E-47

ISSN 1181-6465

Legislative Assembly
of Ontario

First Session, 39th Parliament

Assemblée législative
de l'Ontario

Première session, 39e législature

Official Report of Debates (Hansard)

Wednesday 28 October 2009

Journal des débats (Hansard)

Mercredi 28 octobre 2009

Standing Committee on Estimates

Ministry of Health
and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

Chair: Garfield Dunlop
Clerk pro tem: William Short

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111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON ESTIMATES

Wednesday 28 October 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Mercredi 28 octobre 2009

The committee met at 1551 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Garfield Dunlop): We'll call the meeting to order. Minister Matthews, I want to welcome you back today, along with the deputy minister and everyone from the Ministry of Health and Long-Term Care. When we adjourned yesterday, Ms. Gélinas had 10 minutes left in her rotation for the third party. You can start today with the remaining 10 minutes.

M^me^ France Gélinas: I'm off of the headlines and I'm now into the nitty-gritty of health care spending. I would like to start with primary care. I don't know who does primary care, but be ready; I have a whole bunch of questions. The first one has to do with the rollout of the nurse-practitioner-led clinics. I know that the first one is in Sudbury. Everybody's very proud. Three more have been announced. How much money has been spent so far, and how much longer before we get to 25?

Hon. Deborah Matthews: Deputy, over to you.

Mr. Ron Sapsford: For the current fiscal year, there were, I think, 50 in total approved. The implementation is proceeding. I'll call Josh.

M^me^ France Gélinas: Josh, you're the lucky winner.

The Chair (Mr. Garfield Dunlop): Could you state your name, please?

Dr. Joshua Tepper: Hello. I'm Joshua Tepper, assistant deputy minister, Ministry of Health, serving under Deputy Sapsford.

We have currently announced another call for both NP-led clinics and family health teams. The applications have been submitted, and the ministry has had an opportunity to review them in conjunction with some input from the local health integration networks. We are in a position to make final recommendations to the deputy and to the minister in the very near future about possibilities for the next implementation.

In terms of the specific allocations in both the previous and what may be coming in the next wave, I'd have to get back to you with specific numbers on how much has been spent on the NP-led clinics.

M^me^ France Gélinas: I would appreciate that. You said your review will be finished soon, and you will be able to make recommendations, I guess, to your minister. What kind of timeline are we looking at before announcement?

Dr. Joshua Tepper: That's at the privilege of the minister.

M^me^ France Gélinas: Okay. Any idea?

Hon. Deborah Matthews: It would be premature for me to speculate on that.

M^me^ France Gélinas: Fair enough. I would appreciate the numbers. The request for proposal that went out was for 15 new ones?

Dr. Joshua Tepper: Of the family health teams and the NP-led clinics, that's correct.

M^me^ France Gélinas: Fifteen of each?

Dr. Joshua Tepper: No, no. Sorry, let me just get the numbers exactly right for you—for eight additional nurse-practitioner-led clinics.

M^me^ France Gélinas: Okay.

Dr. Joshua Tepper: And we received applications and they've been reviewed.

M^me^ France Gélinas: And did you receive more than eight applications?

Dr. Joshua Tepper: Yes, we did.

M^me^ France Gélinas: Do you feel confident you will make recommendations for all eight?

Dr. Joshua Tepper: Yes, I do. I know we will.

M^me^ France Gélinas: Okay. Of the three that were announced before, can I have numbers as to how much money has been transferred to them?

Dr. Joshua Tepper: Yes.

M^me^ France Gélinas: Thank you. If I can have it by total amount as well as categories of staff that have been funded, I would appreciate it.

Dr. Joshua Tepper: Sure.

M^me^ France Gélinas: Thank you. Do you foresee doing another round? When are we going to get to 25, I guess?

Mr. Ron Sapsford: That part that is tied up in our fiscal estimates for the next year, so the announcements that have been made are within our capacity for the current fiscal year. Then future expansion will depend upon our budgeting process for next year.

M^me^ France Gélinas: Are we still committed to 25 within this mandate, as in, this government's four-year mandate?

Mr. Ron Sapsford: The current expectation is we'll complete that work, yes.

M^me^ France Gélinas: Okay. Thank you.

Hon. Deborah Matthews: Maybe I could just add that a clear priority for us is better access to primary

health care, and the nurse-practitioner-led clinics have shown—I think you'd agree—in Sudbury that it really is an option that works.

I actually have a nurse-practitioner-led clinic in London that's done in partnership with the university. It's quite an interesting model too. I, too, have seen first-hand how the care provided through nurse-practitioner-led clinics can really serve an important need in a community. So I'm committed to the model, and we're working to maximize the skill set of the nurse practitioners.

M^me^ France Gélinas: Very good. Thank you. That's all good news.

Now to community health centres and AHAC. The 21 new community health centres and 15 satellites: How many of them are up and running and how much money has actually been transferred to those?

Mr. Ron Sapsford: I can get that information for you.

M^me^ France Gélinas: Thank you.

I realize you're new, and if you're not comfortable you can tell me, but is there still a commitment from this government to have community health centres?

Hon. Deborah Matthews: Yes, absolutely. Again, I have one in my riding; I've seen first-hand the work they do for people who would have difficulty otherwise accessing the kinds of services they need. I actually have spent quite a bit of time at my community health centre. They recently built a satellite and are truly much more than a community health centre; they really are the hub of the community. They have a community kitchen. Our youth outreach workers, actually, through the Ministry of Children and Youth Services—their home is in the community health centre. The value, particularly for marginalized people, is immense. We know that people who face economic challenges also have unique and high health care needs, so reaching out to those people, being there for them with the services they need, is absolutely something we want to continue to do.

M^me^ France Gélinas: I'm really pleased to hear you say this, and I'm pleased to see the level of knowledge that you bring to your portfolio already. Congratulations. You're doing well.

Hon. Deborah Matthews: Thank you.

M^me^ France Gélinas: There are some issues with community health centres, one of them being the funding of physicians. The funding model used to be straight salaries for physicians; it is now a blended salary and incentives, which is causing the model of community health centres a lot of headaches. This new funding model for their physicians does not work for the interdisciplinary team and the type of work that they do. Is there a willingness within the ministry to change that and bring the compensation for physicians back to straight salaries?

Mr. Ron Sapsford: Yes. The ministry has been extremely flexible on funding models for physicians, as you probably are aware, all the way from fee-for-service to models that are full salary. In many cases, however, it's dependent upon the physicians involved as to what model they prefer to work in. So the ministry is certainly open, or we don't have a specific, rigid policy position on that. We're more interested in looking at models that work and in bringing the greatest amount of medical attention to patients. That's something we would certainly be open to.

1600

M^me^ France Gélinas: If the OMA group that represents CHC physicians wants to change their remuneration back to straight salaries rather than salaries and incentives, this is something that they could bring directly to you?

Mr. Ron Sapsford: Yes, provided it doesn't come at a huge cost. There's always something to talk about when you change models, but yes, in principle I think that's a fair thing to do.

The Chair (Mr. Garfield Dunlop): A minute and a half left, France.

M^me^ France Gélinas: You'll come back to me, though, right?

The Chair (Mr. Garfield Dunlop): Yes, we'll come back. You'll get two more rounds today.

M^me^ France Gélinas: That always stresses me out.

Can I have a list of the funded positions in CHCs, as well as how much money was spent on physicians, nurse practitioners etc.? Of the money that you transferred to CHCs, how much was for the different categories of professionals and other staff?

Mr. Ron Sapsford: As summary information—total CHCs, and then total RNS, or whatever the case may be?

M^me^ France Gélinas: That's correct. And if they come by LHINs, you can give it to me by LHINs; I'll put it together. If they come ministry-wide, I'm happy to see them all together.

Mr. Ron Sapsford: Okay.

M^me^ France Gélinas: And the last-minute question on CHCs is: The level of funding right now does not allow them to provide pensions, which becomes a huge recruitment issue. For some of the professionals—if we think about dietitians, dietitians make way more money in hospitals, and they also get a pension plan through HOOPP when they join the hospital. They're having a tough time recruiting and retaining them because of that issue, as well as many other staff. There are interdisciplinary dietitian teams that are being set up more and more in hospitals rather than in the community because of that unbalance. Has the ministry looked at ways to bring community health centres on an equal footing so they can afford pension plans for their staff?

Hon. Deborah Matthews: I can tell you that this is an issue that is new to me. I'll see if my deputy has any insight to bring to this.

Mr. Ron Sapsford: I think that as one looks at the health system in the broadest sense and in the long range—we look at options for transformation in the health care system, so better integration, more seamless movement of patients across a variety of providers. One of the issues that comes up when one is looking at human resources planning is this particular issue. The ministry has spent some time trying to understand the dynamics of the issue. We're not in a position of finalizing positions or have a

specific policy position to take forward, but I could say that we're well aware of the issue and have spent some time trying to understand, as you've suggested, what the impact of those differences or those variations across the health system means for moving the health system forward in a more integrated fashion.

The Chair (Mr. Garfield Dunlop): Thank you very much. We'll now go to the government members. Mr. McNeely.

Mr. Phil McNeely: Thank you, Minister, for being here today. You went through your presentation on the wait times website the last time we were here, and I thought that was quite good regarding where we're getting to on wait times.

In 2003, maybe in 2004, we had a report—I don't know what the institution was that made the report—that showed that the wait times in Ottawa were the highest in the province. I think the province at that time was broken down into 14 areas—the LHINs hadn't come on—and Ottawa had the longest wait times. And some of the members were asked, "Well, what is that to people who have been around a few times?" and they always said, "Well, Quebec." There was a lot of interchange with Quebec patients in the Ottawa area. I'm not quite sure what Quebec had to do with it, but in any case, it was a fact that we had less than one half of the MRIs in the province if we compared it to what Toronto had. Since that time, we've doubled our MRIs in Ottawa, so things have gone well. We've had expansions at the Montfort, at the Ottawa Hospital, at the Queensway Carleton and at the Civic part of the Ottawa Hospital as well.

One of the issues I feel needs a lot of work or dollars is the avoidance of our seniors who need care getting into acute care beds in hospitals—that's what has been identified. I don't know the issues that well, but that's what has been identified by our hospital leaders as one of the big issues they have to deal with. "Who gets the long-term-care beds?" That is often the question we hear. The hospitals may be last to get their patients moved to long-term care or some other level of care where they could open up that hospital bed. I think you mentioned that 18% of the beds in hospitals are beds that are occupied by people who probably shouldn't be in the hospitals, that acute care that they were getting—they're past that stage and they can go out to another level of care, whether it's care at home or care in the community or long-term care.

I think you also mentioned that some had pilot projects going on where nurses were meeting these patients as they arrive at the hospital and trying to see what level of care, what institution, where should they be going, and trying to give the—I suppose the level of care gets where it can't be handled anymore, and what is the option? It's to phone the ambulance, and the person often ends up at the hospital.

Better use of the long-term-care beds has been an issue, as well: whether the right people are in the long-term-care beds, or are they getting there too early? When they compare us to other provinces, I think I saw in the auditor's report that our patients may be staying longer in long-term care, which may be an indication that they're getting in too soon. This is a very difficult issue, of course.

So the pilot projects—I think the Queensway Carleton is doing that. They have a nurse who is trying to help move these patients to other areas of care, if that's possible. What do you see going forward for that?

The LHINs are looking at different projects for the aging-at-home strategy, which is a big investment we've made. We had some projects in our own area, where they were working with the local resource centres. How much can be done? How do we unblock that problem the hospitals have? What do you see as the way of moving these people to the right level of care faster and not tying up our acute care beds?

Hon. Deborah Matthews: Thank you very much for your question. I think I'll take a shot at it and then happily will turn it over to others who can add more detail. I think you've really described what the thinking is behind the development of the LHINs, which is the integration, right? It's putting the "I" in the LHIN, getting those services to hospitals, the other services available in the community, be it home care or Meals on Wheels or transportation to appointments or housekeeping services or visiting services—integrating the services in the community to really wrap around the person who is needing to use the health care system. I'm really proud of the work that the LHINs have been doing because they really have brought together so many of the previously uncoordinated services and wrapped them around the patient and the patient's family. The family, I think, is an important part of the care plan for people, particularly people who are aging or people who are recovering from surgery or whatever. I think so many of us now live far away from our families; our families are smaller, so we really need to maximize the community supports that are available, to be there for people when they need them.

The emergency room and ALC strategy that we spoke about earlier is really trying to address the issue that you've raised: Are we giving people the right amount of care in the right place at the right time? I think we would all agree that we can do better. We've made some big strides, but I still think we can do better.

1610

As we move forward, bringing down those emergency room wait times—we're not going to be able to do that unless we actually address the issues that you've raised about having adequate numbers of beds for people in long-term-care homes and also transition beds. People might not need to move into long-term care, but they don't need to be in the hospital either, so providing those services. I think there are some terrific examples in different communities where, through the LHINs, the CCACs and the hospitals, everybody really is working together to address this issue.

Of course, as our population ages, this situation is going to become more and more acute, so we'd better get it right now if we want it to be there in years to come.

I'll now turn it over to my deputy to add or anybody else.

Mr. Ron Sapsford: In the question and the minister's answer, I would start by simply underlining the fact that there is no one single solution or one single area that can solve the problem entirely. The strategy that's been put forward is to invest in a whole variety of areas which together will improve the overall operation of the system.

We're focused initially, because it's a symptom of the broader system problem, on emergency rooms and wait times in emergency rooms. There, there's been money devoted to helping hospitals manage their flow to help them reorganize the way in which they manage emergency department patients. The ministry's funding has provided them incentives to actually bring their wait time numbers lower. We're beginning to see some improvement as a result of those strategies. Those are directed inside the hospital.

On the outside, there have been investments in additional nursing staff, particularly with respect to long-term-care-home residents. Oftentimes an elderly person in a home will become ill with a undifferentiated problem, and in the past the response has been to call the ambulance and send the person to the emergency department. Many, many times, the patient could be managed better in the home, and so sending nurses who have expertise in geriatric care out to the homes to assist in the care of the resident and also to support the team in the nursing home or in the long-term-care facility removes the need to actually move people from one facility to another.

Other areas of investment are in community support services, so if there were better alternatives in the community to keep people at home as opposed to in an institution, that's a better quality of life for individuals. The minister talked about a number of the initiatives. Some of them include increasing the hours of care that are provided by the home care program both in terms of professional support as well as homemaking services. Those hours, for instance, have increased from 80 to 120 hours in the first 30 days and from 60 to 90 hours of care in the subsequent 30 days. So a broader scope of services as well as the amount of time that someone could be under care at home are both ways to allow more care to be provided in the home.

In the aging-at-home strategy, a whole series of other initiatives are really coming from the health care system as opposed to the ministry putting forward these proposals, where local health integration networks have sat down with their providers and really thoroughly tried to assess what kind of program or service we need to have in place to allow people who need care in the community, what would help. We've had over 240 proposals submitted, and I believe about 200 of them are either funded or are in the process of funding. So resources were put forward by the government to address those kinds of creative initiatives. Examples of those are Home at Last, which provides a unique mix of services to support that individual in the home. There's another program called Home First. Rather than make the notion that if you're admitted to an acute care facility and need continuing care, automatically you're going to long-term care, let's first try Home First, then subsequently, if care in a long-term retirement residence is required, make the decision not in the acute care facility, but from the home. That's another approach to try to alleviate the pressure on hospital acute care beds.

The other area I've mentioned—there are many others—is that the ministry has supported the opening of interim long-term-care beds, so that where we do have some capacity, those beds are being opened. Those decisions are being made by local health integration networks. The ministry's only condition is that it complies with the requirements of the Long-Term Care Act, but funding is being used for that. The other area that we're looking at is supportive housing and expanding the stock of supportive housing as opposed to long-term-care beds or additional acute care beds.

Taken altogether, as I've said, there are a number of initiatives aimed at different parts of the health care system, but all aimed at shifting the burden of care from institutions into the community so that people can live longer in their own homes and the required care is brought to them, as opposed to moving them into institutional facilities.

Mr. Phil McNeely: That's interesting, because we have a project just in the development stages now. We have the Orléans Urgent Care Clinic, and I think something like 20 doctors share the time there. They do about 40,000 procedures a year. I think they're these emergency procedures like fixing broken bones, taking stuff out of eyes and sewing people up—class 4 and 5 of the emergency procedures, they've told me; I'm not quite sure. But they do that and they do it very efficiently.

They built the clinic 15 years ago, and they're doing very well. They're taking a lot of the load off the Ottawa Hospital and off the Montfort Hospital in our local area. We've got this project, the hub, that I'll have to be talking to the minister about, but about half of the hub would be the Orléans Urgent Care Clinic way of doing things and then a new family health team that was approved last year, which is just getting under way now. Tied into that would be day surgery, possibly dialysis and possibly some cancer treatment. That would all be in one facility to try to get it away from the big hospital concept to a local community project and have these services delivered in the community. This would be something that we'd really like.

One of the issues—and I'm not sure that you can answer. You probably can't answer it today. I think there are maybe one or two others like the Orléans Urgent Care Clinic in the province, but it's very successful in our area and we'd like to see it continue. We think there's value for dollars there. Comparisons have been made for these class 4 and 5 emergencies, the comparison of cost in the clinic and cost in the hospitals. It hasn't been refuted; it was maybe a third of the cost in the community. It's working well and we'd like to see that continued.

One of the problems is that the doctors—and I understand that the OMA sets the rates, doesn't it? Those rates are negotiated with the Ministry of Health and Long-Term Care, and they've had difficulty getting resolution to that. But I just feel that that would be a good direction to go in. They have been very successful for 15 years. They like the independence, they still work at hospitals, but they get paid much more at a hospital or other facility than they do in their own clinic. It just means they have a hard time attracting doctors. The Minister of Health and Long-Term Care came in a year and a half ago and solved our issue, and they're still working very well, but I would leave that with you if you don't have specifics on it. It is something that is working well in health care in our area, and I'd like to see them getting paid sufficiently so that they can keep doing it. I'm not sure if you're aware of the specific issue.

1620

Mr. Ron Sapsford: Well, not to—

The Chair (Mr. Garfield Dunlop): About four minutes, Deputy, on the answer.

Mr. Ron Sapsford: Oh, I'll speak fast. The physicians started a model of care—and I don't dispute the value of it—levels 4 and 5, and I think in some cases they're treating level 3 patients as well. Their model has outstripped the funding mechanisms that were available to physicians in that practice, and that was what led to the questions to the ministry. As I understand it, we have provided funding that will take them through into the middle of next year. But I take the point. Something has to happen if the model is to continue.

Most of these sorts of programs that do exist are often affiliated with hospitals. One I'm familiar with is the Stoney Creek Urgent Care centre that's operated by St. Joseph's Healthcare Hamilton, which is a very similar model. They're taking care of levels 4 and 5. Where patients come in with more severe conditions, they're referred on to hospital, but they certainly do provide a lot of primary and low-level secondary care. So I think the model is worth looking at.

The issue we've had is that we've never had a particular funding model that would apply to independent groups of physicians who choose to set up that kind of care, but we'll continue to work with this group of physicians to try to find a resolution.

Mr. Phil McNeely: And if our project's successful, they will be affiliated with the Montfort, so that may resolve itself. I understand additional funds can come in under that program.

Have we got a couple more minutes?

The Chair (Mr. Garfield Dunlop): You've got a couple of minutes left right now, yes.

Mr. Phil McNeely: Does anyone else wish to be involved?

Mr. Charles Sousa: Yes. Thank you, Minister, for being here as well. In my riding of Mississauga South, I've got a couple of great hospitals, Trillium Health Centre and Credit Valley Hospital. Both of them have done a tremendous job of expanding and increasing, and there are some challenges with that. Maybe we can talk about that later on, but right now, I wanted to—and you've spoken about the wait times. We've spoken a little bit about the aging-at-home strategy.

In my riding, we have a very mature community, many more seniors coming on board. There are two areas. One is the care practitioners and nurses, the issue of quantity of care versus of quality of care. Maybe we can expand upon that. The other one is attraction of doctors in the communities generally and the shortages that seem to be evident in some communities. What are we doing, then, to facilitate the attraction of doctors in medical schools—I know we're doing something in Mississauga—and the issue around accreditation for those international graduates?

The Chair (Mr. Garfield Dunlop): Deputy, you've got about a minute left to answer this.

Mr. Ron Sapsford: We're doing many things, starting with the increase in medical school enrolments, so a commitment to an additional 100 positions, approvals for the University of Toronto medical school to expand into Mississauga. I think there are—don't quote me—58 positions in the undergraduate complements. Over a period of time, there will be several hundred medical students operating out of that campus of the University of Toronto.

We've changed some of the policy around international medical graduates. I believe it's over 200, maybe 225 of positions that are reserved for international medical graduates to upgrade their training as is required by the evaluations they go through. So we've had a number of new international medical graduates licensed in Ontario, and they're out now in the field practising.

There have been several initiatives that are well under way. There are more to come, particularly in the case of Mississauga. The role that those two hospitals will play in the training of new medical undergraduates will be, first of all, a new role for them and, secondly, quite an important role.

The Chair (Mr. Garfield Dunlop): Thank you very much, Deputy and Mr. Sousa. We'll now go to the official opposition: Ms. Witmer.

Mrs. Elizabeth Witmer: Before I begin, I want to personally extend my congratulations to the minister. As a former minister, I'm sure you've no doubt discovered this is a huge ministry, tremendous responsibilities, but you have the opportunity to work with some fine people and I just want to personally wish you well. I have no doubt you'll do a great job.

I would like to read a number of questions into the record, and I want just to state up front that I don't wish that the minister or her staff would respond to these questions at this time. Rather, I'd like the minister to respond to the questions by submitting answers in written format to the committee members at the earliest possible convenience. However, I will also be posing some questions to which I would like responses today, so I put that up front. Perhaps I'll begin with some of the questions where I know you're not going to—I say that based on knowing that you can't be prepared for everything,

despite the fact I had at least one critic who I think thought we all had it up here somewhere, but it's not possible in health.

The first one is related to polling. I'd like this committee to be provided with a list of all polling that has been conducted or commissioned by the ministry since 2008, including the following: the data and results of the polls; the dates of the polls; the purpose of the polls; the firm contracted to execute the polling; and the amount of money that was paid for the polling. I would also like to have this committee provided with copies of all reports, memoranda, briefing notes and invoices related to all focus group discussions commissioned by the Ministry of Health. So those questions relate specifically to polling and focus groups.

The second question that I have—again, I'm just looking for a written response to the committee—relates to internal audits. I would ask that you would provide this committee with all final reports completed by Ontario's internal audit division which have been submitted to the Deputy Minister of Health since 2003.

Next are questions related to emergency departments. I guess you're going to have a similar challenge to what I had. We used to have the flu and that's why we introduced the universal flu vaccine, but you've got a huge challenge on your hands with H1N1. Anyway, the questions that I would like prepared for the committee are as follows: if you could provide the committee with a list which details the number of ALC days in each LHIN for every year since 2003; secondly, if you could indicate how much funding from the aging-at-home strategy has been distributed by Ontario's 14 LHINs, and if you could break that down and show how much has been distributed by each one of the 14 LHINs.

The third question here is if you could provide a list which outlines all recipients of the aging-at-home funding, and again, if you could separate that by the LHIN and by the year, and also the projects that the money was used for; and if you could, as well, provide a list which outlines the emergency department wait times for each hospital in Ontario by month since 2003, and again, if the information could be separated out by the 14 LHINs.

The next question: Which communities are being currently consulted about introducing an urgent care centre by the Ministry of Health?

The last question under this category: Which emergency departments in Ontario is the Ministry of Health considering transforming into urgent care centres?

Now I want to go into the questions that are related specifically to local health integration networks. The first question—again, I just want a written answer for the committee—is if you could provide us with a list of all the consulting contracts handed out by Ontario LHINs since 2006. This list should include which firms or individuals received the contracts, how much they are valued at, and whether they were tendered using a competitive bidding process.

1630

I do have a few questions here that I'd appreciate a response to. My first question—

Mr. Ron Sapsford: Is this more of the written, or do you want to go to—

Mrs. Elizabeth Witmer: I'm going to ask you for a personal response, Deputy.

Mr. Ron Sapsford: Okay, if I might just clarify. I followed all of the questions, and the only one I'll flag immediately—you asked for wait times by emergency department from 2003.

Mrs. Elizabeth Witmer: Yes, right.

Mr. Ron Sapsford: The difficulty there will be that we didn't have that information as far back, but what I could commit to do is certainly provide whatever we have.

Mrs. Elizabeth Witmer: That's fine; sure. Obviously, if you don't have the information, you're not able to provide it.

Mr. Ron Sapsford: It wasn't recorded that far back.

Mrs. Elizabeth Witmer: That's right. I understand, and thank you.

So my first question is one related to the LHINs. I just wonder, Minister, whether you consider the position of chair of a LHIN to be a part-time or a full-time position.

Hon. Deborah Matthews: I have to tell you that I don't know whether that is considered a part-time or a full-time job. Obviously, the CEO is a full-time job, so I'm just not aware of how that is structured.

Mrs. Elizabeth Witmer: Do you wish to answer that, Deputy?

Mr. Ron Sapsford: Whether I thought they should be full-time or part-time?

Mrs. Elizabeth Witmer: No, do you consider the position of chair a full-time or a part-time position?

Mr. Ron Sapsford: There are both at the moment. Some chairs are considered full-time and others part-time, so we have a mix of the two. Whether one should opt for one or the other is, I think, where your question is, and I don't have a particular view on that. The policy at this moment is that both can coexist.

Mrs. Elizabeth Witmer: So why would one chair of a LHIN, since they all have similar responsibilities, be considered part-time and one be considered full-time, if the responsibilities of the 14 LHINs are supposedly identical? I guess I don't quite understand why some would be full-time and some would be part-time. Are they not all being reimbursed the same amount of money?

Mr. Ron Sapsford: Well, they're reimbursed on a per diem amount, I believe—

Mrs. Elizabeth Witmer: I'm sorry?

Mr. Ron Sapsford: A per diem amount. I think some view their role on the community engagement side. If you remember, they're relatively new, so I think at the beginning, the initial appointments of chairs of LHINs, because it was a start-up, and there was a feeling that they needed to get to know their communities and to develop those relationships—so the role of the chair would be more geared to developing those relationships with other providers. Some felt that that required more time than perhaps others who use different techniques of engagement with their communities.

So it really came from the start-up phase of that. Now we're three years later and I suppose it's a question that could be asked as to whether there's a need for that particular style into the future. But I think it had more to do with the notion of start-up as a new agency. Its clear role was to develop working relationships with a broad array of health care providers, both deliverers of service as well as boards of governors of a variety of agencies. That was felt to be important to establish the relationship, and that it would take longer, and hence more time.

Mrs. Elizabeth Witmer: I think you've indicated that they are paid a per diem as opposed to a salary.

Mr. Ron Sapsford: That's my understanding, yes.

Mrs. Elizabeth Witmer: So the remuneration, then, would be dependent on the amount of time that they would claim to be on LHIN business.

Mr. Ron Sapsford: That's right.

Mrs. Elizabeth Witmer: Okay. When we take a look at the fact that financially, everybody is tightening their belts—and certainly we are asking hospitals to tighten their belts; the LHINs have asked them to tighten their belts, and we certainly know what has happened to some of our hospital CEOs when belts haven't been tightened fast enough—would you agree that board members of the LHINs should also show similar restraint in their own personal expenses?

Hon. Deborah Matthews: Yes.

Mrs. Elizabeth Witmer: What type of expenses do you think would be allowable?

Mr. Ron Sapsford: The expense allowances would be defined in the accountability agreements, I'm quite sure: so the normal costs of business, travel expenses, accommodation where that's necessary; for instance, if they're holding a meeting in a part of the area where they don't reside. Beyond that, expenses directly related to their role and function as directors of the LHIN would be the policy position.

Mrs. Elizabeth Witmer: And would that include conferences here or in the United States?

Mr. Ron Sapsford: Certainly here. If there's a meeting in Toronto where they're gathering together, then the expenses of travelling would be included; correct. Management Board put out some directions earlier this year about managing discretionary funds more tightly, as you've suggested. One of the ways one does that is through restricting travel and those sorts of things.

So that information was provided to all our agencies. I wrote to them all, actually, in the spring with the notion of tightening up on discretionary expenses, including travel, and I would expect all of the LHINs would have responded to that.

Mrs. Elizabeth Witmer: All right. I'm now going to turn to nursing. I don't think you can provide me with the response to the question I have, but I'd just like to know how many baseline hours of nursing care or services were provided by registered nurses, registered practical nurses and personal support workers in each of the years 2007-08, 2008-09 and this coming year, 2009-10. I'm looking for the baseline hours of nursing care that were provided by each one of those groups of health care providers for those three years. You don't have to answer that—

Mr. Ron Sapsford: Across the whole health care system?

Mrs. Elizabeth Witmer: Yes.

Mr. Ron Sapsford: Or within a particular program?

Mrs. Elizabeth Witmer: No, within the whole system, if anybody has any idea: hospitals, long-term care.

Mr. Ron Sapsford: I'm gasping.

Laughter.

Mrs. Elizabeth Witmer: Home care.

M^me^ France Gélinas: Physicians' offices.

Mr. Ron Sapsford: I can say that in certain areas, yes, probably we could. In other areas, because we don't have the same information system, perhaps not. But we could do our best to gather it.

Mrs. Elizabeth Witmer: If you could do that, that would really be appreciated.

I'd actually like to turn to home care. Again, I don't believe that you'd have these, so you can bring them back to the committee, but simply: What is the total amount of money that is spent on CCAC administration costs, including case management?

Secondly, what are the cost projections for growth in the public CCAC home care sector in Ontario for fiscal 2010-11? How much money does each LHIN receive?

Next, how much of the total aging-at-home funding has been used to enhance home care service volumes for Ontarians through funding transfers to the CCACs, and what was the percentage and total of CCAC funding used to service acute care discharges, including emergency room discharges in 2007-08 across the province? And what was the percentage of CCAC funding used to service referrals from family doctors in those same two years, 2007-08?

1640

This one is important, as we look forward to—if indeed the government does go ahead with the HST. Will the government allow a point-of-sale rebate for the HST for Ontarians who purchase home care services above volumes determined as eligible by the CCAC system? Maybe you would have an answer to that one verbally. No?

Mr. Ron Sapsford: No. I do have the one about expenditures by LHIN for 2009-10, on page 115 of the estimates. It's laid out clearly, LHIN by LHIN, what the estimates are for the current year's expenditures, with a comparison of the increase over last year's estimates. There is about a $586-million increment, so their total expenditures are about $20.917 billion. That information is in the estimates.

Mrs. Elizabeth Witmer: It's contained in the estimates on that page?

Mr. Ron Sapsford: Yes. I think one of your questions was about 2010-11.

Mrs. Elizabeth Witmer: Yes. Looking forward, what are the cost projections for growth in the publicly funded CCAC home care sector?

Mr. Ron Sapsford: That would be the subject for our next budget period. Beyond a general sense of what an increment might be, I couldn't be precise about that.

Mrs. Elizabeth Witmer: Okay.

Mr. Ron Sapsford: But for most of the rest of it, we'll do our best.

Mrs. Elizabeth Witmer: Okay.

Mr. Ron Sapsford: The question of HST?

Mrs. Elizabeth Witmer: Yes, whether you're going to allow a point-of-sale rebate for the HST.

Mr. Ron Sapsford: We would have to consult with finance on that. They're managing all of the exceptions. I think the general principle is that their current policy position is that exceptions or exemptions will be difficult. But if this is a particular area of interest, we can certainly consult and see what the position on that is.

Mrs. Elizabeth Witmer: There is certainly some concern by both the recipients and providers of home care services as to whether there's going to be an additional financial impact.

Mr. Ron Sapsford: Right.

Mrs. Elizabeth Witmer: The last one is about home care. Is the demand for home care—and I ask you this—exceeding the supply in Ontario?

The Chair (Mr. Garfield Dunlop): You have two minutes left in this round.

Mr. Ron Sapsford: Okay.

Hon. Deborah Matthews: Let me just try. I remember so clearly our 2003 election campaign, and going out and talking to people. I remember so clearly a gentleman I met in his home. His wife was very ill. She was in the hospital. He desperately wanted her to come home. He said: "I want to cook her meals. I want to bathe her. I want to look after her. I'm prepared to do that. But she needs more care than the number of hours she's currently allowed, so she's in the hospital. She's not happy, I'm not happy, and it's costing the system a lot more."

I think that's why we've increased the number of home care hours that are available for people. Just as a matter of principle, the right thing to do is to bring them home and let the families do their work. The limit on the number of hours of home care available really did present problems. So, as the deputy said earlier, we've significantly expanded the number of hours that people can have at home. I think your question is, would people like even more?

Mrs. Elizabeth Witmer: Yes, I'm asking, does the need for home care exceed the supply that we have in the province? I think, as MPPs, we're all contacted by people who are looking for support, and perhaps their loved one is forced to stay in the hospital longer because there is no support at home.

Hon. Deborah Matthews: And absolutely a real priority for us is to provide the supports at home, if at all possible. I think you would agree, having been Minister of Health, that "What is the need?" is often the subject of conversation. Some of the very, very difficult work that our CCACs do is assess how much need there is in a particular home.

The Chair (Mr. Garfield Dunlop): Thank you very much, Minister, and Mrs. Witmer. We'll now go to the third party. Ms. Gélinas, you've got 20 minutes.

M^me^ France Gélinas: You have agreed to give me the staffing levels for the different CHCs and the total amount of budget. Could I have this separated as to the 21 new ones and 17 new satellites, having their staffing levels separated from what exists in the current 52 that were there before, just so that we can—

Mr. Ron Sapsford: Differentiate.

M^me^ France Gélinas: Yes. Just have them as a second—the same idea: the staffing levels, the amount spent, but separate those two groups.

Mr. Ron Sapsford: I nod yes. What we will have to do to get that, I'm not sure. I'm almost certain we don't have it immediately available, so it may mean that we've got to go back out through the LHIN to the actual provider, get that information directly and assemble it. Just so you're aware, that potentially is the process we'll go through.

M^me^ France Gélinas: Okay. I know you provided that to me last year.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Okay, thank you. The next one has to do with AHACs, aboriginal health access centres. My opening question is the same: Is AHAC a model that you intend to keep in the future?

Mr. Ron Sapsford: Yes, the government policy remains committed to it. Aboriginal health service delivery is an important issue for the Ministry of Health, both in the north and in urban areas. We found the AHAC model to be very successful. It puts the governance and management of those kinds of services in the aboriginal community, and their results are very good, so I don't see any change to the current policy on that.

M^me^ France Gélinas: That's good news. You know that they're having issues with pay equity, where they don't get funded the same amount for the same practitioner, so the line budget for their nursing is not the same as you get in a CHC? This becomes even more of a gap when you talk about nurse practitioners. Is there any work within the ministry to bring parity to salaries of professionals, including specifically nurses and nurse practitioners?

Mr. Ron Sapsford: The ministry does not negotiate salaries and wages for these agencies. We provide the funding base, usually on proposals that they submit. Sometimes after the fact, people discover these particular problems. I want to make it clear: The ministry doesn't have a fixed policy position that all salaries are the same, because the individual providers are responsible for the hiring and management of their own staff and their own salary administration policy.

We are aware, though, that across the health system there are differences. As I said earlier, the whole issue of integration and how we manage cross-organization consolidation is a similar issue to this one. I'm aware of it. I don't have an answer for you that the ministry is moving

to correct a perceived imbalance, but certainly we're looking at those sorts of issues.

M^me^ France Gélinas: Thank you. My next line of questioning has to do with oral health and the $45 million that was announced to be spent to increase access to dental services. I want to know how much of that money has flowed and how long before the rest of it flows.

Hon. Deborah Matthews: Let me respond to this one. Again, the deputy may well add to that.

This is an issue that I have been focused on from my work in children and youth and on the poverty reduction front, because it is a component of the poverty reduction strategy.

Through the Ministry of Health Promotion, we've expanded CINOT up to age 18, and it now covers more procedures for children in need of treatment.

We remain committed to the implementation of dental programs for low-income kids. I think it's safe to say that we're continuing to work through some of the implications of that.

M^me^ France Gélinas: Deputy or Minister, any idea when the money will flow? There is $10 million that did go to CINOT. There's still $35 million out of the $45 million that was promised, but I cannot see any expenses anywhere within your ministry to show that this money has actually flowed.

I realize that there are five ministries that handle dental care. Is there a lead ministry, and is that you?

Hon. Deborah Matthews: Yes, the lead ministry for this program is the Ministry of Health and Long-Term Care.

M^me^ France Gélinas: It's the Ministry of Health? Can you answer my question as to how much of the money will flow?

1650

Mr. Ron Sapsford: The allocation for this year, whether it all goes this year, at the point we're at, I'm not sure. The second phase of the program required basically a new program intervention. Unlike CINOT, where we had an existing program and we're simply expanding the age, we're actually looking at different models of delivering the second phase of it. So the focus for most of this program will be on public health units, in some cases CHCs, but in many cases that involved creating space: dental suites, chairs and questions about how the allocations would be managed across the province to get a fair allocation. In some parts of the province, there were suggestions about travelling dental vans as opposed to people coming to a single location.

Those were some of the factors taken into consideration. Allison can probably tell us where the specific parts of the implementation are at this point.

The Chair (Mr. Garfield Dunlop): Your name, please, ma'am?

Ms. Allison Stuart: Allison Stuart, acting assistant deputy minister, public health division, Ministry of Health. In terms of this next phase of the program that the deputy was talking about, we have sent out to all of the health units a template for them to make a business proposal back to us in terms of how they would like to work with services that are in existence in their communities to address this need. Our expectation was that the feedback on these proposals would be in by the end of November. We're having to look at that just from a logistics perspective because of H1N1 and everybody focusing on that. If, however, they were able to get it in by the end of November, then the work plan has money being released this fiscal year.

M^me^ France Gélinas: Have some of the health units or maybe CHCs started to receive money so they can buy dental chairs and do that kind of work, or has none of the money flown?

Ms. Allison Stuart: The money has not flown—flowed—

M^me^ France Gélinas: Sorry.

Interjection.

Ms. Allison Stuart: —or flown—for the dental chairs and so on. That's part of what they'll be submitting back in terms of what equipment they need and want to address how they're seeing it happen in their community, and as the deputy mentioned, some may choose to go with a mobile van—those sorts of things.

M^me^ France Gélinas: So the answer to my question is, the money has not gone?

Ms. Allison Stuart: That's correct.

M^me^ France Gélinas: Okay.

Hon. Deborah Matthews: But if I could just add, on the same topic, as you know, I'm sure kids whose parents are on social assistance have dental coverage now, and I think that the initiative to move forward to dental coverage for all low-income kids is a major step forward.

M^me^ France Gélinas: Absolutely. I would like to extend it one more step to where adults with dental needs who are not on social assistance also get access. Is this in the cards at all, or is this something you—

Hon. Deborah Matthews: Let me just say that it's something that, of course, I would love to see, but it is not in the fiscal plan at this moment. But as you know, in our poverty reduction strategy, we're committed every five years to going back to develop new initiatives—or the government of the day will go out and consult—and it may well be that that might be a component of a future poverty reduction strategy. But in this case, we are looking at better dental care for kids.

M^me^ France Gélinas: Thank you. My next question has to do with breastfeeding, and I understand some of it goes to the Ministry of Health Promotion but some of it comes to you as well. I know that the Ministry of Health Promotion is working with the health units to start developing a breastfeeding strategy, and I'm hopeful, anyway, that it has happened. Has the public health unit been contacted? What stage of the process are they at? Are there resources allocated to roll out a breastfeeding strategy in Ontario?

Hon. Deborah Matthews: That is in the Ministry of Health Promotion, but I do want to commend you for your advocacy on this issue. I know you've been

speaking to that since you were first elected, and I have a feeling you won't be stopping any time soon.

M^me^ France Gélinas: Yes, and not going anywhere fast.

If it was the health units going ahead with implementing a strategy, the money would come from health promotion; it wouldn't come from health?

Hon. Deborah Matthews: That's correct.

M^me^ France Gélinas: That's correct? Okay.

I'd like to know: Will the funding announcement for the late care nursing initiative for 2009-10—where are we at with this?

Mr. Ron Sapsford: I'll ask Dr. Tepper to speak.

Dr. Joshua Tepper: Thank you very much for the opportunity. A couple of things: In previous years, we haven't had the ability to evaluate the success of this program very well to assess its effectiveness. It has been a program that's been around for a number of years, as you know. But our ability to know what benefit it was having in what different sectors and how to improve it has been unclear from the evaluations to date. We worked with the sector and with the nursing representatives to develop a more robust evaluation system, with research expertise in the nursing field to develop that.

We then also looked at last year's program and made some better refinements to collect better data in the application process and then opened an application process online to the field. The application process has now been closed and we are in the process of vetting the applications and will be prepared in a short time to present to the deputy and then to the minister a list of possible recipients—institutions and the individuals within those institutions who could be funded through this program.

M^me^ France Gélinas: Can I have a list of the funding by agency for this initiative that has flow—I'm not using the right—

Dr. Joshua Tepper: In previous?

M^me^ France Gélinas: Yeah.

Dr. Joshua Tepper: Sure.

M^me^ France Gélinas: It's "flowed"?

Dr. Joshua Tepper: Flowed, yes. In previous years?

M^me^ France Gélinas: Sure. Thank you. I may need you again.

There are a number of reports regarding nursing. I know that the Ministry of Health and MTCU are reviewing a report that provides a potential work plan for a nursing education review. I wanted to know if I can get access to those reports. There are also the results of the Ministry of Health's HHR study that examines the supply and demand issues. Are those documents that you can share with us?

Dr. Joshua Tepper: You're correct. There are two separate reports. They were actually organized by the same nursing expert, Dr. Gail Tomblin Murphy from Nova Scotia, a recognized expert in this who has also done work nationally and internationally in this area. The education document was an extremely high-level scoping to assess whether there could or should be further work done to look more in depth at this area. The other document, which has been commissioned out of health alone and not jointly through the ministries, has not yet been completed. I believe I will have it probably by mid-November, in two weeks, for review. I've seen a preliminary only at this time.

M^me^ France Gélinas: Are you at liberty to share any of those reports with me? As well, are there any other reports that deal with nursing staffing numbers, either by classification or by sectors of Ontario's health care system that you could share—

Dr. Joshua Tepper: Within the province of Ontario those would be the two predominant ones, and mainly the one that will soon be received. Again, the one that was jointly commissioned through TCU and health is extremely high-level and was mainly done to assess whether or not—

M^me^ France Gélinas: But can I have a copy?

Dr. Joshua Tepper: We should be able to provide you a copy. I will work with my colleagues at TCU as well.

M^me^ France Gélinas: When the other one comes forward, is this a document that you would be at liberty to share?

Dr. Joshua Tepper: I believe so. I haven't seen it yet, so I would need to discuss it with my deputy.

M^me^ France Gélinas: Okay. Let me know one way or another if you can share it.

Dr. Joshua Tepper: Absolutely.

M^me^ France Gélinas: You may not want to go away.

Dr. Joshua Tepper: I may wish to go away, but I may not be able to.

Laughter.

M^me^ France Gélinas: All right. I don't feel really warm and fuzzy, but I'll keep on going.

The Chair (Mr. Garfield Dunlop): You have five minutes left.

M^me^ France Gélinas: The number of nursing positions that were created in 2008-09: Can I have that number?

Dr. Joshua Tepper: Absolutely. If you give me 30 seconds, it's right on the seat. But I can give it to you broken down. I have it with me.

M^me^ France Gélinas: And can we have it for what has been created so far in 2009-10?

Dr. Joshua Tepper: If you give me 20 seconds, I can get that for you.

M^me^ France Gélinas: And while you're at it, any projections for 2010-11 and how many of them will be full-time.

1700

Dr. Joshua Tepper: To your last question, it will again depend on the fiscal situation and the allocation of funds, so that would be harder for me to speak to. If you give me 20 seconds, I can answer the first two.

M^me^ France Gélinas: All right. Do you keep track of how many nursing positions are full-time?

Dr. Joshua Tepper: Yes, we do. We do that in a number of different ways. One is through the college of nurses database, which is available online. Actually, it's a

fantastic website and has a lot of data. We also are able to collect it through a series of other data mechanisms, sector by sector. We have both some full-time and part-time; some of it is reported by hours.

In response to your first question, in 2008-09 there was a total of 737 positions that were created. In 2009-10 to date, there are 410, but we are confident that we will, by the end of this fiscal year, meet the budget commitment to over 900.

M^me^ France Gélinas: I can look up the college of nurses website. I would be more interested in the numbers that you collect outside of the college of nurses on the number of full-time nursing positions.

Dr. Joshua Tepper: Again, as an overall percentage, I believe we are now at 64%, which is an increase from about 59% a few years ago. I can get you the RN-to-RPN variation in that number.

M^me^ France Gélinas: Sounds good. Thank you.

Dr. Joshua Tepper: My pleasure.

M^me^ France Gélinas: How much funding has been allocated to the new graduate full-time job guarantee this year, in 2009-10?

Dr. Joshua Tepper: It's approximately $78 million to the new graduate guarantee in this year.

M^me^ France Gélinas: And all of this has been spent?

Dr. Joshua Tepper: It will all be spent, because nurses graduate at approximately four different time periods during the year, particularly RPNs. The vast majority of RNs graduate in one springtime period; there are one or two smaller graduating classes. But RPN graduations are actually spread out quite consistently throughout the year, so what happens is, after they graduate, they actually have a period of time when they can take a few minutes or take a breath, recover from exams and settle down before they actually have to go through the process of applying and matching through the process.

Once they apply, they have up to three months of funding, so again, depending on when they graduate, how much time they choose to use before entering the program and then how much of the time allocated—some of them bridge much earlier, and some of them take the full time—the money will flow accordingly. The money is not fully expended at this point in time, but our prediction, consistent with each year of the program, is that it will be fully expended by the end of the fiscal year.

The Chair (Mr. Garfield Dunlop): You've got time for one quick question.

M^me^ France Gélinas: One quick question.

The Chair (Mr. Garfield Dunlop): You've got just about a minute left.

M^me^ France Gélinas: Then I'm just going to ask a whole bunch of questions that you can give me the answers to in writing. How many new FHTs are coming online? How many do we have now? How many have been approved? You've just had an RFP for how many?

What is the spending budget for the FHTs, the family health teams, that are operating right now? Here again, I would like it broken down by categories of workers: how much for physicians, how much for nursing, different types of nursing etc., the breakdown of the staff.

I would also like any documents on salary parity for the same professionals. Let's start with nurse practitioners: any document that talks to salary parity between hospitals, AHACs, community health centres, FHTs. Let's start with nurse practitioners and nurses. If I have those, I will be on the right path.

Are any nurse practitioners being paid through OHIP—through fee-for-service—or are they all on salary? They're all on salary? Okay. I would like to know the total number of nurse practitioners working and what sectors they work in and how much money we spend within those different sectors.

The last question is: Is the ministry interested in having nurse practitioners treat and discharge patients from in-patient facilities? That would require a change to the hospital act, I take it. Is this something that your ministry is considering or is interested in?

The Chair (Mr. Garfield Dunlop): Okay. Thank you very much. You've got those questions. We'll now go to the government members. Mr. Sousa, you've got 20 minutes.

Mr. Charles Sousa: We did talk a little bit about the doctors at the last go-round, so I want to expand a little bit more on the nurse practitioners. A number of the aging facilities, seniors' homes and so forth in my riding are operating well. They're certainly at capacity, and many of the families and so forth have expressed the desire to reassess and attract more of those nurse practitioners. It's not just a matter of the quantity of time they're looking for, but it's also that quality of time.

I guess, based on your stats, you have issues as to how long certain residents need their respective care, but of course everyone is different and every situation is different. I wanted you to elaborate, if you may, on the degree of attraction for these nurse practitioners and what we are doing to enable them to provide the appropriate level of care in those nursing homes, and then I can go on to something else at this point.

Hon. Deborah Matthews: Your question was specifically about nurse practitioners in long-term care homes?

Mr. Charles Sousa: Correct.

Mr. Ron Sapsford: There currently isn't a complement per se of nurse practitioners in homes. I think where they tend to be used is on the hospital side, sending nurses out to long-term care homes when people get sick, as I said earlier. That generally requires an advanced skill in nursing, and to the degree that we have registered nurse practitioners with geriatric specialty or sometimes internal medicine, these would be the nurses that would be used for that particular purpose. I don't remember the exact allocation, but there were positions allocated based on the size of the area and the number of homes and so forth.

If you turn to the question of nurse practitioners in terms of the primary care questions, which is really more about where our formal nurse practitioner teams are

being put into place—the one in Sudbury was mentioned earlier—they're the model in terms of future placement and demand for service. We've tried to assess population and need in a couple of ways: first, obviously anecdotally, where we receive a lot of concern from communities about lack of access to primary health care practitioners. As well, the ministry started a program called Health Care Connect a year or so ago, which is a phone-in or online way for people to say, "I need a family practitioner," or "I need a primary care practitioner," and through nurses at the CCACs they're actually providing linkages with practitioners who are able to take on care.

We're also using that information community by community to establish where the greater need is. If in a particular community we have a lot of requests for referrals through Health Care Connect, that's another indication that this is perhaps a community where we need to put the next team, whether it's a family health team or a nurse practitioner team.

This new measurement tool is an active way to actually move people to care, but also to assist the ministry and the government in determining where the new ones which are in the budget going forward should actually be placed so that we can satisfy the greatest need.

I don't know whether Dr. Tepper has anything to add.

Dr. Joshua Tepper: There are perhaps two other things that I might add. One is that we've consistently increased the training positions. They've gone from 75 to 150 to 168 last year to 186 this year, and we'll be at 200 shortly. Just increasing the capacity and the number has been very helpful, but beyond that we've really worked hard to make sure that the educational program is preparing people and allowing people to be learning in their home situations or in their home communities, particularly in rural and smaller centres as well.

We have a grow-your-own nurse practitioner program which has been quite successful in allowing nurses to come from the local community to go back to school with financial support, with some support for backfilling and then to complete their training, which allows the community then not to feel their losses as deeply and also to have greater security that the nurses will come back. That's a bit of a first in Canada and has been quite successful.

1710

Finally, the deputy spoke in detail about some of the modelling. Ontario is also the only jurisdiction to have an NP-based HHR model. We used a national model and purchased it for Ontario, and then used Ontario-based data in order to run different assumptions, which has also been helpful working with multiple providers to understand better under different scenarios where we might have the best application and use.

Mr. Charles Sousa: Can you elaborate a little—sorry, Minister.

Hon. Deborah Matthews: I was just going to add that I think the position of nurse practitioner is one that is really gaining a lot of credibility in the sector. I think we've actually doubled the number of nurse practitioners. I think we have about 1,300?

Dr. Joshua Tepper: Just under 1,000.

Hon. Deborah Matthews: Just under 1,000 nurse practitioners?

Dr. Joshua Tepper: Primary care nurse practitioners.

Hon. Deborah Matthews: And nurse care practitioners in total? I'm sorry; I'm not supposed to be asking you questions here, am I?

Dr. Joshua Tepper: Friendly fire.

Hon. Deborah Matthews: We've really seen an expansion in the number of nurse practitioners, and as a result, I think that there are a lot of opportunities to continue to explore where a nurse practitioner can actually do the right job.

Mr. Charles Sousa: Can you elaborate also now a little bit on the patient safety initiative? I'm just wondering if the initiative is just about reporting infection rates on our website or on the government website, or is there more to it than that? Is it having an actual impact on safety? And do you have stats to back up the initiative?

Mr. Ron Sapsford: Yes. It's an important initiative, and I think the decision of the government to make the results of these safety indicators public is a great stimulant for hospitals, in this case, to look at the issues of safety. Not to say they haven't, but in any case, when you're reporting information, people pay a different kind of attention to it.

The safety indicators that were used—I don't remember all of them, but three of them were related to infections, such as ventilator infections in intensive care units and infection rates. Here they are: C. difficile; MRSA, which is methicillin-resistant staphylococcus aureus; the standardized mortality rate ratios, so death rates, which is a program managed by the Canadian Institute of Health Information—this is a national system of comparing death rates in hospitals; hand hygiene compliance; central-line infection rates—that would be patients in ICUs; the surgical site infection prevention rates; and the surgical safety checklist. Those are the nine identified areas.

There are standard best practices behind each one of these. So in order to get better results, it implies that the hospital has to take very specific actions. Many of these are well-researched, out of mostly US literature; I think it's the Patient Safety Institute, and in Canada it's a program called Safer Healthcare Now. These are the kinds of standards where one can show great progress in the quality of care and patient safety in institutions. Taken all together, it's not just publicly posting them; it's identifying what those measures are so that everyone is aware and giving hospitals and clinical staff the time to work on the process and the tools that are necessary to see improvements.

Just as an example, C. difficile rates, after posting a year or so ago, dropped markedly all across the province, and we're at a very low rate of infection now. I'm not aware of the details on each one of these, but we could certainly get the most recent results. But as I say, it's posted on public websites, so the detail is freely available.

Mr. Charles Sousa: Thank you.

The Chair (Mr. Garfield Dunlop): Mr. Ramal?

Mr. Khalil Ramal: How much time do we have left?

The Chair (Mr. Garfield Dunlop): Ten minutes.

Mr. Khalil Ramal: Ten minutes? Okay.

Welcome, Dr. Matthews. These are very important issues that we've been debating today, and thank you for coming before our committee to answer our questions and educate us on many different complexities and issues and on things you as the Minister of Health and the Ministry of Health have done since we were elected to office in 2003.

You talked yesterday about waiting times in the ER. As you know, many people go to the ER because they don't have a family doctor. Plugging the ER costs the system a lot of money. You spoke about initiatives that happened in London to make the whole thing faster and quicker. Are you trying to apply this model, which you already implemented in London, across the province of Ontario in order to speed up patient service?

I know my colleague on my right side here asked questions about family doctors and foreign-trained international doctors. You talk about the nurse practitioners who have taken many different initiatives and expanded their role to be able to do more work in many different communities, especially in the rural areas. What's your plan overall to speed up the procedures and apply it across the province of Ontario in order to reduce the waiting times more?

As you know, yesterday through your videotape you said that we've made a lot of progress on many different fronts, especially cataract surgery, hip and knee replacements, MRIs and many, many others. There are still many other procedures not being speeded up, and many people wait for months and years to be able to see a specialist doctor in order to deal with their issues and their concerns. What are you doing in this regard and how can you see it in the future being applied across the province of Ontario?

Hon. Deborah Matthews: First, let me make it clear that my doctorate is not a medical doctorate; it's a Ph.D. like yours. So just in case anyone thinks I might be able to perform any particular procedure, I can't.

Mr. Khalil Ramal: According to the law, I guess we can call you a doctor.

Hon. Deborah Matthews: Thank you.

The whole issue of wait times is fundamental to the confidence that people have in our health care system in Ontario. I am enormously proud of the health care system that we have built here, and the more debate I see about health care south of the border, the more I think Ontarians really value the health care system that has been built here since—when would we call the beginning of this health care system, OHIP in the 1960s? Yes? I just think that over the past 50 years, governments have made decisions that have served to either strengthen our health care system or let it deteriorate. As I see what's happening south of the border—and I think all of us are seeing stories about how people are not served by the health care system there—I just become more fiercely protective and determined to build confidence in the health care system here.

What I hear over and over again is that people are very, very pleased with the quality of health care that they get in Ontario. I hear over and over again—I'm sure everyone else does—that people got great care. The problem, though, was access to that care. It was how long they had to wait before they got the service.

As a government, we focused on improving wait times for five key procedures, and we have demonstrated beyond a shadow of a doubt that when a government makes that a priority where we actually measure our progress, where we actually show how we're going to measure our process and then publicly report on it and make the right strategic investments, we really can make a difference.

As a result, I think there is an enhanced confidence in the health care system. We hear less and less about privatization in Ontario, we hear less and less about moving to a two-tiered system, and I think it is in large part because people now have more confidence that the health care they need will be there when they need it. It has been one of the true successes of our time in office so far.

Having said that, we're not there yet. We have demonstrated that we can make measurable and quite dramatic improvement when we put our mind to it. We did expand our wait time strategy to include pediatric surgery. Again, as I look through the website—and I encourage anyone to actually do the same and to look at the website—I think we still have much to do when it comes to pediatric wait times. We've made good progress but we're not there yet.

1720

Tackling ER and ALC is really a very, very big step forward. You've talked about access to primary care. When people don't have a family doctor or that primary care, they do turn to the emergency rooms, because when they are sick, they need help. The fact that we've increased the number of Ontarians with primary care by 800,000—almost a million more people now have access to primary care than did before—clearly will have taken some pressure off the emergency rooms. But again, there's so much more to do. We've set a target of four hours as the length of stay in an emergency room—that's our target, that 90% of people will be out and headed back home within four hours of arriving at the emergency room—if they have a less complicated health issue. We've set eight hours as the target province-wide: 90% of people with more complicated health care needs will be either admitted to the hospital, if they need to be, or on their way back to home or somewhere else within eight hours.

A number of different strategies are required to make that work, to meet those objectives. We are starting to see improvements, but we have a ways to go before we get there.

I can tell you, we're committed to continuing to make the investments we need to do—investments in dollars and, more important, in the integration of services. The

fiscal reality is that this is not just a temporary situation. Moving forward, we're going to have to get more value for the dollars that we spend in health care and in other government services. So getting that integrated service, where patients get what they need when they need it, with the right combination of services, is really going to allow us to have a sustainable health care system.

I keep saying that as our population ages, the demands on our health care system are going to get much, much greater. So if we want the system to be there for our generation and for our children's generation, we're really going to have to make the right choices, the smart choices, and invest in the kinds of things that we've been talking about over the last couple of days.

The Chair (Mr. Garfield Dunlop): You've got about 30 seconds.

Mr. Khalil Ramal: I want to thank the minister for coming before this committee and wish her luck with her new portfolio. I think you're going to do an excellent job, and hopefully you can help us, as citizens of this province, and lead us on the right path.

Hon. Deborah Matthews: Thank you.

The Chair (Mr. Garfield Dunlop): Now we go to Ms. Witmer for 20 minutes.

Mrs. Elizabeth Witmer: Thank you very much, Mr. Chair. I would certainly agree: I think we do have an outstanding health care system in the province of Ontario. I think we should be proud of what different governments have attempted to do. I think everybody tries to do what's right on behalf of the people. But the costs and the aging population are going to create some stress as we move forward, and it will be a challenge.

I can remember my daughter having some American friends over one time. They'd come up for Thanksgiving and they were saying their system was so superior. I realized she had overheard me, because she gave quite a passionate defence of our system as opposed to theirs. But anyway, we'll all continue to do what we can. The needs, the demands, are there, and we'll move forward.

I have a couple of questions of you which I'll ask you to respond to verbally, and a few others. I have a lengthy issue that I want to deal with, and for most of those I would just ask for a written response.

The first topic I want to ask you about would be: When was the last time that the employees within the ministry were informed about their rights and protections under the whistle-blower legislation, or was that ever done?

Mr. Ron Sapsford: Yes, it would have been done at the time, because all ministries responded to that implementation. In terms of staff education, I know it's raised on orientation. We've had a couple of cases where, in fact, employees have resorted to that and it was dealt with effectively, so I know it has been used.

In the cases I'm aware of where the ministry was required to respond, we responded to the commissioner, I believe, and the problems were resolved.

Mrs. Elizabeth Witmer: I guess as a follow-up question, then, were the ministry employees asked at any time to share possible conflicts of interest? Would they be at any time asked to do that, or again, is that part of the hiring or—

Mr. Ron Sapsford: To my knowledge, not directly. I know that where people are called upon to make decisions where there might be a conflict, the expectation is that that would be declared, yes.

Mrs. Elizabeth Witmer: I ask the question based on the fact that as an elected official, whether it's as a trustee of a board, which I used to be, or as an MPP, and particularly in cabinet, you of course are made aware of the fact that if you have a conflict, you need to declare it. I just wondered if that happened within the—

Mr. Ron Sapsford: People who are in positions to make decisions where one would be concerned about those sorts of conflicts are well of aware of it. It's also an important consideration when people leave the public service—

Mrs. Elizabeth Witmer: That's right.

Mr. Ron Sapsford: —because that can give rise to potential conflicts on the outside. I know that in those circumstances, that's carefully documented and people are given guidance about what to avoid and where conflicts need to be declared.

Conflicts are quite a routine request to the deputy minister's office where employees are engaged in activity outside of work, and often the request comes, "Is this is a conflict?" or, "I would like to declare a conflict. What should I do about it?"

Sometimes it's not just a conflict but also the perception of conflict, so there are sometimes detailed instructions back to employees in those situations, not to say, "You can't do that activity," or, "Stop doing it," but, "If you're going to engage in it, here are the things you have to do when you're engaged in that activity." So the conflict piece is quite a common declaration.

Mrs. Elizabeth Witmer: Yes. And you're right. You mentioned the perception. Oftentimes, perception is reality. Thank you very much.

Now I'm going to turn to one of the topics that I would say has always been near and dear to my heart, and that is long-term care. I guess this is where we start to find some of the challenges with the aging population, the increased needs that they have and the complexity of the residents in long-term-care homes. I don't anticipate that you're going to be able to provide me with responses, but I am extremely interested in the responses. I would hope, and I have no doubt, that members of this committee are as well; certainly my colleague, who is now the critic for health. I'd appreciate it if you could respond in writing.

I just want to take a look at this year. Again, you can provide a written response. The ministry did find $43.5 million in its budget to partially address a five-year erosion in funding for housekeeping, laundry, maintenance and other services that help to maintain a long-term-care home's capacity to provide residents with the quality of care and the living experience that they need and deserve. I just want to ask the minister if she could

confirm that this funding is going to be retained in 2010 and beyond, or are homes going to be forced to reduce those services and increase the risks everywhere from infection control to the home's ability to provide the higher care levels required to move the patients out of the hospitals?

1730

Mr. Ron Sapsford: The $43 million that you mention was a one-time allocation.

Mrs. Elizabeth Witmer: So there's no guarantee for 2010, Deputy?

Mr. Ron Sapsford: The question will be put into our estimates process this year, and the decision then would come from the government's budget considerations. In the current year at least, apart from that one, there were also increases in the acuity fund, where money is allocated based on relative acuity, where, in some homes, you may have a larger group of patients or residents who need more care. There was a $40-million stabilization amount. There were also monies to annualize the increase for personal support workers that were put into place the year before and some additional money to increase the comfort allowance for residents as well. On top of that was the $40 million that you've mentioned.

Mrs. Elizabeth Witmer: The $43.5 million, yes. So I hear you say that there's no guarantee, but it would be something that you would put into your request for next year. Okay.

The next issue: I've asked about it before in the home care sector, but this new harmonized sales tax is going to add over $14 million in additional annual operating costs to some of the 360 long-term-care homes after the province's other tax measures have been accounted for. Basically, this is a new tax on the services provided to the 40,000 residents who live in the homes that are operated by the private sector. Because of the sector's funding framework, operators don't have any opportunity to recoup these additional costs. If they can't, we'll probably see service reductions in these homes—on average, perhaps one full-time position, I'm being told.

Will the minister commit to ensuring that the new tax does not create inequities in the service provided to residents based on whether they live in private sector homes or public sector homes and extend the MUSH sector protection to all the long-term-care homes, not just the public sector ones? I would hope your answer would be yes.

Hon. Deborah Matthews: Let me tell you that, of course, an HST question has to be referred to the Minister of Finance or the Minister of Revenue.

Mrs. Elizabeth Witmer: Right, and we haven't even passed the legislation yet.

Hon. Deborah Matthews: No, we haven't yet. I think the implications of this shift in taxation are going to play out differently in different sectors. We are obviously committed to improving services for people in long-term-care homes. I can't speak directly to the issue that you've raised, but we're committed to improving services.

Mrs. Elizabeth Witmer: I certainly hope, Minister, that you'll do everything you can, because the loss of one more position in a home could certainly have a devastating impact as that population ages and they have more complex care needs.

The next one is the 2008 budget, which committed to funding 2,400 additional personal support workers over three years and 2,000 more nurses over four years in long-term-care homes. We know that about one third of the PSWs were funded in 2008, but we also know that no new positions have been added this year. There have also been about 600 new nursing positions added in conjunction with the implementation of the MDS/RAI care planning system. The question is, when will the rest of the personal support workers and nurses be funded? When will those positions that were promised be funded?

Mr. Ron Sapsford: Some of the monies I referred to earlier were to provide for that. There was money for annualization of that. In terms of the subsequent years, I can't answer that directly, but certainly we'll get that information for you.

Mrs. Elizabeth Witmer: Okay. Because that commitment was made in 2008, and I think there was an anticipation that the money would have flowed by now, and those positions are badly needed. So I'd appreciate it if you could follow up.

The next one is beds. Only about 5,500 beds were applied for under the first phase of the capital renewal program. We have to renew 35,000 older long-term-care beds. This was below what the ministry's target was, which I understand was 7,000 beds, and obviously reflects the fact that the program's funding framework isn't working.

I ask you, Minister, and I'm not looking for a response today: Would you commit to reviewing this? And would you look to establishing a funding framework that would actually respond to the economic realities in the long-term-care sector? That would be my request.

The next one is: The ministry is now aware that additional beds are required for project viability under the capital renewal program, and that such beds do provide the potential for local ALC solutions. Again, I would just ask the minister to commit to ensuring that this viability is achieved through maximum flexibility for existing bed movement between the LHINs and/or the strategic addition of new beds. It's an issue that I hope you will take a look at.

I want to now take a look at the act, and maybe somebody could answer this one: When will the new Long-Term Care Homes Act and the regulations finally be proclaimed? Do we have a date?

Mr. Ron Sapsford: We're targeting early next year.

Mrs. Elizabeth Witmer: In 2010?

Mr. Ron Sapsford: In 2010. The development of the regulations—as you remember, this new piece of legislation merges three prior pieces of legislation.

Mrs. Elizabeth Witmer: Yes.

Mr. Ron Sapsford: So the regulatory development has been very complicated. We initially thought it could

be done at once. There was then a decision to put it into two phases in order to manage the process. The first phase is now finished and regulations are completed.

The second phase dealt more with the care requirements. Those regulations were developed. They've been publicly posted. The time for public posting has now finished and we've had a significant response. In some of the responses, it's clear that we're going to have to rethink a few parts of the regulations, based on that feedback.

So initially the time frame was for early in the new year. We're sort of in that time frame, depending upon how much additional work we have to do as a result of the public consultation. But it's on track.

At the same time the ministry is looking at changes in its inspection protocols, to be consistent with the new model that's being put forward.

Mrs. Elizabeth Witmer: I guess, along with that, the Long-Term Care Homes Act and the accompanying regulations are going to increase the operating costs for homes in areas like dietary staffing, dietitian time, changes in the bed thresholds for administrator and director of nursing and personal care coverage in small homes, as well as the costs of transitioning to what we've just talked about, this new regulatory framework.

I just would like you to consider this and, hopefully, be able to respond in writing: Would the minister confirm that these additional costs are going to be funded, and that homes are not going to be forced to reduce their existing care and services if they're going to be given new legislative and regulatory requirements? I just would say to you: This is a concern for homes.

I'll go on here. In 2004, the ministry committed to work with the long-term-care sector to find a long-term solution to the inequities in care and service delivery capacity of long-term-care homes based on the differences in the property tax treatment. That has been an issue. Some homes pay property tax and others don't, even though all homes receive the same level of funding. Again, I would just ask the minister to commit to making this a priority, and if she would work with her colleagues in finance and elsewhere to find a resolution to that particular issue.

The next one: Given the human resource issues that are impacting all of health care—and, of course, particularly long-term care—I hope that the minister will ensure that Bill 168 does move through as quickly as possible.

I want to move now to long-term-care homes, but also to the drug benefit.

1740

The Chair (Mr. Garfield Dunlop): You've got about three minutes left, by the way.

Mrs. Elizabeth Witmer: Okay. The ministry should be aware that the current Ontario drug benefit program review has significant risks for the delivery of pharmacy services in long-term-care homes, including the ability for homes to meet the regulatory provisions of the new Long-Term Care Homes Act. I'd just ask the minister to prepare a written response, to demonstrate that she's going to ensure that as a result of this review, pharmacists remain incented to deliver quality pharmacy services in the homes and that homes are supported in meeting their regulatory requirements.

As you can appreciate, long-term-care homes do have lots of questions that remain unanswered. This is sometimes a neglected part of our health care system. These people don't protest; they're not out on the front lawn. But their needs are increasing, and I would just personally ask you, Minister, to commit your attention and do what you can.

In conclusion—

The Chair (Mr. Garfield Dunlop): You've still got about two minutes.

Mrs. Elizabeth Witmer: I've got two minutes.

The Chair (Mr. Garfield Dunlop): Yes.

Mrs. Elizabeth Witmer: Well, in my two minutes, I have lots more questions I could ask, but anyway, I do thank you for appearing here, Minister. I think you're off to a good start.

I just want to thank the staff of the ministry. I know that you face very challenging times from time to time. We certainly went through them when I was there. I do appreciate the commitment, dedication and the hard work of everybody.

Hon. Deborah Matthews: Thank you very much.

The Chair (Mr. Garfield Dunlop): Thank you very much, Ms. Witmer. We'll now move over to the—

Interjection: Fifteen minutes.

The Chair (Mr. Garfield Dunlop): About fifteen minutes, then, before the vote, okay? You go ahead. We'll tell you when—

M^me^ France Gélinas: We'll get started. I also want to keep on asking questions on long-term care. The first one is: Can I have a copy of the 2009 template service agreement document for long-term-care homes?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Thank you. How many homes have not yet signed the 2009 service agreement, and can I have the names of those homes that have not signed their 2009 service agreement?

Mr. Ron Sapsford: I suppose that we would have to go out—we'll do our best, yes.

M^me^ France Gélinas: Okay. If it comes by LHINs, it's fine too.

Mr. Ron Sapsford: Okay.

M^me^ France Gélinas: Is the ministry still requiring quarterly staffing reports from long-term-care homes?

Mr. Ron Sapsford: It's not quarterly. If I'm not mistaken, it's semi-annual. And yes, we are. Some of the problems in getting the data and getting it organized are still with us. But yes, the program continues.

M^me^ France Gélinas: So they will be covering a six-month period?

Mr. Ron Sapsford: I believe that's the reporting period, yes.

M^me^ France Gélinas: When was the most recent staffing report? What is it dated and what period of time does it cover?

Mr. Ron Sapsford: I believe we have until the end of fiscal 2008, but we're just in the midst of refining the 2009 data.

M^me^ France Gélinas: Okay, because—

Mr. Ron Sapsford: It would be for the first part of the fiscal year 2009.

M^me^ France Gélinas: So it would be to March 31, 2008?

Mr. Ron Sapsford: Yes, I believe that's right.

M^me^ France Gélinas: When the new computer system is in place—the long name escapes me but it will come back to me—will we continue to have staffing reports? Will they be for the same period of time—six months? Will they be coming at a more—how can I say it?

Mr. Ron Sapsford: More regularly?

M^me^ France Gélinas: Yes.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: They will, eh? I always have to file freedom of access of information to get those reports. Is there any intention to make those reports public? There was talk about every home reporting on their level of staffing. Are we going to go this way?

Mr. Ron Sapsford: The public reporting piece would be different. The way you're asking for the information is by category of staff and those sorts of things. I don't think we've given consideration of public reporting as part of the homes' public reporting, to that level of detail, but rather, total hours, those sorts of considerations.

M^me^ France Gélinas: So I shouldn't have brought the two together. Every quarter—because I thought they were every quarter—I submit a freedom of access of information to your ministry, asking for the staffing level. Is there any intention of ever making those documents public so I could access them without $5?

Mr. Ron Sapsford: It's not part of our plan, no. Maybe we could give you a standing order.

M^me^ France Gélinas: Can I ask for the most recent one through estimates and save myself five bucks?

Mr. Ron Sapsford: Yes, you may.

M^me^ France Gélinas: Thank you. There has to be an easier way.

When the auditor last reviewed long-term care, he made many recommendations. One of them was, could the ministry carefully articulate the boundaries around funding envelopes? We all know that we have nursing and personal care programs, support services, raw food and other accommodation. The auditor had recommended that those be better defined. Has this work been done?

Mr. Ron Sapsford: We're in the middle of it now. We've instituted a full funding review of long-term-care home funding. You're aware that we're on a per diem with adjustments and have the envelope approach. That work is midstream right now, and I suspect sometime next year we'll be in a position to do the consultation with the field that that kind of change would mean and, one would hope, come to a new funding model.

M^me^ France Gélinas: Who is in charge of conducting this review?

Mr. Ron Sapsford: That's in our financial portfolio in the ministry.

M^me^ France Gélinas: Okay. So we will review what goes within each envelope because, from not-for-profit to for-profit, what goes into other accommodation and what goes into personal support vary greatly. There will be strict guidelines for the ministry as to—

Mr. Ron Sapsford: Yes. That's all part of the review.

M^me^ France Gélinas: That's all part of the review? Has a decision been made regarding incontinence products and in which envelope they should be?

Mr. Ron Sapsford: I don't know. I would not think so, at this point.

M^me^ France Gélinas: Okay. Because that was also a recommendation—that incontinence products be brought back to the accommodation envelope. It will be decided at the same time as the rest of it?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: Remind me of the time frame for those reviews?

Mr. Ron Sapsford: We're hoping for next year to have that work finalized, in 2010.

M^me^ France Gélinas: Oh. Can you put a month—

Mr. Ron Sapsford: I can't put a month on it. I know it's scheduled for the next fiscal year.

M^me^ France Gélinas: Okay. We can always ask you again next year.

Mr. Ron Sapsford: If you want, I'll find out more detail and report it as part of your question.

M^me^ France Gélinas: Okay; I'd love that. Thank you.

We've heard that the Ministry of Health is undertaking a review of funding of the long-term-care sector. This is the same review?

Mr. Ron Sapsford: Yes, the same thing.

M^me^ France Gélinas: Are the terms of reference of this something that you can share?

Mr. Ron Sapsford: I don't see why not, no.

Interjection.

M^me^ France Gélinas: I heard a "yes" from the—okay. I would like you to share that.

Mr. Ron Sapsford: Sure.

M^me^ France Gélinas: We know that the Ombudsman has done a report on long-term care. Has he shared that with you?

Mr. Ron Sapsford: No.

M^me^ France Gélinas: It's not at that point yet. Okay. If anybody remembers, under section 39 of the LHSIA, it calls for "a comprehensive review of this act and the regulations made under it no earlier than three years and no later than four years after this act receives royal assent." This review is to be conducted by a committee of the Legislative Assembly and is to make recommendations to the assembly within a year of the commencement of the review.

According to my trusty little calendar, it would kind of be now. Do you know if the ministry is going to go ahead and talk to the assembly about this?

Mr. Ron Sapsford: It's in active discussion right now and will be with the minister, but that will then come

forward to the House, to make a decision about how that review should be conducted. But yes, we're well aware of it, and the time frame for that review would be in the next—well, I think the wording is, it starts within a certain period. It must start within the next six or seven months.

M^me^ France Gélinas: Okay. Is it too early to tell which committee of the Legislature it's going to go to?

Mr. Ron Sapsford: That wouldn't be our decision. I don't know.

M^me^ France Gélinas: Minister, do you know?

Hon. Deborah Matthews: No.

M^me^ France Gélinas: Okay. Very good.

Coming back to the staffing report, you know that I have been asking for freedom of access so I have copies of the staffing report. It basically showed that the nursing and personal care pay per resident was at 2.836 in 2005, 2.841 in 2006 and 2.881 in 2007. So we're talking about—

Interruption.

M^me^ France Gélinas: That's the vote, isn't it? So we're talking about an increase of 2.3%, 0.1% and 1.4%, but during the same period of time, we saw funding increased to the tune of 3.4% in 2006, 4.5%—how come this disconnect? How come, when we invest so much more, we get so little in staffing levels? It doesn't seem like value for money there.

Mr. Ron Sapsford: Of course, part of the increased costs is the cost of wages, goods and services, drugs and everything else. So part of the total increase goes simply to provide the same service that we already have, and then marginal amounts to increase the number of staff.

This goes back to the question of targeting increases to very specific outcomes. The minister talked about it in terms of emergency rooms, wait times and so forth. Similarly, here, where we vote more money specifically for increases in staff, we've got to put in the measures to be able to account for it, which answers your question about the follow-up. Sometimes there's a great tension, though, between increased costs from inflation and so forth versus hiring new staff. This becomes part of the discussion between the ministry and the long-term-care field about the level of funding and how much is required to offset inflationary pressures versus new service pressures. So we—

The Chair (Mr. Garfield Dunlop): Ms. Gélinas, I think if we can cut it off there now, you'll still have 10 minutes when you start back on Tuesday morning.

With that, we'll adjourn the meeting. We'll reconvene on November 3 at 9 o'clock in the morning, and we'll start with the NDP for 10 minutes. The meeting is adjourned.

The committee adjourned at 1751.

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