Order F08-11

MINISTRY OF HEALTH

Celia Francis, Senior Adjudicator

June 11, 2008

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Summary: The applicant requested a copy of the Ministry of Health's audit report of the Medical On-Call/Availability Program. The Ministry disclosed the report in severed form, withholding portions of the report under ss. 15(1)(l) and 17(1)(d) and (f). At the inquiry, the applicant attempted to raise s. 25 but was not permitted to do so. The Ministry dropped s. 15(1)(l) and did not address s. 17(1)(f). The Ministry was found not to be authorized to withhold the information under s. 17(1)(d) and is ordered to disclose the information it withheld under that section.

Statutes Considered: *Freedom of Information and Protection of Privacy Act*, s. 17(1)(d).

Authorities Considered: B.C.: Decision F07-03, [2007] B.C.I.P.C.D. No. 14; Order 01-10, [2001] B.C.I.P.C.D. No. 11; Decision F08-02, [2008] B.C.I.P.C.D. No. 4; Order 02-38, [2002] B.C.I.P.C.D. No. 38; Order 01-20, [2001] B.C.I.P.C.D. No. 21; Order 00-24, [2000] B.C.I.P.C.D. No. 27; Order 00-10, [2000] B.C.I.P.C.D. No. 11.

1.0 INTRODUCTION

[1] The NDP Official Opposition Caucus ("applicant") requested from the Ministry of Health ("Ministry") access to a number of internal audit reports, including the record in issue here, which is a report on the Ministry's Medical On-Call/Availability Program ("MOCAP report"). In response, the Ministry disclosed a copy of the MOCAP report but withheld portions under ss. 15 and 17 of the *Freedom of Information and Protection of Privacy Act* ("FIPPA").[1]

[1] The Ministry did not initially specify the subsections of ss. 15 and 17 on which it was relying to deny access. This was not helpful to the applicant and the Ministry should be more specific in its future responses.

[2] The applicant requested that this Office review the Ministry's decision. Mediation resulted in the Ministry disclosing some more information and clarifying in a second decision letter that it was applying s. 15(1)(l) and ss. 17(1)(d) and (f) of FIPPA to the withheld information.[2] Mediation was otherwise unsuccessful and the matter proceeded to an inquiry under Part 5 of FIPPA.

[3] This Office gave notice of the inquiry to the Ministry, the applicant and, as an appropriate person, the Ministry of Finance, which conducted the audit and prepared the audit report for the Ministry. The Ministry and the applicant both made submissions. The Ministry of Finance did not make a separate submission but indicated, through legal counsel, that it agreed with the Ministry's arguments.

2.0 ISSUE

[4] The Ministry stated in its initial submission that it was no longer relying on s. 15(1)(l),[3] so I need not consider this exception.

[5] The applicant argued for the first time in its initial submission that s. 25 of FIPPA applies. I explain below my reasons for not accepting the applicant's submission on this section.

[6] In its initial submission, the applicant also referred to ss. 13(1) and 13(2)(g) as being relevant sections. The Ministry did not apply s. 13(1), however, and I do not therefore need to consider these provisions.

[7] As for s. 17, the Ministry's second decision letter said it was relying on ss. 17(1)(d) and (f). The notice for this inquiry stated that ss. 17(1)(d) and (f) were both in issue and the Ministry listed both provisions as being relevant at the beginning of its initial submission.[4] However, the Ministry provided argument and evidence only on "undue gain" with respect to s. 17(1)(d) and nowhere addressed s. 17(1)(f). I have therefore not considered s. 17(1)(f) here.

[8] Accordingly, the only issue before me is whether the Ministry is authorized by s. 17(1)(d) to refuse access to information. Under s. 57(1) of FIPPA, the Ministry has the burden of proof.

3.0 DISCUSSION

[9] **3.1 Preliminary Issue—**The applicant raised the argument in its initial submission that s. 25 of FIPPA applies to the report.[5] The applicant did not

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[2] According to the portfolio officer's fact report that accompanied the notice for this inquiry and para. 4.04, Ministry's initial submission; Bennett affidavit, para. 5 and Exhibit "D".
[3] At para. 3.01.
[4] At para. 4.06.
[5] This section imposes a duty on public bodies to disclose information without delay, whether or not a request has been made, in certain circumstances.

mention s. 25 in its request for review. Section 25 is not listed as an issue in the notice for this inquiry and there is no indication that the applicant raised it as an issue during the eight-month mediation period.

[10] The first mention of s. 25 is in the applicant's initial submission where it argued, among other things, that disclosure without delay is necessary as,

> … the audit relates to immediate and urgent problems of providing medical attention on an emergent basis. Disclosure is clearly in the public interest and is of an urgent nature.[6]

[11] The Ministry did not object in its reply to the applicant's attempt to add s. 25 at this stage. It did however assert, with reference to relevant orders and case law, that s. 25 does not apply in these circumstances.[7]

[12] It is clear from previous decisions that a party cannot introduce a new issue at the inquiry stage unless permitted to do so. In Decision F07-03,[8] Commissioner Loukidelis rejected the public body's attempt to add s. 17 just before the inquiry. He noted that it was not a case where the public body had just learned of new evidence it could not reasonably have known earlier. Similarly, in Order 01-10,[9] the Commissioner did not allow the applicant to introduce s. 25 at the inquiry stage and commented that the applicant failed to explain why he had not raised s. 25 earlier. I did not allow the applicant to add new issues and records in Decision F08-02,[10] noting that one of the purposes of mediation is to crystallize the issues and to allow applicants to raise issues that they wish included in an inquiry.

[13] I have decided not to permit the applicant to introduce s. 25 as an issue at this late stage. The applicant could have raised s. 25 as an issue at any point in the eight-month mediation period but apparently chose not to. It gave no explanation as to why it waited until its initial submission to introduce s. 25. Section 25 overrides all other sections in FIPPA and it is not appropriate to spring it on the Ministry at this late date without warning.

[14] Even if I were to consider the applicant's arguments, however, I would, expressing only my preliminary view, reject them. I accept that the public might be interested in reading the withheld information in the MOCAP report. There may also be a public interest in full disclosure of the report. These are not the tests for s. 25, however. There is nothing in the report to plausibly suggest that, in view of the tests for s. 25, there are any imminent risks to the health or

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[6] Page 4, initial submission.
[7] Paras. 4-12, reply submission.
[8] [2007] B.C.I.P.C.D. No. 14.
[9] [2001] B.C.I.P.C.D. No. 11.
[10] [2008] B.C.I.P.C.D. No. 4.

safety of the public or other similar urgent and compelling reasons for immediate disclosure such that disclosure is required.[11]

[15] **3.2 The MOCAP—**The Ministry provided some background information on the Medical On-Call/Availability Program ("MOCAP"), saying that it

> compensates physicians who are part of a call rotation (or physician group) for providing new or unassigned patients requiring emergency care with continuous coverage that meets the standards of care as a minimum requirement of response to emergency on call.[12]

[16] The purposes of MOCAP, which began in 2001, are to:

- Meet the medical needs of new or unassigned patients requiring emergency care by providing continuous coverage, as determined by the health authority (HA), at acute care hospitals, Diagnostic and Treatment centers, and specified emergency treatment rooms;
- Meet standards of care as a minimum requirement of response to emergency on-call;
- Ensure that physicians providing coverage as part of an established call rotation (or physician group) are compensated for being available to provide this service;
- Ensure on-call coverage under this program translates into a sustainable workload for participating physicians; and
- Address gaps in continuous, sustainable on-call coverage with innovative, workable solutions that are consistent with program requirements.[13]

[17] Under the MOCAP policy framework,[14] a physician belonging to more than one call group can be paid on a daily basis for participating in only one call group at a time, including "Doctor of the Day".[15] In addition, physicians are not eligible for MOCAP compensation where they are already being paid under certain alternative funding arrangements.[16]

[18] The health authorities determine the call groups required. They have contracts with physician call groups to provide specified coverage and are

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[11] See also Order 02-38, [2002] B.C.I.P.C.D. No. 38 and Order 01-20, [2001] B.C.I.P.C.D. No. 21.
[12] Para. 4. 27, initial submission.
[13] Para. 4.28, initial submission; paras. 5-7, Frechette affidavit; paras. 3-4, Sidhu affidavit.
[14] The Ministry provided me with a copy of this document, which states that it was revised July 6, 2004.
[15] The Doctor of the Day program has the objective of providing medical care to "orphaned patients", those who do not have a general practitioner (GP) or family doctor or the GP or family doctor does not have hospital privileges. GPs providing doctor of the day coverage are compensated at an agreed-on rate; para. 10, Frechette affidavit.
[16] Para. 4.29, initial submission; para. 18-19, Frechette affidavit; paras 7-8, Sidhu affidavit.

responsible for providing payment to the call groups. Physicians, as part of a call group, are required to report certain information to the health authorities, including the dates of shifts each member of the call group worked and disbursements of funds to call group members. Payment is to be made only for on-call/availability services provided.[17]

[19] The budget for the MOCAP is $126.4 million for each of the fiscal years 2006 to 2012[18] and approximately 47% of the province's physicians receive compensation under the MOCAP.[19] A MOCAP advisory committee monitors MOCAP implementation. Its responsibilities include developing program accountability and evaluation criteria and making recommendations for program modifications.[20]

[20] **3.3 The Record in Dispute—**The record in dispute consists of the MOCAP report, which is approximately 50 pages long, and a two-page covering memorandum of September 20, 2006 from Dan Ho, Acting Executive Director Internal Audit and Advisory Services, Ministry of Finance, to Gordon Macatee, Deputy Minister, Ministry of Health, and Stephen Brown, Assistant Deputy Minister of Medical Services, Ministry of Health. The report covers the fiscal year ended March 31, 2005 and states that fieldwork on the audit was completed in November 2005.

[21] According to the executive summary of the report, the Ministry of Health contacted the Ministry of Finance for assistance in auditing the MOCAP as part of "a broader and more comprehensive review" the Ministry of Health had initiated of the MOCAP:

> The specific assistance requested by the ministry from IAAS[21] included an assessment of the integrity of internal controls, compliance of contracts and billings with policy, eligibility of services billed, and the adequacy of overall monitoring of expenditures; and to report any potential exceptions, issues and significant internal control weaknesses for the fiscal year ended March 2005; and to make recommendations to address these issues and to further strengthen the professional management and integrity of the program.

[22] Dan Ho's memorandum says the following about the outcome of the audit:

> We found that the ministry and the Health Authorities (HAs) have established controls to assist achievement of the MOCAP objectives. In particular, a policy framework is in place, a contract template intended for use across the province has been developed, and a committee was created

[17] Paras. 21-23, Frechette affidavit.
[18] Exhibit "B", Frechette affidavit.
[19] Paras. 13 & 15, Frechette affidavit.
[20] Para. 9, Frechette affidavit.
[21] Internal Audit and Advisory Services, Ministry of Finance.

> to oversee the program. The HAs are required to provide quarterly and annual financial reports to the ministry. However, we noted some key areas where internal controls can be improved, including performance monitoring, accountability for program monitoring, and …[phrase withheld]. Internal controls also need to be strengthened in the contracting, payment and monitoring/reporting processes.
>
> Our recommendations include exploring the feasibility of a province-wide centralized, electronic invoicing/scheduling system, which includes a database of physician payments, providing information and the capabilities to assist the HAs with MOCAP monitoring and reporting. …[sentence withheld].

[23] The report notes that the Ministry of Health and the health authorities had already addressed some of the recommendations by the date of the report and would address others in future. Although the applicant refers to the report as being "heavily censored",[22] I note that, in fact, the Ministry disclosed much of the report, while withholding some portions dealing with areas the auditors had identified as needing improvement. These withheld portions are the subject of this inquiry.

[24] **3.4 Financial Harm**—Section 17(1)(d) of FIPPA reads as follows:

> **Disclosure harmful to the financial or economic interests of a public body**
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> 17(1) The head of a public body may refuse to disclose to an applicant information the disclosure of which could reasonably be expected to harm the financial or economic interests of a public body or the government of British Columbia or the ability of that government to manage the economy, including the following information: …
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> (d) information the disclosure of which could reasonably be expected to result in the premature disclosure of a proposal or project or in undue financial loss or gain to a third party; …

[25] Section 17 has been the subject of many orders. The standard of proof that a public body must meet to establish that s. 17 applies is set out, for example, in Order 00-24:[23]

> … As I noted in Order No. 00-10, the standard of proof for harms-based exceptions is to be found in the wording of the Act. The standard in s. 17(1) is that of a reasonable expectation of harm. The harm feared under s. 17(1) must not be fanciful, imaginary or contrived. Evidence of speculative harm will not satisfy the test, but it is not necessary to establish a certainty of harm. The quality and the cogency of the evidence presented

[22] Page 6, initial submission.
[23] [2000] B.C.I.P.C.D. No. 27, at page 4.

> must be commensurate with a reasonable person's expectation that the disclosure of the requested information could cause the harm specified in the exception.

[26] Commissioner Loukidelis considered the meaning of "undue financial loss or gain" in the context of s. 21(1)(c)(iii)[24] in Order 00-10,[25] where Pacific Western Brewing Company had requested certain information about Molson Breweries and Labatt Breweries. He considered the "ordinary meanings" of "undue", such as "unwarranted, inappropriate, improper" and "excessive or disproportionate". He also noted that, whether or not the expected gain or loss is significant, it may also be "undue". He concluded the following:

- any financial loss to Labatt and Molson would be "undue" because it would be both "unfair and inappropriate" and significant ("in the millions of dollars");
- although the evidence did not allow him to determine how much Pacific Western would save by not having to pay for the information, any corresponding gain to Pacific Western would be "undue", because it would gain valuable competitive information for free, "a competitive windfall" or "something for nothing"; and
- Pacific Western would gain "some competitive advantage" over Labatt and Molson because it could make inroads into their market share.

Undue financial gain

[27] The Ministry provided the bulk of its submission on the s. 17 harms on an *in camera* basis.[26] I am therefore constrained in what I can say about it. I can, however, say that, while the *in camera* portions primarily re-state concerns the auditors expressed in the MOCAP report, they also suggest ways in which disclosure of the disputed information could, in the Ministry's view, result in "undue financial gain" and thus financial harm to the Ministry and government.

[28] The Ministry began by arguing that, when physicians submit bills inappropriately, without having provided any service, any financial gain to them would be "undue", as they would have gained "something for nothing", "a windfall through dishonesty".[27] The Ministry then explained that the Billing Integrity Program ("BIP"), a program of the Ministry's Audit and Investigations Branch, is responsible for detecting, deterring and recovering inappropriate Medical Services Plan ("MSP") billings. In certain cases, the BIP may conduct an audit of a health practitioner's medical records and billing practices, usually covering

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[24] Section 21(1)(c)(iii) prohibits disclosure of certain types of third-party information which were supplied in confidence, "(c) the disclosure of which could reasonably be expected to … (iii) result in undue financial loss or gain to any person or organization".
[25] [2000] B.C.I.P.C.D. No. 11.
[26] Paras. 4.30-4.37, initial submission; para. 25, Frechette affidavit; paras. 11-15, Sidhu affidavit.
[27] Para. 4.15, initial submission.

a five year period.[28] In these audits, the BIP usually focuses on "over servicing", where "a practitioner renders more services than medically required", and "misbilling", where "the fee item submitted for payment is not consistent with the service actually rendered". The Ministry said that, in "rare cases",[29] the BIP finds evidence that a "practitioner submitted claims knowing that the benefit had not been rendered or that the nature or extent of the benefit that had been rendered had been misrepresented".[30] The Ministry said that, following audits of physicians for "potentially inappropriate billing practices", it recovered $3,228,757 from 2002 to 2007 as a result of "mediated settlements and hearings".[31] Thus, the Ministry said, there is a "very real potential for physician over billing in the health care system".[32] The concern that there is a potential for physicians to make inappropriate billings underpins the Ministry's s. 17 arguments.

[29] The Ministry noted that the Commissioner has said that disclosure under FIPPA is public disclosure, except for access by individuals to their own personal information. As such, the Ministry continued,

> …any disclosure of the information at issue in this inquiry must be treated as disclosure to the world at large, including to any physicians who may choose to exploit the information at issue for inappropriate financial gain.[33]

[30] The applicant said that the MOCAP is "not without controversy" and that there is "some question about whether this is the best system to compensate on-call doctors". It said that, after receiving the "heavily censored" audit, the Opposition raised questions in the Legislature about "inappropriate billings, mismanagement of the program, a deliberate whitewash of the content of the report and the secrecy around the audit".[34] Access to the full report would, in the applicant's view, enable members of the public who use emergency services to determine how effective the MOCAP has been.[35] It suggested that the audit uncovered "significant problems" with the MOCAP[36] and that the withheld portions indicate "even more damaging" findings.[37] While the Ministry may be withholding the information in question out of embarrassment, the applicant said,

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[28] The Ministry said that the Medical Services Commission has the authority under s. 36 of the *Medicare Protection Act* to audit practitioners' payment claims and their patterns of practice and billing. It has delegated this audit function to the Audit and Inspection Committee which may order the BIP to do an audit; para. 5, Anderson affidavit.
[29] The Ministry did not say what proportion of the total these "rare cases" represent.
[30] Para. 4.21, initial submission.
[31] The Ministry said that the figures on cases and total amounts received only dealt with audits where there were recoveries and do not reflect "no finding audits" or billing issues that the BIP may have resolved through other means such as "direct practitioner education"; para. 17, Anderson affidavit.
[32] Paras. 4.18-4.25, initial submission; paras. 8-17, Anderson affidavit.
[33] Para. 4.13, initial submission.
[34] Page 6, initial submission.
[35] Page 5, initial submission.
[36] Page 4, initial submission.
[37] Page 6, initial submission.

there is no basis in FIPPA for such an action.[38] It urged me to consider, not only the financial and economic interests of the public body or government, but also those of the physicians and patients affected by the MOCAP. It suspects that the Ministry's decision to withhold the information in the audit report has more to do with concealing "mismanagement and disorganization" and less to do with financial or economic harm to the Ministry or government.[39] "Politically motivated severing is unacceptable", it said.[40]

[31] The applicant was sceptical of the Ministry's "speculative" arguments and evidence,[41] saying that the Ministry essentially asks me to assume that:

- "all physicians are thieves";[42]
- "all/most/many physicians are dishonest, and would take advantage of any opportunity to cheat the system";
- physicians are "predominantly untrustworthy and, as a whole, will seek to steal from the Ministry by inappropriate reporting and billing";[43]
- the Ministry's "audit practices"[44] have not changed since the report was written in November 2005 and, "despite apparent and identified problems", will not change;
- "physicians who are intent on cheating the system would not have other ways of finding out how to do so"; and
- physicians have not already found these things out by other means.[45]

[32] The more appropriate assumption, the applicant argued, is that physicians are ethical and will not steal from the government. It drew my attention to the Canadian Medical Association Code of Ethics which requires all physicians to be aware of their legal requirements and "to use health care resources prudently".[46] In any case, the applicant argued, stating that there is "very real potential for physicians over-billing" does not "provide proof of a correlation of fraud with the release of this information". The Ministry must, the applicant said, "show cogent, case-specific evidence" that disclosure "will directly result in a substantially larger number of fraudulent claims than those already experienced"[47] and that

[38] Page 6, initial submission. The Ministry disputed this, saying the applicant had provided no evidence to support its allegation regarding embarrassment; para. 13, reply submission.
[39] Page 7, initial submission.
[40] Page 8, initial submission.
[41] Page 6, reply submission.
[42] Page 6, reply submission.
[43] Page 4, reply submission.
[44] I take the applicant to refer to the Ministry's and Health Authorities' internal controls for the MOCAP.
[45] Page 4, reply submission.
[46] Appendix 1, reply submission, item 44.
[47] Page 3, reply submission.

the Ministry "would have no way to stop them".[48] In the applicant's view, the Ministry has not done so.[49]

[33] I do not read the Ministry's submissions as suggesting that "all physicians are thieves", "dishonest" or "untrustworthy". Indeed the Ministry neither says nor implies any of these things. However, it is implicit in the Ministry's submissions, in particular the reference to the results of the audits of MSP billings, that the Ministry believes that, armed with the complete MOCAP report, unscrupulous physicians are likely to take improper financial advantage of the MOCAP, on a smaller or greater scale, to the financial detriment of the Ministry or government, where they would not have done so before, and that, moreover, the Ministry and the health authorities would be powerless to prevent this from occurring. This also suggests that doctors would do so, knowing it might not be in their patients' best interests. The solution, it seems to me, is not to withhold the information but rather to strengthen internal controls for the MOCAP so as to minimize the potential for inappropriate billings and to encourage and monitor physicians' compliance with MOCAP reporting requirements.

[34] The Ministry provided evidence to suggest that physicians have, in "rare cases", knowingly submitted inappropriate MSP billings, although it did not say what percentage of MSP claims this represented nor what dollar amounts were involved. But this evidence of past fraud is not enough. Evidence of apparent wrongdoing in unspecified "rare cases" in the past does not, in my view, support the Ministry's contention here that disclosure of the information in issue might be used by some physicians to defraud the MOCAP and thus make an "undue" gain. The Ministry's arguments are speculative and do not suffice to establish a reasonable expectation of harm under s. 17.

[35] For the reasons given above, I find that s. 17(1)(d) does not apply to the withheld information.

4.0 CONCLUSION

[36] For the reasons given above, under s. 58 of FIPPA, I make the following orders:

1. I require the Ministry to give the applicant access to the information in the MOCAP report that it withheld under s. 17(1)(d).

2. I require the Ministry to give the applicant access to this information within 30 days of the date of this order, as FIPPA defines "day", that is, on or

[48] Page 4, reply submission.
[49] Page 4, reply submission.

before July 24, 2008 and, concurrently, to copy me on its cover letter to the applicant, together with a copy of the records.

June 11, 2008

ORIGINAL SIGNED BY

Celia Francis
Senior Adjudicator

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