying in here that this allows people to—and you mention it a couple of times—shop around for a vendor for themselves, that's great in areas where there's that opportunity to have that choice, but in parts of the province, we don't have choices like that. We don't even have a vendor in a local community at all. What happens when people need to have supplies, and you start talking about shipping and handling and all these other costs of bringing technicians out? Where does that get covered in all of this?

Ms. Brenda Kritzer: Shipping and handling of supplies?

Mrs. Maria Van Bommel: Of supplies, of the equipment itself, of all of those things. Who pays that?

Ms. Brenda Kritzer: We pay the approved price rate. If there is shipping and handling, that would be either part of the vendor's markup or the vendor may pass that on to the client.

Mrs. Maria Van Bommel: So in other words, there's a disadvantage to people who don't live in areas where vendors are readily available, that they can go and get, say, the hearing device or the insulin pump or anything like that.

Ms. Brenda Kritzer: Our policy is that the vendor cannot charge more than the approved price.

Mrs. Maria Van Bommel: So when we talk about cost-sharing making it fair for everyone, it is then fair for those who live in rural and northern areas?

Mr. David Hallett: Yes.

Mrs. Maria Van Bommel: Okay. Thank you.

Ms. Brenda Kritzer: It should be the same price.

The Chair (Mr. Norman W. Sterling): Go ahead, Mr. Zimmer.

Mr. David Zimmer: So here's what I'm troubled by; it sort of sends a tremor through my confidence on this issue.

The assistive devices program is a program run by the civil service. The civil service, by definition, are expected to be professional managers. Professional managers manage things and they have supervisors who manage the managers.

What really sets me off is, when I listen to all of the very good things that you've said about the changes that you're going to make and you're going to do better and you see the errors of your ways and all of that sort of stuff, I have to ask myself: How is it that professional managers, brought in to manage a specific program, the assistive devices program, don't catch all these managerial shortcomings that you've acknowledged until after the event and, indeed, after someone like the Auditor General goes in and quickly points out the managerial failings? The mea culpas follow the event. It just boggles my mind that professional managers aren't in there at the front end. That's what management is all about. Can you help me with this anxiety that I have?

Ms. Ruth Hawkins: What I would like to say—you've raised a very good point, which is that some work was done in terms of catching irregularities, whether it be in claims or whether it be in authorizer/vendor relationships. We certainly have tried—we had and have identified areas where there were some definite issues—

Mr. David Zimmer: Look, I don't mean to interrupt you. I appreciate that you've identified these things, but all of this exercise, this conversation that you're about to embark on, is hindsight. Can you tell me why professional managers didn't catch this at the front end? That's what management is all about, not looking back and saying, "This is where it came off the rails." Professional managers keep things on the rails. So why weren't things kept on the rails?

Mr. David Hallett: Mr. Zimmer, I'll try to answer that question straight up on this.

Mr. David Zimmer: Yes.

Mr. David Hallett: The popularity of the program over the last eight years, as I mentioned earlier, has gone dramatically up. The Auditor General reports that the expenditures from 2001-02 went up 91%. The number of clients on the program went up 58%.

As I mentioned earlier in another answer on this one, I think the issue is that the popularity of the program and the volume of people on the program may have outpaced our ability to size up the organization to support it. With 38 people that started off the program—

Mr. David Zimmer: Let me stop you there. A responsibility of management is to identify bottlenecks in whatever process they're managing. At some point with this overload—and I appreciate the overload; I appreciate the consequences and the difficulty in dealing with that—the solution, or the responsibility of the managers, is to jump in and say, "There is a serious bottleneck here, and we have got to unblock this." Was that done?

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Mr. David Hallett: I can't speak about the past and what was done by past leadership. What I can tell you, having the benefit of the Auditor General's report, is that I'm better positioned to look at this program and determine how to move forward.

Mr. David Zimmer: So you don't know.

Mr. David Hallett: That's the answer.

Mr. David Zimmer: All right.

The Chair (Mr. Norman W. Sterling): Can you provide to the committee whether there were any requests by management over the last 10 years for additional staff to deal with this problem? Were there requests to Management Board? Surely you could have gone to the Management Board and said, "Give me 10 more staff and I can save you $10 million?"

Mr. David Hallett: I don't have the answer today, but we will look into it and we will be pleased to provide you with follow-up.

Mr. David Zimmer: I'd very much appreciate it.

Just so I can get my head around the human aspect of this, can somebody walk me through the process of how someone gets an assistive device? Let's take a moderately complicated wheelchair: Somebody's out there and something has happened to them—an accident—and they need this chair, so I guess they call or something. Can you tell me how it works from the start to how they actually get the chair and are in it and away they go?

Ms. Brenda Kritzer: Okay. An individual presents with a clinical circumstance. Initially, the conversation tends to be with the physician, but not always with the physician. In this case, it would likely be a physician within a hospital setting.

The individual, first of all, is going to be referred to a professional who can do an assessment. In this case, that assessment would likely be done by an occupational therapist or a physiotherapist. That occupational therapist/physiotherapist will work with the individual in their home to determine what the appropriate device is for them and what kind and size of seating they require

etc. They may be applying for both a wheelchair and a wheeled walker. The assessment will look at your requirements, your ability to manipulate the device, your physical requirements etc. The therapist will also take a look—

Mr. David Zimmer: Let's assume that they've settled on the kind of device. What I'm interested in is how you go out and get the device: who you cut the deal with, how you decide how much to pay for it and all that stuff.

Ms. Brenda Kritzer: The therapist and you, the client, will complete most of the application, and the therapist will provide you with, or should be providing you with, a list of registered vendors in your community or close to your community who can meet your needs.

Mr. David Zimmer: And that list is maintained by the ministry?

Ms. Brenda Kritzer: Certainly we have a list of all of them, but they will generally have a list of the vendors in their area.

Mr. David Zimmer: That list has to be vetted by the program?

Ms. Brenda Kritzer: It's registered vendors.

Mr. David Zimmer: How do you get on to that list?

Ms. Brenda Kritzer: You have to be registered with the ministry.

Mr. David Zimmer: Okay. Tell me the process for a wheelchair manufacturer to get approved on the list.

Ms. Brenda Kritzer: A wheelchair manufacturer would look to have the device approved as a device that we will list. A vendor will submit an application package to us that will include the types of devices that are carried and what kinds of professional staff they have on hand to provide assistance; there are various business requirements as well.

Mr. David Zimmer: Now tell me how you go about settling the price of the assistive device.

Ms. Brenda Kritzer: The pricing of the device is set by requiring manufacturers to provide us with the cost of a device—a single wheelchair—to a vendor. So it's not a discounted price. What is the manufacturer's price to the vendor? We collect that from all manufacturers of a particular device, and then we set the price.

Mr. David Zimmer: So it's not necessarily the one at the lowest cost. Is that right?

Ms. Brenda Kritzer: It may be, for example, that there could be 15 different varieties of wheelchairs, so we may list all 15, and we're listing the manufacturer's price.

Mr. David Zimmer: How do you decide which chair to give the person, and at what cost? That's what I want to know.

Ms. Brenda Kritzer: The decision around which chair is appropriate is made between the client and the authorizer, who is the therapist working with them.

The Chair (Mr. Norman W. Sterling): You said the manufacturer's price wouldn't be a discounted price. When you walk into any store, you see the manufacturer's suggested retail price. Is that what you're working off?

Ms. Brenda Kritzer: No. We're asking them what the price is to the vendor for that device, and then we allow the vendor a markup.

The Chair (Mr. Norman W. Sterling): To sell one to the vendor or sell 10 to the vendor?

Ms. Brenda Kritzer: To sell one.

The Chair (Mr. Norman W. Sterling): Even though most vendors would buy 10?

Ms. Brenda Kritzer: It depends on the community. In some communities, of course, a vendor can afford to carry a larger volume of some devices, and in other areas they can't.

The Chair (Mr. Norman W. Sterling): When the person goes in with the suggested price—let's say it's $500—can the vendor say, "Look, I'll do a special deal with you. You won't have to pay your 25%."

Ms. Brenda Kritzer: If they wish, they can do that. We pay one price.

The Chair (Mr. Norman W. Sterling): In other words, the person who's getting it may not pay anything even though they're supposed to pay 25%?

Mr. David Hallett: In certain situations it's possible.

Mr. David Zimmer: Those are my questions, Chair.

The Chair (Mr. Norman W. Sterling): Ms. Sandals, did you have a few questions?

Mrs. Liz Sandals: Madame Gélinas raised the whole issue around professional misconduct and how you communicate with the professional colleges. I guess two questions here: One, do they accept your complaint if you lodge a complaint? Is the Ministry of Health on their approved list of people from whom they will accept a complaint? It's not a given, if you're dealing with the College of Physicians and Surgeons, that they will accept essentially a third party complaint—you're not the client. Is there any issue there?

Then, could you give us a little bit more of a sense of when this whole business happens in the reverse direction, which the auditor raised, if the college for some reason withdraws membership—either the person didn't pay a fee or it's a discipline issue. How do you get those people taken off your list of approved whatever? Could we talk about the back and forth both ways?

Ms. Brenda Kritzer: In our meeting with the colleges recently, as I said, we asked them to review the auditor's report and recommendations. Naturally, as with the College of Physicians and Surgeons, they prefer that a complaint come directly from the person who is impacted: the patient or client. And what we have always done in the past is ask the client to ensure that they're contacting the college to explain their complaint.

Mrs. Liz Sandals: But realistically, if it's conflict of interest, as long as the patient got the wheelchair, they actually don't have a complaint. It's us, as the taxpayer, who have the complaint.

Ms. Brenda Kritzer: Exactly. What we have agreed with the colleges is that we will forward to them the concerns we have. So, when we are doing an investigation and we arrive at a point where we're saying, "Yes, there's an actual conflict of interest," we will inform

them that we are investigating this conflict of interest, and probably of the actions we're taking.

But that does not necessarily mean that the college is going to take action, because their definition of a conflict of interest is not necessarily ours. Ours is from the perspective of our program. For example, the audiologists' college allows audiologists to actually sell the device, whereas we're saying that an audiologist is not the person who should be selling the device.

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In terms of the reverse part of your question, when you asked how we are keeping up to date, the colleges are now required to publish online on their websites a list of members and also publish any conditions that may be attached to a person's registration with the college. We will be using that, and we will be implementing a process of a sort of random audit that progresses through the year, so that we're looking at the current registration status of the authorizers in all the colleges.

In addition, every two years, we do send out a form to the authorizers requiring them to provide us with their current registration status. The auditor noted that we hadn't followed up on cases where they hadn't submitted, and we have been doing that. We will ensure that that process is tightened up and that we are doing that every two years.

Mrs. Liz Sandals: If I could just comment, going back to the first part of the question, if we're dealing with this conflict-of-interest issue and it isn't necessarily professional misconduct and it isn't necessarily criminal fraud, which the OPP would be interested in, that really leaves it an issue between the Ministry of Health and its registered vendor. It's really sort of falling back to the Ministry of Health to deal with the issue, because it wouldn't meet the threshold of what the other two players are concerned about; it's a Ministry of Health issue. Thank you.

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

M^me^ France Gélinas: The auditor mentioned that, as you know, ADP is not the only one that pays for assistive devices. Certainly WSIB pays for quite a lot of them, and the same thing with Veterans Affairs. The auditor has identified duplicate payments, where clients made a claim to ADP but also made a claim to either Veterans Affairs or WSIB—I suppose there could be others—and that there is no information-sharing agreement in place between ADP and WSIB. How do you go about making sure there are no duplicate payments?

Ms. Brenda Kritzer: We did investigate the findings of the auditor, and it's our determination that there was not duplicate payment; the WSIB had paid 25% on behalf of the client, and we had paid 75%. Unless we are able to examine the specific records that the auditor is referring to, it's our finding that there is not a duplicate payment currently.

M^me^ France Gélinas: But the auditor goes on to say that the ministry has recovered $110,000 worth of duplicate—

Ms. Brenda Kritzer: That's right, and that is where there is a payment—could I just take a moment to provide a little bit more explanation? The process that WSIB uses to determine whether or not they will be paying versus our process is quite different. We're testing for hearing, whereas they're looking not only at the question of hearing loss but what is the cause of the hearing loss. Quite often there's a delay before someone is actually given a hearing aid, and they will pay for it. So we sometimes find ourselves paying for a hearing aid and later making a recovery from WSIB because they have, subsequent to our providing the hearing aid, made a determination in favour of the client. That's where a duplicate payment may occur and we do a recovery.

In terms of the information-sharing agreement, we have had, in the past, an information-sharing agreement regarding hearing aids. We have met with WSIB, and we have agreed with them that we will work toward establishing a memorandum of understanding regarding the sharing of information on all device categories.

We're also looking at Veterans Affairs Canada. Veterans Affairs Canada, however, indicates that their policy is that provinces are the first payer in all instances except, again, hearing aids.

M^me^ France Gélinas: So you will be developing an information-sharing agreement with WSIB. How long a time frame are we looking at?

Ms. Brenda Kritzer: I expect we would have that in place in early April.

M^me^ France Gélinas: And for Veterans Affairs?

Ms. Brenda Kritzer: Veterans Affairs: Again, there's some consideration. We've contacted them; we've had some discussion with them. They're taking a look at it, but they have made clear that their policy is we pay first.

M^me^ France Gélinas: The auditor also mentioned that only 40% of the people who receive the $600 for ostomy supplies had submitted receipts. That leaves 60% of them who did not. How come?

Ms. Brenda Kritzer: Again, it's not a requirement that they submit receipts. Currently, our requirement is that they hold on to their receipts for a period of time, during which we may ask them to submit as part of an audit process.

We have taken note of the auditor's recommendation and will be strengthening our processes to ensure that we are sending out more frequently to check on whether or not the person still qualifies for the grant.

M^me^ France Gélinas: And you wouldn't put in place a program where they submit $600 worth of receipts once a year and just be done with it?

Mr. David Hallett: We'll be looking at it.

M^me^ France Gélinas: Okay. That's it for me.

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

Mr. Peter Shurman: Just a couple, quickly: The auditor's report came out about a year ago. In the period of time that has elapsed—a year—has the ministry terminated any agreements with vendors or authorizers?

Mr. David Hallett: Just a point of clarification: It came out in November 2009.

Mr. Peter Shurman: Two months ago?

Mr. Jim McCarter: A fairly final copy of the draft report maybe six months ago.

Mr. Peter Shurman: Six months ago.

Mr. Jim McCarter: Ballpark.

Mr. Peter Shurman: Okay. Any terminations since then? Can you give us numbers?

Ms. Brenda Kritzer: I believe we have terminated one vendor. We have probably sent out in the neighbourhood of 40 to 50 letters to vendors requiring an explanation of what we see as irregular billing patterns and a potential conflict of interest with authorizers.

Mr. Peter Shurman: Just a couple of questions on the review process: The auditor reviewed a sample of client files from two major vendors in home oxygen, but the two vendors account for more than 60% of the home oxygen supply. One third of the files showed that no assessments had been done for the past 18 months, no test results had been recorded or the results indicated that the clients no longer met the criteria for long-term home oxygen supply. What's the movement on that in the period of time that has elapsed?

Ms. Brenda Kritzer: Are you asking about the particular instances that were identified by the auditor?

Mr. Peter Shurman: No, I'm just concerned with the volume here. If you've got two vendors who are doing 60% of the home oxygen and you've got the no-assessment situation for 18 months or no test results being recorded, what has happened in the six months, and is that—again, I'm not trying to answer the question for you—in the realm of your computer and your reporting capability?

Ms. Brenda Kritzer: What we have done, as David described, is implemented or released an RFP that does require annual testing and confirmation by the physician for the continued need for home oxygen. In developing that—

Mr. Peter Shurman: I don't want to interrupt you, but I want to get the complete thought. If it requires those things, does it also clearly say that, absent those things, things just drop; we no longer pay?

Ms. Brenda Kritzer: That we will not be paying them? We provide a period of time, but I can look into that, sir, and come back and clarify whether or not our RFP has been that specific in terms of actions we will take if the test is not provided.

Mr. Peter Shurman: I would hope so.

On ostomy supply—I believe you just touched on this, but I want to go back to it for a second—I notice that only 40 of 287 clients had been reviewed, and that review is quite old; the last review was 2005. The ministry said that it would reinstate the review process. Has that happened?

Ms. Brenda Kritzer: No.

Mr. Peter Shurman: When would you expect that to happen?

Ms. Brenda Kritzer: It will be happening this year. We will be doing that immediately.

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Mr. Peter Shurman: I'm going to ask one more question, and I suspect the answer is the same. This is pertaining to insulin pumps. The auditor reviewed a sample and noted the cases where the delivery date of the pump preceded the date of the client's eligibility, which is mind-boggling. The auditor suggested to the ministry that it might wish to examine its current policy, but said that if it is deemed appropriate, it should be enforced. I would think it's deemed appropriate across the board. This is the taxpayer funding something that is, yes, vital on the one hand, but on the other hand, has to be verifiable. Where are we with that?

Mr. David Hallett: We will be reviewing it this year.

Mr. Peter Shurman: This is the last point I want to make, and it kind of brings us full circle to the first point that I made: It sounds to me like all of the questions and all of the answers from all sides of this table come to the same conclusion as the auditor, and it seems to me that you do too—without trying to put words in anybody's mouth—that there's a lot wrong, that the auditor is basically correct in his findings, that you agree with that, that things are going to change and that, if we were to be here a year from now, most of them would have. Is that a summary I can take home?

Mr. David Hallett: I'm fortunate enough to come into a new position and have the benefit of having an Auditor General's report that gives me a lot of information to make some substantive changes to that program, to make it better for the clients who are served across this province by it.

Mr. Peter Shurman: Thank you.

The Chair (Mr. Norman W. Sterling): Vis-à-vis hearing aids, you say it's a flat price of $500 and you don't know whether the person receiving the hearing aid has actually paid anything or not. Is there any limit on the number of hearing aids an individual can get?

Ms. Brenda Kritzer: We will fund $500 for one hearing aid for each ear.

The Chair (Mr. Norman W. Sterling): Can they go back the next year and get another $1,000?

Ms. Brenda Kritzer: No. Currently, we've defined a period of three years. We're looking at that in terms of whether or not hearing aid technology is at the point where we can extend the point where a replacement hearing aid would be appropriate after a longer period of time.

The Chair (Mr. Norman W. Sterling): How long has it been $500?

Ms. Brenda Kritzer: I can't tell you how long it has been $500, but I would think it has been that for many years.

The Chair (Mr. Norman W. Sterling): Hasn't the price dropped? With all electronic devices, you would expect a decrease in price.

Ms. Brenda Kritzer: Our understanding is, in the market, the average hearing aid is probably $1,000. WSIB is currently paying about $1,400 per hearing aid—

The Chair (Mr. Norman W. Sterling): We had WSIB here last week, and I wouldn't suggest you suggest that they run their shop with a sharper pencil than you.

Have you ever asked the manufacturers of assistive devices like scooters and wheelchairs for their price for two chairs or 10 chairs? Do you ask them those questions?

Ms. Brenda Kritzer: No, we haven't. You're asking whether we asked them what the discount is that they are providing. As we complete our current pricing review but go into a more in-depth review of how we are setting prices, we will be looking at how we can capture discounts, and whether we can capture discounts and still provide access to clients across the province.

The Chair (Mr. Norman W. Sterling): Any further questions?

The Auditor General told us that the waste here was in the tens of millions of dollars. Can you say to us that you will come back with a plan that will save us tens of millions of dollars?

Mr. David Hallett: The intent is to go forward and develop a more robust modernization of the assistive devices program, with the intent of achieving value for money, including the issue of, can we drive the costs down? If we drive the costs down, we should be making savings.

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

Mr. David Zimmer: In answer to one of my questions, you made the point that you've recently arrived. That's fair enough. Who was in charge of the assistive devices program previously?

Mr. David Hallett: I don't have the answer.

Ms. Ruth Hawkins: The position reported to the assistant deputy minister of corporate services, and that particular position reported to me, too, for a period of time, as executive lead.

Mr. David Zimmer: Did you ever lower the boom on the manager of the program?

Ms. Ruth Hawkins: We certainly have had many discussions around the work that needs to be done. Certainly, we monitored very closely the work that needed to be done, and we also have looked at what needs to be done. Frankly, this report helped us move even further.

Mr. David Zimmer: So the managerial shortcomings were identified?

Ms. Ruth Hawkins: I think there are many areas that have been identified as areas that we have looked at, need to look at and will continue to look at.

Mr. David Zimmer: Were there any personal consequences involved for any of the folks in charge of the shortcomings?

Ms. Ruth Hawkins: I guess that's a matter of interpretation.

Mr. David Zimmer: Thank you.

The Chair (Mr. Norman W. Sterling): Thank you very much. I'd ask people to stay back for a few minutes so we can instruct our researcher with regard to the report.

The committee continued in closed session at 1443.

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