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Legislative Assembly of Manitoba

Standing Committee on Public Accounts

Chairperson
Mr. Larry Maguire
Constituency of Arthur-Virden

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Fortieth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday, April 25, 2012

TIME – 7 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Larry Maguire (Arthur-Virden)

VICE-CHAIRPERSON – Mr. Gregory Dewar (Selkirk)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon. Mr. Gerrard, Hon. Mr. Struthers

Mr. Allum, Ms. Braun, Messrs. Dewar, Helwer, Maguire, Pedersen, Whitehead

Substitutions:

Mr. Friesen for Mrs. Stefanson

Ms. Wight for Mr. Jha

APPEARING:

Mrs. Myrna Driedger, MLA for Charleswood

Ms. Carol Bellringer, Auditor General

WITNESSES:

Hon. Ms. Oswald, Minister of Health

Mr. Milton Sussman, Deputy Minister of Health

MATTERS UNDER CONSIDERATION:

Auditor General's Report–Report to the Legislative Assembly–Audits of Government Operations, dated November 2009

Chapter 2–Personal Care Homes Program

Auditor General's Report–Follow-Up of Previously Issued Recommendations, dated March 2011

Section 1–Audit of the Pharmacare Program

Auditor General's Report–Follow-Up of Previously Issued Recommendations, dated January 2012

Section 10–Monitoring Compliance with The Ambulance Services Act

Section 11–Pharmacare Program–Part 2

Section 12–Personal Care Homes Program

Section 13–Winnipeg Regional Health Authority–Administration of the Value-Added Policy

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Mr. Chairperson: Welcome, everyone, to our April 25th Public Accounts Committee meeting. Standing Committee on Public Accounts, please come to order.

The meeting has been called to consider the following Auditor General's reports: The Report to the Legislative Assembly–Audits of Government Operations, dated November 2009–Chapter 2, the Personal Care Homes Program; as well as the Auditor General's Report–Follow-Up of Previously Issued Recommendations, dated March 2011–Section 1, Audit of the Pharmacare Program. And, as well, Auditor General's Report–Follow-Up of Previously Issued Recommendations, dated January 2012–Section 10, Monitoring Compliance with The Ambulance Services Act; Section 11, Pharmacare Program, Part 2; Section 12, Personal Care Homes Program; Section 13, Winnipeg Regional Health Authority, administrative–Administration of the Value-Added Policy.

Are there any suggestions from the committee as to how long we should sit this evening?

Mr. Blaine Pedersen (Midland): I would suggest that we set midnight as an end date–end time on this tonight and, of course, if we run out of questions before then we would consider finishing before then, but I'd like to see it set as midnight for now, rather than setting an earlier date–earlier time and having to keep asking for extensions.

Mr. Chairperson: Is everyone in agreement with that, or what's the–

Yes, the recommendation was to sit until midnight or as–I'm assuming, as he mentioned, that if there's no more questions we'd quit earlier than that. Agreed? *[Agreed]*

I see nods of the heads. Okay, thank you.

Also, are there any suggestions as to the order in which we should consider these reports that are before us this evening?

Mr. Pedersen: Mr. Chairman, I would suggest we set–consider them in a global fashion, because I believe it's the same minister and deputy minister for all the reports, so if we could do it globally that would work much better for everyone.

Mr. Chairperson: Committee agree?

Mr. James Allum (Fort Garry-Riverview): Sorry, it wasn't clear to me what globally means.

Mr. Chairperson: Oh, well, my experience, I guess with globally, yes, is that we just deal with them all at one time, instead of going through the order that they're in. And so we would deal with them as–the questions could go back between–perhaps between Pharmacare and personal care homes. I would assume that we will probably deal with them in a more orderly fashion than that, but globally means that you can ask questions on any area that's before us.

And I saw another hand here. Mrs. Driedger, did you have a question?

Mrs. Myrna Driedger (Charleswood): I was just going to indicate that we deal with the personal care home issues first, and then move into the Pharmacare issues, and deal with the personal care home issues all globally and then the Pharmacare issues globally. And then the other two reports or chapters.

***** (19:10)

Mr. Chairperson: Is that satisfactory with everyone? Deal with personal care homes first and the Pharmacare issues in both reports secondly and then section 10 and 13, Ambulance Services Act and the Winnipeg Regional Health Authority act, after that if there's time or questions? Okay.

Seeing no other suggestions, we'll move forward in that matter. So on the first report–I want to, first of all, before we got that far, I'd like to welcome the minister and ask her to have the deputy minister come and join her, as well, and staff.

And, before I ask the Auditor General for her opening comments, Madam Minister, I would appreciate it if you could do some introductions of the team that you have with you this evening. Thank you.

Hon. Theresa Oswald (Minister of Health): I'm privileged tonight to introduce to you Milton Sussman, Deputy Minister of Health; Bernadette Preun, assistant deputy minister; and Hana Forbes, a very brilliant person from the department on all matters: personal care home, Pharmacare and beyond.

Mr. Chairperson: Thank you for those introductions, and welcome.

I would turn it over to the Auditor General then, followed by opening statements from the deputy minister and members as well–so.

Ms. Carol Bellringer (Auditor General): With me today are Sandra Cohen, who is the assistant Auditor General of our value-for-money audit services; and Grant Voakes, who's the audit principal responsible for the personal care home audit. I'll introduce the other staff as well at this point. James Wright is with us and he worked on the value-adds audit. And John Donnelly is trying to hide at the back there, but he does a lot of the support to our entire process of working with the Public Accounts Committee. So I want to acknowledge him as well.

I'm actually–I'm going to include my comments on the follow-ups, because we have actually already followed up the personal care home audit. And that's included in the 2012 follow-up report. The committee has considered our follow-up reports fairly regularly now. So I'll just summarize where we are with our follow-up process. We're currently reviewing all outstanding recommendations one year after the audit report is released. Previously we had been doing it three years after the audit report was released. And so now that it's one year, we'll continue to report on the status of implementing our recommendations for three years only. We report a status as described to us by program management, and then we don't do a full audit, but, rather, we assess the plausibility of that information. When the assertion is made that the recommendation has been implemented, we do look at some evidence to support that.

The personal care home audit was, as you've mentioned, it was chapter 2 of the November 2009 report to the Assembly. This has already come to the Public Accounts Committee. So it was September 2010 that the audit report was considered. We have described it, but I'm going to go through it briefly, because a number of the committee members are–were not at that meeting and are here tonight.

So first we examined the department's processes for ensuring the quality of care in personal care

homes. Secondly, we looked at the assessment and placement procedures for admission to the personal care homes, including management of wait-lists. Third, we assessed the department's long-term capital planning for meeting future bed needs. And lastly, examined the department's processes for ensuring financial and operational accountability, including funding mechanisms and public performance reporting.

We found that regulated PCH standards were in place, and generally consistent with other jurisdictions in Canada. The teams visiting personal care homes to assess compliance with these standards had appropriate skills and training.

We did recommend that the department adopt a more risk-based approach to selecting the homes to visit and the standards to assess, that they conduct some visits on an unannounced basis, and during evenings, nights and weekends, and extend the visits to facilities with interim PCH beds.

While the department followed up on required improvements, we identified in the report that it needed to better verify the corrective actions reported by the homes. It also needed to summarize and analyze the province-wide results of standards visits to identify trends and improve outcomes.

We compiled this information at the time of our audit and found that more than 50 per cent of the homes did not meet four of five core standards. This reflected the strict assessment methodology used, as well as the level of compliance.

In the area of licensing, we found that the department had established a review process for renewing PCH licences. We recommended that it develop formal licensing criteria and processes for issuing new licences.

In examining wait-lists, we found that the RHAs monitored and managed the wait-lists, but some RHAs did not have systems to track how long each of the seniors had been waiting or the average wait time.

In the area of long-term capital planning, we found that the department gathered some related data but hadn't reassessed its capital funding requirements to reflect the current status of the Aging in Place strategy or the current PCH capital needs identified by the RHAs.

And, finally, in looking at financial and operational accountability processes, we found that different PCH funding formulas had evolved over the years and were no longer logically supported by current data and analysis. We also noted that, unlike the not-for-profit personal care homes, the for-profit homes were not required to provide audited financial information. We found limited public reporting on key personal care home information, such as the results of the standard visits, wait-lists, and wait time information.

Now, we have conducted a follow-up, so that's included in the January 2012 report and we noted in there that the department had fully implemented nine of our 16 recommendations, and I have a feeling the department's probably going to get into the list of what's in process, so I'll stop there.

Mr. Chairperson: Okay, thank you very much for those opening remarks, and I would ask the deputy minister to move forward if he has opening statement. Welcome.

Mr. Milton Sussman (Deputy Minister of Health): Mr. Chair, because these have come before the committee before, I don't have any opening statement and will just respond to questions.

Mr. Chairperson: Yes, okay. Well, thank you. This is both–there's two parts there, I guess. We have the one that has been before and then there's this–the January 2012 that we're dealing with tonight as well that hasn't been before but we'll proceed. We'll move forward.

I'll open the floor to questions.

Mrs. Driedger, I–we'll have a couple of comments maybe a little later on, but go ahead.

Mrs. Driedger: Okay, I just–I want to start to out with just a very brief statement about the significance of this audit because I think it's very important and a very timely audit and I think it shone a light on some glaring holes in personal care homes and I'm hoping that tonight we will see that there has been movement towards seeing–

Mr. Chairperson: Excuse me, if I could, I'm sorry. I got ahead of myself. I was looking at questions but you do have an opening–some opening comments that you'd like to make? We would need leave for that, I guess, because it's of the critic area and not a committee member. Would that be a–ask the committee to–you'll have to ask; I can't ask for leave.

Is there leave? *[Agreed]*

Okay, proceed, then, Mrs. Driedger. My apologies for the confusion.

Mrs. Driedger: Thank you, Mr. Chair.

So, hopefully tonight we're going to see that some of the recommendations that were in progress have now been moving forward. I think we also need to be acutely aware of today's and tomorrow's demographics, in terms of our aging population and the challenges that that is going to impose on our health-care system.

The more research I'm reading and the more commentary that I'm hearing from across Canada and, you know, even around the world, it is becoming more concerning in terms of our–whether or not we're going to have the ability to meet the challenges that are going to be before us.

***** (19:20)

I think there is a sense of urgency to this because–for anybody that's been in health care for any length of time, you'll know that it takes about 10 years to bring about a change, and we know that the baby-boomer demographic is upon us. So I think there is some real urgency to address these issues around personal care homes and I don't think it's something that can be left. It's something that has to be dealt with now. So I'm hoping that with the questions we have tonight that–and the answers, that we will see progress towards addressing the auditor's recommendations.

Mr. Chairperson: Thank you for those comments. And before we get into questions, I just want to remind all members that questions tonight are of–to be of an administrative nature and placed to the deputy minister, and that if there's any policy kind of questions–type of questions–that we're leaning in that way–the minister may choose to answer those, and–or the deputy if they wish to, but policy type of questions, I think, would be answered by the minister.

And so, I'll open the floor to questions.

Mrs. Driedger: The–yes, the first question I'm–I really would like to know is how many personal care home–care homes there are in Manitoba and how many personal care home beds?

Mr. Chairperson: I'm sorry. Yes, Mr. Deputy Minister.

Mr. Sussman: There are 125 personal care homes in Manitoba–excuse me. The exact nature of the number of beds is been shifting as we've been looking to convert a number of the beds from–to multibedded rooms to single or double-bedded rooms and with the implementation of different types of housing supports. So we are trying to compile the number, and we–I will be able to provide it to you and–at a later date, the exact–we wanted to confirm the exact numbers.

Mrs. Driedger: When the deputy is providing those numbers, can he also provide the number of spots for assisted living and also supportive housing?

Mr. Sussman: Certainly. We can provide a–comprehensive numbers on the number of PCH beds, the–we can break it down by for-profit and not-for-profit, and supportive housing and assisted living. We don't fund assisted living, so it would be the supportive housing.

Mrs. Driedger: In regards to the standards visits, there had been concern at the time when the report came out that half of the PCHs did not meet four of the five core standards, and I wonder if the deputy minister can give us an update in terms of whether or not that has changed, how many are now meeting the core standards and how often standard visits are done, and how many you would do at one time.

Mr. Sussman: Could I get clarification when you say how many we would do at one time?

Mrs. Driedger: Standards visits per year, for instance, and how many PCHs would be involved in getting their standards looked at on an annual basis.

Mr. Sussman: So we–Mr. Chair, we approximate–we do approximately between 78 and 80 standard reviews a year. We formally do 26 reviews, which are scheduled to–we've made a commitment that each–every two years, we would do standards reviews at each personal care home. So those 26 are done, but we do additional standards reviews beyond that, and that accounts for the difference between the 26 and the approximately 78-80 standards reviews.

Mrs. Driedger: Can the minister tell us who goes out to do these reviews?

Mr. Sussman: It's a standards consultant from the department and a representative from the region–are involved in every standards review.

Mrs. Driedger: And can the deputy minister indicate the criteria that are now followed? And I'm assuming there's a checklist of some kind that is involved with this. I'm assuming it involves integrated care plans, use of restraints, pharmacy

services, safety and security, staff education. Are those the standards then, the core standards, that are evaluated when you go out to look at the–whether or not the PCHs are meeting standards?

Mr. Sussman: The core standards are reviewed at every visit and there are additional standards that–an additional seven standards for–are reviewed at each visit.

Mrs. Driedger: Can the minister–deputy minister give some indication about these seven extra that he's mentioning?

Mr. Sussman: In Manitoba there are 26 standards in the standards legislation. So it would be seven of the remaining 21 that we would pick to do the review on, things like infection control, nursing services, things like that that aren't part of the–that are beyond the core standards.

Mrs. Driedger: And can the deputy tell us where this information can be found? Is it kept someplace publicly? Is it put on a website, or where would one find this information?

Mr. Sussman: At this time we don't have public reporting. We are looking at a template on how we would post this information. The standards, there's a whole series of data that is collected in these standards visits and information. We're trying to create a template that will monitor the quality of personal care homes and provide the kind of information that would be useful to Manitobans in assessing–in looking at those personal care homes. So that reporting template is under development as we speak.

Mrs. Driedger: Can the deputy indicate how long it's been under development and when he expects it to be completed?

Mr. Sussman: The template's been in the process under the–in the last six months, and I can't give you a firm date on when we expect it to be in place, but it is a high priority. I think we are focused on it and it will change now. As far as the merger of the regional health authorities, we will have to just to make sure that they can provide that information to us as well.

Mrs. Driedger: Can the deputy indicate what they're aiming for? Are we looking at six months, nine months? I mean, there must be a goal towards which there's–the department is striving, because he is correct. With the merger of the RHAs immediately upon us this is going to be critical information. So I wonder if he has a goal in mind.

Mr. Sussman: So this template is also part of–it's really in response–to the amendments that were passed last spring that really require RHAs to post safety and quality indicators for all of their facilities, and the PCH–excuse me–the PCHs would be included in that reporting and we are moving quite quickly. And we–it is, I would agree with you, it is critical for Manitobans to see this information. I think that was, I think, part of the intent of the changes.

And so, again, I think we're moving very quickly. I can't–I–certainly our target is to try and get it done in this year, but, again, I can't commit to that date till we've gone a little further in the process.

Mrs. Driedger: Can the deputy indicate who's involved in that process?

***** (19:30)

Mr. Sussman: Sorry. It's a–it's the departmental staff working with regional health authority staff, so it's got to be applicable on–and working with other stakeholders on what those quality indicators–and we've also been working with the Manitoba centre on health policy on trying to look at what some of those quality indicators and the quality indicator template could be.

Mrs. Driedger: Just getting back now to the PCHs that didn't meet the core standards, can the deputy minister indicate if the department has carried out any subsequent inspections which would indicate that this situation has improved?

Mr. Sussman: Mr. Chair, whenever a personal care home doesn't meet a standard, we always develop a–an action plan to resolve the deficiencies in that–or to work towards getting that standard in place, and each one of those is followed up by another standards review or another visit, to ensure that the standards and the action plan that's been developed to address the standards have been addressed. And–so we follow up on every core standard or every standard that hasn't been addressed.

Mrs. Driedger: So can the deputy indicate, because last time that the Auditor looked at this, half of the PCHs did not meet four of the five core standards–is there a new number he can present now to tell us whether or not or how far this has progressed and improved?

Mr. Sussman: The integrated care plan, 61 per cent of the facilities met this standard. The standard on the use of restraints, 52.9 percent of the facilities met

the standard. The pharmacy service, almost 69 per cent–68.7 per cent. The safety and security, 85.4 per cent of the facilities met the standard, and the staff education, 71.1 per cent met the standard.

Mrs. Driedger: And can the minister indicate that–do those percentages represent the whole, all the PCHs?

Mr. Sussman: Yes, it represents all 125 personal care homes in the province.

Mrs. Driedger: And can the deputy indicate how many unannounced visits happened last year in 2011?

Mr. Sussman: In 2011, there were 17 unannounced visits. That number was down slightly from the previous year, and that related to vacancies in the branch that we have subsequently filled. So we anticipate in the current year that we will get back up to the 26 to 30 range of unannounced visits.

Mrs. Driedger: I note that the goal was to perform follow-up visits to 30 per cent and now the deputy's indicating that it could be 26 to 30 per cent. Has his department bumped that down?

Mr. Sussman: Sorry–in 2010 we obtained the–over the 30 per cent. We did 34.6 per cent. In 2011 we did 26.1 per cent of follow ups, and again, that was because we were down on staff.

Mrs. Driedger: And what I probably just did was get something mixed up, and that was unannounced visits versus follow-up visits.

So, getting back to unannounced visits, the deputy indicated that in 2011 there were 17 unannounced visits. Am I correct?

Mr. Sussman: Yes.

Mrs. Driedger: Sorry, and in 2010 how many unannounced visits would there have been?

Mr. Sussman: Twenty-six.

Mrs. Driedger: And what is the anticipated number of unannounced visits this year?

Mr. Sussman: Twenty-five.

Mrs. Driedger: Are these all scheduled visits or basically, truly, is unannounced, and do you do any on evenings, nights, or weekends?

Mr. Sussman: They're truly unannounced. The facilities aren't aware that we were coming in, and we have done some on the evenings and weekends. One was done during the evening and two were done on the weekend.

Mrs. Driedger: Are you finding anything interesting or different on shifts?

Mr. Sussman: The things that we're finding on the different–sorry–on the different times that we've gone are mostly staff-related; they–related to any of the standards that we haven't seen any real change.

Mrs. Driedger: Can the deputy indicate whether PCH standard visits are being made to facilities with interim PCH beds?

Mr. Sussman: At this time, they're not. We are still working through the process of how do we adapt the standards to interim personal care beds that are in an acute facility or–and with some limitations, based on the fact that they're in a–in–the only interim beds still in the province are all at Misericordia Health Centre and the staffing, the physical layout are really based on an acute care model with some modifications.

So we are in the process of looking at our standards and trying to adapt them, based on the interim care beds, but the–all of the processes that are in place to ensure that quality occurs in all of our health-care facilities are in place at Misericordia. We're confident that they are providing safe care. We will go in to do a–to follow-up if there is an issue or if there's a protection of persons in care. We'll follow-up at Misericordia on any reports of abuse and investigate them. So we are, I think, confident that the care that is provided is high quality, but recognize that I think we need a more rigorous process and are in the process of modifying those standards to apply.

Mrs. Driedger: It was a recommendation by the auditor, you know, back in–many years now, 2009, so we're now into 2012, where the recommendation was to extend the standard visits to interim PCH beds. I guess I'm a little bit confused. I do know that the Misericordia is where all the interim beds are. I do know the floor model is certainly not the same as in a personal care home, but it seems to me that a lot of these standards wouldn't matter what the floor model necessarily looked like because we're talking about integrated care plans, restraints, pharmacy services, safety and security, staff education. That shouldn't have anything to do with, you know, sort of the physical, necessarily, structure, unless the deputy can give me some indication that maybe there are some issues around the floor model or the way the place is set up. But it would seem to me that a lot of

these standards should be able to be applied even at the Misericordia, and I wonder why it would be taking this long to move in that direction.

***** (19:40)

Mr. Sussman: I think there has been a fair bit of work looking at trying to lower the number of multibedded rooms at Misericordia, trying to look at the overall need for interim care beds. I think it is an area that we need to continue to focus on. And I think you are correct that we should be able to adapt the standards or–and there may be particular aspects because of the difference in the nature of the staffing and the different nature of the facility. We should be able to adapt those standards to ensure that there is a high quality and safe care–and it remains part of our goal.

Mrs. Driedger: Can the deputy indicate whether that is actively being pursued or it's just sort of on a wish list?

Mr. Sussman: It is actively being pursued. We're doing a further site visit in which case we are going to try and present to them which standards we think are applicable and get their feedback.

Mrs. Driedger: One of the other recommendations that was a work-in-progress is the department verify the corrective actions reported by PCHs in their action plans and progress reports using a combination of risk-based follow-up visits and signed declarations of verification from the RHAs.

The follow-up visits, are you actually doing these regularly and consistently, and are they risk based in terms of what you're looking at? And maybe you could explain what the signed declarations of verification means?

Mr. Sussman: So there is follow-up visits on all of the action plans. It is certainly risk based in that it–if there are clearly identified risks to patients, that we prioritize those follow-up visits, and we have developed a process we are rolling out in this current year where we will get the sign-off by the RHAs–of the verification, sorry.

Mrs. Driedger: Can the deputy just indicate or explain to me what this signed declarations of verification from the RHAs means?

Mr. Sussman: After every review there is–and where there's a deficiency cited, there is an action plan that the facility has to submit on how they intend to address that. And it's that follow-up to that–the action plans have been implemented that will require the verification by the RHA as well, because the RHAs have the funding relationship with the personal care homes and the ongoing discussion of services and programs in the personal care home.

So I think the Auditor General rightly pointed out that we needed–they needed to have that verification as well.

Mrs. Driedger: When the deputy was indicating the percentage of PCHs that met standards, I guess the interpretation would have to be that there aren't any PCHs meeting all of the standards. Is that–would that be correct?

And core standards–sorry–they didn't previously meet four of the five core standards. Would that number be the same today?

Mr. Sussman: Sorry, I don't have the breakdown by core standards but there are personal care homes that have met all of the standards, and we can provide those numbers.

Mrs. Driedger: And are there some personal care homes that aren't meeting very many of the core standards?

Mr. Sussman: We haven't identified any. We have identified some personal care homes that we feel that we need to monitor more closely and we have–and we've done that as part of the licensing process, where we've identified that their licence is under review because we've got concerns that their–of–with their ability to meet certain parts and some of the issues that have been identified. And we are monitoring that and doing follow-up visits to ensure that they are meeting those standards.

Mrs. Driedger: Can the deputy explain how accreditation of PCHs fits in with all of this and the differences between standards, visits and accreditation?

Mr. Sussman: The standard visits are licence requirements in the province of Manitoba. The–and there are certain specifics that–those 26 standards are ones that we review. And we do standards reviews to ensure that they are–they're updated.

The regional health authorities, as part of the changes to the act, are all required to be accredited. And accreditation looks at the best practices and their ability to meet core competencies or core requirements. They're required–sorry–required organizational practices, is the term Accreditation Canada uses, and we've required that all RHAs be accredited.

Personal care homes are part of that accreditation. We think it's a support to the standards process and a further enhancement of the quality indicators. And it looks at–in–there are similarities, but I think it's a broader look and much more focused on all of the quality-type indicators. So we think it's a very good complement to the standards.

Mrs. Driedger: The auditor had found that the department had not developed formal criteria for licensing. Can the deputy indicate whether that has now been rectified and that you now have formal criteria for licensing?

Mr. Sussman: We do have criteria for the licensing of personal care homes. We have–we've also developed criteria for the renewal of licences and how that renewal process is done. And we've also got a place where we now have a process for determining if certain conditions or–like a review of a facility's licence can be–should be put in place.

So we now have what we call under review, which is where we–there have been concerns that either fewer than three of the five core standards have been met or fewer than seven of the overall standards are fully met, or, in situations where, through the licence renewal process or through concerns, we've had some evidence of risk to resident safety or restraint used that's–are in contravention to the act, or that come out of the unannounced visits if there are issues and we–a licence under review really requires both ongoing monitoring on the part of the region and the department and clear expectation of remedial steps that need to be taken, and timelines to do that.

***** (19:50)

Mrs. Driedger: Often our PCHs required to be licensed?

Mr. Sussman: Annually.

Mrs. Driedger: So can the deputy indicate that this–that a review goes on at–in looking at each PCH before that licence is given to them?

Mr. Sussman: Yes, that–it does, and we do have the criteria for reviewing that before each licence is renewed.

Mrs. Driedger: Are there any PCHs right now under review or having a conditional licence?

Mr. Sussman: There are two personal care homes that are under review. There are none with a conditional licence.

Mrs. Driedger: I'd like to move into wait-lists and talk a little bit more about that, and I wonder if the deputy minister can indicate how many people in Manitoba are currently on a–on the waiting list to get into a PCH.

Mr. Sussman: Again, the–it's similar to the personal care home beds. This is a number that is quite–it changes with the–with turnover in personal care homes. So I can–I will get back to you on the exact number waiting.

Mrs. Driedger: I guess I find both of the answers interesting in that, at this point in time, the government would not have an answer as to how many PCH beds there are currently in the system that they are funding, and then to also say–the Auditor certainly was able to find out as of December 31, 2008, that there were 1,137 seniors waiting for PCH placement. Certainly, I would think that that should be something at the tip of the deputy minister's fingers, because in order to properly plan for meeting the needs of all these people, that's pretty significant information that should be readily available.

Can the minister tell us–or deputy minister tell us why this information isn't readily available for tonight's meeting?

Mr. Sussman: I think the intent is to provide you with the most accurate information, and so I want to make sure that I've got the most up-to-date, current information, and I want it to be accurate. So I will do that and I'll do it quickly.

Mrs. Driedger: Well, thank you. I don't suppose the assistant deputy minister sitting next to the deputy might have that information in her file?

Mr. Sussman: Sorry. Hana is the acting director of the long-term care program and–continuing care program, sorry–and again, I think she gave me the same information about that, but we want to make sure it's accurate.

Mrs. Driedger: Can the deputy indicate when I might get that information provided?

Mr. Sussman: We'll provide it very quickly too.

Mrs. Driedger: Does the department track how many patients that have been paneled are waiting for a personal care home bed but are currently in an acute care bed?

Mr. Sussman: We do have–that the–I think very accurate data in Winnipeg. I think rural Manitoba or

regions outside of Winnipeg continue to be a challenge for us, and we have to do that manually. So we are pulling that information together, and will–we will provide it.

Mrs. Driedger: Can the deputy explain how the department, then, can go about planning for the number of PCH beds you need out there if you don't have a good idea at any given time of how many PCH–or panelled patients are waiting in an acute care bed for a PCH bed?

It would seem to me that in order to go forward and properly plan for how many acute care beds you need versus how many more PCH beds you need to put in place in the province–it would seem to me that this kind of information would be critically relevant and be, again, at the deputy's fingertips. And it doesn't seem that that's the case.

Mr. Sussman: The regions have all of that information at their fingertips. It is–so we just want to connect with the regions and make sure that we've got the accurate information.

This information is a part of planning for a new personal care home development, and where that demand–but we–but it's much larger than that as well. It does include the changes in the demographics, the changes in health status. So are the seniors that–what's the usage of personal care homes? What's the age demographics? What's the acuity of people in personal care homes? What is the projection that that will be going forward?

Because as we develop a personal care home, it has to be in place for many years. And you want to get the right number and the right place. And we did get–do some of that analysis, and the Manitoba Centre on Health Policy did provide us with some initial information. We've now asked them to go back and look at, and also provide us with, that information by individual regions and parts, but break it down within the regions of where the personal care home beds would be required. So it is coming; it is all part of that process.

Mrs. Driedger: Can the deputy indicate when that study that he was just referencing will be completed?

Mr. Sussman: The initial study has been completed that gave us an idea of how many beds we need. The more detailed analysis should be in–within the next two years.

Mrs. Driedger: Can the deputy indicate how many beds we do need as has been determined currently?

Mr. Sussman: I can forward the information from the report to–and provide that information.

I–as a result of that information, we did announce that we were going to invest $200 million in providing additional personal care home beds over the next number of years, and have announced new personal care home initiatives in Holy Family in Winnipeg and Lac du Bonnet, and one in Niverville and Morden–Tabor.

***** (20:00)

Mrs. Driedger: Can the deputy indicate if there are any other personal care homes that might be on the horizon to be announced in other parts of the province?

Mr. Sussman: We have taken the centre's policy–or the centre's document. We are working with that document in planning. We're also working with all of the regional health authorities on what they see as the priorities within their regional health plan. And so we'll be combining those pieces and–with any of the information that the centre is able to provide us on an ongoing basis as they're doing their analysis, and that would be the basis of our plan going forward.

Mrs. Driedger: When RHAs put forward their capital requests based on what they see as a priority need, does the department always agree with the RHAs or can–do you sometimes override what a region might think is a priority? Like, we look at Tabor Home, and that went on for quite some time and that was a priority for them, but nothing really happened for a very long time. So does the department override some of the capital requests that come forward from RHAs?

Mr. Sussman: When we look at our capital plan, every–the RHAs all submit a priority, or a list of things that they think are capital requirements. That list always eclipses our ability to fulfill all of those requests. So it is a process of working with the regional health authorities trying to look at the needs, trying to identify what are the requirements across the province and how can we best address that across the province, and the whole range of capital requirements. And it is a prioritization process that goes on and that–in that process, as things develop, RHAs may then say this is our top priority, and then something else comes up and they change their mind of what their top priority is. So it is an ongoing discussion and collaboration on trying to decide which ones we want to move forward on.

Mrs. Driedger: In the Aging in Place strategy I understand that there was a component of that that basically referenced closing 600 beds as part of the strategy in moving, you know, making more supportive care spaces, more assisted living spots. Is that actually what ended up happening, especially with the movement to–and which I support–as having single, you know, bed rooms? I am not in disagreement with that from–versus, you know, two people sharing a room, but was there movement towards closure of 600 beds?

Mr. Sussman: We have been working to deal with the multibedded room issue, and that continues to be a priority and something we will continue to strive with.

I think when we started looking at the plan, I think we asked the Manitoba centre on health policy to really confirm the direction that that personal care home–that there may be a reduction in personal care home beds. That–of the–that review pointed out that we needed additional beds and we've been working to implement that.

Mrs. Driedger: In looking at–back to wait-lists, and the deputy minister had certainly been talking about it, but indicating that there was no system really to track how long patients were waiting for a bed. And I note, in a letter to Mr. Borotsik from the minister and the deputy, probably after one of these meetings, that PCH wait times are currently not reported to Manitoba Health, that the data is manually collected in all regions for planning purposes. Currently, this data is not collected in a standardized fashion that allows a summary to be provided. Work is under way to implement a provincial database that will be used to collect provincial performance indicators, including data related to PCH use.

That was January of 2011; we're now, you know, over a year past that. Is there progress towards, you know, achieving some of this, because it would seem to me that this is all integral to good planning?

Mr. Sussman: I think the work is ongoing. I think there is progress. I think it reflects to some of my comments that I made earlier as part of the–sort of the template of quality and public reporting that we are trying to achieve. And it is part of the work that we're doing with our health IT folks and the regional health authorities.

Ms. Erna Braun (Rossmere): One of the recommendations was that a long-term capital plan–

Mr. Chairperson: Oh, Ms. Braun. Could you move your mike just a little bit closer?

Ms. Braun: Sorry.

Okay. One of the recommendations was to develop a comprehensive capital plan. And I wonder if the deputy minister could indicate us–give us an update and some references have been made to a comprehensive capital plan. Is there any update that he might provide for us?

Mr. Sussman: So, the planned–it included the announcement of the $200-million investment to add hundreds of PCH beds over the next years.

I've already mentioned we are looking at funding beds in–or an expansion of Holy Family PCH and a new PCH in Lac du Bonnet and the new–there is a new 80-bed PCH which opened in Winnipeg and our–and 80 new PCH beds are being developed in Morden and an 80-bed PCH in Niverville. But that whole–it was part of an ongoing strategy so, the centre, when they made that recommendation, really did point out that personal care homes are only part of the equation.

***** (20:10)

More beds are part of a continuum of services that need to be provided to people. So, we have been looking at investing in home care, in enhancing the home care service, so that it can provide additional supports so that people may be able to live longer in the community and not have to enter a personal care home. We've–we're looking at additional supported housing options to address the needs and more specialized–more supports to caregivers, again, to help support people living in the community as an alternative to a personal care home.

Ms. Braun: Further, I wonder if the deputy could indicate whether the additional or the more detailed in-depth report that the centre is coming up with–is that going to guide you in further aspects of the plan?

Mr. Sussman: Yes, very much so. I think we asked–so the report gave us broad numbers on where we need to invest and what kind–what the demand might be for new beds. I think we really wanted to be able to look at what the different regions in the province are–where was the demand. There are some regions where the population has plateaued and the number of people over the age of 75, which are the major users of personal care homes, is starting to plateau or decline. And so that has to be factored into where you put a personal care home.

And there are communities now where the demographics are such that there will be more people over the age of 75 who require, and they don't have enough, beds. And so we're trying to get the analysis done in a more granular way so that it can guide where the specific areas in the province that we need to invest. And what are the kinds of investments? Are they all personal care homes, or is there a need to put supported housing in those environments or other kinds of supports as well?

Mr. Cameron Friesen (Morden-Winkler): I would like to thank the Auditor General and her staff for appearing here tonight, as well as the minister and the deputy minister and his staff. Thank you for being here this evening so that we can ask these questions.

My question is for the Auditor General. I'd like to go back a little bit earlier. The question was asked whether the deputy minister could provide information about the number of people currently awaiting placement, and those numbers were not available. My question for the Auditor General would be this: How was the calculation made in 2009 of how many people were awaiting placement?

Ms. Bellringer: We did obtain all of that information from the department.

An Honourable Member: How long did it take you to get it?

Mr. Friesen: Well, that's a good question. How long did it take to obtain the information?

Ms. Bellringer: Appreciating that we weren't tracking it, so this is an approximation, probably about a week.

Mr. Friesen: So the information, when it was obtained, would it have been obtained from each RHA and then the data would have been assembled into one figure?

Ms. Bellringer: It's our recollection that the department obtained the information from the individual RHAs and then brought it together.

Mr. Friesen: So–I'm not sure this is a question for the Auditor General, but it would be reasonable to assume that the information could be received again the same way, in the same amount of time?

Ms. Bellringer: I'd say, yes, it's reasonable. You know, I do want to say, you know, and I don't want to suggest that it's something that you should have every second, but I do think it's pretty basic information that I would expect the department would get on a regular basis.

Mr. Friesen: I notice in addition to that, that indicated as a work-in-progress, the Auditor General was recommending that to the department and the RHAs track and monitor wait times to first and preferred PCH placement offers, as well as the number of seniors waiting for PCH admission.

My question for the Auditor General is, what would satisfy you with respect to this? How would you want to see this with respect to the number of seniors waiting for personal care home admission?

Ms. Bellringer: We don't have–we're not going to wade into the policy issue around what that–what the answer should be, but having the information–we would expect that it would be available.

We also appreciate that it's not as straightforward as it may first appear. There are certain things, for example, if somebody has an initial request and then they have a preference as to where they'd like to be placed, and then something's made available that's not their preference, they can decline it. And so that has a fairly significant impact on the wait time. And so we appreciate that it's not a simple calculation that we would expect could be easily resolved, but we would like to see a public reporting of the basic information with the explanation that would allow you to interpret it.

Mrs. Driedger: My colleague's question brought something else to mind. People that are out there working in personal care homes indicated to me that what we've been tracking are, you know, patients that have been panelled, but there are probably just as many people out there waiting to be panelled. Does the deputy minister have any sense of how long it takes a patient to get panelled and make it onto that list of somebody waiting for a bed?

Mr. Sussman: I don't have an exact–we don't track how long you wait to be panelled. We do have a process that works through the Home Care program to do the assessment and the panelling process. We strive to ensure that it is done in an expedited way, and it's certainly done based on if there's a risk that is–that–to the person's safety, that is prioritized as far as a panelling process and–but in that process we also, though–when people are panelled, they get to really state where they would choose to be, where–what's their home of choice, and we support them in trying to either remain in the community or to go to a personal care home that they may go to temporarily

until that personal care home of choice becomes available. So we–other provinces, though, have policy where you go to the first available personal care home bed, and we haven't chosen to adopt that in Manitoba. We don't think it fits our needs appropriately.

Mr. Reg Helwer (Brandon West): Through you to the deputy minister, Mr. Chair: Have the wait-list policies always been consistent across RHAs like that in terms of your home of choice and being placed in a temporary one and then moving along?

***** (20:20)

Mr. Sussman: Yes, I think that has been the policy some.

We provide, you know, a choice for people, but sometimes if there isn't–if that home has beds that are available, the person can move directly into it. Other times, if there aren't beds available, they may move to another personal care home first and then as beds become available in their home of choice they would move to their home of choice.

Mr. Helwer: When the initial merger of the Winnipeg RHAs happened, did the temporary placement then move to become all of Winnipeg as opposed to just in that particular RHA or was there a period of time where you staggered that type of thing? Do you understand what I'm getting at here? If you had RHA1 and RHA2, if you had your home of choice selection in RHA1 and you were placed in a temporary care home in there, when the RHAs merged in Winnipeg, did that then the whole of Winnipeg become an opportunity for that temporary home?

Mr. Sussman: I should clarify the merger of RHAs in Winnipeg. In–when regions were created in Winnipeg, there was a hospital authority that provided hospital services and there was a long-term care and community authority. The long-term care authority dealt with all of Winnipeg, so the policies would have affected all of Winnipeg. The merger wouldn't really have changed that practice.

Mr. Helwer: Well, I'm not sure if I can ask this question then. I guess where I'm going is now there's a lot of concern with what's happening with the mergers, and if an individual in Brandon is on a waiting list for a care home in Brandon and there isn't one immediately available, would, for instance, a–in a whole merged scenario, would a care home in Baldur be the temporary placement now that it's a large region, or do you keep that, you know, temporary care homes just in Brandon for people, or how is–and this is maybe, you know, off the topic kind of way–but these are the questions I'm getting asked from people in Brandon right now.

Mr. Chairperson: I would rule it as simple–fairly similar to the previous question. So, Mr. Sussman.

Mr. Sussman: I think that it's a process that we are going to have to evolve with the new regional health authorities. I think there are a number of factors that will come into play and, certainly, the distance from–if it is in another community, the distance from that community to the home community will become a factor in this as in any determination of that policy, but–which is really how it works in the existing regions. So I think we are very conscious that any movement outside of your community has to be something that is relatively close. We do recognize that the challenges that that provides for families and are sensitive to it, and we only use that when the demands–if it's in hospital, if the demands in the hospital are such that we're preventing people who are acutely ill from accessing the services because there are people waiting a placement.

Mr. Helwer: I guess my personal experience with the wait-lists, the way that I see it sort of happening right now is you have–a person might be at spot number five, for instance, on–for a particular care home and they may be aging in place as such, but you have people that are placed in other facilities that may come in to–not really bump that person down, but if they were in facility A and they really wanted facility B, they have priority on the wait-list, then, over the person in slot 5, shall we say. And then you also have, I guess, some ability to say if someone is more at risk in their aging-in-place home, then, that's particular in slot No. 5, you might be able to take them ahead of that person. And it seems to be a fairly fluid, with the best intention to make it work for the people the best way on the list.

Is that–it's kind of a–like, I'm saying it's not written in stone, but it's–there are some–there is some flexibility in the system. Is that the case?

Mr. Sussman: I think you highlighted the complexity of it. I–it is a complex system.

There are–we do try very hard to honour people's requests and be true to that. We do rely on the assessment in the medical or care assessments of what the requirements are and what the risks are. And so there are situations where that may happen, where someone who is very much at risk and there

isn't at all a safe environment, where that may delay somebody getting to their home of choice, I think.

But we also do try and get them into a safe bed. We don't try and bump their–move–they don't bump their priority of home of choice, if you understand what I'm getting at.

Mrs. Driedger: The deputy indicated earlier that there are 125 personal care homes in Manitoba. I know there used to be 126. What happened to that one?

Mr. Sussman: We'll double-check, but there was a personal care home, and I've forgotten the name of it, on Pembina Highway that was converted–it was closed and turned into supported housing and assisted living. And–but Southeast Personal Care Home was added, so we'll double-check.

Mrs. Driedger: In 2007, the government earmarked $40 million to be spent over four years on hiring more staff for personal care homes, and then the auditor had found out a year later that only $5.2 million of the $40 million had been spent.

I, in touring some PCHs, have also been told by them that that money hasn't necessarily gone to hiring staff that are direct caregivers but perhaps to physiotherapists or to other needs.

Is there some flexibility that the personal care homes have when they have received that money? If, indeed, all $40 million has been distributed, were they supposed to only hire staff in–that were giving direct care? Because I'm certainly told in–by a number of them that that's not what they used the money for. They needed it for a number of other things, including some capital upgrades or whatever, and that's where some of that money went.

So, did you track whether or not that $40 million was spent on staff, and can you give us an update on that?

***** (20:30)

Mr. Sussman: So the $40 million was targeted at staffing. It was a variety of staffing, nursing staffing, also Allied Health staffing, which would be the physiotherapists and health-care aides as well.

And to date, as part of that, we've hired 650 nurses and health-care aides that have been added to the PCH system since that time. And we've also increased the direct care and that's–the staffing was really to increase the amount of direct care to residents to 3.7 hours per day, which was–I think the commitment was originally to 3.6. I think we are tracking at 3.7.

Mrs. Driedger: Can the deputy minister tell us whether or not a registered nurse is to be on duty on every shift?

Mr. Sussman: So the plan should–is to have an RN on duty. In some situations there–an RN hasn't been available and there are plans in place to have a LPN on duty, but access to an RN through other mechanisms, if necessary.

Mrs. Driedger: Well, considering the scope of practice of an LPN is not the same as the scope of practice for a registered nurse, are you saying that sometimes a personal care home that might have a couple hundred patients in it, might not have a registered nurse on duty there to be in charge?

Mr. Sussman: The only area where we find that we're having challenges are outside of Winnipeg in rural areas. And in those situations where we can't staff a particular shift with an RN, there is a RN on call at all times, that, if required, they are–they will either come in or will provide the information on through the phone or through other communication means.

I do want to clarify, though, that the scope of practice of nursing, as you know, has significantly changed. The training for practical nurses has changed. We are looking at the whole issue of, is the scope of practice–has it changed enough for LPNs that that requirement or that plan that there be an RN on every shift, is that still something that is necessary or with the changing scope in practice of licensed practical nurses, can they be responsible.

And we've been working the provincial nursing counsel and the long-term-cares groups and the regions to try and really look at our policy to see if–does this continue to make any–to be relevant given the changing training.

Mrs. Driedger: Can the deputy indicate what the, you know, whether or not today's policy, as it stands right now, is that a registered nurse must be in charge on every shift?

Mr. Sussman: That is the policy, but we recognize that there are exceptions and we've developed a strategy to deal with problems where they haven't been able to staff at that level.

Mrs. Driedger: And why haven't they been able to staff at the proper level?

Mr. Sussman: I think it's tied into the difficulties that many rural small sites have in recruiting trained professionals. We are working to enhance the attraction and ability to recruit, but it is the same issue.

Mrs. Driedger: Is the deputy indicating, then, that the reason for this is a nursing shortage in rural Manitoba and perhaps even Winnipeg within personal care homes?

Mr. Sussman: I don't think that that's what I'm indicating. I think personal care homes, particularly on a night shift in some rural communities, are–do have trouble recruiting enough RNs for personal care homes, but I think the number–and I think we have increased the number of nurses in the health-care system. I think there will continue to be that demand. We're going to continue to provide the training and the recruitment efforts necessary to ensure that the services are provided.

Mrs. Driedger: Considering that respite beds are a component of personal care homes and in Winnipeg–I believe there's only 24 or 25 respite beds–is there a movement to increase more respite beds in the city?

Mr. Chairperson: Madam Minister.

Ms. Oswald: Oh, yes, thank you, Mr. Chair.

And I just seek your guidance on this matter–haven't been at Public Accounts for a while. These are very important questions without a doubt about our health-care system, you know, our nursing complement and scope of practice and percentage of hours per day and, you know, all very worthwhile topics.

Knowing, of course, that Committee of Supply is coming up and that, you know, we have a number of reports to go through tonight, I just seek your guidance on whether or not we might be inching outside of the scope, with an upcoming opportunity to discuss these very important matters or if in fact, you know, we are still within the purview of the personal care home review as done by the office of the Auditor General. Just seeking your guidance on that.

Mr. Chairperson: Well, I have let a number of these go, I guess, at this point, and I know that if there's an issue of policy that the minister wants to address, I would entertain that. And I want to make sure that we, while we're not supposed to be entertaining policy questions tonight, I understand, we want to stick to facts in regards to the Auditor General's report.

And so, perhaps, the questions can be asked in a different manner or other areas, but–so we'll watch the proceedings from future questions.

Mr. Sussman: I think it is part of the analysis that we are looking at, and it is–and as we're looking at new beds in Winnipeg, that will be a factor in our planning.

Mr. Chairperson: Yes, Mrs. Driedger. Then Mr. Gerrard.

Mrs. Driedger: I'm zeroing in on the–almost the end of my questions, so the one thing that happened last year was the moratorium that was placed on–and it was a memo that was actually sent out in Winnipeg by the WRHA indicating that personal care homes could only admit patients from hospitals and not from the community.

I would note right now with the latest numbers that there are 358 patients waiting in the community for a bed, and that is higher than it's been since–oh, my goodness–for a couple of years, and in the hospital in Winnipeg, there are 90 patients waiting for a PCH bed.

So I'm assuming these are panelled patients. There's probably maybe double that out there waiting to be panelled, but it's significantly worse than it was half a year, a year ago.

Is there another moratorium going on that we don't know about that is keeping more panelled patients in the community, and why are the number of PCH–or patients that have been panelled still in hospital beds unable to get out of them and move into a PCH? I'm assuming it's because we don't have enough beds.

***** (20:40)

So these are numbers that are actually getting worse and not better, and what it's telling me, quite loudly, is we don't have enough PCH beds right now. So, it's worse. Is there a moratorium on, or what's going on?

Mr. Sussman: So, we acknowledge there is a need for more beds. I think we–that's why we have announced the expansion at Holy Family, that's why Southeast was open. So we are–that's why we were looking at new supportive housing options and enhanced home care, to help support people living in the community. So we are aware of the need and are

trying to address that need. The–there isn't a moratorium on that is only admitting people from hospital to personal care homes at this time.

Mrs. Driedger: Just a final question. The–I've been tracking average length of stays in WRHA hospitals for a while and Manitoba always is worse than any other province in Canada, and most other provinces–or cities, the average length of stay was maybe nine days, seven days, six days; Manitoba was sitting around nine. The latest numbers I have are showing that our average length of stay in Winnipeg hospitals is 10.5. That's worse than it's ever been since I've been watching it for the last dozen years.

Does that have anything to do with the number of panelled patients that are stuck in acute care beds? Does that impact these numbers, or is it our surgical patients that are accounting for longer stays here and more exposure to infections and everything else? What's causing it?

Mr. Sussman: Well, we are constantly looking at the reasons for the length of stay. It is a challenge in Manitoba, but it is a challenge across the country, on lengths of stay. But we are very diligent in ensuring that we're not trying to discharge people inappropriately, that they have the supports in place so that discharge is an effective discharge, that it's to the appropriate place, that they have appropriate kinds of supports to ensure that they are not presenting into hospital again. And that is something that we are focusing on with–particularly with Winnipeg Regional Health Authority, looking at alternate lengths of stay, alternate levels of care days, and that is a focus on that. It–and is getting significant attention from the region.

Hon. Jon Gerrard (River Heights): Yes. You said earlier that the number of homes that meet the restraint standard is 52.9 per cent, which means essentially half of the homes are not meeting that core and very basic standard.

Why do you have such a high proportion of homes not meeting the standard?

Mr. Sussman: So I think in our review of the homes in–with this standard, it is a fairly thorough analysis of the standards and what goes into the reason for the needs, the need to restraint, and what alternatives to the restraint have been explored and what the benefits of the restraint would be to the resident.

And I think where we found is the assessment has been there. Where we still think there are some areas that need improvement is in the area of looking at alternatives to the restraint and what those benefits might be.

So I do want to clarify that the restraints aren't being used without some assessment and some plan to do–to use those restraints. But some of the follow-up and are–aren't at the standard that we'd like.

Mr. Gerrard: Yes. What–tell me, when you find personal care homes which aren't meeting the standards, what action is taken.

Mr. Sussman: As I mentioned earlier, we expect the personal care homes to develop an action plan that would address that. We work with the personal care home in the region to ensure that that action plan is implemented, and then we do the follow-ups to ensure that it has been.

Mr. Gerrard: Is there a requirement that they meet the standard by a certain time?

Mr. Sussman: The first action plan is due within 60 days of the review. So there is a time frame that we are asking them to address that, and we can–we go back and follow up to see that they've done it.

Mr. Gerrard: Yes. I'm just surprised with all the action in the follow-up and the inspections that you still have so many which are not meeting the standard.

Mr. Sussman: I do want to clarify that, when we say that only 52 per cent haven't met, it's on that initial–have met it, it's only–it's on that initial standards review. So all of them would follow up. It is a–we would follow up with all of them to ensure that they were meeting the standard and take the steps necessary to do that.

***** (20:50)

It is, I think, one of the most complex standards with–and we have a policy of least restraint in Manitoba, the use of the least restraint, and we are quite vigilant in ensuring–and it's the detail of what alternatives and what the benefits are that haven't been documented as well as we think is necessary. So I think we have set a very high bar with this and we will continue to have that high bar.

Mr. Gerrard: One of the issues that has come up in Manitoba in the last two, three years has been the rather high number of people in personal care homes who are on antipsychotic drugs. And I just wondered, since the Manitoba health Centre for Health Policy study which showed about one in three

people in personal care homes are on antipsychotic drugs, whether any action has been taken given that, you know, the majority of those being used which are new generation antipsychotic drugs are–actually have black box warnings about not using those in patients with dementia and, of course, many of the patients in personal care homes have some level of dementia.

Mr. Chairperson: I'm assuming this has to do with staffing guidelines, so, Mr. Sussman.

Mr. Sussman: So as we do the standards review, and that policy on the restraint standard, we also do look at the use of chemical restraints as part of that process. And we have initiated some pilots where we are putting nurse practitioners into personal care homes and we've seen marked decrease in the use of those medications.

And there has been a program that the–we have been running in Winnipeg, it's called Improvex *[phonetic]*, I think, is the name of the program that is looking at these type of–at the prescribing practices for these type of drugs, and where they seem to be inappropriate there's follow-up. These are reviewed by other physicians and pharmacists, and where there seem to be inappropriate prescribing that's pointed out to the physician who prescribed them, and it's part of an effort to work with the physicians and really telling them information about their practice, that sometimes in doing their jobs they don't see some trends that they might be–or patterns that they might be falling into.

Mr. Gerrard: Moving on to the question of construction planning. You know, notwithstanding the fact that, I mean, right now you don't know precisely how many beds there are, what would be your goal in five years from now in terms of the number of personal care home beds that you would have in Manitoba?

Mr. Sussman: So I think that is the work that we've asked the centre to better inform. So to give you an exact number we have–I think the Auditor General in her report identified that we probably–that we needed to invest approximately $176 million to address personal care home beds. We've committed $200 million to address that, and we are working with the Manitoba centre to identify the exact number and the stages at which different parts of the community will require those beds.

Mr. Gerrard: One of the issues that, of course, has come up in the last couple of years is the fact that some patients with Alzheimer's disease in particular may, on occasion, you know, need slightly different conditions than the average personal care home resident in terms of keeping them, you know, not being aggressive and so on or not wandering or what have you.

I'm just wondering about what the plan is, moving forward, in terms of whether you've got in mind a per cent of beds, which would be there for, you know, people with particular characteristics and which would need a slightly different personal care home bed environment.

Mr. Sussman: I think we're taking several approaches to dealing with dementia in personal care homes. We have launched an initiative called P.I.E.C.E.S., which is providing dementia education to all personal care homes in Manitoba, and we're providing that training to help staff in personal care homes. And you're quite correct that dementia is a major part of personal care homes right now in Manitoba.

So we are trying to train staff and give them the skills to help work with people with dementia so that to–as to avoid aggressive behaviours and to mitigate–when it does happen, strategies to deal with that. And in the new PCH planning and construction, we are looking at special care units that would focus on more aggressive or more complex behaviour–behaviour–requirements. The new PCH in Niverville has a special care unit that's being developed.

Mr. Chairperson: Ms. Bellringer has a comment, if I could.

Ms. Bellringer: I just wanted to clarify one thing just so that it's not misunderstood in terms of what we were reporting on the long-term planning. The reference in our report to the $176 million, we had just included that information if the beds were to be increased by approximately 10 per cent, that that's what the cost would be. We were not suggesting that that was the number that we thought it should or should not be. We just used it as a reference point.

Mr. Chairperson: Thank you for that clarification.

Mr. Gerrard: Thank you. That's my questions for the moment.

Mr. Pedersen: To the Auditor General: January 2012, page 86, recommendation No. 14, can you explain what No. 14–what your–where you're going with that?

***** (21:00)

Ms. Bellringer: Mr. Chair, to fully understand where we were going with that, if you go back to the original report, it appears first on page 79, and what we had found–I mean, just to quickly summarize it, what we had found is that, and you can see it right in the conclusion on that section, the model's evolved over the years, and so it became, if you will–it wasn't like a zero-based budgeting approach. So it wasn't a reconstruction every year, but rather a bit of a–you take last year's and see how much it has to be adjusted by, and so we thought that over time that that had not necessarily–it was no longer reflecting as accurate as it could be.

So the recommendation was looking at the funding to make sure that the–if you compared current information and assumptions to what was required that the funding model accurately reflected that. It–if you go to page 78, the first full paragraph at the top there, we've got a pretty comprehensive description of what we had found at the time that some PCHs were having–were getting higher per diem funding levels than others. A lot of it was, as I say, it gets built on the–just the buildup of what happens over time. And we would have expected the differences to reflect something other than what we found.

Mr. Pedersen: So then the question goes to the deputy minister: Is this happening now, these funding options? Is there supporting documentation, then, for the different funding levels?

Mr. Sussman: We continue to fund regional health authorities on a global funding basis. It's the region that then allocates it to the personal care homes. There has been an effort in Winnipeg to move to a more standardized approach, but we are, I think, and virtually every jurisdiction, are examining the ways that we fund regional health authorities and looking at alternatives to global funding mechanisms for regions, and our department is actively looking at the different funding models to fund regional health authorities more appropriately–in a more structured way. I may have misspoken with "appropriately." I think it–and that–so that work is ongoing, and we intend to look at the funding for regional health authorities as part of–or of personal care homes as part of that assessment of how we fund regional health authorities.

Ms. Bellringer: And, just to add a little bit to that–I mean, we appreciate the complexity. If you've got a global funding model, it's usually a better management tool. I mean, it doesn't–it isn't prescriptive, so it does allow whatever organization is receiving it to have some flexibility. If you go line by line, it's a lot easier to go back and compare the detail and see if what they are spending is exactly what you had funded, but it's too prescriptive and we would not expect that to be the case. So we understand the difficulties in global funding models and that it isn't necessarily something–we're not expecting that it be broken down to that kind of detail on an annual basis, but every now and again the funding model on the global basis does kind of go a little bit–it's not balancing quite as well as it should. And I think there's–I don't think that we're raising anything that the department wasn't already aware of, that there is a little–and we did identify the fact that the department would have to work with the RHAs to do this, because the funding is flowing through the RHA and not directly to the PCH.

Mr. Friesen: My question is for the Auditor General. I'm looking at the January 2012 follow-up report, and I'm looking at the recommendation No. 13.

I'm wondering if you could comment on the recommendation where it's stated that the department develop a PCH facility long-term capital plan consistent with demographic and population trends, the current status of the Aging in Place strategy and current PCH capital needs identified by the RHAs.

You provide just a little bit more explanation of why you recommended exactly that.

Ms. Bellringer: There've been a number of questions throughout the night that I think are answering that in part, and we do in the report, it's–just going back to the original report, on page 75, the Aging in Place strategy came in after the long-term capital plan. The funding requirements that we were looking at were established before the Aging in Place strategy was put in place, and so it needed to be updated to reflect that. Certainly, it's the RHAs that have the more detailed information that flows into that and therefore the reference to the RHAs. And we've heard a number of initiatives that–and studies that are–have already been completed and others that will be completed that would provide the kind of information we were looking for.

Mr. Friesen: My question for the deputy minister then: So to what degree do demographic and population trends–or how do they figure in when you're developing the long-term capital plan now? What weight is attached those criteria?

Mr. Sussman: I'm not sure I can give you the exact weight. It is part of an assessment of the requirement. It is a major factor. It is also looking at what is the expected health of the various demographics. So, as we're aging, we're also aging healthier, and people are going into personal care homes later than would have happened a number of years ago. And it's those kinds of trends that also play–that are also factored into the analysis. So it isn't just what's the projection of people over 65. It is much more nuanced than that.

Mr. Friesen: For the deputy minister: What is the formula that's used, then, to determine–and my apologies if this was already answered earlier this evening–but what is that formula, then, that's used to determine the number of beds? Is it per a thousand citizens over the age of 75, or is there a standard measurement tool that you use? Or is it more flexible than that?

Mr. Sussman: I don't know that it's a benchmark. The typical measure of–is population per 100,000 over the age of 75. But it isn't–there isn't a bench–a formula that says this is how many you have to have.

Mr. Friesen: I'm thinking in particular of communities across Manitoba where Statistics Canada data is now indicating that there are population growth rates that outstrip the Manitoba average. I'm thinking of places like Brandon and Steinbach and my own communities of Morden and Winkler, where the latest growth figures show Morden at 18.9 per cent and Winkler at 17.2 per cent, the RM of Stanley at over 31 per cent. So a combined growth rate within the region of 22 per cent approximately.

And I'm just wondering about, in a community like this, or other communities that are similar across Manitoba, then, what kind of priority, then, is attached to those communities. I guess what I'm wondering about is how heavily that issue of population growth is used to adjudicate on issues of whether or not to proceed with a personal care home.

***** (21:10)

Mr. Sussman: Certainly, the needs of a community are going to be part of the factor of determining whether we put a personal care home, but it really will depend on analysis of that growth. So is that growth all young? So what is the projection of time from when that cohort will reach the age of 75, and what will the rest of the population that's in that community be at that time? So that analysis is part of it. The regions are constantly helping to update that information, but it isn't as–it isn't just the growth in a community. Again, because often the new immigrant growth, not exclusively, but many are young and the use of personal–now, families that come with them may require personal care home beds, but–so it is a much more detailed analysis of what is the growth and what are the characteristics of the growth.

Mr. Friesen: And, of course, the Auditor General did demonstrate that, as well, in citing both demographic and population trends. And I would assert as well that, you know, areas like Brandon and Steinbach and Morden-Winkler tend to attract a demographic of more senior people, in any case, because there are people who come off the farm, they retire into town and they buy property, eventually move into personal care homes in that way. But I appreciate what you're saying.

The question I have for the deputy minister, then, to follow, would be–you mentioned earlier that the RHAs, the regional health authorities, they submit their capital requests, and that, in essence, always demand exceeds supply, and we understand that there's a finite resources for your department to provide facilities for capital construction.

But, just in terms of that prioritization process–I'm not sure if this is a question for the deputy minister or for the minister. But, then, I'm wondering about what the effect of the amalgamation of RHAs will be on an RHA's ability to advocate and to provide a strong voice for those capital requests that it deems to be priority.

Ms. Oswald: Well, you opened the door for me to answer, and it sounded policy-ish to me, so I thought I'd give it a whirl, if that would be okay with you, Mr. Chair.

Without a doubt, the mergers of the regional health authorities are going to require a shift in ways of thinking, on a number of fronts. But these shifts don't mean that they will be for the worse. It's my view that they'll be for the better.

One of the elements that we tabled in legislation last Friday, in addition to enabling the mergers, and looking at executive CEO contracts, and so forth, one of the most important, if not the most important aspect of that legislation is the requirement of what we've called local health involvement groups. Without a doubt, as the regions get larger, there will be a need for communities to have a strong say in advocating for what they want in their communities. I can tell you that I have found that communities

across Manitoba, quite honestly, haven't had any difficulty advocating for personal care homes for their communities. They're very passionate; they care about their families and they've done that.

And we want to make sure that within that context there is a channel and a way for that to happen, so that local communities can have that strong voice to the RHA, who will continue to be tasked with prioritizing. So, we will blend, you know, very solid, third-party, you know, non-partisan, arm's-length analysis from the reputable Manitoba Centre for Health Policy to guide us in the how and the where and the when. We will rely on our regional health authorities, as merged, but we're also going to be looking very closely at these local health involvement groups, so that they have a voice and a say, so that we're making good medical decisions and that we're making good decisions for communities. And that's going to be really important, going forward. I would agree with you.

Mr. Chairperson: Question, Mr. Friesen, on a factual nature.

Mr. Friesen: I thank the minister for her answer. I look forward to hearing more about the local health involvement groups and how we think that would address those challenges.

My question for the deputy minister to follow that in my last line of questioning for him would be this: that relating to senior citizens and others who are awaiting placement and then in facilities outside of their home communities, I'm wondering how you would speculate that the amalgamation of RHAs might affect people who are awaiting placement but housed in alternate facilities awaiting care.

Right now, there's people, let's say, from Winkler who might be in a facility awaiting placement. They might be in Swan Lake or they might be in Morris. Would this open the door, then, for people to be awaiting placement but housed in alternate centres, but perhaps in Vita or Sprague or MacGregor?

Mr. Chairperson: Yes, Mr. Sussman, I'll allow you to answer that, only because it's fairly much along the same line as the question that we had earlier this evening.

While they're conversing, it was all within one region that you're talking about it, wasn't it? Before, they were in different areas–

An Honourable Member: Different regions.

Mr. Chairperson: Different regions.

Mr. Sussman: So I think the answer is quite similar to the one I gave before, I think. The mergers are really happening as we're developing other personal care home beds, so we are building the Tabor Home.

The intent will always be to try and provide the home of choice and try and provide that as quickly as we can. We are going to have to be very sensitive in– as we merge regions, that we don't create situations where we're making it unmanageable for families and–to help support their loved ones while they are waiting for their home of choice. So I don't think that you will see situations where–well, I know you won't see situations where we're going to dramatically increase the distance that you have to travel to see your loved one.

So it will be something that we will be looking at quite closely as we're merging the regions, again, to try and be sensitive to the ongoing supports that people are–in personal care homes require from their families.

Mr. Friesen: Thank you for that answer.

My–the final line of questioning, then, for the deputy minister would be this: that the 2009 report indicates that long-term planning is required to ensure that the right number of personal care home facilities and beds are in the right geographical areas to meet the future demands of growing senior population, understanding everything that you've said earlier about making sure that the–that care is taken to measure the growth of a community on a variety of factors, I'm wondering about, even now– and I know that the community of Morden is very grateful for the decision to proceed with the Tabor Home–there's concern expressed by a wide variety of health-care professionals that perhaps the facility is not large enough, reflecting the growth of the community and the demographic growth that has taken place in that sector.

Mr. Deputy Minister, I'm wondering if you would comment on whether the 80 beds is adequate to meet the needs of a community that is growing at 22 per cent.

Mr. Chairperson: I think–if you want to answer that, you're welcome to, Mr. Deputy Minister, but we're verging on a particular location. I know we've got lots of reports. There's lots of room in here to be

talking about beds in different regions, so I'll allow the answer.

Mr. Sussman: I think we are–that is the request that we've got and the work that we've asked the centre on health policy to review, the analysis of the demographics and health trends and all the other factors, and work with us on where are the appropriate places in the province for us to invest in building new personal care homes.

***** (21:20)

Mr. Chairperson: Thank you. Are there any other questions?

I know we've had a good discussion on personal care homes and I'd like to be able to move forward onto some of the others, but I see one from Mr. Helwer here, before we go.

Mr. Helwer: I think, probably through to the deputy minister, the Auditor General did make some reference here to capital projects and I'm wondering, in the personal care home structure, are the capital projects she refers to tendered or sole-sourced.

Mr. Sussman: Our capital process is that all of these would be tendered.

Mr. Helwer: Is there ever a time that some of these capital projects are sole-sourced?

Mr. Sussman: Our practice going forward is that all of them are tender.

Mr. Helwer: Well, I thank you for that response, but I guess we're talking about these reports here in particular. Were there any projects during the date of these reports that were sole-sourced?

Mr. Sussman: Sorry. They were all tendered.

Mr. Helwer: Through you to the deputy minister, is there a dollar level where a tendering process is not required?

Mr. Sussman: There wouldn't be a PCH that would fit an amount that wouldn't be tendered. So any PCH capital construction would be tender.

Mr. Helwer: Is the Auditor General find that they use acceptable tendering processes?

Ms. Bellringer: We didn't look at tendering in the–when we did the PCH audit. One of the reports on tonight's list is that of the value-added policy, and we did look at capital projects in that context, which would be only for the Winnipeg Regional Health Authority. So it's only an element of what you're talking about and the only concern we had there around tendering was for the project consultant services.

Mr. Chairperson: Okay. We're moving along. Are there any other questions on personal care homes then?

And if I–if I'm seeing none, then if there's no further questions on the area, then does the committee agree that we have completed the consideration of Chapter 2–Personal Care Homes Program of the Auditor General's Report–Report to the Legislative Assembly–Audits of Government Operations, dated November 2009; and Section 12–Personal Care Homes Programs of the Auditor General's Report–Follow-up of Previously Issued Recommendations, dated January 2012? *[Agreed]*

We will now proceed to the area of the Pharmacare programs. The floor is now open for questions.

Mrs. Driedger: And when we look at the cost of the drug program, I note that in 2008 Manitoba publicly financed 53 per cent of prescription drug costs, and in 2011, from the government's annual report, I note that that number has slipped to 47 per cent. Am I accurate in understanding that we have gone from 53 per cent down to 47 per cent in terms of the percentage of drugs that are publicly financed? And to the deputy minister.

Mr. Sussman: I'd have to confirm those numbers, but our–I think that our sense is that that is roughly correct. I think that will change somewhat, though, with the change in our–the coverage for cancer drugs. So, cancer drugs–or oral cancer drugs now, and supportive drugs for cancer are all going to be covered by Manitoba Health, so there won't be any charge, including a deductible for those drugs. So I'm not sure what the effect of the total will have on the number, but we expect that it will have some.

Mrs. Driedger: Can the deputy indicate what might have caused this slip from 2008 to 2011, going from 53 per cent of public funding to now 47 per cent, which means that, basically, 53 per cent of Manitobans are, you know, paying for their own medications and the government's only now covering 47 per cent. Like, what caused the slip?

Mr. Sussman: I think there's a–it's a complex set of factors that go into that number. So, everybody in Manitoba is eligible for Pharmacare and can apply for Pharmacare coverage, and our coverage is quite comprehensive. So it is a factor of people–new

things, new drugs being prescribed that people are buying that are–that either aren't applying for Pharmacare because their employer might be covering them, or they haven't reached their deductible, so I think there's a whole range of those factors that play into that.

But we haven't changed the eligibility as far as that all Manitobans are eligible, and we have, I think, quite a comprehensive Pharmacare program. And I think it compares, I think, that more–or compares very well across the country. In fact, I think we have a very generous plan–comprehensive plan in comparison to other jurisdictions.

Mrs. Driedger: I note that from–and this is 2010, it must be CIHI's report indicating that Saskatchewan covered 56 per cent–56.3, and Québec covered 51.7, and Manitoba was at 47.6. So, you know, we are up there, but certainly there looks like there's better coverage in those other provinces. But we certainly seem to be, you know, somewhat in the middle of the pack. So I do thank the minister for that–or the deputy minister.

He made a reference to deductibles, and can he indicate what percentage the increase in the deductible was in 2011?

***** (21:30)

Mr. Sussman: So in 2011, the increase to the deductible was .08 per cent. And going forward we have linked the increases of–to–going forward we have linked the increases to–of the deductible to CPI and–which we believe is more–much more appropriate and certainly doesn't necessarily reflect the increase in drug costs or drug expenditures.

Mrs. Driedger: Can the deputy indicate what that percentage increase then would be for 2012? Has that been set and then does it stay like that for the whole year?

Mr. Sussman: It's 3 per cent for 2012 and it stays for the year. For the following year it would only go up by the increase in the CPI–sorry.

Mr. Chairperson: Yes, Mr. Sussman?

Mr. Sussman: Could I clarify? In 2011 it–I misspoke. It wasn't .08 it was .8.

Mrs. Driedger: And just–so that I'm–I've got this correct, then. And so in 2011 the deductible increased by .8 per cent and in 2012 it's increasing by 3 per cent? Okay.

When it comes to drugs and pricing of drugs, who actually negotiates the price of a product?

Mr. Sussman: The department people in our drug program negotiate the price.

Mrs. Driedger: Is it–like, do several people sit down or one person? Is it a group process?

Mr. Sussman: There are several people from the department that negotiated–negotiate the rates, including legal counsel.

Mrs. Driedger: So if a pharmacist were to tell me that there was only one person involved in direct negotiation with every company before listing a product, and that that person essentially had sole decision-making authority on what did or did not get listed, would that not be an accurate statement?

Mr. Sussman: There isn't sole decision making. It does go up through the process within the department. And I would point out as well that we are now working with our western partners, the other jurisdictions, to look at some of the negotiation for some new drugs across the western provinces.

Mrs. Driedger: I noticed in Saskatchewan's health plan that they were talking about bulk purchasing, but the only people that were involved in that were those that were in the New West Partnership and that they were sitting down together to negotiate. Manitoba was not part of that.

Are you saying that you are part of that negotiation with those provinces in the New West Partnership?

Mr. Sussman: I want to clarify what I was talking about was pricing, which is different than the purchasing.

So we have been collaborating on pricing across the provinces. On purchasing, we have a joint process with Saskatchewan on cancer drugs. Alberta is–I think, recently joined that process. And we are open to working on collaborative models and it is a discussion that comes up across the country at FPT meetings constantly.

Mrs. Driedger: I was reading in some notes that I had that there had been an effort a few–well, probably more in the mid-2000s, where Manitoba tried to get into a bulk-purchasing process for generics with Saskatchewan and Saskatchewan didn't want to have anything to do with Manitoba in doing that.

Is it something, though, that the western provinces already do and we're just not part of that?

Mr. Sussman: As I mentioned, I think we have been doing work with Saskatchewan, and now Alberta, on the oncology drugs. These–we are working on looking at these options. These–the discussion of group purchasing is been happening both at western province level but also at an FPT level, and the Council of the Federation is really directed all jurisdictions to start to look at this much more aggressively.

And there is a bit of a difference in the purchasing. The purchasing for facilities is somewhat different than the purchasing for pharmacies. And we utilize MedPro and Medbuy in our purchasing of–for facilities, which are group purchasing efforts that cross–that aren't exclusively in Manitoba.

Mrs. Driedger: Does RHAM have anything to do with negotiating any of these–this bulk purchasing?

Mr. Sussman: Yes, it's between RHAM and the logistics program within the WRHA that are a part of this. RHAM is the Regional Health Authorities of Manitoba.

Mrs. Driedger: Can the deputy minister tell us how often Manitoba's formulary was updated in the last year?

Mr. Sussman: So Bulletin 66 was the only update last year, and we have actually just signed a new bulletin today.

Mrs. Driedger: Can the deputy minister indicate why Manitoba would've only updated their formulary once in a year?

***** (21:40)

Mr. Sussman: I think there was significant negotiations going on with new brand entrants into the market. I think these were pretty complex, and we have instituted a process now where we're negotiating utilization management agreements with the companies for new entrants, and that's–and we are looking now at–so that was a complicating factor. I think we now have set a target that we will update the formulary quarterly.

Mrs. Driedger: Why is it that Manitoba has a reputation right across Canada for being the worst in the country for updating their formulary? You know, you look at some of the other provinces. You know, British Columbia was doing it monthly; Alberta, quarterly; Saskatchewan, quarterly; Ontario, monthly; Québec, more than monthly; Nova Scotia, eight times a year; New Brunswick, 13 times; Newfoundland, 24 times; PEI, 12 times; northwest territory, quarterly; Manitoba once.

They all would be in the same boat of trying to find efficiencies and savings. And I do note that, you know, the auditor, back in '06, indicated that although other–although all other provinces have experienced cost escalation with their drug programs, Manitoba experienced higher average costs escalation than most other jurisdictions.

So we, you know, we were paying more for drugs, we're not getting the cheaper generics on there very quickly. All the other provinces are way ahead of us. We've got a horrible reputation right across the country, at many different levels, whether it's pharmacists or, you know, the public, for being really poor at updating our formulary. And that's been like that for a long time. Why has that not changed in the last decade?

Mr. Chairperson: I only go back and allow the question because we've looked back at number of reports. This is the last time that we'll have an opportunity to ask questions on the 2011 report. It's not included in any of the future follow-ups, and it does refer back to the previous reports. There's about three reports that have come to the 2011 report, so, please proceed.

Ms. Oswald: Yes, thank you. I'd like to respond the question, if I could, Mr. Chair.

Mr. Chairperson: Yes, go ahead.

Ms. Oswald: Yes. Thank you.

So, as recommended by the Auditor General, and I believe we owe her office a debt of gratitude, because, really, she got us on the path of looking at new policies for the–or the acquiring of new drugs onto our formulary, particularly guiding us down the path of utilization management agreements. This, you know, hadn't been done in Manitoba before, setting a generic submission policy; we hadn't done that before.

And, so, without a doubt, transitioning into this new mode of acquiring new drugs did take some time. We wanted to ensure that we got it right. And so our bulletins coming forward were less frequent than they had been in the past. But I do want to be absolutely clear that we have, I think it's the highest in Canada, I may stand to be corrected, but the highest penetration rate of generics into our system,

which means that we have worked hard to be able to get more generics onto the Manitoba formulary, which means, broadly, we are saving more money than other jurisdictions, because we have that generic option.

Further, we know that by being able to actually do the work to transform how we put drugs on the formulary through these UMAs, if I may go forward calling them, we have been able to save significant–significant–amounts of money and also work into those agreements, things like guarantee of supply, which hadn't happened in the past, and also working out arrangements that, if, indeed, other jurisdictions were to secure a lower price for a drug, that essentially we would get a do-over, and we would be able to go back and secure that price as well.

So, in fact, with the bulletin that was signed today, there were two generics on it. You know, we'll be learning about these in the coming days in a release, that we were able to get back down to 25 per cent of the brand name cost, because another jurisdiction was able to do that. So we were able to buy onto that.

Overall, you know, we have been able to save millions of dollars through these UMAs. We haven't gone as swiftly as some other provinces that hadn't totally changed the landscape on how they were doing things like we did. But we have heard the department now–that things are running smoothly, the companies are becoming more and more familiar with our UMA process, that a commitment to add to our formulary, at minimum quarterly, it–we think will be very good for Manitobans and for adding new drugs.

So it has been a transition period; we acknowledge that, but we're also getting very, very good results as a result of taking the time to do that transition, and we thank the Auditor General.

Mrs. Driedger: The minister, I know, has been saying that for a number of years, but there are experts out there that are indicating she's absolutely wrong, that, in fact, by the fact that the government has dragged their heels on adding generics to the formulary that, in fact, we'll never make up for the loss. Whether it's individuals who have been stuck having to pay for it, for the brand names, whether it's a Pharmacare program or the private insurance that the longer the government did not update the formulary that, in fact, we will–nobody in any of those three areas are going to recoup what was lost.

And there are a lot of experts out there that are really good number crunchers in this that, actually, have indicated to me that the minister is totally wrong in what she says about this. In other provinces–

Mr. Chairperson: I'm going to caution the member that we're edging into areas of perhaps questions that could be used in Estimates coming forward. But I want to try to keep it to as factual of statements out of the Auditor General's reports as we can, and I appreciate the indulgence of all members.

Mrs. Driedger: Thank you.

With the–only updating the formulary once, I want to give the minister and–in the last year, I want to give the minister an example of what that actually ended up costing Manitoba based on a drug called Plavix. And, because Manitoba did not put that onto the formulary at the same time other provinces did–and this was just very, very recent–Manitoba was having to pay $2.65 for the brand pill, and every other province–BC was $1.11; Alberta, $1.18. You know, Saskatchewan, 92 cents; Ontario, 66 cents; Québec, 76 cents; New Brunswick, $1.32; Nova Scotia, $1.18; PEI, $1.32; Newfoundland, they weren't in there. So the national average was $1.18 per pill of this Plavix, while Manitoba was paying $2.65. We were the last ones to put this drug, this generic drug, onto the formulary. In that period of time–in a three-month period of time, because the government did not put that generic on there, we could have saved $2 million in three months. That amount is then–the ordinary Manitoba who couldn't get the generic of the drug was stuck paying double what other provinces were.

The Pharmacare program suffered, so the cost per month–

An Honourable Member: Point of order, please.

Point of Order

Mr. Chairperson: Ms. Braun.

Ms. Braun: With the assistance of the Chair, could you make a suggestion in terms of whether this is bordering on policy discussion?

Mr. Chairperson: I'm allowing it to go; we're looking at the sections in here that we're looking at the Pharmacare programs and the audits of them. I'm assuming that there's an example here that's going to relate to a question in regards to the audits, to the deputy minister.

We're not here to ask policy of the minister. I remind members that this is to be facts that'll go to the deputy minister. I thank the member for bringing that to our attention.

* * *

***** (21:50)

Mr. Chairperson: Mrs. Driedger. Are you finished?

Mrs. Driedger: And, indeed, it does go to, you know, the updating of the formulary, and it's just an example I want to point out to the deputy minister and to the government that there needs to be a better way of getting generics onto the system a lot more quickly and I'm glad to see that they've made a commitment to update the formulary quarterly. That would certainly position us a lot better.

I've got examples of other drugs, but I'm certainly not going to go into them, but although maybe I should. There were four other drugs that cost–that Manitoba didn't put onto the formulary and it cost us $10 million more because Manitoba did not proceed to update the formulary and put generics on there.

Mr. Chairperson: If I could interject. Just, again, we have the prime example. I think that we've used that–you've got a good point, you've made it and if you have a question of the deputy, I would ask you to proceed. Thank you.

Mrs. Driedger: I do and I would ask the deputy because it certainly looks–and I have to go back to the original comments that came out of the Auditor General's report that indicated if there weren't changes that Manitoba's Pharmacare program would not be sustainable, that procedures and processes needed to be improved in order for Manitoba's Pharmacare system to be better managed, and that was the, you know, some of the biggest components of the Pharmacare audit initially was that the program was mismanaged. And, when you look at the whole issue of generics, I mean, that's an integral part to some of the comments made by the auditor at the time.

So, in looking at it that way, the Manitoba society for pharmacists has–or is asking and, actually, many pharmacists right across Manitoba are wondering, and I'll ask the deputy minister, where they are in terms of generic prescription drug pricing. I'm told that all the other provinces, and I may not have that accurate, maybe that should be the question: Have all other provinces already set generic prescription drug prices? Have they settled on price reforms based on that, and is Manitoba the last one to get there?

Mr. Sussman: I think it's only Alberta–or, sorry, BC and Ontario that have introduced legislation to set percentages. We are looking at those changes. BC just introduced, I think, the legislation in the last day or two. So we are going to be looking at that as part of our ongoing review.

But we've taken a bit of a different approach. We think we are getting comparable savings, not and–but our generic UMA agreements, our utilization management agreements, go beyond just the pricing. So they set prescribing criteria. They set communication and education plans for the drugs. They also allow us to look at the optimal use and really improving our–in looking in optimal use, we're looking at clinical practice guidelines related to that. We're looking at the value base of the new medication and what the utilization plan and projection is, and how the addition of that drug will actually impact effectiveness or improve quality of life. What is the benefit to Manitobans of having this added to the formulary? The agreements also include the price adjustment downwards that the minister talked about, and it also does speak about ensuring that there's supply for the province.

So we think it's a much more comprehensive approach, but–and in a number of cases we've been able to get lower prices on some of our generics than other provinces have. We–that's not to say that with the introduction of what Ontario has done, and Ontario is such a huge market that they affect things across the country, and BC is also a large market, so we are going to look at the changes that they've introduced and then try and see what assessment they might have on our program and whether we need to revise it appropriately.

Mrs. Driedger: I note that in March of this year that Newfoundland just went to lowering generic drug prices. So these provinces are talking about being able to have a drug price, and the minister did indicate earlier that you were able to successfully get a deal on a generic drug at 25 per cent of brand cost. Is that where–what you are looking at in–on a go-forward basis in terms of trying to negotiate deals?

I know that–I think it was Ontario that was looking at 50 per cent and then they dropped down to 35 per cent because they didn't find that was enough. I'm not sure where BC's at. But are you–have you got

a goal? Is that what you're looking for, setting some kind of a percentage that you would accept in terms of paying for a generic?

Mr. Sussman: So I think whenever we're looking to negotiate these agreements, we're looking across jurisdictions at what the pricing is across jurisdictions.

What Ontario did was introduce legislation to bring it down to 20 per cent now. There, originally, I think, was 25 and they reduced it to 20. And BC has introduced–reduced it to 25 per cent within the last couple of days.

I think what we have done is we are looking at those things, but we have been looking whenever we've negotiated an agreement on what other provinces have been paying and we're always trying to strive to get the lowest that we can get. And in the situations where we're not–where other provinces are able to negotiate those deals, the agreement allows us to go back and open that and look at us getting a lower rate.

Mrs. Driedger: The Manitoba Society of Pharmacists was indicating that in a letter that was sent to me–I'm thinking that it probably went to the minister as well–that most Canadian provincial governments have already finalized their consultations and introduced price reforms for generic prescription drugs. And they say that the prices for hundreds of generic drugs have been reduced in several provinces and price reform in Manitoba will be substantial. It has been estimated that in excess of $100 million in savings can be achieved annually in Manitoba.

Would the deputy agree that that seems to be what we could save here if we move forward with a generic prescription drug price reform?

***** (22:00)

Mr. Sussman: So I think it's–I think the concept of generic drug reform, I think all provinces are looking at this. Our utilization management agreement is Manitoba's form of generic drug reform–drug pricing reform. And I think with the introduction of what Ontario and BC are doing, I think we're going to have to, obviously, study that. But the UMAs and the bulletin that we listed today, we estimate that we will save $10 million on the generic pricing with the listing that we signed today.

So we think that this process of our utilization management agreement will get those savings. I think we are doing the reform. I think we are also getting added value in the other components of the agreement that we think differentiate our approach from other provinces.

Mrs. Driedger: The pharmacies, the pharmacists that are out there, I guess, may be feeling some concern or some pain in terms of what this might do for funding. Is the policy that the government's going to bring forward–will it do something that will help to support pharmacists out there? Will you be looking at, you know, reimbursing pharmacists, for instance, for consultation or what they call cognitive services or, you know, teaching, or is there going to be some way that when you move ahead with generic price reforms that you soften the blow?

Mr. Sussman: So in Manitoba we have an all-in fee and we don't regulate the professional fees that pharmacists charge. Other jurisdictions have taken a more legislative approach. So in–I think we are feeling that some of that addresses it. As pharmaceutical practice is changing, we are going to have to examine that as the evolution of the practice, and that that analysis is going on.

Mrs. Driedger: Can the deputy tell us where Bill 41 is at, as it certainly addresses some of the, you know, concerns and recommendations? That was passed in '06 and it's not been proclaimed yet.

Mr. Chairperson: I think that's bordering on policy, but the minister and the deputy look like they're prepared to answer that, so I'll let them go.

Mr. Sussman: So we are eager, I think, to see that this act be put in force because we believe it does have the ability to provide better patient care and the potential to save additional dollars.

We've actually offered the Manitoba Pharmaceutical Association to support and move the process towards completion. And we've been facilitating discussions with the stakeholders, the College of Physicians and Surgeons of Manitoba, Doctors Manitoba and DSM in that process, and we've been very aggressively trying to move that forward, and we believe that we will be able to proclaim the act by the end of the year.

Mrs. Driedger: Can the deputy tell us–I think this came up at an earlier meeting–what the percentage of family doctors who have subscribed to the electronic medical records system? I think we heard a response back then it was 34 per cent of family physicians have an electronic medical records system in place. I wonder if that has improved since 2010.

Mr. Chairperson: I'd just like to remind the member that–I don't know if there's a reference there to the Pharmacare program–

An Honourable Member: Yes, that is. That comes out of the Pharmacare.

Mr. Chairperson: Just bring it there. You want to move forward with that then.

Mr. Sussman: The number has improved. We've introduced what we feel is a very successful plan to have family physicians implement the electronic–the EMR. We had targeted a thousand physicians to–as part of this project. We are fully subscribed. So a hundred–a thousand physicians have already committed to implement the EMR and are in the process of doing that. And we've–and so we–as part of that plan, we set up interim targets that we–as far as the rollout and the use and practice and then demonstrated that it's actually being used in a clinical set–in a clinical manner, and we've met those targets.

I think, with the additional thousand, that we're probably at over 50 per cent of Manitoba family physicians have a functioning EMR.

Mr. Helwer: I guess, the question we have here we've kind of been perplexed about, probably to the Auditor General. We've got, you know, this report was first done in '06 and you've done an update here in 2010, and there are a number of recommendations that are still outstanding. So how do we follow up on a, you know, a report of this age to see that these recommendations will, in fact, be acted upon, or how would that work?

Ms. Bellringer: Our office is not planning to continue to monitor it, not because we don't think it's important, but because we think it's dated now. And so, when we do our audit plan for next year, we'd consider what aspects of it we may want to include or not and get current information on.

We've talked at various committee meetings about the potential of this committee requesting, say, an action plan or something that would give you a full picture of what's going to be done in the future. You know, it does get into the discussion around you can't monitor everything all the time, so you've got to pick your spots. So I mean that's really where we're coming from, but not to suggest that–and we really just can't spend our time continually monitoring absolutely everything that we look at or we'll never get on to something new.

Mr. Helwer: Well, I guess, to just follow up on that, to the Auditor General. Obviously, you wouldn't have made these recommendations unless you thought they were relevant and important, and are they still relevant and important and how do we decide if they are without going back and re-auditing, or what can be done to–we can't obviously compel anybody to follow your recommendations, but, as I said, you wouldn't have made them if you didn't think they were important.

Ms. Bellringer: That definitely, I mean, the recommendations were significant then, and I'd suggest they still are. We do have a process of reporting that something's in progress and not giving you enough information to really assess this. Is it, you know, 10 per cent along the way or 90 per cent along the way? Which is really where the committee's going to have to ask just the department for that kind of action plan to know if, you know, how far along it is.

***** (22:10)

Some of the recommendations are fairly broad in nature, like a comprehensive plan. I mean, you know, a strategic plan for any organization is something that you should be working on on an ongoing basis anyway. A lot of the specific recommendations that were included in that report have since been implemented, so it's not to suggest that everything was ignored. And there has been progress on many of these things.

I don't have a simple answer for you, because that's one of the most complex issues this committee has been trying to come to terms with in all the six years that I've been working with you. So, yes, it's important. Yes, you should get some information; some of it you'll get through your Estimates process, some of it every year, and some of the annual report information will provide the nature of the recommendations that we were looking at here.

And we will have other audits that will touch on some of the aspects, and I can't really single out any one of these other than to suggest that there is a bit of a common theme that you'll see in a number of reports and, even including the personal care homes tonight, around performance information. And it's one of the most difficult things to–for governments to–it's a very common issue in other jurisdictions as well, to nail down how much information is enough information and how much is too much. And that is something we keep trying to push for additional

public information on many aspects, and that's in this report as well.

Mr. Helwer: I guess probably then through to the deputy minister, you know, there are eight items that are a work in progress here, and can you comment on any of them that you feel are almost done, to this committee? So I mean, we have difficulty passing a report if there are this many items, I think, outstanding to be worked on.

Mr. Sussman: In evaluation practices, I think we're quite close to doing that. I don't know if you want me to go through all eight or–

Mr. Chairperson: Mr. Helwer.

Mr. Helwer: I'm most interested in which ones you're very close to, and then if you want to comment on where you see yourself on the rest of them. So, if we start from–on page 17 there, numbered 1 to 22, I guess.

Mr. Sussman: Can I clarify talking part 1 or part 2 or both?

Mr. Helwer: It's part 1, I believe, we have here. I believe it's part 1 that we have on–the report is the follow-up, March 2011, follow-up of previously issued recommendations–part 1, page 17 that we're referring to.

Mr. Sussman: So the–I'm just reconciling numbers. Recommendation No. 1, the program direction. I think we are setting measurable targets for health outcomes, and we are, I think, we have built in a process throughout the department of trying to link in all of the strategic directions within a program to the strategic directions of the entire department. And we have implemented a process where that–where work plans are developed on a three-month basis of what we want to achieve within those three months, and then there's a department-wide review of the progress on those work plans that happens. And then the following–the coming three months are also laid out, what those plans.

So we do think that the program direction and the targets are being set. I think we're trying and working at aligning that with all of the other strategic directions of the department so that there is that kind of an alignment across the department.

I think the program monitoring–I think that, again, I think, we have really, I think, gone a long way in determining what some of the factors and what the performance metrics that we want to track and are looking at measuring those on an ongoing basis.

So I think we do have the components of an internal evaluation framework. And so I think we have made significant progress in that. And all of the UMAs that we have have evaluation points, and those UMAs are reviewed annually. So we think that there is significant progress.

So I think the work that we still have to do is documenting our plan for following up on the evaluations and that we are currently–that work is currently under way. And we are–we have developed and are now starting to roll out a pharmacy contract that we will be presenting to pharmacies to be part of our drug program, and the contract is set–has been developed, so we're just in the process of now starting to work with the pharmacies to negotiate signing that agreement.

So I think on compliance with the legislation, I think, we are trying to identify and assess the risks of the key components and we are linking that risk assessment to part of our overall departmental risk management strategy. And there has been a working group in the department set up, a risk management working group within the branch to do that risk assessment and to develop risk management guidelines to address the specific issues with the provincial drug program.

So, on the drug selection and costs, we do have a lot of controls to ensure that we have price validity in DPIN on the initial negotiation of the UMA. And then any changes to the UMA, there are controls in the DPIN system that don't allow for a different price for reimbursement, and any–the only change that can happen in that system can only–has to happen in Manitoba Health.

So and I think some of the other work I've talked a little bit about. We are a member of the western collaboration pricing and purchasing collaborative, and we are established–we are participating in the establishment of a brand and generic product price quotation system for the western jurisdictions. And we are working on an audit process to ensure–so work is starting or is in process on an audit process to regularly assess the price validity in the DPIN system.

***** (22:20)

So, I'm not sure I'm answering your question. I think what I would say is we are taking these recommendations quite seriously and there is a lot of

work within the department to ensure that we're following up and that work is continuing. So when the Auditor General said that these were important–and you asked about that–I think we still see these as important and have committed the department to addressing them.

Mr. Helwer: So all of these eight say they are work-in-progress, and you've referred to various aspects of them. Is there any–are there any of them that you don't intend to complete?

Mr. Chairperson: Mr. Sussman–sorry.

Mr. Sussman: Sorry. No, we intend to complete them all.

Mr. Helwer: Well, Mr. Chair, I guess the next logical question is, when?

Mr. Sussman: I think, as you got a sense, this is a very complex field. I think we are moving this as quickly as possible and we are devoting significant departmental resources to achieving this. And some of them require work with other parties. The bill that we are talking about, we had to work with the pharmaceutical association to develop those regulations. That work is ongoing and we're providing the supports to help move that faster. I don't know that I could give you specific dates on when we will achieve them, but it–but is–but, yeah, our commitment is that we're going to do this as quickly as we possibly can.

Mr. Helwer: Do you feel that trying to comply–and this is very subjective, I guess, with–trying to comply with any of these goals are taking important resources away from other more important areas that you might deal in?

Mr. Sussman: I think all of the work of the department is a balance. You're trying to balance a whole series of initiatives and a whole series of demands and I don't know that we're unique in that, but all of our work is that balance, so I don't think this is taking away work from–or taking away attention from other important areas. I think we really do that assessment on an ongoing basis and try and move them forward.

Mrs. Driedger: Can the deputy minister indicate whether the comprehensive plan is something that is publicly available? The one that's referenced in the Auditor's Report, that a comprehensive plan be developed for the strategic direction reforms for Pharmacare? Is that something that is made available to the public anywhere so that there is some sense of the direction that the department is taking?

Mr. Sussman: Aspects of it are publicly available, so the framework for utilization management agreements are public. They're known to drug companies to–we make those available to a variety of stakeholders. I think the overall departmental plan is a work-in-progress and it hasn't been made publicly available.

Mrs. Driedger: Can the deputy indicate whether there was a recent drug program management review undertaken?

Mr. Sussman: Can I ask for clarification? Can you be more specific? Was there an overall review of management of the provincial drug program, or are you looking at something else?

Mrs. Driedger: No, and I'm not necessarily being, or inferring that it's–it was a major review but, did the–was there an internal review recently done of the management of the program?

Mr. Sussman: Well, I think we are really–we are reviewing the role of the provincial drug program and whether we have the appropriate structures in place to support it and, certainly, we are always looking at a review of our UMA agreements, and particularly in light of the changes that we've already talked about, so those kind of reviews are starting to take place within the department.

Mrs. Driedger: Has there been a restructuring of personnel within the Pharmacare program? Any new people involved in new management positions or was there a new deputy–assistant deputy minister or director recently put in place?

Mr. Sussman: There hasn't been a change in ADM. Bernadette is still the ADM responsible for the provincial drug program. We have appointed a new executive director to assist in the review that I just talked about and–so that has taken place.

Mr. Chairperson: Are there any further questions in regards to Pharmacare programs?

Seeing no further questions on the area of Pharmacare programs, does the committee agree we have completed this consideration of Section 1–Audit of the Pharmacare Program of the Auditor General's Report–Follow-up of Previously Issued

Recommendations, dated March 2011, and Section 11–Pharmacare Program–Part 2 of the Auditor General's Report–Follow-Up of Previously Issued Recommendations, dated January 2012.

Is there agreement on that?

An Honourable Member: No.

Mr. Chairperson: No? No?

Mr. Chairperson: *[interjection]* Yes, I mean if there's–I'll open–the minister would like to make a comment?

Ms. Oswald: I'm sorry, Mr. Chair. I just had my hand up before he had posed that question. I was just, you know, in the spirit of appreciating moms and stuff. If–is there any way the committee could signal if you're going to be asking more questions on personal care homes, or can I send Hana home? Like, have you decided that yet?

We just–well, you signalled a global discussion, so I just wanted to be compassionate. Is that okay?

Mr. Chairperson: No, we're finished with the personal care part; thank you very much for your attendance.

***** (22:30)

Mr. Chairperson: And in regards to–just in regards to the section that I just asked for agreement on, there was no agreement, and so it will come back at a future meeting.

So I will open the floor then to sections 10, the Monitoring Compliance with The Ambulance Services Act, and Section 13, the Winnipeg Regional Health Authority administration of the value-added policy.

Are there questions in regards to these? Either of those, yes.

Mrs. Driedger: No ambulance questions, but I do have some questions related to the value-added policy. One of the recommendations from the Auditor General was that the WRHA publicly disclose vendor payments and value adds, and the auditor had indicated that the WRHA does not publicly disclose bid pricing.

And the question I have for the deputy is: What is the rationale for not disclosing vendor payments, and how are those vendor payments different from those that are disclosed in volume 2 of Public Accounts?

Mr. Sussman: I think there has been a difference of the interpretation of this part. I think the WRHA's rationale for not providing the information is that they thought it might inhibit the best price, but in many of their agreements there is still a clause that contains confidentiality. I think we are working with the region to look at taking that clause out of future agreements. I think that's consistent with the recommendation. And so, that is an ongoing discussion we're having with the region.

Mrs. Driedger: Can the Auditor General indicate if she's satisfied with that response?

Ms. Bellringer: We're actually continuing discussions with–it's through Department of Finance. We've actually made a broader recommendation in one of our Public Accounts reports that the disclosure of vendor payments be expanded to the entire government reporting entity. At the moment it's only required in volume 2 of Public Accounts for the amounts that flow through the core government, and we think that that should be expanded to cover everything.

At the moment the threshold is 5,000, so if you recall there's a really detailed series of payments that flow; they're all disclosed in volume 2 of Public Accounts. Five thousand is too low of a threshold, so we think that that should be reviewed. So we've made that recommendation in another report, and we're monitoring it there in the context of the–because the value-add policy had been removed, we've sort of covered it off. Within the context of this report you won't see it again, but we are monitoring it through Public Accounts.

Mrs. Driedger: One of the recommendations, also, from the original report was that the WRHA develop a formal documented policy for capital project tendering. And the WRHA response was that they currently follow a general procurement policy for all capital projects, and also for all of the province of Manitoba's Treasury Board capital construction authorization policy, but recognizes the value of developing a formal, separate policy for capital project tendering because of the nature, size and scope of these projects.

My question would be is where has that ended up in terms of whether or not that has proceeded.

Mr. Sussman: When we looked at that recommendation, we felt it had application across the province–that it wasn't just Winnipeg that it was appropriate for. The department actually undertook to draft the policy, which we did, and we sent out in March of 2011 to the regions, and the regions are in the process of implementing that policy.

Mrs. Driedger: Can the minister give us just a flavour of what that policy includes?

Mr. Sussman: I–we can provide the detail of the policy. I think, at its core is the requirement that it be tendered, but the other details of the policy–I don't have the policy in front of me, but we can provide that.

Mrs. Driedger: Can the deputy indicate, do they set a price–like a cost of something and above that particular cost is when they have to then go out to tender?

Mr. Sussman: So the policy didn't set a price threshold, and, in discussion with the regions, we are looking at potentially drafting an amendment to the policy to set a price limit at $25,000, but at present, there isn't a price limit, so they are tendering. The requirement is that they would tender.

Mr. Chairperson: Are there further questions on the section?

Mrs. Driedger: I'm just looking at the next recommendation with a question.

Is Treasury Board approval still required a minimum of three times for each construction project in excess of $500,000 at the design phase, the tendering phase and the construction phase?

Mr. Sussman: Yes, there still are requirements for approvals at various stages. I'm not sure it's as straight a line as was described, but there are multiple approval levels that are still required for any capital project.

Mrs. Driedger: And is–does that mean, like a building project or purchase of some capital equipment?

Mr. Sussman: It–this is talking specifically about capital projects, but it also applies to some specialized equipment.

Mrs. Driedger: Such as what equipment would you–would the deputy be referring to?

Mr. Sussman: Diagnostic imaging equipment is an example. So, scanners, MRIs, ultrasound.

Mrs. Driedger: So, just so I understand correctly, for those equipment, you have to tender. Is that correct?

Mr. Sussman: Yes.

Mrs. Driedger: I didn't know that.

Is there other equipment, then, besides scanning equipment? Is it based on a price or is it just like a high level piece of equipment?

Mr. Sussman: There is an amount. I can get the exact amounts that–we can provide that. I don't have it in front of me.

***** (22:40)

Mrs. Driedger: Can the deputy indicate where that kind of information would be held, or is it through legislation or policy?

Mr. Sussman: Yes, this is mainly our chief financial officer's area, so that's why we're doing some of the consulting. We can get more of the specifics and get back to you, but I think we are trying to follow the practices, the general accounting practices, or I'm not sure of what–it may be me mixing up the exact term. But I can get you those answers.

Mr. Chairperson: Are there further questions on either of those sections, 10 and 13?

Point of Order

Mr. Gregory Dewar (Selkirk): Mr. Chairman, on a point of order, I'm just wondering, earlier on in the committee when we were dealing with the Audit of the Pharmacare Program, you posed the question to the committee members as to whether or not there were any further questions and there was a no, which is, of course, the right of committee members. Can you tell me whether that was for Section 1–Audit of the Pharmacare Program, or did that also apply to Section 11 of the follow-up dated 2012, Pharmacare Program–Part 2?

Mr. Chairperson: My understanding was it was for both sections, but I could break them down and ask for that as well. But right now, it was, we–I asked for both of them together. There was a no on that, so

we'll bring them both back, unless there's further agreement to change that. Okay, thank you, Vice-Chair.

* * *

Ms. Bellringer: It's just a quick thing. Just in the original report on the value adds, we did have the purchasing policy at the back as appendix E. It has a lot of the information around the requirement for tendering. It's also got some reference to the agreement on internal trade, which drives a lot of the situations when, because of the agreement on–the interprovincial trade agreement, that that will require certain things to be tendered in a public way. So we did have a little bit of information on that right in the original report. *[interjection]*

That's the May 2010 Winnipeg Regional Health Authority–Administration of the Value-Added Policy. The follow-up report was referring to the status of those recommendations, but the original report did have some of the policy–the actual purchasing policy information in it.

Mr. Chairperson: Okay, seeing no further questions, does the committee agree that we have completed consideration of Section 10–Monitoring Compliance with The Ambulance Services Act, and Section 13–Winnipeg Regional Health Authority–Administration of the Value-Added Policy of the Auditor General's Report–Follow-up of Previously Issued Recommendations, dated January 12th–January 2012, pardon me?

Is there agreement? *[Agreed]*

This concludes the business before us this evening.

The hour being 10:44, what's the will of the committee?

An Honourable Member: Committee rise.

Mr. Chairperson: Yes, just before we rise, I'd like to just say I appreciate the attendance of everyone this evening, of all members, and if you could leave behind all of the books that you don't need tonight, it's just an opportunity to be able to reuse them in the future for the subsequent sections that we'll have to deal with. Thank you.

Committee rise.

COMMITTEE ROSE AT: *10:44 p.m.*