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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Pursuant to Standing Order 108(2), the study of technological innovation, which is one study that we have been doing.... It's been extremely interesting, one of the best studies that we've done.

As individuals we have Dr. Jason Sutherland, assistant professor, and Emad Guirguis, general and cosmetic surgeon.

Dr. Guirguis, do you mind beginning? You have your PowerPoint in front to of you. You have a 10-minute presentation, sir.

Thank you.

Dr. Emad Guirguis (General and Cosmetic Surgeon, Lakeview Surgery Centre, As an Individual): Thank you very much.

It's indeed an honour to be invited to speak to this committee.

I've been in practice now for approximately 20 years. I graduated from McMaster University, where I attended medical school. I went on to the University of Ottawa, where I trained in general and cosmetic surgery. I practise in Barrie, Ontario, my hometown. The University of Ottawa and Ottawa bring back a lot of memories.

After 16 years of practice in a hospital setting, we came up with a concept that was literally out of the box. It was innovation in delivering health care in out-of-hospital surgery facilities—advanced health care, including general anesthetic procedures. As a model, while we do many procedures at Lakeview Surgery Centre, we are going to present the obesity management with the lap band program.

In summary, we're going to talk about creating an accredited surgery facility: how it's done, how accreditation licensing takes place, and why we focus on obesity. We will talk about our lap band program—what is a lap band? I brought a model, which we'll see during the presentation—and our own Lakeview Surgery Centre experience.

In building the centre approximately four years ago, we consulted with the City of Barrie building and zoning department. We worked very closely with them, in compliance with all their regulations. We bought a property, literally on the water, on Kempenfelt Drive. We created a separate front entrance, graded the driveway for full wheelchair access, and developed a new electrical transformer for some of our advanced equipment. We installed a generator for backup electricity, and then built a side entrance and exit for evacuation, in the event of an emergency.

We installed a commercial elevator that has high capacity, redesigned the flooring and ventilation using advanced technology with engineers and architects who specialize in health care facilities. We installed oxygen, suction, and medical air in the infrastructure of the building. So everything is actually built into the infrastructure of the building.

Literally, we have a fully accredited and licensed operating room with a view of Kempenfelt Bay and a four-bed recovery room, which also looks onto Kempenfelt Bay.

Keep in mind this is a fully accredited licensed facility. There's a private accreditation group called the CAAASF, the Canadian Association for Accreditation of Ambulatory Surgical Facilities. Plus, in the last two years the College of Physicians and Surgeons has recognized that this is an evolving field, doing out-of-hospital surgery, including advanced surgery. The College of Physicians and Surgeons inspects the facility, as well, to make sure it is in compliance. Essentially, we have created a hospital in an out-of-hospital facility.

As you can see, obesity is defined by the BMI, or body mass index. Normal weight is under 25 BMI. We focus on managing the severely obese and morbidly obese patients with a BMI of over 35. There are very interesting trends in obesity in Canada. In 1985, across the country, less than 10% of the population at that time was obese. Fast-forward to 2006, and now we have the majority of provinces with an over 20% obesity rate. The average Canadian overall obesity incidence is 23%. Not only is this astounding, the growth in our obesity population, but the associated chronic medical conditions that have a major impact on health care funding and expense are directly associated with the level of obesity.

For example, in regard to high blood pressure, there is about four times the likelihood patients will have high blood pressure, if they're in the obese category, and six times the likelihood they will have type 2 diabetes, sleep apnea—where they literally fall asleep during their sleep with heavy snoring, gallstone disease, or strokes. These are all associated with increasing obesity.

Furthermore, the mortality rate is on the rise. It is directly linked to obesity rates. In 1980 there was only about a 5% mortality rate associated with obesity; as we get into the 2000s, in 2005 it approached 10%.

● (1535)

The surgical options are twofold. There's the lap band and the gastric bypass.

Do diets work? This is a very typical study looking at diets.

When a person starts a diet, and it doesn't matter which diet it is.... When a person who is in the severely obese category starts a diet, they will lose some weight initially. But when you track those patients a year and five years after they have started a diet, no matter what diet it is, whether or not it's associated with counselling, the obesity rate is actually higher. So in fact, conventional diets exacerbate obesity, something we're not told by the diet industry.

I brought the lap band. The concept is.... We create two things. One, we create a small pouch for the stomach. The patient eats food, and after eating a small portion they feel satisfied, and they feel satisfied for a longer period of time. The patient doesn't get hungry between meals. Two, we're also compressing the vagus nerve, which is the nerve that gives us the feedback mechanism to fullness and satisfaction.

Essentially, there are two things. There's an anatomically small stomach, plus we're also compressing the vagus nerve for the feedback loop to feel satisfied with meals.

This is adjustable and reversible. This is what we call a port. This is all underneath the skin attached to the muscle. We can adjust the degree of compression around the stomach and the pouch. So much like our waist, as we lose weight the circumference of the waist goes down; it's the same with the stomach. We lose weight, and the circumference of the stomach goes down. So the patient comes in for what we call adjustments. We put in some salt water, which snugs up the lap band.

We are looking at what we call the green zone. This is what we're achieving with the lap band. We put in enough saline so that patients feel satisfied with small portions. They have good weight-loss control, and there are no abnormal or punitive symptoms, such as discomfort or acid reflux. There are patients in what we call the yellow zone. That's when there's not enough fluid in the band. Then there's the red zone, if the band is too tight.

We can adjust it, and we have control over the degree of satisfaction with meals.

All of what we call the co-morbid or associated conditions with obesity decrease substantially after the lap band surgery, including high blood pressure, diabetes, sleep apnea, and acid reflux. Furthermore, the death rate associated with obesity drops significantly after a patient has had a lap band. There is quite a major difference in the death rate between the two.

This has become very accepted in the medical field. There are several societies now. The Canadian clinical practice guidelines recommend bariatric surgery, lap band surgery, or gastric bypass surgery for patients who are obese with associated medical conditions. It's highly effective in achieving sustained weight loss in resolving co-morbidities.

At Lakeview Surgery Centre we have developed a team. I am the medical director. We have a nurse who is the director of weight management. We also have a certified dietician, a psychologist, and a personal trainer who work with our patients to ensure long-term success of this really chronic condition. It's now accepted that obesity is a chronic condition, untreatable by conventional means.

In terms of the first 59 patients we operated on with the lap band, you can see the starting weight at the top with the dark bar, and the end weight below. As you can see, some of our patients weighed over 400 pounds. All of the patients are losing weight successfully, and more importantly, are keeping the weight off. The average weight loss was 45 pounds, or approximately 20% of the patient's total body weight. The range in patients just starting the program is from three pounds to patients who have lost over 100 pounds, with a small number of complications.

This is just a case in point, in conclusion. A patient came to us in 2010. She was 57 years old. Her BMI was 46. She weighed 304 pounds. She had high blood pressure. She had acid reflux. She was on two medications for those conditions. We tracked all the patient's progress with a graph. After 21 months, she lost 101 pounds, or approximately 33% of her body weight. Her BMI dropped from 46 to 30, and she came off all her medications. This is what a typical patient looks like. It is a very rewarding field, to work with patients who are obese who finally achieve success after years of agonizing diets and yo-yo dieting.

In conclusion, out-of-hospital surgery facilities are innovative and safe in delivering health care to our communities. The lap band program, specifically as a model that we used here for this presentation, is safe and effective in combatting the obesity epidemic.

● (1540)

Thank you very much for your attention.

The Chair: Thank you very much. That was very interesting.

Now we'll go to our second guest.

Dr. Jason Sutherland, please.

Dr. Jason Sutherland (Assistant Professor, Centre of Health Services and Policy Research, University of British Columbia, As an Individual): Thank you.

I'd like to take the first couple of minutes to introduce myself. I'm a faculty member at the Centre for Health Services and Policy Research at the University of British Columbia in Vancouver, where my specialty lies in evaluating the organization, delivery, and funding of health care systems. I'm a Scholar of the Michael Smith Foundation for Health Research and I'm also Canada's Harkness Fellow in health policy.

I'm currently studying the health reforms that President Obama has enacted in the United States in Medicare. I'm working in Washington, D.C., as a foreign scholar for the next 10 months.

[*Translation*]

I welcome your questions in both English and French.

[*English*]

The international results are in. Canada again ranks last in the ranking of the top 11 industrialized countries in terms of access to many kinds of hospital-based care and specialized care, with substantial waits for hospital care and to see a specialist. I think the persistence of these trends is demonstrating that we are clearly performing very poorly on some aspects of the health care delivery system.

Recent data also shows that Canadian governments are spending over $60 billion a year on health care in the provinces, with another $30 billion each on drugs and physician care, based on 2012 statistics provided by the Canadian Institute for Health Information. Where does this put us internationally? We're definitely in the top percentile for spending per capita among nations. This draws a really harsh light on the paradox between our very poor access to specialized care and our very high expenditures.

Given these findings and the persistence of these findings, we should be paying much more attention to how we spend these massive amounts on health care. The way we pay for our health care provides incentives for providers of health care to act in certain ways and engage in certain behaviours. For example, global budgets, which are the way that we fund most health care providers, reward cost minimization and rationing of health care.

What are the results of the behaviours that we're currently paying for? There are many examples of inefficiencies, ineffective care, and unsafe practices in health care. Two significant ones certainly spring first to mind.

First, from time of referral, the time to see a specialist often exceeds more than 12 months. In other words, from the referral from your general practitioner to a surgical consultation, the median time exceeds a year. That's a long time if you're in agony, or your quality of life is suffering, or you're debilitated.

Second, this is very shocking but is not news to many of you who work in the health care industry: every single day there are thousands of patients who are in hospital beds and are ready to be discharged safely, but there's no place for them to go. They even have a name for them: “alternative level of care”. It's a very prevalent problem in our Canadian hospitals. This use of hospital beds is inefficient and unsafe for patients and has detrimental effects on the hospital staff who care for them. It's also associated with the clogging of our emergency departments, something I've written about extensively.

We should, I believe, expect more from our health care system and strive for a high-performing health care system on cost efficiency, access, higher quality, and safe care. In my forthcoming report on the use of funding methods to change the delivery of care, I advocate using policies that have been proven effective in other countries in improving access, especially to surgical care. I also advocate that we curtail policies that ration resources and restrict access to care and lengthen wait-lists.

To do so, we should create incentives for the health care system as to what we think we want from it. For example, if our policy imperative is to improve access, then we should use a funding mechanism that rewards access to hospital-based care. This is known as activity-based funding and is the predominant form for funding hospitals across the industrialized world. There are also many strategies that other countries have developed for mitigating the risks of rising expenditures from these kinds of methods.

Similarly, we can develop, design, and implement incentives for community care providers to pull waiting patients from the hospitals when it is safe to do so; I refer back to my comment that every day in hospitals there are thousands of patients who are waiting to go home. By doing so, we'll improve our access to hospital-based care for those thousands of patients waiting for their elective surgeries and hopefully improve the clogging of our emergency departments.

● (1545)

Now I want to highlight the two provinces that are trying to figure out how to use these innovations to try to achieve their policy aims of improving access.

First off, British Columbia is starting implementation and experimentation with activity-based funding for elective procedures, as a small proportion of overall hospital funding, to increase the volume of elective surgery and improve access and decrease wait-lists. An evaluation is ongoing of the effectiveness of these policies, but they're widely implemented in many other countries.

On the other hand, Ontario is using a new policy initiative for certain chronic conditions, tying funding to best practices of care. That is, they are funding, they are creating incentives, to reward providers to provide the evidence-based care that patients with those conditions have. This is known as QBP, for quality-based procedures.

A third example originates in the United States. I'm currently studying it. It employs innovative strategies for addressing the seams between the silos in the delivery systems. That might be between post-acute-care providers or between the hospital and home. Known as bundled payments, the incentives are based on reducing avoidable or unnecessary care. Research has demonstrated its feasibility in some Canadian provinces already.

So what's missing from these policies in order to execute innovations to address the limitations in our current health care system? Well, much work needs to be done. Our national health information agency has to adapt and provide the plumbing for these innovations to be successful. I think this is an achievable goal in the short term.

In the medium term, I believe one agency should also specialize in identifying innovative and successful health delivery strategies that work in regions or in provinces and in disseminating that information elsewhere. Currently there's not a clearing house for good ideas, and I think that would be a useful role to be played in the medium term.

In the long term, I believe there's a very prominent role to be played by collecting patient-reported outcomes and patient-reported experience measures so that we can tie patients' experiences and their outcomes with how to direct care and resources to those who need it the most, and waiting patients.

With that, I conclude. I'd like to thank the committee for the opportunity to present my views on the state of innovation in the health care system in Canada.

● (1550)

The Chair: Thank you very much, Dr. Sutherland. Some of your ideas are very insightful, and we look forward to hearing more.

We'll now go into our seven-minute Qs and As, when we will give the committee members a chance to ask you those questions.

We'll begin with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson.

Thank you to both of our witnesses for being here today.

At the beginning of your remarks, Dr. Guirguis, I think you said that your facility is "a hospital in an out-of-hospital facility". That sounds like a bit of an oxymoron, but I think we understood what you meant.

I wonder if you could tell us about the Lakeview Surgery Centre. Is it a private facility?

Dr. Emad Guirguis: Yes, it is.

Ms. Libby Davies: For your patients who go there, how are they covered? You're in Ontario, right? Are they covered through OHIP, the insurance plan in Ontario? How does that work?

Dr. Emad Guirguis: That's actually an excellent question.

Lakeview is funded completely outside the taxpayer's purse. We funded the centre ourselves. We did not ask the provincial or federal government for any funding for the centre.

In terms of the procedures that are performed there, we are total advocates for the Canada Health Act. We believe the population has access to insurable services and everyone should have equal access. So right off the bat we're proponents of the Canada Health Act.

That said, we have performed both OHIP-covered procedures, or public-covered procedures, and private procedures. If a service is insured by the provincial government, then we do not charge any extra for that procedure—for example, inguinal hernia repair, thyroid surgery, breast cancer surgery—whereas if it's not covered by the government purses, if you will, then the patients or third-party insurers would fund that procedure.

Ms. Libby Davies: But there's no sort of extra-billing for any procedure that is covered under OHIP, like—

Dr. Emad Guirguis: No, we're totally respectful of—

Ms. Libby Davies: —use of private rooms or anything like that?

Dr. Emad Guirguis: No.

Ms. Libby Davies: It would be as if you went to any other publicly funded facility?

Dr. Emad Guirguis: Exactly. Of course, the challenge from an operational point of view is that if a procedure is covered by the provincial government, such as a hernia, for example, we can only bill the province for the procedural fee alone, so that the owners ourselves would have to absorb all the other costs: the nursing costs, the anesthesia costs, and the facility costs. It becomes very difficult to perform publicly funded procedures in an out-of-hospital facility.

However, the provinces.... For example, Ontario has said that it would like to see more procedures that are publicly funded procedures funded in out-of-hospital facilities. We really believe strongly that this is the way of the future. You extract out procedures that can be done safely as outpatient procedures and have them funded properly in an out-of-hospital facility.

Ms. Libby Davies: Okay. I wish we could have more time to go into this, because I do feel that it's a bit of a murky area in terms of what we consider to be a private facility and what kinds of fees are charged, but anyway, I did want to ask you that basic question.

I'd like to turn to Dr. Sutherland.

I think what you're putting forward is quite fascinating. There's a question that just jumps out at me. We know that health care is provincially delivered, but of course there is major federal funding. In your opinion, are there any mechanisms at the federal level or any incentives? Is there anything that exists that actually would be taking us in the direction of activity-based care or some of the other models? It seems like such a hodgepodge, right? It's happening in B. C. and it's happening in Ontario, and I think our research notes say it's also in Alberta.

Why isn't it happening across the country and what is the gap federally? If you could really identify that, that's what we need to focus on to figure out what we should be saying to the federal government to ensure that these good models for funding, which in the long run will be better for the system, are actually being activated.

● (1555)

Dr. Jason Sutherland: Those are very complex issues you're raising there in a very long question. I'll try to knock them off as I can. First off—

The Chair: I think you can do much better than that, actually.

Voices: Oh, oh!

Dr. Jason Sutherland: First off, specifically with regard to activity-based funding, I think the promise of that mechanism is certainly aimed at improving access to surgically based care. There are limitations to it that are associated with the often increasing physician- and hospital-based costs with regard to an increasing volume of care. If you're willing to go with a policy imperative of improving access, this proves to be an effective mechanism for doing that. Given that many countries have tried this, it's well known what the side effects are and how to guard against those side effects.

However, I would point back to the federal wait-times strategy as one effective mechanism that actually opened the door for activity-based funding at different levels in Canada. Many provinces use that as a contracting mechanism to bulk-purchase additional surgical care from their hospitals or from their health authority's or health region's hospitals. I think that was very effective in improving access for elective care, and I think it's certainly one mechanism that could be logically extended into many other conditions beyond the Cinderella services.

Ms. Libby Davies: Are you talking to the five areas that were identified? They were knee surgery or hip surgery.... Is that what you're referring to?

Dr. Jason Sutherland: Yes, and cataracts and cancer. There's a number of the five that I would deem to be almost Cinderella services that have benefited from the additional contracting on that. It is a mechanism that can be expanded essentially to all elective surgeries quite readily.

Ms. Libby Davies: Is there anything else that we should be considering for the federal government to do in terms of advocating for more of a national perspective on these different types of funding models? Is it targeting funds to particular outcomes and saying that if you want this extra money you have to show that your outcome is whatever you base it on?

Dr. Jason Sutherland: Well, I think the federal wait-times strategy was a very innovative method for trying to get this contracting with activity-based funding down, because now the provinces are very familiar with the mechanism. At the same time, it opens the door for perceived inequities between different kinds of surgeries if you're not in the Cinderella services of the five conditions. For example, hernia repairs may get pushed out for additional hips and knees, because the marginal revenue goes to those patients.

The Chair: Thank you, Doctor.

We'll now go to Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair.

Thank you for the testimony so far.

First, to Dr. Guirguis, you did a lot of emphasis on obviously obesity management. I want to know what you think the consequences are of obesity on the health care system. I think it's important to realize the types of savings that could be found through innovation.

Do you have any figures in terms of the cost consequences?

Dr. Emad Guirguis: I do. In general it's obviously in the millions. The lead conditions associated with obesity—high blood pressure, type 2 diabetes, sleep apnea, cardiac disease, heart attacks—are massive components of health care costs.

There are actually specific cost-analysis studies that look at the cost savings. I didn't present them today, but the cost savings with lap band surgery and gastric bypass surgery are in the millions.

Keep in mind that these are chronic conditions that are constantly taxing health care dollars and health care energy with family physicians. Looking at this model, once you have patients in your program and you're able to get their BMIs under control, their conditions decrease quite substantially, along with their reliance on medication. Lost time off work is another issue as well.

So it's millions. I can get specific numbers for you, but it's definitely in the millions.

Mr. Patrick Brown: You mentioned lap band surgery, and the answer made me think of the whole issue of medical devices. In 2011 the audit of Health Canada by the Auditor General's office said that one thing that needed to be addressed was the approval of medical devices in a timely manner. That was an area that needed improvement.

I think that's important to talk about here, because obviously new medical devices are one of the tools for innovation. What have your observations been, Emad and then Jason, about barriers we have with the federal government? Do you have concerns about the process we have for the approval of medical devices?

● (1600)

Dr. Emad Guirguis: Speaking personally, there haven't been any issues raised with the efficiency of approving the lap band as a medical device. It was approved initially by Health Canada in the late eighties. In 1993 the first laparoscopic, or less invasive, procedure was carried out.

The band has undergone several modifications. It is a process that generally takes one to two years for FDA approval in the States and Health Canada approval in Canada. It does take between six to 12 months on average, if you have an existing device that is modified, to approve the modification as well.

Mr. Patrick Brown: In terms of your device, has it been more challenging to have it approved in Canada as compared with other countries?

Dr. Emad Guirguis: For the lap band, there's no evidence that Health Canada has been slower at approving it than in Europe and the United States.

We actually just came back from Mont-Tremblant, where we had a lap band meeting. The actual innovator of the lap band was there, and we had a dialogue over dinner. There was no mention of any difficulties as far as getting it approved.

Mr. Patrick Brown: Jason, do you have any observations on the regulation of medical devices?

Dr. Jason Sutherland: I'm sorry, I don't have insight into medical device evaluation.

Mr. Patrick Brown: One direct question I had for you, Jason, was in regard to your research with CIHR. I've asked this question before about CIHR. Do you believe there's an adequate level of collaboration in the type of research we're doing that leads to innovation?

I think of juvenile diabetes, where they're doing research in both Canada and Australia on an artificial pancreas. I know that in the case of JDRF, they were pooling their research.

Do you notice that's happening pretty broadly at CIHR, being someone who has worked with them?

Dr. Jason Sutherland: I do know that many of my faculty colleagues do have international collaborations, but it is also hard to know. Having worked in the NIH a little bit as well, with grant funds from there, they actually tend to be a little more insular and have fewer international collaborations.

However, I believe there is certainly space for trying to develop, identify, and then scale up effective strategies or policies much more quickly than is done now. I know that CIHR effectively tries to implement a knowledge translation component into each research project. However, I think there is a central role that could be played in identifying effective strategies, pushing them out, and scaling them up with resources much more quickly than leaving it to individual investigators or researchers such as myself, where the payoff in terms of my time disseminating research, rather than creating it, is very low.

So I think there's a role for central agencies to identify good ideas, evaluate them, and scale them up.

Mr. Patrick Brown: Emad, I want to ask one question just to play devil's advocate. I remember when we studied obesity here at the health committee, one thing I asked about was that obviously people are exercising less and less. There are more distractions with video games and TV, with 300 channels instead of two, and there are fewer kids at the park across the street. Given that challenge, do you think we should be relying on innovation to combat obesity or are there other things the government should be doing to address that? Do you have ideas regarding possible innovation other than something surgical?

Dr. Emad Guirguis: That's an interesting point.

As with any health care policy, prevention is always prime above treating the disorder. However, we're here now. The evidence shows that if you can get children exercising at an early age and prevent childhood obesity and prevent early obesity, then you're winning. If you can sustain that lifestyle, combined with portion control and exercise, then you're going to have great success in keeping the population at a healthy weight.

However, the problem is that once patients are obese, it's a whole different equation. These patients feel anguish over losing their weight. We see them in consultation. They are exercising aggressively. They're trying portion control. They yo-yo back and forth among multiple diets.

Now the evidence shows that once a person is obese, they have a new set BMI that's like a spring. No matter how hard they diet, they spring right back to that BMI and often one that is higher, so it becomes very difficult to lose weight and keep the weight off. That's the big challenge with obesity. Once a patient becomes obese, it turns into a chronic condition.

● (1605)

The Chair: Thank you.

Dr. Emad Guirguis: You bring up an excellent point, but to reverse obesity with exercise and diet alone is virtually impossible. From the studies that show us it can be done, usually 1% or 2% of the population can keep the weight off after two years.

The Chair: Thank you, Doctor.

Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Madam Chair.

I want to start with a question on the obesity piece. I know that in fact not every province funds the innovative surgery you do with a lap band. Is there a guideline that says you have to be over a certain weight, that your BMI has to be over a certain number in order for it to be fundable, or is it never fundable?

Dr. Emad Guirguis: The lap band has variable funding across Canada. Alberta funds the lap band. Quebec funds the lap band. The challenge, though, is the amount of funding required to fund a procedure like the lap band, because it really is a chronic condition. It requires very intense follow-up and care.

The gastric bypass and another surgical procedure called the gastric sleeve are publicly funded in all provinces.

Hon. Hedy Fry: Thank you.

Dr. Sutherland, I think what you're talking about is really extraordinarily important for us as we look at how we spend appropriately. I know that many of us who have been in the health care field for the longest time have always felt that hospitals are rewarded for spending badly, because the next year they get a bigger budget, as opposed to what you're suggesting, which is activity-based funding.

Is activity-based funding in this project that's going to go on in B.C.—and we're looking at this as a best practice—going to be based on everything, or only on the five areas for bringing down wait times? Is it open to any kind of activity funding?

Dr. Jason Sutherland: If we're going to limit the discussion to the experience in B.C., there are several different initiatives within their patient-focused funding there. One of them is the activity-based funding. Another of them is called the procedural care program, which does bulk contracting with hospitals for incremental surgical volume.

Activity-based funding is across the board, so it weights all hospital activity equally. However, it's for only a small portion of the health authorities' or hospitals' activity. It's about 17% of the health authorities' or hospitals' funding. It applies to only the largest hospitals since they feel that the hospitals can achieve economies of scale without jeopardizing access in smaller communities. It's not across the board, and it probably should not be applied across the board for everyone. They've sensibly, as have many other countries, restricted it to the largest ones.

Hon. Hedy Fry: You talked about the quality-based incentives that are going on in Ontario, for example. Can you give me an example of how that is working? Is everyone building up some sort of outcomes-based analysis that says this is achieving these results in certain areas? Can you talk to me a little bit about whether there is data supporting this and what the quality-based incentives are in Ontario?

Dr. Jason Sutherland: The British Columbia experiment with activity-based funding is essentially intended to provide more care. It is about decreasing length of stays and decreasing wait-lists. There are no outcome measures in terms of patient-reported outcome measures or patient outcomes, although we are looking at read-mission rates and mortality rates to see if we detect changes.

The program in Ontario, the quality-based procedures initiative, is a very new initiative. It is essentially pulling together clinical panels of expert clinicians in every field, identifying for that condition what the best practices should be and how to line up the funding behind them, and then matching the funding cross-continuum to that. They currently are just compiling their clinical panels. Some of them have met, including those on chronic heart failure, congestive heart failure, hip fractures, knee replacements.

So a number of them have already met, and they are developing these guidelines. They intend to match the funding, but it has not actually been implemented to the degree that they've been able to delineate what the best practices are. They are doing so now.

Hon. Hedy Fry: Do I have some time left?

The Chair: You have one more minute.

Hon. Hedy Fry: Thank you.

My concern is that if we don't have some outcome measures, we won't know whether this is working or not or whether it's just based on a grand idea. That's the first thing I would like to see, then, if there's an ability to build in outcome measures.

Second, I would like to ask if there is a look at not only funding activity-based incentives and, as Ontario is doing, quality-based incentives; is there also a way in which even within the hospital you can look at the appropriate person to do the care? Is there any work on that?

For instance, do you need to use a physician to do something that, say, a nurse could do, or a midwife could do, or somebody else could do with the same results but at a more cost-effective value? Is that being looked at?

● (1610)

Dr. Jason Sutherland: I'll try both of those.

To the first point, one of my recommendations, and one that I think is really important, is to start to collect outcome measures and patient-based outcome measures that we can tie these results and these initiatives to.

In fact, I'm actually running the only population-based, patient-reported outcome measures, funded by the Canadian Institutes for Health Research, in the Vancouver Coastal Health authority right now. I think it's a great initiative to understand how the dynamics of preference-sensitive and supply-sensitive care are affected by these funding mechanisms, but I would like to see that expanded. I think there's definitely a role for pushing out standards and identifying what standards are in terms of outcome so that we can compare between and within procedures, and between and within provinces, in the allocation of resources.

There are many people working on the efficiency and the health human resource question you're bringing up. I'm less familiar with that, but I know a lot of efforts are ongoing in the field.

The Chair: Thank you.

You actually have about 30 more seconds, Dr. Fry.

Hon. Hedy Fry: Perhaps you want to elaborate further, Dr. Sutherland.

Dr. Jason Sutherland: Well, I'd like to come back to the patient-reported outcome measures work, which I think is critically important to the future of our health care system.

What we're seeing is that there's only one nation in the world, and that is England, that is currently collecting population-based outcome measures on just a very narrow sliver of supply-sensitive and preference-sensitive care conditions. I think it should be cross-spectrum for the population so that we get a sense of where the resources are needed and which patients are suffering.

We need to start collecting this data when the patients are on the wait-lists, not just pre- and post-operatively but really through the whole trajectory of their care. When they show up at their GP's office with chronic pain and unmanageable conditions, and their quality of life is going down, that's when we should start measuring them.

The Chair: Thank you so much.

Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you.

First, to Dr. Guirguis, just so I'm clear with regard to your Lakeview Surgery Centre, are you the sole owner of that, or do you have other doctors that you are in partnership with?

Dr. Emad Guirguis: I am the primary owner, yes.

Mr. Ben Lobb: Okay. So when you were designing this and building this, you used, as I think you said in your presentation, your own money.

Dr. Emad Guirguis: Yes. It was funded...and it was an ambitious project.

Mr. Ben Lobb: Just on that part of it, then, you would have had a fair bit to do with the actual concept and design of the building.

Dr. Emad Guirguis: Correct.

Mr. Ben Lobb: You mentioned in there all the technical features that are in the design of that building.

How do you go about doing that? Are there companies in Canada or the United States? Or who do you deal with to come in and design it and basically lay out the technology to use?

Dr. Emad Guirguis: That's an excellent question.

I was looking for one person to coordinate the whole project, but unfortunately there isn't one coordinator who exists to lead the whole design of an advanced surgery facility.

I went to guidelines that had been established over the last 20 years by the Canadian association for ambulatory surgery facilities. They have literally pages of guidelines to meet the standards of safety and effectiveness for a surgery facility. I basically followed them and then contracted out engineers who had a background in health care design, and architects. In terms of the building, we worked with the building department in Barrie, Ontario.

It took about nine months to build the facility. We opened in May 2009. It was ambitious. It took a lot of energy and capital costs, and obviously operational costs. We realized afterward that we were undercapitalized, but thankfully it's going well.

Mr. Ben Lobb: You could probably spend a whole hour talking about the technological innovations just in your building.

Dr. Emad Guirguis: Absolutely, and I didn't want the message to get lost in obesity. I think both are important. I was using obesity as a model to say that out-of-hospital facilities can actually function quite safely and have great potential to save taxpayer dollars. I think that's a key message in this. The colleges across the country now are recognizing that and licensing the facilities for safety.

In Ontario, for example, 350 facilities were inspected. Three hundred passed and are licensed, but the vast majority of those are cosmetic surgery facilities. Lakeview is very unique in that we're administrating health care and chronic care through the lap band program.

● (1615)

Mr. Ben Lobb: I wish I had 15 minutes to ask you all the questions I have here, but there is one other question I wanted to ask you. You mentioned that OHIP covers the cost of the procedure, but then obviously you have your staff and all the other ongoing overhead. Does that fee you get from OHIP cover it all then, or how else do you...?

Dr. Emad Guirguis: That's an excellent question. I think that's pivotal to the whole concept of out-of-hospital facilities.

Initially when I started the project I was very altruistic, and I really wanted to do the whole scope of general surgery. Then the sobering reality hit me that from the standpoint of funding, it wouldn't be possible to do the majority of publicly funded procedures while being respectful of the Canada Health Act, which I support.

I believe the future of health care will be performing out-of-hospital surgery-facility procedures in facilities that are owned privately but funded by the government so you can deliver public health care privately, if you will, while still being respectful—

Mr. Ben Lobb: I have just one other question, because my time is running short.

Given that it just started in 2009, it's not as though you have a decade's worth of experience, but do you have data to compare whether your patients have gotten infections? When you compare all that to getting the procedure in a hospital, how do you stack up? I would think you're way ahead of them.

Dr. Emad Guirguis: We looked at our data for hernia procedures, and we found that our results, for an out-of-hospital facility, were better. We looked at it objectively. A medical student studied our results, and we found there was a slight decrease, for example, in infection rates and other outcomes.

Mr. Ben Lobb: I have one last quick question, because I don't know anything about what you're doing.

How did you learn how to install that thing? You probably think it's crazy that I'm asking you that, but you're a doctor, so how did you learn? Did you get certified on how to do this? Could you give us a second on that?

Dr. Emad Guirguis: First of all you need to be a board-certified general surgeon to do this procedure. It's done laparoscopically, so with a minimally invasive surgery.

We have some of the basic skills, but because it is a new procedure, we are mentored by a surgeon who has performed over 1,000 of these procedures. There's a systematic mentorship program. In our case it was Dr. Steve Miller from Drummondville, Quebec. He came to Lakeview. He showed us how to do the first few procedures. Then he assisted, and then he stepped aside and watched us perform the procedure. After approximately 25 cases, he certified us and felt we were safe to perform these alone.

It's much like a pilot who's learning to fly a new airplane. He still has the fundamental skills of flying, but he will have to learn the idiosyncrasies of a specific procedure. It's an excellent question.

Mr. Ben Lobb: Is there any more time? Do I have another 10 minutes left?

The Chair: I'm sorry. I wish you did, Mr. Lobb, because those were very interesting questions.

We can go on to the next five-minute lineup. Maybe you could persuade somebody to let you ask some questions there too.

We'll start with Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

My thanks to our two guests for coming here to shed a little more light on the issue for us.

My question is for Mr. Sutherland.

I listened carefully to your presentation. You said that Canada was the last of 11 developed countries in terms of access to specialized care. You also talked about the pay-for-performance funding policy, whereby payment is used as an incentive to health care providers to achieve a certain benchmark.

In your view, could pay-for-performance funding be effective in promoting innovation in health care systems? Could you also give us an example of how this works in Canada or elsewhere, please?

● (1620)

[*English*]

Dr. Jason Sutherland: I believe that activity-based funding is an innovation in Canada. It does not mean that it's an international innovation, as many countries have transitioned to activity-based funding. The United States was first off the mark in the late 1970s, followed by some states in Australia, which since have been followed essentially by all the Nordic countries, France, and England, Ireland, Germany, and Japan.

While it's definitely not an innovation, there's much we can learn from those systems. I don't think you can take a cookie-cutter approach to these very complex systems and apply them in an entirely different country's context, such as ours, where we have fee-for-service physicians who are very powerful, plus a global budget-based hospital system. Contextualizing that will be very tricky in Canada. That's why I think it's a very innovative approach for both Ontario and British Columbia to proceed in this way.

The Chair: Go ahead, Ms. Sellah, two minutes.

[*Translation*]

Mrs. Djaouida Sellah: My question is for Dr. Guirguis.

There are other treatments, other methods to combat obesity. The balloon is not the only one.

Could you tell me if the material you are presenting here is approved by Health Canada?

Could you then tell me if the balloon stays in the patient's stomach permanently? Finally, what are the side effects and risks associated with the balloon?

Dr. Emad Guirguis: I attended French school in Egypt, but in Barrie, there is not a lot of French. If you don't mind, I will answer in English.

Mrs. Djaouida Sellah: Go ahead.

[*English*]

Dr. Emad Guirguis: The answer to the first question is, yes, it is totally Health Canada and FDA-approved.

The answer to the second question about the balloon is it stays in for six months. There are balloons now being developed that could stay in for up to 12 months. But it comes out. So the chance of regaining the weight is higher than with the lap band because it's not a permanent device.

I should mention too in response to Patrick Brown's question, the balloon was approved by Health Canada first and still hasn't been approved by the FDA, although it's been proven to be quite safe and effective.

The third question was about the complications of the lap band; there are two complications. One is slippage of the band. It can slip out of position. This complication has gone down significantly since the new design of the band that came out in approximately 2009. The way it's designed, it stays in position. We have a technique whereby we sew it in position in the stomach. So number one is slippage, which is very rare.

Number two is erosion. The band can erode through the wall of the stomach. Usually it's not life-threatening bleeding, but it can cause bleeding much as an ulcer would. That's correctable. We go in and unbuckle the band. In the majority of cases, the erosion will heal on its own. We just have to remove the band. Then six months later, once it's healed, we go back in and put in another band. Slippage is also quite correctable. We go back in and reposition it and re-secure it with a new tunnel around the stomach.

The Chair: Thank you, Doctor.

I will now go to Ms. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair.

I want to welcome both of you here, and I've appreciated what you had to share with us.

Dr. Guirguis, last week I had the opportunity to be in India and tour a state-of-the art surgical facility, which sounds as if it had a funding model very similar to what you are operating under in terms of a privately built facility. But definitely fee-for-service is what you would have as a physician to do surgery and what have you.

I'm not sure that I completely understand the arrangement between a facility like yours and the provincial government. Would you be willing to explain that a little more?

● (1625)

Dr. Emad Guirguis: Currently in Ontario there are no specific arrangements with respect to out-of-hospital facilities and provincial government funding, except that we can perform publicly funded procedures and bill for the procedural fee alone. So that's currently the state of out-of-hospital facilities.

But I do acknowledge that there are several countries now performing publicly funded procedures such as hernia, thyroid surgery, and my specialty in an out-of-hospital facility while receiving public funding. I believe that this is a model for the future. The provincial government in Ontario has already expressed in several press releases that it would like to see more and more procedures performed in out-of-hospital facilities. Two examples are cataract surgery and endoscopy. However, with the current model, if we were to take on the large volume of publicly funded cases and only bill the procedural fee, we would go bankrupt. That's the stark reality. I'd love to do it, altruistically speaking, but the funding just isn't there for the majority of publicly funded procedures.

Mrs. Kelly Block: In conversation with one of my colleagues about the lap band procedure, you mentioned that it wasn't hard to get approval from Health Canada for this. But I'm sure that with the innovative way you are operating your facility there must be some red tape you had to deal with. Could you give us any ideas on where red tape could be cut in federal legislation so that it would help individuals like you develop more facilities like this?

Dr. Emad Guirguis: That's an excellent question. As for red tape, the biggest challenges were in the initial building, the nine months it took to make sure the building codes, fire codes, elevator codes were in line with the City of Barrie and building standards. Then it was making sure, specifically for the surgery facility, that we meet the pages and pages of criteria for safety such as sterility, backup generators, and emergency evacuation. Those were the biggest challenges.

The inspection process is fairly intense. There is the CAAASF as well as the College of Physicians and Surgeons. It took months to prepare for the inspections. In Ontario you can't just open an out-of-hospital facility and start operating as we did two or three years ago. It has to go through a very intense process.

On the question of funding, I may be repeating myself a bit but an important message is that we hope the federal government would make recommendations saying that out-of-hospital facilities are safe and effective and should be viewed as a viable alternative for delivering publicly funded, medically necessary health care. We want to be respectful of the Canada Health Act, and we want to provide health care that is necessary for the communities, but we believe our model can administer that health care in a cost-effective way. For example, we could look at tendering contracts for hernias or thyroids or other publicly funded procedures. We believe that those patients don't need to be in a hospital setting. They don't require hospitalization; they don't have complicated illnesses that require critical care admissions. We believe we can perform this quite safely and effectively outside.

The Chair: Thank you very much.

Now we'll go on to Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much, Madam Chair.

My first question is for Dr. Sutherland.

That was a great presentation, but the information that you shared with us troubled me. You have made a sad observation. In fact, Canada ranks dead last in a number of areas, although we spend a great deal of money in Canada. You said that the provinces and the federal government are spending $60 billion on health care, $30 billion on drugs and on physician care, but that it takes about 12 months to see a specialist. That is a rather bleak picture.

You mentioned a number of possible solutions to improve the situation. However, I do not expect changes to take place overnight. You mentioned the possibility of using residential and long-term care centres more to free up hospitals, to serve the people better and perhaps to even get people to be more independent in their own homes.

Some health agreements were signed in 2004 and objectives were set. Some areas were more critical and the feds allocated budget envelopes specifically for those sectors. Do you feel that, in the next agreement, which should be signed in 2014-2015, we should make sure that there is funding set aside for long-term care?

It is annoying, because the provinces are spending the money as they see fit. Would it not be a good idea to establish criteria or performance objectives for more specific investments, such as long-term care?

● (1630)

[*English*]

Dr. Jason Sutherland: That's an excellent question. We could spend an hour talking about it, but I think long-term care is a critically important and growing sector where there are many opportunities to align funding with the objectives you want to achieve.

For example, there are initiatives occurring in Ontario and Alberta to line up the funding for long-term care homes based on the acuity, the clinical complexity, and the physical needs of the patients in the long-term care residential home sectors. I think these are important steps in sort of a case-mixed-based funding or activity-based funding for other sectors.

However, there are also opportunities for integrating quality measures because the standardized data collection is already occurring. So for example, if some of these long-term patients are cycling in and out of the hospital because they're not receiving adequate wound care or physiotherapy while in the long-term sector, those should be important indicators that there are problems of quality there and potentially provide opportunity to align the funding of these institutions or facilities with what you want to achieve, whether it's functional independence or quality of life as high as possible for some of these patients. So, absolutely, yes.

Mr. Dany Morin: I just want to make it clear. In your point of view, you're saying that the next health accord should tie specific issues such as long-term care with federal funding. Are you suggesting that some of the money be delivered to the provinces if certain objectives were achieved?

Dr. Jason Sutherland: I think that there are definitely opportunities. However, as I go back to my first recommendation, I think that the national health information agency needs to make and can make short-term strides on implementing standardized data collection in the provinces that are not doing so, because otherwise, you're just pouring more money after more money and you don't know if you're getting good value for that money.

Notwithstanding that fact, there are many provinces that are collecting the standardized information upon which you can make inferences about cost effectiveness, quality, and efficiency. I think in those provinces it certainly would be very easy to measure domains and measures in these different domains.

Mr. Dany Morin: How much time do I have?

The Chair: You have about 30 seconds.

Mr. Dany Morin: Okay, good.

Are you also saying that the national health agencies should have a bigger role or just disseminate the best practices more?

Dr. Jason Sutherland: Specifically with regard to the Canadian Institute for Health Information, I think that they should be much more proactive in collecting data in the provinces because right now that collection is voluntary in a number of provinces. If those provinces don't have the infrastructure, electronic or physical, the data is not making its way into the system.

The Chair: Thank you so much, Dr. Morin, for your very good questions.

Now we'll go on to Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Madam Chair.

Thank you, witnesses, for coming here this afternoon. I would like to go back to Dr. Guirguis.

I'm still not quite clear how it works in the Ontario set-up because you said you respect the Canada Health Act and procedures are paid by OHIP or the provincial government.

In the case of this procedure for obesity, what percentage of the total cost or total fee would that constitute?

● (1635)

Dr. Emad Guirguis: I'm not sure I understand the question.

Mr. Wladyslaw Lizon: For that procedure, If I'm a patient how much would you charge me for it?

Dr. Emad Guirguis: It's the procedure plus basically lifelong care. The fee is $18,000 for the program.

Mr. Wladyslaw Lizon: How much is covered by the province, by OHIP?

Dr. Emad Guirguis: Zero.

Mr. Wladyslaw Lizon: In this case it's zero.

Dr. Emad Guirguis: In this particular case OHIP will cover other alternatives. It will cover the gastric bypass and another procedure called the sleeve, where you create a sleeve, but it currently doesn't fund the lap band.

Mr. Wladyslaw Lizon: It doesn't cover this. Do you have procedures that you prefer that are covered by OHIP?

Dr. Emad Guirguis: Yes. At the beginning we were doing more and more of them. We did hernia repairs, thyroid—

Mr. Wladyslaw Lizon: Okay. Let's take hernias.

Dr. Emad Guirguis: It's all covered, yes.

Mr. Wladyslaw Lizon: Let's take hernias. You have a patient and you said only the procedure is covered, the other parts of the cost are not covered. Who covers that part?

Dr. Emad Guirguis: We absorb the cost.

Mr. Wladyslaw Lizon: You absorb it. So you don't charge the patient.

Dr. Emad Guirguis: No. That's the dilemma. When you look at the funding model, it's not sustainable to do it with the current structure of funding so that either then I choose to say, okay now, publicly funded procedures we'll still keep in the hospital for the time being, but in the future what we hope to see, and the provincial government has said this, is to do more and more procedures like cataracts and scopes, and I would add other procedures like hernia cases, properly and fully funded in and out of hospital facilities, much like they would fund them in a hospital, except we believe we can do it in a more cost-effective fashion.

Mr. Wladyslaw Lizon: Therefore, I would suspect that the same procedure—in this case we're discussing hernias—if it's done at a hospital would cost more money than it costs at your facilities. Therefore, hospitals can be saving money but actually contracting you to perform the procedure. Is this happening at all?

Dr. Emad Guirguis: The provincial government is just starting the dialogue in Ontario on that with cataract surgery and endoscopy.

But not only do we believe it's cost-effective, we believe we can deliver it more efficiently, that we can shorten the wait times substantially.

As Dr. Sutherland mentioned, when you have specific funded procedures for wait times such as cancer operations, hip replacements, cataracts, what happens is there's a collateral effect on other procedures, such as hernias and gallbladder surgery. Now they essentially, practically speaking, get bumped back, so we're getting phone calls at Lakeview Surgery Centre from patients who are getting agonizing pain, gallbladder attacks. They can't always access the hospital in a timely fashion, and while we would love to bring them in, we have the facility, we're qualified to do them, we're not funded.

But we can shorten our wait times very significantly and save the federal and provincial governments a substantial amount of money.

I believe the health care model in the future is to keep the Canada Health Act intact but deliver outpatient surgery care, such as general surgery, gallbladder, hernia, thyroid surgery, in and out of a hospital facility. You'll shorten wait times and you'll save the government substantial money.

Mr. Wladyslaw Lizon: Okay. Now I have a few technical questions on this procedure, on this lap band. After it is installed and there is that cable with the little device, how does it work? Is it that one you adjust?

Dr. Emad Guirguis: Yes. This is called the port, so this is a hollow—

Mr. Wladyslaw Lizon: Where does the port go?

Dr. Emad Guirguis: The port is attached to the muscle in the left mid quadrant, right here in the abdomen. You don't see it. It's actually underneath, attached to the muscle. We stitch it in the muscle.

Mr. Wladyslaw Lizon: How do you access it?

Dr. Emad Guirguis: Our nurse, who also happens to have had a lap band by the way, does the adjustments. She has a patient lying down on their back with a slight arch on the back, with a pillow behind their back. Then she can palpate and feel the port. There's a special one-way needle she puts into the port and this is hollow and communicates with the circumferential balloon system, and you can fill the port with saline and, as a consequence, snug up the band, much like a belt. We lose weight, our waist goes down, and we snug it up.

The Chair: Thank you very much, Mr. Lizon. That was a very interesting question.

Mr. Wladyslaw Lizon: That's it?

The Chair: I gave you 20 seconds more, Mr. Lizon.

Mr. Wladyslaw Lizon: Thank you, Chair. I appreciate it.

The Chair: You're so welcome.

I want to welcome Mr. Rankin to our committee.

You're up for questions now for five minutes.

● (1640)

Mr. Murray Rankin (Victoria, NDP): Thank you very much, Chair.

Thank you to both of you for your excellent presentations.

I'd like to start with Dr. Sutherland. I'll take you back to your opening remarks where you identified three potential approaches that might lead to some success. You talked about activity-based funding and quality-based precedent in Ontario, and then you started—and I don't think you had time to give us much more—on the American innovations, which you called bundled payments, and on trying to break down the silos. I think you said that they might work in some provinces.

How would they work in Canada? Are there any insights that the practice might give us?

Dr. Jason Sutherland: Essentially a bundled payment is a fixed amount for taking on all aspects of financial and clinical risk for a patient for a given period of time. For example, if you are hospitalized for a knee replacement, you're essentially given a sum, just as the federal wait times did for a knee replacement. You're given a sum for that procedure, but it covers all aspects of care, including the physician care, the hospital-based care, plus all the rehabilitative care post-hospitalization. That may be in-patient rehabilitation or outpatient rehabilitation as well as some home care.

During that time you are financially at risk for re-hospitalization. Because re-hospitalizations are very expensive, we want to provide very effective care to keep people at home and rehabilitated.

Bundled payments are being implemented as a broad policy experiment in the United States to see if they will improve outcomes and reduce the rate of cost growth.

I have actually led some research in Ontario, using their utilization databases, which has proven that bundled payments are technically feasible, so I know they are technically feasible in some locales. There are opportunities to move in that direction for a good number of conditions.

Mr. Murray Rankin: Now I'd like to build on the question of my colleague Dr. Morin. I think you indicated that the Government of Canada requires the provinces to provide certain data. Would that therefore result in conditional funding? Would that be consistent with the Canada health transfer, or is this a whole new way of doing business?

Dr. Jason Sutherland: To my mind it's a new way of doing business, but I think that sort of a spur to provide this sometimes expensive data is critically important to move us to the next level.

For example, if we required patient-reported outcomes data, these could ostensibly be appended to routine hospitalization data already collected, but now they could be collected from the perspective of the patient, who would report on their outcome measures or their experiences during hospitalization.

It might be somewhat or even relatively expensive to set up, although the infrastructure for hospitalization data has been there for many years.

Mr. Murray Rankin: Institutionally, would it be Health Canada that would best play this clearing-house role that you contemplate, or would it be CIHI?

Dr. Jason Sutherland: It would be CIHI. CIHI currently collects all sorts of utilization data. Those include outpatient data; in-patient data; and data on long-term care, residential care, and home care as well.

Mr. Murray Rankin: If I understand it properly, your criticism is that you've been feeling frustrated—if I read between the lines—at having to do the dissemination. You'd rather do the research. Nobody is doing the dissemination at the federal level.

So you're suggesting a new mandate for CIHI in that regard.

Dr. Jason Sutherland: I think they are reluctant to take the information in the different data sets and link it together to demonstrate a cross-continuum picture of care of Canadians. Respectfully, I think there are a lot of policy and privacy implications, but they can be and are addressable within the provinces as well.

However, I think they have the technical expertise. Certainly if we are able to articulate how this can improve the efficiency and effectiveness of funding, then I am.

Mr. Murray Rankin: May I ask one more question?

The Chair: You have one more minute.

Mr. Murray Rankin: Thank you.

You mentioned, intriguingly, that only the U.K. seems to be doing patient-reported outcome-based measurements. I find that strange. Why aren't other jurisdictions jumping to do that? Do they not recognize how that data would add value?

Dr. Jason Sutherland: In the U.K. they've followed a very interesting model in that they've linked physician payments with the collection of patient-reported outcomes data. So physicians are obligated to instruct their patients to collect patient-reported outcomes data pre- and post-surgery, so they are able to understand the brief trajectory of change in a patient's health.

First of all, it's for only five conditions, and they are preference- or supply-sensitive conditions: vein ligation, hernia, hip, knee, and one more as well.

They are definitely going for areas where they feel they can improve the effectiveness of the care delivered and change the value-for-money proposition.

● (1645)

The Chair: Thank you, Dr. Sutherland.

Thank you, Mr. Rankin.

We'll now go to Mr. Wilks.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Mr. Chair, and my thanks to the witnesses for being here.

I want to focus, Dr. Sutherland, on ALC or alternate levels of care for patients, especially as we start to get into this aging demographic of all us baby boomers. This will be upon a lot of people for the next 20 or 30 years.

As I understand it, about 14% of hospital beds in Canada are filled with patients who could not be discharged but who require alternate levels of care. According to that research, there are considerable downstream consequences to having high numbers of ALC patients in acute care settings. This includes staff turnovers due to pressure from high hospital rates, reduction in availability for emergency room admissions, facility transfers, and elective surgeries. In addition, ALC patients face risks associated with prolonged hospital stays that result in more than 70,000 avoidable adverse events each year.

I have four questions. I'll give them to you and you can answer as you can. What are the costs to the health care system associated with ALC patients? What are the structural factors in the health care system that have resulted in longer hospital stays for patients no longer requiring acute care services? What role could health funding policies play in addressing this issue? Are there any best practices in Canada or other jurisdictions that reduce the number of ALC patients in acute care settings? If so, can you provide some examples to the committee?

Dr. Jason Sutherland: Those are four excellent questions. It sounds like a final exam I'd give to my graduate students.

Mr. David Wilks: And you'll be assessed on that.

Dr. Jason Sutherland: Fair enough.

Certainly, the costs of ALC are not well recognized. A lot of the costs are essentially the suffering of patients who are not able to access the beds that are occupied.

Just for clarification, ALC patients are hospital patients who are ready to be discharged but can't be placed in the community. They're clogging up hospitals and resulting in indirect clogging in emergency departments. I'm not aware of the costs, although I am indirectly aware that hospitals use ALC as a cost-minimization technique to keep under the global budget. This means they don't have their foot fully on the pedal of ALC. Those are the cheapest kinds of patients in the hospital. They require minimal nursing care, minimal drugs, and they're going to be replaced by a high-cost patient.

Second, with respect to the structural factors of ALC, the lack of robustness in many communities has to do with community-based providers. For example, behavioural or geriatric patients with behavioural conditions are fairly rare but difficult to place. The post-acute-care community doesn't have the robustness to accept patients with high or different intensities, or receive the funding associated with them, because they receive a global budget. Those expensive patients are viewed as cost drivers rather than revenue drivers.

That leads to the third question of how to align the policy incentives or create policy incentives to reduce ALC. It follows from the first point that if you want a robust post-acute-care sector you have to pay for it and align the funding with the kind of care you want to provide. If it's expensive and difficult to place patients, you make them almost like revenue-type patients for post-acute-care providers. They'll attract more revenue so they can build specialized facilities and hire or train new staff to deal with those patients.

Lastly, we come to the best practices that reduce ALC. I'm not aware of best practices to reduce ALC, because it seems to be a made-in-Canada problem. In fact, it exists across Canada in every single province from coast to coast. The rates vary in some provinces. Internationally, they get around this by adding capacity and driving up the costs in community care. If we were to do the same and add community-based care to reduce ALC, this would induce higher utilization of hospitals, which might be something we want.

There are no best practices. But there's certainly the opportunity to improve the robustness of the community care setting and take those patients out. As you pointed out, reading from my research, this is really good for a lot of these hospitalized ALC patients, it's good for the staff of the hospitals, and it can also improve the patients waiting for hospital-based care.

● (1650)

The Chair: Well, Dr. Sutherland, I think we'll all give you an A-plus, because that was very well done. Thank you.

Dr. Carrie, you're next.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

So many questions, so little time, but I'd like to continue with what my colleague was talking about, these alternate levels of care and the statistics that he brought up. Because people aren't being discharged, there could be as many as 70,000 avoidable adverse events. That statistic is just incredible. Some things were brought up today such as a different pay model. Dr. Guirguis said that the funding model that we have now is unsustainable.

It's a real challenge in our country. How do you introduce competition into health care fields within the Canada Health Act? It seems to be very challenging.

Dr. Sutherland, you talked a little bit about community-based providers. My understanding is that in Britain, for example, when people are discharged with things such as diabetes, they have follow-up right in the person's home. In other word, it avoids that expensive re-hospitalization; it pretty much cuts it right down. But in Canada it seems that we have a bias where we'll pay for the most expensive care.

The provinces will pay for a medical doctor to do a house call. My background is that I'm a chiropractor. A lot of seniors have musculoskeletal stuff. We had paramedics in here who do community para-medicine, which would cost the system a lot less, especially if you're doing these discharges and trying to avoid re-hospitalization.

I was wondering, with the research you're doing, which I understand is funded by CIHR or CIHI, has anybody looked at the potential savings if we asked the provinces not to have these biases towards different professionals? Somebody who's a midwife, for example, can actually go out and more cheaply provide in-home services to a woman who has just had a baby instead of having her keep coming in. As I said, there are all kinds of services—paramedics and occupational therapists—but they can't build a provincial plan because it seems as if there's this built-in bias. Has anybody looked at anything like that to put competition in the system?

Dr. Jason Sutherland: Yes. From my own point of view, I think it's a really thorny issue, because as you add different types of providers to the community care sector, they will provide good quality care for people who need it. As you described, we are biased to providing the most expensive type of care, which is hospitals. Unless we have the will to close those hospital beds, they will fill them with someone else. Those people will then be re-hospitalized, and we're stuck with the same problem of having alternate level care patients in those beds or delivering additional preference- or sensitive-supply care. But those beds will be filled unless they're closed.

Mr. Colin Carrie: Okay, so we've got to tell the provinces—

Dr. Jason Sutherland: It will be just adding more expenditures to more expenditures.

Mr. Colin Carrie: This is it. Is seems there's no model to take a look at an innovative way of providing services in the community. As my colleague so rightly said, with the demographic shift, where we're all getting a little bit older—

Dr. Jason Sutherland: Well, I wouldn't be so pessimistic.

Dr. Colin Carrie: Oh, good.

Dr. Jason Sutherland: I think some of these innovations that we talked about—for example, bundled payments, whereby you can be innovative in the sphere of care providers and provide different types of skilled care in that bundle of care, but at the same time in combination with policies that are reducing the capacity of hospital-based care—can be achieved to a point to be cost neutral; however, there are trade-offs. It is very politically challenging to close hospital beds, but there are opportunities, so I'm not as pessimistic.

Mr. Colin Carrie: Do I have a little bit of time?

The Chair: You do, you have one minute.

Mr. Colin Carrie: Okay.

Just to continue with the demographic shift issue, we're not graduating enough gerontologists, for example, with what we're looking at over the next 20 years. Have you looked at the different pay models? Right now in Canada we have this pay-per-service—most doctors get paid by the service—versus salaries. Have you looked at different models that might be of benefit as we go through this demographic shift? As I said, can we start utilizing professionals who might be able to provide the services within their scope of practice much more cheaply for the provinces?

● (1655)

Dr. Jason Sutherland: I'll condition my statements on not being an expert in health human resources, but I know that there are opportunities to change the mix of trained professionals providing health care. However, at the same time, a lot of the costs being driven by the aging baby boomers, for example, are driven by the increasing intensity of the health care services provided. For example, we have new and innovative diagnostic techniques, new and expensive therapies, and also devices. These are increasing the costs as well as the aging of the population, so I think we have to view it in the frame of several different cost drivers there.

The Chair: Thank you, Dr. Carrie. Thank you very much, Dr. Sutherland.

We'll now go to Dr. Fry.

Hon. Hedy Fry: Thank you, Madam Chair.

I think the whole idea of collecting data and having a clearing-house is key to what you're saying, Dr. Sutherland.

I know that the whole HHR efficiency piece has not been tested at all.

Those are two big issues that were there in the 2004 model from the accord in which people were going to look at this and focus on it. For instance there are community care models—just to follow up on what Dr. Carrie was saying—and I know in places like Calgary they were using the multidisciplinary model of different HHR people to do appropriate care. As pilot projects, these community care groups were being rewarded based on the number of people they were able to keep out of hospital. So in fact they were freeing up beds in hospitals by doing this community...and mixing it with home care nursing. They were able to keep tabs on people and keep them well, keep them from getting so acutely ill they had to go to hospital, and using the appropriate caregiver.

Because they were given an incentive and rewarded at the end for the number of patients they kept out of hospital there was that incentive model.

The clinic I visited in Calgary had shown that they had a 25% drop in hospitalization rates. Do we have that information for any other such models that were started with the 2004 accord? Do you know about those? Have you been following them?

Dr. Jason Sutherland: I believe there is some emerging evidence coming out of Ontario, the Institute for Clinical Evaluative Sciences, regarding their family health teams in Ontario. I'm not familiar with the evaluations and the results but I believe they are currently starting to emerge.

I know that for the Calgary group there aren't formal evaluations on the effectiveness of these interventions or the aggregations of providers. Nor are there evaluations of the new primary care teams that are being developed and implemented in British Columbia.

Hon. Hedy Fry: They've been going now for four or five years? So you're back to data collecting again. We're back to the need for collecting information, data, etc., and disseminating it appropriately.

Dr. Jason Sutherland: Yes, and I think there's definitely a role for—and I would lobby for—a national role that is able to quickly identify new and innovative cost-saving, high-quality, effective care and disseminate that quickly and assist the provinces in scaling that up quickly as well.

A lot of the innovations around the reorganization and delivery of health care don't have that evaluation. So we'll only know that it costs money but we won't have any outcomes associated with it.

Hon. Hedy Fry: Thank you.

The Chair: You have about another minute, Dr. Fry.

Hon. Hedy Fry: Why is it the U.K. model, which is looking at patient-reported outcome measurements.... For instance, vein ligation is not a massive intervention. Do you have any understanding of why they picked those very minor pieces rather than looking at some of the more costly interventions?

Dr. Jason Sutherland: I think it was quite strategic in how they picked their procedures because they elected to choose preference- and supply-sensitive conditions and probably in surgical specialties where they had the least resistance or surgical groups who were trying to advocate for additional funding there. So I think that's on that triad of the different factors as to how they pick them.

Also, for them I think it is assessing whether or not they have the informational capacity to be able to link all the cost data, the hospitalization data, and now the patient-reported outcomes data. That they're now bearing fruit from this and able to discuss effectiveness at a population level is truly outstanding. Although we don't hear any rumblings of expansion of this program I certainly think it's something we should take a hard look at.

● (1700)

The Chair: Thank you so very much, Dr. Fry.

We've come to the end of two complete rounds. It would be my suggestion that we stop at this point unless the committee wants to continue. If you want to continue we could go through another round. But I'm not sure that everyone has a list of questions. What is the will of the committee?

Ms. Libby Davies: I have one more question if it's possible.

The Chair: We'll go through the natural....

Are there any other questions?

Dr. Carrie?

We'll go through the second round.

Ms. Libby Davies: Or maybe one more each.

The Chair: We'll do it properly or we won't do it at all.

So we'll go back to the seven-minute rounds, and we'll start with Ms. Davies.

Ms. Libby Davies: Why don't we just do five minutes, or even one little question?

The Chair: We'll go to five minutes, okay, if you want. We'll just do one and one?

An hon. member: One and one, yes, why don't we do that?

The Chair: Okay.

Ms. Davies, go ahead.

Ms. Libby Davies: Yes, that's what I was suggesting.

The question I wanted to get at, Dr. Sutherland, is this. You've talked a lot about hospitals, and I just wondered if you are applying your research and the work that you're doing at the Centre for Health Services and Policy Research to other areas, such as primary care, for example. It seems to me that's a huge issue as well in terms of fee-for-service and how that whole model works, or rather doesn't work.

Then my added-on question is, who else is doing this research in Canada? It seems to be such a huge issue. Is it mostly through university settings and research centres that it's being done? I know you are funded by CIHR, but is there any other body that's doing it at the federal level? I'm just curious about how much we are into this. Or are you out there in this field breaking new ground?

Dr. Jason Sutherland: I'll try to hit off the questions. I'm not an expert in primary care evaluation of interventions, especially on the service delivery side. I do know there are networks of primary care researchers across Canada. In British Columbia, Alberta, and the Maritimes, primary care research is very large. My focus of expertise is in community care. So that would be anything delivered out of the hospital that is not primary care, and funding models for those, plus also hospital-based care.

As you rightly pointed out, that's where my emphasis has been, with less discussion on primary care.

The other part is, there are very few researchers looking at funding policies and evaluating funding policies for health systems, and studying health system design effectiveness and interventions on them in Canada. I believe that there are only several CIHR-funded researchers in Canada in this area, and I would dearly love that there were more.

The Chair: Thank you.

Dr. Carrie, you had a question.

Mr. Colin Carrie: Yes, thank you very much.

And thanks again, witnesses.

Dr. Sutherland, first, I just wanted you to elaborate on this pay-per-service versus salaries. I have friends who are medical doctors, and for them to have a full roster of geriatric patients...each patient takes half an hour. So it's hard to make a living. Basically, with a pay-per-visit service you can only see maybe 16 patients a day if you're totally booked. Some of these patients even take longer.

So I was wondering whether you see any solutions that we can look at for pay-per-service versus salaries.

The other question I had was for Dr. Guirguis, about the bundled services, and I can see there's again a bias. I'm a patient, I want to go to your clinic. If you're going to provide that service for me, yes, OHIP will pay you as the surgeon to do it, but then in a hospital, the operating room would be paid for, the doctor would be paid, and then the nurses would be paid, the follow-up care in the rooms afterwards for two or three days, whatever it is, would be covered.

You're absorbing some of that right now, but with this whole idea of bundled services, do you think with your innovative model of delivery, if bundled services were more available, that you could save the system money? Are there efficiencies to be had in that type of situation?

It's Dr. Sutherland first, then Dr. Guirguis second, if that's okay.

Dr. Jason Sutherland: I'd be happy to start off with that.

I think there is evidence that fee-for-service works for getting more. Paying on a piecework, patchwork basis provides an incentive to work more, to see more patients. For those doctors who have an above-average case mix or acuity in their patients, certainly it's a disadvantage to them when they're paid on the average.

On the other hand, there is some evidence that salaried physicians certainly back off in terms of the amount that they're willing to work. They're less willing to work on call, they're more willing to go home at 5 p.m., things like that.

First, this is why my recommendations are around defining what we want to achieve first and then aligning the funding incentives behind it. I think that a mix that will probably work in Canada is a model that achieves a salary plus a partial fee-for-service payment that encourages people to work more, if that's what we want.

● (1705)

The Chair: Dr. Fry, do you have a question?

Hon. Hedy Fry: Dr. Carrie asked a very interesting question.

The Chair: Excuse me. I'm sorry. I missed something.

Did you have a question, Dr. Carrie?

Mr. Colin Carrie: I had a second question for Dr. Guirguis, but if I was out of time....

The Chair: Sorry about that. Go ahead.

Sorry about that, Dr. Fry.

Dr. Emad Guirguis: I want to start with some good news, and that is innovations in health care can save money. We often don't think about it that way, but when I was at the University of Ottawa, we were in transition from performing gallbladder surgery from an open procedure with a large incision and hospitalization for seven days and a six-week recovery from work to laparoscopic gallbladder surgery.

We started with an overnight stay with two nursing visits at home, and then we scaled it back to one nursing visit. Then we realized with the innovation we could do minimally invasive surgery as a day surgery procedure. We looked at social and health care costs and found we were saving a substantial amount of money on social costs, recovery, and getting back to work, just looking at Ottawa as a general experience.

With that I believe the next level is to take that innovation further, and now take outpatient surgery, and perform it in out-of-hospital facilities. I believe we can save costs, and as I mentioned before, wait times.

We are inundated with phone calls from across the country to be on this. Obviously with online availability of access to information at least, we're getting phone calls on a regular basis from patients from several provinces asking if we can perform their gallbladder or hernia surgery in a timely fashion because they have to wait nine months, 12 months, and sometimes even longer for procedures such as that or carpal tunnel surgery.

We would love to be able to do that. We have no limits, if you will, as far as how often our operating room is open so in an out-of-hospital facility we could provide more timely access in a cost-efficient fashion and in a bundled fashion, as you mention.

The Chair: Thank you.

Dr. Fry, did you have a question?

Hon. Hedy Fry: Yes, thank you.

I was going to follow up on Dr. Carrie's question with regard to payment schedules and whether you pay on a salary basis or on a fee-for-service basis. I'm really glad to hear Dr. Sutherland suggesting a mix really works because it has been shown that low productivity occurs.

You get a salary, fill the day, you go home at five, you don't want to do house calls, you don't want to do any kinds of other emergency surgeries, and your productivity drops. So you're going to need more people to perform the same work. Salaries are going to be paid to those more people.

At the same time some things lend themselves to salaried work. A lot of cognitive work like dealing with a geriatric patient or dealing with a psychiatric patient lends itself to spending that time. So I was really glad to hear you suggest that, because there used to be the sense a while ago that there was this either/or, one was better than the other, and that was it, or one was worse than the other.

Do you have any studies going on right now here in Canada on looking at those models and how they work? That's my question to you, Jason.

You then opened a can of worms, Chair, because my question is simply this. We all know one of the five principles of medicare and of the Canada Health Act has to do with public administration, not necessarily public delivery. There is evidence to show that private delivery of services can ease the burden on the public sector, providing that this private service deliverer follows the Canada Health Act to a T and contracts out based on that and doesn't do extra billing.

How do you see that working with expanding the kinds of services you are talking about?

I'd like to hear Jason's answer first on the work on this.

Dr. Jason Sutherland: Two researchers in Canada are looking at the use of incentives for physician-based productivity, and I can certainly refer you later and send in those studies.

● (1710)

Dr. Emad Guirguis: First of all, I think one of the issues we haven't discussed is medically necessary services. For example, the Ontario government has looked at the schedule of benefits of what is insured and what is not insured, and they have determined certain procedures were publicly funded that are not medically necessary, if you will, for example, a lipoma benign cyst, a benign mole that has no threat on the patient's medical health.

I think we need to look at that federally and provincially. What is medically necessary? Because certain services are currently on the fee schedule that may not be medically necessary.

Second, should 100% funding be provided for privately owned out-of-hospital facilities? There would be total compliance with the provinces as far as the Canada Health Act is concerned. That said, one of the challenges is how we come up with a balance as far as autonomy while at the same time being respectful of the Canada Health Act, for example, restricting the number of procedures. How would you come up with that number? I think those all have to reviewed in a dialogue.

The Chair: Thank you so very much.

I thank you for coming here today and being our witnesses. It was nice to have the two of you because you had more time for your answers. I want to thank you for your insightful comments.

Committee, I want to thank you as well.

The meeting is adjourned.