HANSARD

Second Session - Thirty-Sixth Legislature

of the

Legislative Assembly of Manitoba

Standing Committee on Law Amendments

Chairperson
Mr. David Newman
Constituency of Riel

Vol. XLVI No. 6 - 7 p.m., Tuesday, October 15, 1996

MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Sixth Legislature

Members, Constituencies and Political Affiliation

Name	Constituency	Party
ASHTON, Steve	Thompson	N.D.P.
BARRETT, Becky	Wellington	N.D.P.
CERILLI, Marianne	Radisson	N.D.P.
CHOMIAK, Dave	Kildonan	N.D.P.
CUMMINGS, Glen, Hon.	Ste. Rose	P.C.
DACQUAY, Louise, Hon.	Seine River	P.C.
DERKACH, Leonard, Hon.	Roblin-Russell	P.C.
DEWAR, Gregory	Selkirk	N.D.P.
DOER, Gary	Concordia	N.D.P.
DOWNEY, James, Hon.	Arthur-Virden	P.C.
DRIEDGER, Albert, Hon.	Steinbach	P.C.
DYCK, Peter	Pembina	P.C.
ENNS, Harry, Hon.	Lakeside	P.C.
ERNST, Jim, Hon.	Charleswood	P.C.
EVANS, Clif	Interlake	N.D.P.
EVANS, Leonard S.	Brandon East	N.D.P.
FILMON, Gary, Hon.	Tuxedo	P.C.
FINDLAY, Glen, Hon.	Springfield	P.C.
FRIESEN, Jean	Wolseley	N.D.P.
GAUDRY, Neil	St. Boniface	Lib.
GILLESHAMMER, Harold, Hon.	Minnedosa	P.C.
HELWER, Edward	Gimli	P.C.
HICKES, George	Point Douglas	N.D.P.
JENNISSEN, Gerard	Flin Flon	N.D.P.
KOWALSKI, Gary	The Maples	Lib.
LAMOUREUX, Kevin	Inkster	Lib.
LATHLIN, Oscar	The Pas	N.D.P.
LAURENDEAU, Marcel	St. Norbert	P.C.
MACKINTOSH, Gord	St. Johns	N.D.P.
MALOWAY, Jim	Elmwood	N.D.P.
MARTINDALE, Doug	Burrows	N.D.P.
McALPINE, Gerry	Sturgeon Creek	P.C.
McCRAE, James, Hon.	Brandon West	P.C.
McGIFFORD, Diane	Osborne	N.D.P.
McINTOSH, Linda, Hon.	Assiniboia	P.C.
MIHYCHUK, MaryAnn	St. James	N.D.P.
MITCHELSON, Bonnie, Hon.	River East	P.C.
NEWMAN, David	Riel	P.C.
PALLISTER, Brian, Hon.	Portage la Prairie	P.C.
PENNER, Jack	Emerson	P.C.
PITURA, Frank	Morris	P.C.
PRAZNIK, Darren, Hon.	Lac du Bonnet	P.C.
RADCLIFFE, Mike	River Heights	P.C.
REID, Daryl	Transcona	N.D.P.
REIMER, Jack, Hon.	Niakwa	P.C.
RENDER, Shirley	St. Vital	P.C.
ROBINSON, Eric	Rupertsland	N.D.P.
ROCAN, Denis	Gladstone	P.C.
SALE, Tim	Crescentwood	N.D.P.
SANTOS, Conrad	Broadway	N.D.P.
STEFANSON, Eric, Hon.	Kirkfield Park	P.C.
STRUTHERS, Stan	Dauphin	N.D.P.
SVEINSON, Ben	La Verendrye	P.C.
TOEWS, Vic, Hon.	Rossmere	P.C.
TWEED, Mervin	Turtle Mountain	P.C.
VODREY, Rosemary, Hon.	Fort Garry	P.C.
WOWCHUK, Rosann	Swan River	N.D.P.

LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON LAW AMENDMENTS

Tuesday, October 15, 1996

TIME – 7 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. David Newman (Riel)

VICE-CHAIRPERSON - Mr. Gerry McAlpine (Sturgeon Creek)

ATTENDANCE - 11 – QUORUM - 6

Members of the Committee present:

Hon. Messrs. McCrae, Reimer

Messrs. Ashton, Chomiak, Dyck, Lathlin, McAlpine, Newman, Penner, Pitura, Ms. Wowchuk

APPEARING:

Mr. Tim Sale, MLA for Crescentwood

WITNESSES:

Bill 37–The Ambulance Services Amendment Act

Mr. Dwayne Forsman, Manitoba Prehospital Professions Association

Bill 49–The Regional Health Authorities and Consequential Amendments Act

Ms. Glenda Doerksen, Private Citizen
Mr. John Nicol, President, Union of Manitoba Municipalities
Ms. Lois Creith, Manitoba Northwestern Ontario Conference of the United Church of Canada
Ms. Laurie Potovsky-Beachell, Manitoba Women's Institute
Ms. Georgia Wiens, Private Citizen
Ms. Aline Audette, Private Citizen
Ms. Robinson, Manitoba Health Organizations
Ms. Lorraine Sigurdson, Canadian Union of Public Employees, Manitoba Division
Ms. Marilyn Goodyear Whiteley, President, Manitoba Association of Registered Nurses
Ms. Diana Davidson Dick, Executive Director, Manitoba Association of Registered Nurses
Ms. Vera Chernecki, Manitoba Nurses' Union
Mr. Rob Hilliard, President, Manitoba Federation of Labour
Mr. Harold Shuster, Manitoba Medicare Alert Coalition
Mr. Alan Sweatman, Convalescent Home of Winnipeg
Ms. Debra Mintz, Private Citizen
Ms. Sharon Macdonald, Private Citizen
Ms. Brenda Maxwell, United Nations Platform for Action
Ms. Yvonne Peters, Chairperson, Women's Health Clinic
Ms. Barbara Wiktorowicz, Executive Director, Women's Health Clinic
Mr. Desmond Conner, Community Coalition on Mental Health
Ms. Monica Singh, President, Provincial Council of Women of Manitoba
Ms. Jenny Gerbasi, Coalition to Save Home Care
Mr. John Poyser, Manitoba Association of Community Health Centres
Mr. Bernard LeBlanc, Private Citizen
Mr. Ian McMahon, Private Citizen

MATTERS UNDER DISCUSSION:

Bill 37–The Ambulance Services Amendment Act
Bill 49–The Regional Health Authorities and Consequential Amendments Act

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Mr. Chairperson: Good evening. Will the Standing Committee on Law Amendments please come to order.

This evening the committee will be considering two bills, those being Bill 37, The Ambulance Services

Amendment Act; and Bill 49, The Regional Health Authorities and Consequential Amendments Act.

Before the committee proceeds with consideration of bills, it must elect a new Vice-Chairperson. Are there any nominations for the position of Vice-Chairperson?

Mr. Peter Dyck (Pembina): Mr. Chairman, I would nominate Gerry McAlpine.

Mr. Chairperson: Mr. McAlpine has been nominated. Are there any other nominations? Seeing none, Mr. McAlpine is duly elected as Vice-Chairperson.

To date we have had a number of presenters registered to speak to the bills referred to for this evening. I will now read aloud the names of the persons who have preregistered for these bills. With respect to the first, Bill 37, The Ambulance Services Amendment Act, persons registered to speak are: Dwayne Forsman of the Manitoba Prehospital Professions Association.

With respect to Bill 49, the presenters registered so far are: Hila Willkie; Eugene Kostyra; Marilyn Goodyear Whiteley, President, and/or Diana Davidson Dick, Executive Director of the Manitoba Association of Registered Nurses; Vera Chernecki; Rob Hilliard; Ellen Kruger; Glenda Doerksen; David Tesarski; John Nicol; Alan Sweatman, a replacement for Tony Fraser for the Convalescent Home of Winnipeg; Debra Mintz; Sharon Macdonald; Brenda Maxwell; Valarie Price; Barbara Wiktorowicz; Don Porter; Desmond Conner; Monica Singh; Lois Creith; Jenny Gerbasi or John Robson for the Coalition to Save Home Care; John Poyser; Evelyn Shapiro; Esyllt Jones; George Muswaggon; Linda Clark; Bernard Christophe; Bob Minaker; Laurie Potovsky-Beachell; Peter Olfert; Ben Hanuschak; Albert Cerilli; Georgia Wiens; Carmela Abraham; Bernard LeBlanc; Ian McMahon; Annette Hupe; Lucille Barnabe; Elizabeth Smith; Aline Audette; Donald Davis; Luke Jegues; Vernon Lyss; Kevin Richardson and Pat Charter.

If there are any other persons in attendance today who would like to speak to the bills referred to for this evening and his name does not appear on the list of presenters, please register with the Chamber Branch personnel at the table at the rear of the room and your name will be added to the list.

In addition, I would like to remind those presenters wishing to hand out written copies of their briefs to this committee that 15 copies are required. If assistance in making the required number of copies is needed, please contact either the Chamber Branch personnel or the Clerk Assistant and the copies will be made for you. On which bill did the committee wish to hear from presenters first, Bill 37 or Bill 49?

An Honourable Member: 37.

Mr. Chairperson: Bill 37, agreed? [agreed]

Did the committee wish to establish a time limit on presentations heard this evening?

Some Honourable Members: No.

Mr. Gerry McAlpine (Sturgeon Creek): Mr. Chairman, in view of the number of–in all fairness to all those who have come here this evening, I think it would be in order to recommend to the committee to limit presentations to 10 minutes. [agreed]

* (1910)

Mr. Chairperson: Inclusive of questions and answers, is that your intent?

Mr. Dave Chomiak (Kildonan): Mr. Chairperson, I think that, given the significance of both of these bills and the fact that the public and individuals have taken the time to come out to this committee, it is incumbent upon us to allow them certainly more than 10 minutes to make their presentations. In fact, we in the Legislature have a longer time period. We are even permitted 30 minutes to debate the bill and I think anything less than 30 minutes–in fact I would argue that they be allowed the time to make their presentation and a time for adequate questioning. Anything less, I think, is basically a circumvention of democratic principles. These are private citizens and individuals representing groups who have come to talk about significant changes, I will say revolutionary changes to the health system in this province under this bill, and they deserve the opportunity to have their voices heard, to make their presentations and to make the impact and to provide us with their experience and knowledge of health care changes.

Given that particularly Bill 49 was brought upon us with virtually no warning, given the fact that Bill 49 came about out of the drafting department of the minister I presume, given the fact that Manitobans have not had an opportunity to discuss this bill–

Point of Order

Mr. McAlpine: Mr. Chairman, on a point of order, I believe that all we are doing here is establishing a time limit in which the presenters–and I do not believe the member and his entourage of explanation in terms of the bill and the whys and the wherefores of that–I would ask that you rule him out of order. I think that he has made his point and I think that is really all that has to be said.

Mr. Steve Ashton (Thompson): On the same proposed point of order–I do not think it is a point of order–the member for Kildonan was very clear. He was talking about the need to allow for far more than 10 minutes in the way of presentations, and I would suggest that we allow the member for Kildonan and other members of the committee who wish to make presentation on this matter to speak on that particular proposal. I wish to speak as well on the substantive motion. I assume that the members opposite are moving here, and I would also perhaps suggest that if they are moving a motion and we put it in that form and then perhaps debate it formally–because I think that would probably be the appropriate way to proceed, but the member for Kildonan was certainly in order in terms of the subject matter of the time limit.

Mr. Jack Penner (Emerson): On the same point of order, Mr. Chairman, I respect what Mr. Chomiak has said, and I hear what Mr. Ashton is saying, and I wonder whether the people around the table might agree that there need to be some limitation of time. I would ask colleagues around the table to respect what we have come to accept as a committee procedure, at least during the recent times, and that is a limitation but a reasonable limitation. I wonder whether you would accept and whether the mover, if it was in fact a moved motion, might accept the fact that we could extend the time of presentation and questions to 15 minutes instead of the 10 minutes that was suggested.

Mr. Chairperson: You are really not addressing the point of order with those comments but the merits on the point of order. I would rule that there is no point of order.

* * *

Mr. Chairperson: I would invite Mr. Chomiak to continue with the caution that hopefully once we go through these preliminaries we can get down to business and hear from the presenters, and hopefully we do not take too much time on the preliminary debates which have a legitimate purpose. But I know Mr. Chomiak wishes to finish his remarks.

Mr. Chomiak: Thank you, Mr. Chairperson, and I appreciate your comments. I do not want to take valuable committee time debating this point as well except that it is necessary I think because of the significance of these two bills and Bill 49 in particular. I think it is a recognition of the importance of these bills, and I think if we really believe in the principle of public participation and if we believe in the principle of allowing the public to have a say, then I think it is highly undesirable to require time limits on citizens of a 10- or even a 15-minute nature that would not permit them to adequately present their concerns as well as for us to question them on the significance of this.

Again, I just close by indicating we in the Chamber ourselves, although we have time limits, have allowed ourselves 30-minute speeches on this bill. I think that anything under that–in fact, I would argue that given the public only has one opportunity to make presentations and we have three opportunities to debate the bill in the Legislature, I would be of the view that the public ought to be allowed all reasonable time to make their presentations and that we not impose time limits. If we do decide to impose time limits, it ought to be at the very, very high end and not at the low end. Those conclude my comments.

Mr. Ashton: I am extremely concerned about the process we are following here and in particular the fact that the government has basically adopted through its use of majority on committee the whole concept of time limits. It seems to be with each committee hearing moving the bar lower, so to speak, to the point now where we are talking about what I think would be an absurd restriction on the right of members of the public to make presentations.

Mr. Chairperson, I refer you back to some committee hearings that I know you spent many hours sitting in and made presentations to in a former life before being elected as a member of the Legislature, and I have sat here until all hours of the night listening to members of the public. I sat here until four in the morning once.

Mr. Chairperson: Living proof that it did not make any difference.

Mr. Ashton: And the Chairperson says, living proof that it did not make any difference. There is always hope. Hope springs eternal that the government will listen to the many people making presentations because this is a very detailed bill and there are a lot of concerns that have been expressed about the bill.

I just point–you have read the list of the presenters but I think one of the important things to notice here, and why I think this talk of a time restriction is absurd, are the organizations that are represented: Manitoba Health Organizations, CUPE Manitoba, MARN, MNU, MFL, Manitoba Medicare Alert Coalition, Canadian Federation of Labour, Union of Manitoba Municipalities, Convalescent Home of Winnipeg. [interjection]

You know, the government members in the committee say, we have read that through, but this is a series of people who are listed to present on this bill who represent many different diverse interests in our Manitoba society. I think it would be absurd to expect any of the groups to be limited to a 10-minute presentation. In fact, Mr. Chairperson, I would apply the same to individuals too because before this committee, all presenters are equal.

I just do not see how we can in any way, shape or form have a time limit on a bill that is as detailed and as sweeping as this. I want to just say that I find it unfortunate at a time in this session when we are dealing with a lot of bills that are going to have a very significant impact on our Manitoba society, when a lot of people are talking about not only the process that we are following now but the new processes that are going to be set up, that we are dramatically changing the way things are done.

Even in this bill we are going to see major powers vested in the minister and a whole new structure set up. It seems to me that these are the times and these are the occasions when in the committee we should err on sitting here as long as possible, as long as it takes to listen to the members of the public. There are a grand total of 43 presenters. Our caucus in the NDP is willing to sit and listen to them. We obviously are not going to finish tonight, and if it means further committees we will do that.

I would just finish my comments by pointing out that this is a unique session in the sense that we have both a spring and a fall sitting. We are going to be sitting for another four weeks. We are obviously not going to spend all of that time listening to presentations so I would strongly urge the government to withdraw this time limit–by the way, this is, as I said, something they recently have been imposing in committees–and particularly to withdraw what I consider a rather offensive limit. I mean, to limit these kind of presenters on such a detailed bill, with the number of implications in this bill, I think would be an affront to the democratic process. I would suggest we vote on this particular motion, vote it down and proceed to hear members of the public and be prepared to sit here for the next number of days or however long it takes to hear the members of the public.

Mr. Penner: Mr. Chairman, I do not want to belabour this discussion any more than it needs to be belaboured, but I take exception to some of the things that the members opposite have said, and that is, No. 1, the importance of the individuals making the presentation. To me, and I hope to all members of this committee, each and every presenter here is of equal importance, and that should not be understated. I take exception to the comments that Mr. Ashton made, saying that there were significant–

Point of Order

Mr. Ashton: On a point of order, Mr. Chairperson, I said very distinctly that all presenters before this committee are equal. I would appreciate it if Mr. Penner, if he does not recall that remark, would check in Hansard and perhaps withdraw that remark.

My reference to the organizations here was the fact that many of them–in fact, I have already seen some of the briefs. MHO has a very detailed brief–have very lengthy presentations, or a number of them anyway that I have

already seen. I stated very clearly and my exact words were: We are all equal before this committee. That is, by the way, why we do not want 10-minute limits, why we want to allow for as much presentations as the members of the public wish to make before this committee.

* (1920)

Mr. Chairperson: There is truly a dispute as to the facts. Maybe I could just interject. We are planning, if we run out of time this evening hearing everyone or we choose to discontinue, we have time scheduled beginning at seven o'clock again tomorrow evening for the purpose.

We went through a long proceeding just the other night with respect to one of the other pieces of legislation and, by agreement, a 15-minute time limit was set. It actually worked quite well, but there is no need, the committee has no obligation to agree to a time limit. There is a certain impact on everyone in the room who is a presenter in terms of trying to protect their time and that sort of thing, so that is an aspect to this. It appears as if there is not agreement whether or not there should be a time limit.

Mr. Penner: I would like to conclude my remarks, Mr. Chairman, if you would allow. I think we should also not leave on the record unchallenged the theory that this government is the innovator or the inventor of limitations on presentations.

I can remember in a previous lifetime, presenting in this very same room, when there were time limits established on committee hearings. It is certainly not a new phenomenon, and it is something that has happened previously, and I suppose will continue. It is, of course, the decision of the committee that allows that decision to be made.

Mr. Chairperson: I also do remind everybody that written submissions are, of course, part of the process and they are considered by the members of the committee and the presentations are also recorded in Hansard, and, on request, a written submission in lieu of an oral submission can be treated as if read onto the record, so there are all kinds of options available.

Mr. McAlpine: Mr. Chairman, as the original mover of this, I would offer a suggestion on the basis of your lead and the member for Emerson (Mr. Penner) of 15 minutes. I think it is really important that we have an opportunity to hear–we have 44 presenters here, and if we allow half an hour, as the member across the way has suggested, that will take us to 7:30 tomorrow morning, and I do not think that is really fair to the people who have come here tonight to make a presentation. In saying that, I would suggest to the committee that we offer 15 minutes for presentation and questions.

Mr. Chomiak: Mr. Chairperson, I do not accept that reductionist argument, the argument that because we might be here till 7:30 is not justification for the public to make presentations. It seems to me that what we might recommend is that the presenters make as reasonable a presentation as possible but that we will not set time limits and that presenters be cognizant of the fact that there are other presenters. I think that is a reasonable position to take. Presenters know there are other people in the room, that they have other considerations, and we leave it at that and allow individual presenters to make their own determination as to how long they should provide us with information, because it is our job to listen and to receive this presentation. So I would counter by not using that reductionist argument and saying perhaps we acknowledge the presenters are all here, they know how many presenters are here, and they can use their own good judgment and discretion to determine how long they make their presentations.

Mr. Chairperson: The first question then will be whether or not they should be restricted to 15 minutes, Mr. McAlpine's recommendation.

Voice Vote

Mr. Chairperson: All in favour say yea.

Some Honourable Members: Yea.

Mr. Chairperson: Opposed say nay.

Some Honourable Members: Nay.

Mr. Chairperson: The motion carries.

Mr. Ashton: I would ask for a count-out vote.

A COUNT-OUT VOTE was taken, the result being as follows: Yeas 6, Nays 4.

Mr. Chairperson: The motion carries at six to four.

Mr. Ashton: Mr. Chairperson, we also wish to raise a matter related to the committee. One of the aspects of this bill is its sweeping implications for all areas of Manitoba. We believe that the committee should meet throughout Manitoba. It is not the first time this has been the case. Legislative committees have met–I have been a member of committees that have met throughout the province. Given the real importance of this particular legislation to the regions of our province, we believe that legislative committee hearings should be held at least in each separate health region of the province.

I would note, by the way, there are approximately eight or nine out-of-town presenters. I know, just from my own personal experience, that if–in fact, from talking to people in my own constituency–hearings were held in Thompson there would be a significant number of people who would make a presentation. Unfortunately, many people are not able to come into Winnipeg due to the eight-hour drive, and I would suggest that would be very much the situation elsewhere in the province. We do not have the ability necessarily in a committee to schedule those committee hearings, but we would like some expression from this committee to the government House leader. I can indicate as the House leader for the NDP caucus that we certainly would support that.

I would stress again that this session of the Legislature does not end until November 7, so there is a golden opportunity here to have hearings on a bill that is going to have a dramatic impact on health care throughout Manitoba and particularly in rural and northern Manitoba. Regardless of which side we are on in the many issues in this bill, I think that is one thing we all agree on. So that is why I would move that this committee recommend that it travel to hold public hearings on Bill 49, The Regional Health Authorities Act, in each separate health region of the province.

Mr. Chairperson: The motion reads, I move that this committee recommend that it travel to hold public hearings on Bill 49, The Regional Health Authorities Act in each separate health region of the province. Is there any debate on this motion?

Hon. James McCrae (Minister of Health): Mr. Chairman, before any of my other colleagues in this committee contribute to this particular point, the honourable member for Kildonan should be reminded that the process that has led us to this point is quite different from the one referred to in his initial comments when he suggested that Bill 49 was something which came up recently or in some way was revolutionary in its construction or in what it does.

The process that brings us to the presentation before this Legislature last June, of Bill 49, The Regional Health Authorities and Consequential Amendments Act, was one characterized by public consultation, public hearings, public meetings, appeals, more public meetings, so that to characterize it in the way that he has would be quite incorrect. There have been numerous opportunities for public input throughout this province at the various public hearings that were held by the Northern and Rural Health Advisory Council, from whose report we have Bill 49 before us, and again at this committee we have further opportunities for public input. So, if we are going to consider the kinds of things that are being put forward by the honourable member for Kildonan (Mr. Chomiak), it ought to be borne in mind that there has indeed been more public input with respect to Bill 49 than its counterpart anywhere in Canada. Manitoba has had a far more consultative approach, indeed I suggest that some 15,000 Manitobans have been involved in providing their advice to government and to the various task forces and committees, about which the honourable member talks, from time to time over the space of the last four, five, six years.

I just wanted to put that on the record. It might be helpful at this point, Mr. Chairman, if I very briefly, in conjunction with what the honourable member is putting forward, place on the record some more recent history of this, what I will call evolutionary approach to health reform in Manitoba.

In June, we placed before the Manitoba Legislature Bill 49, The Regional Health Authorities and Consequential Amendments Act, the bill that is before us this evening. At that time, in my numerous meetings with interested organizations and individuals, I made it known that indeed the bill had been placed before the Legislature, that the Legislature would adjourn at the end of June or thereabouts and resume in the fall and that

during the intervening period I invited everyone with whom I spoke to review the bill and to review it in conjunction with all of the activities that led up to the introduction of the bill in the House and let me know what their concerns were.

* (1930)

It has been a few months of dialogue and consultation; a few recurring themes have become clear. One of those themes is that people simply want to know that the guiding principles in the Canada Health Act are somehow going to be protected, observed, respected as we go forward with changes in our health system. After we hear the presentations from the people appearing before this committee, it will be my privilege to act on my consultations, Mr. Chairman, and to introduce an amendment to this legislation which indeed does make reference to the Canada Health Act and the principles of universality, portability, accessibility, public administration and comprehensiveness. That would be my intention, and those who wish to make presentations on that point may find that instructive as we begin this process.

Mr. Chairman, in addition, we have had significant discussions with faith-related organizations in Manitoba about Bill 49 and it is our intention to bring forward amendment to the bill to take note of and to ensure that the concerns that have been discussed with us by representatives of faith-related organizations will indeed be acted upon and will be taken seriously. This was something that I invited them to do last June, was to prepare to critique the bill and that we would be open to the suggestion that potential changes could happen so that the bill could be made truly a made-in-Manitoba health reform endeavour which indeed the bill is as it is but will show evidence of that made-in-Manitoba format even more so once we have the amendments before the committee.

The third main area, Mr. Chairman, had to do with the appointment of a commissioner to help us resolve labour issues which arise as a result of the transitions that are necessary because of changes in governance and changes in our health system in Manitoba. The concern that I have heard repeated is that there is no end date with respect to the activities of the commissioner, and another concern was that the commissioner's authority might not be overridden by a court if that were attempted.

We have in mind to bring forward an amendment to put a sunset on the activities of the commissioner, and we have tried to make it clear that the work of the commissioner should be restricted to issues that arise strictly in relation to transitions required as we move to this new system and not to in any way permanently replace the authority or powers of the Manitoba Labour Board. We wish to make that very clear, and we will do so by way of amendment after we have heard the presentations from the members of the public.

There was one other area that I think we would like to move forward with an amendment on, and that is the suggestion that the decisions of the commissioner may not be the subject of any appeal to any court. Apart altogether from the fact that the language in this legislation is strikingly similar to legislation passed in various areas of statutory law in Manitoba not only by the present government but by previous governments, I would like to make it abundantly clear to people that issues related to natural justice and issues related to the jurisdiction of the commissioner ought indeed to be potential subject matter for some appeal to the courts. Just in case that is not clear enough in the present language of the bill, which it is to people who have reviewed this from a legal standpoint, but just in case it is not adequately spelled out, I propose to move an amendment to deal with that issue as well to ensure that people understand that nobody is above the courts of our land when it comes to issues related to jurisdiction or natural justice.

I think it might be helpful at this point, Mr. Chairman, to put those things on the record for the purpose of those wishing to make presentations, that indeed we have been listening and we are prepared and have been all along to be amenable to potential amendment should that be appropriately indicated. We feel it is and we will be moving in that way. Thank you.

Mr. Chairperson: Thank you, members of the committee and presenters, for your patience. I did not intervene, this was not right on the motion but I am sure everyone here appreciated it as being a timely comment and because that comment was made, I will invite Mr. Chomiak after Mr. Lathlin addresses the motion, to speak to what the honourable minister has just said, if that would be acceptable. Mr. Lathlin had his hand up to

speak to the motion and I thought it appropriate to hear Mr. Lathlin.

Mr. Oscar Lathlin (The Pas): Thank you, Mr. Chairperson. First of all, I would like to apologize to the public for waiting for us here for a long time now while we are going through this bit of a debate here. Secondly, I want to say that I am all for the motion of the member for Thompson (Mr. Ashton) in regard to having this committee hear presentations at meetings that could be held outside of Winnipeg. Thirdly, I could not just ignore the minister's statements in regard to the representations that have been made over and over again on this legislation, on this bill, on this health reform, this particular part of the health reform.

I was present at a meeting that was held in The Pas at the town library of some of its health officials who are members, where I listened to presentation after presentation made by aboriginal people, requesting the minister to ensure that the composition of their regional health boards reflect the population configurations from that area, which in Norman Region, for example, over 50 percent of the population is aboriginal people, and so it made sense to the people who made those presentations that the board be comprised of at least 50 percent, or at least very close to 50 percent of the board, aboriginal people. The minister ignored those representations.

Today, people are still asking very pertinent questions. In The Pas, for example, they are asking a lot of questions; people do not know. How can the minister sit here and say that people have a good idea of what they are getting into? They do not, because why would the chief executive officer of Norman regional health area, Mr. Hildebrand, tell the people at Swampy Cree Tribal Council, Cree Nation Health, and The Pas Health Complex, that we need more time. There is no way that we are going to be able to implement this by December, Mr. Hildebrand quite rightly is asking. And that is the chief executive officer of the Norman Region. I kid you not, this is what he said.

Why are people still asking the minister why he is not prepared to allow 50 percent representation on the aboriginal board? Why are people within the proposed board asking themselves, well, when does our authority start? When do we start spending money? Why have those appointments not been completed yet? On the Norman board, for example, there are six vacancies, and so I could not allow the minister to just gloss over that and say, well, you know, everything is in place and we are ready to go and it is the NDP that is causing the delay with all their questions. That is not so. Real people, in The Pas area, anyway, the ones that I talk to, are asking all sorts of questions.

The mayor of the Town of The Pas has organized a forum where people can go and express their concerns. They have had meetings with the local hospital board there, and so, no, the question has not been answered. There are still a lot of concerns that people have and that is why I think that it is our responsibility as a committee, it is this government's responsibility, it is this minister's responsibility that he go out there and listen to the people. Thank you.

* (1940)

Mr. Chomiak: I, too, will restrict my comments because we do want to get to the public hearings, and I apologize as well. Just two brief points.

Firstly, the minister, I think, is inaccurate in his statements. The minister did not even accept the recommendations of his own northern and rural task force in terms of the composition, the structure and the makeup of the boards, which is one of the issues of major contention.

Secondly, it sounds to me like the minister is speaking in favour of our motion to go on the road and to tour Manitoba. If the government is prepared to make four amendments to this act without having the opportunity of the public to be heard, think of how much better we can make this act if we go on the road and we talk to citizens around Manitoba and see what changes are necessary to this act. So, since the minister seems to be in favour of us going on the road and taking this act to the regions and having the regions have real input, I move the question that we have the question on the committee going on the road.

Ms. Rosann Wowchuk (Swan River): Just briefly, I want to indicate that I support the motion put forward by my colleague.

The minister has said there have been many opportunities to speak on this bill and on this matter, but in actual fact, the recommendations have not been accepted that have been put forward by the committee that listened to rural Manitobans. The implications on the delivery of health care by this bill will be tremendous in rural Manitoba, and we should take the opportunity to go out and hear those people, just as government backbenchers are going out to listen on issues of daycare, on education, family services. If the backbenchers can travel, there is no reason why this legislative committee cannot travel throughout rural Manitoba and give those people who will be impacted on this bill an opportunity to have input.

When the committee was meeting in rural Manitoba nobody ever thought that there would not be elected boards, that these boards would be appointed only by the minister. Nobody ever thought that there would be a possibility that there would be user fees in our health care system. Nobody ever thought that this bill would give the minister the power to overrule what the boards were doing. Nobody ever thought that the Minister of Health would have the power of a mini-Labour minister. There are many different issues that are brought up in this bill that were not brought up and discussed at the committee hearings. In fairness to rural Manitobans and the people that we represent, we must go out to hear what–and give people the opportunity, not only those people who can travel here to Winnipeg but the rest of Manitoba whose health care system will be dramatically affected if this bill goes forward.

Mr. Chairperson: Is there any other debate on the motion or is it time for the question?

Voice Vote

Mr. Chairperson: All in favour of the motion, please say yea.

Some Honourable Members: Yea.

Mr. Chairperson: All opposed to the motion, please say nay.

Some Honourable Members: Nay.

Mr. Chairperson: The Nays have it.

Mr. Ashton: I would request a recorded vote.

A COUNT-OUT VOTE was taken, the result being as follows: Yeas 4, Nays 6.

Mr. Chairperson: The motion is defeated, six to four.

Mr. Tim Sale (Crescentwood): Mr. Chairperson, just for the record, neither Mr. Gaudry nor myself are members of the committee and therefore could not vote on either of the motions that have been put.

Mr. Chairperson: I would invite everyone to move the mikes closer to them if they are going to speak, so that everyone in the back of the room is able to hear and the Hansard reporter can also hear.

Did the committee wish to hear from out-of-town presenters first? [agreed]

Did the committee wish to indicate at this point how late it is willing to sit this evening?

Mr. Ashton: I would suggest that we set a time of 11 and reassess at that time. Usually, if there are people that are still here that want to finish on that day, that is the usual courtesy. I would hope that we would not sit too late because if we are talking about conveniencing members of the public, I do not think people want to be sitting here for the next four hours and particularly since we have another scheduled date. In fact, we might want to suggest, too, that if there are people, members of the public who would prefer to come back on the other scheduled date that that perhaps be something that could be arranged as well.

Mr. Chairperson: Is that proposal agreed? [agreed]

We will review the situation at 11 p.m. this evening. People at the back can be forewarned, and if you are far down the list you may wish to reconsider your position from point to point throughout the evening and make your views known to the Chamber personnel at the back of the room.

How did the committee wish to deal with the names of the persons who are not in attendance this evening? Shall the names be dropped to the bottom of the list if the

person is not in attendance when his or her name is called? [agreed]

Shall the name be dropped from the list if the name is called a second time and the person is still not present?

Mr. Ashton: No, I would suggest–what I am suggesting is there may be people here tonight, I mean, if I was No. 39 or 40 or 41 on this list, I do not think I could reasonably expect to be here tonight but if that name is called I would not want that person to lose their right to speak. I am suggesting some flexibility on that. I think normally when we go through these things, particularly with 43 presenters, we usually do not find it is any great difficulty. Usually the committee at some point in time runs through the list and there are just no more presenters there, so I would not want to see a rigid rule of dropping off the list just in case there are some people who wish to come back another night. I would not want to see them dropped off if we got down to 25 or and they are willing to come back.

Mr. Penner: Mr. Chairman, I respect what Mr. Ashton is saying. However, we would not be setting precedent by indicating to the people that are here today that they should fully expect to present tonight, that we would be willing to sit as a committee till such a time that we have heard all of them. So, with those people who are here today, I would suggest that you give every indication that this committee is willing to sit till the hour that we have heard everything.

Mr. Chairperson: I think that is the intent that I understood from what the committee said, but we are going to review at eleven o'clock as to how far we would go, but so no one is deprived of an opportunity, the caution has been given that we expect you are going to present this evening, unless there is another arrangement made later this evening, differently.

Is that agreed? [agreed]

Bill 37–The Ambulance Services Amendment Act

Mr. Chairperson: Now then, dealing with Bill 37 first. We only have one presenter on that one and that is Dwayne Forsman. Would Mr. Dwayne Forsman please come forward to make your presentation to the committee. If you have written copies, you could–do you have written copies of your–

Mr. Dwayne Forsman (Manitoba Prehospital Professions Association): Yes, we do. I just brought one and some of the staff went to copy it for committee members, so I am not sure where it is right now.

Mr. Chairperson: You could begin your presentation orally and it will be circulated in due course.

Mr. Forsman: Thank you, Mr. Chairman. I am here on behalf of the Manitoba Prehospital Professions Association which represents many of the individuals which provide prehospital emergency medical services to the citizens of Manitoba on a daily basis. In this capacity, we have made recommendations to the government during the development of this piece of legislation and the regulations which will affect our members in the provision of this emergency care.

We believe that the recommendations given will contribute to an improved delivery of prehospital emergency medical services in the province of Manitoba, and the Manitoba Prehospital Professions Association would like to begin by thanking the Emergency Services Branch of the Department of Health for the opportunity to provide input into this important document which will impact on the health and welfare of Manitobans.

There are, however, issues that the Manitoba Prehospital Professions Association feels is worth further comment and should be considered in more detail prior to the passage of this act. The act and regulations now incorporate the provision of transport services by non-ambulance stretcher companies. The Manitoba Prehospital Professions Association has been lobbying to have these companies regulated and are very pleased to see if they will now become regulated by Manitoba Health.

* (1950)

It is proposed that the title of Bill A65, The Ambulance Services Act be amended to The Emergency Medical Response Act. The Manitoba Prehospital Professions Association strongly advises that the government consider The Emergency Medical Response and Health Transportation Act as being a more descriptive and

suitable title for this piece of legislation, which includes emergency as well as transport by nonambulance stretcher car companies.

With regard to persons being transported by non-ambulance stretcher car companies, we have noted that they will continue to provide service to private residences. The Interfacility Transport Working Group Report dated November 1995 Recommendation No. 7 states that nonacute services be limited to transporting only nonacutely ill patients. The report further states, it may be appropriate in some settings to limit nonacute stretcher services to transport only between bona fide health care facilities. In this scenario, trained and qualified health care personnel will, at the very least, have had the opportunity to screen patients medically at either end of the transfer.

In addition, the report of the Non Ambulance Stretcher Transport Committee dated December 15, 1994, states in Recommendation No. 6 that approval for stretcher car services into new response districts should be through the local governing agency. Recommendation No. 10 of the Non Ambulance Stretcher Transport Committee states that guidelines for acceptable passenger selection should be developed from medical, nursing, provider and user groups. Recommendation No. 12 from the same report states that the ambulance act title should be changed to reflect all modes of transport.

The Manitoba Prehospital Professions supports the recommendations outlined in these two reports commissioned by the Minister of Health (Mr. McCrae). The Manitoba Prehospital Professions Association has concerns with respect to the scope of practice for stretcher transport attendants. We feel that the requirement for the 16-hour first aid and eight-hour CPR training may not adequately prepare them to assess the stability of patients and that incorrect assessments will result in delays in requesting prehospital emergency medical services that could negatively affect patient outcomes.

As well, there are concerns regarding the dispatch of stretcher cars to possible life-threatening emergencies because no independent triage method exists. Stretcher services receiving calls may inadvertently be dispatched to calls requiring the skills of EMS personnel. An example would be, which happens fairly regularly, is a call may be placed from a private residence to one of these companies which accepts their own calls to transport an individual to a hospital or whatever. The stretcher car company would arrive, and the attendants would find an individual who is actually quite ill, for whatever reason, and have made decisions, in some cases, to instead call the ambulance service. The ambulance service would then respond and then transport the patient to the hospital. This delay in accessing the proper system is very concerning to us as practitioners.

With respect to the ground ambulance regulations, the Manitoba Prehospital Professions Association is pleased to see the inclusion of a driving component in the requirements for licensure which will act to improve and promote safety for prehospital emergency medical services and the general public. It is important that the provision to obtain a certificate of completion from an emergency driving program be required for all levels of provider, from ambulance operator to paramedic.

A very important amendment to the regulations, which requires that services with call volumes exceeding 2,000 calls in the last three years, must provide advanced life support in the form of emergency medical technician paramedic. The Manitoba Prehospital Professions Association views this as a very positive change to the way prehospital emergency medical services will be delivered to the people of Manitoba. It has been some time since the last revision of this act, and we view this as an important opportunity to develop and enhance the prehospital emergency medical system.

With the development of the regional health authorities and changes to the delivery of acute care, we see the delivery of prehospital emergency medical services as part of the continuum of care as well as a potential safety net for acute care hospitals.

Improving the skills of prehospital emergency service providers will meet the needs of the public as well as be a cost-effective means of supporting the acute care delivery system.

In closing, the Manitoba Prehospital Professions Association would like to thank those present, the government and the Department of Health, for the opportunity to provide input into this important legislation.

Mr. Chairperson: Thank you, Mr. Forsman.

Mr. Dave Chomiak (Kildonan): Thank you for your presentation, Mr. Forsman, and I appreciate your comments. I take it from your comments that you have had access and have had an opportunity to review the regulations that are attached to this particular piece of legislation.

Mr. Forsman: Yes, we have had opportunity to look at the regulations, both for ground ambulance and for nonambulance stretcher car companies.

Mr. Chairperson: I appreciate that. I did have some difficulty following some of your points because we in the Legislature have not been provided with the regulations by the government, which has been a problem. We have asked for the regulations, and we have not been provided them, so we do not know in fact what the effect of this legislation will be. So we are at a distinct disadvantage.

I am wondering if, since the minister will not provide us with the regulations, perhaps your organization could provide us with the regulations so that we could then make appropriate amendments to the regulations in the act in line with some of your own recommendations.

Mr. Forsman: We were provided with them just very recently within the last week to make comment to Manitoba Health. I do not know why you did not get them, but I suppose, sure.

Mr. Chomiak: I thank you for that. Just a final question, in theory, of course, we agree with you. We support this piece of legislation, but again, without having the regulations, we could not, we did not, know what the ramifications would be.

In general, would you be in favour of amending the bill along the lines of the recommendations that you stated in your presentation, including the recommendations from the November report, the December report, the scope of practice and the dispatch, that if all of those four matters were dealt with that you would feel comfortable with the passage, as well as the name change, of the passage of this piece of legislation?

Mr. Forsman: Yes, absolutely. For the most part, it is a very positive piece of legislation and the regulations are very positive. We have lobbied hard for a number of years to have these companies regulated and are quite pleased to see it finally coming to fruition. There are just a few points that need to be cleared up so that the public safety is still kept in mind and that we do not have people slipping through the cracks that do happen today from time to time.

Mr. Chairperson: Thank you very much for your presentation. Any other questions? Thank you very much.

Bill 49–The Regional Health Authorities and Consequential Amendments Act

Mr. Chairperson: I now call upon the first out-of-town speaker with respect to Bill 49, and that is, according to my list, Glenda Doerksen. You may proceed, Ms. Doerksen.

Ms. Glenda Doerksen (Private Citizen): Thank you. I work as a full-time registered nurse at the Dauphin Regional Health Centre and I have lived as a resident of the Parkland Region of Manitoba for 24 years. It is in that capacity that I speak to the committee tonight.

Bill 49 outlines a radical change in the delivery of health care services in rural Manitoba. Why then is it that the only hearing on the subject is in Winnipeg? Although we have already had discussion on that tonight, as a rural resident, I find that offensive, and not only that, but there was no advance notice given in my community of the time and place of the one hearing that would be held.

I do not dispute that regionalization may be a beneficial concept. However, I do have serious concerns with Bill 49 as it is written. The absence of any mandate to uphold the five principles if the Canada Health Act is very distressing. Indeed, there seems to be a conscious effort to open the door to direct contravening of the act.

A case in point, article 25 states that regional health authorities may, and I quote, " . . . charge fees for health services, or categories of health services, directly to the person who received the services . . . ."

As a nurse in rural Manitoba, I recognize a high level of lower-income families and elderly residents who

cannot afford the financial burden of user fees. Studies have shown that they do not act as a deterrent to abuse of the system, but they do act as a stumbling block to those who cannot afford them, causing many to delay seeking medical assistance until their condition has worsened, leading to more costly treatment in the end.

There is no clear definition of the term "reasonable access." Who will define "reasonable"? Mr. Chairman, 20 to 30 miles may not seem excessive when you live in Winnipeg but, when winter comes, two miles is often impossible to navigate in the country. Many rural communities have become retirement centres with a high percentage of senior citizens, many of whom do not have ready access to transportation outside of their community.

What is needed is a community health centre model where the necessary services are provided under one roof to decrease administration costs but improve access to the services needed by the members of the community, which leads to another concern.

* (2000)

Why is there no mandate for community input into the determination of health services needs? Reference to health advisory councils state that they, like the boards, will be appointed or elected. Why is this government so determined to overrule the democratic process and appoint the positions on boards and councils? Surely the electorate, who know the potential candidates, can make a wiser choice as to who should represent their interests than a minister who has little or no direct knowledge of the nominees. A clear election process, including the length of term of service, should be a part of the bill.

In Part 1 of Bill 49 there is a reference to the contracting out of health care services. The economic impact of this is a grave concern, for example, private nursing agencies charge a facility as much or more for the services of a registered nurse as the present union-negotiated wage. However, the nurse is paid $8 to $10 less per hour with no benefits. That means $8 to $10 less per hour to spend in the local grocery store, the local garage, the local restaurants, and I could go on. Because, in most communities, the hospital is one of the major employers, the spin-off effect of lower wages is of major consequences to the economic well-being of the entire community. Not only that, but because the vast majority of private health companies are headquartered outside of Manitoba, the profit-margin dollars are walking right out of our towns, right out of our province and, in some cases, right out of our country.

Finally, I cannot neglect to express my outrage at the unprecedented authority mandated to the commissioner appointed to determine union representation. To think that one individual has the power to undo years of fair labour practice and collective bargaining rights is beyond comprehension in a democratic society. I am proud and pleased to be a member of the Manitoba Nurses' Union, a democratic organization sensitive to my unique workplace responsibilities and needs, if I am to work in a climate conducive to allowing the provision of quality care to my patients. To think that my membership in MNU is at the whim of the commissioner and the Minister of Health (Mr. McCrae) is totally unacceptable. Will this government soon be telling me which church I may attend as well?

Mr. Chairperson: Thank you very much for your presentation, Ms. Doerksen.

Mr. Dave Chomiak (Kildonan): Thank you very much for that presentation, and I could not help but note in the beginning part of your presentation the incredible irony of the fact that you had to come in from Dauphin to make a presentation on a bill that is going to affect dramatically the way of life, not only your way of life, but the whole community in Dauphin.

I wonder, can you give me your experience in terms of the consultations that have come about in your community and with yourself and your fellow citizens with respect to this bill?

Ms. Doerksen: With respect to Bill 49, I am not aware that there have been any consultations. The Northern and Rural Advisory Committee did have a hearing–it is probably close to two years ago now–in our community, but in terms of Bill 49, there has been nothing. Indeed I have made a point of contacting as many nurses in the communities surrounding the area that I could because I have worked and lived in other communities than Dauphin, and nobody has a hot clue what is going on with Bill 49. They are asking me the questions.

Mr. Chomiak: Would it be fair to say that this bill has basically come to the community right out of the blue and that the citizens of the area have had virtually no opportunity to comment on this particular bill?

Ms. Doerksen: To my knowledge, that would be correct.

Mr. Chomiak: Mr. Chairperson, I assume that your comment about election of the boards comes from the northern and rural task force committee that had made a report, as you said, a couple of years ago. Is that where you mention the fact that that committee or that body had recommended elections of boards and board members?

Ms. Doerksen: I did not make reference to that at all. I am just taking my understanding from Bill 49 itself and the fact that the boards have all been appointed, and the Minister of Health was quoted in the Free Press in June as saying that he had not made any determination that he was prepared to follow through with the recommendations of the Northern and Rural Advisory Council to have the boards elected.

I am aware of that fact, but it was not part of my presentation. But there has been no work done whatsoever in my area that I am aware of to even start the formation of the health advisory councils.

Mr. Chomiak: Are you familiar with who your board members are?

Ms. Doerksen: Yes, I do know who they are.

Mr. Chomiak: How did you obtain information about who your board members were?

Ms. Doerksen: I attained that information through the Manitoba Nurses' Union.

Mr. Chomiak: So are you saying that generally in the community then, if someone wants to find out who their board members are, they have to go to someone like the MNU or some other body to find out who their board members are that represent them on the regional council?

Ms. Doerksen: I am sure that at this point in time, if they were aware, they could contact their local MLA to receive this information. Unfortunately, a lot of the general public are not aware of whom they can go to get this kind of information. I do believe that our local newspaper in Dauphin–I cannot speak for the other local newspapers. I do believe that they did–well, I know they printed the names of the chairpersons, but I am not sure whether they ever printed the whole committee.

Mr. Chairperson: Any further questions? Thank you very much for your presentation, Ms. Doerksen.

Mr. Dave Tesarski, Canadian Federation of Labour. Being one of the out-of-town presenters, his name was called. His name will now go to the end of the list. Mr. John Nicol, President of Union of Manitoba Municipalities. Mr. Nicol, welcome. You may proceed.

Mr. John Nicol (President, Union of Manitoba Municipalities): Thank you very much, Mr. Chairman. I will keep my remarks based strictly on how this bill affects local municipal government.

The Union of Manitoba Municipalities appreciates the opportunity to provide our comments on Bill 49, The Regional Health Authorities and Consequential Amendment Act. UMM represents 166 municipalities across Manitoba, including all of the 106 rural municipalities, 14 local government districts, 23 villages, 20 towns and three cities. The mandate of the UMM is to assist member municipalities in their endeavour to achieve strong and effective local government. To accomplish this goal, our organization acts on behalf of our members to bring about changes, whether through legislation or otherwise, that will enhance the strength and effectiveness of municipalities.

Health care reform has long been an important issue for the UMM. Our member municipalities have had a direct interest in the performance of their local health care facilities arising from their responsibility for facility deficits. Because of this fiscal connection, many municipal officials sit on health care facility boards. In broader terms, municipal officials are representatives of their communities and as such are interested in ensuring that their residents have access to quality health care services.

While we recognize that Bill 49 will impact on many aspects of the health care system in rural Manitoba, our

comments today will be limited to those matters we believe are of primary importance to our membership.

First is the election of directors. We wish to address the selection of directors for the regional health authority. When the regional structure was first announced by the province, there was strong expectation that most, if not all authorities' directors, would be elected by the residents of the regions. UMM is therefore opposed to the provisions in the legislation, which states that directors can be appointed or elected, leaving open the possibility that all of the directors could be appointed by the minister.

The argument has been made that unlike municipalities and school boards regional health authorities will not have the power to raise revenue through taxation and consequently do not need to be elected. Although the authorities will not have the power to tax, nevertheless, it is critical the directors have the support and confidence of the residents in their regions. There are few public services which are as important to the public as the provision of health care. Therefore, we strongly believe rural Manitobans should have the opportunity to choose the individuals who will be allocating their health care resources. When announcing the regional authorities one year ago, the minister stated that healthy communities are best achieved through the participation of individuals in the communities where they live and work.

* (2010)

There is no better way to ensure this participation but by allowing residents to elect the directors for their regional health authority. UMM recommends the directors be chosen by a process which includes elections and appointments. We would support a majority of the directors being elected by the public, the remainder being appointed by the minister. As was pointed out by the Northern and Rural Health Advisory Council in their recommendations to the minister, a small number of ministerial appointments could serve to fill gaps in expertise or better reflect the region's population diversity.

We also believe that the process for elections and appointments should be clearly set out in the legislation and not left to regulations, as the act now states. Rural Manitobans should have a full and clear understanding of how their health care representatives are chosen.

In addition, we are opposed to the measures allowing the minister to appoint the chairperson of the authority. Once again, the UMM strongly believes it is essential for the chairperson to have the confidence of the directors and residents of the region. We also feel the chairperson should be accountable to more individuals than just the Minister of Health. Therefore, we would recommend the chairperson be elected by the directors.

On regional health authorities' deficits, a second important aspect of Bill 49 is municipal obligations for hospital deficits. Our membership has never supported municipal property taxes being used to cover health care overexpenditures. Accordingly, we are pleased municipalities will no longer be responsible for health facility deficits which are incurred after the coming into force of The Regional Health Authorities Act. We note, however, that there are no provisions regarding the liability for deficits incurred by regional health authorities. UMM recommends the legislation clearly states municipalities have no financial responsibilities for the operations of the regional health authority. We believe adding such a section will clarify the intent of the government and will prevent the possibility of municipalities being requested to cover the deficits of health authority.

In regard to the physician shortage and supply in rural Manitoba, the shortage of physicians in rural Manitoba is one of the most serious health care concerns for our member municipalities. For the fourth consecutive year, the Union of Manitoba Municipalities convention delegates will be discussing a resolution asking the province to address the problem of physician shortages. The Department of Health has indicated the regional structures will enhance the recruitment of physicians to rural and northern areas because the pooling of resources will create an improved support system. We hope the regional system does in fact improve physician recruitment, but we still believe there is an important role for the Department of Health to play in finding solutions for this critical problem. Union of Manitoba Municipalities strongly encourages the department to work closely with regional health authorities to ensure the issue of physician shortages is addressed.

In closing, the Union of Manitoba Municipalities thanks the committee members for their consideration of our concerns and recommendation regarding Bill 49. We

look forward to future consultations and discussions on the health care system in rural Manitoba.

Thank you, Mr. Chairman.

Mr. Chairperson: Thank you, Mr. Nicol.

Mr. Chomiak: I would like to thank you on behalf of all committee members for the presentation. I think you have made some very, very valid points. I wanted to query you on the deficit issue as you now understand it. The situation, as you understand it, is that after the regional health authorities come into effect, it is basically in limbo with respect to what will happen if those regional authorities should incur a deficit. Is that your understanding?

Mr. Nicol: Our understanding is, yes, it is.

Mr. Chomiak: Has there been any discussion between the association and the Department of Health with respect to clarification as to what will happen to those debts in the future?

Mr. Nicol: The minister has had a number of meetings with us and has indicated to us that we will not be held responsible, municipal tax levy will not have to go toward paying these deficits.

Mr. Chomiak: So you have received assurances from the minister that municipalities will not be responsible. Have you been given any clarification whether that will be amended to put it into the act in order just to put some validity to those assurances?

Mr. Nicol: I waited for the right length of time this time, Mr. Chairman. Yes, the minister has not said that he would amend it. He has given us his assurances, though, that municipal tax levy will not be covering this deficit, and as with all of you fine people, we have to take you by your word, Sir.

Mr. Chomiak: Has there been any discussion? Do you think that your association would be in favour of having regional hearings with respect to this bill to allow your individual members and your individual communities to have an opportunity to make a presentation?

Mr. Nicol: Personally, yes, that would not bother me at all. We have not discussed it as a board though, Sir.

Mr. Chomiak: One of our concerns about the bill is the fact that if a regional health authority should determine, in its own wisdom, that they want to provide a certain type of health service and the minister disagrees that health service should be provided, then the local authority is completely responsible for the funding of that particular aspect of health care. For example, if one regional board decides they want to fully fund, say, chiropractic visits beyond the present 10 visits per person up to, say, 25 visits per person, for example, and the minister decided that is not the case, then the regional board will be responsible for it.

That will, of course, require the regional board–if they wish to have a health service, in their own wisdom they think is necessary for their community to provide that service, do you have any idea where they might have access to funding for that other than from provincial government?

Mr. Nicol: My understanding is that there will be allocated so much per capita, and they will make the designation of what happens to their money.

Ms. Rosann Wowchuk (Swan River): Thank you for your presentation, Mr. Nicol. Mr. Nicol, you raised a couple of issues. You raised the issue of elected directors and the deficit and also addressed the shortage of physicians in rural Manitoba, but other than the concern about the deficits and the concern about the election of officers, is the UMM in favour of all other aspects of this bill?

Mr. Nicol: As it reflects on municipal government and our powers to tax and how we raise the funds off our property tax, that is basically what our statement was all about.

Ms. Wowchuk: You addressed the concern about the shortage of physicians in rural Manitoba. Do you have, or did your organization have, any concerns that restructuring under regional health boards could in fact result in centralization of services in larger areas and could result on negative impacts on smaller facilities? I will use the Parkland for an example, where the largest facility is in Dauphin. Smaller facilities, like Grandview, Gilbert Plains, Swan River, could have services drained from them which would then, in fact, have a negative

impact on those communities and a negative impact on the people in the area.

Did you have any discussion on that, that regionalization could in fact create problems as far as providing service and attracting physicians?

Mr. Nicol: We have had that for a number of years and have taken that to the government consistently, perhaps, over the last four years that that is a major concern in rural Manitoba.

Ms. Wowchuk: Just one more question, did your organization have any discussion on the part of the act that allows the regional health authorities to charge user fees for services which again, if implemented, could have very negative impacts on the people living in rural Manitoba? Did you have any concerns with that clause in the bill?

* (2020)

Mr. Nicol: No, we did not. As I said, we based ours strictly on how it affects municipal government.

Ms. Wowchuk: Just one more question. With respect to the elections of people to the board, I think that is a very important aspect and would not be very difficult to implement. We have school board elections. We have municipal elections. Do you see any difference in holding elections for municipalities, or did you have any discussion as to how we could possibly hold those elections, whether they would coincide with municipal elections or school board elections? Did you give any thought to that?

Mr. Nicol: I did not believe that it would be that difficult to set up. As you people all realize, we are smart enough to elect you people and members of Parliament. I think we should be smart enough to elect health boards.

Ms. Wowchuk: Thank you, Mr. Nicol. I agree with you on that. That is why I have such concern that the minister is choosing to appoint boards rather than elect them.

Mr. Tim Sale (Crescentwood): I just have one question. Have any of your members expressed to you concern that as currently appointed directors of hospitals and personal care homes in their own communities where they make decisions concerning the operation of the hospital and personal care home–they actually manage it and run it–under this act, they will have no more authority whatsoever to be a part of any of those facilities' operation or management or policy or anything else.

Has any of your membership raised this question in terms of the ability of small towns to maintain their hospitals? I think of towns like Birtle, for example, where they are very proud of their facility, but under this act they will no longer have any say in its management or operation or structure, for that matter.

Mr. Nicol: No, I cannot say that they have brought it personally to us. A number of our municipal people are involved. The government has chosen to appoint a number of municipal people to some of these authorities, and I believe they are working through that side.

Mr. Jack Penner (Emerson): Mr. Nicol, again, I thank you for your presentation. As usual, your sense of humour has not left you, and I congratulate you for that. I appreciate your humour in your chairing your municipal meetings, as I do now, and you have a way of sort of wording things that leads one to the edge of smiling periodically. I think we need that once in a while.

You indicate in your presentation the difficulty that many of our communities in rural Manitoba have in soliciting and recruiting doctors, and that is of course true. I think we all experience, those of us who represent rural Manitoba, that difficulty. Were it not for doctors trained in other countries, many of the communities in my constituency would simply be without a doctor.

Is there an enhanced ability in your view under this act as you read it for you to interact as an organization and as a municipality to support the solicitation of locally trained doctors to a greater degree and thereby enhance the ability for local facilities, rural facilities, to solicit locally Manitoba trained doctors?

Mr. Nicol: I do have some problem with that. We have not been very successful in rural Manitoba in the past of being able to get physicians and doctors to move to rural Manitoba. Some of us are too close to the city, and that is where I live, very close to the city. The doctors tell me, well, we do not want to drive all the way out there and live in the city. If you live out a little bit farther, you are

obviously too far, because they cannot get the services they want.

We have had difficulty all the way along recruiting physicians and surgeons. We are hopeful that this will work. I am sure there are ways that will have to be done. If we are restructuring health care, we are going to have to change it to make it possible.

Mr. Penner: Well, thank you, Mr. Chairman, I agree with you. It has been very difficult for local health boards to solicit local doctors or Manitoba-trained doctors to serve in their community. It has not been that difficult to solicit people from South Africa, India and other countries to come to our rural communities and practise in our rural communities, and many of these doctors being excellent, excellent physicians. Were it not for them, as I said before, many of our communities would be without physicians. There is not question about that. So the local health boards have been rather successful in being able to attract those people, foreigners, to our land and to our province to practise here. They have become, in many cases, very good citizens of those communities, very interactive.

In your view, under this new legislation, is there any provision that you see that will enhance the ability to ensure that some of these locally trained doctors will in fact practise or want to practise in our rural communities under this new legislation?

Mr. Nicol: Specifically, Sir, I cannot say that there is, but judging on past performances, we have not been too successful in the past, and I am just relating it to that.

Mr. Chairperson: Mr. Lathlin, one short question.

Mr. Oscar Lathlin (The Pas): Thank you very much, Mr. Chairperson. I will make my question into a two-part question, Sir. That is, aside from your concerns as a UMM official, that is, you know, those should be elected rather than appointed and then perhaps you would be happy with a mixture of elected and appointed positions and the deficit situation and also the physician shortage, I could not agree with you there more because in The Pas, where I come from, we have that problem consistently. It does not seem to get better.

What I wanted to ask you, though, was, you say that you recognize that Bill 49 impacts on many aspects of the health care system other than the three areas that you mention in here. Are you aware of what those impacts are that you mention?

Mr. Nicol: No, as I said, I am only here representing our organization which deals with municipal health. I am certain the concerns that you are looking for will be brought to you by any number of people who have studied the act much more than what I have. The concerns, as I say, that we have are based on how it affects us.

Mr. Lathlin: Okay, the (b) part of my question, Mr. Chairperson, Mr. Nicol, and that is: I do not mean to be facetious or to be disrespectful, but I, on the election, on the deficit, on the physician, cannot seem to get a reading as to whether you are in support of this legislation or whether you have concerns with it.

Mr. Nicol: Certainly, we have concerns. We have concerns, as I say, over the deficit. We have concerns over the election. We have concerns over the appointment of chairpeople. These are the things, and this is where municipal government in Manitoba is going. We are not interested in picking up deficits or a health authority. We have one place to tax. You people have a number of places, gasoline and cigarettes and everywhere else. We have one place, on the land that a person owns or their house. People in Manitoba, we cannot afford anymore taxes, whether it is for us, you or federal.

Mr. Chairperson: Thank you very much, Mr. Nicol, for your presentation this evening.

I would now like to call on Mr. Don Porter, Manitoba Association of Optometrists. Mr. Don Porter. Mr. Don Porter not being here, his name will go down to the end of the list, and I will now call on Lois Creith, Manitoba Northwestern Ontario Conference of the United Church of Canada. Ms. Creith, you may proceed.

Ms. Lois Creith (Manitoba Northwestern Ontario Conference of the United Church of Canada): Good evening, Mr. Chair, and committee members. My name is Lois Creith from La Riviere, Manitoba. I am here as a trustee on the board of Prairie View Lodge, which is a long-term care facility situated in the town of Pilot Mound, about 200 kilometres from here.

* (2030)

Prairie View Lodge provides personal care and enhanced housing for seniors in our community, which serves an extended catchment area of southern Manitoba.

Prairie View Lodge is sponsored by the United Church of Canada and is a member of the Inter-Faith Health Care Association of Manitoba. It is a corporation with by-laws which indicate the nature of its governance. I am sure that this is also true of the other faith-related institutions within the Inter-Faith Association.

We have received assurance from the Minister of Health through the Inter-Faith Council, and also tonight, Mr. McCrae had stated that he will introduce some amendments to the governance issues as they relate to our organization. It would have been preferable that these views previously agreed to in the Memorandum of Understand which I witnessed, which was signed by the Minister of Health, the Honourable Jim McCrae, and the Inter-Faith Care Association on October 27, 1994, if it would have been included in the proposed Bill 49.

I respectfully submit that the facilities within the Inter-Faith Health Care Association possibly require a special article within Bill 49 which would recognize their incorporated status and permit them to maintain their own governance, faith, culture characteristics and moral and ethical standards.

I trust that this has just been an oversight rather than an intentional move to ignore the rights of such a major sector of the health care providers. If the government's position has changed, this should be publicly stated and not to occur by omission.

If it is the government's intent to honour the Memorandum of Understanding agreement, there exists, as yet, no meaningful provision, possibly, I could say, creative stewardship in the act to the assurance of the continuation of the faith-related facilities.

It is our understand that there will be sweeping regulatory powers foreseen in Bill 49 as it now stands. Sections 59 and 60 of the act allow a wide range of decisions to occur by regulation, and we may end up with health by decree.

Section 51(6), page 32, of the act under, Content of regulation, as in other sections of the act, relegates the fundamental details of the regional health authority to a regulation. I recommend prescribing the compositions of the board in the act and not the regulations. Further, in Section 51(7), the act relegates the selection method of the directors to a regulation. I would recommend election requirements should be included in the act. This is to do with the regional health authority.

Wherever possible, I feel implementation details and future directions should be included in the legislation rather than in regulations.

I would propose that government should state clearly under what principles the system will operate so that all Manitobans know what the rules are and, if the rules are to be changed, that the changes occur through the legislative process and not by regulatory decree.

Bill 49 appears to disregard the value of faith-based healing and care. Step by step it removes the meaningful role of the religious communities in the health care of our people. It is reminiscent of laws passed in former communist regimes which sought to discredit religious and personal values while further empowering the bureaucracy of state.

This Bill 49 seems unprecedented in its power over other legislation and over legally established faith-based organizations such as Prairie View Lodge. To quote just two sections of the act of concern to me, I quote Section 6, page 7, where it says: "The minister may (a) acquire, for and on behalf of a regional health authority, by purchase, lease, expropriation or otherwise, lands, buildings or both for the purposes of acquiring, constructing, expanding, converting or relocating a facility or providing health services under this Act; and (b) upon acquisition, dispose of the lands, buildings or both to the regional health authority on such terms and conditions as the minister considers appropriate."

Further, from Section 28(1) on page 21, I quote: "No person may construct, establish, operate, renovate, expand, convert or relocate a hospital or personal care home in a health region without the approval of the regional health authority for the health region."

These two sections take away all the meaningful power of the local board of trustees.

Going on further, Section 32(1) under district health advisory councils: Unless the minister approves otherwise, a regional health authority shall establish at least one and no more than four of these councils to advise and assist the board of the regional health authority.

This appears to us to be another level of bureaucracy. I suggest, as faith-based and community governance, I see no need to make these councils mandatory.

I would like to thank you for your time to listen to what I had to say. May I conclude this presentation with a little thought, that you can table whatever legislation that you like. It might be challenged in the courts, but rest assured, the United Church of Canada and Prairie View Lodge Corporation intend to continue with their mission.

Thank you.

Mr. Chomiak: Thank you very much for that very powerful and very accurate presentation. Have you been given any indication as to what is going to happen to your particular board?

Ms. Creith: We have not got it in writing. We have a lot of things in our head of what might happen. We may be evolved, I think is the word, as what is going to happen to us. We might dissolve.

Mr. Chomiak: So, has there been any official contact from any direct authority of the Department of Health to your board to give you any indication whatsoever as to your status?

Ms. Creith: I would say, not directly in writing.

Mr. Chomiak: Are you incorporated by a separate act?

Ms. Creith: We are incorporated under the United Church of Canada in the health act.

Mr. Chomiak: So I take it, your status is that you are not. Did you incorporate under your own act? I think your point is well taken about a legal challenge in the court, because I think, aside from the fact that this act may open itself up to a number of legal challenges, I am not certain if it is in fact legally permissible for the Minister of Health to actually take over your operations in the manner–particularly, because you are incorporated under a separate act. Have you had any indication of that?

Ms. Creith: Not that I am aware of.

Mr. Chomiak: We have heard this evening, the minister assuring us that some kind of assurances will be given, and you have indicated that some assurances have been given to the association, the general faith-based association. We have heard of that as well. Have you drafted or had the ability to draft any kind of potential amendments to the act? You talked about a special section that actually would protect faith-based institutions. Have you had occasion to draft anything like that, and if you did, would you be able to share it with this committee?

Ms. Creith: I personally am not in that position, but the Interfaith Council, which is the council that represents the interfaith association , will be acting on behalf of the interfaith association.

Mr. Chomiak: Are you aware whether or not they in fact have drafted anything, in other words, rather than accept perhaps an amendment from us here who may err again, is there any kind of recommendations you might have with respect to how the legislation should be amended? Do you know if there is anything that has been drafted or can be prepared to forward to us for our use?

Ms. Creith: I personally am not prepared to share that with you, but I do know that the interfaith association, the Interfaith Council have had meetings with the Department of Health.

Mr. Chairperson: Thank you very, very much for that presentation, Ms. Creith. Next, George Muswaggon. Okay, not being here, his name will be dropped to the end of the list. Laurie Potovsky-Beachell. You may proceed

* (2040)

Ms. Laurie Potovsky-Beachell (Manitoba Women's Institute): Thank you, Mr. Chairman, honourable members of the standing committee. Manitoba Women's

Institute is pleased to have an opportunity to make this presentation on Bill 49, The Regional Health Authorities and Consequential Amendments Act.

To give you a little background, Manitoba Women's Institute is a grassroots organization that began in 1910–

Mr. Chairperson: Could you just speak maybe closer to the mike and speak up. I think it is the one in the centre.

Ms. Potovsky-Beachell: Is that better?

Mr. Chairperson: Is that better? Carry on.

Ms. Potovsky-Beachell: Where did I leave off? Manitoba Women's Institute is a grassroots organization that began in 1910 with the purpose of providing education to women and families on a variety of topics, including health, agriculture, home economics and cultural activities. It is nonpartisan, nonsectarian and nonprofit. The organization operates under The Manitoba Women's Institute Act of the Manitoba Legislature, administered by the Manitoba Department of Agriculture.

MWI's mission statement is, Manitoba Women's Institute is a women's organization which focuses on personal development, the family and community action, both locally and globally.

The organization is a member of the Federated Women's Institutes of Canada and the Associated Country Women of the World. Currently, the membership in Manitoba numbers 868, with 58 local branches located throughout the province. Provincial memberships have recently been made available to include individuals, and 95 percent of our members live in rural Manitoba, 36 percent of whom live on farms.

Manitoba Women's Institute feels a general concern that Bill 49 bestows regulatory powers that work to the convenience of lawmakers and not to the advantage of those affected by the consequences. It has been suggested that where it is not possible or advisable to include details in legislation, the act should state principles under which the system will operate. Our organization would strongly support that position.

The core service agreement is a perfect example. Without clear references at least to broad categories of insured services, it will be too easy under the regulatory powers of this proposed legislation to deinsure services without sufficient notice to allow for genuine public debate.

This situation is particularly alarming since the act is, unfortunately, silent on any commitment to uphold the five principles of the Canada Health Act and universal access to health. Even an amendment upholding the principles of the Canada Health Act does not really alleviate the threat of legislation that would allow fees for presently unnamed and unspecified services. If it is not the intention of the government to deinsure services, I personally believe that they should so state that in the act.

The concerns stated above, when viewed through the dissatisfaction with present imbalances on RHA boards, particularly those relating to gender, generate additional uneasiness regarding future selection of board members. Quite specific recommendations were made to the minister by the Northern and Rural Health Advisory Council, which set up board composition, size, selection method and terms of office. Indeed, a schedule for phased elections was included in the time line of those recommendations.

MWI supports the election of a majority of RHA board members with limited appointments, no more than 25 percent, by the minister and RHAs to achieve balanced representation for gender, cultural diversity or population. MWI does not support ongoing ministerial appointment of future boards because, in our view, this would obliterate all accountability of regional board members to the communities they are supposed to serve. Neither does MWI support ongoing ministerial appointment of RHA chairpersons, who would be more properly chosen by the boards themselves. Excuse my voice. I have had a bout of laryngitis.

Although a backlash has developed these days against affirmative action, the special role which women have in relation to the health system, not only because of their own but as guardians of family health as well, needs to be recognized throughout the legislation and in the policy development process in relation to regionalization.

Minimally, these measures should include reference to women's health in a statement of principles which would

frame the legislation, measures to ensure adequate representation on RHA boards and on advisory committees to the RHAs, measures taken to educate present and new board members about women's health issues, a requirement that each RHA establish a standing women's health advisory committee, a stipulation in the act that women's input be solicited during the development of regional health plans, areas of service important to women such as reproductive health services be included within the core services agreement.

Our organization is a participant in an ongoing informal working group which is made up of a wide spectrum of organizations and individuals concerned about the impact that regionalization will have on women's health.

We support the following specific proposals for amendments to Bill 49. Part 1, Section 2(2), this section states that not only the act but also the regulations will supersede other statutory acts. Regulations should not supersede provisions in statutory acts. Part 2, generally, powers of the minister are very broad. At the end of Part 2 add a new Section 8 to read: In exercising his or her powers under this act, the minister shall (a) undertake broad consultation with boards, providers and the public and (b) announce any proposed changes to the health care system with appropriate time and mechanisms for users and providers to respond.

Section 3, under Part 2, subsections (1) and (2), Provincial objectives and priorities, and Prescribed health services and standards. These sections should not be permissive. It is imperative that the minister state provincial objectives and priorities and health services and standards prior to transferring responsibility or services to RHAs. The "mays" should be changed to "shalls." These priorities and objectives will serve as the basis for planning and for outcome evaluation.

The minimum level of health services to be made available to all Manitobans should be broadly defined in subsections 3(2) such as health education, health promotion and disease prevention, communicable disease control, public health services, social services, home care services, long-term residential care services, rehabilitative services, chronic care services, acute care services, palliative care services, diagnostic services and emergency services.

Bill 49 makes no reference to the Canada Health Act. A new section should be added, subsection 3(3), to read: The minister in exercising powers under subsection 3(1) and 3(2) will do so in a manner consistent with the provisions of the Canada Health Act.

Part 4, Section 14(1), regional board selection process. Concern that selection being done by appointment with no timetable in the legislation as to when the selection process would change over to elections, the appointed board has a high likelihood of becoming motivated to please the minister in its decisions. Future boards should be consumer based, with a substantial majority of directors elected. It would be best to leave a small number of board positions–up to 25 percent of total board members–to be filled by appointment by the elected board members in order to ensure appropriate reflection of the demographic composition of a particular region. A time limit should be stated in the legislation as to when elections would have to take place.

Section 14(2), Terms of office. Terms of office of indefinite duration are not appropriate. Maximum terms of office of RHA trustees should be set in the legislation with staggered terms to provide continuity in the conduct of RHA affairs.

Section 14(4) Chairperson and executive members. The act provides for RHA chairs to be appointed by the minister. RHA directors should elect the chair as per common practice.

* (2050)

Section 23(2)(j), Duties of regional health authority. The current wording states that the RHA shall comply with any directions given by the minister. Amend to read, comply with provincial objectives and priorities and with prescribed services and standards as per Section 3(1) and 3(2).

Section 24(1), Proposed regional health plan. Insert after 24(1): Regional health plans which provide for the planning or delivery of community health services must be consistent with the principles of primary health care delivery, including integrated multidisciplinary, intersectoral involvement, holistic view of the individual, emphasis on health promotion, policies and programs reflecting ongoing community-based input and perspectives.

Section 24(2), Consultations. Consultation as presently provided for in the act is too limited and does not ensure that citizens and health care providers are included in the development of a regional health plan. This section should be rewritten to read: In the course of preparing a regional health plan, the regional health authorities shall (a) undertake a wide ranging and inclusive consultation process, including public forums; and (b) have regard to the terms of the provincial objectives set by the minister under subsection 3(1); and (c) the wide ranging and inclusive consultation process should ensure adequate input from women and cultural communities residing in the region. RHAs should also be required to establish a standing advisory committee on women's health concerns.

Section 25, General powers of regional health authority. This is but one of many references to the charging of fees for unnamed services. We do not support the deinsurance of health services and do not believe that such an important issue can be left to the regulations. At a minimum, the act should state that fees shall not be charged for categories of services listed under Section 3(2).

Section 33, Minister may provide funding to regional health authority. Funding approval is at the minister's discretion. This leaves the RHAs in an awkward situation since they will be mandated by law to provide services for which funding is permissive. Amend to read "shall provide appropriate funding." Insert mechanisms to ensure that funding is based on a written, objective process and assessment of need, not on a political basis.

Part 5, General Provisions, Sections 59 and 60. Regulations by Lieutenant-Governor-in-Council and regulations by minister. These articles allow an overly wide range of decision to occur by regulation. Many of the items listed under Articles 59 and 60 should be included in the act, not in regulations. In particular, definitions for words and phrases used in the act brought categories of services which will continue to be insured without the charging of fees, membership, selection and nomination procedures and terms of office for directors, principles respecting funding of health authorities.

In summary, Manitoba Women's Institute appreciates the opportunity to make this presentation and hopes that the concerns expressed and the amendments suggested will be given all due consideration. Ultimately, the importance of gaining public confidence by making the regionalization process as transparent and participatory as possible will determine the success of the reform initiative.

Mr. Chairperson: Thank you, Ms. Potovsky-Beachell.

Mr. Chomiak: Again, thank you for the presentation. Again, the validity of this process is confirmed by this presentation, which has specific recommendations for a multitude of amendments to this act, and notwithstanding that we believe that this act is a very bad act, I think that the amendments, as I read them, would be implemented and could be put in the act and would make a bad act perhaps palatable if these amendments were included. We will endeavour to try to urge the government to amend accordingly.

I think it is very significant that you hit on some fundamental points about the regulatory power versus the legislative power, and I wonder if you could outline for us whether you have had access or any review of any regulations that have been put forward under this act. Have you had any opportunity to review any regulations?

Ms. Potovsky-Beachell: No, we have not, and that is one of the things that alarms us. I must say that it is only an accident of being from out of town that I have read out these proposed amendments first, because I am sure you will hear them echoed from several different groups in tonight's presentations. We worked together to develop them, so this is not totally an initiative of Manitoba Women's Institute.

Mr. Chomiak: Well, I thank you again for that because I think they are very valid. The other very significant point you raise is the whole issue of deinsurance, and I agree with you that in fact, if there is going to be no attempt to deinsure, then why would the government not put that into the act? Are you aware of, for example, this year what services the government has deinsured in terms of health care?

Ms. Potovsky-Beachell: Not specifically, but I do know that we are presently paying for services, and if that is what the government intends to imply in this bill, then I think that is what should be stated. Certainly, I think, any thinking person is going to have to accept the fact

that there will be some degree of deinsurance happen, but it has to be an absolutely transparent process, and I think it needs to be based on the needs assessment that the regional health authorities do as they relate to their own regions.

Mr. Chairperson: Thank you very much. One short question.

Ms. Wowchuk: Thank you for the presentation. I want to ask you specifically about a section of the bill that you did not cover, but one that was raised by Women's Institute at your annual meetings and that being the district Health Advisory Councils. If I recall correctly, members of the Women's Institute were concerned that the district health councils were the closest body to the people that were supposed to be represented, but in the recommendations that came forward from the northern and rural task force, the district health councils would have no funding, and there was concern about how they would actually operate and how people would be representative of the people. Is that still a concern or is that anything that has been discussed further by the Women's Institute, and do you have any further recommendations on how that should be dealt with?

Ms. Potovsky-Beachell: It has not been discussed further, to my knowledge. Unfortunately I was away, so I was not at the conference. I was not involved in that particular discussion, but I think that the selection process generally is of great concern to our organization.

Mr. Chairperson: Last? Last?

Ms. Wowchuk: Last one, yes. We have concerns about the number of women that were appointed to be representatives on the boards, and I wonder whether the Women's Institute was aware and made any efforts or put names forward to try to get more women representatives on the regional health authorities?

* (2100)

Ms. Potovsky-Beachell: Certainly I think the Women's Institute members have received a great deal of encouragement to participate. That is what our organization does. We basically encourage our members to be involved publicly on issues of this sort. As a matter of fact, there are three Manitoba Women's Institute members who are on various regional health authorities presently. We certainly hope to have more, but as I am sure you are undoubtedly aware, it is oftentimes difficult to be involved. Women's schedules these days, and particularly rural women have a very heavy schedule in terms of homekeeping, care of various generations, working outside to keep the farm going. It really is a battle. So hopefully there will be more women stepping forward. I am chair of women's health issues for Manitoba Women's Institute, so I take a personal interest in encouraging women to participate.

Mr. Chairperson: It has to be real short, Mr. Penner.

Mr. Penner: Mr. Chairman, I really appreciate your indulgence here. You indicate that as far as Section 33 is concerned, the minister may provide funding, funding or approval is at the minister's discretion, and then you go on to say that there should be an amendment to read, you shall provide appropriate funding. What would you deem as appropriate funding?

Ms. Potovsky-Beacher: I cannot even balance my own cheque book so that kind of a question is difficult, but as I recall from discussions on the Northern and Rural Health Advisory Council, the appropriate funding was to be done by formula, funding formula, which, I must say, we have not yet seen and have had a little trouble getting any information on.

Mr. Chairperson: Is this committee prepared to give leave to Mr. Penner to ask one more brief question?

Mr. Penner: Just one short question and maybe more of a comment than a question. One of my gravest concerns in the current health care system as structured now, allows for the operations of district health provision in a deficit sort of situation, that the municipalities are then asked to pick up the deficit either through taxation or local fundraising efforts, which in my view has always been a concern, allows for the provision of different levels of health care in different communities. That has been the case in this province. That is a history in this province. Those communities that are affluent are able to in fact provide better services than those that are not. This in your view, and I am sure I have heard your organization address that issue before in my previous lifetime, and certainly, do you think that this new bill and

act and the regional provision will help stem that and provide more equal services in the community?

Ms. Potovsky-Beachell: That was the objective in terms of the Northern and Rural Health Advisory Council, was to distribute the funding so that it was used so that every region received the funding that they required to provide good health care. But, first of all, we need a core services agreement to determine what services are going to be covered under that, and then we need a needs assessment from each regional health authority so that the board members of that health authority can look at the resources that they have within that region and put them to the best use possible. I do not know that I have answered your question specifically.

Mr. Chairperson: Thank you very much for your presentation. You will be pleased to know that the next two presenters listed from rural Manitoba are both female. I would now like to call on Georgia Wiens. You may begin.

Ms. Georgia Wiens (Private Citizen): Yesterday was Thanksgiving Day, and I am thankful for my good–

Mr. Chairperson: Would you please speak into the mike so everyone can hear. Thank you very much.

Ms. Wiens: Okay, I will begin again. Yesterday was Thanksgiving Day, and I am thankful for my good health and the level of health care we have been able to enjoy. My concern is the future of health care. Because I am presently today speaking on a personal level, I will tell you briefly a little about myself.

My name is Georgia Wiens. I live in a small farming community north of Winnipeg. I am a wife, a mother and a daughter. As long as I can remember, my mother has suffered from multiple sclerosis. Twenty years ago, I took over the care of Mom, already very debilitated from her disease. For the greater part of those 20 years, she has also suffered with senile dementia. She is now in the end stages of those diseases and still at home. I have been able to maintain a normal family life and career with many thanks to community support health services. I could not have done without their help.

As I voice my concerns today, I hope that I represent others in the community who are unaware of health care changes set out by Bill 49. I have read over The Regional Health Authorities and Consequential Amendments Act twice and, for the most part, feel I understand it. Understanding the act has not left me with any measure of reassurance that we will have quality health care provided and universal accessibility once the bill is passed. I am left with more questions than answers.

My first concern is the ultimate power the minister has to control and dictate the provisions of health care in this province. His goals and objectives are unclear. Whenever the minister has been questioned about any decisions he has made, his only theme has been the loss of transfer payments from Ottawa. Should I assume then that the goals and objectives are monetary and the standard of health services will be measured accordingly? How can only one person have the infinite wisdom to make final decisions about a dynamic field as health care effectively, unless of course you have only one focus–money? So at what human cost are the changes of health care going to be made?

My second concern is the pyramidal-type structure of the regional health authorities. Everyone appointed or elected will have to adhere to the rules, restrictions and standards set out by the minister and cabinet at all costs.

Whose needs are we fulfilling? As the regional authorities attempt to set up plans for delivery of health services, they have limited autonomy. Under the circumstances, if I was appointed director I would be anxious to please the government and the needs of the people would be secondary. My job would depend upon it. If there was a public outcry of mismanagement of services the board would be to blame, not the government, and no one would be held liable. The damage would already be done. Where is the accountability of the government in setting up a responsible, effective health care system?

We watch helplessly while members of the board of regional health authorities are appointed or elected. Elected by whom? If I had the privilege to vote I would like to see representation by prudent business people whom I could trust to be fiscally responsible, members of clergy and ethnic groups, and most importantly experienced individuals who have worked in the health care field. Who best could represent health needs than

those who have directly cared for the sick, dying, injured and handicapped and have also witnessed the waste and abuses of the system? The health care needs of many are dependent on the management and decisions of a few people, so it is so important to have qualified individuals of integrity and conscience sit on these boards.

I am concerned about changing standards in health care delivery. Agreements can be made for the purpose of providing health services with for-profit organizations. I saw firsthand what effect this has on caregivers in the community. During the home care strike Mom and I had a home care worker helping us. She refused to go on strike only because she felt committed to us. With the threat of privatization, she retired soon after the strike, feeling unappreciated by her employer for her long years of service. Presently, we now have a young home care worker who has invested her time and money in health care education. In January she will be leaving home care to pursue education in another field of work as she feels there is no future in health care. She is an excellent worker and a great loss to health care, specifically home care.

There seems to be a changing trend towards a rapid turnover of caregivers, never achieving full commitment and satisfaction in their jobs. The result of all this can only be erosion of health care delivery at all levels of health care as more for-profit agencies emerge and agreements are made.

There is made mention of the establishment of charitable foundations by regional health authorities. I wonder what the public's response will be after some of their health services are deleted or fee-for-service initiated. I have visions of regions having varying degrees of health care and services depending upon how affluent they are. Is this universality of health care delivery?

* (2110)

In conclusion, I would like to thank you for your time in listening to me speak tonight. I did not come here with high expectations of changing things but hopefully serious consideration. My mom will pass away soon, but my twin sister also has suffered from MS the past 18 years and I fear for her care. We should all be concerned as one day we all need qualified, efficient health services, and will they still be there?

Mr. Chairperson: Thank you very much for the presentation.

Mr. Chomiak: Again, thank you for that presentation. In coming from someone who has the experience and the care that you have provided I think is pause for all of us to think about. I might add that again this just serves to demonstrate how important these public hearings are.

There is nothing I could say that actually I think could highlight better the issues that you have raised, nothing that I could say that could do it better. I just want to point out to you that it is interesting, are you aware of the fact that you make the point, and I think very, very validly, that people who provide care ought to be eligible to participate in the regional health boards. It is interesting, I am not sure if you are aware, are you aware that the original northern and rural task force that supposedly set up Bill 49, the government accepted some of their recommendations, rejected a lot of their recommendations? But if there is one recommendation I think they should have rejected, it was the recommendation of that task force that people who provide health care not be eligible to participate on the boards. I think your point is well taken. I agree with you and I am trying to quickly pose this into a question. I think there is a lot of wisdom in what you said, particularly with respect to having caregivers being participants on the boards because I think there is a real validity in having people who provide that care, particularly in smaller communities, with their expertise and knowledge they ought to be representative on the boards. I guess I am just saying, do you agree?

Mr. Chairperson: Thanks for that presentation, Mr. Chomiak, and thank you very much . . . .

I would now like to call on Aline Audette. You may begin.

Ms. Aline Audette (Private Citizen): Hi. I am sorry, but I am really nervous and this is my first time ever having to do this, but I will do my best.

I am a private citizen and I also work at St. Boniface Hospital as a nursing assistant. I also was part of the

negotiating team that we just had for negotiations with St. Boniface Hospital, so this bill really upsets me a lot because when we were going through negotiations we fought tooth and nail to keep our no-contracting-out clause. That meant a lot to our members; it meant a lot to me. This commissioner, from what I understand, is going to have the right to just take that away or amend it to whatever suits them so they can privatize laundry services, which we have already heard about. We have heard about the urban-shared facilities, which is really scary for our members because it means a lot of our members' jobs and my coworkers' jobs.

The laundry services is one of the first things that from my understanding is going to go. I work on a ward where I have difficulty getting linen in the morning to make a patient's bed, so they have to sit up in a chair because there is no linen. So they sit in a chair they are uncomfortable in, they are sick, they are vomiting, but they have to stay in it because I have no linen. I feel that is going to get even worse if we do not even have our laundry services within our facility.

Food services, as well, that is another area that kind of concerns me, and also from my understanding the commissioner will have the right to choose which union I have. I voted in UFCW. I strongly believe in UFCW. They have been really good to us, and I would like to keep them there. I do not want somebody telling me who my union is going to be. That is another concern of mine.

Also, my father had a stroke in July and I have seen the health care services–the other side, and it stinks. My dad stayed on a stretcher that was this much too short for three days in emergency and I could not do anything about it because there were no beds. There was only a stretcher for him to lie on. Those kinds of things are concerning me with Bill 49 because if it is already this bad and Bill 49 comes in, you know, it is going to be even worse. What is going to happen to my dad from here? I mean, he has to go to a nursing home now so what is going to happen there? Is he going to get taken care of? Is he going to have linen to have his bed made when he needs to get back to bed? I mean, I see patients right now that I take care of who are dying, and I do not have time to spend 15 minutes holding their hand just to make them comfortable because I have 14 other patients that I have to take care of. This is every day at St. Boniface Hospital, and it is very sad. It is hard.

But anyway, going back to this commissioner, I think it is something that all our members are really upset about. Again, we received a lot of support during negotiations because the no contracting out meant a lot to our members, and I fought a long time for that. I stayed away from my family for six to eight weeks spending time educating people and telling them what no contracting out meant, if it came out of their contract, what that meant to them. Now here we are again having to fight all over again. That is all I have to say.

Mr. Chairperson: Thank you very much for that heartfelt presentation.

Mr. Chomiak: Thank you again for the presentation, and I just want to express our admiration for your coming out because that is what we as legislators who are supposed to be managing health care ought to be hearing in the committee, and we ought to be hearing this every day.

With respect to the contracting out and the commissioner, have you been given any indication with respect to Bill 49, when and if it will apply to St. Boniface Hospital?

Ms. Audette: Not to my knowledge when it is going to take effect, but we did hear through negotiations that if our no-contracting-out clause was not there, they would be privatizing, and it would be gone.

Mr. Chomiak: Also, with respect to Bill 49, are you aware of the implications in terms of contracting out for home care services and other services outside of Winnipeg as Bill 49 applies?

Ms. Audette: Yes, I have been hearing how it is going to affect.

Mr. Chomiak: If you have an opportunity to indicate to the minister what the significance is for you between contracted-out work and private and nonprofit, what do you think you should say or could say to the minister with respect the privatization of health care?

Ms. Audette: Well, I feel, working at St. Boniface, we talk about continuity of care all the time, and with privatization, you do not get that. You get just whoever they send in. I have had friends who worked for

privatization, and they say, you just get tossed wherever you need to go. It is never the same. You never get to see the same faces. It is frustrating for the patients and for the person who is trying to provide good care and, you know, to get to know these people and get to be their friends. These people are sick. They like to have somebody familiar taking care of them, and that will not happen with privatization.

Mr. Chomiak: Thank you.

Mr. Chairperson: Thank you very much for that presentation. We have now completed the out-of-town presenters, so I will go back to the beginning of the list. The first speaker on that list is now the speaker, and that is Hila Wilkie, Manitoba Health Organizations. I am told by the honourable minister that you look more like Marilyn Robinson.

Ms. Marilyn Robinson (Manitoba Health Organizations): Mr. Chairman, it will not be Hila Wilkie. I am speaking on behalf of the MHO board of directors.

Mr. Chairperson: You may begin.

* (2120)

Ms. Robinson: Yes, I am speaking on behalf of the MHO board of directors.

Manitoba Health Organizations, MHO, is pleased to have this opportunity to present to the standing committee on Bill 49, The Regional Health Authorities and Consequential Amendments Act. We commend the Minister of Health (Mr. McCrae) for his proposed amendments announced earlier this evening. However, there are a number of issues that remain outstanding.

I am circulating copies of our full report which has been previously circulated to all MLAs and to our membership last month. In the interest of time, my presentation will focus on the key issues raised in our paper.

With a voting membership of 160 health care agencies across Manitoba, including all publicly funded nonprofit facilities, MHO truly represents the views of the health care sector. MHO has a long tradition of working with the government of the day to ensure the best health care system for Manitobans. The MHO response to Bill 49 was developed through a member task force and was subsequently explored in multiple member forms in rural and urban centres.

The issues and proposals which we raise in this presentation are based on the concerns expressed by the majority of trustees and administrators across the province. At the outset, MHO would like to acknowledge the magnitude of the task undertaken by the authors of Bill 49. Of necessity, our presentation will focus on those aspects of Bill 49 which we find ambiguous or ill advised, but it is not our intent to undermine the efforts which have gone into developing this draft legislation. We support the need for structural and operational changes and are prepared to work actively with government to effect those changes.

I will now focus on the main points of our presentation. Government's July 18 Brandon announcement and the August 20 Next Steps announcement in Winnipeg have important implications for Bill 49. MHO membership, both urban and rural, overwhelmingly supports one act governing both urban and rural health regionalization with modifications to Bill 49 to reflect the recent urban announcements. MHO believes that a potential delay in passing Bill 49 to make these necessary modifications will be balanced by the benefits of having one integrated act. MHO and our urban members will be pleased to participate in discussions to identify and resolve any issues arising from this recommendation.

Almost one-third of MHO member facilities are faith related. These members are very concerned that there exists no provision in the act to assure the continuation of faith-related facilities. If it is government's intent to honour the Memorandum of Agreement signed in the fall of 1994, then the intent of that memorandum should be included in the act. We commend the Minister of Health (Mr. McCrae) in heeding the concerns of the faith-related facilities. We caution, however, that if the proposed amendment is not extended to all health care facilities and agencies in the province, questions will be raised regarding the perceived privileged status of the faith-related facilities. Our members, including the faith-related facilities, have indicated that the autonomy, mission and values of all facilities and agencies should be respected.

MHO members agree on the need for strong health authorities which would fulfill three roles within the health region, that of planner, funder and service provider of a direct or indirect nature. MHO believes that a broad and flexible interpretation of the provider role is essential. Some health authorities may find that it is appropriate for them to be the main direct provider of services because most of the health corporations and health care organizations in their region have chosen to wind up their operations.

In other regions, where health corporations and health organizations opt to continue as service providers, it may be more appropriate to introduce an element of competition into the provision of services to ensure maximum efficiency and quality.

Health authorities could enter into a process of tender and negotiations with providers regarding types and volumes of services to be delivered within fixed budgets. Providers could include private entrepreneurs, local or district health boards and the service arms of health authorities formed as a result of the wind-up of some corporations. An appeals process could ensure that contracts are granted on the basis of objective criteria and not through bias or preferential treatment.

MHO considers that a flexible approach, open to public scrutiny, reflects the spirit and intent of Bill 49. It respects the principles of public accountability, decreased bureaucratization, community input and decision making close to home. Additionally, the injection of healthy competition will result in cost efficiencies in the delivery of health services. Just as importantly, this flexible interpretation will increase buy-in to the regionalization process by answering the concerns of existing local boards and provider groups which would prefer to retain some degree of autonomy. This alone will assist with the quick and successful implementation of health authorities across Manitoba.

For the remainder of this presentation, I will speak to the eight overriding concerns expressed by MHO membership.

First, considerable concern has been expressed in regard to the apparent degree of concentration of all decision-making power at the ministerial level. The degree to which all decision making is centralized in the ministry appears to contravene the publicly stated position of government to decentralize decision making. Under such an approach, it would be unfair to hold health authorities accountable since they would have no true power.

The act could encourage government to micromanage health services delivery. In our view this would be ill advised. All operating and decision-making power should be delegated to the RHA on a day-to-day basis, with the minister intervening only in extraordinary circumstances.

Second, there is concern over the extensive regulatory powers foreseen by Bill 49. The new health system would be allowed to evolve via regulation and without mandatory public input or legislative scrutiny. Major programs could be wiped out without any public input. We recommend that wherever possible, specifics of system changes and directions be included in the legislation rather than in regulations. Where it is not possible or advisable to include such details in the legislation, government should state under what principles the system will operate.

Third, we are uneasy that Bill 49 proposes to allow regulations arising from this act to supersede other acts established under statutory authority, including The Labour Relations Act. Allowing regulatory power to overrule statutory power is an uncommon practice and one which our members find unacceptable.

Fourth, the bill, as currently written, is almost entirely silent as to the nature and status of community health centres and the delivery of their services. The community health centres welcome the emphasis on community-based systems as announced in The Next Steps initiative, but urge government to amend the bill to give effect to this emphasis. The Health Advisory Network task force on primary health care (1994) identified and drafted a series of guiding principles for the delivery of primary health care. Manitoba Health has the opportunity to take the lead in this field and enshrine reference to these guiding principles in the legislation.

Fifth, the act is generally silent in regard to any appeals processes. We believe that appeals processes provide necessary checks and balances, in particular in relationship to the establishment, variation, amalgamation or

dissolution of health authorities, disputes between health corporations and the health authority, consumer appeals and the resolution of labour relations issues. These appeals mechanisms should be described in the act and should have time limitations to avoid abuses such as using appeals as a stalling mechanism.

Sixth, MHO members are convinced that Part 6, Transitional provisions respecting labour relations and employees, could be dealt with in a less adversarial manner. We acknowledge the need to move with some expediency in resolving any labour issues related to regionalization. However, we maintain that individuals affected by system changes need to be treated fairly and equitably. We fear that the proposed process will create animosity from the outset and it is not in the interests of health care.

* (2130)

As an alternative, we recommend that the task of addressing labour relations issues be assigned proactively to the Manitoba Labour Board, which is an existing and proven body for the resolution of labour relations issues. However, if government is determined to pursue the commissioner approach, we recommend an amendment to the process, such that the commissioner be appointed under the Manitoba Labour Board and be required to conform with their processes. Provision should also be made to provide the opportunity for voluntary co-operation of unions, as well as for conciliation and mediation and an appeals process.

Seventh, as the act is written, it adds levels of bureaucracy to the existing system. We propose that district health advisory councils not be mandatory except in those areas where existing local boards choose to wind up operations.

Finally, MHO members have concerns relating to the repeated references to the charging of fees for unnamed services. This is not balanced by any reference to the level of services which shall remain insured. At a minimum, the act should include broad categories of services which will continue to be insured, for example, health education, health promotion and disease prevention, communicable disease control, public health services, social services, home care services, long-term care residential services, rehabilitative services, chronic care services, acute care, palliative care, diagnostic services and emergency services.

In closing, MHO would like to emphasize that we recognize the need for change and that our major concern is that we work together to provide quality health care to Manitobans at an affordable cost. Thank you.

Mr. Chairperson: Thank you, Ms. Robinson.

Mr. Chomiak: Thank you for the presentation and thank you for also providing the presentation to all the MLAs early in September in order to allow us to acquaint ourselves with the position of MHO, and the paper goes on to talk about numerous, I think upwards of 50 separate items of possible amendment and changes to the act.

I guess I am surprised that the government would not have consulted more extensively previously with MHO with respect to this act if, in fact, there was a consultation process at all, and I wonder if you can give me any ideas as to the consultations that took place prior to MHO actually seeing this act.

Ms. Robinson: The consultations that took place were more specifically with the Northern and Rural Health Advisory Council through that particular network.

Mr. Chomiak: So we had the northern and rural task force recommendations, and then the act was drafted, so is it correct to say that MHO did not see a copy of this act until it was presented in the Legislature?

Ms. Robinson: That would be correct. We did not see a preliminary draft that I am aware of.

Mr. Chomiak: I do not mean to put you on the spot, but it does strike me as passing strange that a body as representative of health institutions and the like as MHO would not have an opportunity to review an act prior to its being forward, an extensive act like this.

Have you had an opportunity to consult with the minister respecting your 50-odd recommendations for perhaps changes in the act, and can you give me any indication as to the possibility of those extensive amendments taking place?

Ms. Robinson: Yes, Mr. Chomiak, we have had an opportunity to meet with the minister and the Premier (Mr. Filmon). That meeting took place two weeks ago, three weeks ago, and we did have an opportunity to discuss some of the highlights of our 50-something recommendations for change. I think that if there is any intent to make any amendments based on that, you would have to ask the minister about that.

We did feel that there was a good hearing, that several of the issues that we had raised we were led to believe they did attract some attention and would be looked at more seriously. We would hope that we would have further discussion if there are any amendments that are proposed as a result of our meeting.

Mr. Sale: Is Mr. Chomiak finished, Mr. Chairperson?

Mr. Chairperson: He deferred to you.

Mr. Sale: Oh, I am puzzled I must admit. I read your presentation in its longer form before the hearings and you have just highlighted what you called major and overriding concerns, which listed some seven or eight major issues, and then your brief goes on to deal with at least seven more parts of your concerns and then, in fine print, you have 79 concerns. Yet you say you support the principle. It seems to me, by the time you deal with 79 concerns and seven overriding concerns and some other major concerns, that the principle is about all that is left.

Ms. Robinson: We support the need for change, if there is indeed going to be change or health reform take place in this province, and certainly we support the need for legislative change to the structure of our health care system and to the operational directives that make the system work.

Mr. Sale: I did not really mean to be facetious in this because it seems to me the implication of what you said almost at the outset was that this bill should be delayed and should be redrafted, not just in minor technical ways but in very substantive ways, not only following your comments but the comments of some other presenters who proceeded you.

Would it be MHO's recommendation that this bill be withdrawn and redrafted?

Ms. Robinson: We certainly support the need for some extensive reworking to be done on this bill. Whether the decision is to withdraw the bill and start over again or to work on the major areas that need to be refined, I think will come out of this hearing when you hear from a number of constituents who have very similar concerns.

We have flagged the issues that we find difficult to come to grips with, and in trying to understand where the health care system is going, we believe that there is extensive reworking that needs to be done, as we have detailed here. It is more than a little fine-tuning and a little tinkering.

Mr. Chairperson: Mr. Sale, the last question perhaps?

Mr. Sale: Mr. Chairperson, I am sure you are aware that the process that we are in now is going to last, perhaps at best, two or three days, and there will then be clause-by-clause consideration. The minister will introduce, he has indicated, four amendments. That falls some 74 short of what you think is needed.

Do you really think that there is reasonable time in this session of the Legislature to accomplish the kind of reworking, given that it is highly likely that this bill will pass through committee by use of the government's majority within a week or so? Is that enough time to do the task that you have indicated in this brief?

Ms. Robinson: Without knowing the extent of the four amendments that the minister has proposed–I mean, you know when I grouped my presentation, I took globally six or seven or eight recommendations and rolled it into one descriptive paragraph or two descriptive paragraphs, so without knowing the extent of the amendments that are proposed, it is difficult to know. I find it difficult to answer your question as to, you know, what the intent of those amendments is and what it would mean in terms of the debate and the reworking of the bill.

Mr. Sale: So it might have been helpful, then, if you had those amendments before you, rather than being forced to present in the dark.

Mr. Chairperson: Thanks for that submission. Thank you very much for your presentation.

I would now like to call on Lorraine Sigurdson, who is here in place of Eugene Kostyra. You may begin Ms. Sigurdson.

Ms. Lorraine Sigurdson (Canadian Union of Public Employees, Manitoba Division): I am here representing the Canadian Union of Public Employees, and we welcome this opportunity to address your committee on Bill 49.

We represent over 8,000 health care workers in virtually every area of the province and, at the back of the brief, we have a list of all the health care facilities and health agencies where CUPE members work. They are from the largest health care facility in the province to the smallest.

We recognize that change is necessary in our health care system, but we submit that the nature and potential consequences of the changes facilitated by the passage of this bill may do more harm than good for the delivery of health care in the province.

* (2140)

CUPE members are very concerned that with the implementation of Bill 49 the government is opening the door to user fees, greater privatization and divergence from the principles of the Canada Health Act for health care in Manitoba.

Under Section 25 of the bill, a regional health authority may, where authorized by regulation, charge fees for health services or categories of health services directly to the person who received the services at rates fixed in or calculated in accordance with the regulations.

In Section 31, a regional health authority has the ability to make agreements with government agencies, it is listed in our brief, but the section that concerns us is, any other person or group of persons.

These sections have no place in Canadian health care legislation. User fees and agreements with profit-based, private companies will drastically change the nature of our health care system. The minister referred earlier to the Canada Health Act, and the five fundamentals of that act are universality, comprehensiveness, accessibility, public administration and portability. The minister referenced those principles earlier.

We are concerned, regardless of what the amendments to the bill say, that the existence of Sections 25 and 31 clearly jeopardize those principles. It is CUPE's submission that any reference to fees for service in relation to health care should be deleted from the bill. The introduction of a two-tiered health care system is contrary to the principles of the Canada Health Act and an unwarranted step toward the Americanization of our health care system.

This is in violation of the principle of accessibility, one set of services for the rich, those with money, and less service to the poor.

We further submit that privatization of the health care sector will ultimately affect the level of health care provided to Manitobans, bring down the salaries of those working in the health care sector and, consequently, the economy of the province and increase the profits for companies such as the American-based Marriott Corporation and other companies whose primary aim is to make a profit for its owners and shareholders. These companies are not concerned with the delivery of health care services in accordance with the fundamental principles of the Canada Health Act, which calls for public administration.

Privatization is also related to the whole question of comprehensiveness, as in the Canada Health Act. Health care in Canada is a $72.5-billion market. Corporations are currently positioning themselves to enter the publicly administered and funded portion of that market. Private corporations who deliver health care services stand to reap considerable profit from any narrowing of the definition of comprehensiveness. Bill 49 puts considerable power into the hands of the provincial government to make changes through regulation, which facilitates the corporatization of health care.

We believe that comprehensiveness under the Canada Health Act means that all medically necessary services provided by hospital and doctors should be insured. This is supported by the fact that the Canada Health Act provides for a dollar-for-dollar penalty in cash transfers to the provinces where provinces permit charges for insured health services. Alberta was recently penalized $3.6 million over a period of seven months for allowing facility fees in private clinics. The financial consequences are therefore significant for allowing fees to be charged.

Is the process necessary? CUPE submits there is no evidence that the process of regionalization as proposed in Bill 49 will necessarily make health care better. The indications are that the effect will be the reduction of services and jobs.

The reduction of jobs will be particularly hard in rural Manitoba, where jobs are scarce. This will be devastating to the rural economy. It may also pose a threat to the health of health care workers thrown out of jobs and unable to find other work. In 1994, the Manitoba Centre for Health Policy and Evaluation released a study which clearly showed, and I quote: Health of Manitobans varies markedly in relation to our socioeconomic status.

This government has not addressed the issues of labour adjustment for health care workers, and this bill does not protect workers from job loss.

Reduction of services in any health care facility has negative implications, but for rural Manitobans this means access to service will be further limited by the increased need to travel great distances to receive services. Rural Manitobans already have to travel to larger centres to receive specialized services. Will they have to travel miles to receive basic medical attention?

Regionalization may take place, but, clearly, it need not be implemented with provisions like those in Bill 49. Mergers have occurred in health care in the past without the necessity of legislation of this nature.

In February of 1973, the Health Sciences Centre was formed. Attached to this brief is a copy of The Health Sciences Centre Act. There is no reference to the drastic and severe provisions in relation to labour relations as is contained in Part 6 of Bill 49. Nothing in The Health Sciences Centre Act overrides collective agreements or existing certifications. This merger affected two separate CUPE locals with their own collective agreements and their own seniority lists, and that was accomplished with the labour laws existing at the time.

The CUPE locals merged, collectively bargained the merger of the collective agreements and new seniority lists. The merger affected over 1,000 members of these two CUPE locals. This is more support staff than would be affected in many of the rural health authorities which are being created. No legislation intruding into employees' rights was required. The process of merging of unions was done without it being forced upon them. The people involved had a voice in that determination.

There are other examples in rural Manitoba. Health facilities in rural areas have merged in the past, and this has been accomplished without legislation like Bill 49.

In the fall of 1992, the unions representing health care workers in Winnipeg and the 10 urban health care facilities negotiated the Letter of Understanding on Redeployment Principles. This Letter of Understanding has been ratified by unions and employers in 81 facilities in this province. This agreement was negotiated without legislation. The unions and employers recognize that change is ongoing in the health care system, and we are working to protect workers from this change. We have also worked together in the Provincial Health Care Labour Adjustment Committee, which has made recommendations to government.

The Letter of Understanding on Redeployment provides for preferential consideration for laid-off health care workers for jobs created in health care facilities other than those from which they have been laid off. These are in addition to recall rights.

By September of 1996, 921 health care workers have been laid off. Three hundred and ninety-four of these workers have obtained permanent or temporary positions through the redeployment agreement or through recall to their facilities. We know that the redeployment program has worked. Unions and employers agreed upon measures which should be put in place by government for additional labour adjustment. We did not need the interference of a commissioner to do so. We have the will and the ability to deal with these issues.

The redeployment Letter of Understanding is one more right which should not be affected by legislation. Part 3 of The Labour Relations Act contains successor provision and common employer provisions. These are specifically designed to deal with the situations where employees of predecessor employers are intermingled, and there are references from Canadian labour law which I leave for you to read in the brief.

The Manitoba Labour Relations Board is one of the six in the country which has the power to modify, alter or restrict the operation of collective agreements as necessary to fashion rational, viable bargaining relationships contained in Section 56(2), which is there for your information.

Whether you support the principle of seniority or not, an arbitrator has described seniority as follows: Seniority is one of the most important and far-reaching benefits which the trade union movement has been able to secure for its members by virtue of the collective bargaining process, and that is one of the thorny issues that will have to be dealt with.

When two or more facilities are merged under one regional health board, the employees will be intermingled. In labour law, intermingling involves the mixing of members of two unions or persons covered by separate collective agreement who perform the same job function. Complex issues will arise, but the Manitoba Labour Board has the experience and expertise in dealing with these sorts of matters on the basis of Manitoba jurisprudence and board policy.

* (2150)

Further, the process is undemocratic. The provisions of Bill 49 enable the commissioner to designate a union as the bargaining agent for the employees of the regional health authority. Although the commissioner is required to consider any consensus reached by unions representing the employees, he or she need not implement it.

Further, although the commissioner may order a vote, the commissioner is not required to do so. The legislation may result in employees being represented by a union of which they had no choosing. The certification process under The Labour Relations Act covers these sections.

The Labour Board has the same authority as a commissioner, but the Labour Board is a tripartite board consisting of a management nominee, a labour law nominee and a chairperson. The commissioner, under Bill 49, may consider the representation of the unions involved. However, ultimately, the decision is final and not reviewable unless, of course, as the minister indicated earlier, it is reviewable in the courts.

Bill 49 gives the commissioner the authority to make recommendations concerning the composition of bargaining units, which unions should be certified and other such matters as the commissioner considers appropriate. These determinations can obviously have serious consequences.

We submit that it is unnecessary and unfair to provide one individual with the authority to remove a bargaining agent's right and possibly impose a different bargaining agent. Bill 49 imposes no requirement to conduct a hearing, unlike hearings held by the Manitoba Labour Board, where the board has a chance to cross-examine witnesses and evidence is sworn.

We further submit that Bill 49 does not provide sufficient protection for employees affected by regionalization of health care services. The bill does not ensure that any employees will be hired by the new employer. Unless there are provisions imposing the recognition of successor rights and imposing obligations to hire the employees, the regional health authority could choose, at the time of takeover, to downsize.

In that regard, the bill does not require that the new employer recognize previous service. They will all be new employees of the regional health boards. Even if their collective agreements had provisions contemplating successor rights and ensuring the portability of service, employees with the regional health board will start the service on Day One of the takeover by the regional health board unless provisions are mandatory regarding recognition of service.

Service, of course, is extremely important for the calculation of benefits such as vacation, pay increments and seniority. Job security should increase with service. Even if the existing collective agreements require recognition of past service in related employee situations, the regional health authority would have no obligation to do so. The legislation should contain provisions to ensure that service is recognized.

Bill 49 does not ensure that employees' accrued rights will be respected. Employees have certain accrued rights with their former employer, which, in absence of a provision in the commissioner's recommendations, will not be binding on the new employer. These types of accrued rights can be as simple as the vacation which has

been earned up to the time of takeover. It would include things such as banked sick leave, accrued rights to preretirement leave and the like.

Further, because there is a new employer, unless there are specific recommendations contemplating successor rights, people on leaves of absence, sick leave, long-term disability and even vacation may have no right to return to work with the new employer.

We submit that certain protections should be included in the legislation, including the following. All employees should become employees of the regional health authority. All employees should be employed by the regional health board on the same terms and conditions as to salary and benefits. All accrued benefits should be protected and preserved.

If downsizing is required, then at least it might be accomplished on a layoff-bumping basis providing some protection for those employees who have provided more years of good service to health care in the province and are deserving or our recognition.

Mr. Chomiak: Thank you very much for the very instructive presentation. If I had to summarize the presentation–and as I say it is very instructive and very detailed–would it be correct to summarize it in two points; firstly, that the government has the existing authority under the present Labour Relations Act to carry out, if they proceed on regionalization, to do it with the existing authority, firstly, and secondly, there have been examples of reorganization, most notably through the Health Sciences Centre that have already been carried out and that have been effectively carried out without the need for such dictatorial powers as are envisioned in this act.

Would that be a fair summation of your presentation?

Ms. Sigurdson: Yes, the Health Sciences Centre is the largest example, but there have been examples all over the province where employers have merged. Collective agreements have been merged and so on without anyone telling us how to do it.

* (2200)

Mr. Chairperson: Thank you very much for condensing a long presentation.

Marilyn Goodyear Whiteley, President of the Manitoba Association of Registered Nurses and Diana Davidson Dick, the Executive Director, as well. Welcome.

Ms. Marilyn Goodyear Whiteley (President, Manitoba Association of Registered Nurses): Thank you, Mr. Chairman. The Manitoba Association of Registered Nurses, MARN, is pleased to have this opportunity to comment on Bill 49 before its passage through the Legislative Assembly is completed.

As the regulatory and professional association for over 10,500 registered nurses, MARN's mission is to regulate the practice of registered nurses and the quality of nursing to protect the public interest. While we will be conveying a health care provider perspective on the bill, it is important to be aware that it is being done in the context of an association with the legislated mandate to protect the public from harm and act in the public interest.

Before responding to specific sections of the bill, we would like to identify several broad issues. Number 1, purpose of the act: Over the past several months, we have suggested waiting for the evaluation of the regionalization of other provinces before proceeding. MARN has raised the issue of how health reform is unfolding in Manitoba. We need to look to other jurisdictions where regionalization is occurring for evidence that health outcomes and status are improved and that money is saved.

In British Columbia, Health Minister Joy McPhail directed her ministry to put all regionalization activity on hold while its implications are assessed. A report is expected shortly.

Similarly, a recent CBC radio program, Ideas, provided extensive discussion on New Zealand's health care reforms. New Zealand's reliance on market forces to increase the participation of the private sector in the delivery of health services has not achieved some of the major objectives of the reform. In general, waiting lists for elective surgery in public hospitals are increasing at the rate of 10 percent to 15 percent a year. The most recent figures cited were an increase of 35 percent in an eight-month period.

Problems with respect to access to primary care remain essentially the same after four years of health reform.

Government spending on health care services has increased from 6.5 percent of GDP in 1986 to 7.7 percent of GDP in 1994, primarily as a result of the reorganization and increased bureaucracy needed to manage the tendering and bidding related to competition for contracts.

It was suggested on the program that there are many gaps between the theory of health reform and its reality. One commentator reminded the listeners why New Zealand was the first country in the world to move to a public hospital system in the 1930s. The market system does not work well in providing cost-effective health services to all members of society. Beyond that, once government funding for health care drops below a certain point, leverage and control are lost.

Bill 49 provides a stated purpose of the act, but lacks a reason or justification with respect to improvement of health outcomes and reducing costs to the system.

Number 2, Structure of the Act. The Regional Health Authorities and Consequential Amendments Act is very much a bare-bones framework for carrying out the purpose of the act, creating regional health authorities with the responsibility for ensuring for the delivery and administration of health services within defined geographic regions.

As the act now stands, much of the detail for carrying out this purpose will be defined in regulation. While there are administrative and political advantages to having details about RHAs in regulation as opposed to the act itself, we cannot allow expediency to replace public scrutiny and debate in the Legislative Assembly, especially, particularly, with respect to such fundamental issues as the selection and terms of reference of RHA boards.

Moving to the next paragraph on page 3. Despite our view that it would be prudent to delay the process, we provide our comments, recognizing that these concerns are not likely to be acted on. In keeping with this government's partnership approach to health service restructuring, we urge Manitoba Health to be broadly consultative in developing the regulations associated with the act. We recommend that this government flesh out subsections (a) through (h) under Section 59 to be redistributed to relevant parts of the act.

In addition, given the large investments that Manitobans have in their health care system, we recommend that all regulations related to this act be regulations by Lieutenant-Governor-in-Council in order to take advantage of the regulatory review committee's ability to require public notice of the regulations. We believe a commitment from government to publish notice of the regulations, in order to receive feedback from the general public, would be seen as a positive initiative.

For No. 3, on page 3, I refer you to the importance of the determinants of health for future planning.

Number 4 of our broad issues, on page 4, responsibility, accountability and authority. The act specifically states the responsibilities of RHA and the duties of their respective directors and the duties and responsibilities of RHAs. RHA board members can be held accountable by the ministers if those duties and responsibilities are not carried out in good faith. Since there is no commitment in the act to elected boards of RHAs, there is no accountability to the public through an election process. In our view there should be dual accountability under the act, accountability to the public and accountability to the minister. As it now stands, accountability rests with the Minister of Health (Mr. McCrae), who appoints the directors of RHAs, provides funds to RHAs to carry out their responsibilities and develops the regulations to determine the parameters of the authorities of RHAs. Therefore, the public should continue to hold the minister accountable for the delivery of health services.

I refer you to the matter of legal liability in the next paragraph on page 4, and then on the top of page 5, I am going to abbreviate some of our comments here. Part 1, Interpretation, the issue, the definition of health care provider. We recommend with the rationale that we have provided that subsection (a) under health care provider be deleted. Issue, meaning of health services, we also recommend there is a redefinition of health services in the context of the continuum of care rather than the services provided by health care providers such as physicians and nurses.

Page 6, issue, conflict with other legislation. We have great concern when regulations under one act supersede other legislated statutes as stated in this section. This is not the norm in terms of the relationship between

regulations and statutes and is a means of amending existing legislation without the benefit of the legislative process, a public and democratic process that provides opportunity for debate of the issues. For this reason, we believe that having regulations supersede statutes is not in the public interest. Recommendation: Remove the phrases "or the regulations" and "and the regulations" from the preamble of Section 2(2).

Page 7, Part 2, Powers of the minister. The powers of the minister with respect to health service delivery are really quite extensive and centralized in the present system. In our view the centralized power of the minister is in no way diminished in this bill. We question whether power centralized with the minister is consistent with creating regional health authorities. Bill 49 is a restructuring of the way in which health services are delivered in the rural and northern parts of this province.

In recent years, there has been much discussion concerning sustainable development and sustainable communities. Government in Manitoba has been in the forefront of these discussions. However, the formation of RHAs, which centralizes power and responsibilities in a remote agency, works in the opposite direction from that of sustainable communities. It is only possible to have sustainable communities when community members or their representatives have direct responsibility for operating the services they need. Bill 49 is not consistent with the notions of participatory decision making and development.

Times of change are difficult as we make the transition from the old way of doing things to the new. While we are not opposed to change, it is at times like this that we need to have the reassurance that changes are being framed in the context of principles to which we, as Manitobans and Canadians, subscribe. This bill provides an opportunity for government to demonstrate a commitment to the principles of the Canada Health Act: accessibility, universality, public administration, portability and comprehensiveness to community education, development and involvement in decision making about health and health care. Concerns about the scope of the powers of the minister may be mitigated if there is some assurance that they are guided by the principles that are commonly accepted across Canada.

Our recommendation: Add a section or subsection in support of the principles of the Canada Health Act.

Issue: Standards for the provision of health services. Under The Registered Nurses Act, MARN has the legislated mandate to "develop, establish and maintain standards for the practice of nursing." Other health professional regulatory bodies have similar mandates. We recognize the importance of government establishing and monitoring consistent standards across the RHAs in order to ensure that people receive adequate and quality care. Under Bill 49, the scope of the standards to be established by government is unclear. As a self-regulating profession, we are opposed to a section in another act diminishing or compromising MARN's mandate with respect to professional standards related to registered nursing practice.

* (2210)

Our recommendation: Include a definition of standards for the provision of health care services in Part 1 of the act that clarifies that the intent of this section is not to regulate self-regulating professions and to provide the resources that allow regulated professionals to meet their standard under their respective acts.

Part 4, Regional Health Authorities, Structure and Administration: Our recommendation here: Commit to RHA boards with the majority of board members being elected, with the remainder being appointed for specific expertise and defined number and terms of office in the act.

Issue: Duties and directors of RHAs: Our recommendation is substitute the following for 17(b): Act honestly and in good faith with a view to the best interests of the health of the people living in the region.

Issue: Meetings open to the public: We recommend changes to Section 19(b) to 19(c) and insert the following as a new 19(b): All other meetings shall be open to the public with exceptions prescribed in the regulations.

Division 2: Responsibilities, Duties and Powers of Regional Health Authorities: In this section, we pick up on two important points, the connection with the communities and their participation in preparing a regional health plan. Our recommendation is, under Section 32, add a subsection that creates a health care provider council under the act with a mandate to advise RHAs.

Under Section 24(2), include: District health advisory councils, health care provider councils after the words "Indian Bands."

Issue: Charging fees for health services: Our recommendation is that no user fees be charged.

Issue: Health care providers and standards: We recommend that we create a definition of prescribed standards under Section 1 of the act that does not limit or abrogate the legislated mandate of regulatory bodies with respect to professional standards.

On page 13, Transitional Provisions Respecting Labour Relations & Employees: We recommend deleting part 6 of the act and replacing it with a part that directs the Manitoba Labour Board to manage labour relation issues arising during the transition to regional health authorities under this act with appropriate consequential amendments and resources. Thank you.

Mr. Chairperson: Thank you very much for the presentation.

Mr. Chomiak: Thank you very much for, again, a very informative and useful presentation that parallels many themes that we have heard here tonight, as well as some interesting new suggestions.

I have three basic questions. The first is–I am only a legislator in the Legislature and we are only responsible for making laws, and I have been unable to ascertain whether or not there will be a separate act with respect to Winnipeg. You indicated at the beginning of your presentation that other legislation will be introduced. I wonder if you might outline for me how you can make that statement with respect to the provision of whether or not Winnipeg will be included in this act.

Ms. Diana Davidson Dick (Executive Director, Manitoba Association of Registered Nurses): It was our understanding from the briefing that was provided to us on August 20 that there was an anticipation of separate legislation that would deal with a Winnipeg health authority.

Mr. Chomiak: Thank you for that. I also think that it was very perceptive that you should note the similarity between–that you should use New Zealand as one of the examples. From my review, and I am only a layperson, of the provisions and of the act, it is clear to me that the government model, the closest government model that this government is adopting is the New Zealand model with respect to health care, and in fact, it mirrors the New Zealand model from my review. I think it is very instructive and informative that you should bring forward New Zealand as an example of what is happening with respect to changes in Manitoba. I might add that Manitoba has even sent officials down to New Zealand to review their system, something that I do not think has been done in other parts of Canada or other parts of the world, so it is pretty clear and I think it is very perceptive of you to use New Zealand as a model.

Can you just outline for me the figures that you had about the waiting list period? Was that from the Ideas program or did you have access to other documentation or studies with respect to New Zealand?

Ms. Whiteley: I believe we got that basically from the program.

Ms. Dick: You are quite right. We did get it from the program and we have asked for their research but beyond that we have–I think that what happened in New Zealand, for a period of time it was popularized as being very effective but time has shown that there are some significant social problems associated with the changes in many aspects of New Zealand society but particularly with health care, with respect to the rate of poverty on the increase, youth crime on the increase. Also, they began with the recognition that there was a need for change, but I think there is some very thoughtful analysis now that is suggesting that they went in this direction too deep and too far.

Mr. Chomiak: Thank you for those comments. There is much I would like to query on, but again I recognize that there are other presenters. I just want to make one final–and perhaps you might have a comment on this. I am actually saddened by one of your statements, and I guess it is reflective of the situation, in my opinion, of health care in Manitoba, where you say on page 3, "We provide our comments recognizing that these concerns are not likely to be acted on." I think that for me sums up one of the real difficulties in health care, something I have characterized, that health care reform in Manitoba has been a monologue disguised as a dialogue and that it

is unfortunate that an organization like MARN that represents as many people as you do would have to make a statement like that to the legislators in this province. It indicates the state of consultation in health care. I do not know if you might want to comment.

Ms. Dick: I would like to comment. That is made in light of a number of factors with respect to restructuring of health care across the country. It is not intended to single out the government of Manitoba as being aberrant. We have noticed in terms of restructuring and within institutions, for example, across Canada and the U.S. and in other western industrialized countries, that there are fads that take place with restructuring, and perhaps the restructuring that is occurring now in some institutions does not necessarily have the evidence to support the changes that are being made.

With respect to regionalization, it has been our observation that across Canada it is sweeping the country without necessarily an evaluation of how it is unfolding in each province. It is within that context that it seems to be part of a national and international movement, and that is why we make them, not that we have a failure of confidence in this government as distinct from other governments.

Mr. Chairperson: Thank you very much for those presentations. You will get the last one, okay Mr. Lathlin?

Mr. Lathlin: I would like to also acknowledge the quality of the presentation. I am from The Pas, and I read with interest the start of your presentation where you say that while you would be conveying a health care provider perspective you would be presenting your material in a context of an association with a legislated mandate to protect the public from harm.

I have always wondered, because I travel around the North quite extensively, and I usually visit nursing stations wherever I go. My wife is a nurse; that is why I visit nursing stations. I have a vested interest. But I hear all kinds of stories that come from the nurses with respect to the type of facilities that they have, and whenever I come out of those communities I often ask myself the question, are we not supposed to have someone looking or monitoring standards in this province in regard to nursing?

* (2220)

I am just wondering whether yourself, madam, have been to any reserves where the nursing stations are located. I was also wondering whether in your opinion those standards that are set out in your organization are being adhered to.

Ms. Dick: I guess what–oh, pardon me.

Mr. Chairperson: He is just asking for indulgence I think for another question from the committee. Will the committee allow another question after this one?

An Honourable Member: Yes.

Mr. Lathlin: Sorry. Secondly, the second part of that question. In your opinion, with health reform, with regionalization, do you think that that situation that exists on the Indian reserves–after all, you licence the nurses who work there–will that situation be exacerbated by what is about to unfold?

Ms. Whiteley: In response to your first question, yes, I have visited in reserves of the North. My background is pediatrics, and I have travelled throughout the North in that capacity. We do see a lot of burnout in nurses at nursing stations, and we do hear a lot from them in terms of an inability of them to meet their mandate in terms of caring for the people that live on the reserves or in the general communities.

As far as the situation being exacerbated, we have a consultant at MARN in the area of nursing practice, and over the past couple of years since restructuring has been going on, she has received quite an increase in the number of complaints and concerns from the public and from other nurses directly related to the restructuring process. We are seeing this throughout the province, not just within the city. I hope that answers your question.

Mr. Chairperson: Thank you very much for your presentations. Ms. Dick, you wanted to add.

Ms. Dick: I would like to add to what the president is saying. There are some very serious problems with respect to a situation in nursing stations and critical incident stress where nurses in that situation and in other situations are not being provided with the resources for

them to meet the standards of practice that flow from The Registered Nurses Act. Those resources include time, they include energy and staff, and it is very serious. Our mandate is restricted with respect to responding to complaints against members in taking action directly.

However, we have proposed with the Minister of Health (Mr. McCrae), and he has greeted this suggestion favourably, that we take a systems approach to standards so that we deal with all aspects of institutional or community or nursing station care delivery. That would be a major partnering, but there is a very serious problem and I underline what the president has said.

Mr. Chairperson: Thank you very much for your presentation. I would like to call next on Vera Chernecki. You may begin.

Ms. Vera Chernecki (Manitoba Nurses' Union): Thank you. I hope you can stay awake until you can hear the presentation on my brief. I know it is getting close to the hour you are going to re-evaluate. I am not going to go through the entire brief. I am going to be summarizing and highlighting some of the areas of concern, but I certainly encourage all members of the committee to read the entire brief.

The Manitoba Nurses' Union appreciates the opportunity to present to this committee our concerns regarding Bill 49. The MNU represents 11,000 nurses working in a variety of health care settings across Manitoba. Our members are extremely concerned about the way in which regionalization is evolving. Bill 49 raises more questions about regionalization than it answers.

As Bill 49 is rushed through the Legislature, the public and health care providers have only minimal information about what Bill 49 will mean to health care delivery. The time lines for implementation are completely unrealistic, we feel. Other provinces have learned that moving too quickly toward regionalization can do more harm than good. I point to the Nova Scotia government that in August put a halt to the changes that were going on regarding regionalization and also infused an additional $65 million into the health care system.

We have seen the creation of 10 regional health authorities in rural and northern Manitoba, one in Brandon, and two superboards in Winnipeg this year. We know that government budget cuts will necessitate these boards to implement further bed closures and resulting layoffs. The total number of bed closures in Manitoba thus far since 1992 is now approaching 1,000. Along with these bed closures have come nursing deletions and the replacement of nurses with unlicensed health care workers.

Ever since the arrival of Connie Curran, decline in quality of patient care has been a consistent concern amongst nurses. We have seen yearly increases in the number of workload staffing reports completed by nurses. These reports document unsafe or potentially unsafe patient care conditions.

In 1995, our members filed 898 work situation reports, and 2,915 nurses signed these forms. Eighty-seven percent of nurses also indicated that nursing work is intensifying, burdening nurses with increased stress and risk for occupational stress-related diseases. Ninety percent say that restructuring has not helped nurses to deliver quality care.

In addition to the bed closures and layoffs in Winnipeg, the regional health authorities must cut $100 million from health care budgets in rural Manitoba over the next two years. Will rural access to health care be reduced? Access to care is always a challenge in a province like our own, with a widely dispersed population and many people living in fairly extreme isolation. How do we measure the impact upon rural communities of massive job loss and closure of health care facilities?

Nursing work is one of the few job opportunities available to rural women which provides a good income, and many farming families are dependent upon nursing wages to survive. The rural economy in Manitoba is partially sustained through the earning of health care workers and their families and will suffer a blow beyond the actual number of health care jobs lost.

It is very important that the human cost to nurses, patients and communities be stressed in this anonymous process known as regionalization. First and foremost in our minds should be the implications of this legislation upon Manitobans, on those both needing and providing health care. The Manitoba Nurses' Union requests that the committee address several key issues regarding Bill

49. The first is that the legislation must clearly define standards and principles for health care across the province. Bill 49 gives the Minister of Health (Mr. McCrae) the power to prescribe what health care services will be provided by RHAs and to set standards of delivery.

Neither prescribed health services nor standards are defined in the act. The act should be amended to ensure that its regional health delivery meets the standards for our health care system as outlined in the Canada Health Act. The principles of universality, comprehensiveness, accessibility, public administration and portability, to be consistent with the five principles of medicare references in Bill 49 to charging of fees for health services, must be removed.

* (2230)

Bill 49 refers to health care providers as either employees or as individuals under contract to provide health services. Given the recent government decision to privatize home care services in Winnipeg, we are concerned that the RHAs may be encouraged to contract out nursing care delivery to for-profit agencies. Public nonprofit health care delivery must be maintained with the principles of the Canada Health Act.

We also feel that ministerial power and the role of regional boards must be clarified. The legislation lacks clarity about who is accountable for our health care system, regional health authorities or the provincial government. Political accountability must be clear.

Bill 49 consolidates control over our health care system in the hands of a Health minister and the provincial cabinet. Part 2 of the act gives the minister an extremely broad range of powers for both the planning and implementation of a regionalized system which contradicts the government's claim that it is delegating control to the regions.

The Manitoba Health Organizations and others have also stated their concern about this section. Regional health boards will shoulder the responsibility for changes in health services without any real power to respond to public concerns. They will have to make some very difficult decisions about how to best implement and allocate limited resources. Bill 49 implies that regional boards will be pressured to conform to direction from the minister and may actually have little flexibility in providing health care services based on the needs of the region and local community.

With the power for setting health care expenditures and approval of regional health plans firmly in the hands of the Health minister, in what sense will this legislation result in decentralization? On the issue of fully democratic and publicly accounted regional boards, we feel that regional health boards and district health councils should be elected, and health care workers must not be excluded from running for election in the regions where they are employed.

Although Bill 49 itself is not clear, the government has implied that for nurses to sit on the regional boards is a conflict of interest. Why not allow nurses on regional boards to declare conflict of interest on an issue-by-issue basis. That is done on many committees. Nurses have valuable expertise to contribute to health care planning. Regional boards need a balance between laypeople such lawyers, business people and accountants and those with experience in the health care system.

Our members are concerned that the bill does not outline the role of community health centres in the future of health care delivery. One of the most serious weaknesses of Bill 49 is that it misses the opportunity to foster true community-based care. In fact, it does not refer to a CHC model as a part of the regionalization process at all. For example, Bill 49 perpetuates fee for service.

The legislation should specifically mandate the creation of community health centres and define fundamental guiding principles for CHCs as a basis for an improved primary care delivery system. The MNU recommends that district health councils be utilized as vehicles to organize and develop a province-wide network of community health centres. This would be consistent with the recommendations of the Northern and Rural Health Advisory Council.

The MNU cannot state strongly enough its opposition to Part 6 of Bill 49. It is our position that Part 6 must be removed in its entirety from the act. The legislation gives the Lieutenant-Governor-in-Council the power to appoint a commissioner who will possess unheard of and

sweeping control over health care workers, their collective bargaining representatives and employers.

The potential scope of the government's interference in union-employer relationships is truly deplorable and is a breech of the MNUs right to self-government. The commissioner's recommendations to the government will be implemented through regulations made again by Order-in-Council. These regulations will supersede The Labour Relations Act. Changes can be made to union certifications, including which employees are included in the bargaining unit. Collective agreement provisions can be modified or restricted. The commissioner can determine how collective agreements will be interpreted. He or she can define or redefine seniority rights. Although regionalization will raise some important labour relations questions, the measures taken by the government in Part 6 of Bill 49 are unnecessary.

The Labour Relations Act and the Manitoba Labour Board have functioned well in overseeing labour relations in health care throughout the last 25 years. Neither the MNU nor any other health care unions, nor the MHO have called for changes to this proven mechanism. Bill 49 is also silent on who will be the employer in the regionalized system. Will a nurse be employed by the regional health authority as opposed to the hospital or personal care home? It is MNUs position that the employer must remain in the workplace.

With administrators not physically located in nursing workplaces, it will be even more difficult to solve problems than it is now. If the current employer-employee relationship is altered and the RHAs become the employer, which we are not advocating as I have already mentioned, there must be a continuation of MNU bargaining unit rights and that is successorship.

As the legislation is now worded, nurses are given no protection from losing rights based on years of service with the employer, such as acknowledgment of seniority in the job selection process, layoff and recall protection, vacation and income protection in the case of illness or short-term disability. Successorship rights for employees must be guaranteed and should not be left to the discretion of the commissioner.

Another unresolved labour relations issue is the future of provincial central table negotiations between the MNU and the MHO. Manitoba nurses have strived for central table bargaining since the mid-1970s. Central negotiations now cover over 90 health care facilities across the province. There are advantages to the central table for both union and management. For nurses, it helps guarantee consistencies in terms and conditions of employment. Of benefit to both union and employer and ultimately the government are the time efficiency and cost-effectiveness of the central process. While we are not opposed to regionalization as a concept, we do urge the government to bring forth a humane form of regionalization.

Bill 49 will affect nurses in several ways. Funding reductions will mean job losses impacting nurses, their families and communities. As facilities merge and possibly close, union representation, collective agreements and seniority are no longer secure. The pressure of providing quality patient care in a context of downsizing and restructuring will place added stress on nurses in their workplace.

As regionalization unfolds, there must be a labour adjustment strategy in place to help nurses through the process. The Provincial Health Care Labour Adjustment Committee, of which MNU is a member, has made the following recommendations to government, and we continue to await government to implement some of these. They are listed on page 17 of your brief: All health care employers in Manitoba must belong to the redeployment program; as an alternative to layoffs, the government must offer an adequate Voluntary Separation Incentive Program and early retirement incentive programs; an education and retraining program is necessary; an Employee Assistance Program and an employee counselling program should be implemented throughout the health care system; and the government should do a comprehensive study on health care human resources.

We feel these recommendations should be implemented immediately.

In conclusion, the MNU does not support the passage of Bill 49 as it currently reads. The Regional Health Authorities and Consequential Amendments Act will become a central defining act of our health care system. It is crucial that the act be clear, well thought out and that it form the basis for a strong medicare system for

Manitobans now and in the future. Bill 49 leaves too much unsaid, leaves too much power in the hands of the Health minister and contradicts the principles of the Canada Health Act. The legislation also poses a clear threat to the collective bargaining rights of nurses. Part 6 of the act must be deleted. If the remainder of the bill is not improved by this committee to address our concerns and those of other members of the public, we believe it should be withdrawn. Thank you.

* (2240)

Mr. Chairperson: Thanks for your presentation.

Mr. Chomiak: Thank you again also for the presentation. Again, another excellent presentation with some very specific recommendations which I hope are considered and acted upon.

I am struck by the fact that you make reference to CHCs, and many other presenters have made reference to CHCs, and the fact that MNU in a very open process had a public presentation, which was attended by many health officials with respect to CHCs and how we could implement it, and the fact that there is no reference in this act to the whole concept, indeed the funding and the operation of CHCs. Do you have any idea as to–since the government sent a series of officials to the presentation that was made by MNU with respect to CHCs, do you have any idea what the status is with respect to the government of an approach to CHCs?

Ms. Chernecki: I guess we could put Mr. McCrae on the spot here. We have presented to the Health minister, as well, and to the deputy minister and received a positive response with regard to our community health centre's document, and that is why we feel that this is an appropriate time. We have written to the chairpeople of the regional health authorities and asked that they have us down for presentation and that they seriously look at implementing at least one pilot project in each of the regional health authorities, but we have not heard a positive response with regard to that.

Mr. Chomiak: Mr. Chairperson, hope springs eternal. My next question is, are you aware of any nurse representatives or any nurse input with respect to this legislation, or the ramifications of this legislation, knowing full well that there are no nurses on any of the boards? Has there been any input sought from any nurses as far as you know with respect to this?

Ms. Chernecki: Not to my knowledge.

Mr. Chomiak: On page 17, I think the adjustment committee and the recommendations have been outstanding for some time with respect to a proper labour adjustment strategy in this province, given the number of layoffs and the number of cuts in health care in this province. Can you give me any idea when the health care Labour Adjustment Committee made these recommendations to government?

Ms. Chernecki: The recommendations have been made several times, and I think they were just recently resubmitted about three or four months ago, and again, I have been awaiting to see some action on that. When you mention the labour adjustment strategies, we have had many discussions with many of the nurses in the facilities. We know that if there was an adequate voluntary separation incentive plan and an early retirement program that many nurses are nearing that age where they could retire. It would be a much more humane way of relieving some of the pressure in the health care system with regard to some of the changes that are happening, rather than just having people being wiped out as entire categories of nurses, such as the LPNs have been experiencing or the SIPs not being offered at appropriate times when some facilities are making their decisions to downsize.

Mr. Chairperson: One last question.

Mr. Chomiak: Yes, one last question. In one of the presentations, reference was made that by September 1996, 921 health care workers have been laid off. Do you know whether that includes RNs and LPNs?

Ms. Chernecki: I am not sure. I know that we still have over 400 nurses on layoff at this point and I believe there has been 700 and some nurses laid off since health care reform began.

Mr. Chomiak: So I just have to extrapolate, then, the reference to 900 workers in the CUPE is probably exclusive of nurses.

Ms. Chernecki: I would think so.

Mr. Chomiak: So we are talking about 1,600 people, perhaps, since health care reform has been upon us.

Ms. Chernecki: Yes, likely.

Mr. Chairperson: Thank you very much for your presentation. Rob Hilliard. Mr. Hilliard you may proceed.

Mr. Rob Hilliard (President, Manitoba Federation of Labour): Mr. Chair, the Manitoba Federation of Labour is the largest central labour organization in Manitoba representing 35 major unions and close to 400 local unions who are members of the Canadian Labour Congress. These public- and private-sector affiliates are the means by which over 85,000 working men and women bargain collective agreements, settle workplace concerns and undertake programs to improve their social and economic condition. Union members elect delegates to their own union's conventions and those of the MFL, as well as other central labour organizations, to determine policy, review finances and give direction to their elected leadership on what courses of action to pursue between conventions. One of these initiatives is representing the interests of union members before government panels, such as this committee, putting forward their views and concerns on proposed legislation.

The Manitoba Federation of Labour has many concerns about the contents of Bill 49 and how it will impact the delivery of health care in Manitoba if it is implemented in its present form. However, this presentation will focus on those elements which directly affect health care workers and labour relations, specifically Part 6. Our affiliates and other progressive organizations will put forward views on Bill 49 that reflect our concerns about the bill's impact on the quality, accessibility and availability of health care in Manitoba.

The government of Manitoba has introduced sweeping, regressive changes to legislation affecting workers in this province. These changes are contained in a large number of bills, one of which is Bill 49. Since the fall of 1995, the Conservatives have said these changes are necessary to increase the power and democratic condition of union members in Manitoba. This argument is not credible when this package of legislative amendments is examined. Taken collectively, these amendments are meant to discourage and limit the ability of working people to form or join trade unions, disrupt the ability of union members to encourage positive social, economic and political change, make it easier for hostile employers to break unions, make it more difficult for unions to effectively represent the interests of their members, limit workers' ability to run their own organizations and weaken the ability of working people to negotiate with their employer for improvements in their workplace and in their standard of living. Do these things improve either the power or the democratic condition of union members in Manitoba? Of course, they do not.

The labour relations provisions that are contained in Bill 49 contradict the suggestion that the Conservatives are enacting legislative amendments to increase the power and democratic condition of union members. Instead, they support our analysis that these amendments serve an ideological and political purpose that is intended to ensure that the Conservative government's right-wing agenda is quickly implemented without being troubled by any need to accommodate different interests in our province.

Section 63 of Bill 49 makes provision for the appointment of a commissioner who will have extraordinary powers. We acknowledge and, in fact, credit the government's stated intentions to make amendments to this section of the bill which would provide for a defined time for the commissioner to be involved in this process, as well as an amendment which would allow for an appeal of any decisions made by the commissioners. However, we must at least reserve judgment until we see those amendments before we fully appreciate what they may entail. Nevertheless, we remain very concerned about this section of the bill. For example, with the approval of the Conservative government cabinet, this commissioner who will no doubt share the views of the current government, will be able to determine which bargaining units different health care workers will belong to and which unions will represent those workers. This commissioner will also have the power to change certifications that have already been approved by the Manitoba Labour Board. The commissioner will even have the authority to change clauses in existing collective agreements.

If the government is trying to provide itself with the tools to accommodate the challenge of merging jurisdictions that will flow from the creation of regional

health authorities, then it is reinventing the wheel. These tools have existed in The Manitoba Labour Relations Act for decades. They are understood by both unions and employers. They have functioned efficiently.

Clearly, the government is endowing itself with powers that ignore the rights of health care workers. The government is not seeking to facilitate effective labour relations. It is trying to subvert them and gain complete control over the process without regard for the wishes of working people in this sector.

* (2250)

It is the tradition in countries that subscribe to even the most rudimentary democratic principles to allow these decisions to be made by the affected employees. To put it more bluntly, working people have a democratic right to determine which union they wish to belong to or even to decide to create their own new union. These are rights guaranteed not only by The Manitoba Labour Relations Act but by no less an authority than the Charter of Rights and Freedoms.

It is true that Bill 49 allows for the commissioner, at his or her discretion, to order a vote among the affected employees in order to determine their wishes. It is also true that the commissioner should consider factors such as the history of trade union representation, any consensus reached by unions representing health care workers and other unspecified factors. However, allowing one government appointee to decide whether or not employees will be allowed to vote is simply not democratic.

Similarly, requiring the same individual to consider several factors before making a decision in no way changes the fact that it is still one individual who will be empowered by government legislation to make important decisions about people's lives without regard for the democratic traditions and procedures that have been well established in labour law.

Just as workers are entitled to freedom of association, their right to good-faith free collective bargaining is recognized by long-standing tradition in Canada and by international conventions as enunciated by the International Labour Organization. Canada has indicated its support of this right by signing the ILO Convention that describes it.

It is undemocratic for a commissioner and the provincial cabinet to determine the terms of a collective agreement, to unilaterally amend a bargaining unit certificate or to determine the interpretation or applicability of collective agreement clauses.

These are inappropriate intrusions by the government into the labour relations universe, even if for a short period of time, an environment where collective bargaining challenges have been dealt with successfully by workers and employers for decades.

It is more appropriate that the Manitoba Labour Board retain its jurisdiction over labour relations in the health care sector using the provisions of The Manitoba Labour Relations Act as its guide for decision making. It has the expertise to deal with the evolution in this sector that Bill 49 clearly anticipates.

The Manitoba Federation of Labour is opposed to the inclusion of these measures in Bill 49 that will drastically alter the democratic rights of health care workers. They will violate health care workers' Charter of Rights and Freedoms guarantee to freedom of association. They will violate their right to free, good-faith collective bargaining. They will virtually ignore the successor rights provisions in The Manitoba Labour Relations Act for health care sector workers.

They will subjugate health care sector workers to arbitrary decisions made by a political appointee and endorsed by cabinet. They will remove the procedural safeguards contained in the Rules of Board Practice of the Manitoba Labour Board for applications and hearings.

The MFL urges the government to amend Bill 49 by completely deleting these sections and these measures. Procedures already exist for the orderly determination of labour relations issues which Bill 49 contemplates. These procedures have withstood the test of time and are respected by labour relations practitioners. We can see no reason why they should be bypassed now in favour of a system that places authoritarian control in the hands of one person.

The potential for distrust and disruption are significantly increased. This would not be a desirable outcome at any time, certainly not during a time of great change when co-operation would be a benefit to all.

Thank you very much for taking the time to listen to this.

Mr. Chairperson: Thanks, Mr. Hilliard.

Mr. Chomiak: Thank you for the presentation. Again, we also appreciate some of the very interesting suggestions. I think many of them have been reflected over and over again in the hearing as we have gone on tonight.

You were too kind, I thought, when you indicated that you were going to review the minister's amendments and not comment on them until you had an opportunity to review them, and I noted that in your presentation you did not make reference to the particular sections that the minister said he was going to amend, but it seems clear to me from your presentation and from presentations that were made previous that there is no good reason for the commissioner to have these extraordinary, undemocratic powers when in fact all of the same goals could be achieved by using the existing legislation that we have in Manitoba. That is so fundamental because it begs the question, if we have existing ability to deal with the issues contemplated, then why would the government see a need to introduce into the process this most undemocratic and almost totalitarian approach? You were very kind in not attacking that directly, and perhaps the question is answered in the fact–[interjection] Well, the member for Emerson perhaps wants to know the question. The question is, why do you think the government is doing this?

Mr. Hilliard: Frankly, Mr. Chomiak, we are a little puzzled by it as well. I think that labour relations history in this province clearly demonstrates that these kinds of situations have already been handled. They have been handled successfully; they have been handled fairly; and, perhaps most importantly of all, the decisions are accepted by the participants because of those factors. The difficulty that arises here is that a great deal of authority is going to rest in the hands of one person, who is going to have a huge amount of power to make decisions over people's lives, and they are not going to have the ability to participate adequately in that process. They are, therefore, going to feel a great deal of distrust because of it. So there is a huge potential here for causing a lot more problems, but, frankly. we see no reason at all why this measure has to be taken because there are well-established procedures now. They have worked well in the past, and there is simply no evidence to suggest that they cannot work now either.

Mr. Chomiak: Further to that, it does not make any sense if you are changing as dramatically as this government is the approach to health care and you are badly managing it in the first place, but you are introducing so many changes and you are taking on so many issues, why, when you have legislation in effect, would you want to put in place these most extraordinary powers? It just does not make any sense, and either the government is very stupid or the government has an agenda that is intent on, frankly, breaking the labour movement in this province. Do you have any comment on that?

Mr. Hilliard: You will hear from us at other committee hearings. We do have views on a number of other bills, but, frankly, that is the conclusion we have arrived at. When you take a look at amendments that are contained in half a dozen different bills, it clearly is directed at minimizing and even completely neutering the effect of the labour movement in terms of government legislation. I think, as well, if you view how government has treated its own employees in the bargaining process, it reveals that agenda as well. We are greatly concerned about that potential by the government in terms of–I think it is important to point out here when anybody attacks the labour movement, they are not attacking union bosses, which does seem to be the favourite two words of certain members of this government at least, at least if you read it in Hansard. I think they are the most common words that are in Hansard. You are attacking the rights of citizens of this country because citizens have the right to freedom of association, and for workers that means that they have the right to join a union. That is already established by case law, so when anybody, any government attacks legislatively unions and their right to exist, they are attacking the rights of its citizens, and I think that is a very dangerous trend.

Mr. Chairperson: Thank you very much, Mr. Hilliard.

I would now like to call on Ellen Kruger. Is Ellen Kruger here? We have now reached eleven o'clock. Is Ellen Kruger not here?

Mr. Harold Shuster (Manitoba Medicare Alert Coalition): Ellen Kruger is not here, but I am here

representing the Medicare Alert Coalition, if you want to continue.

Mr. Chairperson: What is your name, sir?

Mr. Shuster: My name is Harold Shuster.

Mr. Chairperson: Mr. Shuster? Representing the Manitoba Medicare Alert Coalition?

Mr. Shuster: That is correct.

Mr. Chairperson: While you are getting positioned up there, is it the will of the committee to continue to proceed?

* (2300)

Mr. Chomiak: Mr. Chairperson, I think we are proceeding quite well. We have heard some excellent information. Since there is already a scheduled meeting of this committee tomorrow and since many people who are going to make presentations are already present in this Chamber, I am wondering if we might not say, perhaps suggest, that we go to about midnight and then reconvene again tomorrow at seven o'clock. This will give ample notice to the individuals who have yet to present, give them some idea and means of planning their time. I am almost looking to my fellow committee members, as well as to the audience, to see whether that would be an acceptable alternative rather than have people stay here well into the wee hours of the morning when in fact we are already scheduled to reconvene tomorrow at seven o'clock.

Mr. Chairperson: 7 p.m. tomorrow.

Mr. Penner: Mr. Chairman, I know that some of the members need to get regular hours for sleep and stuff like that. Some of us have had to put in very significant hours this week in our duties here as well as on our farms, so some of us have gone around the clock for a number of days. We know what it means to be tired and working without sleep for a while. I would suggest you reference me, and when I fall asleep, that might be the time to adjourn.

On a more serious note, I also recognize the fact that there are a number of people here who in all probability will have to go to work tomorrow morning and fulfill their duties at work positions, so I would respect that and suggest that we continue hearing the presenters tonight until we finish the presentations and deal with–and then move on to other business tomorrow in this committee.

Mr. Chairperson: My sense is that we have a lot of staying power and patience at the back of the room, and a lot of people are going to be very disappointed tonight if they are not given an opportunity. Can I suggest this, that we take another look at things at midnight? Can we see where we are at that point, maybe review it from time to time rather than waste time now?

Mr. Chomiak: Mr. Chairperson, perhaps we can canvass the individuals who are yet to present to see if there is any kind of possibility or consensus. We are now at No. 5 on persons registered to speak. We are coming on No. 6, and we still have to go up to roughly 43–no, probably at about 35. Perhaps we want to canvass the individuals here to see if people can come back tomorrow.

Mr. Chairperson: Can I suggest, the way it is that, if people definitely want to present tonight, maybe they should so indicate to the Chamber staff at the back and then those can be identified? That would be most helpful. Those who want to present no matter virtually what time we go to tonight, if that satisfies that concern. That is so agreed, then, members of the committee? Okay, that is agreed.

Mr. Harold Shuster, you may now proceed.

Mr. Shuster: I think what I will do, given those comments–Ellen Kruger will be available to present tomorrow night, and I would feel more comfortable with her making the presentation. So I will cede my spot for tomorrow night and allow those who want to make presentations tonight to go forward.

Mr. Chairperson: Okay, I will then have to move you down to the end of the list, and you will be in that position on the list. Okay.

I now call on Alan Sweatman. Alan Sweatman is replacing Tony Fraser for the Convalescent Home of Winnipeg, according to my note here.

Mr. Alan Sweatman (Convalescent Home of Winnipeg): I am not actually replacing him, Mr. Chairperson. He is sitting here, but Mr. Tony Fraser is the administrator of the Convalescent Home.

Mr. Chairperson: Thanks for that clarification.

Mr. Sweatman: I held my breath when that last thing happened because I have three of the board members who have been sitting here since seven o'clock, so thank you for hearing us.

We do not have a brief as such, but what I would like to do is hand out–it is now being handed out; we have only eight copies. I am sorry, but it is not a brief as such. It is, as you will see, a history of the Convalescent Home, 100 years of caring. It is in great demand because it is being used to assist in the fundraising that is a constant matter for the home, and so Tony was able to bring eight copies and if you would just bear with us and share one. I am not going to read it all to you. I just want to draw some of the things to your attention.

The book, just commenting on it generally, it really amounts to the 100 years, 1883-1983. I like to think of it, and you will see what I am saying when you read through it, this is a history of volunteerism in this city. I do not think I need to remind any of you–

Mr. Chairperson: I am sorry, Mr. Sweatman. Maybe we could have some quiet at the back of the room so that Mr. Sweatman can make his presentation. If you please try to keep it down. Thank you.

Mr. Sweatman: I was saying, the book, the history, in the form of a history of the home which covers that 100 years, you really have in a capsule form what amounts to a history of what I call volunteerism. I do not think–you must be aware of what I am about to say. It is almost a truism.

If you think you are going to have difficulty, and I sympathize and so does the home with the difficulties in the health care field and the costs and the need to control them, but if you think you are going to have trouble and you are no matter what you do, get rid of the volunteers and the costs will go right through the roof. You absolutely cannot get along without them.

I would like to direct your attention briefly to what the Honourable Duff Roblin wrote, under no compulsion to do so I should add, as a foreword to this history, and I will read two paragraphs. I will be brief. I am reading from the bottom of the foreword, it is on page vii. He said: What I shall also never forget is the zeal, dedication and determination of the leaders of the home–he means the Convalescent Home–in those days, that the great work of their predecessors should not be abandoned but that, in conformity with changing public attitudes, a new financial relationship between the home and the government should be established. It would contribute to the betterment of Manitobans in need, particularly those of advancing years, but the home insisted on their separate identity and their leading role. The government agreed that this was right.

And over the page: I believe the spirit of community service the home exemplifies is not exhausted. In some sense, today's public policy may seem to have brushed to the side. These words fit today, I would remind you, but we owe it to the human condition to make sure that the spirit of service is not forgotten, its present practice encouraged and its potential for future good recognized and enhanced.

Mr. Chairperson, if I was part of the government of this province, the last thing I would try to do is push around the ladies who run the Convalescent Home. You may have the legal power, plainly you do under Bill 49 and plainly it is going to become law with some clarifying amendments and very shortly, but coercing volunteers is almost an oxymoron. It will not work. I am assuming the bill, as I say, is going to pass, substantially as is, and may I earnestly urge the government to mount a very serious, not a cosmetic, but a serious campaign with every volunteer organization in the health field to persuade them, not coerce them, persuade them that these powers, for whatever reason you felt you needed them, and that is your call, are not intended to be as coercive in practice as the words would appear to indicate because, if you try it, you will just get in an awful mess.

I would just like to give you a small, anecdotal thing. It may sound irrelevant, but I was struck by it tonight listening to some people.

Shortly after the end of World War II, I was in Germany on business briefly, and it was at the time when

the Germans, you know, they had lost the war and they were trying to show that they were friendly. They wanted to be part of the western world, and plainly they have succeeded, but they were not sure how to go about it, so they tended to be obsequious almost, and my story really relates to the people I was dealing with. You could not find anyone who had ever been a Nazi and, in the hotels, the staff had plainly been instructed to, whatever Herr so-and-so wanted, it was bitte schön, danke schön, bitte schön, danke schön, anyway, whatever I wanted.

* (2310)

But, you know, when I went into my room, they had, as we do in our hotels, notice to guests, and they had made a translation in English. What the notice said was, breakfast is obligatory. I thought, breakfast is obligatory? I am not going to eat breakfast, you know, and I called down and I said, do you not mean, breakfast is included? A little pause. I will phone you back, sir, and they phoned me back. No, breakfast is obligatory.

Do not try and make volunteerism obligatory. That is all.

The ladies are concerned. They really do not believe that anybody wants to push them around, but you really, really must mount a serious, not cosmetic, serious campaign to persuade people like these ladies and all the volunteer organizations that you really do need them and that they should not go away and you really do not want to run their organizations. Thank you.

Mr. Chairperson: Thank you very much, Mr. Sweatman. Any questions?

Mr. Penner: Thank you very much, Mr. Sweatman. I concur with you to the greatest degree. Having a father who is currently in a personal care home and having had a father-in-law who just passed away not too many months ago because he died of cancer, our family has spent an inordinate amount of time in hospitals and care homes in the last couple of years. The volunteerism and the dedication of these people in communities that want to give of themselves to other people is absolutely astounding and phenomenal, and they make the life much easier and much more comfortable for those who have to either stay in personal care homes or hospitals, in many cases.

So there could not be a greater degree of appreciation by people of this committee and our government of the recognition of the services that these volunteers and their organizations provide to our health care system in its totality. I am sure the minister would confirm that if the minister chose to get involved in the debate, but it certainly would be far from our intention or, I should say, some of the committee members' intention, to do what you are suggesting might be implied by the bill, because we will depend on their volunteerism. We will need their services, maybe even to a greater degree in the future than we do today.

Mr. Sweatman: Well, thank you. You need to say so, that is all I am saying. Thank you.

Mr. Chairperson: My 89-year-old mother whose name appears in that book you presented and served on the board of that home–

Mr. Sweatman: I thought you would pick that up, David.

Mr. Chairperson: –will not rest unless I make sure that what you have said is listened to by government. Thank you very much, Mr. Sweatman.

I would now like to call on Debra Mintz. You may proceed, Ms. Mintz.

Ms. Debra Mintz (Private Citizen): My name is Debra Mintz, and I have lived in Manitoba for 22 years. I have worked as a registered nurse for 20 of those 22 years, the last 16 years of which have been in the emergency department of a tertiary care hospital. This experience gives me the advantage of viewing Bill 49, The Regional Health Authorities and Consequential Amendments Act, from two perspectives. As a health care consumer and as a health care provider my concerns are identical from each perspective.

If questioned, most Manitobans would reply that we live in a democracy, but in order for that to be true our Legislature, courts and society must govern themselves in a democratic fashion. Democracy, as defined in the Merriam Webster Dictionary, includes the following: A government in which the supreme power is held by the people; and the absence of hereditary or arbitrary class distinctions or privileges.

In order to safeguard the democratic process, Bill 49 must be amended to ensure elections for the regional boards and chairpersons. As is, Bill 49 requires the initial appointment of these positions, and it does not guarantee elections for subsequent board members.

As recently as September 26, Health Minister Jim McCrae, while making a presentation at St. Boniface General Hospital, was asked if he had considered or would consider making these positions elected. The minister's response was a definitive no. This position is unacceptable as it makes the regional health board accountable only to the Minister of Health.

Recently we have read of a board chairperson who spends large blocks of time out of the country. I ask you, would your constituents accept your representing them from a winter home in the southern states? More importantly, should they?

An elected process makes the chairperson and board members more accountable to the public. With amendments to guarantee elections to these boards and chairs you must then make amendments so that the regional boards are legislated with the authority to have real and meaningful power to affect changes in the delivery of health care separate and apart from the wishes of the Minister of Health. This is obligatory if this reform process is to have any credibility.

In order for me, as a health care consumer, to have any faith in this reform process, you must ensure that the decisions that my regional board makes are based on the needs of my community. By mandating elections and then empowering these boards you will have established a more democratic balance by holding the people in these positions accountable to the people of the regions.

Without empowering the regional health boards the Minister of Health (Mr. McCrae) remains directly responsible for health care decisions.

The entire Part 6 of The Regional Health Authorities and Consequential Amendments Act must be removed from Bill 49. Left as is, this section gives ample evidence that this legislation is undemocratic. By setting out the appointment of a commissioner, who for an unspecified period of time is granted excessive authority, this section is egregiously antidemocratic. This commissioner would be allowed to decide how I personally will be represented and allows this all-knowing person to overturn any portion of a duly negotiated contract that he or she does not like.

In Section 75, Bill 49 states that the regulations which will implement this act will supersede The Labour Relations Act. The Labour Board itself has said publicly that Part 6 is redundant, as the current legislation sets up a fair and reasonable process to protect the rights of employers as well as workers. By endorsing this section, you are in effect saying your government has the right to make one law for health care workers and one law for the rest of Manitobans. It is a telling commentary on political alliances that Part 6 seems to enact onerous and solitary restrictions on all health care workers except physicians. Removing Part 6 of the act would leave the present Labour Relations Act as the governing legislation in labour-employment issues for all Manitobans.

As a professional health care provider, I am alarmed that this legislation does not set the five basic principles of medicare as the standard for health care delivery. It is important that universality, accessibility, comprehensiveness, public administration and portability be included to ensure that health care continues to be the right of every citizen of Manitoba regardless of their ability or lack of ability to demand it.

If any of you have personal, private reservations about this act, I encourage you to step away from the political party agenda and speak out. I strongly believe in this process of allowing the general public and affected groups to give their views on the issue. I do believe that there is room in this process for a balance of outlooks. In order for this process to have credibility, there must be a true and honest effort on the part of the government to gather concerns and viewpoints and incorporate them into the legislation.

* (2320)

Those of us who came here tonight have done what we can. Now I implore you to do your part and make amendments to Bill 49 to maximize the quality of health care in the province and to ensure that the rights of all Manitobans, health care workers as well patients, are upheld

Mr. Chairperson: Thank you for your presentation.

(Mr. Gerry McAlpine, Vice-Chairperson, in the Chair)

Mr. Chomiak: Again, thank you for an informative presentation.

If I had to capsulize, I think in your presentation you captured something that I think has been suggested before but perhaps was not put in as succinct terms, and I wonder if you agree with me with this in the essence of your presentation in that it is incredibly ironic that a bill that is purported to give power and authority and rights and input to the grassroots is in fact as undemocratic and as authoritarian as this bill is.

It is incredible irony, is it not, that a bill that is supposed to seek out people–and you are a nurse in the emergency who has the expertise and some of the knowledge of the system that could help us out–are actually cut out of the process with a bill that does not really seek information from the grassroots or seek input but in fact is very, very totalitarian and top down. I wonder if you might comment on that. It just strikes me as the great irony of this bill, and your presentation kind of brought it out I thought.

Ms. Mintz: I think it is a loss for all Manitobans that health care workers are being barred from the health care boards, the regional health boards in their areas. I think that health care workers, the people who are at the front lines of health care, are the people who can give some of the major pointers on what needs to happen in health care reform. We are not adverse to health care reform. We are unfortunately adverse to the way that it is going on at this time, which is rather a chaotic kind of experience for someone working in the system.

Mr. Penner: I appreciate the presentation you made, and, as well, I appreciated the comments that you just made. I respect the view that there needs to be some consultation or views around the table when decisions are made affecting the nurses or the health care workers; in other words, whether they be doctors, nurses or others. However, I believe that currently happens in our community when the health board meets–and I meet very often with them.

We have nurses sitting around the table, we have doctors sitting around the table, not as board members but in an advisory capacity to the board. So the issues and the views are currently made aware of the issues and views of the medical profession of the whole spectrum, and it always appears to me that this is an exceptionally functional way to deal with the care issues on an ongoing basis, and that there is constant consultation between the two groups. Do you see that that would change dramatically with the new system in place?

Ms. Mintz: I guess I would ask you the question, if you feel that these people are playing such an important part as your advisors, why then can they not be part of the elected board?

Mr. Penner: I appreciate that question, and I will try and give you a very straightforward, honest answer. If I am an employee of yours, I would expect the respect of the consultation process to be ongoing. However, I would not expect to sit on your board of directors to tell you how to run your business. I would expect the consultation constantly that you and I would share, but to be on the decision-making body is–I am not sure whether that is an appropriate application of the total process.

Ms. Mintz: I suppose that the best answer I could give you is that on a daily basis nurses have to enact two roles. They have to enact the role of being an employee in many instances, but they also have to step out of that role then and always act as a professional in providing the best care possible. I believe that on your board nurses would be able to do that. I do not believe that they would be curtailed in any way. I believe they would be one of the biggest assets to your board.

Mr. Vice-Chairperson: I would like to thank you for your presentation, Ms. Mintz.

I now call Sharon Macdonald. Do you have presentations to distribute? Please proceed.

Ms. Sharon Macdonald (Private Citizen): Thank you, Mr. Chairman, for the opportunity to present to the committee this evening. I will limit my remarks to three important areas regarding Bill 49. By way of introduction, I am a medical doctor. I have worked in public health for the Ministry of Health in the past, and am currently at the University of Manitoba involved in providing health care services to Northern Manitoba.

The three important areas I would like to address are, firstly, the protection of the health of the public which is

the duty of the Minister of Health. Second, the authorizing, the charging of fees for health services or categories of health services directly to the person who received the services, under Section 25 and they repeat it again under Section 59, and thirdly, I would like to make a few short comments on Section 74 regarding the commissioner.

The health of the public is the central issue on which I wish to make comments. The introduction of Bill 49 has clouded, I believe, the responsibilities of the Minister of Health and the proposed regional boards regarding public health. The power of the Minister of Health has been undermined by the failure to clearly delegate responsibilities to protect the health of the public through the appointment, particularly, of medical officers of health and other officials under The Public Health Act as a consequence of the proposed amendments to current legislation.

Under The Public Health Act, 2.1 the duties of the Minister of Health include the supervision of all matters relating to the preservation of life and the health of the people of the province. Within this act, a number of responsibilities are delegated to medical officers of health, public health inspectors and public health nurses in the enforcements of regulations under The Public Health Act. Now, currently, the health of the public is protected by the Minister of Health who requires the appointment of the medical health officer for each municipality or local health unit under The Health Services Act. In the proposed Bill 49, it is not clear how or by whom the health of the public will be protected. The interaction between municipal and regional authorities is unclear.

(Mr. Chairperson in the Chair)

I call your attention to Bill 49, Division 2, Section 23(2)(a) which states: a regional health authority shall promote and protect the health of the population of the health region and develop and implement measures for the prevention of disease and injury.

How will the new health regions carry this out? Is the Minister of Health divesting himself of the responsibility under The Public Health Act for the protection of the health of the public?

Amendments to other legislation, as recommended in Bill 49, also weaken the ability of the Minister of Health to protect the health of the public. That is, under Bill 49, Section 80(6) amendments to The Health Services Act will repeal Part I, the local health units, and Part 2, medical care districts. The amendments to The Public Health Act deletes the responsibility of the municipality to appoint a duly qualified medical practitioner to be the medical officer of health of the municipality. The amendment in Bill 49 states only that the minister may, not shall, appoint medical officers of health for the province. It is a bit of a circular argument. The justification for this, of course, is that you have also proposed deleting the local health units under The Health Services Act. Therefore, under Bill 49, there is no requirement or structure for appointing medical officers of health.

* (2330)

Who is responsible for the health of the public, the Minister of Health or each regional board? Who will carry out the regulations under The Public Health Act? How will issues of provincial importance be addressed? We regularly see the need to cross regional boundaries in times of epidemics or during environmental catastrophes which pose a hazard to the health of all of the public.

Any new regional legislation must be clear about whose responsibility it is to protect the health of the public. We would note that in the introduction to Bill 49, it is meant to be an act which provides services. I argue that it is the Minister of Health's responsibility to protect the health of the public. It should not be delegated to a health region. Regions are merely structural units by which to provide service.

The Minister of Health needs the ability to assess and respond to health hazards. He needs the ability to appoint duly qualified practitioners to act on his behalf. Indeed, legislation should direct him to appoint medical officers of health who are capable of providing him with advice on how to investigate and alleviate hazards to health. The legislation should be explicit about how the responsibilities of a municipality under The Public Health Act will coincide with those of a health region under Bill 49. This will require further amendments to Bill 49 to make sure that The Public Health Act and the powers of the minister are not undermined. At a minimum, the amendment to Section 4(1) of The Public

Health Act at least should read, the Minister of Health shall appoint medical officers of health for the province, or the Minister of Health could delegate that to the regions. However, it must be so stated.

On the second item, authorizing charges to the public, in Section 25, and again at Section 59, it is noted that the Lieutenant-Governor-in-Council may make regulations authorizing the charges of fees for health services or category of services directly to the persons who received those services. This section leaves open the interpretation that authorizing of charges may include a user fee imposed on the public. The Minister of Health (Mr. McCrae) has not identified the core health services which will be made available to the public. He has not indicated what will not be charged as a fee to the public.

The tax structure in Manitoba provides access not only to the insured services under the Canada Health Act, but also the public health services which were previously funded by municipalities. This section of Bill 49 is too permissive. The Minister of Health should be prepared to identify within the new act the core services available to the public, otherwise the interpretation of this may allow health regions to charge fees for a variety of services which the public already thinks is included in their tax base. This should be defined within the act, as the regulations can be changed easily and may not require public consultation.

Thirdly, a short comment on the role of the commissioner. As we have already heard from several presenters, the appointment of the commissioner may have some use in providing the transitional environment respecting labour relations and employees. However, in my opinion the powers attributed to the commissioner are unduly extensive. The commissioner has the protection of The Manitoba Evidence Act. Under Section 74, the general jurisdiction provided to the commissioner is very broad. It does not appear to protect the rights of the individual. What is the intent of government in this regard? Are these powers not too broad and too powerful for an individual? Is the delegation of such powers to an individual in the best interest of the public and in the best interest of the provision of health care? Will these sections serve the public well?

I argue that the powers are too inclusive. The ability to override other legislation such as The Labour Relations Act provides potential for conflict. Let us remember that within the health care system the period of transition to regionalization in and of itself will bring a degree of instability to the system. While there may be merit in recognizing the redeployment of staff is an issue during the regionalization process, the powers of the commissioner, as granted in the current Bill 49, are seen as dictatorial, not allowing for due process and overriding the rights of the individuals. Is that the intent of government?

A couple of final comments. Other sections which would benefit from clarification include Section 25(a) "provide for the delivery of social services, with the approval of the minister."

Social services is not defined. Within the repeal of The Health Services Act or sections thereof it is noted in Bill 49, Section 80(2), that social services has the same meaning as under The Regional Health Authorities Act. Therefore it would seem that it should be defined.

In Bill 49, Section 60(k) reference is made to a service provider advisory committee; however, there is not a further description that I can see or definition of such a committee. What is the intent within this act for providing for a service provider advisory committee?

The proposal of this new legislation may have some merit. The most significant drawback is that the Minister of Health has not made it clear within the act and revisions to the current legislation how he will safeguard the health of the public. He must assure the public that revisions to the Public Health Act will maintain his current ability to act in their best interests.

The minister must also clarify what health care will be made available within a core services package. He must also not appear to invoke draconian methods to push regionalization through. Thank you.

Mr. Chairperson: Thank you, Dr. Macdonald.

Mr. Chomiak: Thank you very much again for an excellent and informative presentation. I note in two specific areas you have made reference to points that have not been raised tonight. The first is the social services provision, which I agree is very ambiguous and almost appears to be an add-on because there are no real

defining characteristics. But very significantly, and something that I had not noted, was the whole question of the public health officers and the medical officers and that whole issue of the role of the minister in protecting the public health and the appointment of medical officers. How many medical officers–do you know roughly how many we now have in Manitoba?

Ms. Macdonald: There are probably about 10 appointed under The Public Health Act currently.

Mr. Chomiak: But since there is no provision in this legislation, it certainly does read as if that power is going to be delegated to the regional health boards, does it not?

Ms. Macdonald: It is ambiguous in that regard. If you look at the intent of the legislation, it does say that the regional boards will promote and protect the health of the public which is in, I would say, conflict of The Public Health Act. It has also been noted that this act will have precedence over other acts, to my way of understanding, so the minister under this act does not have to appoint medical officers of health.

Mr. Chomiak: In your opinion, in your experience, do we need 10 medical officers of health, one for each region, or do you think we would require more to actually undertake the activities that are necessary?

* (2340)

Ms. Macdonald: In my opinion, there should be one medical officer of health for each region, but the Minister of Health should also continue to have advice which is now in the form of a chief medical officer of health, and there are also other medical officers of health that provide a central advisory role to government. I think that this is an important role which should continue, given that the responsibility of the Ministry of Health–a residual responsibility of the Ministry of Health one would expect to be that of setting standards across the province, and there is a need for co-ordination of initiatives such as the current measles vaccination policy. If the Minister of Health did not have a central body on which to advise him, then you would have 10 regions doing whatever they liked about measles vaccination.

Mr. Chomiak: From your own experience, do we presently have the adequate resources to adequately fulfill the role and duties of the Minister of Health responsible for public health? Do we have enough person power in place right now to undertake that role?

Ms. Macdonald: You know it is difficult going from budget year to budget year to figure exactly what the dedicated budget is to medical officers of health. If there was one medical officer of health for each region and three to five medical officers of health that would provide a central function of advanced epidemiology, surveillance and monitoring of diseases across the province, reporting and investigations of particular things like environmental health which were very complex, then I would think 15 would be the upper limit. It might be between 12 and 15 would adequately serve the needs of the province. There is also the city of Winnipeg which traditionally has two medical officers of health appointed.

Mr. Chomiak: Would the role and function of a medical health officer in a prophylactic sense for monitoring for things like hamburger disease and the like, would that be a role and responsibility of a medical health officer or would it fall under some other auspices?

Ms. Macdonald: That would be the role and responsibility of a medical officer of health, a medical health officer.

Mr. Chairperson: Thank you very much for your submission, Dr. Macdonald. Brenda Maxwell, please. You may begin.

Ms. Brenda Maxwell (United Nations Platform for Action): Anybody awake? Okay. We hereby adopt and commit ourselves as governments to implement the following Platform for Action ensuring that a gender perspective is reflected in all our policies and programs. That came from the Beijing Declaration which was adopted by the world's governments, Canada included, September 15, 1995, at the Fourth World Conference for Women. Our government has therefore promised to the people of Canada, which includes the people of Manitoba, that all new policies and programs will be assessed in terms of their impact on women, as well as on society as a whole.

I am here tonight representing the UNPAC, The United Nations Platform for Action Committee of Manitoba. It is a coalition of over 50 NGOs, or nongovernmental

organizations, working to ensure that our government respects and follows through on commitments as agreed upon in the Platform for Action that resulted from the Fourth World Conference of Women last year.

So what I have handed out to you is two things. One, the three-page document which is just the notes that I am using to talk to you this evening, and it is a condensed form of the eight-page attachment which is beside it and which you can review for further details on the issues. But I will try and be brief, so I should be finished within about eight minutes and 59 seconds.

Our specific concerns regarding Bill 49, all right, I will go through them.

One, the opportunity for public input, we have heard a lot about that this evening, so I will just comment that given the absence of data on such critical aspects as the core service agreement, application to Winnipeg, funding principles, divergence from the recommended election of board members to government-appointed ones and lack of input from those sectors of society most impacted by health care decisions, it seems at the very least premature to consider passing Bill 49. We urge the government to delay passing it until more information is released relating to the operation of the regional health system, and there has been adequate opportunity for public education and input.

Second issue, recognition of the special position of women in relation to health services, in the expanded form, I have gone through a lot of the areas of impact on women, and I will condense it to the following for this presentation. To date, the discussions around the regional health authorities do not inspire women with confidence that their views are being perceived as essential in contributing to the solutions to current health care issues.

The Platform for Action summarizes women's plight. The prevalence among women to poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision making are social realities which have an adverse impact on their health.

The Platform for Action goes on to urge governments to design and implement, in co-operation with women and community-based organizations, gender-sensitive health programs, including decentralized health services that address the needs of women throughout their lives and include women, especially local and indiginous women, in the identification and planning of health care priorities and programs and to pursue policies to eliminate poverty among women in order to improve their health.

In relation to regionalization here in Manitoba, legislative and policy measures ought to include reference to women's health in a statement of principles framing the legislation. Adequate representation of women on the regional health authority boards and advisory committees, education of new regional health authority board members about women's health issues, establishment by the regional health authority of a standing women's health advisory committee–we understand from your comments earlier that this is the intent of government, and we would like to see that go through–insurance of women's input in the development of regional health plans, areas of services as outlined in the Platform for Action should be in the core services agreement. It would also help if discussions in progress, such as the women's health policy paper, were made available for community consultation at the earliest possible time.

3. Lack of democratic process in the selection of the regional health authority board. I will not flog this much more because it certainly has been raised enough times this evening, but in order to ensure accountability to people in the region and to ensure that the governance of the health system is not dominated by a desire to please the minister owing to appointment by same, it is important that the selection of these boards be by election from their communities.

Future boards should be consumer based with the substantial majority of directors elected. It would be best to leave a small number of board positions, about a quarter, to be filled by appointment by the elected board members in order to ensure appropriate reflection of the demographic composition of a particular region, including parity of representation of women and the diversity of people living in a region.

4. Lack of commitment to uphold principles of the Canada Health Act and universal access to health

services. Again, I am happy to hear the minister this evening that the Canada Health Act will be upheld. However, the proposed act has references to the charging of fees for unnamed services without reference to the level of services to remain insured. At the very least, this act must include a commitment to uphold the five principles of the Canada Health Act, an outline of services which will continue to be insured, and those were very nicely outlined by Laurie Potovsky-Beachell earlier and they are also in the expanded version of my talk this evening. Commitment to the non-for-profit, public nature of the health care system would preclude moving additional aspects of health care to the for-profit sector.

5. Lack of funding commitment. Whereas the purpose of the act is to give power to the regional health authorities to make decisions about health services in their region, there is no corresponding commitment on the part of provincial government to fund the required services at an adequate level. In fact, it would appear that the regional health authorities could act as the buffer for funding cuts while minimizing political damage. The regional health authorities will have to implement the necessary cuts in order to meet budget reductions, making it difficult for communities to hold provincial government accountable for the service reductions. This is not the first time this has been raised this evening either.

* (2350)

6. Extensive regulatory powers and powers of the minister. We are concerned that there are many important matters being left to regulation rather than being outlined in the act. If regulatory review is done before a subcommittee composed of government members only, with public input not being required, and/or board members are appointed, it means that the health system could evolve without public input. We recommend that specifics of system changes and directions should be included in the legislation rather than the regulation. Again, this has been mentioned by other groups this evening. Where this is not possible, government should state under what principles the system will operate, and these principles should be clearly enunciated in the legislation so that Manitobans know the rules. If these rules are to be changed, then the changes occur through the legislative process and not by regulation.

It is also of concern that Bill 49 proposes to allow regulation arising from this act to supersede other acts established under statutory authority. This is an uncommon practice and superimposes publicly unscrutinized regulations over publicly debated legislation.

Conclusion. Meaningful, practical solutions can be created by government departments, the business sector and nongovernmental organizations coming together on an equal basis, with equal representation of men and women and input from all people affected by policies and decisions. If the government of Manitoba aims to optimize our health, which will maximize our potential both individually and collectively and result in the advancement of the society as a whole, then surely this will require the inspired and intelligent participation of all Manitobans in the discussions about our health and well-being.

I will take exception to a few of the comments that have come up this evening about the lack of either trust in government or lack of a sense of any change happening as a result of our speaking. I think the majority of the people here this evening are here this evening because we do want to have that trust in government, and we want to be listened to and our input taken seriously.

The women of Manitoba ask that we be viewed as an intelligent, capable resource, offering talents, insights and a vision which are desperately needed in the current health care reform. We believe that it is time for the institutions of the world, composed mainly of men, to use their influence to promote the systematic inclusion of women, not out of condescension or presumed self-sacrifice, but as an act motivated by the belief that the contributions of women are required for society to progress.

Thank you for allowing us the opportunity to offer our contributions, which we sincerely hope will assist in improving the health of all Manitobans.

Mr. Chairperson: Thanks very much, Ms. Maxwell.

Ms. Wowchuk: Thank you for the presentation, and thank you for also reminding us of the commitment that was made by government by signing the Beijing Declaration and working to include women more in the roles.

You said that one of your concerns–you mentioned here that we must have adequate representation of women on the regional health boards and advisory committees. In your opinion, what is adequate representation?

Ms. Maxwell: Reflecting the percentage of women in the population.

Ms. Wowchuk: Which is, I believe, over 50 percent?

Ms. Maxwell: It is over 50 percent. That is correct.

Ms. Wowchuk: It is something we have raised right along. I, personally, and all members of our caucus were very disappointed with the poor representation of women on the advisory board, as well as representation from other groups such as aboriginal groups. We felt very much that there has to be a broader cross section of people brought in to have true representation and meeting the needs of all people.

You mentioned here also, you said it would also be helpful if discussions in progress, such as the women's health framework policy paper was made available. I am not familiar with that policy paper. Can you tell me which–

Ms. Maxwell: Unfortunately, I do not know anything more about it than that it is under discussion right now, and that is exactly the type of discussion we would like to be made aware of before it comes out as either a proposed act or a proposed policy. You know, bring it out for public discussion prior to that so that we can be part of the discussion process and contributing at the early stages and not in a token fashion, not present us something and then get the opinions of the aboriginals, the women, the elderly, the youth, you know, to actually include the people of Manitoba in the discussions at the earliest stages because honestly, the people that live in this province are the resource that is going to make health care better and the society better, and we have to be treated with that degree of trust and respect right from the start. So do not wait until policies are about to be implemented, bring them out to the discussion early.

Ms. Wowchuk: Thank you, and I guess I will have to get more information on that policy paper, but I want to just say, in conclusion, that I support what you are saying. We have said that it is wrong for this bill to go forward at this time without more discussion, and what we would really like to see is it go back to the community and have more input so that we come back with a bill that really reflects the needs of the people of Manitoba.

Mr. Penner: I am really, really intrigued by your presentation, and I could not agree more with the statement that we should have more women involved in our total system, but tell me something. I am a member from rural Manitoba. I have spent most of my life in public affairs of one kind or another, whether it is farm organization or many of the other boards and commissions or whatever you have that it takes to run rural Manitoba.

How do you convince women that they should become much more involved than they are, especially in rural Manitoba? How do you convince a farm wife to walk away from her farm and her family and serve in those capacities? It was something that absolutely, totally confounded me when I was the chairman of the farm organization, the general farm organization, where we tried to solicit board members, especially women to become board members, and we found it virtually impossible to ask these women to spend that much time away from their homes and their farms to become involved.

I would certainly appreciate your advice as to how we are able to convince those people to become much more involved, because we would certainly love to have them.

Ms. Maxwell: By men taking on some of the roles that women are doing.

Mr. Penner: And many of us do, but being a farmer, it takes a total effort these days to keep a farm afloat by both partners and the involvement of both, and men do pitch in whether you like it or not and take on in most cases, because last night I had my seven-year-old grandson with me in the tractor till midnight because his mother was on the other tractor whipping the leaves off the sugar beets so we could harvest them and because there were not enough people that we could find to hire. There is not anybody out in rural Manitoba that we could hire to do that job. So it takes that total commitment and we all pitch in and do each other's jobs. But I would like to ask you, how do we convince these women to become involved?

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Ms. Maxwell: Statistically, women bear most of the responsibility for looking after their families whether employed outside the home as unpaid volunteers or in the community, women still get paid less than men in Canada. We get 70 percent of what men make doing the same jobs, so it is a matter of education and support and it honestly is a matter of men understanding these issues so that they are supportive enough and welcoming enough to women so that in a situation where a man and a woman were deciding who should be at this meeting, that it would be an equal decision. It would not just be the woman needs to be doing the responsibilities that she is used to be doing, it is an education, it is an effort in order to improve the health care of Manitobans, the gender issues are a real significant priority and it is education and it is a sincere effort on the part of men, especially those in power right now and those in leadership positions.

I mean, look, the reason that women are not more on board is because they do not have the same opportunities presented to them that men do. They do not have the freedom and that is what we need to work on. And it is a matter of education and it is also a matter of what willingness to work together. Most women do not see this as wanting to be better than men. It is a 50-50 contribution in society and men right now have to play more of a supportive role, especially those men that have any insight into those issues.

Mr. Chairperson: I will allow Ms. Wowchuk, with the leave of the committee, to have the last word together with Ms. Maxwell.

Ms. Wowchuk: Mr. Penner raised an issue about why women do not become more involved and how difficult it is for women to take on some of these roles. I want to ask you if you think the lack of daycare, particularly in rural areas, and other supports that we have seen cut back are having an influence and whether those are things that we should be bringing forward to allow more women–

Point of Order

Mr. Chairperson: There is a point of order being raised and probably quite rightly. We are getting off topic. Point of order being raised.

Mr. McAlpine: Mr. Chairman, with all due respect to the presenter, I think we are hear to debate or to listen to the presenters of this bill, not to talk about daycare.

Mr. Chairperson: Same point of order, Mr. Chomiak? You have more to say. Go ahead, Mr. McAlpine.

Mr. McAlpine: I believe in all fairness to the other presenters that are here that we owe them the courtesy of staying on topic with regard to this bill, not to be talking about and getting into issues and provoking debate or anything like that, which the member for Swan River (Ms. Wowchuk) is doing and leading us down another path. I would ask you to bring her to order.

Mr. Chomiak: Yes, Mr. Chairperson. This question is entirely in order; entirely on topic. The presenter made the point that women are not adequately represented. The member for Emerson (Mr. Penner) asked why that was the case, and in fact the member for Swan River then subsequently asked in order to clarify the very same question. So it is precisely on point, it is precisely dealing with the question raised by the member for Emerson, and I think that we ought to allow the presenter to deal with the question.

Mr. Chairperson: I would rule that you can proceed with the question that you are about to pose, and then Ms. Maxwell can respond and then the presentation will be complete.

* * *

Ms. Wowchuk: I will just continue my questioning, and I would like to ask whether you feel that–

Mr. Chairperson: Question, I thought.

Ms. Wowchuk: –you feel that the lack of daycare services that we have has an impact on women not being able to put their names forward to participate in this board and other roles that you feel are very important for women.

Ms. Maxwell: There is no question that daycare and help for caring for the elderly and other members of the household that tend to be women's roles are hindrances in having women participate more fully in these organizations.

Mr. Chairperson: Thank you very much for that spirited presentation, Ms. Maxwell.

I now call on Barbara Wiktorowicz. She is not listed for tonight; she is listed for tomorrow.

Ms. Yvonne Peters (Chairperson, Women's Health Clinic): Good evening, good morning, I am not too sure what it is. My name is Yvonne Peters, and I am the chairperson of the Women's Health Clinic. With me is Barbara Wiktorowicz, who is the executive director of the Women's Health Clinic, and she will now be assisting in providing further information and answering questions.

I guess the thing about waiting so long is–well, I guess after that last presentation we are all awake, but–I am not sure that we have anything new or surprising to say, but we would like to restate and emphasize some of the important points that have already been made this evening. You hopefully will have copies of our written submission. We will not be going through it word for word, but I will be highlighting some of the key issues.

The Women's Health Clinic is pleased to have this opportunity to present to the standing committee on Bill 49. The Women's Health Clinic was established in 1981 by an extensive network of women's groups, consumers, volunteers, as well as health care providers to promote the health of women in Manitoba. We endeavour to give voice to the perspectives and needs of women from a diversity of backgrounds and to provide effective programs and services to address the needs of women.

Our mission statement declares that we are a community health centre based on the principles of feminism, equity and diversity, promoting the health and well-being of women. The Women's Health Clinic's approach is to facilitate the empowerment, choice and action for women.

We offer a wide range of services including primary medical care, consultation regarding particular health concerns of women, nutritional and emotional counselling, information sessions and support groups, as well as information packages and resources around a variety of women's health issues.

In our submission we will highlight some of our concerns regarding Bill 49; however we would like to say that the Women's Health Clinic is generally supportive of many of the goals of the act such as the creation of mechanisms to increase co-ordination among health service providers and to increase local control over health services. However, as I said, we do have some major concerns with the bill which we would like to share with you tonight.

For the purposes of brevity, our presentation will focus on those issues which are of greatest importance to the clinic and to women. We are members of the Manitoba Association of Community Health Centres, which I think you will be hearing from later, and the Manitoba Health Organizations, which you have already heard from, and we do support the recommendations which they are making in their presentations.

I would like to list six concerns that we have, and I will go through them quickly. First of all, concern No. 1, the recognition of the special or unique position of women in relation to health care services. Women face particular challenges in achieving good health. Some of these challenges which you have already heard about in the previous speaker and which are very succinctly outlined in the Beijing Platform for Action–I will not go through all of the various relevant things that the platform says, but I will just note that the Platform for Action emphasizes the need to hear from women at the margins in formulating policy and designing programs. There is strong recognition in the platform of the economic and environmental determinants of health. It calls on governments and other appropriate bodies to pursue social human development, education and employment policies, to eliminate poverty among women in order to reduce their susceptibility to ill health and to improve their health.

Now how does this apply to the regionalization process? Well, international documents such as the Beijing Platform for Action for Women is not just some document that floats out there in space. It has been signed onto by the Canadian government and is something we should try to implement at all levels of government.

* (0010)

The unique role which women have in relation to the health system should, therefore, be recognized throughout

Bill 49 and the related policies and practices. Legislative measures must be sensitive to the fact that women come from a diversity of backgrounds. At a minimum, these legislative and policy measures should include–you have heard this before, but I would like to emphasize it because I do think it is very important–a reference to women's health in a statement of principles which should guide the legislation: measures to ensure adequate representation, that is, gender parity of women on the regional health boards, on advisory committees and on district advisory committees; measures to educate current and new regional health board members on women's health issues; a requirement that the regional health authority establish a standing committee on women's health issues.

I would just like to emphasize that out of all the various recommendations that we are making we think that this is something that could easily be done and would certainly be a good-faith step towards an attempt to support and recognize the unique considerations and role that women's health has in the regionalization process. A stipulation in the act that women's input be solicited in the development of regional health plans and other mechanisms to ensure input from women, and this can be done through various educational and consultative measures. The development of services important to women, such as reproductive health services, which should be then included in the core services agreement.

We are aware, as the previous speaker was, that Manitoba Health is preparing a women's health framework policy paper which we urge the government to release for community consultation as soon as possible. Such a framework paper would be an excellent tool for educating the public as well as regional health authorities. We cannot tell you much more about it than the previous speaker, except to say that we know it is being developed or that it exists in some form and that it would be useful to have that document released.

Our second concern, the lack of commitment to uphold the principles of the Canada Health Act and universal access to health services. You have heard this before but let me emphasize. The act currently includes repeated references to the charging of fees for unnamed services, and while we are alarmed at this we are even more alarmed that this is not balanced by any reference to the level of services which should remain under the insured services. We are concerned about the fact that this may allow for further de-insuring of health services. We do not believe that such an important issue, that is, what services will be provided by the health regions, can be left solely to regulations. At a minimum, we believe that the act should include the following: A statement of commitment to uphold the five principles of the Canada Health Act which you know and I do not need to repeat for you. An outline of broad categories of services which will continue to be insured including health education, health promotion and disease prevention, communicable disease control, reproductive health services, public health services, social services, home care services, long-term care residential services, rehabilitative services, chronic care services, acute care services, palliative care services, diagnostic services and emergency services.

We also support the commitment to a non not-for-profit public nature of the health care system which we feel will preclude the government or regional health authorities from moving towards a health-care-for-profit type of service.

Our third concern, the lack of funding commitment. The purpose of this act is to create regional health authorities and give them power to make decisions about health services to be provided in their region. However, there is no corresponding commitment on the part of the provincial government to fund the required services at an adequate level. The provincial government has already stated that it plans to reduce the health care budget dramatically in the coming years in order to adjust to projected reductions in federal transfer payments. We are concerned that regional authorities will be required to implement the necessary cuts in order to make budget reductions. We are aware that the government may be reluctant to make a statutory commitment to fund regional health authorities; however, we believe that at a minimum there should be mechanisms or assurances put in place to ensure that the regional health authorities can provide the required services.

Our fourth concern, the extensive regulatory powers and powers of the minister. We are concerned that many very important matters are being left to regulation rather than being incorporated into the act. We realize that this is often the way that legislation is developed; however, we understand that the regulation-making process is not always a public process and that organizations such as

the Women's Health Clinic may not have an opportunity to participate in the development of the regulations.

We also realize that perhaps matters have been left to the regulatory-making power in order to ensure the expedient passage of the act. However, we urge the government to review those regulations to determine if there are some matters which could be incorporated into the act for certainty and for clarity. Where it is not possible or it is more appropriate to leave items in the regulation, we urge the government to ensure that the regulation-making process is subject to public scrutiny and that the public has ample opportunity and time to have an input into the development of the regulations.

Fifthly, implications for health care workers. We are also concerned about this issue. Regionalization has very major implications for everyone employed in the health care system. A large majority of these employees are women, many of whom are immigrants and many of whom are working at lower-paid positions in the system. We are concerned that sections of the act dealing with labour issues have the potential to be adversarial. We believe it is important that individuals affected by the restructuring that will take place be treated fairly and equitably. We are very concerned about the broad powers given to the commissioner by the act, and, in particular, we are concerned that in certain situations the commissioner can operate independently of the Manitoba Labour Board and without any demonstrable public accountability. Again, at a minimum, we would urge that, if a commissioner is to be appointed, he or she be appointed in accordance with the rules and regulations governing the Labour Board under the Labour Relations Act and such a commissioner be accountable to the Labour Board.

* (0020)

Sixthly, need for commitment to community-based health services. As stated earlier, there is no commitment to fund a range of health services in the act. In particular, there is no commitment to encourage the development of more community-based services. Providing more services closer to the community has been a stated goal of the government's health reform since the 1992 Action Plan was announced. In order to ensure that a sufficient range of primary health care services is developed, the principles of primary health should be added to the act. These are identified in the government's Health Advisory Network task force on primary health care, which was developed in 1994. Including these principles will ensure that regions are required to provide services from a community-based perspective and address determinants of health. The importance of an appropriate and adequate system of primary health services, which acknowledges the unique social and economic situations of women, is recognized in the Beijing Platform for Action. The principles of community-based services should be a primary driver of the services contemplated under Bill 49.

I will leave it there except to say that we sincerely hope that the regionalization process will not undermine the many gains made by community centres, such as the Women's Health Clinic. We not only provide services to women, but are able to have services that are developed by women for women, and we do this through a number of ways. We have many volunteers who assist us. We also have surveys and consultations with the community, but we also have a board of directors consisting of women, which is not only accountable to the Women's Health Clinic, but accountable to women and ensures that women are very involved in the development of services that are of concern to them. We have, actually, in our brief, outlined some of the specific changes we would like to see to the act. We are certainly not legislative drafters, but I am sure that you will be able to judge from the spirit and intent of our recommendations the type of changes that we are contemplating. We would be happy to answer your questions.

Mr. Chairperson: Thank you very much for a very well-prepared and clear presentation.

Ms. Wowchuk: Thank you as well for a very good presentation. There are a couple of questions that I wanted to ask you. You said, and other people have raised this as well, that there should be a requirement that the regional health authorities establish a standing women's health advisory committee. Is it your idea that there should be a standing health advisory committee for each regional health authority, or would that be a central standing women's advisory committee to address women's concerns?

Ms. Peters: Ideally, I think, we would like to see each regional health authority establish an advisory committee to address women's issues and to ensure, because we

understand that each regional health authority will be fairly autonomous, that the services that women require are actually considered by the regional health authority. Ideally, we would like to see such committees established in each regional health area.

Ms. Wowchuk: Thank you, and I am sure that the government will listen to that and look at ways that we can ensure that women's issues are addressed. Just another question: On the implications on health care workers, you talk about the majority of the employees who are women, many of whom are immigrants and many who are working in the lower-paid positions. When we look at this legislation, we see that the proposal is with the commissioner, and we have heard other presentations that many of the rights of workers could be undermined under this commissioner. When we see the implications, as you say, the majority of women that will be affected, why do you think that the government would be wanting to put in place legislation that would undermine women in such a way?

Ms. Peters: I am not sure that I am really able to put myself in the shoes of the government in answer as to why they would want to do that sort of thing, but perhaps I could defer to Ms. Wiktorowicz. When in doubt–.

Ms. Barbara Wiktorowicz (Executive Director, Women's Health Clinic): I am not sure I could respond either. Maybe Mr. McCrae can answer that question.

Mr. Chairperson: One last question, Mr. Chomiak.

Mr. Chomiak: Thank you for, again, a very informative and helpful presentation. I am glad you made reference to the task force in primary health care which, as one of those many health reports, it seems to have disappeared into the black hole of the Department of Health. My specific question for the Women's Health Clinic, since you are relatively unique in Manitoba, do you have any idea whether or not you will be falling under the auspices of Bill 49 or whether you will be falling under the auspices of the new proposed act that is going to be proposed for the City of Winnipeg? Do you have any indication or idea under which jurisdiction you will fall?

Ms. Wiktorowicz: We are also unclear whether there will be a separate act for the City of Winnipeg. My understanding is that there will not be a separate act, but that there will be amendments to Bill 49 right now. So I guess there are different understandings in the community about it. I presume that Women's Health Clinic would fall under it as a funded health service, under one of the regional authorities, the community and long-term care authority in Winnipeg.

Mr. Chairperson: Desmond Conner, please. Thank you very much for your presentation.

Desmond Conner, please. You may proceed.

Mr. Desmond Conner (Community Coalition on Mental Health): Good morning. It is so late that even the dog fell asleep.

The Community Coalition on Mental Health was founded in 1984 with a mandate of promoting comprehensive mental health services in Manitoba consistent with the principles and policies recommended by the Mental Health Working Group Report (1983).

The Community Coalition on Mental Health is a voluntary, nongovernmental umbrella organization of agencies, professional associations, self-help groups and individuals. The coalition is represented on the provincial Advisory Council on Mental Health, and various members participate in provincial, professional and community committees and task forces which keep us informed of current issues.

In October 1994 we presented a brief to the Northern and Rural Health Advisory Council consultation process in response to their discussion paper. In our response to Bill 49, we will refer to this paper and often reiterate what we said there. In Bill 49, there is no reference in the bill, which has been mentioned by other people presenting before, to the essential principles which had formed the basis of the legislation. These should be clearly stated for present and future legislatures, governments and the general public to see and understand.

The key principles, which should be included in the bill, are:

1. The Canada Health Act, again, which has already been mentioned, that the five basic principles are universality, accessibility, comprehensiveness, public administration and portability. We believe that all

Manitobans endorse these principles and expect all new legislation to respect them, and we support, therefore, the minister's proposals to make reference to these principles which he articulated here tonight.

2. Northern/Rural Health Association principles. We strongly endorse the four principles which include

(i) A broad definition of health including services and programs beyond those which are Manitoba Health funded and extending to other ministries as well as community organizations. Quote: The health sector cannot act alone, because most of the determinants of health fall outside its purview. . . . Collaboration across many sectors, along with the active support of the general public is the key–end of quote. So says the Strategies for Population Health document, which was prepared by the Federal/Provincial/Territorial Advisory Committee on Population Health for the ministers of Health meeting in Halifax in September 1994. Manitoba was represented on this committee by an ADM, Sue Hicks. We feel that this omission from Bill 49 is a crucial mistake.

* (0030)

(ii) A broad range and scope of community involvement must be encouraged and facilitated in planning, delivery, assessment, evaluation and governing of health services. Local delivery of services should be emphasized.

The absence of this principle in the proposed act implies the establishment of a top-down, autocratic system. The regional health authorities have already started with boards and even a chair appointed by the minister. There is no definite provision for the election of boards or mention of how any community involvement could be facilitated in the various phases listed in this principle.

The regional health authorities and councils must provide a clear channel of communication from the individual consumers, families, other caregivers and volunteers to those in charge. Without this, there is no public input or accountability to those who receive the services. Bill 49 does not provide for this vital link.

In order to ensure adequate representation of mental health constituents, consideration should be given to having the existing regional mental health councils become subcommittees of the proposed regional health authorities. Further consideration should be given to including a representative from mental health on the regional health authority board itself.

Once regional health authorities are established and operating, then consideration should be given to phasing in mental health services in consultation with each of the regional mental health councils. The reason for suggesting this phasing process is to safeguard the process that has been made in building trust and including consumers and families in the planning and development of needed programs. This involvement by those in need of help is the essence of the principles of the Northern/ Rural Health Association's proposal. It should not be jeopardized in any way and could form the basis of proof that local participation ensures appropriate regional service delivery.

(iii) An integrated and co-ordinated continuum of service affecting health is essential to respond to and address effectively and efficiently the health needs of individuals, families and communities. Such an integrated system would ensure equal availability and accessibility to core health services. We note that there is no definition of social services, as we mentioned before, in the act, nor is there any mention of how regional health authorities and councils should or could co-ordinate their planning and service delivery with other sectors.

(iv) All health services must be sensitive to ethnocultural diversity and foster individual choice for lifestyle and intervention decisions. We do not find in the bill a reference to the representation of multicultural or aboriginal populations in the various health regions. There is no safeguard to ensure that these citizens would be represented by the ministerial or Lieutenant-Governor-in-Council appointments. How then can appropriate services be delivered and guaranteed?

3. Principles of service of mental health service. At the time we would also like to refer to principles under which our coalition functions, which were reviewed and approved by our membership in 1994, quote: The Community Coalition on Mental Health believes that a comprehensive continuum of mental health services is required to meet the needs of those most at risk as well as those who are endeavouring to be as independent as

possible. The range of services must be: (1) regionalized, available and accessible; (2) individualized, balanced culturally and geographically relevant; and (3) locally co-ordinated, governed and accountable.

While our principles refer to mental health, we would suggest that they could and should apply to the full continuum of health and social services in Manitoba. Bill 49 should be amended to reflect all of the above stated important principles. These principles should also be translated to the operation of the regional health authority and district health council.

Two final concerns with respect to the bill include regulations and minimum standards:

1. Regulations/Regulatory Power: A major concern with Bill 49, section 2(2), is that it proposes to allow regulations, as yet unannounced, which would arise from the act to overrule other acts expressed and established under statutory authority. Allowing regulatory power to overrule statutory power would set a legal precedence which would be unacceptable as it is not safeguarding the long-term public interest.

2. Minimum Standards: In relation to the decentralization of responsibility for the delivery of health care, we believe that minimum standards will have to be set to ensure the equal availability of quality care of Manitobans wherever they live. In mental health services, equal regional access is already a challenge. Decentralization could fragment the system and make it more unequal unless this principle is safeguarded throughout the process. We also feel that there should be a mechanism for evaluation and appeal built into the legislation. This goes back to the basic rights under the Canada Health Act.

Conclusion: On behalf of the members of the Community Coalition on Mental Health, we thank you for receiving this presentation. Our mission and principles date back to the beginning of Mental Health Reform in 1983, and we continue to believe that they are fundamental to any changes in the structure of health and social service governance and service delivery in Manitoba. It will not be in the public interest to pass Bill 49 as it is presently drafted without inclusion of the underlying principles and consequential structural changes we have recommended. Thank you.

Mr. Chomiak: Thank you, again, for an instructive and informative presentation that also raised some new and significant issues. We had some discussion in our caucus and there was some difficulty about how we would deal with the regional health authorities and the input of existing regional mental health councils and individuals and groups. I think your suggestion for the process is a very, very good one of having subcommittees as well as the phasing-in process. I think that is a very helpful and instructive suggestion in order to ensure that those services do not get lost in the overall transformation of the system.

But your suggestion on the next page about the principles for delivery of mental health services, while I recognize you indicate that the provisions for the range of services should probably apply to all services, would you be averse to an amendment to the act that would ensure that mental health services, at least, would be delivered on the basis of the three recommendations you make on that page? Would you think that that would be helpful?

Mr. Conner: I think that would be very helpful in order to do that.

Mr. Chairperson: Thank you very much for your presentation. The next presenter is Monica Singh, President of the Provincial Council of Women. Thank you. You may begin.

Ms. Monica Singh (President, Provincial Council of Women of Manitoba): Thank you, Mr. Chairperson, I suppose you have heard it all. I do not know if I am coming with anything new, but on behalf of the Provincial Council of Women of Manitoba and the Immigrant Women of Manitoba, of which I am the past president and their representative on the provincial council, I thank you, your committee, for giving me this opportunity to bring our concerns to you.

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This is a presentation by the Provincial Council of Women of Manitoba, which brings together 24 member organizations representing over 75,000 women and their families. The purpose of this diverse group of professional associations, church and multicultural organizations is to study issues and influence political decision making for the well-being of society through education and advocacy. So, ladies and gentlemen, I

sincerely hope that I, and all of us here this evening, would be able to make and influence political decisions here tonight. I am one of those people who feel that the voices of the people must be heard, and smart politicians listen to the people.

In October of 1994 we presented a joint brief with two of our federate members–Manitoba Women's Institute and the Consumers' Association of Canada (Manitoba Branch) to the Northern/Rural Health Advisory Council. In it we commended the hearings as the "beginning of volunteer public consultation process," and recommended "it continue with more interaction between professionals and providers on one hand and health care consumers on the other." We also said, "We believe that consensus comes through research into the experience of other jurisdictions and negotiations amongst all stakeholders–professionals, bureaucrats and consumers"–perhaps we had better add the politicians or government of the day as well.

Now we feel betrayed because this process did not continue. Bill 49 was conceived, in our opinion, by bureaucrats and medical professionals and is not based on the principles and goals which we so warmly endorsed from the discussion paper on Northern/Rural Health Authorities.

There should be a preamble to this act and a section on principles and guidelines. We refer you to the draft Sustainable Development Act for the format and even some of the content and we have given you appendices. Our reason for doing that is because we have done a lot of work in that area and we do believe that Health is all tied in. It is pretty universal. Health is not an object by itself. You are influenced by the environment and staying at home–attending board meetings, that is all very good for the men–not just staying at home and minding the children and the farm; we need to get out too.

We also feel betrayed because Bill 49 is not based on the holistic approach to health, the broader definition of health, that lists all the health determinants such as proper living conditions, employment, social support, networks, et cetera. The definition that was supposed to guide us to an integrated and co-ordinated continuum of health and social services responding to the needs of individuals, families and communities.

We feel betrayed by the omission of health standards that are not spelled out. Where is the definition of "Social Services," a term that is in the act but is not defined?

Bill 49 is a narrow top-down, regulatory bill based on a professional/medical model without any regard to the holistic approach to health and the need to integrate this ministry with others. There are no doors left open to include other ministries. Bill 49 creates a hierarchy unto itself. Whether the model is part American or part from New Zealand or elsewhere is academic. What we have here is the legislation to create a "bureaucratic nightmare." As the outcome of New Zealand's so-called reforms was called on the CBC "Ideas" program aired on Tuesday, October 8, in New Zealand they have fragmented their services, partially contracted them out, increased their bureaucracy and have not saved a penny. How could we do the same? Perhaps this committee and the Manitoba Health should listen to that program.

Bill 49 is dangerous, if not illegal, as it sets out its regulations, as yet undisclosed, to take precedence over other statutes that are already legislated. It also does not protect the principles of the Canada Health Act. We feel betrayed by Bill 49 which was drafted without the participatory democratic process. What sort of respect does this show for all the volunteers and trustees who have already established so many fine health organizations and facilities in Manitoba? Why are the regional health authority boards not to be mainly elected with only a few appointments? Where is the trust?

Regional health associations, mental health councils and the like should form the basis for finding the people to serve at the regional authority level. It should be a grassroots-up system and not a top-down appointment process. District health councils, and we have stated, where you have Bill 49–I am afraid I did not write this, so I cannot be too sure what part she is quoting this from–should represent their various constituents. The minister should not dictate how many board members there should be or how they must be chosen. A common generic consultation with some flexibility could cover that. Refer to the Manitoba Family Services, The Roles, Responsibilities and Functions of a Board, of February 1992 for details.

We need strong, viable regional health authority boards representing all the stakeholders in each region. They

need to be people of good will, with particular backgrounds to represent the various district interests and stakeholders who are willing to negotiate for and provide the best possible health and social service continuum for their own constituencies.

We feel betrayed by Bill 49, which places too much power in the hands of the government of the day through the Minister of Health, the cabinet which controls appointments by the Lieutenant-Governor-in-Council. Bill 49 also gives the labour relations commissioner vast powers. But nowhere in Bill 49 do we find an appeals process, as is included in the draft sustainable development act. Accountability to the public is missing throughout, as well as protection of and safeguards for the public interest and those who may run into difficulties not envisioned by the legislators on the regulations. If the regional health authorities boards are appointed to rubber-stamp government regulations, there is really no purpose in having them. Bill 49 does not protect the services stipulated in the Canada Health Act. These, too, should be dealt with in the principles and guidelines.

Bill 49 seems to allow health authorities to contract out. The Provincial Council of Women is opposed to contracts with private, for-profit organizations. The overseeing bureaucracy will still have to ensure quality and accessibility, so any savings appears to be on the backs of low paid health care workers who are mainly women and, I might add here, many of whom are immigrants, among the poorest women in the province.

It should be clearly understood that $10 an hour is not a high wage to ensure long- term, properly trained and bonded workers. If these workers cannot get a full week's pay or if they have to travel between jobs on their own time and at their own expense, then $10 an hour rate is not enough. The health committee needs to recognize that the provisions of Bill 49 to charge fees and to contract out are not provisions that have been discussed and approved by a majority of Manitobans. We feel betrayed by a bill that includes these provisions.

It will be a betrayal of trust if health services are treated as commodities and become de-insured. Under the NAFTA rules, any such service can never be protected again and is open to competition in the open market. We need to be sure that this is in the long-term public interest before we act. We need to be sure. We feel betrayed and insulted by the manner in which Bill 49 is being presented and pushed through before proper discussion and planning, before proper principles and guidelines are in place, and before we know what the prescribed core services are or for what regulations.

Haste makes waste, as the writer of this paper says. This is not a process we can condone in any way, and, as I said prior to reading this, we sincerely hope, the Provincial Council of Women, we do believe in consultation, and we have been consulting with the province for 50 years come 1997. We respectfully ask you to reconsider, make the amendments that the minister has so honestly said he will do, and, perhaps, add a few more so that those of us here this evening who have taken the trouble to come out would be more comfortable to work. We are the volunteers. I represent a voluntary group of women. I call myself a career volunteer, so for me to work with you I have to be comfortable with what you are doing. Thank you very much

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Ms. Wowchuk: Thank you for your presentation. It is interesting that both you and the last speaker from the Canadian Mental Health Association stated that there were principles outlined from the northern and rural health association that were not included in this act, and that is causing you concern.

You talked about amending the bill and listening to what the minister said and accepting the amendments. I want to ask you if you think that this bill can be amended to a point where you can accept it, or do you believe that we would be better to go back to the people and do more consultation and do more work so that we can include all those principles and come back with a better bill that would ensure that we do not have user fees, a bill that would not invade the working rights of people that are working in the institutions that we have, or do you think that this bill can be amended to a point where it would be acceptable for you and the women that you represent?

Ms. Singh: The ideal situation would be to take it back to the drawing board, but would that be possible? I do not know. If it was left to you, the powers to be, you are the people who make the final decisions, and I am not one of those people who believe that this is just a public relations exercise. I do believe that changes will be made today to the bill. This is not a public relations exercise.

We are here to advise you and you will take our advice, that I do believe. To what extent? I hope as much as possible.

Mr. Chairperson: Thank you very much for your presentation this morning. Jenny Gerbasi or John Robson.

Ms. Jenny Gerbasi (Coalition to Save Home Care): Hi, my name is Jenny Gerbasi, and I am speaking on behalf of the Coalition to Save Home Care, which is a nonpartisan, independent coalition of clients, client advocates, informal caregivers and citizens. In addition to the 15 copies of this brief presentation, we have also made available to your committee an equal number of copies of the "100,000 Voices" report, and our recently produced information brochure, entitled "Profit-Making Has No Place in Home Care."

The "100,000 Voices" report summarizes public thinking on the future of home care in Manitoba as expressed May 8 and 9, 1996, in hearings organized by our coalition. Our information brochure elaborates further on the massive public outrage around this government's continued rush to invite profit-making corporations into home care, without one shred of supporting evidence on its side and, indeed, with overwhelming evidence on the side of maintaining the not-for-profit, public Home Care program.

However, we are aware that this committee was not struck to consider the government's misadventures in home care and that the issue before you is the proposed legislation called Bill 49. We trust that the numbering of this bill was not chosen in homage to the San Francisco 49ers. We understand it is the football team of choice of the majority of California Health Care Corporation executives, who, as we speak, are awaiting further good news that Manitoba is open for health business. Our apologies for this attempt at humour, and it is rather sinister humour, for if any of you have read the Minister of Health's solicitation of interest document, you will note it invites interested corporations to consider, and we quote: business opportunities in the industry of home care–from page 3 of the August '96 privatization tendering document.

So what is it about Bill 49 that would cause our coalition to appear before you today? Surely, for-profit privatization of home care is only a Winnipeg phenomenon that cannot possibly spread to rural and northern Manitoba under the innocuous terms of Bill 49. The most hopeful among us would say, well, let us examine the evidence that is before us in this draft bill.

No. 1. Part 1, Definitions: home care is listed as a health service. So far, so good. Part 2, Section 3(2). "The minister may prescribe (a) health services which must be provided or made available by a regional health authority; and (b) standards for the provision of health services." This seems to mean that home care will not necessarily be one of the health services under the umbrella of regional health authorities. Maybe the minister will decide instead that it be run by one of the for-profit corporations that are about to establish a home care foothold in Winnipeg. After all, these are national and franchise-type businesses. Surely one or more of them could handle home care in rural Manitoba.

But let us say instead the minister does include home care as a prescribed health service that must be provided by a regional health authority. Maybe then he will make open bidding by private, for-profit corporations one of the standards that must be met. After all, do we not all subscribe to the fairness notion? If you do it in Winnipeg, to be fair, you have to do it in the rest of Manitoba.

In short, this section and others leave all the power and discretion with one person, and leave the regional health authorities only the unenviable task of carrying out what the minister decides he wants them to do and under what conditions. Is this absolute power, or what?

Part 2, Section 3(3). "The minister may give directions to a regional health authority. . . for the purpose of (a) achieving provincial objectives and priorities." With this government this spells serious trouble for home care clients and workers in rural Manitoba. For the present governmental home care objective is clearly one of creating business opportunities for private, for-profit home care corporations.

That this objective results in decreased quality of care for clients and the impoverishment of workers by drastic wage cuts is presumably just one of the minor unfortunate consequences of living in this competitive, business-oriented society.

Part 2, Section 5. "The minister may enter into agreements for the purposes of this act and the regulations with . . . (f) any other person or groups of persons." Look out, rural Manitoba, this section again opens the door for the minister to strike an agreement with X-care corporation to provide home care in any or all regions of Manitoba.

Part 4, Division 2. This division deals with the responsibilities, duties and powers of regional health authorities and expands on the regional health plans that they must develop. Now, requiring plans seems to be an infinitely sensible thing to do. Indeed, when home care began in Manitoba in the early '70s, it was preceded by a plan that was developed with much input from people who knew what was happening with the increasing numbers of old, frail people in our midst and with the increasing insistence of our disabled citizens to be dealt with as citizens and not as objects. It was also a plan that was supported by the public and by health professionals; thus, one would think that, if regions are allowed to make plans and if they consult properly with the people involved, surely all our previous concerns about problems with for-profit privatization will disappear into thin air.

After all, rural Manitobans, like Winnipeg Manitobans, have said in large numbers that they want the nonprofit home care services they now have. So is that not what a regional health plan will produce for them? Well, we must tell you that we think not, due to two serious flaws in this act. First, all plans must be approved by the minister before they are acted on. If he does not like them, he just sends them back until the rural folks finally get them right. Will the present minister not simply send back any plans that support continuing with the present home care public, nonprofit approach? After all, he has not followed the wishes of seniors, disabled citizens, and his own advisory groups in Winnipeg, so why would he do any different in rural Manitoba?

Second, although there are passing references to elections of health authority directors, there was nothing in the act that requires or even values elections. Thus, we are left with the real possibility that boards will simply be made up of political friends of the ruling party, being paid to do the political wishes of their masters. So if you thought that regional democratic processes would save the day for home care, do not look for it in this act.

Part 4, Section 25, a regional health authority may (e) where authorized by regulation, charge fees for health services, or categories of health services. Many people at our public hearings expressed the fear that fees for home care services were about to be imposed. Government representatives, including the present Minister of Health (Mr. McCrae), reassured them that this would not happen. And now, in this new, major provincial health act, we find a section that gives such a power to regional health authorities. If it looks like two-tiered health care and if it reads like two-tiered health care, maybe the fears of people are correct. Maybe this is the start of legislated two-tiered health care. The very principles of medicare are being toyed with here, and the Manitobans who elected this government certainly did not give them a mandate for that.

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To conclude our formal presentation here, we wish to leave you with several quotes from panellists at the September 26, 1996, Public Forum on Home Care held at Grant Park High School in Winnipeg. This event was organized jointly by our coalition and the provincial and Winnipeg Councils of Women. The Minister of Health was invited to attend to apprise the public of the current state of home care privatization plans, but neither he nor a departmental representative came.

From Patrick Kellerman, a home care client: George, my home care attendant, is always there. He is a salt of the earth type of guy. He helped me understand I did not have to lose my individuality even as my physical condition gets progressively worse. He treats me in the most professional manner, and I suspect he brings that to all his clients regardless of their personal circumstances. During the strike, I was served by four different people from private health care companies, so I did not have continuity of care in any sense. Three of these four individuals told me they were looking for other work because they could not live on what the private companies were paying them.

From Aline Duval, aged 73, who cares for her husband, a victim of a debilitating stroke, in their suite with the help of home care attendants: My husband now has his very intimate personal needs attended to by four good, warm people, with whom we have developed a bond over time. When the private companies took over during the

strike, on Day One nobody showed, on day two nobody showed, and on day three the person who came said she would not come back again because it was too far to travel.

Low wages by the private companies means a revolving door of staff and a decrease in the quality of care. Clients and informal caregivers like myself feel completely betrayed by the Health minister as he pushes through privatization against our wishes.

The final quote, from Brother Thomas Novak, O.M.I., a pastoral community development worker. Quote: I fear that the present strategy to privatize home care is not just a tragic example of shepherds feeding on their own sheep, but even worse of shepherds selling their sheep to the wolves. The Canadian Council of Catholic Bishops said that all economic policies should be developed according to three fundamental principles: (1) the needs of the poor have priority over the wants of the rich; (2) the rights of workers are more important than the maximization of profits; (3) those who will be most affected by the decisions of the powers that be, especially those who are most vulnerable, must have a voice in the decision-making process. To me it is very clear that the proposed process to privatize the delivery of home care services directly contravenes every one of these principles. Unquote.

We leave you with these very recent statements of concern about home care to assure you that there still remains virtually zero public and client support for this government's headlong rush to let profit-making companies share the home care wealth through a redistribution of our tax dollars.

We urge you not to pass this bill in its present form. If passed, the present Winnipeg home care privatization horrors will soon be visited on rural Manitobans, but this time the Minister of Health (Mr. McCrae) will claim he did not do it. He will say instead it was those regional health authorities that in theory at least are supposed to represent the will and best thinking of regional citizens that did the deed. Such a claim will be fraudulent given all the power this bill assigns to one government minister. Thank you for listening to this presentation. We welcome any questions.

Mr. Chairperson: Thank you very much.

Mr. Chomiak: Thank you very much for this presentation, and I commend you and the coalition for all the wonderful work you have done in the past few months to help preserve the health care system that Manitobans have clearly stated they wanted.

I think the concerns you raise are quite real and I think are grounded in fact. Is the coalition aware, for example, that the government has, even before this bill has passed, cancelled contracts in rural Manitoba with respect to laboratory and imaging services in anticipation of the passage of this bill and in probably some move to privatize those services even more so than they are? Is the coalition aware of the unilateral cancellation of the contracts by the Minister of Health (Mr. McCrae)?

Ms. Gerbasi: Yes, we had heard about that, yes.

Mr. Chomiak: Also, I had occasion to review the Treasury Board submission that originally alerted the public to the fact the government was intending to privatize home care and talked about the user fees and all of the aspects of home care that were very public and, again, I noted in that document that the plan was to move this service to rural Manitoba. I am not sure if the coalition is aware, but I think your recognition of the dangers of this act permitting the minister to do that are well founded and I urge you to be vigilant because clearly the Treasury Board submission clearly indicates that they intend to move into privatizing home care in rural Manitoba. Do you think that is at all feasible in rural Manitoba, notwithstanding you indicated that these companies some of whom have flurried in and out of the province, that these companies would be able to offer their service in rural Manitoba?

Ms. Gerbasi: Well, it depends on what you mean by feasible and whether it would be a very good quality service. I certainly would not expect that in Winnipeg or in the rural areas. I think they probably would have difficulty getting around from place to place because it is without travel time and all that sort of stuff that is an issue in the city. In the rural areas, I cannot imagine how they would find staff willing to do the job at all. I mean, it is difficult enough to find staff even among unionized home care workers with benefits, because it is such a difficult job and even at $10 an hour which they do not even all make that much as a home care attendant, even then they are always looking for staff because it is a

difficult demanding job that does not pay that much. If they lower the wages 40 percent as the company is up to that much of a difference in wages, I think the system is going to be a disaster, rural or city.

The more the privatization comes in, there has not been any evidence. We have been asking and asking for evidence. Even the government's own advisory councils and panel that looked into recommending improvements on home care, they all said that privatization would reduce the quality and increase the cost and I am sure it is the same, rural or city. There just is not any evidence. The public has asked for evidence. We have had public hearings in May asking for evidence and we just do not get a response. We would like the government to listen to who we represent–disabled people, seniors, church groups, religious groups, ordinary citizens. We just want to see democracy; we just want to be listened to. We just want to have some answers, and there is no evidence that this privatization introducing profit into the system is going to make the system better. There is evidence it is going to make it worse. It is going to cost more and the only thing that I can see saving the government money is charging for the services and no longer covering them. That is the only thing that makes sense logically which the public did not elect anybody to do, and they do not have a mandate to do that because the people of Manitoba do not want that.

Mr. Penner: Mr. Chairman, a few questions. What do you do for a living?

Ms. Gerbasi: What I do for a living? Well, actually I happen to be a nurse, but my work on the coalition I do as an individual citizen. I do not know why my personal–

Mr. Penner: Do you work full time for the coalition?

Ms. Gerbasi: I am a volunteer, but I do not know why you are asking me all these questions like that.

Mr. Penner: Well, there is a good reason. You made a statement in your presentation saying: During the strike, I was served by four different people from private health care companies, so I did not have continuity of care. Three of these four individuals told me they were looking for work; otherwise, they could not live on what the private companies were paying them.

Can you tell this committee what those people, those three people who are looking for other work, were being paid?

Ms. Gerbasi: Well, that quote was from Patrick Kellerman; that was not from me. That quote was from Patrick Kellerman, a client of Home Care who has multiple sclerosis, who spoke as a panel member. I did not say that; those were his words. We were just demonstrating his experience with his home care workers; that is the purpose of that quotation–it was to show that workers–an example from a client–that their home care workers were paid so little that they were looking for other work.

* (0110)

Mr. Penner: What is little? Do you know what the–

Mr. Chairperson: Mr. Penner.

Mr. Penner: Can you tell–I am sorry, Mr. Chairman.

Could you tell this committee what private companies are paying their home care workers today?

Ms. Gerbasi: Well, figures from the MGEU and that I have heard of during the strike, it was published–it was, I believe, around $6.50 an hour for a home care attendant for a private company as opposed to the starting wage, which was $8 and up to $11 or something, between $8 and $11 for a government worker, I believe.

Mr. Chairperson: Last question, Mr. Penner.

Mr. Penner: Mr. Chairman, I met during the home care workers' strike with two home care workers, both of them working for government Home Care and private firms. They had two jobs; they both received 50 cents an hour more with the private company than they did with government. They were being paid $11.05 an hour by government, and they were being $11.50 an hour by the private firms.

Ms. Gerbasi: A health care attendant was being paid $11.50?

Mr. Penner: Health care attendants, yes.

Ms. Gerbasi: Well, that is completely contradictory to everything I have heard from everyone else. I have never heard that anywhere.

Mr. Penner: That is the reason I asked the question.

Ms. Gerbasi: Yes, well, the figures were published repeatedly in the media and everywhere during the strike, and the wages were 40 percent lower, up to 40 percent lower. I think those figures have not really been questioned by too many people. I think that is pretty clear that the private companies pay lower wages. I do not really think that is a question.

Mr. Chairperson: Let Ms. Gerbasi have the last word here. Fine. Mr. Chomiak.

Mr. Chomiak: Just for the member for Emerson (Mr. Penner), I have seen the figures from private companies that show the wages are considerably lower and those are quite public. I am sure that the minister who contracts out could provide you with that.

Mr. Chairperson: Mr. Penner, did you have a last word?

Mr. Penner: Mr. Chairman, all I am asking is that, when we talk about these, when we make these allegations, show me, put the numbers on the table, verify them, and I have no problem accepting that, but until somebody does that, I will question what the salaries are that are being paid these people. We talk about these continually, and yet I find no verification in the numbers. Very seldom that I can get anybody to substantiate this with a pay stub.

Ms. Gerbasi: Could I respond to that?

Mr. Chairperson: You will have the last word. This is the last word, Ms. Gerbasi.

Ms. Gerbasi: Okay. I think one of the reasons–there is a lot of secrecy around the way workers are treated in a lot of the private companies. There is a lot of secrecy and it is difficult to get those numbers, but those wage numbers are available. There is no question about that.

Mr. Chairperson: Thank you very much for your presentation.

I will now call on John Poyser. You can proceed, Mr. Poyser.

Mr. John Poyser (Manitoba Association of Community Health Centres): Good morning, Mr. Chairperson; good morning, members of the committee. You will all be pleased to know that I have just laid a $2 wager with the Sergeant-at-Arms that I can finish my presentation in under six minutes.

An Honourable Member: Including the questions and answers.

Mr. Poyser: Well, I am not accountable for questions and answers.

I am making this presentation on behalf of the Manitoba Association of Community Health Care Centres. We are of the view that this government has made some significant progress in the development of health care policy, policy which emphasizes the shift from institutional-based care to community-based care, a shift in emphasis which carries with it the promise of a healthier Manitoba at a lesser cost. It focuses on the delivery of primary care at a community-based level rather than waiting for a patient to present at hospital in a state of crisis. It was policy emphasis which found its first priority statement with The Action Plan in 1992 and was recently restated and re-emphasized in the Next Steps initiative. It amounts to an important policy advance.

The bill before us, however, is lagging far behind. It is silent as to the nature and status of community health centres. The bill itself does not even recognize their existence. It is silent as to the nature and status of neighbourhood resource networks. It is silent as to what this government means by community health services. It is silent as to how community health services are to be developed and delivered. It is also silent as to how communities and neighbourhoods are to remain meaningfully involved with the delivery of their health care.

We invite you to identify and define both community health centres and neighbourhood resource networks as health care providers. We invite you to define community health services. We invite you to put mechanisms in place to ensure that neighbourhoods and

communities remain actively involved in the planning, delivery and evaluation of their health care services.

The paper we have distributed sets out some mechanisms under which those results might be achieved. We have suggested that you define community health services in an open-ended fashion, one which includes a clause to allow for such other health-related services as may be required by the community and approved by an RHA. We suggest you leave local boards active in identifying community needs in concert with district advisory boards or even in lieu of district advisory boards. We have also suggested that you make local boards responsible for the administration of funds, not all funds, but certainly those funds which they garner through local fundraising efforts and certainly those funds which are paid to them by government departments other than the Department of Health. Right now social services are being delivered under the same roof as health services through many of the community health centres in the province. We suggest you insert a definition of social services in this bill and also ensure that the mechanisms are in place in the bill to ensure intersectoral co-operation for the delivery of health care across the continuum, including social services.

We also suggest that you make RHAs community sensitive. That can be achieved, firstly, by ensuring that the membership of the boards of RHAs includes representation from the communities that RHAs are to serve; also, that mechanisms be put in place in the bill to make consultation mandatory, both at the initial set-up phase and on an ongoing basis with a regional health authority.

Finally, we invite you to entrench principles in this bill that guide in the delivery of primary health care in realizing the promise of achieving health care in Manitoba at a lesser cost. Community health services must be efficiently and effectively delivered. Some years ago, the Canada Health Act was put in place and incorporates the principles which we are all well familiar with, and we were, as were most of the individuals in the audience today, pleased to hear the minister indicate that those principles were going to be entrenched in this bill.

Efforts in more recent years have focused on the development of principles to guide the delivery of primary care at a community-based level, and as we have heard, the Health Advisory Network task force on primary health care rendered a report containing 13 principles to guide in the delivery of primary health care and that report still awaits government approval.

We urge you to enshrine those principles in this bill. We are not the first to urge that tonight. You have already heard Manitoba Health Organizations suggest that. We have already heard the Manitoba Women's Institute urge you to do that. You have heard MNU urge that on you, and you have heard the Women's Health Clinic urge that on you. We think it is a very important change which you could make to this bill, and we are confident that if you were to make that change it would result in better services to Manitobans. Thank you.

Mr. Chomiak: Thank you for the presentation. Can you define for me–in the spirit of things I am moving very quickly–what a neighbourhood health resource network is from your perspective?

Mr. Poyser: From my perspective, no.

Mr. Chomiak: Do you have any idea what the minister was referring to when he referred to that in the Next Steps process?

Mr. Poyser: There is no concrete or operationalized definition, but at the same time there was some guidance in the materials that government distributed in conjunction with the announcement.

Mr. Chomiak: And what is your understanding of what those consist of?

Mr. Poyser: At 1:20 in the morning, I am not going to challenge my memory by trying to recollect the provisions that were in the materials. I am not trying to be difficult. It is just something that others in the room could speak of better than I at the moment.

Mr. Chomiak: Yes, thank you, and I was not meaning to be difficult. In fact, because the concept of neighbourhood health resource networks sort of came out of the blue, and I was wondering if someone from the community, community participation, could perhaps define it for me a little better since the minister has not. But I was not trying to put you under–I realize it is

difficult. At 1:20 in the morning, it is even more difficult.

Mr. Chairperson: Thanks for your presentation in the wee hours. I would now like to call on Bernard LeBlanc.

* (0120)

Mr. Bernard LeBlanc (Private Citizen): I am just a regular person that works in the health care system in a job that is probably going to be devastated in the near future. I always promised my kids that I would always do my best for them, so that is why I am up here speaking. I said I would try to do my best to guarantee them a future that they could at least look forward to, not be scared of.

Last year we went into negotiations and we made concessions so we could maintain our no-contracting-out clause and our follow-our-job clause, I do not remember the exact words. It is 1:20 in the morning. I will speak fast because I see guys bobbing around me here. Their eyes are closing. You know, I am just going to allow myself the courtesy of speaking.

Floor Comment: Where are the eyes closed?

Mr. LeBlanc: I see people bobbing, people turning in their chairs, so I will carry on quickly.

We work at the hospital. We try and do a good job. I have put in many years there and a lot of my colleagues have put in many years, and what we are seeing right now is the slip of paper being pulled away from us. We are being teased and the carrot is getting further away and we cannot catch up. I have not prepared what I am saying, so if I tend to wander, I will apologize right now. We see a government in front of us dealing with health care that seems to have only one matter in mind, to save money at any expense. I am the poor guy on the totem pole. I have a bunch of my friends we work with together. We are the low guys on the pole. We are going to suffer the most because as we see the bill going, it is going to open up the doors for private companies to come in and take over, like we will use the Marriott Corporation versus Cara. They certainly do not have the benefits we have that we fought for through the years. We just did not suddenly have these things pop out of the air. We took a stand to get these benefits. They are going to be taken away from us. You can tell me they will not be, but for the way I can see the government going, I have a funny feeling that I will be working for somebody else providing the company really needs a guy that is a little older than the younger people who they will be hiring. I am also a little nervous.

I would also like to comment on the fact that until three weeks ago I had no idea there was a Bill 49. I found that kind of a mystery that a government that was elected for the people, that is here to represent the people, does not give the people very much information. They kind of leave us again, dangling, trying to taste the God-forsaken carrot that we just cannot catch up with. I found that kind of strange that people that are here to represent us, to do the best for us, did not really give a lot of information available to the general public–or I could not find it in the paper. If saw two quotes in the paper, about this big, in regard–I cannot remember the quote exactly what it says–that this will open up the doors for privatization in the health care system.

In regard to my children I feel a little bit disillusioned, shall we say, that in the future the health care that was available for me will not be available for them unless they can pay for it. If I can I will relate a little story that happened at the St. Boniface Hospital. I will not really give any names because that is unimportant. But it happened on I believe it was a Monday or a Sunday evening. There was a phone call received in the emergency ward by, we will use a name, an executive, and he called ahead to say that his sister-in-law was coming in, and he would like her taken right away. Well, at that particular time there were people who had spent a day and a half in the hallway of the hospital. Mysteriously enough, this person's sister-in-law was in a room in about an hour and a half. So we have already got, even before we have got the two-tiered system, we have a two-tiered system. The people who can exert a little bit of authority are exerting it, and those who cannot, I will use myself for an example, would probably have to wait in line for maybe four or five hours, maybe stay on a stretcher in the emergency ward of the hospital.

I am not being probed by anybody in back saying, say this, say this, say this. This is what I have seen. This is what I feel. We are going to lose something that is very important to the little guy. The big people with a lot of money can afford to buy the insurance, can afford to pay

the health care, but people like me cannot. I am sure in a couple of years I may not be able to afford user fees. So I am going to have to make a decision now. How often do we go to the doctor? Once in a while, just a teeny-weeny bit. I am saying this because I do not have the information and resources available to me as the people in front of me do as to say, well, no, that is not true; it will not be like that in a couple of years. I can guarantee it. Because through the years I have been guaranteed a lot of stuff, and especially over the last eight years from the government. We were always kind of guaranteed maybe we would always have final offer selection. Well, that disappeared, so why should little things like health care be any different?

I am rambling; I am speaking fast; I am incredibly nervous, and I would just like to say that I like the union I have. The UFCW has done a good job for me. They have stood behind me contrary to the people on this side of the room that have suddenly, like I see, keep pulling that little piece of paper. Gee, Bernie, you will not be able to retire because we are going to contract out those services, and the company that is going to take over they do not really do a pension plan. And do not worry about all them years you put into the hospital because they really do not exist anymore. They are just not there.

You are going to appoint a single commissioner, so technically if I understand the concept, it is almost like a dictatorship. He is going to dictate to me what I have to do and what is going to happen. He is going to dictate the contract, providing the company keeps me on, that I will be able to work with. I am sure that the contract we get probably will not benefit the employees that much. It will probably be more of a benefit to the government who are really–the impression I get is that they are here to save money at any expense. The bottom line is a dollar. I do not think the commissioner is going to want to rock the boat too much because he has got this nice new job and say, no, no, wait a minute, maybe we should think of the employees or maybe we should think of the people that are going to be using the health care system as opposed to the government that he wants to keep his job for.

That is all I have to say, and if I offended anybody, I would like to apologize.

Mr. Chairperson: Not at all. Thank you, Mr. LeBlanc.

Mr. Chomiak: I do not really have a question, I just have a comment and that is, thank you for coming in. I think your kids should be really proud of you for coming and doing what you did, sitting up here till 1:20, making a presentation which I know is difficult in front of all of us, because what you did is you did something for your kids tonight and for other Manitobans. I think what you speak is something that I think the vast majority of Manitobans feel, and I appreciate the fact that you came out here tonight a lot.

Mr. LeBlanc: Thank you.

Mr. Penner: Mr. Chairman, I also appreciate the sincerity with which you made your presentation.

We all have kids–

Mr. LeBlanc: I realize that. I am not mindless.

Mr. Penner: –and some of us came here to this Legislature, to serve here, because of our kids, because we are concerned for their welfare in the future. We are also concerned that they are able to afford to receive at least partially the services that we, as older members in society, have received, that our kids and their kids are able to maintain at least some semblance of a health care system that will service their kids. You know, I have a little granddaughter who has leukemia. She spent two months at the Health Sciences Centre, chemotherapy–I do not know whether you have ever gone through that–so we know what health care services are like in this province. It is probably better than any health care service you could buy anywhere else in the world, so we are trying to maintain that, protect it, that that little child will have those services when she has a recurrence of her disease. That is why some of us came here.

You mentioned that we on this side were pulling small pieces of paper very gently away from you. I guess that is talking about money, and I have no problem with that. However, I just want to remind you that the party sitting on the other side of the table, in Saskatchewan within two weeks of being elected, closed 52 hospitals, bang, withdrew those services from rural Saskatchewan, and look what is happening in B.C. today and that is the party on the other side of the table. We have–

* (0130)

Point of Order

Mr. Chairperson: A point of order has been raised by Mr. Chomiak. A point of order has been raised, Mr. Penner.

Mr. Chomiak: Mr. Chairperson, I know that you are allowing a fair amount of latitude tonight, and I recognize that in fact I did not have a question, I had a comment. I did not go on at length. The member is now debating; he is now not even dealing with Manitoba, but dealing with other jurisdictions. I wonder if you might call him to order.

Mr. Chairperson: Mr. Penner, would you just wrap up your question?

* * *

Mr. Penner: It might take me a while, Mr. Chairman, because I feel very strongly about this issue. We came to this province, we came to this government, some of us, to make sure that changes would be made to continue to provide services for our future generations and not saddle them with a huge debt that some members on the opposite side saddled us with, so we came here with that intent to ensure that services would be able to be maintained in the future.

Now, I ask you, you told us you came here because you wanted your kids to have pride in you. Are you also going to be able to have pride in telling your kids that you saddled them, or that those members on that side of the table saddled them, with a huge amount of debt that they are going to have to pay so that you and I could live in comfort?

Mr. LeBlanc: If I could reply to that, it might not be a lengthy as Mr. Penner's, I think that, if you were to come forward and ask me, Mr. LeBlanc or Bernie, or whatever word you want to use to call me–constituent, private citizen–would you be willing to pay a little extra money every year to keep what you have now? I would. I am sure my children, in the future, if you ask them, would you guys be willing to make a little bit of a sacrifice to keep what your father had? They have seen it work good for me.

My kids see me at home every night now for the last three and a half, four weeks, see me sitting at home. You know, I put on a good face and all that, but they know I have got something bothering me. I have got my future health care. I have got my future for a job. As it is now, when I turn 55, which is in 13 and a half years, I do not have a very big pension, but I would have enough that I could make a place for somebody else to take my place. I am not going to walk away with $45,000 a year pension. I am not going to walk away with 8 million benefits. I do not even get the perks right now of a free lunch once in a while at work. We do not get any of this.

I would be willing to make that sacrifice, and I do not think that the government we have now has come forward and asked the people of Manitoba, would you guys be willing to make a sacrifice so that you could maintain the services you have now in the future?

We see people flying away on holidays here and there. We see people in our hospital itself constantly getting free catered lunches. Every day they get a catered lunch, and when we bring up the topic, what happens? What we are told is, well, it is because they have got to work through their lunch hour. Every day. If we have to make the sacrifice, why is it always the little people at the bottom of the food chain that have to make the sacrifices as opposed to the people who can afford it?

You are going to come back with a pretty darned good comment, I know that, because I have been watching you all night and when people are talking you have been kind of reading and turning away and some of the people at this table have gotten up and left during the middle of a conversation. You can make your comment and that is fine. I will listen to it 150,000 times and it is fine, but I am willing to make that sacrifice and I am pretty sure the other people sitting in this room would make the same darned sacrifice I would just to ensure that our kids can maintain what we have now.

I do not have the pleasure of a big education, and I do not have the fortune that my father was able to put up a lot of money for me. I got through by busting my ass, by working hard and making sacrifices. For my kids, I do stuff for them and I know for a fact if you came to the people of Manitoba and said, would you be willing to pay a little more to keep what you have now, I am sure they would. That question has never been asked of us, to anybody here.

Mr. Chairperson: Well, we are going to use up the full 15 minutes before we are through, it looks like. Mr. Penner. We have three minutes.

Mr. Penner: Mr. Chairman, I concur that if the question was asked that there would be some people in society that would say, yes, we will pay a bit more–

Mr. LeBlanc: Not the ones that want to privatize.

Mr. Penner: –to maintain the services. However, when I first ran for election and when I ran last time for election people told me in no uncertain terms, no new taxes. That meant no more money. People in rural Manitoba, many of my neighbours do not have the money to pay the extra that you are asking for. There is not any more money. Sorry about that. These are farmers and they provide the food that you eat every day and they provide it at the price that they cannot afford to maintain themselves in business. That is who we are dealing with. You are talking about an entirely different–

Mr. LeBlanc: I think you are off topic.

Mr. Penner: So all I am asking you, sir, when you talk to your kids, are you willing to saddle them with another billion dollars worth of debt that they will have to pay for you so you do not have to pay more, or should we start putting some processes in place that will allow us to deliver a quality health care system for as little money as possible? In other words, get as much bang for your buck as possible.

Mr. LeBlanc: Okay, I will say one last thing. I think if your kids would look back and say, my father did all these sacrifices for me, my parents made these sacrifices for me, would I make a sacrifice for them? If you have real love for your kids, your kids will say, sure, I will make those sacrifices for me. If your kids are just waiting for you to kick off so they can get their inheritance, they will probably say, hell no, I do not want to pay for that guy, because I want more money in my pocket. I have a feeling my kids would make the sacrifice and I have a feeling that the minority of people who say they do not have the money come from–[interjection] Should I be allowed to speak or is this how you guys usually run the place?

Mr. Chairperson: Carry on.

Mr. LeBlanc: My point is that if I was asked and I think if maybe where Mr. Penner here comes from, it is probably maybe a little poorer area of town or maybe they are cheaper with their money. I cannot vouch to say. I do not know where he comes from.

An Honourable Member: It is a farm.

Mr. LeBlanc: It is a farm. There are lots of farms. Most farms apparently now are owned by corporations, from what we have been led to believe through the media, although the media does not lie of course.

Anyway, I just want to say in closing, I will not say another word. I will walk away from this podium. Thank you very much for letting me speak and I have a funny feeling that if you went to the people of Manitoba, a lot more of them would feel like the regular working class guys as opposed to the people that are rich and have money and can afford to pay what they want. Thank you very much.

Mr. Chairperson: Mr. Ian McMahon.

Mr. Ian McMahon (Private Citizen): I do not think I can follow that one.

I am a health care worker and work at St. Boniface Hospital. I am also a union member. You are talking about appointing a commissioner. It will be the be-all and end-all of health care.

At St. Boniface Hospital, we went through a situation last year which concluded this year which I can relate to a commissioner of health being in place. We started negotiations with the hospital last March '95. Around about July, we got a piece of paper thrown at us by the executive of the hospital, 2 percent wage rollback, one-year contract, take it or leave it. Well, we left it. We then got back together earlier on this year, and we successfully concluded a contract with St. Boniface Hospital. But it was kind of ironic that every time we came up with a proposal that was acceptable to the union and the hospital, they told us, we cannot say yes; we have to get back to government for their okay. Now is that what it is going to be like if it is a commissioner, if we are negotiating with a regional health care authority as a union so that you represent a thousand workers, that we

cannot negotiate with the employer, that we have to negotiate with the government-appointed commissioner? It smacks of a dictatorship. You are going to have a commissioner appointed by the Minister of Health. You are going to have a board–regional, district, whatever you want to call it–appointed by the Minister of Health and probably in conjunction with the commissioner.

How many people sitting at this table were appointed to the Legislature of Manitoba? None of you. You were all elected, and that is one thing I have heard tonight over and over again. The public has to have some input into this board, and it is not going to be appointees on these boards. They are going to do whatever the minister or the commissioner says. You are not going to have anybody standing up and saying, no, enough is enough.

To go on to something different, I have been a member of my union since I came to Canada in 1983. I have been on the negotiating committee for five terms, five times now. We have never had a strike at St. B where our union has been involved. We have always come to a conclusion, sometimes with a little push from government, sometimes with a little push from the union, and sometimes with a little push from the employer, but we have always come to an agreement. When we have negotiated that agreement–we will say it is a three-year agreement–we have agreed, as a union, as the employees, to live up to what is in that agreement, and the employer does the same.

Now this commissioner, the way I read the bill, after–we will say a four-year contract–after two years he can come along and say, well, this part of your agreement is now null and void. He can reopen it. He can take out. He can put in. Now, on the opposite side, does that let me as an employee who has signed an agreement promising that I will not strike during the time of that agreement, does that give me the right to say, okay, I am going to strike next week? Is it tit for tat, or is it one-sided? I ask you that question.

* (0140)

The government of Manitoba has had a bad year this year as far as strikes are concerned, whether it be health care, the casino workers, whatever. In my view as a shop floor worker, if they think this year is bad, if this bill goes ahead and there is a commissioner appointed and willy-nilly interferes with the collective bargaining process which has been in for years now, the government has not seen anything. I think the Winnipeg General Strike will look small because there are over 30,000 health care workers in this province. I think that they could rally quite strongly with their siblings, families, friends.

As far as the government goes, I do not know if they are going to be in for another term because, when I or we voted the government in, we were told health care was not going to be touched. I also have been here long enough to realize that the hospital system that we had before Connie Curran was fat. It needed trimming. I am the first one to admit that, and I am sure everybody in this room will admit that it needed to be trimmed. But the process that was followed was what everybody was up in arms against, bringing in an American to tell us how to trim our health care when the Americans are looking at our health care system. I do not know. I think the government has got a plan. I think it is a draconian plan, to be honest. If this bill goes through you are going to put government-labour-management relations back 50 years.

I hope that the committee sitting here tonight has been listening to what people have been saying, because those are the people who elected you, those are the people who are involved on the shop floor of health care.

I know Mr. McCrae was in St. Boniface Hospital a few weeks ago and Dr. Lertzman, who was out meeting with him, he took you down through the emergency department, and it was full of stretchers. One of my co-workers tonight, Aline, is still sitting back there, told you about her father, had a stroke and spent three days in the hallway because there were no beds upstairs.

Being in the hospital for 13 years now, I have seen the hallways busy. I have seen the emergency department with stretchers in it, but nothing like it has been over the last two and three years. It is almost a daily occurrence now at St. B to have stretchers with patients in the hallway not for eight, 10 hours but for two or three days. We have gone from an 800-bed facility down to 550.

I urge the minister to seriously think about where the money is going and to start reopening some beds, because we are an aging population. It is only going to get worse. I am sure everybody in this room, and I am looking at the guys in front of me, and I think you are all just a wee bit older than me, some day down the road you are going to

need a bed in a hospital for one reason or another, and the way you are going at the moment, that bed is not going to be there. Thank you.

Mr. Chairperson: Thanks, Mr. McMahon.

Mr. Chomiak: Just one clarification, and I think you have made a significant point. You have noticed the beds and the stretchers you said for not just eight hours but patients lying in stretchers for three or four days, and you have noticed it particularly the last two years. Has this been a cyclical thing or is it generally now the pattern at St. Boniface hospital most of the time?

Mr. McMahon: I think actually now, especially over the last two or three months, I work in the Intensive Care Unit, which is coronary, cardiac arrest. If a patient comes in having a heart attack and we are full, we have an option, transfer him to another hospital within the city. That is why there is a–it is called the ICU bed co-ordinator. Our admitting department can phone up this co-ordinator and get a bed check for the whole city within 20 minutes. The bed checks recently are coming back. Health Sciences, zero; Seven Oaks, 199 bed; St. B, full; Vic, full. There are not the beds there.

If you are lying in emergency having a heart attack, that is one of the best places to be, to be honest, but the premium place is upstairs in the coronary care unit. Now, we have six beds. Two weeks ago we had four patients who were all on the transfer list. They were being kicked out of the CCU onto the general medicine ward. We did not have any place to put them. There were no general medicine beds and St. B, in my view, is a leader in the sense that they are trying to cut down hospital stays of the patients.

Now, to go from 800 down to 550, something there tells me that if people are still coming in, we have a new, on the same topic as coming in in the emergency department–I have to have a drink, excuse me, I am drying up. If you are brought by ambulance from home, there are different codes that they bring in. If you say you are having chest pains, shortness of breath but you are conscious, relatively stable, you will come in as a green. If you are unstable, you are amber, and if you are really, really unstable, you are a red.

Over the last month there have probably been about six times that St. B has had a green and an amber diversion on reds only, no exceptions. That does not happen very often. Health Sciences was the exact same. We thought when the Health Sciences Emergency department closed for renovations that we would be overrun. We were not because a lot of the–well, Health Sciences, there is trauma in a sense, but a lot of it is walking-in wounded, as we call it. But for us to have a green and amber diversion, reds only, no exception, six to eight times over the last couple of months, that is a lot. We are not the only hospital. Other hospitals are experiencing the same thing because the staff, because we have been cut back over the year, the staff can handle it, but it takes longer. The stress buildup is tremendous at the moment in that place.

Well, I think one of the nurses' reps tonight said they lost about 800 positions from MNU. I could not honestly tell you how many we have lost at St. B. On the support staff side, I think it is over 300 now, but the people are still there. Two or three years ago, you may have eight patients to look after, some of the wards at the moment, one orderly has 18 patients. Now, you are talking 18 patients that that orderly has to get up, give them their a.m. care, bathe them, make the beds. We do not have time to converse with the patients nowadays. It used to be go in, sit down, talk to them, joke with them, not spend all day with the one patient, but you could spread it out over the whole ward. Now it is run, run, run.

Coffee breaks? Sometimes they are a thing of the past. The patients come first, and this bill does not put the patient first because you people peeve off the health care worker. Stress levels are going to go higher, they are going to be short-tempered. The thing is just going to break down. I do not want to see that. I love working with people, not sick people, but it just so happens they are.

A lot of people do not understand what is happening to health care until they become a patient in a hospital, and they put a light on for a bedpan and they have to wait 15, 20 minutes, and by the time you get there, you are too late, and people are not happy with that, they feel uncomfortable. Something is going to have to be done. Hopefully, this bill will go back to the drawing board if you have been listening to everybody tonight, and

hopefully they will come up with something that is acceptable, not just to the unions, but to everybody in this province.

Thank you.

Mr. Chairperson: Thank you for a controlled and thoughtful presentation.

That is now the close of all these submissions which are scheduled for this evening. I would like to announce that presenter No. 40, Donald Davis, has requested that his name be dropped from the list. We will recognize that.

I also want to remind all present the committee will be meeting again at 7 p.m., October 16, that is later today, to continue with both Bills 37 and 49, probably in the same location. Thank you very much for your patience and participation.

Committee rise.

COMMITTEE ROSE AT: 1:50 a.m.