PROCESS REVIEW AND EVALUATION OF THE EVIDENCE-BASED HEALTH TECHNOLOGY ANALYSIS PROGRAM IN ONTARIO

Naomi Aronson
Blue Cross Blue Shield Association
USA

Michael Drummond
University of York
UK

Stuart MacLeod
BC Provincial Health Services Authority and University of British Columbia
Canada

Review dates: March 24-26, 2008
Submission date: April 30, 2008
1. **BACKGROUND TO THE REVIEW**

This review follows an earlier review of Ontario’s evidence-based health technology analysis program in February 2005. The central features of the program are the analyses undertaken by the Medical Advisory Secretariat (MAS), located within the Ministry of Health and Long-Term Care (MOHLTC) and the recommendations made by the Ontario Health Technology Advisory Committee (OHTAC).

Since the 2005 review, a number of changes have occurred in the Ontario health care system as a whole, as well as within OHTAC. On April 1, 2007, Ontario began full implementation of a new health care delivery administrative structure, where local health services are now governed by 14 Ontario Local Health Integration Networks (LHINs). Among other responsibilities, Local Health Integration Networks are responsible for overseeing health allocations within their area of jurisdiction, and working with all local health care service providers within their geographic area through health care provider accountability agreements. The objectives of the local health integration network are to plan, fund and integrate the local health system. Boards of the LHINs are appointed by the provincial government. The boards, in turn, hire employees to examine local planning needs and provide local service standards. Physician fees and payments remain a provincial responsibility, as do several other priority services including hospital care. The province is charged with a stewardship responsibility for the overall provision of health care in Ontario.

In January 2006, OHTAC revised its terms of reference to ensure that recommendations would be made to the Ontario health care system on its website, as well as to the Ministry of Health and Long-term Care. OHTAC also added a seat in its membership for a LHIN representative. LHINs have been invited to participate at OHTAC, to submit applications to OHTAC and have been added to distribution lists for all communications materials, etc. The OHTAC membership also now includes members from community health services, including home care and the Community Care Access Centres.
OHTAC has been able to provide grants of five years duration to the Program for Assessment of Technologies in Health at McMaster University and to the Toronto Health Economics and Technology Assessment Collaborative at University of Toronto, to provide stability to the Ontario field evaluation initiatives. In addition, a grant has been provided to the Human Factors Usability Laboratory at the University Health Network, which is conducting human factors analysis of technologies where safety concerns have been raised by OHTAC.

Since the 2005 review, three sub-committees of OHTAC have been struck, and have reported with recommendations to OHTAC in the areas of Public Engagement, Decision Determinants, and Knowledge Transfer. As a result of recommendations of these sub-committees, OHTAC has generated new opportunities for public engagement, is testing a framework for decision making based on the GRADE methodology, and is finalizing and branding a new communication strategy for implementation in 2008.

The Ministry of Health and Long-term Care and OHTAC has become increasingly interested in seeing reviews which have broader system impacts than those of single technologies. Ontario is calling these reviews of comparative and grouped technologies mega-analyses. For example, MAS is currently conducting a mega-analysis of the technologies being proposed to manage wounds, to review the evidence on the effectiveness of interventions for the prevention and treatment of pressure ulcer care, to recommend those interventions that will optimize patient outcomes, and to develop an evidence based disease transition model for pressure ulcer care in Ontario that can be used by policy decision makers to maximize investments that are most likely to improve patient outcomes. This type of analysis is clearly consonant with the Ministry’s new stewardship role.

2. OBJECTIVES OF THE REVIEW AND EVALUATION

The objective of the review and evaluation was to identify areas that may require different/new processes and methodologies. All aspects of the health technology and policy analysis program were examined, from the methodologies of the
evidence-based reviews and mega-analyses, through to the implementation of recommendations by government policy makers. This included an evaluation of the interface between MAS, OHTAC, health care providers, and the Ontario Ministry of Health and Long-term Care.

Some key issues for examination were:

- the methodologies and quality of the systematic reviews;
- OHTAC’s engagement with stakeholders (eg the public, Ontario Medical Association (OMA), Ontario Hospital Association (OHA), individual hospitals, manufacturers);
- the interactions of MAS/OHTAC and its MAS-funded parallel OHTAC programs (THETA, PATH, Human Factors Usability Laboratory);
- the examination of the OHTAC decision-making process;
- the use of Expert Panel Advisory Committees;
- the assessment and uptake of OHTAC recommendations (a) by the health system and (b) the influence OHTAC has on the uptake of technologies that are based on its recommendations;
- whether current resources are adequate for OHTAC to fulfil its mandate;
- whether OHTAC should be legislated;
- recommendations for future directions by MAS/OHTAC.

3. **CONDUCT OF THE REVIEW AND EVALUATION**

The review and evaluation consisted of two main activities:

(i) a review of documentation provided by MAS;
(ii) interviews with key informants, who included MAS staff, OHTAC members, government policy makers and other external users of the Ontario evidence-based health technology analysis program. The interviews were conducted during the period March 24-26, 2008, mostly in person. A list of individuals interviewed is given in Appendix 1. In addition, a general meeting was held with MAS clinical epidemiologists and policy analysts.
4. FINDINGS

4.1 General Findings

Ontario’s evidence-based health technology program has matured considerably since the earlier review in 2005. The OHTAC members interviewed continue to have a strong belief in the role of the Committee and its ability to influence the use of health technologies in Ontario. In addition, despite the substantial workload, they remain very committed to the task.

The program continues to enjoy broad support from all its stakeholders. Notwithstanding the detailed comments below, none of the informants had anything very negative to say about the program. As in 2005, there was widespread praise for the activities of the Medical Advisory Secretariat and its leadership.

Many of the suggestions made in the 2005 report have been acted upon. For example, OHTAC has broadened its membership to reflect the changing nature of Ontario’s healthcare system. Topics have been referred to the Committee from a broader range of sources, including the MOHLTC, which has asked MAS and OHTAC for help in achieving some of its strategic objectives (eg in improving services for the elderly).

OHTAC and MAS have also broadened their horizons, by continuing to explore opportunities to support evaluations for Ontario’s Public Drug Programs in addition to undertaking a number of cancer specific evaluations with Cancer Care Ontario.

Sub-committees have been formed to improve OHTAC’s performance in several of the other areas identified in the 2005 report, such as the involvement of the general public in its decision-making processes and the communication of its recommendations to its stakeholders and more generally.

The field evaluations, which had just begun in 2005, have begun to bear fruit and have been widely praised both within Ontario and beyond. They are also consistent
with a worldwide movement towards ‘coverage with evidence development’ (Tunis and Pearson, 2006)

Finally, there was some improvement in the feedback from the MOHLTC to OHTAC on the actions taken following its recommendations. However, some of the broader challenges in implementation of OHTAC’s recommendations remain.

More specific findings are given below. These are organized in the following way: (i) Governance and structure of the program (ii) Evaluation methods (iii) Processes and operating procedures (iv) Communication and implementation of findings/recommendations.

4.2. Specific Findings

4.2.1. Governance and Structure of the program

The current program is closely aligned with the MOHLTC, with MAS being based within the Ministry and OHTAC being one of the Ministry’s expert advisory committees. Some informants raised the question whether there would be advantages to re-establishing the program as an independent agency at ‘arms length’ from the Ministry.

This issue arose part-way through the evaluation, so was not discussed with every informant. However, we were not persuaded that the benefits of such a structural change would outweigh the costs. Given the current composition of Ontario’s healthcare system, OHTAC is likely to have more influence if it stays closely aligned with the MOHLTC, assisting the Ministry in the achievement of its strategic objectives. Any perceptions of lack of independence can be dispelled through OHTAC’s engagement with a broad range of stakeholders, a process which the Evaluation Team believe could be improved (see below).

Although there was general satisfaction with the structure of OHTAC, two issues were raised about membership. The first was an observation that the representation from the hospital sector had shifted from Chief Executive Officers (in the early days
of OHTAC) to Chief Operating Officers (at the present time). Our view was that, far from reducing the hospital sector’s commitment to, or involvement in, OHTAC, this shift strengthened it. Indeed, one of the observations made in 2005 was that although CEO-level involvement and commitment was important to the Committee, hospital-based members should ideally be individuals who have knowledge of the day-to-day issues with the use of technology, such as Chief Operating Officers.

The second issue concerned industry membership on OHTAC. The industry informants commented that, while their informal links with MAS and OHTAC were good, there would be benefits from formalizing this process. Particular areas of involvement mentioned were in the selection of topics and the ability to comment on evaluations or recommendations. Industry representation on the Committee was suggested as one way of achieving this.

The Evaluation Team noted that this model existed to good effect elsewhere, such as in the Committee structure of the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom. However, the majority of informants interviewed felt that, in the Ontario context, the negative perceptions arising from industry membership might outweigh the positive aspects.

Some of industry’s needs will be met by the suggestions for increased stakeholder involvement outlined below. In addition, MAS/OHTAC might consider establishing an Industry Liaison Group, where issues pertinent to the industry could be discussed. Such a group could more effectively represent the diverse needs of industry than would a single industry appointment to OHTAC.

4.2.2. Evaluation methods

There was widespread praise for the quality of the evaluations performed by MAS, which focussed mainly on systematic reviews of the clinical evidence. Some informants were less sure about some of the economic analyses undertaken as part of the program, perhaps reflecting the complex nature of some of the economic models and the need for assumptions. However, as far as we could tell, the quality
of the clinical and economic analyses performed within the program was comparable to those in the better HTA programs worldwide.

The field evaluations undertaken as part of the program also attracted widespread praise. This praise concerned not only the methods of the evaluations, but also the active engagement of clinical specialists across the Province (for example, as in the field evaluation of drug-eluting stents).

In respect of the systematic reviews, we noted two issues that merit more exploration. First, many of the topics being investigated were also being investigated elsewhere (ie by HTA programs in other jurisdictions). We wondered whether more extensive collaboration with other groups performing reviews would reduce duplication of effort.

Secondly, the involvement of clinical content experts in reviews, while it existed, appeared to be rather uneven. We recommend that this process be reviewed, in order to ensure that content area knowledge was adequately incorporated into systematic reviews.

A major recent development was the introduction of mega-analyses. That is, rather than considering individual technologies in isolation, in a mega-analysis they would be considered as part of the process of care, perhaps in the context of managing a particular disease or condition.

We are in broad agreement with this development, since it makes sense to assess one or more technologies in a broader context. For example, the approach should work well in diseases where there are good epidemiological data and/or economic models (eg diabetes), or in processes of care where there are several competing technologies (eg wound care). However, one of the topics chosen, ageing in the community, is extremely broad.

The majority of informants were also supportive of mega-analyses. In particular, those academic groups with experience of economic modelling were enthusiastic. However, those MAS staff undertaking systematic reviews were unsure of the
implications of these broader analysis, because both the literature searches and data extraction associated with systematic reviews require closely defined topics. Therefore, attention needs to be paid to these methodological challenges. Similar issues have arisen in the development of evidence-based clinical guidelines by NICE in the UK. The problems were handled by more precise scoping of the analyses and the development of specific clinical questions, upon which the systematic reviews could be focussed. Therefore, the experience of MAS and OHTAC with the first group of mega-analyses should be reviewed and the need for any changes in the approach assessed.

The Evaluation Team noted that those undertaking the systematic reviews were extremely busy and that there had been a high turnover of staff. Therefore, if mega-analyses are added to the existing role of MAS in assessing individual technologies, staffing levels and issues of recruitment and retention will need to be re-assessed.

4.2.3. Processes and operating procedures

With respect to the selection of topics, it was noted that the program was now responding to requests from a wider range of stakeholders, including the MOHLTC. The Evaluation Team was supportive of this development and felt that MAS and OHTAC should consider more topics aligned with the strategic objectives of the MOHLTC, such as those that are the subject of the current mega-analyses.

In addition, the Team felt that MAS should conduct its own horizon scanning to identify topics and to ascertain which of these were being tackled by other HTA agencies.

At the same time the original concept of MAS and OHTAC constituting a single portal for the introduction of expensive new technologies to Ontario hospitals should not be abandoned. Rather, this may become a smaller proportion of activity in the future, as other areas of MAS/OHTAC work expand.

Some informants felt that MAS and OHTAC, in common with most HTA agencies worldwide, did not pay sufficient attention to the disinvestment agenda; that is, the
need to identify technologies that should be abandoned because they are of limited value. The fact that this topic has not been satisfactorily addressed anywhere suggests that it may pose difficulties. Nevertheless, it deserves priority consideration since one of the common reasons given for not implementing OHTAC’s positive recommendations is lack of funding. Removing some technologies from the healthcare system could free resources to enable other technologies to be introduced

With respect to involvement of stakeholders, the main question was how MAS and OHTAC could build on the excellent relationships already developed. Some HTA programs, such as that operated by NICE in the UK, involve stakeholders at several stages in the process, including the scoping of topics, commenting on draft reports and, if necessary, appealing decisions. Some informants noted that, whilst being desirable, stakeholder involvement could add to the time OHTAC takes to conduct an evaluation and to make recommendations.

Bearing this in mind, stakeholder feedback could be obtained at the scoping stage as long as this was time-limited. In addition, time for stakeholder feedback on OHTAC’s recommendations could be obtained by using the period that currently exists between the making of the recommendation and posting of the review on the Ministry website. Instead of just using this period to obtain the Ministry’s reaction, it could be used to obtain feedback from all stakeholders on the review and the recommendations.

Some stakeholders expressed a concern that, when the OHTAC decision was to request a field evaluation, there was no opportunity to comment on the proposed methodology of the study. The Evaluation Team understood that, since external academic units conducted the field evaluations, OHTAC may be reluctant to impose restrictions. However, we felt that this was a legitimate concern and that the units undertaking field evaluations should make their research protocols available for stakeholder comment.

Finally, with respect to the involvement of the general public, the Evaluation Team felt that the deliberations of the Public Engagement Sub-Committee had covered the key issues in a comprehensive fashion. At the time of the review the Sub-
Committee was close to making its final recommendations to OHTAC. The Evaluation Team was comfortable with the range of options being considered and would encourage OHTAC to act on one or more of them.

4.2.4. Communication and implementation of findings/recommendations

The Evaluation Team was informed that OHTAC was giving detailed consideration to communication activities, linked to the deliberations of the Knowledge Transfer Sub-Committee. Up until the present day, the main vehicle for communication has been the OHTAC component of the MOHLTC website. At least one informant commented to the effect that, given the amount of material on the Ministry website, it was not easy to access the OHTAC material.

As with the work of the other sub-committees, this committee has generated a range of proposals but the final way forward has not been determined. We would encourage OHTAC to implement one or more of the measures being proposed.

One initiative we did welcome was the proposal to publish the MAS evaluations as a series, rather like the technology assessment reports commissioned by NICE. (These are published in a Medline-listed journal called Health Technology Assessment, which currently has an impact factor higher than many health services research journals.) We believe that publication of MAS evaluations will increase the knowledge and recognition of the program both within Canada and beyond.

In the case of NICE reports, the publications identify the names of the individuals that contributed to them, and can therefore be used by those individuals in career development. However, among MAS staff we did not find a strong desire for a parallel opportunity. This came as a surprise to us.

On area of particular importance is that of internal communication within MOHLTC. Our impression, from talking to some informants, was that the political benefits of an evidence-based policy for health technologies were not widely recognized. Also, knowledge of the work of MAS and OHTAC had been better assimilated in some Ministry divisions than others. However, we did hear that there
was a mechanism in place to take OHTAC recommendations and to explore the implications for the activities of different Ministry divisions.

This brings us to the difficult area of implementation of OHTAC recommendations. As in the 2005 review, this was the most frequently mentioned area of concern by informants. The 2005 review made 4 recommendations relating to implementation. One of these, that the MOHLTC should improve the feedback given to OHTAC on the actions taken following its recommendations, has been acted upon. Another, that more consideration should be given, jointly by OHTAC and MOHLTC, to the pathways through which different recommendations should be implemented, has been partly implemented.

We did not hear that budgetary provision had been made to allow some OHTAC recommendations to be implemented within year, or that business plans for the adoption of new technologies, based on previous OHTAC recommendations, had formed part of the broader discussions with hospitals and other healthcare facilities about operating budgets. Nevertheless we do acknowledge that this could become a legitimate activity for the LHINs.

Whilst recognizing problems over implementation, none of our informants claimed that this was easy. Funding may not be available in the short term, or some recommendations may not fit with the Ministry’s strategic objectives. Others may require a complex mix of changes in the funding and organization of healthcare. Nevertheless, there was a general feeling that the implementation issue needed to be tackled if an evidence-based program in HTA was to be sustainable in the long-term.

One approach would be to build on the existing process operated by the Health System Information Management and Investment Division of MOHLTC. Namely, a policy implementation brief could be developed for OHTAC recommendations. The brief could consider issues such as: (i) who needs to do what (ii) is funding required and (iii) what would be a reasonable timescale for implementation? (Indeed, some of these issues could be anticipated much earlier in the process, when the topic is first scoped by MAS/OHTAC.) It may not be possible to undertake this for every single OHTAC recommendation, and we do support the
suggestion that there should be a division of recommendations into those that need MOHLTC actions and those that do not.

Another approach would be to analyse how other jurisdictions deal with the issue of implementation. Of particular interest would be those jurisdictions where the recommendations of the evidence-based HTA process are mandated. This approach is widespread for recommendations relating to pharmaceuticals (including those in Ontario), but less prevalent for recommendations about procedures and devices. One example is NICE in the UK, where the recommendations from all technology assessments must be implemented by the National Health Service in England and Wales within 3 months. Also, in the US, there is a strict deadline for implementing Medicare coverage decisions. The Federal Register notice states ‘Generally, we expect a payment change effective within 180 calendar days of the next full calendar quarter that follows the date we issue the decision memorandum. This time is necessary to identify and make any necessary coding, payment and system changes’.

Relevant questions in such a review of experience in other jurisdictions would include (i) are recommendations fully implemented even when they are mandated (ii) what factors encourage or hinder implementation (iii) what measures are taken to facilitate implementation and (iv) what are the difficulties caused by mandating implementation?

Finally, it might be helpful to convene a workshop on the theme of implementation, involving members of OHTAC, Ministry divisions, academics and representatives of the broader healthcare system. It would also be informative to develop several case studies of implementation/non-implementation, based on previous OHTAC recommendations.

5. CONCLUSIONS AND RECOMMENDATIONS

Ontario’s health technology assessment program has developed considerably since the previous review in 2005. It also continues to enjoy widespread support from all
its stakeholders. At the same time there is a widespread feeling that the program is at a key stage in its development. Based on this review and evaluation, the following recommendations are submitted for consideration:

1. Given the current organizational structure of the Ontario healthcare system, the governance and structure of the evidence-based health technology analysis program is fit for purpose and does not require revision. Nonetheless, closer alignment with LHINs should be sought as their roles continue to evolve.

2. The activities of MAS/OHTAC should continue to be more aligned with the strategic objectives of the MOHLTC, as this maximizes the potential for policy impact. However, the program should retain the role of being the main portal for the introduction of potentially disruptive technologies into the Ontario healthcare system.

3. A more formal mechanism for involving industry should be considered, such as an Industry Liaison Group.

4. In conducting systematic reviews, MAS should seek collaborations with other similar HTA entities, so as to promote mutual learning.

5. MAS should ensure that relevant clinical content experts are always consulted by the team undertaking systematic reviews.

6. The first group of mega-analyses should be assessed in order to learn lessons for the scoping and conduct of future studies.

7. Given the expanding role of the Medical Advisory Secretariat, issues of recruitment and retention will need to be reviewed and staffing levels will need to be increased.

8. Since the availability of funds is one of the challenges in implementing OHTAC recommendations, more attention should be paid to the disinvestment agenda.
9. MAS/OHTAC should continue to involve key stakeholders in the HTA process, especially in the scoping of assessments, commenting on draft reports/recommendations and in commenting on proposals for field evaluations.

10. OHTAC should adopt the recommendations of its Public Engagement Sub-Committee regarding involvement of the general public in its activities.

11. The efforts to improve communication with OHTAC’s various audiences should be supported. Particular attention should be paid to internal communication of OHTAC’s role, activities and recommendations within the Ministry itself.

12. Consideration should be given to developing a policy implementation brief for all OHTAC recommendations requiring Ministry action.

13. An analysis should be conducted of the pros and cons of making OHTAC recommendations mandatory, drawing on experience from other jurisdictions.

14. A workshop should be convened involving OHTAC, the MOHLTC and other interested parties to discuss the issues surrounding the implementation of OHTAC recommendations. The discussions would be informed by the analysis suggested in (13) above and by considering some case studies based on past examples of OHTAC findings/recommendations.

ACKNOWLEDGEMENTS

We are grateful to Les Levin, Birth Jorgensen and the staff of the Medical Advisory Secretariat for the production of excellent documentation and for their cooperation during our site visit. Most importantly, we are grateful to those interviewed for giving their time to participate in this review and evaluation.
REFERENCES


APPENDIX 1: INDIVIDUALS INTERVIEWED

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Ames</td>
<td>Government relations, Johnson &amp; Johnson Canada, senior position MEDEC</td>
</tr>
<tr>
<td>Chaim Bell</td>
<td>Chair, Knowledge Transfer Sub-committee; General Interest – Inner City Health Research Unit, St Michael’s Hospital. Physician &amp; PhD in Clinical Epidemiology</td>
</tr>
<tr>
<td>Melissa Brouwers</td>
<td>Director, Program in Evidence-Based Care; Assistant Professor, Dept. of Clinical Epidemiology &amp; Biostats, McMaster University</td>
</tr>
<tr>
<td>Stephen Dibert</td>
<td>President &amp; CEO, MEDEC</td>
</tr>
<tr>
<td>Tony Easty</td>
<td>Ph.D, Director, Medical Engineering, UHN; Dept. of Medical Engineering Toronto General Hospital; Director Program for the Human Factors Analysis of Medical Device Technologies</td>
</tr>
<tr>
<td>William Evans</td>
<td>OHTAC Stakeholder; President, Juravinski Cancer Centre, Hamilton Health Sciences Corporation</td>
</tr>
<tr>
<td>Greg Flynn</td>
<td>OHTAC Stakeholder; Past-President, OMA; Managing Directory Quality Management Program – Laboratory Services</td>
</tr>
<tr>
<td>Ron Goeree</td>
<td>Associate Professor, Clinical Epidemiology &amp; Biostatistics, Faculty of Health Sciences, McMaster University; Director Program for Assessment of Technology in Health (PATH) in Health Research; Economist.</td>
</tr>
<tr>
<td>David Henry</td>
<td>CEO Institute for Clinical Evaluative Sciences (ICES).</td>
</tr>
<tr>
<td>Ana Johnson</td>
<td>Chair, Decision Determinants Sub-Committee; Canada Research</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Birthe Jorgensen</td>
<td>Chair in Health Policy, Queen’s University. Health Economist.</td>
</tr>
<tr>
<td>Murray Krahn</td>
<td>Director, Medical Advisory Secretariat, MOHLTC.</td>
</tr>
<tr>
<td>Les Levin</td>
<td>Head, Medical Advisory Secretariat, Ministry of Health &amp; Long-term Care.</td>
</tr>
<tr>
<td>Mary Catherine Lindberg</td>
<td>Executive Director, Council of Academic Hospitals of Ontario</td>
</tr>
<tr>
<td>Diane McArthur</td>
<td>Cabinet Office, Health &amp; Social Policy</td>
</tr>
<tr>
<td>Sandy Nuttall</td>
<td>OHTAC Div. Rep; Director, Healthcare Innovation and Investment Strategy, Health System Information Management &amp; Investment Division, MOHTLC.</td>
</tr>
<tr>
<td>Gino Picciano</td>
<td>OHTAC Stakeholder; Senior Vice-President &amp; COO &amp; CIO, Ottawa Hospital.</td>
</tr>
<tr>
<td>Ronald Sapsford</td>
<td>Deputy Minister, Ministry of Health &amp; Long-Term Care.</td>
</tr>
<tr>
<td>Wendy Seed</td>
<td>OHTAC MOHLTC Div. Rep Manager, Public Educations &amp; Marketing Communications &amp; Information Branch, Ministry of Health &amp; Long-Term Care.</td>
</tr>
<tr>
<td>William Shragge</td>
<td>Vice-Chair, OHTAC; Chief of Staff, Niagara health System; Chair OHTAC sub-committee on formalizing strategic alliances; Cardiac Surgeon.</td>
</tr>
<tr>
<td>Helen Stevenson</td>
<td>Executive Officer &amp; Asst. Dep. Minister, Ontario Public Drug Programs.</td>
</tr>
<tr>
<td>Terry Sullivan</td>
<td>CEO Cancer Care Ontario</td>
</tr>
<tr>
<td>Michael Thoburn</td>
<td>OHTAC Stakeholder, Executive Director, Professional Services Dept. Ontario Medical Association.</td>
</tr>
<tr>
<td>Frank Wagner</td>
<td>Chair, Public Engagement Sub-Committee; Toronto Community Care Access Centre; U of T Joint Centre for Bioethics; Bioethicist.</td>
</tr>
<tr>
<td>Charles Wright</td>
<td>OHTAC Stakeholder; Consultant, Medical and Academic Affairs, Canadian Health Services Research Foundation.</td>
</tr>
<tr>
<td>Dan Wright</td>
<td>Assistant Dep. Minister, Treasury Board Office, BPS Supply Chair Secretariat</td>
</tr>
</tbody>
</table>
Catherine Zahn  
Chair, OHTAC; Executive Vice-President, Clinical Programs and Practice, UHN.