Second Session - Thirty-Seventh Legislature

of the

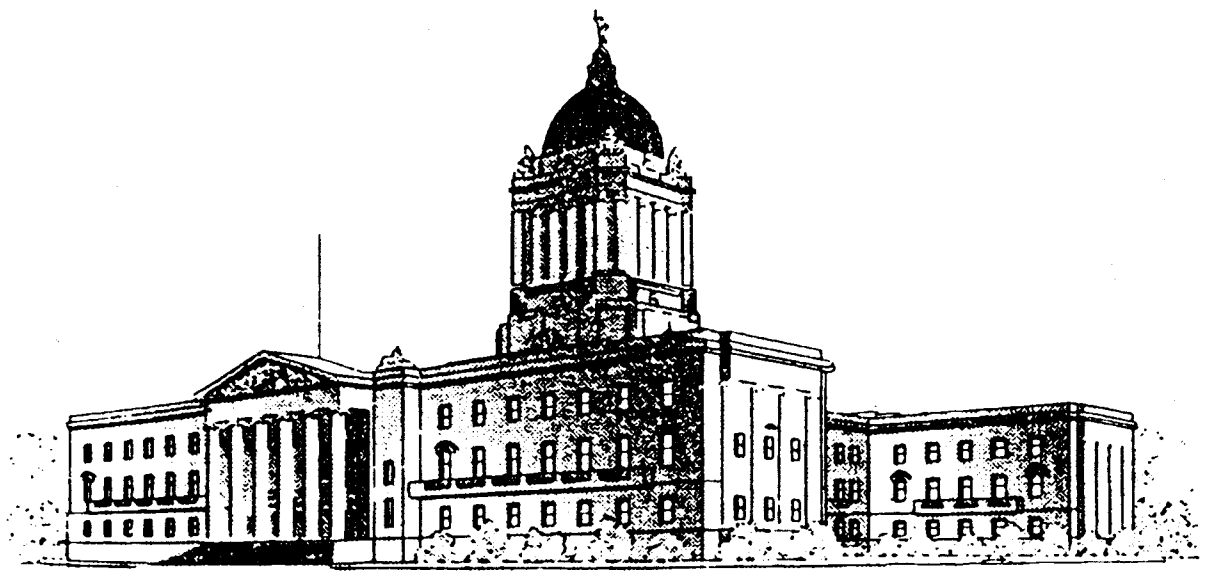
Legislative Assembly of Manitoba

Standing Committee

on

Municipal Affairs

Chairperson
Mr. Tom Nevakshonoff
Constituency of Interlake



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Thirty-Seventh Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON MUNICIPAL AFFAIRS

Tuesday, July 3, 2001

TIME – 6:30 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Tom Nevakshonoff (Interlake)

VICE-CHAIRPERSON – Mr. Harry Schellenberg (Rossmere)

ATTENDANCE - 11 – QUORUM - 6

Members of the Committee present:

Hon. Ms. Barrett, Hon. Mr. Chomiak, Hon. Ms. Mihychuk, Hon. Mr. Sale

Mr. Derkach, Mrs. Driedger, Messrs. Loewen, Nevakshonoff, Schellenberg, Struthers, Tweed

APPEARING:

Hon. Jon Gerrard, MLA for River Heights
Mr. Darren Praznik, MLA for Lac du Bonnet

WITNESSES:

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act

Mr. Cory Sul, Private Citizen
Mr. Robert Chernomas, Canadian Centre for Policy Alternatives
Mr. Albert Cerilli, President, Manitoba Federation of Union Retirees
Ms. Margot Lavoie, Manitoba Oblate Justice and Peace Committee
Mr. Thomas Novak, Manitoba Oblate Justice and Peace Committee
Ms. Carolyn DeCoster, Private Citizen
Ms. Madeline Boscoe, Women's Health Clinic
Ms. Carol Scurfield, Women's Health Clinic
Mr. Paul Moist, Canadian Union of Public Employees
Ms. Lorraine Sigurdson, Canadian Union of Public Employees

Bill 50–The Regional Health Authorities Amendment (Accountability) Act

Ms. Heather Temple, CEO, Middlechurch Home of Winnipeg
Mr. Michael Doiron, Interfaith Healthcare Association of Manitoba
Mr. Raymond Lafond, Catholic Health Association of Manitoba
Mr. Réal Cloutier, Winnipeg Regional Health Authority

WRITTEN SUBMISSIONS:

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act

Ms. Linda West, Private Citizen

MATTERS UNDER DISCUSSION:

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act
Bill 28–The Labour-Sponsored Investment Funds (Various Acts Amended) Act
Bill 50–The Regional Health Authorities Amendment (Accountability) Act

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Mr. Chairperson: Good evening. Will the Standing Committee on Municipal Affairs please come to order. This evening the committee will be considering the following bills: Bill 25, The Health Services Insurance Amendment and Consequential Amendments Act; Bill 28, The Labour-Sponsored Investment Funds (Various Acts Amended) Act; and Bill 50, The Regional Health Authorities Amendment (Accountability) Act.

We have presenters registered to speak to both bills. Is it the will of the committee to hear public presentations on these bills first? *[Agreed]*

I will then read the names of the persons who have registered to make presentations this evening. For Bill 25: Cory Sul, private citizen; Robert Chernomas, Canadian Centre for Policy Alternatives; Albert Cerilli, President, Manitoba Federation of Union Retirees; Michelle Forrest, private citizen; Paul Moist, President, Canadian Union of Public Employees; Margot Lavoie and Brother Thomas Novak, Manitoba Oblate Justice and Peace Committee; Carolyn DeCoster, private citizen; Madeline Boscoe and Barbara Wiktorowicz, Women's Health Clinic.

On Bill 50, we have Michael Doiron, who is going to be speaking for Suzanne Dunwoody, of the Interfaith Healthcare Association of Manitoba; Raymond Lafond, who is going to be speaking instead of Francis Labossiere, of the Catholic Health Association of Manitoba; Andrew Ogaranko of Pitblado, Buchwald & Asper; Heather Temple, CEO, Middlechurch Home of Winnipeg; and Réal Cloutier of the Winnipeg Regional Health Authority.

On Bill 28, we have no presenters.

Is there anybody else in the audience who would like to make a presentation and has not yet registered? You may do so with the staff at the back of the room. For the information of presenters, please be advised that 20 copies of any written versions of presentations would be appreciated. If you require assistance with photocopying, please see our staff at the back of the room.

I would like to inform the committee that a written submission on Bill 25 has been received from Linda West, private citizen. Copies of this brief have been prepared and distributed to committee members. Is it the will of the committee for this written submission to appear in the committee transcript for this evening? *[Agreed]*

We have two out-of-town presenters in attendance this evening. Is it the will of the committee to hear from these presenters first, and in what order does the committee wish to hear the remaining presenters?

Mr. Stan Struthers (Dauphin-Roblin): Mr. Chair, I would suggest that we do, in fact, hear the out-of-town presenters first and that we begin with Bill 50. *[interjection]* Okay, I suggest then we continue on with Bill 25, seeing as we already have one presentation put forward on Bill 25, I will get my numbers straight yet, and then move on to presenters on Bill 50, followed by clause-by-clause on all those bills after we have heard from presenters.

Mr. Chairperson: Is what has been proposed acceptable? Is that the will of the committee? *[Agreed]*

How does the committee propose to deal with presenters who are not in attendance today but have their names called? Shall these names be dropped to the bottom of the list and then dropped from the list after being called twice? *[Agreed]*

Is it the will of the committee to set time limits on presentations?

Mr. Struthers: Mr. Chair, I would suggest that we follow standard practice on these committees, 15 minutes for presentations, 5 minutes for questions and answers, take it as 20 minutes altogether. If a presentation exceeds the 15 minutes, then I think it is understood that that time would come out of the 5 minutes of questions and answers, for a grand total of 20 minutes per presentation.

Mr. Chairperson: Is that the will of the committee?

Mr. John Loewen (Fort Whyte): Well, it may be the policy of the members opposite to limit presentations. I would not say that we concur with that, just for the record. I would disagree, if somebody has reached their 15 minutes of presentation time, if it is the will of the committee to let them finish, that should not impact on the question time. So at 15 minutes, we should either agree that we will allow the presenter to quickly finish or cut the presenter off and accept his written–but we should, in all

circumstances if we want to, have five minutes of questioning.

Mr. Struthers: Mr. Chairman, what I did describe has been the practice we have used in this committee for every bill we have looked at this spring and for every bill that I remember from last spring, and going back to days when I sat on that side of the table in opposition. That is standard procedure in this committee. It has worked well. I want to make sure that everyone has a chance to present in a timely fashion and have their say on these bills.

My strong recommendation would be that we go 15 for presentations, 5 minutes for questions and answers, and if a presentation does go over that 15-minute mark, that we do afford the leeway of using some of that 5-minute question and answer for the presenter to finish making their presentation.

Mr. Chairperson: Is that the will of the committee? *[Agreed]*

Finally, as a courtesy to the individuals on our list waiting to present, are there any suggestions as to how late the committee should sit this evening?

Mr. Struthers: I would suggest that we hear all of the presentations tonight, and then do the clause-by-clause analysis once we hear the presenters and not worry about a time limit just now.

Mr. Chairperson: Is that the will of the committee? *[Agreed]*

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act

Mr. Chairperson: On Bill 25, I now call upon Cory Sul, private citizen. Mr. Sul, do you have a written copy of your brief for distribution to the committee?

Mr. Cory Sul (Private Citizen): Yes, I do.

Mr. Chairperson: Please distribute it. The page will take it from you. Proceed when you are ready.

Mr. Sul: Thank you for the time to allow my input regarding Bill 25. At first, I was not sure if I was going to make this presentation. However, reading today's paper convinced me that it was the right thing to do.

As you are now aware, my name is Cory Sul, and I am a front-line provider in our health care system. I am a children-oriented dentist who provides care to over 4000 Manitobans from across the province through my private practice in East Kildonan and Concordia Hospital. I also am trained for, regulatorily authorized to and do provide pediatric dental surgeries.

For almost four years, I used to provide my services in the northern community of Churchill. However, I stopped going because of the Government's treatment of my patients in the Winnipeg Region. I recognize that, unfortunately, I may offend some by my presentation today. While God has given me many talents for which I am grateful, he never gave me the ability to pacify egos.

I am here today to point to the importance of proper governance and administration of bills. There is more to good government than just passing bills and starting new programs. This Government loquaciously promotes the Canada Health Act yet, in practice, violates the very principles understood by Manitobans to be contained within. Bold statements without action are unimportant.

In the words of Lech Walesa: The supply of words in the world market is plentiful but the demand is falling. Let deeds follow words now.

From Mother Teresa: There should be less talk; a preaching point is not a meeting point. What do you do then? Take a broom and clean someone's house. That says enough.

The purpose of Bill 25, at least according to the Government's press release of May 23, 2001, is to strengthen and preserve universal access to health care and ensure that the principles of the Canada Health Act are upheld. Using the definition: Insured services are services covered under medicare, as supplied in the aforementioned government document, today in Manitoba this Government is denying Manitobans due

access to medically necessary health care and subverting the principles of the Canada Health Act.

Pediatric patients, medically requiring the Manitoba medicare covered services of an anesthetist during dental treatment, are being denied allotments made under sections 9, 10 and 12 of the Canada Health Act. While I understand that the provider fee for the anesthetic service is being comprehensively covered, some Manitobans are having to pay facility fees in relation to the provision of these ensured services, while at the very same site, the minister pays for the fees of other Manitobans. Patients who cannot afford the Government-authorized dental provider's more expensive fees–which is not an insured service–terms of payment, or who have simply exercised the rights under section 90 of The Health Services Insurance Act to choose their provider, are being denied their entitlement to receive facility fee funding equivalent to other Manitobans. By forcing these patients to pay for their own facility fees, the Government is denying Manitobans unimpeded access to the medically necessary anesthetic services on uniform terms and conditions.

A large number of my patients can afford and are willing to pay the fees hindering their children from receiving the medically necessary services which mandates going to the sites at which facility fees are being charged. Unfortunately, many of the children requiring these services come from underprivileged families and are forced to decide between buying things such as food or paying expensive facility fees to prevent their children from continuing to suffer terribly. Out of compassion, on a number of occasions, I have personally covered the fees for these patients, but this is not my responsibility.

* (18:40)

I recognize that members of the Government may claim that the facility fee being charged to some pediatric dental patients relates primarily to the uninsured dental services. Given that the facility fees are determined by the duration of insured anesthetic services, independent of dental services and that the patient's requirement for the anesthetic services is what mandates that they go to that particular facility, I believe that the charges belong to the insured service.

Nonetheless, if they believe the charges to be dentally related, I cannot understand how the Government can justify using the money of all Manitobans to subsidize the dental care of only some Manitobans. The ethics by-laws of the Manitoba Dental Association specifically points to the inappropriateness for all dentists to participate in any plan or contract that interferes with the public's right to have dental services performed by the dentist of their choice, such as occurs with preferred provider organizations.

It would seem to me that the Manitoba government's actions would constitute it being designated a preferred provider organization. I believe that violating this ethical principle held dearly by the members of the dental community, would jeopardize the participation of all Manitoba dentists in all government-administered dental programs, including the Social Allowances Health Services.

As one who never tries to complain without providing possible solutions, perhaps mistakenly taken by others to infer that I think I can do their job better, I hereby suggest that subsection 64.1(2) of the proposed bill be amended to read: The minister shall not enter into an agreement under subsection (1) unless the minister is satisfied that (a) the surgical facility is accredited by the College of Physicians and Surgeons; (b) the provision of all Manitoba medicare insured services as contemplated under the proposed agreement will be consistent with the principles of the Canada Health Act, the Human Rights Code, legislatively allotted patient's rights and have been considered free of any potential conflicts of interest; and (c) the agreement will serve the public's interest and that reasonable opportunity has been provided to allow for public input regarding the agreement's impact on the broader community.

I stand before you as a single Manitoban in the face of what everyone seems to describe as insurmountable odds. Like many of the bureaucrats I have dealt with, I am sure that some of you cannot figure out why someone would risk what I have to stand up for what is right. The answer lies in understanding who I consider to be heroes, not Neil Armstrong, Bill Gates or even Paul Henderson. My heroes are people such as Abraham Lincoln, King Edward

VIII, Martin Luther King, Elijah Harper, and a Chinese protester standing in front of the tank.

Thank you for your time.

Mr. Chairperson: Thank you for your presentation, Mr. Sul. Does the committee have questions?

Mrs. Myrna Driedger (Charleswood): I wonder if you could just give us an example of the conditions of some of the children that you treat. I did have a father phone me who has a little four-year-old autistic son. It is a very poor family, and they cannot afford to access care. In this case, this little boy, because he was autistic, did not know any differently, and he pulled out two of his own teeth.

I am just wondering if these are the kinds of examples that you deal with on an everyday basis and if you could just paint us a picture of what you are dealing with.

Mr. Sul: The thing is–

Mr. Chairperson: Mr. Sul, I have to recognize you before you respond, for the purposes of Hansard, so go ahead.

Mr. Sul: Thank you. As a front-line provider, on a daily basis, I am faced with the issues of children such as the example you gave. All of these kids, or most of these kids, are kids that are under the age of six, and it is because of the volume of the work that they require, most of them will have seven or eight teeth that are abscessed, six or seven cavities, very large cavities and with pus and abscess material draining into them. Most of them are having to wait for a long time to get this treatment done.

Mrs. Driedger: Can you tell me what kind of daily activities are affected when a child has teeth problems? We are not just talking, I do not think, you know, about having a pain in your mouth. I think there are probably educational factors involved, sleep factors, eating factors, temperament and all of that. Are you finding you are hearing a lot of those issues?

Mr. Sul: There is no question. Most of the time, we get phone calls all the time from desperate parents trying to find ways that they can alleviate some of the discomfort that these children are having. We get calls all night, all hours of the night, from parents that are experiencing these difficulties. They have difficulties with eating. Temperament wise, as you were talking about, a lot of these kids, all they can concentrate on or focus on is the amount of pain that is in their mouths.

Hon. Dave Chomiak (Minister of Health): I am not clear, Mr. Sul, from your presentation, but it seems to me that you are advocating that all the dental services you provide as a dentist should be under medicare. Certainly, that is how it reads. Is that correct?

Mr. Sul: No, it is not. What I am asking for, or what I believe should be done, is that for all patients who are receiving insured services, which includes the anaesthetic services for this work, I do not believe that facility fees should be charged for those patients. I do not believe that the dental work itself is something that the Government ought to be responsible for at this time.

Mr. Chomiak: Can I just ask you how long you have had this problem, in terms of the waiting lists?

Mr. Sul: The problems with the waiting lists precede myself starting practice in Manitoba. I graduated in '95. I had done some extensive work previous to that while I was going through dental school, travelling to some of the reservations and spending time with some of the children's orientated dentists. I understand that the waiting lists have been an issue for a number of years. I do understand that the Government has taken steps to try and alleviate those lists, and, unfortunately, the lists seem to be growing instead of going down.

Mr. Chomiak: Are you aware in the last two years that we have increased the volume and number of surgeries by 30 percent?

Mr. Sul: Yes, I am aware that you have, for selected dentists, increased the number of surgeries that are being covered. It is my opinion that part of the reason why there has been an increase in those lists is because the Government

has funded only certain dentists. What has happened is that there has been a draining of patients from other dentists who provide similar services, and because of that, that is why the waiting lists at hospitals is increasing.

Mr. Chomiak: So, if I could understand, the waiting lists precede, the difficulty precedes your going into dentistry in '95 or graduating, but your concern is that the Government, for the services we provide, do not fund some dental surgeons, do not fund others, or do not fund others as much?

Mr. Sul: They do not fund others. For myself and other dentists that are doing similar procedures, the anaesthetic portion is being covered for our patients. However, there is a facility fee that has had to be borne by our patients directly, whereas for other dental providers, the Government is picking up their complete tab for that.

Hon. Jon Gerrard (River Heights): Thank you for your presentation. My question is, I think, germane to the patients that you are looking after. The long-run solution in any of the children is probably better dental care very early on in life. Would it not avoid much of the need for dental surgery if, in fact, there was a much more vigorous approach to good dental care early on?

Mr. Sul: Certainly, a lot of the problems are issues that take place before we, as dentists, even see the patients. I know that education seems to be a term that is bandied around a lot in terms of a possible solution for this, and that has been something that has been tried by the dental community quite extensively. Personally, I feel that perhaps by teaming up better with our friends in the nursing community, in the post-natal nursing wards, and by stressing the importance of proper dental care for young children is absolutely critical. I find it quite appalling that in our country and in this day and age, probably 40 percent of the patients who come to us for the first time, their parents are not aware of proper dental care.

Mrs. Driedger: Mr. Sul, are your patients part of the 1500 that we hear of as a waiting list for these children, or are yours separate from that?

Mr. Sul: A number of my former patients, because the Government is now picking up the tab if they see other dental providers, are now part of that 1500. In terms of my understanding, for calculation purposes, that 1500 does not include patients on my waiting list.

* (18:50)

Mr. Chomiak: I just wonder if you have an opinion. In 1993 the Government of Manitoba cancelled a children's dental program that provided dental service in rural and northern Manitoba. Are you familiar with that? Certainly, it has been my view, that had that program still been in place, we would see a lot less dental damage that we see right now. Do you have any comment on that?

Mr. Sul: I guess since that precedes really myself being in a position to give a proper opinion on that, I think I would like to refrain from giving an answer to that question. I am not aware of exact figures in terms of the duration of time, you know, when these waiting lists first started to balloon and how successful those programs were for eliminating some of those problems.

Mr. Chairperson: No further questions? Thank you for your presentation, Mr. Sul.

Bill 50–The Regional Health Authorities Amendment (Accountability) Act

Mr. Chairperson: The next out-of-town presenter is for Bill 50. We will switch over to Bill 50 for the one presentation. I call Heather Temple, CEO of Middlechurch Home of Winnipeg. Good evening, Ms. Temple. Do you have a written copy of your presentation?

Ms. Heather Temple (CEO, Middlechurch Home of Winnipeg): Yes, I do.

Mr. Chairperson: You may proceed when ready.

Ms. Temple: This is a short presentation, just to advise you. The copy that you have is there for your reading. I will not be reading it directly, however.

The primary concern is in relation to the WRHA amendments act specifically in referencing article 29. My concern in relation to article 29 is the disputes resolution mechanism. I am from a non-profit personal care home facility, and even though we are aware that purchase service agreements may be under review, the only reference to the disputes mechanism under article 21 is also in relation to the faith-based facilities. Even though we are a non-profit organization, we are not a faith-sponsored organization. My concern is just to ensure that the disputes mechanism, which does not include the arbitration, is addressed for any facility within the–

Mr. Chairperson: Excuse me, ma'am. We are having a little difficulty hearing you. Could you get a little closer to the microphone, please?

Ms. Temple: This keeps falling down. Is it better if I hold it? Okay.

It is mostly in relation to the disputes mechanism under article 29. Very briefly, for those that are the non-profit, non-faith-based facility, there are not a lot of us within the WRHA at this point in time from the personal care home perspective, but I just wanted to bring it to the attention of the committee that within the disputes mechanism, the only reference that I could find under the amendment was in relation to faith-based. I certainly do support their recognition in wishing a disputes mechanism, but I just wanted to bring it to the committee's attention that that is also an issue for us that are non-faith-based or faith-sponsored facilities.

What I would like to recommend is that there be a universal address to that disputes mechanism under article 29 so that should there be any facility, either within the acute care, I guess, or non-acute long-term care sector that does have a concern with the WRHA who issues a directive that we do have that mechanism in place.

The summary is there. What I did include at the end of it was a similar disputes resolution wording which is included in our current purchase service agreements, which I would see very similar to what is under article 29 in the faith-sponsored ones. I would see that being very similar for everybody. Any questions?

Mr. Chairperson: Thank you for your presentation, ma'am. Are there any questions?

Mrs. Myrna Driedger (Charleswood): I am assuming that you would be more comfortable if that was entrenched in the bill and not just in the service purchase agreement. Is that correct?

Ms. Temple: That is correct. It is already in purchase service agreements for both types of facilities now. I guess seeing that coming in under the amendment for one type of facility, I would just like to ensure it is there for any type of facility, just to be fair and reasonable for all parties.

Mr. Chairperson: Any further questions? Seeing no further questions, thank you for your presentation, ma'am.

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act (Continued)

Mr. Chairperson: We will now return to Bill 25. I call upon Robert Chernomas, Canadian Centre for Policy Alternatives. Mr. Chernomas, do you have written copies of your presentation?

Mr. Robert Chernomas (Canadian Centre for Policy Alternatives): Yes, I do. They are right there.

Mr. Chairperson: Proceed when ready, sir.

Mr. Chernomas: I would like to thank the committee for giving me this opportunity this evening. I am an economist at the U of M. My research area is health economics. A couple of years ago, I published a book comparing the U.S. and Canadian health care systems. The Canadian Centre for Policy Alternatives recently asked me if I would review the most current literature on for-profit health care, which is certainly evolving in the U.S. at a rapid rate. That is what this paper presentation is about.

Bill 25 proposes to close loopholes in existing legislation that could allow for the creation of private hospitals in Manitoba. As such, this legislation will help prevent the erosion of public health care in Manitoba.

There is strong evidence from both Canada and the United States that for-profit health care is more expensive, of poorer quality, and less accessible than the public system. It is, therefore, unlikely that introducing for-profit elements to our system will reduce waiting lists for surgery or the number of patients lying in beds in the halls of our hospitals.

* (19:00)

Canada's health care system has a number of obvious problems, including long waiting lists for surgery, and a nursing shortage. In order to determine the cause of these problems and begin to solve them, we must be clear about what the Canadian health care system is set up to do and where the costs have actually increased.

Medicare is mandated to control three subsectors of the health care system: Hospitals, physicians and administration. Since 1971, when the single-payer system was fully implemented, these three subsectors have seen their relative share of the Canadian economy remain virtually unchanged, that is, hospitals, physicians and administrative costs take up no greater share of the economy than they did a quarter century ago. Yet, over the same period overall, health care costs have grown from approximately 7 to about 9 percent of GDP. Where have they grown, if not for hospitals, physicians and administration? The answer is those parts of our health care system that are privately run.

In '93 Canada ranked 16th among the 24 leading industrial nations when public spending was calculated as part of our total health picture. But when the overall health expenditures, which included both private and public, are calculated, Canada placed second, dropping to fifth in 1995. Our health costs have grown, not because of the public system, but because of the mostly for-profit private system that we do not control.

From '87 to '96 the cost of prescription drugs in Canada rose by 93 percent compared to an increase of all consumer prices of 23 percent. Drug costs grew proportionately faster than any other item on the nation's health bill, from 9 percent of total health expenditures in '84 to over 14 percent by 1996.

During this period, spending on hospitals decreased from 42 to 37.3 percent of total health expenditures. Spending on physicians fell from 15 percent to 14.2. If you do the math, you will find that hospital expenditures fell by just about the same amount that drug costs went up.

The U.S. health care system, with its increasing reliance on for-profit health care, spends about 14 percent of its GDP on health care, up from 7 percent it spent in '71. It is well known that the increasingly for-profit U.S. health system is less fair than the Canadian system. Approximately 45 million Americans do not have health insurance and approximately an equal number are underinsured. Yet this inequality does not result in a cheaper system. In fact, for less per-capita government spending, the Canadian system covers everyone, whereas the U.S. covers only the poorest, the oldest, the disabled, and the military. Americans pay more in taxes for health care than we do, and it does not guarantee them care.

What can we learn from the U.S. experiment with for-profit health care? There are three essential areas we would need to explore in order to assess the advantages and disadvantages of the emerging U.S. system. We would need to assess the effects of these reforms on costs, quality and access.

Starting off with cost: In a 1999 article in the *New England Journal of Medicine*, the authors show that no peer review study has found that for-profit hospitals are less expensive than not-for-profit hospitals. On average, they are 3 percent to 11 percent more expensive than not-for-profit hospitals. It is true that for-profit hospitals spend less on personnel, avoid providing charity care and shortened stays, but they spend more on administration, marketing, extra services and executive pay, on top of which they must pay profits to stockholders. When investor-owned hospitals dominate the market, more is paid out by the federal government through its Medicare program, not only for hospital care, but also for home care and care in other facilities.

In another 1999 *New England Journal of Medicine* study article, the authors looked at hospitals in areas being converted from not-for-profit to for-profit and compared their spending with those areas that remained not-for-profit

from '89 to '95. They concluded that spending in the 33 areas converted to for-profit was greater than in the 2860 not converted, not-for-profit areas for hospital services, home health care and services at other facilities, all the categories of service examined.

Quality of care: As we move from cost, if for-profit care is less efficient, then the question becomes: Does it provide better care?

In a 1999 article in the *Journal of the American Medical Association*, researchers concluded that, compared with not-for-profit health maintenance organizations, HMOs, investor-owned for-profit plans had lower rates for all 14 quality-of-care indicators. Investor-owned HMOs delivered lower quality of care in the not-for-profit plans when examining the quality of care for everything from heart attacks to diabetes to eye examinations. With HMOs, while total costs in the for-profit and not-for profit are similar, the not-for-profit plans spend more on patient care. For-profit HMOs provided less preventative care, have higher disenrolment rates, and lose more beneficiary appeals than not-for-profit plans.

In a recent study by the Harvard School of Public Health, 82 583 patients in 182 health plans rated quality of care in the for-profit plans much lower than in the not-for-profit plans.

Finally, access: A 1997 editorial in the *New England Journal of Medicine* expressed concern about the accessibility of for-profit hospitals. They provide fewer money-losing community services, such as care for the poor, 24-hour emergency departments, AIDS clinics, burn and trauma centres and neonatal intensive care units. Private for-profit hospitals will never, the journal argues, provide sufficient care to the poor and uninsured. In a competitive marketplace where cost containment is the rule, if that were true by the way, there is consistent pressure on hospitals to reduce important but unprofitable services and, instead, skim the most lucrative services off the top. Similarly, a parallel for-profit system does not shorten waiting times. It uses the same health care workers as the public system. So, at a time when there is a shortage of doctors and nurses, splitting them between different systems is counter-productive. The fact is well supported by two studies of cataract surgeries, one by the Manitoba Centre for Health Policy and Evaluation, the other by the Alberta Consumers' Association.

Finally, prognosis: The evidence shows that for-profit health care is more expensive, of poorer quality and less accessible. It is, therefore, unlikely to reduce waiting lists for surgery or the number of patients lying in beds in the halls. Spending a dollar on the less efficient for-profit sector means we get less service for the same dollar. Given this evidence, Bill 25 is laudable. The growth of inefficient, inequitable for-profit elements should be stopped in its tracks. In the longer run, rather than moving towards an American-style health care system, Canada should expand its public sector to include drugs, long-term care and better and stronger health care in the community at home. These would be steps on the road to improved efficiency, quality and accessibility. Thank you.

Mr. Chairperson: Thank you for your presentation, Mr. Chernomas. Do members of the committee have questions for the presenter?

Mrs. Myrna Driedger (Charleswood): Mr. Chernomas, have you ever had an opportunity to study the Swedish health care system, and do you have any comment on it?

Mr. Chernomas: I have certainly studied it in the past and have studied the research literature. I have not done it very recently. There are some articles in the newspaper recently which I have looked at, and I think one of the more interesting things is that they experimented with a for-profit hospital and they decided that it was–it looks like they have stopped experimenting. They think it is a bad idea because what they discovered in the for-profit hospital is they began to introduce services which were two and three times what was occurring before, and, therefore, they think probably what they are doing is trying to find the places where the most profit is being made, as opposed to where the patients' needs are greatest. So, from what I understand, they have suspended the experiment.

Mrs. Driedger: We must be reading very different articles because I am hearing quite the opposite in terms of what is happening in

Sweden, and actually, the expansion of programs that is going on down there is a bit contrary to what you have indicated. I am wondering also the–and I do not know if you have run across it. I have been trying to find it. There is an article that came out in one of the New England journals of medicine, and I heard it was quite a flawed study and that the editor, in fact, of that particular journal was chastised quite severely for publishing it. Have you run across that particular article or one that you have since heard that might be a particularly flawed article in terms of the scientific base upon which the research was carried out?

Mr. Chernomas: It is a peer review journal, and I am not familiar with any particular study that there was some question about it. As for other material in Sweden, I would welcome the opportunity if you could give me those references.

Hon. Jon Gerrard (River Heights): A question for you: We have currently probably about 30 percent of health care in Canada not publicly paid for. It is privately paid for in one fashion or another. So we currently have a mix. We currently have what are probably dozens of clinics, from Winnipeg Clinic, the Manitoba Clinic and so on, which are privately owned. Are you advocating that the Government take over all these clinics and operate them?

Mr. Chernomas: One has to make the distinction between for-profit and not-for-profit private health care. There is a different incentive structure in the two systems. In fact, one would argue that our entire health system is privately administered, although publicly funded, I do not know what I said, but obviously it had a dramatic effect–so that that is an important distinction. So there are many countries that have experimented. You know, the British system for example, for a long time was both publicly funded and publicly administered. The Canadian system is a hybrid between publicly funded and privately run. So I think it really matters, the structure, what sort of incentives there are. The for-profit system is different from private.

I think the for-profit system, in particular, has been raising the costs, for example, in pharmaceuticals, and this is no time to do that. But, yes, I would make some serious suggestions about how we might transform how we get our drugs and other parts of our health care, home care as well.

* (19:10)

Mr. Gerrard: Just with respect to the clinics, what you are suggesting is that it depends very much on the operating structure of private clinics in terms of what the final results are in terms of costs and quality, that it would be quite feasible within a public system to be contracting for services in a way that you could comparatively evaluate the delivery and ensure that the standards, both in terms of cost and quality, are high across the whole system.

Mr. Chernomas: I would see no advantage to that. I mean, once again, the incentive structure would not matter, whether it is for-profit or not-for-profit, but I do not see any advantage in having a private not-for-profit over one that is directly under the state's direction. I do not see the advantage.

Hon. Dave Chomiak (Minister of Health): Just a couple of questions. Firstly, thank you for the presentation. I am a bit perplexed, given all of the evidence and all of the studies that indicate a private system is not as efficient and is less effective. Do you have any speculation as to where this enthusiasm is coming from to go private?

Mr. Chernomas: That is a very large question. I would say that part of it is certainly ideological, and part of it is that there is an important sort of trajectory in the world to turn much of the public sector into a for-profit private sector because it is a source of profit.

People with a lot of power are seeking to change the institutions, so there is access to profit. It is true in education. It is true in health care. I would argue that the World Trade Organizations, the GATTs, are all about precisely that.

Mr. Chomiak: What I also see is that because there are no statistics, no studies that can be used to justify it, what the people who advocate this do is run up the flagpole one system after

another. For a while it was Sweden, and then we found Sweden was freezing its privatization experiment. So that one goes down the flagpole.

The next one up the flagpole is France, and they talk about France being so well. What they do not tell you about France is the fact that people have to pay 20 percent of the cost of the health care system. They do not tell you the OECD has said that poorer households and people at the poorer end of the scale do not get access to health care in France. They do not tell you that there is a 13% payroll tax on employers as well as payroll deductions on employees to do France. So they run these systems up the flagpole, but there is no comparative and there is no actual data to justify this privatization initiative.

Any recommendations on other systems or other ways we should be moving, other than the recommendations you made with respect to expanding to include continuing care and prescription drugs, et cetera? Is there anywhere else you suggest we might look?

Mr. Chernomas: Things like community health centres, possibly. I realize what this sounds like in this day and age, a public pharmaceutical approach as opposed to the private sector to do this.

I mean, there are a whole bunch of things that I could suggest with more time, but I would suggest more public rather than more private along these lines. Health care is different as a commodity, very different.

Mr. Gerrard: Just back to your comment that you see no advantage over a private not-for-profit or a government-owned not-for-profit. I mean, if there is not an advantage for a government-owned not-for-profit, is it worth the expense of Government to buy out all the privately owned not-for-profit facilities?

Mr. Chernomas: I would have to look at it case by case, but if it is more efficient to have it government-owned, then I would do it. If it is a small part of the overall health sector that–I do not know. I would have to look at it case by case. By and large, it does not seem to work, the private sector as well as the public sector, but any individual case, I would sort of have to look at it, I guess.

I mean, it is the same resources, right? There is a different incentive structure in different organizations, and one incentive, the single-payer system, seems to work better than any other.

One of the problems with the Swedes is, I would say for years, when I did look at the literature in the past is that they were too fragmented. They did not have a single-payer system. So what happens is you had a variety of different sectors all raising costs at the local level, as opposed to at the top somebody deciding how many MRIs, the equipment and technology that would be produced.

If you have a disorganized system, you are going to wind up with a lot of people making demands for a lot of different technology and also, of course, the costs that go along with that equipment.

That was certainly part of the problem in Sweden when I last looked at it, which has not been for a while, and the Swedes have now gone to, at least experimented at least in the short run, with a for-profit system, but as I said, my most recent and, this is not academic but reading the newspaper, it seems they do not like the results that they have had.

Mr. Mervin Tweed (Turtle Mountain): Mr. Chairman, the minister had asked you what you thought might be driving this question about looking at alternatives and options. I guess I would suggest to the minister, it is being driven by the thousands of people that are waiting on waiting lists for a long period of time, and they are looking for alternatives. I am not saying they know what the answer is, but I am saying it is being driven by them, and I just ask you if you might agree with that or to comment on it.

Mr. Chernomas: Yes, I think there are reforms needed in the health care system without question. What I was suggesting is that into this gap has come with a vengeance a whole lot of for-profit interests that have spent lots of money on research, lots of money on publicity promoting a particular solution to this. I can

bring you long quotes from stockbroking houses in New York talking about the incredible large market in health care and public-sector health care around the world that ought to be exploited, the same thing about education.

What we need to do is we need to get the word out that these are opportunities for us that need to be pursued. These are folks who have more power, I would suggest, in general, than the ordinary folks in Manitoba who have some reasonable complaints about the fact that there are waiting lists for surgery. I can suggest to you in the United States that there are no waiting lists for surgery, but there are lots of people at home in the dark that do not get access to it at all.

Mr. Tweed: Would you suggest, then, another factor that may be part of the drive is the fact that by referring patients to the United States, they come back with quite good stories about the care and the treatment they received? Perhaps in their circles of travel and friends that discussion is taking place, and that might also be driving a little bit again, not necessarily to the American model, but the real need for the change and the ability to look at change and not be afraid of it.

Mr. Chernomas: Two things about that. One, if you are wealthy in the United States, you have access to some very good health care. The second question is that access to that health care–the question is time limited, of course. One of the interesting things about health care is that there is asymmetry of information. You go in with a pain and you are sick and you are worried, it is you or your child. There is enormous pressure to get something done and ultimately you do not really know what the intervention is, whether or not it is appropriate, necessary or not. So you go in and you go to a for-profit first-class American health facility, you will get service and you will get it quickly. The question whether you got what you really needed is a separate question altogether.

So, as I suggested earlier, in a lot of these places a lot more heart surgeries are being performed, a whole range of different services being performed. That would suggest that maybe they are not the services that are necessary. Maybe they are sort of done for profit rather than–so, yes, you go there and if you are wealthy enough you will do quite well, but many Americans would not get access to that in the first place.

Mr. Chairperson: Thank you for your presentation, sir.

I will now call upon Albert Cerilli, President, Manitoba Federation of Union Retirees. Mr. Cerilli, do you have written copies of your brief for the committee?

Mr. Albert Cerilli (President, Manitoba Federation of Union Retirees): Yes.

Mr. Chairperson: Please proceed with your presentation when you are ready, sir.

* (19:20)

Mr. Cerilli: Thank you. Good evening, Mr. Chairperson and members of the committee. The Manitoba Federation of Union Retirees is an affiliate of the Congress of Union Retirees of Canada and makes up the 500 000 union retirees and their spouses. CURC and MFOUR is a member of the Canadian Health Coalition. The Manitoba Federation of Union Retirees wants to commend this Manitoba NDP government and honourable minister, Mr. Chomiak, for serving notice to the rest of Canada that this provincial government will protect all Manitobans on an equal basis for their health care needs.

Bill 25 allows the protection from those that want to profit from one segment of society who fall ill and in need for professional medical treatment. Bill 25 stops those doctors that want to cherry-pick from those that feel threatened and exposed to a sickness in need of treatment. Some will argue that those who can pay should leapfrog those that cannot pay. The Manitoba Federation of Union Retirees does not agree with this principle. In order to place this issue in some historical perspective, may we take you back to why the Canada Health Act and before medicare.

To quote from the collection of individuals who wrote in in 1995 from "The Stories Project" in the book, *Life Before Medicare: The Canadian Experience*, compiled by Helen Heeney for "The Stories Project," Ontario Coalition of Senior Citizens Organizations,

funded by New Horizon Health Canada. Others involved are with foreword by Dr. Michael Rachlis, edited by Susan Charters, illustrated by Doug Sneyd and designed by Justine Orr.

To quote from this recommendation and recommended reading, one reflection by so many that make up this book, I will quote from a Maureen Beardsley from British Columbia who writes: In 1956, my husband was posted in Germany. Just prior to returning home in December 1957, I suffered a gall bladder attack which was tended to at a British military hospital in Germany. When we returned home with our one son who was born in Germany, we purchased Blue Cross to cover me and our son. My husband was covered by the military. In 1958, I had a bad attack. This was a major problem as we had not been in B.C. for six months and, therefore, were not covered by the hospital plan, but thought that the Blue Cross would cover the doctor's fees. A week before the operation was scheduled, B.C. changed the residence stay to three months. We were elated. Our second son was born October 21, 1959. Several months later, when I was visiting my doctor, I found out I owed him $125 for the pregnancy which was not covered, because my husband was not on Blue Cross plan, and that I owed $500 for the gall bladder operation. That operation was not covered after all because it was a prior condition.

We were just devastated and did not have funds to pay. I offered to borrow the money, but our doctor was good enough to allow us to pay him $10 per month. It took us five years to pay off the debt. It was quite a financial burden. That debt was more than we paid for the used car. It was 25 percent of the value of the house we had purchased for $300 down and $25 a month in 1954. Now you can imagine the dollars in this day and age.

If I can pause for a minute, there are a hundred of these stories in the book, and I would recommend that the book be looked at by those who think that privatization is the end to all means of medical care and other means.

The Saskatchewan premier, Douglas, with his then-CCF, now the NDP provincial government, fought all odds to put into place the 1947 hospital care legislation for the province's citizens regardless of financial status and standing and, in 1962, put into legislation the Saskatchewan Medicare Act.

By 1967, the federal government promised to share the costs of hospital insurance plans operated by the provinces. However, the implementation of the recommendations of the report of the Royal Commission on Health Services by Chief Justice Emmet Hall were in for a fight to have the medicare act approved by the Parliament of Canada in December 1966. The provinces had to be forced into developing actual programs to meet the principles of medicare.

In preparing this paper, I will quote from the Winnipeg Labour Council files of mid-1960s. Some of us remember that far back. Some of us were still pretty young. But, in fact, here is what we said at that time. "On December 8, 1967, a letter was sent to the Honourable Lester B. Pearson, Prime Minister of Canada, and to the Premier of Manitoba, the Honourable Walter Weir." Sometimes I wonder where the attitude of the present Tories come from, but if you read history, you can learn a lot from it because those attitudes then are still in existence today.

"On Tuesday evening, December 5, 1967, at the regular meeting of the Labour Council of Winnipeg, a resolution was passed unanimously to urge you to press for the implementation of medicare by the federal government on the scheduled dates of July 1, 1968, without any further postponements."

The letter continued to the Premier of the province. "Mr. Premier, we just cannot afford the luxury any further of depriving our under-privileged and low-income people of proper medical care on a reasonable basis, no further delays," and so on and so on.

The Manitoba Association of Social Workers on February 9, 1968, made a press release, and I quote in part from it, because I think sometimes history tells us a lot from where we came from so we know where we are going and what road to take, because if you come to the fork road and you take the wrong road, then you are in trouble. I tried to stay on the left road,

but sometimes you have to look at the other side as well.

Here is what it said: In light of the exhaustive inquiry into medicare services conducted by the Hall Royal Commission, the Manitoba Association of Social Workers is most discouraged by the Manitoba government's rejection of the idea of universal medical care insurance and its stated intentions not to implement the federal care plan for at least another year. It has been variously estimated that between 150 000 to 200 000 Manitobans are without any medical coverage. These generally are people on marginal or fixed incomes to whom minor illness can result in financial distress and a major one lead to disaster.

I guess you could see from the letter from B.C. that the lady was in a disastrous situation, but the good nature of the doctor helped her out in trying to recover.

If I could pause for a minute, everybody looks to the United States for the make-all, the glory of the buck down there and medical care and privatization, but, in fact, down in the United States, the last figures that we have researched is that 40 million-plus Americans are not covered by any kind of care because it is too expensive. Now, that is the road they have taken. Good luck to them, but keep your hands off our medicare.

The Lutheran Church–oftentimes I quote from the Catholic bishops' papers and so on, and sometimes I quote from the United Church–this time I am going to pick on the Lutheran Church in America. The Canada section at its convention on June 19 and 20, 1967, authorized a paper to be released on social concerns titled, *A Health Charter for Canada a Concern for the Church.*

In its forward it stated, and I quote in part: Public debate on the issue of health care services including the implementation of the Medical Care Act of 1966, medicare, continues. Those doing the debating are mainly the politicians, the professionals and the spokesmen for powerful corporation groups. "What does the consumer have to say?" was a question that was asked in that paper. "Is this a subject coming within the orbit of Christian social responsibility?," was the other question that they asked. A universal plan: The Royal Commission of Health Services attempted to deal with the paradox of our age, the enormous gap between our scientific knowledge and skills on one hand and our organizational and financial arrangements to apply them to the needs of men on the other. Hence, its basic recommendation is that Canada take the necessary legislative, organizational decisions to make all the fruits of health science available to all our residents' health services without hindrance of any kind. Thus universal means that adequate health services shall be available to all Canadians wherever they reside, whatever their financial resources may be. End of quote. Wise words.

* (19:30)

The Royal Commission report by Justice Emmett Hall, and the church, as above quoted, found that in a modern society as in Canada, individual responsibility by itself is insufficient, for there are those of modest means who also deserve medical care as presently available in Manitoba and who deserve to be protected by Bill 25, to keep privatization out, from those who wish to profit from the misery of others. The Canadian health services will survive as long as there are governments and social justice activist organizations such as the church, poverty groups, labour organization, retirees groups and the NDP government to ensure that trade agreements, unfriendly governments and opposition groups wishing to privatize medicare and Crown corporations are neutralized and kept at bay. Bill 25 does that and requires immediate passage.

You know, I just want to pause here for a minute before I close off. The health coalition does its research and seeks legal advice from a variety of groups, and in 1966 during the NAFTA debate and during the Free Trade Agreement debate, we felt uncomfortable with the provision of that trade agreement in that it provided for Americanization of our health care. In 1966, we sought the help of–the coalition did, and on June 11, 1966, we released a legal opinion prepared by Barry Appleton.

On March 13, 1966, we also released the opinion prepared by Brian Schwartz of the

University of Manitoba on the impacts of what would happen with internal trade if not covered, and external trade if not covered. I am glad to say that at that time, the present Prime Minister sought an agreement to make sure that those things were protected, unlike the present situation that is on now.

I may say this because I am worried and concerned that the present debate that is going on on free trade agreements with the Americas will open the door up again in regard to what can happen in trade agreements if the public and the provincial governments are not hammering the federal government to make sure that they stay on the straight and narrow line of universal hospitalization for all Canadians. I say that to you, Mr. Minister, for the purpose of the fact that we are concerned and the things that are happening now with the debate of a special committee of governments between Mexico, U.S. and Canada, on the fact that–

Mr. Chairperson: One minute, sir.

Mr. Cerilli: –there are open borders and new trade agreements. I think that they have to be told that we will not stand by. MFOUR commends the Minister of Health and the NDP government for reinvesting in modern equipment for the health care services and then the people providing this life-giving service.

I thank you for your time.

Mr. Chairperson: Thank you for your presentation, Mr. Cerilli. Do members of the committee have questions?

Mr. Chomiak: Thank you, Mr. Cerilli. I again thank you for your presentation. I just wonder if you might touch on what the implications are from either the Schwartz or the Appleton recommendations of '96 concerning the Free Trade Agreement and its possible impact on medicare.

Mr. Cerilli: The provisions of Appleton dealt with the internal trade agreements. The Schwartz agreement dealt specifically with the NAFTA, and that the provisions in there allowed for investment, if you like, from the Americans to come in here. In some, the concern was so real that this investment would jeopardize our universality and our availability of a public system, that we would be really on a slippery side of the slope towards the privatization, American-style, of health care, and that was the concern.

He highlighted a number of the passages. I have the paper at home. I will mail it to you. I think you will be interested in those two documents, and I am sure that they will serve this committee well, if you like, in regard to what should be done and what should be stopped.

Bill 25 stops the present situation in Manitoba, but there are provinces like Alberta, for example, who are hell-bent on having a two-tier system. It concerns seniors across this country. In November of last year, 13 organizations of seniors met from across this country, representing some two or three million seniors and their spouses. One of the great concerns was just that, that the trade agreement between the Americas and other things of that nature will open up the door. I think that the Schwartz paper will highlight the concerns he had at the time.

Mr. Chairperson: No further questions? Thank you for your presentation, Mr. Cerilli.

Mr. Cerilli: Thank you.

Mr. Chairperson: I now call upon Michelle Forrest, private citizen. She is not here. Her name will be dropped to the bottom of the list and called a second time at the end of presentations. I call upon Paul Moist, President, Canadian Union of Public Employees. Mr. Moist is not present. His name, too, will be dropped to the bottom of the list. I call upon Margot Lavoie and Brother Thomas Novak, Manitoba Oblate Justice and Peace Committee. Does the committee grant leave for both individuals to present jointly? *[Agreed]* Do you have a written copy of your presentation? You may proceed when ready.

Ms. Margot Lavoie (Manitoba Oblate Justice and Peace Committee): Good evening. There are many issues which, at first glance, seem relatively inconsequential and therefore, undeserving of extensive public debate, but some of

them, when considered of all their implications, are revealed to touch the very core of who we are as a community, as a society, as a people.

The question of overnight stays in private surgical facilities appears to us to be one of these issues. The sanctioning of overnight stays in private, for-profit facilities is, we believe, the thin edge of the wedge in a subtle but inexorable strategy of implementing private, for-profit hospitals.

As members of a faith group which has played a long and important role in the development of medical care in the province, we believe that it is the civic duty of some of us to reflect on this critical question. The Oblates, the Grey Nuns, the Sisters of Misericorde, the Sisters of St. Joseph, the Salvation Army, the Mennonite and the Jewish communities have been instrumental in the founding and administration of important health facilities in this province. Churches, faith groups and religious communities practically invented organized health care in this province.

Although it might be argued that these faith-based hospitals and health clinics were in some ways private, they differed enormously from the kind of medical facility targeted by Bill 25. For many years, members of these faith communities made profound sacrifices to maintain not only the institutions they founded, but the very principle of affordable and accessible health care for all Manitobans, always with a special concern for those most disadvantaged. There was never any question that these faith-based medical facilities would ever be money-making enterprises for the communities or churches who founded and administered them.

Indeed, all of these institutions were founded on principles directly opposed to the principles underlying some of the proposed surgical facilities targeted by the bill. The founders of the faith-based institutions, as the founders of secular public hospitals, were acting out of profound spiritual or humanistic ideals of compassion and human solidarity. These men and women opened hospitals because they felt they could not do otherwise. People were suffering and believed it was their believers' duty or their human obligation to do something about it. More often than not, they subsidized the institutions they founded with their own financial resources or by long hours of labour, often for the slimmest financial remuneration or no remuneration at all. The fruits of their sacrifices were reinforced and advanced by similarly minded civic leaders who courageously struggled for many long years to realize a nationwide system of public medical care.

* (19:40)

Mr. Thomas Novak (Manitoba Oblate Justice and Peace Committee): In an editorial on June 23 of this year, the *Winnipeg Free Press* advocated the serious consideration of sanctioning private, for-profit facilities, which would be permitted to keep patients for overnight stays. However, and we imagine it was totally unconscious on their part, on precisely the page opposite, they printed an opinion piece which illustrated one of the fundamental arguments against the establishment of such enterprises.

The article, written by U.S. federal representative Dick Armey, condemns so-called red light cameras as a cash grab. The problem with red-light cameras in the states he has studied, it seems, is not the principle itself of red light cameras. No, the problem is the private company that installed and maintains the cameras and that receives a $70 bounty each time a fine for a red light offence is assessed. This company installed its cameras, not in each city's most dangerous intersections, but at those they discovered to have mistimed signals, where the duration of the yellow light was significantly less than appropriate for that intersection.

I doubt that many *Free Press* readers were surprised by this finding. The primary goal and objective of a private, for-profit company is precisely that, to make profit. This is, of course, not to say that there are not a great many ethical, compassionate and self-sacrificing men and women who have started for-profit businesses. It is only to say that the danger of exploitation is much greater in a private, for-profit system than it is in a public or faith-based system.

Indeed, we already know the experience of provinces that presently allow and even encourage for-profit clinics and hospitals. We know

what services are performed in these facilities. They are not necessarily operations that are most critically needed. Rather, they are the relatively simple procedures that can be performed with the greatest possibility of making profit for the facility and its owners. More complex or higher risk cases are left for the public system. It cannot be otherwise. The rules of the market dictate that it must be so.

Ms. Lavoie: But even were for-profit facilities to operate in such a way that they would entirely complement the public system, the question would remain: Do the people of Manitoba want our medical system to be gradually privatized?

A few years ago, the previous government proposed privatizing a part of the home care service. After a great deal of heated and extensive public debate, it became clear that the majority of Manitobans did not want this part of their health care system turned over to private enterprise. To their credit, the government of the day acknowledged the vigorous public opposition and withdrew the legislation.

Why this vigorous opposition? It is no doubt due to fears about the consequences of privatizing any sector of the health care delivery system, lower wages for staff, the temptation to promote unnecessary procedures and services, et cetera; but we believe the opposition also stems from a more fundamental objection, a radical rejection of the commodification of services that have been traditionally provided as a public service out of a disinterested concern for the public good, out of compassion for those among us who are suffering.

We believe that Manitobans are still fundamentally attached to the philosophy and motivations that underpin the establishment of the original hospital and home care systems in Manitoba. That is, that medical care is essentially not a business; it is a service, a vocation, a sacred calling or duty. The outpouring of public sympathy for nurses and home care workers whenever they go on strike seems to indicate that we still perceive medical practitioners as neighbours in whose care we commend our loved ones when we lack either the training or physical capacity to meet all their health needs ourselves, as extensions of our families.

Manitobans still expect that the primary motivation of those who administer our medical system is the public good, not the good of the public company. We still expect that the personal values of those charged with the medical care of our loved ones are more in tune with the values of self-sacrifice and compassion than those of profit and exploitation. Despite the relentless drive towards globalization of the market economy and the introduction of the profit motive into almost every dimension of human interaction, the people of Manitoba still appear to believe that there are some things that should not be for sale, that there are some things that should be protected from the tyranny of the market, some things that ultimately belong to a totally different universe than the selling of hamburgers or lawnmowers.

Mr. Novak: In his poem, "The Rock," T. S. Eliot, asks: What is the meaning of this city?/ Do you huddle close together because you love each other?/ What will you answer? 'We all dwell together/ To make money from each other'?

Like the poet, we believe there are still values that might motivate men and women to provide services for their fellow citizens and neighbours, other than monetary profit.

We also believe that the people of Manitoba have rejected the piecemeal privatization of their health system, because they fear that the consequence of a slowly privatized for-profit health system is the eventual segregation of health care into a high-quality express system for the wealthy and a minimalized system for the rest of us.

As people of faith, we believe that underlying every public policy there is an implicit theology. We sense that under the movement towards a privatized and segregated health care system, there may lie the following ethical and theological principles: first, that making money and amassing wealth is the fundamental motor driving all productive human activity; and secondly, that it is natural and inevitable that some people have access to a greater share of the resources of the community than others, including those resources such as health care that have their natural origin in human compassion and neighbourly concern.

We reject this unspoken theology, and we would encourage our Government to reject it as well. In its place, we would like to promote an alternative theology, one which has attracted considerable interest due to the dawn of the new millennium.

Over the last three years, churches across the country have been celebrating the Great Jubilee. The Jubilee is a concept that comes from the laws and spiritual teachings of ancient Israel. It is based precisely on the principles of compassion and neighbourly concern of which we have been speaking throughout this presentation. In the vision of the Jubilee, the resources of the earth belong to all. Given a fair distribution of the land and its resources, there can be enough for all, enough food, enough shelter and enough health care.

We believe that it is the duty of a moral and compassionate government to do all that is in its power to ensure that the fruits of the earth and of human compassion be justly and equally accessible to all. In the case of health care, we believe that this can best be achieved through a system that, through our public representatives, is managed by all the people and for the good of all the people, that is, through a public and non-profit health care system.

Mr. Chairperson: I thank you for your presentation. Do members of the committee have questions?

* (19:50)

Mr. Chomiak: I want to thank you for a very eloquent and thoughtful presentation. I underlined certain aspects of your presentation that I was going to repeat, but I ended up underlining so much that I would have to repeat much of your presentation. What I appreciated was that sometimes in the Legislature–you know, we have great sayings on the top of the Legislature and there are representations of some of the great philosophers and lawgivers of all time. We tend sometimes to forget the underpinnings of what we are supposed to do, and I found that your presentation harkened all of us back to some of the fundamental human goals that we all ought to achieve, so thank you very much.

Mr. Chairperson: Comment on that? Any further questions? Seeing none, I thank you for your presentation.

I now call upon Carolyn DeCoster, private citizen. Ms. DeCoster, do you have a written copy of your presentation? Please proceed when you are ready.

Ms. Carolyn DeCoster (Private Citizen): Mr. Chairman, members of the committee, many of the media reports on this piece of legislation have opposed it. The gist of the arguments that I have read is that if the Government were to allow private hospitals, there would be greater access to care and therefore, waiting times in the public sector would come down. I am here tonight to present some research that disputes that argument.

I am a senior researcher at the Manitoba Centre for Health Policy and Evaluation at the University of Manitoba. I have been involved in two projects that have assessed waiting times for several types of surgery. One of the procedures that I studied was cataract surgery. Cataract surgery is available in both the public and private sector. Until January 1999, if patients chose to have their cataract surgery at a private clinic, they had to pay a tray or facility fee of approximately a thousand dollars. Patients who went to a public hospital, and those were Misericordia Health Centre or Brandon Hospital, did not have any out-of-pocket expenses. In both the public and private sector, Manitoba Health paid the surgeons' fees so the extra costs at the private clinics were designed to cover the operating expenses of running a clinic. In the studies that I did, I examined data from fiscal years '92-93 to '96-97, and then subsequently added '97-98 and '98-99, and the patterns that I am going to describe here were the same in both studies.

I brought copies to distribute here of the summarized versions of both studies, and you can download it also from our Web site which is in your notes. I also have here copies of a paper of mine on two-tier health care that was published in a U.S. public health journal.

For my study, I define the waiting time as the time between a pre-op visit to the surgeon and the date of surgery. The first chart, which is

on page 2, shows the waiting times for patients who had their surgery in the private sector versus the public sector. I have only shown five years of data here. What this figure shows us is that waiting times were indeed shorter in the private versus the public sector. If patients opted to have their surgery in a private clinic, they waited around four or five weeks. If they went to one of the publicly funded hospitals they waited eleven weeks in '94-95, and that increased to seventeen or eighteen weeks for '96-97 to '98-99.

So far, all I have shown you is that waits are shorter in the private sector, but what about the argument that having a private sector reduces pressure in the public sector, leading to shorter waits? For that, we need to dig a little deeper. What I did next was to divide the surgeons operating in the public sector into two groups. Some surgeons only operate in the public sector; others operate in both the public and private. In the next figure, I have divided up the public-sector patients according to whether their surgeon operated in the public sector only or in both sectors. Figure 2 shows the waiting times for three different groups of patients. The left-most group of bars shows the waits for patients who chose to go to a private clinic, and it is exactly the same as the first group of bars in figure 1. But here, in figure 2, the patients who chose a public hospital are divided according to whether their surgeon operated only in the public sector or operated both publicly and privately. If a patient had a surgeon who only operated in the public sector, they waited about seven weeks in '94-95 and '95-96 and ten weeks for '96-97 to '98-99, inclusive. In other words, the wait was about two to two and a half months.

On the other hand, if a patient had a surgeon who operated both in the public hospital and in a private clinic, they could expect to wait quite a bit longer. The wait was between five and six months from '96-97 to '98-99. So having a parallel private sector did not reduce waiting times in the public sector. In fact, surgeons who operated privately had longer waits for their public patients.

As a sidebar, I want to add that at the same time as waiting times were increasing, so was the rate of surgery. In the public sector, the rate increased 19 percent between '94-95 and '98-99, even after adjusting for the aging of the population. The volume increased by over 1200 procedures, from 5211 to 6466. So it can be said that an increase in waiting times was due to a cutback in the number of procedures. In fact, my research shows that the relationship between the level of resources and the length of waiting times is difficult to describe. When coronary bypass surgery rates increased, waiting times decreased, but for some other procedures like cataract, breast tumour surgery and tonsillectomy, when the rate of surgery increased, the waiting time also increased.

The figures that I have shown you here are similar to findings in the United Kingdom and in the province of Alberta. In the United Kingdom, there has always been a parallel private sector, and the longest wait procedures are those for which there is the most private practice. There are various theories as to why this occurs. One is that surgeons who have a private practice spend more time there to the detriment of their public-sector patients. Another relates to the way surgeons manage their lists. Some surgeons may put patients on their waiting lists at a lower level of dysfunction than others, and therefore their lists and waiting times are longer even though those patients may not need surgery yet. Another theory is that the private sector siphons off other staff such as anesthetists and nursing staff, leaving less for the public sector.

In Alberta, the Consumers' Association has done a lot of work in this area, and I recommend a report by Wendy Armstrong of the Alberta chapter of the Consumers' Association of Canada titled: *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft.* I do not have copies of that report, but I can get them for you if you want.

There was one very interesting finding in that study which may be relevant to this committee. In Calgary, all of the cataract surgery is contracted out by the regional health authority to private clinics. In Edmonton, about 20 percent is in private clinics with the remaining 80 percent in hospital, and in Lethbridge, 100 percent is in hospital. So in this case, all of the cataract surgery is publicly funded, but the providers are different. Table 1 shows that

Calgary has the most surgeons for its population, and yet the waiting times are by far the longest. Lethbridge and Edmonton had waits of one to two months, whereas the wait in Calgary was four to six months.

Many people ask: How does having a privately managed facility threaten the public sector? I think we have to remember that there is a profit motive, and the only way to make a profit is to reduce services or charge for enhancements above the public reimbursement. I read recently about Australia's bad experience with hiring private enterprise to run public hospitals. It has ended up costing the Australian taxpayers more because several hospitals have had to be bailed out by the government because they were either losing too much money or were cutting services severely to prevent losses.

There is plenty of evidence that for-profit health care is more costly and sells more inappropriate services. It seems obvious to me that it is a road we do not want to go down.

Mr. Chairperson: Thank you for your presentation. Questions from the committee?

* (20:00)

Mr. Gerrard: Carolyn, we appreciate the extent of the research that you have done in a variety of areas and the reports that you have done through the Manitoba Centre for Health Policy and Evaluation.

A couple of things. One, this study was based on where there were facility fees, comparing institutions where there were facility fees and where there were not. Where we do not have facility fees currently in the same framework or they are paid publicly, it is not clear whether the same is going to be relevant in the same way.

Ms. DeCoster: That is true. I do not have data–

Mr. Chairperson: Ms. DeCoster, I have to recognize you. I am sorry.

Ms. DeCoster: Yes, I forgot. That is true. The data that I looked at did not carry on to when there were no longer facility fees. That is partly why I introduced some of the experience in Alberta where there were no facility fees, and yet the waiting times were longer where services were privately operated.

Mr. Gerrard: I think a couple of points. One is it is quite clear from your studies that the waits actually in the private sector were shorter than the public sector. I think there is no argument there. Second, when you looked at this explanation for why you have surgeons who operate in both having longer waits in the public sector, the surgeons who operated both publicly and privately made maximum use of their public-sector operating time.

What that suggests is that the explanation for this is actually much more complex than just the difference between public and private.

Ms. DeCoster: I suppose one of the limitations of the research I have done is that we do not have information in the data that I looked at about clinical symptoms. I put into my presentation that I noticed that some surgeons, and this is basically from research from the United Kingdom, will put patients on the waiting lists sooner than others. What that does is make their waiting list look longer and therefore encourage patients to go to the private sector. Now, I am not saying these patients do not need to have their cataracts operated on. They probably do not need them for some time yet, and maybe, by the time they come to surgery, they will need to have the operation, but having a long waiting list is also a political tool. It is something that is used in bargaining, so if you put patients on the waiting list early, and therefore they have a longer wait, it encourages them to go to a private clinic.

Mr. Gerrard: But part of what you are saying is that there is a lot to do in terms of really standardization of data so that you can make good comparisons and that the reasons for the longer waits in those who operate in both sectors really needs a lot more research before we know precisely why that is occurring.

Ms. DeCoster: I think in Manitoba, that is true. We do not know. There is more that we would need to know to understand all of the ins and outs. There is now a cataract surgery waiting list

registry being maintained at the Misericordia Hospital for all patients who have surgery in Winnipeg, and that includes patients at the private clinics as well, or clinic, I think there is only one, and it includes information on prioritization, but I do not have access to those data. I think that would be very interesting to understand if there were differences between surgeons and the level of visual dysfunction when they were put on the waiting list. There was a study that came out of British Columbia recently. This does not really have to do with private-public medicine, but what it showed was that approximately 30 percent of patients having cataract surgery were having minimal visual dysfunction and 10 percent of them did not meet the guidelines for cataract surgery, so there is a level of inappropriate care as well.

Mrs. Driedger: When you were looking at this, did you take into account a surgeon's popularity and experience as being one of the reasons they might have had so many patients coming to them?

Ms. DeCoster: I did not look at individual surgeons' waiting lists. I was grouping them because we do not look at individual data. I do know that some surgeons are more popular than others, but I think part of that might be because this kind of information is not publicly available, that the referring physicians and patients do not know what the waiting times are for different surgeons. In speaking with ophthalmologists at Misericordia, they say that the procedure itself, the outcomes, are similar whichever surgeon you go to, but I think that because this information is not shared, I mean, certain optometrists probably always refer to the same surgeon when, in fact, they might refer to another one if they actually knew that other surgeons had shorter waiting lists.

Mrs. Driedger: Was a surgeon's speciality skills taken into account because, I understand, there are a couple of surgeons, for instance, that only do certain types of procedures? So when you looked at this, were surgeons' specialities skills taken into account which might explain why some had longer waiting lists than others?

Ms. DeCoster: No. I do know that some of the surgeons that operated only in the public sector do have some subspecialty kinds of interests, and some of the really high-volume cataract surgeons pretty much only do cataract surgery, but, again, in the data that I have, I cannot tell that. We do not have that level of detail, so I did not look at those specialty interests by surgeon.

Mrs. Driedger: Were the ages and conditions of patients taken into account when you looked at this study?

Ms. DeCoster: I did look to see whether there were differences by age, and I did not find any. I do not have, again, data on the patients' conditions. That is where the cataract surgery waiting list registry would be very helpful, because it has some information on visual dysfunction, and that would be useful to have that information.

Mr. Chomiak: Thank you for the presentation, and I know that the Centre for Health Policy and Evaluation is an arm's-length relationship organization from the Government.

Let me just observe something about your report. It is interesting to me that you have provided some credible research data that supports the case that private operating beside public creates more difficulties. You also deal with the Alberta situation, where, again, you have an actual comparison. Then you referenced the Australia experience and you referenced the United Kingdom experience as well.

What strikes me as very, very interesting in this whole debate, is the other side of the debate that advocates going privatization can supply no data to justify their position. Then they pick away at some of the data, but there is no evidence that their position is supported. If there were data like that, clearly, it would be made available, but it is not.

I suggest, and you do not have to comment, that both your report and the report from Alberta and the experiences, certainly, counterclaims like we see from people that talk about France and give us eloquent phrases about France but have no data to support their position. Thank you.

Mr. Chairperson: Comment, Ms. DeCoster?

Ms. DeCoster: No, thank you.

Mr. Leonard Derkach (Russell): Thank you for your presentation. I think all of these things are helpful in terms of trying to deliver a health care system in our province that is not only efficient but meets the needs of Manitobans. I think sometimes, as politicians, we get hung up on ideology and forget about the practical aspects of a system and how we could improve on it, also, perhaps, overlooking or, perhaps, not regarding whether it is private or public but, indeed, how we can deliver the best service.

I would like to ask you a question with regard to the Pan Am Clinic, Ms. DeCoster, specifically because, with the purchase of the Pan Am Clinic, the Government maintains that they will be able to reduce waiting lists and also increase procedures at the clinic. That is their rationale for purchasing the clinic. However, by lifting the cap, I suppose they could have achieved that same agenda.

I am wondering whether, based on the research that you have done, you have an opinion on whether or not the efficiency of the Pan Am Clinic and the services to clients will indeed improve by the purchase of the clinic.

Ms. DeCoster: I am not very familiar with the details of the Pan Am Clinic purchase. So I guess all I can speak to is the literature that I have read elsewhere that suggests that a for-profit facility is not run as efficiently and so it might be possible for the Government to therefore increase the number of services that are offered at a lower cost more efficiently. I do not know all of the details of the Pan Am Clinic.

Mr. Derkach: Well, what do you have to say to Doctor Postl, who actually made statements which are directly contrary to what you have just said?

Ms. DeCoster: Well, without actually knowing what those statements were, I do not think I can address that.

Mrs. Driedger: I am wondering if you are aware of the Montréal Economic Institute publishing a research paper, September 2000, where they stated: Canada's prohibition of voluntary, parallel private health insurance and private medical services in hospitals precludes any Canadian-based comparison and control for the current experiment in provincial government health insurance monopolies.

One would almost think they never then looked at perhaps the Alberta study that you were commenting on or even the Manitoba study, because they are certainly indicating that it is difficult for them to actually compare, when basically in Canada, you know, you do not have two, a public and private system running parallel with each other, that you can effectively make any valid comparisons. It appears that they are saying that it makes it very difficult to actually form any opinions. Are you aware of this particular study?

* (20:10)

Mr. Chairperson: Time has expired. Is it the will of the committee to allow Ms. DeCoster time to answer the question? *[Agreed]*

Ms. DeCoster: It will be a brief answer. I am not aware of that study, so I am afraid that I–it does sound like they did not look at the work coming out of Manitoba and Alberta.

Mr. Chairperson: Thank you for your presentation, Ms. DeCoster. I will call upon Madeline Boscoe and Barbara Wiktorowicz of the Women's Health Clinic.

Ms. Madeline Boscoe (Women's Health Clinic): There are two of us.

Mr. Chairperson: Do you have a written presentation for the committee?

Ms. Boscoe: Not written, I am afraid.

Mr. Chairperson: Okay. Is it the will of the committee that these two individuals present jointly? *[Agreed]*

Ms. Boscoe: I would like to take an opportunity to introduce my colleague Dr. Carol Scurfield, who will be replacing Barbara Wiktorowicz in our presentation tonight.

Mr. Chairperson: Okay. Is there leave of the committee for–what was the name again?

Ms. Boscoe: Dr. Carol Scurfield.

Mr. Chairperson: Dr. Scurfield to replace–

Ms. Boscoe: Barbara Wiktorowicz.

Mr. Chairperson: Wiktorowicz.

Ms. Boscoe: I will give you the spelling later.

Mr. Chairperson: Okay, proceed when you are ready.

Ms. Boscoe: Thank you very much, and thank you for the opportunity to come here tonight. The Women's Health Clinic is delighted to speak in support of this bill. It would help you to know, perhaps, that I am a nurse by training. I co-ordinate the health promotion and community education team and counselling team at the Women's Health Clinic, where we have been involved in an eight-year working group on women and health reform here within the province. I am on a national research team evaluating health service restructuring from a gender-based perspective.

Rather than repeat and reiterate some of the comments that have been made already this evening, because I am sure we all would like to get out of here as quickly as possible, I would like to stress some of the comments that have been made by Bob Chernomas, the Association of Retired Persons, the Oblate and the Canadian Centre for Health Policy and Evaluation.

It is clear to us at the clinic and through our practice that for-profit systems, including private hospitals, increase waiting time and decrease access for the general public. We need to learn from and build on the experiences that have gone on here in Canada and in other parts of the world. We also strongly believe that allowing private hospitals will decrease general access to physicians. There is consistent evidence that a publicly administered system is more cost-effective and provides higher quality of services than a for-profit system.

I would also like to note for the record, that we need to remember that our physicians are a public resource, that public funds primarily pay for the education of physicians. How they spend their time and how those resources are allocated need to be something that is a debate within the public domain. Too often, I think, we have found in our practice that, as physicians drift into private clinics or private hospitals, they are no longer available as early speakers have spoken to.

We also think it is really important to address the issue of equity and the principles here. Private hospitals reinforce inequities and strengthen and reinforce class differences. We do not believe that line jumping is a Canadian value or one that we should be reinforcing. The opportunity to pay out of pocket is a privilege, but it disturbs the public fabric of our system and is something that, I think, we all need to address. This is why I think this issue was such a hard one right now for the public, because it does get at our fundamental beliefs as a society around how we look after each other and who we decide gets cared for first. That is not to say that our public system is perfect, but that the debate and the discussion and how to improve it should be done within the parameters of a public system.

We also want to address the issue of quality assurance. As an agency that has been actively and passionately involved with quality assurance issues in the health system, both by service providers and by institutions, we are extremely concerned with an increased privatization of systems where the transparency that is in place and is anticipated in the system will be less accessible.

Finally, and I am going to hand over the podium to my colleague here, often private for-profit systems are held up as a model for innovation in health system renewal. As staff at a 20-year-old innovative institution within the public system, I think it would be helpful for the committee to hear a little bit about our experiences and our models, because I think we need to differentiate between vision and innovation, and profit. I will pass that over to Carol.

Ms. Carol Scurfield (Women's Health Clinic): Hi. My name is Dr. Carol Scurfield. I am a physician. I was trained as a family physician. I worked in the fee-for-service system. I currently work at Women's Health Clinic, which is a

community health clinic. As well, I worked north in Canada in Churchill and further north and in rural areas. So I have had a fairly broad experience of the health care system as somebody who provides service within it.

I would like to reiterate what Madeline says about physicians being, I think, public servants. It is public money that put me through medical school and gave me the skills that I need to do the work that I do. So I do believe that I have an obligation to provide that service and that it should not be one that people have to pay for yet again, because they already paid to train me.

The issue of innovation, I think, is one that is really important to think about, because it is often touted that a private clinic can give you the most up-to-date facilities, the most high-tech kinds of interventions. I think this is a really short-sighted view of what health is and what health care delivery is. A nice waiting room is not necessarily what is going to give you the best quality of care. I think true innovation involves looking at your health in a very broad perspective, the ideal being you prevent the need for that intervention, that you have good health education. While there are surgical procedures that are not necessarily something you have to jump to right away, in the for-profit system you tend to jump quicker than you would in a system where perhaps you can give that person the skills they need to live with this condition until its time ends because there are things that that happens with.

I think that the Women's Health Clinic is one of the places that has tried to look at health in a very broad sense. We deliver service, but we also emphasize giving people the tools they need to live with the conditions they have and to prevent those conditions, and as well to teach them how do you use the system, because I think there is a lot of use within the system that is not necessarily something that has to happen at that point in time, and I am afraid that the for-profit system encourages the use of the system.

* (20:20)

I think there are some other examples of some innovated services that have happened within the public health system. I was privileged to be involved in the implementation of midwifery, which I think again is a very innovative system that could have quite easily been pushed into the private-for-profit system. We fought very hard to have it included in the public system. I think that is very important, and it does show that innovation can happen within a public system if the will is there.

Quality assurance is another critical issue. Qualify assurance is something that certainly is something that the public system struggles with. I have great fears that in a for-profit system, the struggle would be even greater because you have to get past barriers of a profit-making system which has a management system that is similar, perhaps, to those that you see in the States, which make it very difficult for people to function.

My clients and patients, and it depends on where you work what you call them in this province, want choice in the system. They tell me they want the ability to access the care they need when they need it, and they want a voice in the care they receive, but it does not mean they want to buy it. What they want is a system that is flexible, that listens to their needs, that is responsive and that offers them choices within the system. That is what they want. For instance, if the public thinks that a community-based surgical centre is what would give them the kinds of services they need, then maybe that needs to be looked at, but it should be within the public system so that there is public accountability and direct input into that system.

My colleagues often complain about the system. You hear lots of the physicians talking about how they want a voice in the care that their patients receive and are frustrated often by the system and say it is cumbersome, inflexible. I think they want a voice, and sometimes that frustration boils out into thinking: I will go into the private system. But most of them say they do not want to do that. They would much prefer to work within a system where they feel they can give the care they want to provide.

I do not think that you fix a system by creating a parallel system, and I think that is the risk that we are running here. I am sure that everybody in this room would agree that the

system is not perfect. There is lots of work to be done, but I have never heard anything being fixed by starting another one and trying to fix the other one while you are working with the other system.

I have heard lots of horror stories about the private system in the States, both from patients who had come back and told me about their problems. I have had to deal with women who have had unnecessary surgical procedures in the States while they were away on holidays and then come back, and I have to deal with the fallout of their complications and the fact that they really did not know what they were getting into. Because they could get that procedure fast, they did it and then they thought about it, which is not a good way to enter into any kind of procedure.

I think that a strong publicly funded, universally accessible system is something that is really critical to the quality of life of Manitobans. I do not think we can take any steps that start to erode this system. I think what we need, though, is for health care providers, for consumers, for RHAs and for the provincial government to work together to fix the system. That is what needs to be encouraged, not to start another one. Thank you.

Mr. Chairperson: Thank you for your presentation. Questions from the committee?

Mrs. Driedger: Have you looked at this bill from the point of view of midwifery? I want to give you an example of the definition of private hospital. A private hospital means a house in which one or more patients are received and lodged for care and treatment for childbirth. To me, that definition is very straightforward: A house where a woman is having a baby is now considered a private hospital.

Do you have any concern with that particular definition and all the ramifications from this act that could fall into it? If one were to look at some of the definitions of this act, including surgical facility, which is very broadly defined, surgical service, which has never been defined before and now, in my view, has a lot of twists and turns to it as far as a definition. You could almost assume that if a midwife was delivering a baby and was monitoring vital signs while she was delivering a baby and perhaps gave some mild sedation and maybe inserted a speculum, in fact, what you have is a surgical service going on during the delivery of this baby by a midwife, and there could be a fine of $30,000 then charged against the midwife. It is up to the midwife, then, to prove her own innocence.

I have some big concerns in terms of the interpretation of various definitions in here and how it actually affects midwives. While the minister may be sending out letters assuring everybody that no, no, midwifery is protected in this, what it could end up coming down to at some point is a court case and a judge then looking at these definitions and making the determination as to what that actually stands for.

Certainly, what this bill also seems to do is totally eliminate the possibility of a hospice or birthing centres. I wonder if you have any concerns about that. Now, I understand, maybe, that the Government is not interested in birthing centres, but do you have any concerns around any of this in the act in terms of what it does to midwifery?

Ms. Boscoe: Actually, we have had that conversation, and I think it is really important to differentiate in our minds between innovation in a public system and innovation in a for-profit system. Our concerns are ones, for example, where a birth centre in a private sector would raise the same spectre that we are dealing with right now, which is that user fees would discriminate against women unequally and create an eddy of injustice that will flow throughout the system.

We are passionate about the idea of a birthing centre and more options for women. We are celebrating midwifery even now, a year later. That being said, though, we are quite committed to working within a system for such things as a birth centre or a hospice, but those innovations can take place, just as the Women's Health Clinic does, within medicare. It is possible to be done.

In fact, maybe just to elaborate, we have spent a lot of work in the last decade on the issue of breast implants and access to information. This is a service that is primarily in the for-profit, outpatient clinic facilities in the province,

Mr. Chairman, and despite numerous discussions with ministers of Health and professional accreditation, et cetera, we were unable to get full disclosure of what was going on there or even push for a good client-informed consent, because these things were happening in the private sector without our regular accountability mechanisms.

I think that as women, we engage in the system with high standards and with high expectations and with the desire to use our public, transparent institutions, not to go far afield.

Mrs. Driedger: When I look at the definition of private hospital, it has really nothing to do with whether it is in the public or private system. Basically, the definition, as it stands by itself, is a house where a woman is lodged for the birth of a baby. It does not go into whether that is happening in the public system or in the private system. That is the straight definition of private hospital. So now if one were to look at that, this act does not necessarily always take you down the line as to whether it is within the public or private system.

If you read each clause, clause-by-clause, there are many tentacles to how various pieces of this act are going to impact on other pieces of legislation. The section on private hospital, if one were to look just at that, would mean that a midwife is delivering a baby in a private hospital when she is delivering a baby in a home. In fact, what this also does is it definitely eliminates, according to this bill, in my view, the development of birthing centres, period.

Ms. Boscoe: I must say I did not read it that way, and it certainly is not my interpretation, for example, of interfering with an individual woman choosing to birth at home, which is what I anticipate is behind that question. I do not read that at all into that clause.

* (20:30)

Mr. Chomiak: Before I deal with the inaccurate reflections by the Member for Charleswood (Mrs. Driedger), I just want to comment on your presentation, which I thought was very, very useful. I want to just reiterate a couple of your points: Our physicians are public resources; Do not fix a system by creating a parallel system; For-profit encourages the use of the system; Quality assurances require even greater scrutiny in a private system.

I think by virtue of being a nurse, by virtue of being a doctor, by virtue of speaking as practitioners in a community clinic, you have brought a perspective to this committee that has not been here. We have heard from consumers, we have heard from organized individuals, we have heard from organizations, all valid arguments, and I think you have added a perspective that is very useful. So I thank you for that.

Just, however, though, I have to clear up the inaccuracies I heard earlier. I know this is common. If one is to take any piece of legislation and read a line, one could conclude anything. That is quite dangerous because legislation is generally read together as a piece of a whole act. One could take any word or one could take any phrase of a legislation and say whatever they want.

With respect to the issue of birthings, where a woman is delivering in a home, she is not received and lodged for care and treatment for childbirth. The same could be argued with respect to a delivery that might be for the convenience of the woman giving birth in another person's house. In addition, birthing centres can be allowed under this legislation. The legislation was designed specifically around all of these concerns, and they were all addressed by legal counsel, people who are experts. I am not an expert at putting together the words of legislation. I took courses in it, but I am not an expert at it. There are experts we have in the Legislature who provide that expertise. So I want to assure you that all of those considerations have been taken into consideration when the drafting of this legislation was put forward.

I just want to close again by thanking you for bringing that perspective, your perspective, to this committee and for some of the issues that you brought forward that had not been brought forward before. Thank you.

Mr. Chairperson: Comment, Ms. Boscoe?

Ms. Boscoe: I would just like to add in closing that it might be useful for the committee to take a look at iatrogenic statistics. Doctor Scurfield alluded to the fact that our pell-mell enthusiasm for intervention–sometimes it is a bit of the collusion of the public, consumers, interesting medical shows and practitioners, that there is significant evidence that going in for treatment is a risk in itself. People make mistakes; there are side effects.

Going back to our earlier point around engaging the public in a bit more knowledge about these realities, being on a waiting list, you know the jokes about the death rate goes down when there is a strike by physicians, all those kinds of things, are realities. Though we are not experts, it might be useful for the committee to educate itself a little bit on that and it may take heart from some of the pressure in the lay media about waiting lists. Sometimes waiting lists are good things.

Mr. Chairperson: Time for the presentation has expired. Would you like to seek leave of the committee to pose an extra question, Mrs. Driedger?

Mrs. Driedger: Yes, I would.

Mr. Chairperson: Does the committee grant leave to Mrs. Driedger to ask an additional question? *[Agreed]*

A brief question, Mrs. Driedger.

Mrs. Driedger: I appreciate that from the committee. I just want to let you know I have spoken to a lawyer who has indicated to me that the language in this act is poor. I am glad the minister also just now made a comment about the value of a nursing perspective being brought to this. I am a nurse too. I read this act from a nursing background, a health care background, and that is where some of my concerns come about. If a lawyer tells me the language in this act is poor, it is open to interpretation and misinterpretation, I guess. I just really want to encourage you before we have a midwife out there sued for $30,000 that you are indeed comfortable with this act.

Ms. Scurfield: Well, just to assure you, the College of Midwives, which is the governing body for midwifery, has had their own lawyer look at it and had also met with the lawyer from the Government to seek an interpretation and is satisfied that it protects what midwives need to do in this province.

Mr. Chairperson: Thank you for your presentation, Doctor Scurfield.

Bill 50–The Regional Health Authorities Amendment (Accountability) Act (Continued)

Mr. Chairperson: For clarification, we are going to move to Bill 50 now. Two names from Bill 25 were dropped to the bottom of the list, but that is to the bottom of the list of all presenters tonight, so if any of them have come back in the interim, I apologize, but you will have to wait.

On that basis, I call Michael Doiron of the Interfaith Healthcare Association of Manitoba, who will be speaking in place of Suzanne Dunwoody.

Mr. Doiron, do you have a written copy of your brief for the committee?

Mr. Michael Doiron (Interfaith Healthcare Association of Manitoba): I do.

Mr. Chairperson: The Clerk will distribute it. Please begin your presentation when you are ready, sir.

Mr. Doiron: Mr. Chairman, honourable minister, honourable members of the committee, thank you for the opportunity to address you.

I represent the Interfaith Healthcare Association of Manitoba, an organization which has nine denominational sponsor groups and in the neighbourhood of 35 facilities in the province.

We have an interest in this bill. Faith-based health care, as my colleagues from the Oblates have addressed you earlier on a previous bill so well and so eloquently, was indeed the first health care available in the west, and throughout many uninterrupted years of faithful service, we have provided to the citizens of Manitoba a great deal of service and care.

This Government and many other previous governments have consistently recognized in

many forms, including faith-based agreements, the outstanding contributions made to health care by various denominational sponsor groups.

The Interfaith Healthcare Association of Manitoba is committed to the goals of regionalization in several ways, Mr. Chairman: by promoting and emphasizing effective leadership and accountabilities; building co-ordinated networks; establishing standards, benchmarks; promoting common managerial approaches, shared services and programs; maintaining effective accountability with government and the RHAs; working towards a responsibility matrix with clearly defined roles and responsibilities; determining mechanisms for system-wide consultation and co-ordination of the health system; and partnering with other health providers in meeting the needs of the population it serves.

Having said that, we are aware that in several other parts of the country, regionalization has meant centralization and the eradication of all boards other than the boards of the regional health authorities. We believe that such a view is erroneous and is ultimately quite destructive to the cause of health care. We believe that the most effective form of regionalization includes not a single ownership, but multiple service providers with various perspectives which strengthen and enhance the culture and the quality of care available to the citizens whom it serves.

It is our belief that in five or seven or eight years, when regionalization ceases to be the flavour of the day, the rest of the country may well look at Manitoba and see that we got it right from the start. There is considerable evidence to support this, both nationally and internationally.

We therefore would like to voice our strong agreement with the aspects of this legislation which acknowledge and support the principles of faith-based health care as a value-added, and we applaud any view that recognizes our contribution as worthy of preserving.

We also support the approach of this legislation which chooses to build upon the carefully laid foundation of agreements that have been erected in this province, including the recently signed operating agreement with the Winnipeg Regional Health Authority and the hospitals in this area, also the various service purchase agreements which lay out the principles of mutual respect, responsibilities, collaboration and accountability so as to preserve a spirit of collaboration and co-operation, as together we seek ways to provide the best health care possible for the citizens of Manitoba.

It would be our view that it would be foolhardy and reckless for a government to proceed otherwise.

* (20:40)

While we are committed to the view that the best of life is most often expressed in a community, we recognize and we respect the Government's need to provide for further authority to be extended to the regional health authorities. We believe that this legislation is an attempt to responsibly limit and contextualize such authority in a manner which is as respectful to the structures of health care in Manitoba as is possible in this present climate. Thus, recognizing a certain need for the extension of authority to the RHAs, we therefore applaud the attempt of the presently proposed legislation to be consistent with and to be dovetailed with the existing agreements, especially the operating agreement I just referred to. The members of the Interfaith Healthcare Association of Manitoba entered into and signed the various agreements with the Government of Manitoba in good faith, and we carry out all of those agreements faithfully and respectfully.

We therefore accept and support the proposed legislation in its present form, and we express our view that we will find it to be as balanced and respectful a piece of legislation as possible.

We would, therefore, consider it to be a great loss if it were to fail, and we would therefore like to thank the Department of Health for proposing it. Thank you.

Mr. Chairperson: Thank you for your presentation, sir. Do members of the committee have questions?

Mrs. Myrna Driedger (Charleswood): Just to indicate to you that I have had several

consultations with the faith-based community, and having worked as a nurse, well, at St. Boniface Hospital for a number of years, I have come to respect very much what the value of faith-based health care means to people in those facilities.

So, just to reassure you, we will be in support of this bill. We feel that it is moving in terms of closing the loophole of accountability. While it does not quite get there yet, it certainly is an attempt at this time to move in that direction. As it has been told to me by people in the faith-based organizations, everything has been an evolution. It has been moving forward in that way, and just to reassure you that support for this bill will be forthcoming from us.

Mr. Chairperson: Mr. Doiron, comment?

Mr. Doiron: Thank you.

Hon. Dave Chomiak (Minister of Health): Mr. Chairperson, it is often the case in the Legislature that people actually realize there is more often than not unanimity in what we do. I just want to thank you personally and the interfaith health organization for your assistance in this regard, and your kind words, as well as your assistance during the period of time of the drafting of the bill, where we had many discussions and where I learned, as I indicated to you, many things. I think I am a better educated and a more competent person as a result of that experience. I thank you for that.

I just want to also close by saying publicly at committee what I often have said at many meetings, that we could not duplicate the efforts that are provided by the faith-based institutions throughout our system. We simply could not. We require your assistance and we appreciate it. Thank you.

Mr. Chairperson: Comment, Mr. Doiron?

Mr. Doiron: Just a profound thanks to Mr. Chomiak and just to say that I agree wholeheartedly with everything that you have said.

Mr. Chairperson: Any further questions? Thank you for your presentation, sir.

Mr. Doiron: Thank you.

Mr. Chairperson: I now call on Raymond Lafond, Catholic Health Association of Manitoba. Mr. Lafond, do you have a written copy of your brief?

Mr. Raymond Lafond (Catholic Health Association of Manitoba): No, I do not.

Mr. Chairperson: Proceed when ready, sir.

Mr. Lafond: I will be brief. Honourable minister, honourable members of the committee, the Catholic Health Association of Manitoba represents four sponsors: the Catholic Health Corporation of Manitoba, the Archdiocese of Winnipeg, Sister Servants of Mary Immaculate and the Benedictine Sisters, as well as their institutions and many personal memberships. Within all the institutions, you will see the full continuum of health care, primary care, mental health, residential care, long-term care, acute care.

I should tell you that the Catholic Health Association of Manitoba is one of the nine faith members of the Interfaith Healthcare Association from whom you have just heard, and that we do support the position that was just voiced. Very briefly, the Catholic Health Association of Manitoba is committed to the goals of Manitoba Health and its regional health authorities, namely, maintaining effective accountability with government and RHAs, building coordinated networks, partnering with other health providers in meeting the health care needs of the population it serves.

This legislation, in our opinion, acknowledges and supports the principles of faith-based health care as a value-added, and applauds any view that recognizes our contributions as worthy of preserving for all Manitobans. Our concerns were heard and considered in this proposed legislation. We, therefore, accept and support the proposed legislation in its present form, and we express our view that we find it to be as balanced and respectful a piece of legislation as is possible at this time. Thank you.

Mr. Chairperson: Thank you for your presentation, sir. Any questions from the committee?

Mr. Chomiak: I would just like to repeat, as well, a thank you for your assistance and for the Catholic Health Association. Similar to the comments I indicated earlier to Mr. Doiron, I am very appreciative of your understanding through the process and assistance to us as we worked through the process. Thank you very much.

Mr. Chairperson: Comment, Mr. Lafond?

Mr. Lafond: Thank you. It was a pleasure to work with you, honourable minister, and with the people in your department.

Mr. Chairperson: Any further questions? Seeing none, sir, I thank you for your presentation.

I now call on Andrew Ogaranko of Pitblado Buchwald Asper. Mr. Ogaranko is not here. His name will be dropped to the bottom of the list. I now call on Réal Cloutier of the Winnipeg Regional Health Authority. Mr. Cloutier, do you have a written copy of your presentation?

Mr. Réal Cloutier (Winnipeg Regional Health Authority): Yes, I do, Sir. It is right at the front here.

Mr. Chairperson: Okay. Proceed when ready, sir.

Mr. Cloutier: Mr. Chair, members of the Manitoba Legislature, my name is Réal Cloutier. I am the vice-president with the Winnipeg Regional Health Authority. I thank you for the opportunity to make a few comments regarding the amendments included in Bill 50.

The Winnipeg Regional Health Authority, as you know, is comprised of many health care providers and management professionals who co-ordinate, manage, deliver, allocate funds to and evaluate health promotion and health services in Winnipeg. There are over 27 000 staff dedicated to the delivery of services in Winnipeg with a hundred different organizations, many of which are independent health corporations that operate within the region.

As defined in The RHA Act, our mission is to deliver and administer health services in the Winnipeg Region and to promote and protect the health of citizens. In some cases, services are administered directly by the RHA. In other cases, we have contractual arrangements that govern the way those services are provided. Program management has created teams of specialists who are responsible for program delivery across relevant sites within the region, examples: the surgery program, medicine, and so on.

Regional programs are responsible for overall co-ordination, standards of quality, program development, et cetera. We acknowledge that the sites which deliver care, many of them who are the faith-based organizations, are responsible for managing site resources and issues and collaborating with regional programs.

The region does use a population health perspective to allocate resources based on the needs of specific population groups. This includes a full range of services which most of you are aware of. At times, we do have to make allocation and reallocation decisions, which means we have to take from some and move to others. Certainly, that has a potential for creating discussion and debate.

The health authority respects that individual organizations, which are not devolved into our structure, are accountable to their own individual boards and directors, and there is an appreciation that there is a dual accountability to their board and also to the health region.

* (20:50)

We also recognize the obligation to discuss and negotiate change. The reality is that agreements built on consensus and discussion always have the greatest chance of success. However, when consensus is not possible, the authority does need the ability to make decisions. Certainly, I think the amendments in this bill allow us to do that.

The minister has stated in a press release on the bill that this legislation will assist regional health authorities in providing better patient care on a co-ordinated, system-wide basis to meet the needs of people in the region. We believe the bill is an important step in the direction, given the particular challenges that we face as a regional health authority.

I think one of the presenters this evening spoke to the fact that we have done things a little differently in Winnipeg from other health regions across the country. Yet, in some cases and in many cases, we have achieved at least the same or better success in some of our initiatives. I have included examples within the presentation of some of the program changes that have occurred that have achieved success. In any of the examples that I highlight, whether it is critical care or the relationship with the Winnipeg Fire Paramedic Service in terms of co-ordinating emergency care, some of the changes, when they were first thought and initiated, engaged a lot of people in a lot of debate. Not everybody agreed, but we moved on them and we made the necessary changes to be able to make the system function in a better way. Again, I have highlighted some of the examples.

Of course, one of the things we feel quite proud of is in terms of not only the patient care initiatives that we have undertaken to try to improve the quality of care within the region, but also to inject not only responsibility for quality but also fiscal accountability within the system. While more needs to be done, these are a few of the examples of what has already been accomplished. We note that none of the examples I have talked about infringe on the mission vision of values of sites described within the faith-based agreements, and we do believe the amendments within the act respect those issues.

So, ultimately, the RHA believes that accountability is the key. The Winnipeg Regional Health Authority, in our first report to the community delivered to every household in Winnipeg, said: While we report through our board of directors directly to the Minister of Health, we are equally accountable to the public.

The Government's ability to hold a health region accountable for the fair and equitable delivery of services is only as strong as the health region's ability, in turn, to hold health service delivery sites accountable.

By introducing this legislation, the minister and the Government have strengthened and clarified the lines of accountability and improved the province's regionalized health structure. The Winnipeg Regional Health Authority provides its full support behind these amendments. Thank you.

Mr. Chairperson: Thank you for your presentation, sir. Questions from the committee?

Mrs. Driedger: Thank you, Mr. Cloutier. Can you tell me how this bill, perhaps, might speed up decision-making processes? I am certainly hearing from a lot of front-line workers, more so in the city than in rural Manitoba, who are extremely frustrated with the length of time to get action on significant issues, to the point it feels that sometimes it does affect patient care. Is this bill going to address that in any way?

Mr. Cloutier: I think the bill does two things. It provides a framework for us, a fairly clear framework in which, if we reach an impasse, we can move in addressing that impasse, but I think more importantly, it provides a framework for people to realize there is going to be a certain amount of debate and discussion that occurs. I fully agree that the ability for the system to change to respond to public demands for change means that we have to be able to adopt change more rapidly within the system.

Mrs. Driedger: I have recently spent some time doing a health tour in the province. One of the things I heard over and over again, and this was whether I was in the city or in parts of rural Manitoba, was people commenting to me, generally people within the health care system, but some outside of the health care system, that communication is poor. People do not know what is going on in health care and they want information. Is this bill in any way going to address that issue in terms of keeping people informed about changes or about progress in terms of addressing issues in health care?

Mr. Cloutier: I guess a point of clarification is: When you say people, you are referring, I assume, to both staff and the general public? Okay. I think the bill, quite frankly, the RHA and the facilities that operate within the regional health authority have an onus to communicate and communicate very effectively to the public and staff. I think what this does is that this provides a framework for us to allow decision making to occur in a much more open and communicative way and to allow us to set some

end points on things. The onus in terms of the process of communicating information, though, is really dependent on the manner in which we choose to do that. Obviously, one of the things that we have identified as a priority, as part of our strategic plan, is to be very transparent and open with the public, engage in that debate. We have very many examples in which we have tried to do that effectively.

The bill itself does not really deal with that issue of communication, however. Certainly, it is one of the puzzles, I guess, that enables us to make decisions and to communicate those decisions.

Mr. Chomiak: Again, thank you for your presentation. I have been generally impressed with the work done by the Winnipeg Regional Health Authority. All members of the committee I just draw your attention to–I do not know if you mentioned it, Mr. Cloutier, in your presentation, some of the highlights of the WRHA balanced budget.

For the first time in recent memory, the health system in Winnipeg is balancing its budget. To cite since the beginning of the fiscal year: allowing for greater accountability, reducing the number of long-term care patients waiting for personal care home beds from a high of 290 in '98 to 20 people, incorporating the former Victorian Order of Nurses, the emergency departments are better co-ordinating critical care. We now use fewer ICU beds per capita than any other region and no longer postpone surgery because of the need for post-surgical ICU care. Legal insurance services have been consolidated, allowing us to redirect over a million a year to patient care.

I suppose all of us have a role to play in terms of educating the public. It is not just, I think, a role of the health authority, but all of us who are involved in the health care system ought to have a dialogue and discussion and constantly seek to educate and work both ways. So I thank you for your presentation. I note in your presentation you did also communicate some of the positive aspects that have occurred.

Mr. Chairperson: Comment, Mr. Cloutier?

Mr. Cloutier: No comment.

Mrs. Driedger: Mr. Cloutier, I understand that an RFP went out to look at evaluating the WRHA, and I wonder if you had had any response to that yet and what stage of the process you might be at with that. In looking at that, are you going to be addressing the effects of big bureaucracies on delivery of care? Certainly in the research that I am beginning to do in terms of bureaucracies, I know that we have brought together two health authorities here in the city, and it has enlarged the bureaucracy.

If in fact we look at the literature and what that is actually doing to outcomes, we find that it does create its own set of challenges and in many cases quite severe challenges in the delivery of good patient care. Is the size of bureaucracies going to be dealt with in that evaluation of the WRHA? I guess I am asking too because that is one of the things, if I am hearing anything out there from front line workers, is the complaint that middle management is just growing exponentially. We may have gotten rid of vice-presidents, but the word out there is certainly that there is a huge layer of middle management that has now crept in. I wondered if your evaluation is going to address this issue.

Mr. Cloutier: The RFP closing date has not occurred yet, so we do not have all the responses in yet. The intent of the review is to look at our average cost per waited case within Winnipeg hospitals, the tertiary group being the community hospital grouping and the high-bred facilities which we refer to as Deer Lodge, Misericordia and Riverview. The intent is to look at indirect and direct cost. So certainly the overall intent of this review is to look at issues of funding equity, it is to look at benchmark practice with the intent of looking at how we could better manage within the resources that we have with the overall goal of reinvesting that into patient care.

* (21:00)

Mr. Chomiak: The member cited the fact that we were able to achieve despite protestations to the contrary, fairly effectively, I thought, the WRHA was able to achieve the melding of two separate, in one city, regional health authorities into one organization and a very effective

organization in a relatively short period of time. I was very impressed with the methodology and the fact that we were able to deal with some of the bureaucratic structure that had been left in place with two organizations that were existing in one city and that we have been able to achieve some efficiencies and, I think, a very effective communication between both the community side and the acute care side.

I just realize, as I am making these comments, that I might put you in an awkward position because you are employed by the Winnipeg Regional Health Authority, but I just wanted to put that point in since it was mentioned by the Member for Charleswood (Mrs. Driedger). Thank you.

Mr. Chairperson: Comment, Mr. Cloutier.

Mr. Cloutier: Well, I think the only comment is it is always a challenge to find what the right structure is, the right management structure. I think, clearly, the thing that we have been focussed on is to make sure that people are accountable, that we know who we need to go to for any program within the system, because ultimately defining who is in charge and who is responsible addresses some of the quality and service issues that we as a region have been addressing for the past four years and will continue to address. The structures will continue to evolve and change.

Mr. Chairperson: Any further questions? Seeing none, I thank you for your presentation, sir.

Mr. Cloutier: Thank you.

Mr. Chairperson: We will now go to names that have been dropped from the list earlier.

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act (Continued)

Mr. Chairperson: Returning to Bill 25, is Michelle Forrest, private citizen, present? Seeing that she is not, her name will now be dropped from the list. I now call upon Paul Moist, President of the Canadian Union of Public Employees. Mr. Moist, do you have a written copy of your presentation? Thank you. Please proceed when you are ready to do so.

Mr. Paul Moist (Canadian Union of Public Employees): Mr. Chairman, with me is Lorraine Sigurdson, our health care co-ordinator for the province of Manitoba, and I seek leave for her to assist me with our brief remarks.

Mr. Chairperson: Do we have leave from the committee? *[Agreed]*

Mr. Moist: Mr. Chairman and members of the committee, it is a privilege for us to appear here today before you on behalf of our 10 000 health care workers we represent in Manitoba, amongst the 150 000 health care workers out of our membership of a half a million across the country. We have a presence in the health care sector in all 10 provinces of this country, and it gives us, we believe, a legitimate voice in any debate on the future of our Canadian health care system. We talk a bit in our presentation about federal issues, international trade agreements and their impact on the debate last year in Alberta over Bill 11.

Our leadership role in the campaign to fight off privatization of health care in Canada leads us to applaud the current government for its recent measure to curb the proliferation of private medical clinics through this legislation. Contrary to what some have said, Bill 25 is not a radical piece of legislation, in our view. What it does is that it clarifies the terms and conditions under which private surgical facilities can operate in this province and closes a loophole left open by legislation passed by the previous government. That government laid out the essential features of the act. The current Government has tightened loopholes so that the act more effectively does what it purported to do all along.

Yet these modest amendments, which bring Manitoba's Health Services Insurance Act into closer compliance with the spirit of the Canada Health Act, have been repeatedly portrayed as ideologically driven by the Official Opposition and by some media. In fact, a closer examination suggests that these critics are the ones wearing ideological blinders, and the current government is acting in the interest of millions of Canadians and hundreds of thousands of Manitobans who indicate in poll after poll that they support efforts to maintain Canada's medicare system.

Doctor Godley, the owner of the newly opened private Maples Surgical Clinic, was quoted on June 25 in the *National Post* as saying: The Manitoba government is on an ideological drive to prevent private for-profit centres from opening up. Yet in a news article posted on the Web page of Doctor Godley's Vancouver clinic, the False Creek Surgical Centre, it boasts about how Godley thinks he has found a loophole that allows him to by-pass the Canada Health Act. On the top of our next page is the quote we are referring to, where he calls it: I know it is just a grey zone. Whether it is legal or not depends on how it is seen, and the full citation and the full page from the Web is appended to this presentation.

So here we have a doctor moving to Canada by choice, publicly boasting about how he is operating on the margins of Canadian law while undermining a medical system that the vast majority of Canadians support. The press and some critics want to portray our Health minister as the villain in this piece. Rather, it appears that Doctor Godley and his supporters appear hell-bent to undermine the public health care system, if not in the name of ideology, then for the sake of profits.

The Minister of Health in this Government, in strengthening The Health Services Insurance Act, are attempting to preserve a core value widely held amongst Canadians, accessible universal medicare.

Doctor Godley came here, opened his private clinic and has been demanding that he get public funding ever since. Is this how Manitobans want health care policy to be established in this province? His latest demand is that the Government buy the clinic for $2.5 million. Is it in the public interest for our Government to compensate businesspeople who come here to challenge laws which have been forged by public consensus? Or is not the public better served by a government that challenges a tax on public policy by tightening loopholes, such as Bill 25 does? In its handling of the Pan Am Clinic this Government has demonstrated a reasoned and comprehensive approach to health care policy. Here is a surgical centre with a proven track record of quality and patient satisfaction. The Government negotiated with the owners of the clinic and purchased it, which included compensation to the doctors who had originally invested in the clinic. As a result of this purchase, the Health Ministry can smoothly integrate the Pan Am Clinic into the overall Winnipeg Regional Health Authority.

Unable to find a flaw in this Government's strategy to improve health care for Manitobans, the Official Opposition has resorted to allegations of conflict of interest with respect to the Pan Am Clinic. Now the same Opposition is demanding the Government buy out The Maples Surgical Centre at the owner's asking price. What kind of health care policy is the Opposition advocating? One in which entrepreneurs get rewarded for setting up facilities that do not comply with the spirit of the law. Minister Chomiak's decision to introduce Bill 25 was clearly made in the interests of all Manitobans, and we in CUPE support it.

Ms. Lorraine Sigurdson (Canadian Union of Public Employees): As we said earlier, Bill 25 is far from being a radical piece of socialist legislation as detractors claim. The bill clarifies that only private clinics that have a contract with the Minister of Health (Mr. Chomiak) are entitled to receive public funding. Furthermore, any such contract has to be in compliance with the Canada Health Act. Bill 25 tightens up the loophole Godley tried to exploit in British Columbia by denying third party payments or payments made on behalf of a treated person. Bill 25 also prevents clinics from performing surgeries that require overnight stays. It is this element of the bill that has caused much histrionics from the Opposition. Incredibly, in one news release the Opposition accuses the Government of "putting patient safety at risk," and of "fearmongering." If the claim that Bill 25 puts patient safety at risk is not fearmongering, we do not know what is. The Opposition claims that surgical complications might arise at a private clinic when an overnight stay is required. Mr. Chomiak's answer, one that we endorse, is that patients needing complicated surgery belong in a hospital in the first place, not a private clinic.

In summary, contrary to what some of the press would have people believe, CUPE members, as well as union leaders such as us, are aware that the public health care system in

Canada is in crisis. Provincial governments' spending on health care has been increasing faster than the rate of inflation for years. Yet federal funding provided through the Canada Health and Social Transfer has been shrinking since the early '90s, leading provincial governments across the country to look at different ways to manage the funding shortfall. Some provinces, most notably Ontario and Alberta, are either embracing or contemplating increased private-sector involvement. It comes as no surprise that we stand with the Government of Manitoba in opposition to increased private-sector involvement in the health care system. Manitoba's experience with the former Urban Shared Services Corporation, which went grotesquely over budget in order to serve unappetizing food is only the most high-profile example of private-sector failure.

* (21:10)

Earlier, you heard from Carolyn DeCoster from the Manitoba Centre for Health Policy and Evaluation. This centre has conducted studies which show that introducing private clinics into the system is a poor way to achieve savings, as she eloquently described. A senior researcher quoted in the *National Post* said, that if you allow private clinics into the system, you cannot control costs. Tthe costs skyrocket. It is not hard to understand why. Private businesses need to earn profits. Private clinics grow and become profitable by siphoning off the most lucrative surgical procedures from the public system.

As more and more lucrative procedures become privatized, the public system gets squeezed having to deal with the least economical ones. The proliferation of private clinics will cause significant resources, cash and staff to flow out of the public system. As this occurs, it is our members on the front lines who feel the impact through increased workloads and paycheques and benefits that diminish in value as time goes on. We agree with the Minister of Health (Mr. Chomiak) that the biggest problem affecting this province's health care system is inadequate funding, not a lack of surgical facilities.

Private clinics are not the magic answer to the problems we face. Increased funding needed to recruit and retain qualified staff would go a long ways toward alleviating the pressures facing the system. However, the federal government continues to run billion-dollar surplus after surplus, and cut taxes a hundred billion last fall. Meanwhile, provincial governments are forced to cut back vital public services in order to balance their budgets or download responsibility for providing services to municipalities.

Our union has been working with partners in the Canadian Health Coalition to push for manageable, achievable reforms to Canada's medicare system without compromising the principles of the Canada Health Act. We believe that meaningful reforms can be made and savings realized by much more closely integrating the primary acute system with other components of the health care system, such as long-term care and home care, in a community-based model that would see physicians working under salary rather than being the gatekeepers to the systems that doctors currently are.

We realize that unless significant reforms are made to the health care system, pressures to privatize will continue. We certainly feel that such pressures are usually ideologically based. Proponents of privatization simply believe that the private sector can do it better. In the case of health care it is a baseless claim. Study after study proves that introducing a privatized two-tiered health system is not the solution to the pressure the system faces.

In your appendices we have included a myth-buster from the Canadian Health Services Research Foundation. We would ask you to take a look at it.

Let us not then let ideology be the guide to health care reforms in this province. Let reason and common sense be the guiding values. We believe Bill 25 does that.

Mr. Chairperson: Thank you for your presentation. Are there questions from members of the committee?

Mrs. Driedger: I just have a few. I wonder, Mr. Moist, if you could tell me where you heard that the Opposition was demanding that the Government buy out The Maples Surgical Centre?

Mr. Moist: Through the Chair, we have heard that through the media, and we have witnessed the questioning in Hansard. That seems to be where the Opposition is coming from.

Mrs. Driedger: Just for clarification, then, Mr. Moist, we have brought forward information that we had made available to us that indicated that as long as the physician for The Maples Surgical Centre was having difficulty opening due to all the roadblocks that were being set up, he felt that this was the only way that he could address his financial investment in Manitoba, which he has not found to be a friendly place to do business. That was his request to Government, that if you are not going to allow me to work here, then buy me out. We were the messengers of that particular message. I just want you to be aware of that.

Mr. Moist: Could I reply to that, Mr. Chairman?

Mrs. Driedger: The other thing I would like to just ask you, are you aware of the Fyke report in Saskatchewan, which is called *Caring for Medicare: Sustaining a Quality System*? This is a former deputy minister in the NDP government. I would just like to read you a couple of comments that he made from this report: The culture of health care has to change, Fyke writes in his report, which warns that blindly pumping more money into medicare will merely perpetuate the system's inefficiency. This message will be unwelcome to those who believe that what we need is the status quo, only more of it, more money, more beds, more doctors, more nurses. The claim that health care must have more money to do more good assumes that all of the money is being well spent. This is lamentable. Public funds are being wasted, often in large quantities, at the same time as some people are truly suffering for want of access to timely, quality services.

I wonder if you would like to make a comment on the Fyke report.

Ms. Sigurdson: We are aware of the Fyke report. We do not disagree with any of what was just said. We said, I think, in our presentation that what needs to happen is there has to be health care reform and that there need to be changes in the way the public money is spent and that the system has to be looked at in a different way. We have suggested some of that in our presentation.

We are not here saying that money is the only answer, that throwing more money at the system is the only answer. We need to look at the health care system in different ways and see how health care can be provided in a different community-based way, as we said. We also need to look at the funding for such things as physicians.

Mr. Moist: Well, just on the Fyke report, our union in Saskatchewan has commented on the Fyke report. Here locally we met recently with Finance Minister Paul Martin to echo comments made by Mr. Selinger in his Budget of a couple of months ago that equalization cuts to provinces like Manitoba, Atlantic Canada and Saskatchewan for most of its history, those structural issues are crippling provinces like Manitoba and others' ability to deliver, amongst other things, health care. So, yes, there is fiscal requirements to the system, but there is also structural change required.

Our members tell us here in Manitoba there are 75 vacant beds in private nursing homes, yet the whole community talks about the need for planning for more nursing home spaces. It is not surprising to us representing workers in some private nursing homes that there are those vacancies there. Many of the vacant rooms have four patients to a room. There is nobody in them. So our system needs money, but it needs much more than that, and I would not disagree with a word in your excerpt from the Fyke report.

Mrs. Driedger: I am curious. Towards the end of your summary, you do indicate that significant reforms are needed. Do you have any suggestions other than what you might have just sort of hinted at in terms of things that could be looked at in strengthening health care and sustaining a health care system? Certainly, in Ontario, for instance, they have said that, if their funding continues at the same rate as it is now, by the year 2006, 60 percent of their provincial budget is going to go to health care.

With Manitoba spending, in the last two years, 22 percent more towards health care,

almost half a billion going into health care in Manitoba in the last two years alone and our budget here is almost 40 percent, can you help us by giving us some suggestions as to what kind of significant reforms you might recommend so that we do not see a crumbling medicare system here in Manitoba just because we have not faced some of the funding issues related to it?

Ms. Sigurdson: I am sure we have enough time this evening for all of the suggestions that we have, but there needs to be an expansion of home care services, and there needs to be quicker access to home care services. There needs to be an examination of what role physicians play in the length of stay in hospitals because often patients could be discharged earlier if physicians would be around to make those discharge decisions. There needs to be an examination of the cost of pharmaceuticals, which are probably the largest single increasing cost factor in the health care system, and there needs to be a whole examination.

The frustration about middle managers that you talked about earlier is a frustration that health care workers always have, always see that as being a problem. There are a number of things that are being studied in this province. We are participating in looking at efficiencies with employers, so it is a big question.

* (21:20)

There are a lot of things that we think could be changed within the system. Our members, as well as other health care professionals, have all kinds of ideas of how that needs to be done. Our solution, as I said earlier, is not just to throw money at it. We need to look at the restructuring of the system.

Mr. Chomiak: Mr. Chairperson, I thank you for your presentation and putting into words some of the argument. There is some information that was new to me with respect to some of the information, and I appreciate it.

This myth-busters thing, I think, is useful, too, because, as I said over and over and over again during presentations, the privatizers on that side do not have any data to back up their claim. They say they put Sweden up there, but we know Sweden has changed. They put France up the old flagpole. Then we find out that in France you pay user fees, like 20 percent of the costs, and in France, you pay more of GDP towards health care. They put it up the flag, but they have no studies. So I appreciate your reference to that because we have got to deal with some of the myths that have been put out there, and we have got to deal with some of the facts. So I appreciate it.

I also appreciate the fact that you would offer some suggestions with respect to improving the system. I think that some of the initiatives taken this year with the expansion of the community clinics, the more resources for the first time going to personal care homes in Winnipeg and community centres at 8 percent and 11 percent respectively reflect some of the change in direction, the fact that 50 percent of the programs on the hallway medicine initiative went to community-based care.

I do this at the sake of prolonging debate, but I do find it ironic, maybe you might want to comment, how a party that closed 1400 in acute care beds during the last 10 years is worried about 3 overnight beds in a private hospital. It just strikes me as interesting and a curious irony. I wonder if you might comment on that.

Mr. Moist: Well, through the Chair, I guess, as the phrase was used earlier, we are all messengers, and I guess my message on behalf of our membership to this committee would be that that is not a solution to health care, the random and radical closure of beds to deal with short-term fiscal crisis.

We, as Manitobans, to get back to the last question asked of my colleague, are all going to have an opportunity next year to speak with Mr. Romanow. I would hope everyone in this room is interested in doing that.

Mr. Romanow often talks about coming from the birthplace of medicare as we know it in Saskatchewan. If there was one decision, if history will allow us to revisit it, the creation of the fee-for-service system has created a system that probably is driving costs more than anything, yet a physician in front of you a couple of delegations ago, speaking about the need for

salaried doctors, and it is my own view after a couple of decades of doing what I do currently for a living, of suggesting to you that the strongest union in Manitoba does not belong to the Manitoba Federation of Labour. It belongs to the Manitoba Medical Association. Our federal government and all provincial governments and all unions and all interested stakeholders I think are going to participate in that debate in the next 18 months with Mr. Romanow. If this opportunity is lost in his commission, not to deal with critical issues, such as federal transfers, equalization, the realities of this country and things like fee for service, it will be an opportunity lost, but what are the solutions? Bill 25 is part of the puzzle and there is much more that we will dialogue with all of you on in the weeks and the years ahead.

Mr. Chairperson: Time for the presentation has expired. Thank you very much.

I now return to Bill 50. The last person on the list who was dropped to the bottom of the list earlier is Mr. Andrew Ogaranko. Is he present? Seeing that he is not, that concludes the list of presenters I have before me.

Are there any other persons in attendance who wish to make a presentation? Hearing none, is it the will of the committee to proceed with clause by clause consideration of these bills? *[Agreed]*

Mrs. Driedger: I would like to ask the committee's indulgence that with Bill 25, rather than starting out clause by clause, if we can start out with some general questions as it pertains to the bill?

Mr. Chairperson: Is it the will of the committee that we will deal with Bill 50 first, and then–

Some Honourable Members: Bill 28.

Mr. Chairperson: Sorry, 28 and then 50 and then 25? *[Agreed]*

Bill 28–The Labour-Sponsored Investment Funds (Various Acts Amended) Act

Mr. Chairperson: Does the minister responsible for Bill 28 have an opening statement?

Hon. MaryAnn Mihychuk (Minister of Industry, Trade and Mines): I do. I will keep my comments very brief, Mr. Chairman. This is a bill that reviews the labour-sponsored funds and has been underway for over a year between the Government and both funds, Crocus and ENSIS. This bill continues to harmonize the two acts that govern labour-sponsored funds, and as we promised last fall we would continue to work towards this process. Bill 28 moves us along in that commitment.

The bill also strengthens the fund's accountability to the public by increasing reporting requirements and introduces strict new penalties if the funds fail to meet their pacing requirements. This is particularly relevant to the Crocus Fund which did not have this type of accountability measures and is new to that, but in addition the penalties apply to both.

Finally, this bill empowers fund managers to make decisions that are in the best interests of their funds and investors and reduces the influence or the need for politicians to be involved in the management of these funds. Generally, I think it is wiser to have financial professionals making decisions than ministers responsible for these funds. I think that is good public policy.

In addition, we will be entering three amendments, one in clause 2, which is an error in the French version, so it is an administrative one; clause 14, which is a correction in drafting because this item is already in The Income Tax Act; and finally in clause 36, which deals with when the clauses come into effect and deals with the Crocus act, in particular, and basically is an amendment which ensures that their investment in the True North Project operates under the rules of the old act. So those three amendments will be presented. That concludes my general comments on the bill.

Mr. Chairperson: We thank the minister. Does the critic from the Official Opposition have an opening statement?

* (21:30)

Mr. Mervin Tweed (Turtle Mountain): Mr. Chair, just a few comments. I find it interesting in the minister's opening comments, she talks about the change of direction where the minister

is relinquishing some of her ability and her authority over this fund, and she makes the comment that she thought that was good public policy. She may be right, and she may believe that. Unfortunately, the labour-sponsored investment funds were set up to create venture capital, to create risk capital.

What we see with this type of bill and the changes that are coming forward in it is the very realization that the Government is going to use the labour-sponsored funds to develop and create a public policy with it and invest those funds in those types of areas. I think our issue right from the get-go was the fact that this bill was brought in at the same time, or actually after the fact that the True North Project was announced.

A lot of the public, and I guess ourselves included, see it as an act that is being changed to accommodate certain things that I believe this Government got itself into or down a path on and decided that they could not do it. The changes, rather than being seen as breaking the law, or, if that is too strong a term, falling outside the guidelines and the rules that were there, they choose to change them. It is something that we see on a constant basis.

I think that the other issue that we have seen, and I think it is something that we will continue to question and to challenge, is whether the prospectus that was issued in the spring was really a fair and honest prospectus to the public of Manitoba when they were seeking investment in the Crocus Fund. Obviously, if the issue has been ongoing as long as the minister suggests it has, the public should have been made aware that these changes were coming. Then they would have been able to make a fair and honest assessment of the prospectus that was issued this spring and make their choices as to whether they should invest in the Crocus Fund or not.

By moving the fund or the ability of the fund to invest in things such as arenas, and we are hearing now that it is possible that the fund will be used to develop public housing, I guess all we question is was that the intent of the fund when it was originally set up, and is that what people bought shares in this fund to do? I suggest down the road that people are going to continue to ask these questions, and, as the True North Project unfolds, as it will, and information either is brought to the public voluntarily or leaked to the public and discovered, we are going to find that some of these things that we have asked about and we have questioned are going to come to the forefront and show that perhaps there were some concerns by the public at this time and they should have been addressed prior to it.

Again, we see it as a bill that was brought in late. It was a bill that was brought in strictly to satisfy the True North Project. When you do that and withhold information on other areas of the project, people obviously begin to question and challenge and doubt the sincerity of the Government in what they are telling them and what they are saying to the public as far as public investment and how much is being contributed to the project, and how much is being backstopped by the provincial government. The numbers become questionable, and, again, it creates doubt in people's minds.

I do not think I have anything else to say right now, Mr. Chairman. I guess we can proceed on a clause-by-clause basis.

Mr. Chairperson: Thank you, Mr. Tweed. If there is agreement from the committee, during the consideration of these bills, the Chair will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose. Is that agreed? *[Agreed]*

During the consideration of a bill, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Clause 1–pass. Clause 2(1).

Ms. Mihychuk: I present an amendment to clause 2(1), and I move

THAT the part of the proposed definition "placement peu important admissible" before clause (a), as set out in the French version of clause 2(1)(a) of the Bill, be amended by striking out "0000" and substituting "000".

Mr. Chairperson: It has been moved by the honourable minister

THAT the part–

An Honourable Member: Dispense.

Mr. Chairperson: Dispense. The motion is in order. Honourable minister, comment?

Ms. Mihychuk: No, thanks.

Mr. Tweed: More for just procedure, I believe we have already passed Part I, have we not? Did we not have agreement on that?

Mr. Chairperson: No, sir. We passed clause 1, and I called clause 2(1), and that is when the amendment was proposed.

Mr. Tweed: Clause 2(1).

Mr. Chairperson: Is it clarified to the member? *[interjection]*

Is the committee ready for the question? The question before the committee is as follows–

Mr. Tweed: You are calling the question on Part I, The Income Tax Act.

Floor Comment: No, section 1.

Mr. Tweed: Section 1, okay. *[interjection]* Well, I have a question.

Mr. Chairperson: Mr. Tweed, on a question.

Mr. Tweed: Because I am not sure where it falls in, I am wondering if we might have leave just to ask some questions as we go. If you want to go through it, I can find the exact clause, but I have some questions for the minister on the bill. I am sure if we could get those answered, we could probably make this process a lot quicker. Is that fair?

Mr. Chairperson: If I might just comment, we are on 2(1) right now. The practice is to deal with or raise questions on the particular clause. If you want to just ask general questions of the bill, then you need leave of the committee. Do you seek leave?

Mr. Tweed: No.

* (21:40)

Mr. Chairperson: Okay, then, the question before the committee is as follows:

THAT the part of the proposed definition–

An Honourable Member: Dispense.

Mr. Chairperson: Thank you.

THAT the part of the proposed definition "placement peu important admissible" before clause (a), as set out in the French version of clause 2(1)(a) of the Bill, be amended by striking out "0000" and substituting "000".

Amendment–pass; clause 2(1) as amended–pass; clause 2(2)–pass; clause 2(3)–pass. Clauses 2(4), 2(5), 2(6) and 3.

Mr. Tweed: Mr. Chairman, again, I am not sure if it falls in here, but the questions I have and I ask of the minister are just the simple fact that do we have a legal opinion from the department that suggests that the prospectus that was issued in the spring is valid to investors at this time with the changes that are being made to the act.

Ms. Mihychuk: On that specific area, we are using the recommendation of the Manitoba Securities Commission, which is well aware of all the amendments being presented and feels that it does comply, and there are no concerns been raised.

Mr. Tweed: Will the minister be sending out a notification to all the investors in the labour-sponsored funds in regard to the changes in this legislation and the fact that the changes have taken place after the offerings of the previous tax year?

Ms. Mihychuk: The internal legal advice that the department has received all the way through the process is that the changes to the labour-sponsored funds do not diminish the rights of the shareholders. Shareholders do have the opportunity to come to annual general meetings where issues are discussed. I am sure that the member is aware that labour-sponsored funds have in the past used their ability to go into what would be deemed not standard investments through previous administrations of the previous government and through us. In the cases where the

labour-sponsored funds have come to ask to invest in financial vehicles, for example, both administrations have concurred that that was the wise decision and have agreed with the funds, and that has occurred most recently for the ENSIS funds. So the issue of whether Crocus can invest in True North, as I have said previously, was not illegal. Now they had that ability, they have invested in the Moose, for example, which was also the case that was possible under the old act and under this one.

Mr. Tweed: I believe that any of those investments that were made outside were done with ministerial approval, which now is changing, and they will be able to do it without your approval. But the question I asked was: Will the people that made the investments at the start of the year for the tax credits be advised either by the Government or be instructed by Crocus and ENSIS to report to these people that the criteria has changed from the prospectus that they bought in the new year, and be made aware of the changes? I mean, when people make investment decisions, they look at a prospectus. That prospectus has now changed, and I want to know if they will be notified in some way by either the Government or if the Government will instruct the labour-sponsored investment organizations to do that, to advise Manitobans that the rules have changed.

Ms. Mihychuk: I wish to assure members that there is due process in public committee hearings such as this one right here. I would like to note that there were no presentations today, that the consultation has been with interested parties and that the public has been aware of this bill coming forward by media reports, by House notification and, by essence, by this public committee. I must also say that people who are active in investing in these funds, in my opinion, have a high interest in what happens in the funds and where they invest their money and feel quite confident that they are aware of the proposed changes.

Mr. Tweed: I am glad to hear that the minister has such confidence in the people. By their lack of attendance, it shows that they are not interested. But, again, people who invest in Crocus, as they do in every other fund, get a prospectus. This prospectus outlines the investment vehicles that this fund is going to use. Now this Government, after the fact, has changed that prospectus.

Okay, then my question would be: Will the Government ensure that Crocus issues a release to its shareholders or to its contributors indicating the changes? I think people have a right to know, and the Government has a responsibility to inform them that we have changed the rules of the investment vehicle under Crocus Fund.

I would ask the minister: Would she confirm that she will do that, or ask the funds to do it and advise the investing public in Manitoba that, in fact, what they bought in January is not the same as what they are getting today?

Ms. Mihychuk: Again, I would like to just clarify that the request by the member is beyond scope of the jurisdiction of this department. The issue is actually under the purview of the Manitoba Securities Commission. They have been following issue from the start and will require both funds to issue a revised prospectus prior to selling any more shares, which is an ongoing activity.

Mr. Tweed: Can the minister tell us today if the True North Project would have proceeded without this changed legislation?

Ms. Mihychuk: Absolutely.

Mr. Tweed: Can the minister confirm that it would have only have proceeded with ministerial authority and approval?

Ms. Mihychuk: No, not necessarily.

Mr. Tweed: So then the minister is stating publicly that the Crocus Fund in the previous format could have invested in the True North Project.

Ms. Mihychuk: Yes, that is correct.

* (21:50)

Mr. John Loewen (Fort Whyte): Is the minister aware of any ineligible investments that have been made by the Crocus Fund where a letter of authorization was obtained from the minister?

Ms. Mihychuk: Yes, I have three examples where so-called ineligible investments were given ministerial authority or advancement of the project. In these cases, they were done by the previous administration and were all in successful ventures, for example: National Leasing, Wellington West and Angus Reid.

Mr. Chairperson: Before we go further, I must interject at this time. We are supposed to be discussing clause 2(4).

If we are going to continue in this vein of just general questions, I need leave of the committee. Do I have leave? *[Agreed]*

Mr. Loewen: Is the minister aware, I note that none of those three involved investing in a form of real estate or as was described, an interest in real property or a debt obligation as secured by an interest in real property that is held primarily for the purpose of gaining or producing gross revenue, that is, rent. Would that description not apply to the True North Project, where in fact an entertainment complex is being built?

Ms. Mihychuk: The member asked the question if we were aware of Crocus having invested in ineligible investments. The previous bill had identified a number of sectors which covered areas that were deemed ineligible, and those ineligible areas are now being removed. The fundamental reason is we believe that the fund managers have the ability to make those decisions and come up with sound financial reasons to make those commitments, and in the past both administrations have concurred with those recommendations. Really the ultimate test for the labour-sponsored funds is the return on investment and the number of shares that they can sell during the year. If they are not getting a good return, you will see the shares dropping or you will see less of a return on investment.

So really what we are trying to do is remove government's sort of role in deciding where those investments can go. Financial institutions and flow-through vehicles were deemed ineligible. Now that will not be the case. If you are asking me specifically in the past has there been real estate ventures, I would be glad to answer that question.

Mr. Loewen: I would be glad to hear the answer.

Ms. Mihychuk: No, there has not been.

Mr. Loewen: Can the minister tell the committee the projected asset value of the True North Project once it has been constructed?

Ms. Mihychuk: I want to be as flexible as possible, but really the value of True North is not in the Crocus bill or the ENSIS bill. So I do not see how that really applies. Just to clarify, the investment by Crocus in True North is eligible under this bill, which they want to be considered under the old act just to I think try to assure the community that there is nothing untoward by the bill. So in fact the True North Project and their investment in it would not be deemed a real estate venture.

Mr. Loewen: The minister might want to refer to the term sheet which was tabled in the House, which indicates that the True North Project, and I quote, True North Entertainment Complex Limited, in which Crocus is identified as a significant investor, and I quote from the term sheet, will develop, finance, own and manage the project, the project being the entertainment complex. So if they are going to finance and own the project, they are obviously investing in a real estate project that they are going to own. Does the minister not see that? Oh, you are going to do it through the backdoor.

Ms. Mihychuk: The definition of a real estate venture is one that receives substantially all of its revenue from rent, period. So the term "substantially all," I understand, is a legal term that has definition through the courts.

Mr. Loewen: So the minister is then saying, if I hear her right, that in fact it is her view, the view of her Government, that the investment by Crocus in the True North Project is not a real estate investment because in their belief most of the revenue does not come from the interest in the real property and the production of gross revenue, that is, rent for the True North complex?

Ms. Mihychuk: The department has received legal opinion that that is true.

Mr. Loewen: The term sheet also indicates that the project is a $125-million project. Any

business that I have been involved in, when you construct a building worth $125 million, worth any value, the asset value of the building is what the construction cost is. So would the minister agree that the asset value of this building will be $125 million once it is completed, give or take a little bit that maybe it will be a touch under or a touch over budget?

Ms. Mihychuk: Yes.

Mr. Loewen: Does the minister have a legal opinion that an investment in the True North Project is a qualified Manitoba business in spite of the fact that one of the criteria for a qualified Manitoba business is that it carries on business in Manitoba and has assets of a value less than $50 million and has a majority of its employees in Manitoba, or, secondly, substantially all of its assets would be eligible investments had they been owned by the fund directly and has asset values of less than $50 million? I am having a little trouble understanding, if we are building a $125-million asset, how the investment qualifies under the fact that it has to be invested in an asset of less than $50 million.

Ms. Mihychuk: The member is reading the criteria for what is an eligible investment when it comes to the criteria of pacing. This project well exceeds the $50 million and therefore is not an eligible investment.

Mr. Loewen: Well, if it is not an eligible investment, does that make it an ineligible investment under the act as it exists today? I am having trouble. First, it is not an ineligible investment. Then it is not an eligible investment. What is?

Ms. Mihychuk: There are two steps, two tiers that an investment has to go through. One is whether this is a prohibited investment. It is not a prohibited investment. So then they move on to is it eligible or ineligible. Technically, Crocus has not asked for us to review the project based on the term sheets for eligibility, but if the project is $125 million, it would not be.

Mr. Loewen: Again, I am just trying to clarify how this fits. I believe what the minister has said, in answers to previous questions, it is her opinion and that of the legal department that an investment in this project is not an ineligible investment. It is not an ineligible investment, as is laid out in section 4.03 of the prospectus, and at the same time she is saying it is not an investment in a qualified Manitoba business.

Ms. Mihychuk: Okay, let me try again. There are two tests for an investment. The first is whether the investment is prohibited or not. I understand there is some confusion because the regulations actually use the word "ineligible" to actually imply or mean prohibited. So once they pass that first test, they would then move to the second criteria of whether it is majority in Manitoba and the $50-million value. That determines whether it is eligible for the pacing requirements or not.

Mr. Chairperson: Before we proceed further, I would just like to make the point that this line of questioning is well beyond the scope of the bill before us. The minister is still willing to answer questions, but I just draw that to the attention of the committee.

* (22:00)

Mr. Tweed: Mr. Chairman, I do not know how you can say it is beyond the scope when we are dealing with a specific issue right now that is impacted by this bill. The two were brought side by side into the House together, so I would suggest the questions should be allowed to continue and are not out of line at all.

Mr. Chairperson: For clarification, Mr. Tweed, I did not rule this question out of order, this line of questioning out of order. I merely made the point that we are, in my opinion and the opinion of my assistant here, straying somewhat from the content of the bill. However, if the minister is willing to continue to answer questions in this line, then proceed, by all means.

Mr. Loewen: Maybe we will just try it one at a time then. The minister is saying that the proposed investment by the True North Project–it may have been made already, we are not sure because we have not been informed of all the details, but either the investment or the proposed investment does not qualify as an investment in a qualified Manitoba business entity.

Ms. Mihychuk: From the department's point of view in terms of this bill and the processes that

go on for determining whether it is eligible or not, the department has not been approached by Crocus to review this project or the term sheets, to determine or provide advice as to whether the investment is eligible, eligible for pacing. Given the information that we have received, we do not anticipate that that request will come forward.

Mr. Loewen: Well, I am a little confused, because I asked the minister that question on May 9 and she told me she would take it under advisement and get back to the House. So are you saying now that, you know, here we are almost two months later, and you have not asked Crocus, you have not followed up on your commitment to the House to take the question under an advisement? *[interjection]* Oh, I see.

Ms. Mihychuk: It is up to Crocus to decide if they choose to come and ask for it to be part of their pacing requirements, and they may choose to use their other avenues to make this investment, which we expect. They have not officially come to us to ask us to consider this project as an eligible investment. It is fully legal. It is not required that they come to us. It is up to individual funds to decide whether to do that or not.

Mr. Loewen: Well, the legality has more to do with the Manitoba Securities Commission than with Crocus. The only illegality would be if in some shape or form the Crocus Fund has violated The Securities Act. It has never been at question as to whether they can legally make the investment. They legally can.

What is at question is if it is not an ineligible investment and if the department is wishing to wash their hands of it and not look at it–and it is obviously not an investment in a qualified Manitoba business. I mean, that makes it even more clear why the Government finds itself in the position where it needs to introduce an amendment that wipes out any mention of ineligible investments in the act.

I would ask the minister if she would review Hansard of May 9 and take a look at the undertaking she made to the House to take that information under advisement and to report back either to the committee or to the House in short order; how an investment in a project that is over $50 million, and it is an investment in real property, qualifies under the Crocus act. If Crocus has a legal opinion, maybe tabling that is the answer to the question.

Ms. Mihychuk: I believe on May 9 the member suggested that the investment by Crocus and True North was, in fact, illegal. Since that time I have consulted with the department and the department officials have indicated that the procedure is that the labour-sponsored funds have the ability and it is up to them to decide whether they are coming to Government or not. It is not the practice of this administration or was the practice previously to go and require some sort of reporting or a review of every deal that ENSIS or Crocus makes. However, there is a review at an annual basis of their investments. If there is anything that is untoward, there would be then an audit.

* (22:10)

Mr. Loewen: Well, again, I simply asked the minister to review Hansard of May 9. I did refer to it as possibly being an illegal investment and the illegality, if she will look at it closely, was based on the prospectus. That is what I referred to in the question and that was the supplemental question. She undertook to take the matter under advisement and come back to the House and indicate whether the investment was in fact an eligible or an ineligible investment. I am simply asking you to follow through with that undertaking, review Hansard, and if you do not believe you made that, then tell us that you did not make that commitment, but I would ask you to review Hansard of May 9, first.

Ms. Mihychuk: Well, I think that my record speaks for itself. I try to be as open and forthright as possible and give the Opposition any information that they wish.

The question was whether it was legal or not. I tried to answer it and found that indeed it was not illegal and in fact that the officials tell me that it is inappropriate or it is not proper protocol or the way things are done with labour-sponsored funds for us to go and check out their deals. That is not how it was done under the previous Tory administration. That is not how it is done under our administration.

Mr. Loewen: Well, I would ask the minister if she could identify under which of the four stages of business development she believes that an investment by Crocus in the True North Project is? Is it an early stage investment, an expansion, an internal acquisition or a turnaround? Can she identify to this committee which type of investment category this falls under?

Ms. Mihychuk: That is up to the individual funds to determine what stage they would classify their project investment in.

Mr. Loewen: Well, obviously, the minister does not want to answer questions at this stage. Perhaps she will be a little more open at other stages.

This is another question in regard to the investments of the Crocus Fund. We have seen accounts in the papers in the last couple of weeks, where the CEO of the Crocus Fund is musing that they are going to make investments in housing in downtown Winnipeg. I am wondering if the minister feels that is appropriate under the act and the regulations that stand today.

Ms. Mihychuk: Basically, the investment in social housing or any other investment that the funds, either ENSIS or Crocus, would decide to make would have to meet the tests. If they do not meet the tests, then they do not count towards the pacing requirements.

Mr. Loewen: I wonder if the minister can advise the committee whether she would consider, given her knowledge of the fund, that an investment in housing, which presumably would be real property and if the property was rented would be for the gaining or producing of gross revenue that is rent, the development, subdivision or sale thereof, presumably that is what an investment in housing is, in her opinion would that be an ineligible investment as the legislation and the regulations are written today?

Ms. Mihychuk: The question whether social housing is profitable is one I am sure that the Housing Minister probably has a strong opinion on, but the purpose of Crocus is to return a substantial investment to the people who are investing in Crocus. You know, it is up to the fund managers to decide if an individual project is worthwhile investing in. If Manitobans find that Crocus is not returning an investment return to them that they would expect, that is going to be a very poor investment, and Crocus will have to pay the consequences.

Now, whether it is prohibited or not, that test will change, but whether it is eligible for pacing remains. So if the project, and it depends on the individual project, if the revenues are generated from substantially all, on the basis of rent, then it would be ineligible as it is now.

Mr. Loewen: I do not want to belabour this too much. Time moves on. But I would ask the minister, when she gets an opportunity, to look at section 4.03 of the prospectus which refers to the regulations and indicates that The Fund Act provides that the fund's investment assets be invested as follows and invest not less than 60 percent of its investment assets in eligible investments. They would have to be a qualified Manitoba business.

The minister has indicated investment in True North does not fall under that. The fund must maintain a reserve fund of 15 percent. An investment in True North I do not believe falls under the qualifications of the reserve fund, and certainly the fund has a leeway to invest the balance of its investment assets in discretionary investments, that being the 25 percent.

It goes further on to qualify that discretionary investments may not include ineligible investments, so if it is not a qualified Manitoba business and it does not fall under the qualifications for the reserve fund, which obviously it does not, the minister has already identified that it would not be a qualified business because of the asset size. It can only be a discretionary investment and in that form it must not be an ineligible investment. So, up to the minister to satisfy if the people of Manitoba that the investment is not an investment in interest, in real property or a debt obligation that is secured by an interest in real property. Perhaps the minister would look into that and clarify that for the committee.

I bring that to the attention of the minister so that hopefully she will have some understanding

of why we are going to oppose this bill and, in particular, why we are going to oppose the clause in this bill that repeals section, I believe it is 13 of The Manitoba Employee Ownership Fund Corporation Act which will become known as the Crocus act, because she is changing the very nature of the fund after the fact.

Ms. Mihychuk: I think the member understands there is a certain amount of funds that can be invested in projects and Crocus had that flexibility under the old act and under the new act. In fact, the True North Project will be under the old act, as indicated by the amendment that is coming in at the end of the bill.

* (22:20)

I understand that the Opposition has its own reasons for opposing this bill, and I accept those. However, I would argue strongly that this bill does not come in to provide any kind of secret door for Crocus to invest in True North. This is a bill that has been underway for a very long time, as the member indicated last year when we brought in legislation that there had to be a more comprehensive approach to these funds, and I agree with him. The timing, if I would have had any druthers on it, would have been a little bit different, and I can understand how members would say this bill seems suspicious because the timing is so coincidental. However, I can assure the members, as can legal advice and the authorities in the department and the Manitoba Securities Commission, that timing is not proof and in fact the bill stands on its own merit and the True North Project is under the old bill's guidelines. Hopefully, with that clarification, we can move on through the bill.

Mr. Loewen: Just for clarification for the record, because the minister seemed to indicate that I had some involvement in when the drafting of this bill started, I simply requested last year, when she brought legislation forward that she look to the future and look to harmonizing the bill. I have no idea when the drafting was started, when instructions were given, so I have no way of knowing whether it has been going on for a year or simply been going on once the Premier (Mr. Doer) discovered that his negotiations might be out of order.

Mr. Chairperson: Clauses 2(4) through 3–pass; clauses 4, 5 and 6(1)–pass; clauses 6(2) and 6(3)–pass; clauses 7 and 8–pass; clauses 9(1) and 9(2)–pass; clause 10–pass; clause 11–pass; clauses 12, 13 and 14(1)–pass. Clause 14(2)

Ms. Mihychuk: I am bringing forward an amendment. I move

THAT subsection 14(2) of the Bill be amended by striking out "and" at the end of clause (a) and by adding the following after clause (a):

(a.1) by repealing clause (a); and

Mr. Chairperson: It has been moved by honourable Minister Mihychuk

THAT–

Some Honourable Members: Dispense.

Mr. Chairperson: The motion is in order. No questions? No comments?

Ms. Mihychuk: Oh, oh, I am going to try and clarify something where there is no question.

Basically this provision has been moved into The Income Tax Act, which has stricter investing pacing requirements. It is not required to be in this act. In fact, it was a drafting oversight.

Mr. Loewen: Just for clarification, it is in The Income Tax Act?

Mr. Chairperson: I did not hear that, sir. Did you put a question there?

Mr. Loewen: I was just asking the minister to clarify if this change is in The Income Tax Act.

Ms. Mihychuk: Yes, it is in The Income Tax Act.

Mr. Chairperson: Amendment–pass; clause 14(2) as amended–pass; clauses 14(3) and 15(1)–pass. Clauses 15(2) to clause 17.

Mr. Loewen: Clause 17 is one we would like to deal with separately if you could deal with 15(2) to 16(2) in this go-through.

Mr. Chairperson: Okay. Clauses 15(2), 15(3), 16(1) and 16(2)–pass. Clause 17.

Mr. Loewen: On division. I just wanted to vote.

Voice Vote

Mr. Chairperson: All those in favour of passing Clause 17, say yea.

Some Honourable Members: Yea.

Mr. Chairperson: All those opposed, say nay.

Some Honourable Members: Nay.

Mr. Chairperson: In my opinion, the Yeas have it.

Mr. Tweed: On division.

Mr. Chairperson: Clause 17 is accordingly passed on division.

* * *

Mr. Chairperson: Clause 17–pass; clauses 18 and 19–pass; clauses 20, 21 and 22–pass; clauses 23 and 24(1)–pass; clauses 24(2) and 24(3)–pass; clause 25–pass; clauses 26 and 27–pass; clause 28–pass; clauses 29(1) and 29(2)–pass; clauses 30(1), 30(2) and 31(1)–pass; clauses 31(2) and 32–pass; clauses 33 and 34–pass; clauses 35(1) and 35(2)–pass; clause 36(1)–pass. Shall clause 36(2) pass?

Ms. Mihychuk: No. I have an amendment.

I move

THAT subsection 36(2) of the Bill be replaced with the following:

36(2) Subsection 16(2), section 28 and subsection 29(2) come into force on a day fixed by proclamation.

36(2.1) Section 17 comes into force on January 1, 2002, or any later day fixed by proclamation made before January 1, 2002.

* (22:30)

Mr. Chairperson: It has been moved by Honourable Ms. Mihychuk

THAT subsection 36(2)–

Some Honourable Members: Dispense.

Mr. Chairperson: The motion is in order.

Amendment–pass. Shall the clause as amended pass?

Some Honourable Members: Pass.

An Honourable Member: No.

Voice Vote

Mr. Chairperson: All those in favour of passing clause 36(2) as amended, say yea.

Some Honourable Members: Yea.

Mr. Chairperson: All those opposed, say nay.

Some Honourable Members: Nay.

Mr. Chairperson: In my opinion, the Yeas have it.

An Honourable Member: On division.

Mr. Chairperson: Clause 36(2) as amended is accordingly passed on division.

* * *

Mr. Chairperson: Clause 36(2) as amended–pass; clause 36(3)–pass; enacting clause–pass; title–pass. Bill as amended be reported.

What is the will of the committee? Which bill shall we deal with next, Bill 50 or Bill 25?

An Honourable Member: Bill 25. That will be quicker.

Some Honourable Members: Bill 50.

An Honourable Member: I think we should do 25, but I am easy.

Mr. Chairperson: The minister proposes Bill 50. Is that the will of the committee that we deal with Bill 50 first? *[Agreed]*

Bill 50–The Regional Health Authorities Amendment (Accountability) Act

Mr. Chairperson: Does the minister responsible for Bill 50 have an opening statement?

Hon. Dave Chomiak (Minister of Health): Mr. Chairperson, in the interest of time I do not have

an opening statement other than to indicate that the presenters were obviously in favour of this bill. The Opposition has indicated they are also in favour of this bill, so I think that the matter could be expedited relatively quickly.

Mr. Chairperson: We thank the minister. Does the critic from the Official Opposition have an opening statement?

Mrs. Myrna Driedger (Charleswood): Mr. Chairman, I do have a few words to put on the record. Although we are supportive of the bill, it is not totally unconditional. There are some concerns, and if you look back to second reading on this you will see that a number of comments have been made by us in relationship to this bill. I just will put a few words on the record at this point in time though.

Certainly, it is important to note that Mr. Thomas, in the Thomas report, has made some fairly strong comments in terms of establishing accountability and strengthening accountability within our health care system. His report was the one that followed on the heels of the Sinclair report, which all did arise from the Pediatric Cardiac Surgery Inquest.

Certainly, one cannot argue with the need for accountability at all levels, whether it is at the hospitals, the regional health authorities or at the level of the Minister of Health (Mr. Chomiak), and all of those levels of accountability certainly do need to be well defined. We do have to have a situation or a process in health where people understand who is accountable for what is happening in our health care system.

I think Mr. Thomas was really clear in the comments he was making. We should not have people hiding behind or ducking behind another organization or a person in order to avoid being accountable. I think with the beginning of regionalization, we all acknowledged that it was not all completed at the time that it was implemented or instituted and that over the last few years we have seen an evolution in terms of the evolving structure of regional health authorities and a better understanding of regionalization. I think it has been clear all along that all of the accountability parameters needed to evolve over time.

I think that where we are with Bill 50 does not take us the full distance in terms of closing the loop on accountability, but it does move us along that way. I do not think that this bill is going to provide all of the answers for the minister, because I still think he may find some areas that may be problematic for him. Certainly, I do believe it is part of the evolution of regionalization, not a panacea certainly to some of the challenges that lie before us.

With those few comments, we are certainly prepared to move into some of the questioning. I wonder if it would be acceptable to the minister for a few broad questions before going through the bill. It might speed this along in terms of the questions and answers, rather than trying to do it as we go through clause-by-clause.

Mr. Chairperson: Thank you, Mrs. Driedger. Is it the will of the committee that we deal with a few general questions at this point in time before we go into the bill? *[Agreed]*

Mrs. Driedger: Can the minister give us an example of when an RHA CEO would have the power to give directions? Can he give us an example of when something like that could happen?

Mr. Chomiak: Mr. Chairperson, I do not anticipate, as I said on previous occasions, that this directive power will have to be utilized very often, if at all. One can contemplate a variety of scenarios that might be suggestive of using directive power. I prefer not to. I think that there are a number of channels of accountability, a number of channels that allow for discussion and for resolution of issues before the directive power has to be utilized, and I would suspect that most, if not all cases would resolve themselves prior to having to use directive power.

Mrs. Driedger: Would it be a correct assumption to assume that the minister could override those directions, the power to give directions of an RHA CEO, assuming that the buck stops with the minister on issues in health care? Can he override that directive from an RHA CEO?

Mr. Chomiak: Mr. Chairperson, I am not sure. I thought I heard two different questions in the member's question. The first was can the minister countermand our directives that are made by the RHA, or is the question can the

minister give directives through the RHAs. So I am not sure what the member is asking.

Mrs. Driedger: Actually, that is better than my question. Perhaps the minister could answer both of those.

Mr. Chomiak: Mr. Chairperson, I do not think the minister can countermand directives that the CEO gives, and I do not think the minister can give directives. A minister can certainly give directives to the CEO of the RHA, and CEO of the RHA can give directives through the system, but those directives that are given by CEO of the RHA would have to follow the guidelines as outlined in the act.

* (22:40)

Mrs. Driedger: I am a little bit unclear with the minister's answer. Is he saying that he does not have any authority to tell an RHA CEO what to do?

Mr. Chomiak: Mr. Chairperson, in a typical situation, the minister would not be telling the RHA CEO what to do. The RHA CEO would be operating within the mandate of the annual report, within the mandate of the plan, et cetera. In unusual circumstances or other circumstances, the minister can direct a regional health authority to give specific directives through chief provincial objectives to provide guidelines for coordinating work under the original act. Those were the provisions that were contained within the original act that was brought up in 1997.

Mrs. Driedger: I guess that is the one point of perhaps some of this in looking at closing the loop of accountability that still remains a little bit vague throughout all of this is in terms of the minister's accountability and how that all fits into all of this. As I said, I think this is an evolutionary bill moving in a direction, closing the loophole of accountability, but I still think there are some gaps in it.

Can the minister explain how arbitration to resolve conflicts will actually occur?

Mr. Chomiak: Mr. Chairperson, the provision contained in the act allows that if the health corporation believes the direction is not in keeping with the subsection, that is the subsection dealing with its objectives, they may request that a matter be referred to arbitration. That request goes to the regional health authority and to the minister, and the parties can appoint an arbitrator jointly, but if they fail to do within 10 days after the minister receives their request, the minister shall select and appoint an arbitrator to determine the matter. Then the arbitrator's decision is binding.

Mrs. Driedger: Can the minister explain why this only relates to a health corporation owned or operated by a religious organization and why it is not addressed right across the board, as was made clear to us in the presentation today by the executive director of the Middlechurch Home of Winnipeg, where they feel that for all groups outside of religious organizations they do not have this same ability to resolve disputes? This person tonight put forward a dispute-resolution process.

I wonder if the minister would be willing to give some attention, either tonight or in an amendment, to addressing this beyond just a religious organization so that there is a fair mechanism in place for all health corporations.

Mr. Chomiak: Mr. Chairperson, I think the member kind of misses the intent of the particular amendments that are designed to protect and enhance within the legislation the religious and the faith-based institutions.

Concerns regarding other matters are contemplated within agreements that are entered into under the directive process that is included in the agreements between the regional health authorities and the various organizations, many of which have arbitration provisions contained in them, and they are brought into the functioning of the act under 29.1(5)(a).

Mrs. Driedger: Speaking privately with Heather Temple, Executive Director of the Middlechurch Home of Winnipeg, after her presentation, she indicated that, while there is a dispute mechanism in the operating agreements, she does not or did not feel that it went, I guess, to the same degree that this one did in terms of looking at situations that might be beyond the scope of what is talked about in that operating agreement,

that this has perhaps a broader application for directives that might be related to programs as they are doing specific in some of their facilities and does not feel that same dispute resolution that is in that operating agreement gives them enough protection, as much as this particular one in the act would do.

Mr. Chomiak: Yes, I heard those comments as well from the individual's presentation.

Mrs. Driedger: Does the minister have any comment to make on them and why he would not be willing to address them in terms of this legislation?

Mr. Chomiak: The particular directive power that is provided deals with faith-based institutions firstly. It deals with a narrow parameter of directive power. The authority between a regional health authority and various agencies under it, if subject to arbitration on every case, would make it difficult, I think, largely to function, which is why the original legislation contemplated operating agreements between the regional health authority and the individual organization.

I heard the individual's concerns. I do not think it is a major problem. I think those issues are dealt with by virtue of operating agreements, and I do not think it is a major problem that we have to address in this legislation.

Mrs. Driedger: Not to argue with the minister, I guess, but the particular presenter for this issue did feel it was a significant enough concern and that is why they were here making the presentation tonight. All they were looking for was fairness in being treated the same way as the religious organizations and asking for the same dispute resolution mechanism within the act so that they would have that same ability to address disputes as religious organizations, and they just felt that would have been a fair way to treat them.

Mr. Chomiak: Yes, I have noted very carefully and paid a lot of attention to her presentation.

Mr. Derkach: Mr. Chair, just to the minister, with regard to directions re services provided in the use of funds, does the department have the authority then to direct faith-based health authority to carry out services which may be in conflict with the faith-based institution?

Mr. Chomiak: Two responses: No, because it goes contrary to what is included in legislation, and, secondly, this legislation does not give the minister the directive power. The directive power goes to the regional health authority. If the member is asking if the regional health authority had that power, no, they cannot either, because they cannot go against the basic tenets of the faith-based institution. That protection is built into the legislation. That is why the faith-based institutions strongly support it.

* (22:50)

Mr. Darren Praznik (Lac du Bonnet): I know the hour is late and I am coming from another committee, but I just wanted to make a few comments on the record.

I understand we are supporting the bill generally. I say this only because when I did make my remarks in the House the Minister of Health–I know what that job is like, believe me, the minister has so many commitments–he did not have the opportunity, we really have not had the opportunity to have an exchange about this bill.

I appreciate there is a history here of which I was very much a part in the making, and the minister inherited a regime of dealing with faith-based and the Winnipeg Health Authority and the existence of those health authorities that he inherited from our administration, Mr. McCrae, who was the previous minister to me, and myself. So it is not that one comes to this without that history, but the comment I wanted to make, and I do not even expect the minister to reply to it. I appreciate presenters did come here from the faith communities, and not just the faith but some of our Winnipeg hospitals have non faith-related boards, and praised this bill and this process.

Just for posterity, for history and to perhaps put my warning on the record at this committee, when I read section 29.1(5), which is really the clause that concerned me, and it is more for the

minister's sake and his staff, but I see a process where the regional health authority, who on behalf of this Legislature is spending ninety-nine-point-something percent of the dollars that are expended in operating those hospitals that have their own boards, where the taxpayers are paying for that service, where the Government of whatever political stripe is attempting to get the benefits of regionalization.

I understand that more of the studies that are coming out now across the country tell us that wherever regionalization has been allowed to come to full fruition that we are seeing reductions of waiting lists more than where it has not, that we are seeing improvement of services, the better utilization of resources, which is what it was intended to be. Although this minister, when he was critic, had differences of opinion on some of the ways we implemented, I do not recall him coming out feverishly against regionalization. The fact that he has continued and enhanced them, I think, endorses that move.

What concerned me about this process, and this is, in fact, part of a series of amendments that I made, Mr. McCrae started and I made, and this minister now continues. As this working relationship between regional health authorities and those existing boards evolve, this is one more step. As I said in the House when I spoke on this in second reading, I expect that there will be more changes down the line as the relationship evolves.

What I find most troubling about this is, given that our health care is funded 99 percent from the public treasury in a public system and that the operator of these facilities, although there is some of their own investment, I would argue, a declining equity since the taxpayer pays for most of the upgrades and the improvements, and whatever initial investment they had is probably watered down over the years, that if we are to get the best benefits of our regionalization, the regional health authority has to have the ability to make decisions and implement them.

I appreciate that this bill is attempting to give some security to the existing independent boards in how this will happen, but at the end of the day, when we put into law that in order to finally make the decision and give direction that a regional health authority, and I refer to the B part of this section, will have to demonstrate that it has made all reasonable efforts to consider and accommodate the position of the health corporation on the matter, I find it very troubling. It is not for any other reason than my experience knowing that the amount of effort that will be put in by staff in the ministry, the regional health authority, the minister's office, if the issue is large enough, into satisfying an organization whose operating dollars are coming from the province, to satisfy them that this is a reasonable step. The amount of energy and time that would be put into by staff, unless you have been there, you do not fully appreciate how tough that will be.

My concern is that, with this provision, this section in the bill, even though all these groups like it, and, of course, they are going to like it, because if they do not like a decision the regional health authority makes, it may allow them to go to court and ask the regional health authority to prove that they have taken reasonable issues to consider that this has been done. It does give me some concern that is there, and, again, I think our critic has indicated we are going to support this.

I would say, for the record, that issues of faith on faith facilities have been dealt with by an agreement that the Cabinet of which I was a part signed; I negotiated with those faith facilities. So we are not talking about issues about having to perform abortions in St. Boniface Hospital or do things that are against the tenets of the faith of that institution. That has already been dealt with. What we are talking about here is day-to-day operational issues.

I raised with the minister, and he may want to respond to this, but when I was Minister of Health, Doctor Postl, whom he knows very, very well, was charged with the responsibility to give to us as government an assessment of what changes we needed to make in the Winnipeg hospital system to make the system run better for patient care. Doctor Postl came to see me, and he said, Mr. Minister, do you want me to do our recommendations on the basis of what is politically correct or on what is best for health care for the patients? My answer to him was

simple. I wanted what was best for the patients. That is the way I wanted to plan the system. He produced the blue book with a whole bunch of proposals, and one of those proposals was the consolidation of the cardiac surgery program, one program in one site, and that was supposed to be at the Health Sciences Centre. Doctor Postl made that recommendation to me. He sat in my office and defended his recommendation to many of the critics of that decision.

During the course of the election campaign, and I reference a story that appeared in the *Free Press*: NDP uses St. Boniface as launch pad. There the candidate for the New Democrats, Mr. Selinger, now the Minister of Finance, said the NDP will make sure the Grey Nuns retain control of St. Boniface General Hospital. He said they would halt plans to move the hospital's cardiology program to the Health Sciences Centre. This was a political promise. This was not a consultation with Brian Postl, who had made the recommendations. This was not Darren Praznik's recommendation or Jim McCrae's recommendation or Gary Filmon's recommendation. It was Brian Postl's recommendation, and it was based on best patient care. During the course of the election, Brian Postl was employed by the Winnipeg Hospital Authority. I do not assume he was out advising the New Democrats on health policy. Maybe he was, but not to my knowledge. But here the New Democratic Party candidate in St. Boniface made a promise, not based on best patient care, but based on the political mood of the day. Your party wins the election. The candidate is now an MLA and the Minister of Finance, and within the first year of office, we see–and by the way, Doctor Postl was a good appointment given his experience–all of a sudden we see this political promise fulfilled, and Doctor Postl now saying: Well, things have changed. What had changed was the Government had changed, and Doctor Postl was now being told, I gather, to make political decisions.

I do not blame the Minister of Health (Mr. Chomiak) for that. I mean, political decisions, there is an element of them in health care. All parties do it. But what troubles me at the end of the day, if we are going to see the best work out of regionalization, is we have to let our regional authorities be able to make those basic, operational decisions, and implement them among the hospital facilities in Winnipeg. Now I understand, fully, that we have faith facilities.

We have others, there are the small "p" politics of health care, and this Minister of Health has to deal with those every day. They were my life for two years, they are now his life. I understand that. But my concern, again, comes back to this provision in the act. I know I had to enter into agreements I was not always happy with, either, in order to move on to the next stage. But I just wanted to say, on the record here, that the huge amount of energy that is going to be required by this minister, future ministers, their staff, the regional health authorities, to make decisions that are based on best patient care having to be explained and negotiated and fought over, because a particular hospital does not want to change their way of looking at the world or feels the competitive nature of another facility. My fear is it will drive staff ultimately to say it is not worth the hassle. We will just carry on with the way we are doing things.

I appreciate, again, this is not a perfect world, and I am not trying to be critical of this minister, because I lived his life for two years. I know I had to enter into agreements that I would not always want, but I just wanted to flag today that, in this bill, which we are supporting, I just see this as a potential problem. I wanted to put that on the record, because the day will come, I think, when another Legislature will have to amend this at some other time. Maybe that is the inevitable part of health care. I offer that as friendly commentary to the Minister of Health, and I hope it is taken in that way.

* (23:00)

Mr. Chomiak: I just want to deal with a couple of points that the member indicated. I appreciate the advice; I always do. The decision on the cardiac surgery was not a "political decision," and this is not the forum to discuss that issue. We can discuss that issue. We have been through that. There have been several decisions that I have reversed and made in the last year. I made a decision a year ago on one, and new evidence, or new information, has come to bear, and I have switched around the decision. That has

has happened, and that will continue to happen, based on information that comes forward.

So I just wanted to put that on the record. I do not want to relive old battles at this juncture, because, if we started going down this road, there is a tendency sometimes to get into extraneous issues. Having said that, the only point I close on is that it is some satisfaction to me that the faith-based institutions and the regional health authority both seem happy with this amendment. So I will leave it at that.

Mrs. Driedger: Certainly the Member for Lac du Bonnet (Mr. Praznik) was kind in his remarks on that. I guess I saw that more as political interference in a process. I do not, certainly, have the same view as he did, because I know what he went through in dealing with that situation with Doctor Postl, and Doctor Postl had to work hard to convince us that was the right thing to do. Then, in the election, we see these promises being made with no obvious research done into best practices. In fact, we had a change in what the regional health authority had indicated was the best way to deliver patient care.

There is another situation that is happening right now. I guess I wonder how this does fit into conflict resolution with the situation happening at the Grace Hospital. Certainly, a number of the physicians there have been in touch with me, and feel there is a takeover of 100 of their medical beds. They are extremely concerned about the effect that this is going to have on the community it serves, especially the seniors in that particular area. According to the physicians in this particular facility, at the Grace hospital, there is a very strong objection to this movement by the WRHA. They are particularly concerned because they feel there was not much consultation involved in this, that a decision had been made by an individual within the WRHA to take over these hundred beds. They are concerned as to what is going to happen to the Grace Hospital, particularly to the Grace Hospital as a community hospital. They are worried about the loss of those hundred beds becoming a closed unit and closed to physicians at the Grace Hospital and having that hundred-bed unit operated by the Health Sciences Centre.

Mr. Vice-Chairperson in the Chair

They have indicated to me that what it is going to do is perhaps create a loss of doctors in the system because they are not sure they will have work there and not even sure that there would be work for them in Manitoba. Also, they feel that, while it might alleviate problems for the Health Sciences Centre, in managing a patient flow better, it certainly might in turn create problems for them at Grace Hospital considering that their emergency department is one of the most stressed in the city in terms of hallway medicine. Often, with elderly people requiring medical beds, they are concerned where will these elderly people go and are they going to end up being transported all over the city, and then admitted to hospitals in various parts of the city? For some of these seniors some of them have never ever left St. James.

We have a situation occurring at Grace Hospital, and while I do appreciate the need for regionalization and making the system work better, one also has to realize that decisions need to be fair in the system, and one wonders how one can ensure that that happens.

My question to the minister would be: What recourse does Grace Hospital have, through this particular legislation or otherwise, in terms of resolving this particular conflict, and maybe how could it have been prevented in the first place, so that there is not all this turmoil and anxiety that is going on over in that hospital right now, not only by staff there, but also now we are starting to hear from people in the community who are worried about what this change is going to do their hospital, the one that they know, the one that they access? The West End of Winnipeg has a huge number of seniors in the city residing there. So there is some real anxiety around that issue, and I wonder how this bill either could have prevented that from happening or how it could now deal with the conflict resolution so that everybody in the end is going to find a satisfactory resolution.

Mr. Chomiak: Mr. Chairperson, I am not sure if the question is really in order, but the member who tells us we should close more beds, the member who was part of a government that closed 1400 beds is asking us about the reorganization of a hundred beds that was the same

policy adopted by the members opposite with respect to ICU beds when they were in government, the very same policy, and now tries to wind it into a question dealing with the bill, a decision that has not been finalized, a decision that was communicated for discussion and now tries to wind it into this bill in order to do what? I do not know.

The member says: Well, I have supported regionalization, but, you know, the buts are what, Mr. Chairperson? The system is the same as members adopted, is the same process used by members opposite. This is a member who is advocating we close more beds, who read to me a report during the Estimates process that said

more bed closures are the way to go, and we are not doing that. But, having said that, all we are talking about is a proposal to do some reorganization of beds, to perhaps be more efficient, to perhaps utilize beds better. It is a discussion that has taken place with the hospital. I guess we are going to go down this road, but if we are going to go down this road, that is fine. The decision is not final. The decision was discussed with the Grace. If this decision goes through, there will be a better utilization of beds. Family doctors will not lose the right to admit patients, and it is a proposal that has been discussed at the regional level with a particular institution that has improved in terms of its throughput for the past several years, but there are some problems.

Do not forget that members opposite had problems maintaining family doctors at that institution, and we had to proceed. Members opposite went out and took over a clinic and paid doctors in a clinic, the Assiniboine Clinic, in a secret deal to keep doctors in that area, something that still has not come forward to be made public. We are trying for years to try to do something to maintain doctors operating in that particular end of the city. This is a proposal; it is being discussed, Mr. Chairperson. It is not finalized, but this suggestion that somehow this issue will remove capacity from the system is just not accurate. It is just not accurate. We are not closing beds, as was done for the past decade. The proposal is to reallocate some beds and probably, if the same success is achieved with these beds if it were to go through that was done by the members when they were in government in ICU beds, we would see a better utilization of beds, if in fact that was the case, because that is what happened. The same concerns were expressed when the members, under their regional health authority, put in place a program to utilize beds under ICU beds.

Mr. Chairperson, I do not know how the member is trying to segue a question in dealing with this act. I do not even know if the question is in order with respect to this, but the member is wrong.

* (23:10)

Mrs. Driedger: I am not sure how the minister does not see this question as relating to this legislation, because we have a health corporation here that believes a direction is not in keeping with what they feel is the right thing for the hospital. I am asking him: Does this kind of an example fit with something that could be dealt with through this arbitration process or this dispute resolution process? If a resolution is not going to come about through consultation, is a situation like this something a hospital can take through this arbitration process? That was my question.

Mr. Chomiak: No.

Mrs. Driedger: Well, could the minister explain why a situation like this then could not be taken through the arbitration process?

Mr. Chomiak: That particular circumstance would not apply to the provisions under this act.

Mrs. Driedger: I guess I am not clear on that. I would like the minister to expound on that more, because here we have a situation where a decision is being made for regional purposes in order to deal with regional issues. Then the particular health corporation, I guess, or certain people within that health corporation are having concerns about the effect this will have on their situation. Is the minister telling us then, despite the fact this is a regionally imposed directive that is going to come upon them, they have no right to take this forward for arbitration?

Mr. Chomiak: They have an agreement. It was negotiated between the regional health authority and a particular institution. There is an operating

agreement. There is an operating agreement that operates.

Mr. Leonard Derkach (Russell): Mr. Chair, maybe the minister, not in a confrontational manner, can explain to us how that kind of a situation would be exempt from a direction that would come from the regional health authority. It is just a matter of our, I guess, understanding better how this article would not pertain to a situation the Member for Charleswood (Mrs. Driedger) has put on the record.

Mr. Chomiak: There are operating agreements that have been entered into between regional health authorities and the various corporations. Those particular matters control the management of the corporations within the particular regional health authority. The directive power relates to a particular program that deals with a matter that goes to faith-based institutions, fundamental principles. If that is the case then it can go to arbitration.

Mr. Derkach: Well, then, Mr. Chair, as far as the Grace Hospital is concerned, it would fall under that category. Indeed, if they saw this as a matter that cut to the fundamental issues that facility operates under, is it not one that then would be subject to arbitration, or they could pursue arbitration for, for that?

Mr. Chomiak: A more appropriate example, if the member wants an understanding, Mr. Chair, was the previous government's decision to change Misericordia Hospital from a hospital to not be a hospital. That would be something that could have been put to arbitration when the members opposite decided to close Misericordia. That would be a more appropriate example, I think.

Mr. Derkach: Mr. Chair, then this is no different, because in this case what we are doing is we are reallocating beds for a different purpose. Under that directive, I would assume the facility, corporation, would have access to an arbitration process if they objected to a directive which reallocated the use of a block of their beds.

Mr. Chairperson in the Chair

Mr. Chomiak: No, that would not apply.

Mr. Derkach: Under what terms of the operating agreement or under what legal aspects would the regional health authority deny their application for arbitration? Who makes the decision? If they applied for arbitration under the understanding that this would apply to them, who makes that decision at the end of the day that in fact their situation is outside this particular act?

Mr. Chomiak: If the member carries his argument, if the member thinks about it, if the member carries his hypothetical, and it is only a hypothetical, to its conclusion, that would mean the health authority could make no decisions about anything, any corporation without it being subject to arbitration. That is not what the act contemplates. The act is very clear that their directives can be issued regarding services and uses of funds, with some restrictions, and must be in writing, and it can go to arbitration if it is not in keeping with the principles of the faith based.

Mr. Derkach: Well, Mr. Chair, that is precisely my point. I mean all of a sudden we could have a situation where we have two different opinions on whether or not this is related to the fundamental principles of the faith-based institution. They may feel it is, and they may feel they would come under the direction of this act.

Now, who in the end is going to make the decision that, in fact, they do not have the ability to apply for arbitration? I am just using this as an example. Mr. Chair, if the institution feels they have a legitimate claim to an arbitration process because they have a feeling that this is a fundamental issue for them, then I ask the minister whether or not there would have to be a decision made by someone as to whether or not the act applies to them, and who would make that decision.

Mr. Chomiak: First of all, the example of the use of beds at Grace does not even remotely apply to this. So by using that example I think it distorts the perception as to how this should be utilized. This particular provision is a narrow provision for arbitration in certain circumstances, Mr. Chair.

The Member for Lac du Bonnet (Mr. Praznik) gave the example, I guess an example would be if–I do not want to go to extremes

either. I want to think of something that is not as extreme, like the Member for Lac du Bonnet was talking about, say, abortions at St. Boniface. That would be so obvious. I suppose something like religious ceremonies could no longer be conducted in the chapel of faith-based institutions, so that is another obvious one.

One that would be on the edge and would have to deal with good faith, and do not forget you have to do all kinds of procedures before you go to arbitration, would still allow the health corporation to apply for arbitration, and they would try to agree on an arbitrator. If they could not agree on an arbitrator, then the minister would appoint an arbitrator and the decision would be binding. So there would be a whole bunch of steps that would be entered into prior to going to the purposes of arbitration, keeping in mind there is an operating agreement that is the first line of authority, keeping in mind that all kinds of steps have to be proceeded with in this legislation prior to directives being issued or prior to getting to arbitration, but the example of the Grace and that example does not even remotely apply.

* (23:20)

Mr. Derkach: Well, Mr. Chair, maybe it is a wild example and in the minister's opinion it does not apply, but if you read this particular article it simply talks about a directive or direction given to a health corporation may relate only to matters that have region-wide impact on the regional health authority's responsibility to co-ordinate and integrate health services and facilities in the health region, including planning standards and the allocation of financial and other resources. So the allocation of beds, the changing of the use of the beds, does, in fact, impact financially. It impacts, human resources, all of those things. Even though the definition is narrow, I am sure that one could argue that a particular case fits this bill and could in fact be arbitrated at the end of the day.

My question is not that. My question is: Who makes the decision? If in fact a faith-based institution feels this is a matter they want to take to arbitration, after exhausting all of the other steps in trying to negotiate a settlement, if the faith-based institution feels strongly that this is a dispute that should fall under the act and be arbitrated, who has the authority at the end of the day to say yes or no as to whether it falls within the limits of that bill, the parameters of the bill?

Mr. Chomiak: First off, there is a whole number of qualifications on the directives, but once we get through the qualifications they have to be in writing and reasons have to be filed. Then they have to go through the normal operating agreement. Then the regional health authority has to make reasonable efforts to accommodate the position of the health corporation. Then, after that, and if it is not inconsistent with all of the issues, if the health corporation believes it is not in keeping with the principles of their corporation, they can apply, give notice, if they want arbitration. If the parties, that is, the regional health authority and the corporation, cannot agree on who the arbitrator is then the minister appoints an arbitrator. Then the arbitrator makes a binding decision, and the decision will be whether or not that directive is contrary to the principles of the health corporation and therefore cannot be conducted, or it is in keeping with the principles of the health corporation and can be entered into, can be done.

Mr. Derkach: So in essence, Mr. Chair, at the end of the day, any matter that falls within this definition then can be used as a test case in terms of arbitration settlement.

Mr. Chomiak: I do not think so, and I think reasonable interpretations would be interpreted. Now remember this has also been utilized in operating agreements for a number of years that include arbitration provisions, and this is similar to arbitration provisions in operating agreements. I would think, generally, reasonable considerations would prevail in this regard.

Mrs. Driedger: I guess this leaves me with still a bit of vagueness about it. However, knowing that the faith-based facilities are supportive of this, obviously they have their reasons for being supportive. They have indicated to me they are not sure why this bill was put in place, because really it is not much different than, they are saying, the operating agreements they are living under right now, and we are questioning why

then such a bill would be necessary. They certainly have indicated that it is reasonable considering what they said they saw at the beginning. So I have to assume that– *[interjection]* Oh, it is not even read between the lines. The faith based did say what they saw at the beginning was certainly different from what they are seeing now, and they can live with this and will support this. Knowing they do feel that way, we are certainly prepared to support them in their willingness to move forward with this.

One final question: If an RHA decides, after much thought, deliberation and debate, that a hospital should close, could the minister tell us what is behind his disallowing them the authority to make that decision?

Certainly, he has said they have the authority to make decisions in the best interests of their region. If they were to decide for this area that they wanted a hospital closed, could the minister just indicate what is behind his disallowing them the authority to make that decision in this bill?

Mr. Chomiak: They had that authority through other means. They do not need the directive authority in order to do that. They do not need to do it via directive authority.

Mr. Chairperson: Further questions? No further questions? We will move on then.

During the consideration of a bill, the preamble, the enacting clause and the title are postponed until all other clauses have been considered in their proper order. Is that agreed? *[Agreed]*

Clauses 1 and 2–pass; clauses 3 to 5–pass; preamble–pass; enacting clause–pass; title–pass. Bill be reported.

Bill 25–The Health Services Insurance Amendment and Consequential Amendments Act

Mr. Chairperson: We will now move on to Bill 25. Does the minister responsible for Bill 25 have an opening statement?

Hon. Dave Chomiak (Minister of Health): Mr. Chairperson, at this very late hour, and the Member for Russell (Mr. Derkach) is pointing at the clock, there is much I would like to say. Much has been said about this bill. I only suggest that I thought the presentations tonight at the committee formed a very good cross-section. People who represented workers were there and were positive. People who represented groups and consumers who were involved were supportive. The only medical doctor to appear before this committee was supportive. The nurse who appeared before this committee was supportive. People who ran community centres were supportive. The Centre for Health Policy and Evaluation clearly indicated their studies were in support of this particular bill.

I am not going to spend a good deal of time dealing with this bill because of the time. I know we want to get on to go through clause by clause. There is much I would like to say but, you know, Mr. Chairperson, it was all said during the committee hearings, with one exception. There was a dentist who appeared who had a different issue. There was a broad spectrum across the entire spectrum of support for this particular bill that I cannot duplicate with respect to the matters that were dealt with.

So I am not going to say a lot because it has been said during the presentation to committee by members of the public.

Mr. Chairperson: We thank the minister. Does the critic from the Official Opposition have an opening statement?

Mrs. Myrna Driedger (Charleswood): Let me say something right up front. This is a bad bill. Let me count the ways: (1) it puts politics before people; (2) it decreases access to care; (3) it condemns ailing people to long waiting lists; (4) it compromises patient safety and patient comfort; (5) it reduces choices for patients; (6) it blocks innovation; (7) it eliminates incentives for entrepreneurs who want to improve our health care system; (8) it maintains the status quo; (9) it maintains escalating health care costs; (10) it builds a bigger and bigger and more expensive monopoly; (11) it promotes invasion of privacy and intimidation; and (12) it interferes with the delivery, I believe, through the definitions of palliative care, midwifery and home care.

* (23:30)

The minister has indicated he has no plan for health care, no grand scheme. So, as he said, he is going to try this and this and that, and he will keep what works, and then he is going to discard the rest. I think this is a very irresponsible way to manage our health care system and our tax dollars. Then we see a bill like this arising because of no plan for health care. We see a bill like this that comes up that is just a plain bad bill. When you can find 12 good reasons for not supporting it that certainly does tell you the extent to which this bill goes in terms of being a bad bill.

I think we need to stop the pretence on the political level that the system is fine and innovation is somehow unpatriotic. Leaders are paid to look ahead and prepared to meet changing needs, not remain mired in the status quo like we are seeing with this Government right now. When we address innovation, we do not need fearmongering, which the NDP immediately resort to instead of having an intelligent and open debate, nor do we need sloganeering about two-tier medicare. That leads only to division, zealotry and paralysis, when what Manitobans deserve is informed consensus, creativity and reform. So, too scared to debate the issue of private health care, the Doer government has chosen to simply cut it off with this legislation.

In an editorial in *The Globe and Mail*, May 10, 2001, I would just like to read an excerpt from that. The editorial is entitled, Medicare Myths.

It talks about CIHI, and I know the minister is fond of talking about CIHI, the Canadian Institute for Health Information: CIHI data show that medicare is not financially sustainable. It does not wipe away the differences between rich and poor, urban and rural, or have and have-not provinces. It is time to stop pretending it does.

The editorial goes on to say: The quality of Canadian health care cannot be measured by the amount of public money put into the system, estimated by CIHI at $67.7 billion in the year 2000. Outcomes are what matter.

The final paragraph I will read from that editorial says: Medicare seemed to work when health care was about going to a doctor and being sent to a hospital where you either recovered or died, but that era in health care has disappeared. New technologies have revolutionized medicine, saved lives and enhanced the quality of life for chronic disease sufferers. So have expensive new drugs which consume 15.5 percent of public health care spending versus 8.8 percent in 1975. The challenge, the CIHI report reminds us, is to develop a sustainable system that permits Canadians access to these new treatments without bankrupting the provinces.

Mr. Chairman, certainly we have seen with this particular Government that, rather than looking at how to sustain health care and how to strengthen our health care system, indeed what has happened is the debate has just been basically cut off, rather than getting into looking at what is needed. It is interesting to note that Doctor Hildahl made a comment at the time in March of the year 2000. The doctor was being interviewed, and he said in the particular interview that, in an era of rapidly growing health care costs, private clinics may be one solution to help ease the burden of medicare on taxes. Certainly, an interesting comment being made by Doctor Hildahl in March of 2000.

Let me say something else too. We support publicly funded private clinics and let us be clear here. The context of our comments is around publicly funded private clinics. Manitoba has a solid track record in this area for over three years. We have had three, and they have been a wonderful asset to Manitobans who needed access to care. In fact, they have been performing approximately 3500 surgeries a year, they have taken stress off of our system and certainly were even praised by Dr. Brian Postl during the announcement about the Pan Am purchase, where Doctor Postl indicated that, when the Pan Am was private, it had a lower cost than hospitals, it was more innovative, and it was more efficient. Interesting that Doctor Postl would make these comments about the Pan Am Clinic, certainly recognizing the value that private clinics had to contribute to the system, and now we see with Bill 25 the minister saying that private clinics cost more. Well, here, Dr. Brian Postl said they were lower cost than hospitals, more innovative, more efficient.

We have Doctor Hildahl indicating that in an era of rapidly growing health care costs, private clinics may be one solution to help ease the burden of medicare on taxes, and now we have a Minister of Health (Mr. Chomiak) who is closing the door totally to any possible opportunities in this area that could help Manitobans.

This is hardly in Manitoba what one could call Americanization, but I know the NDP will try to pin this label on us, which, of course, will be deceitful but politically opportunistic for them. We are talking here about three publicly funded private clinics, hardly anywhere near the American system. I am sure the NDP are also going to demonize us by saying that we want to Americanize the health care system, but, for the record, let me say the World Health Organization rates the American health care system as No. 39, France is rated No. 1, and Italy is rated No. 2. The criteria for the rating is also very interesting and very stringent. Canada sits at No. 30 in this system. It certainly tells us that guess where we will be looking when we bring forth ideas about how to improve our health care system. Are we going to be looking to the United States, who is rated No. 39? I do not think so. I think we are going to be looking at opportunities for strengthening our health care system here by looking at European systems that are rooted in values and principles of equality and accessibility similar to our own in Canada.

The public will support us because the public is increasingly frustrated and angry with the waiting lists which are growing under this Government. Certainly the minister must be getting as many calls to his office as I am to mine, where the public is fed up with the waiting lists in our system, and they are looking for some health care reform because, to them, they want access to health care. Even Roy Romanow is encouraging the NDP and others to stop fixating on the U.S. as the only alternative to medicare, and, as he said, and I quote, "We need to get out of that box."

In fact, Mr. Romanow has also suggested that there is room for private delivery of so-called medically necessary services as long as they are paid for by the public purse. Of course, that is what we are talking about here in Manitoba, Mr. Chairman. We are talking about publicly funded private clinics. In fact, Mr. Romanow has suggested that Bill 11, which was so controversial at the time, the Alberta law that allows the public system to pay private surgical clinics to operate on patients who need overnight treatment–he is saying that that does not cross the line. So interesting words coming from Mr. Roy Romanow, as he is moving into looking at health care. Certainly, he is prepared to look outside the box, but we are certainly seeing that, with this particular government, that is not happening.

* (23:40)

Well, the NDP are very comfortable in that box, but we have long since moved past that. We are looking at other systems that provide much better care than we are seeing here in Canada. Obviously, the World Health Organization is an organization that draws great respect around the world. To hear the minister taking pot shots at the effective health care systems of France and Italy is actually a little bit strange considering they have been rated by the World Health Organization, and certainly the World Health Organization is one that has a lot of credibility in terms of what they are doing. The minister has also taken great criticism with the French health care system, which I find really interesting because in France there are virtually no waiting lists. Their system costs them $200 per person per year less than the Canadian system. They achieve a higher disability-adjusted life expectancy, and their system is fairer to the poor as French citizens personally pay less through private insurance or out-of-pocket treatments.

With the fact that they have no waiting lists in that country, Mr.Chairman, it is certainly an area that should be looked at. Certainly, many jurisdictions around the world are moving in the direction. Many provinces in Canada, many jurisdictions in the world are certainly looking to improving their health care system by looking at collaboration between public and private. The member from Turtle Mountain certainly made a good comment earlier in the evening, where he indicated that when you see thousands of people waiting on waiting lists–if you add them up you will find that there are that many–you will find that that is why people are looking at systems like a collaboration between private and health

care, because obviously the monopoly system that is in place right now in Canada is not helping Canadians in their access to good health care.

It is too bad we do not have a better handle on patient outcomes because we would see that certainly we are not achieving the kind of patient outcomes that could be achieved and that other countries are achieving, other provinces are achieving. But what we have instead is a government right now that has put its blinders on and is moving backwards compared to where other provinces and other countries are going. We are going backwards in this province, not unlike what we are seeing with our taxes either in this country. We have an NDP government that does not seem to want to move forward in a number of areas that are important to Manitobans.

Certainly the Doer government would like us to believe that private clinics cause longer waiting lists. We have had some of that discussion tonight. Interesting though that the Montréal Economic Institute, in a research paper completed September 2000, stated the following: Canada's prohibition of voluntary parallel private health insurance and private medical services in hospitals precludes any Canadian-based comparison and control for the current experiment in provincial government health insurance monopolies. Of greater practical interest, however, are the lessons of other OECD countries, especially those in Europe. Unlike Canada, parallel public and private systems have been permitted to compete, co-operate and contract services in a manner, Mr. Chair, which has brought results quite different from those of the Canadian medicare experiment.

With few exceptions, other OECD countries have avoided waiting lists for medical and hospital services and have often provided a higher percentage of government funding for public health services, even with a parallel private system. So through competitive markets along the public and private sectors they have preserved a variety of choices for patients and physicians.

Certainly, Mr. Chairman, with the comments that Mr. Romanow is making, with comments that others in the health care system are making, a lot of health care professionals are indicating that the system is in crisis. Others are certainly spreading their wings a little bit more. Here in Manitoba the NDP obviously have clipped their own wings, and they are not willing to even look at opportunities for improving, because they are truly just stuck in a status quo mode.

When we look at studies, I know the minister is fond of quoting from the Manitoba Centre for Health Policy and Evaluation. I would like to read into the record a letter to the editor which was published in the *Winnipeg Free Press*, Monday, November 20, 2000, from Dr. Michelle Georgi and Dr. Scott Mundle, who are optometrists here in Winnipeg. The title of their letter to the editor is "Open your eyes to cataract surgery reality": We would like to comment on an article in the *Free Press* called "Two-tier health care opponents get ammo."

They are saying this article is misleading and misrepresents the reality of cataract surgery today. It references a Manitoba Centre for Health Policy and Evaluation report that without further explanation seems to indicate that a system with both public and private cataract surgery is worse than a system with only public cataract surgery. The bottom line is the only way to shorten waiting lists in cataract surgery is to make available more surgical time slots. The creation of private surgical time slots helped almost double the number of cataract surgeries performed in the seven-year period from 1992 to 1999.

Near the end of the article, Misericordia Health Centre Medical Director, Dr. Alan Lipson, explains that waiting lists are a result of the aging population and a surgeons popularity and experience. He is absolutely correct, and it is this fact the Government must deal with, not the so-called two-tier option of private surgery. As practitioners who refer our cataract patients to surgeons, if the Health Minister wants to solve the waiting list problem then he should simply open more surgical time slots.

They indicated that the author of the article should stick to the real facts and reality of cataract care, rather than go for the easy sound bite of two-tier health care when that is not the issue.

Mr. Chairman, we have two doctors disputing the Manitoba Centre for Health Policy and Evaluation report about waiting lists, certainly a challenge to the minister that what he needs to look at is a suggestion that they make.

We have a situation in Manitoba where we are going backwards here. Prior to getting into questions, I would like to make, I think, one final comment. I do have a concern that, if appropriate and timely medical care is not available through the public health system and provincial legislation like Bill 25 has the effect of depriving individuals of timely access to health care, I am concerned that this could be a violation of the Canadian Charter of Rights and Freedoms. In fact, section 7 perhaps of the Canadian Charter, where–*[interjection]*

* (23:50)

One has to take a moment when the minister throws out a little shot as to wondering whether that is Doctor Godley's argument. The minister has turned the Doctor Godley situation into a very personal one between himself and Doctor Godley. He has personalized it to the point that it is actually preventing him from looking at how he can improve health care. So he wonders if my thoughts on the Charter come from an argument from Doctor Godley. I would like to assure the minister that, for the past year watching him in action as the Minister of Health, this question came to my mind quite some time ago.

I do have a concern in the area, and I do wonder when we are going to see a point in Canadian health care where the Charter is actually going to be challenged by somebody who is being denied access to care either by legislation like this or by other means where you have governments that, like this Minister of Health, have indicated he has no plan for health care, he has no grand scheme for health care, and he is just going to try a bunch of things. If something works, he is going to keep it, and if something does not work, he is going to move on and try something else. Well, I do feel that is a very irresponsible way to address a very costly system, not just in dollars, but also in what happens to patients in this system.

So I do leave the thought with the minister that at some point there certainly could be a Charter challenge to this for people that are being denied timely access to care. Yet the minister has allowed his personal fight, his personalization of the issue with Doctor Godley, I believe, to interfere in making some good decisions for Manitobans. I do not think he is showing good judgment either in bringing this bill forward or in the way that he has chosen to handle The Maples Surgical Centre. Certainly he could have prevented a lot of that just by moving forward to even address the situation.

It is interesting how he indicated on February 7 that he actually was going to make sure that that clinic could not move into Manitoba, and he indicated that he was going to bring a bill forward. He indicated that he was prepared to change definitions in order to not allow this clinic to come into Manitoba. So obviously Bill 25 is an absolute knee-jerk reaction to the clinic from British Columbia wanting to come into Manitoba.

The Minister of Health has obviously, in the February 7 article of the *Winnipeg Free Press*, indicated that he is going to bring in legislation to block the company's plan from coming into Manitoba. It says in that same article that the minister declined to go into specifics but indicated that could involve changing the definition of a private hospital. So what the minister has done is he has skewed debate. Rather than having an open, honest, intelligent debate about private clinics, he has sneakily just brought in, in a deceptive manner, a new definition rather than actually allowing a good and solid intelligent debate about private clinics.

So now he is talking about private hospitals. Well, private hospitals are a phantom issue in Manitoba. We do not have private hospitals that I know of. The minister is choosing to be very politically deceptive in how he has worded the bill and certainly is skewing the debate. He is doing it in a very dishonest way because he is not allowing Manitobans, I do not think, to see the true picture in this particular issue. I think he has done a huge disservice to Manitobans. He may think that he is doing something good for his ideology, and he sure is not going to compromise his ideology, but as far as I am concerned, he has compromised patient care in Manitoba with this bill.

Mr. Chairman, I am wondering if the committee would allow a number of general questions before we get into the clause by clause. Certainly it would speed up the discussion through the rest of the night by allowing general questions to occur now.

Mr. Chairperson: Thank you, Mrs. Driedger. Normal procedure is to deal with general questions or questions as we go through the bill on a clause-by-clause basis. If you want to pose general questions at this point in time, you need the will of the committee to do so. Are you so requesting?

Mr. Leonard Derkach (Russell): Mr. Chair, with your indulgence, I think we would like to proceed in a general nature where we could ask questions, because if we do it by clause, I think it will just prolong the process.

Mr. Chairperson: Well, I am advised by the Clerk Assistant that, in order to take that route, that leave of the committee is required.

An Honourable Member: I ask for leave.

Mr. Chairperson: Leave has been requested to deal with general questions at this point in time. What is the will of the committee? Is it agreed?

Mr. Chomiak: Mr. Chairperson, I think we could try it out and see what the tenor and flow is and see how that functions. Obviously, the idea is to try to expedite matters and get through this in the most informed fashion. Clearly, there are a number of issues the Member for Charleswood (Mrs. Driedger) needs clarification on. That is pretty clear from her opening statement.

I think we should go through general questions and see what transpires. Let us give it a try.

Mr. Chairperson: Leave has been granted.

Mr. Derkach: Mr. Chair, by way of general comment and question with respect to the bill, I know that we have a different philosophy than the Government does in terms of how we approach health care. I think that it is fair to say that we are trying to do what is best for the clients of the system, but we have two different approaches. The one thing I do not understand is why the minister would introduce legislation that does not cover anything that we have in our province today. We do not have private hospitals in Manitoba at this time, and to bring in a bill that disallows private hospitals in Manitoba just does not seem as though we are addressing a real issue in our province unless the minister has some fear that he does not have a credible enough system, he does not preside over a credible enough system in this province and that in fact somehow under his watch private hospitals may emerge.

The minister cannot say that our administration supports private hospitals, because the record can speak for itself. We did not introduce the concept of private hospitals in this province. It has always been a silent issue. For as long as I can remember, since medicare came in, we have operated under a system where we had a publicly funded public system of health care, with the exception of some private clinics that were augmenting or complementing the health care system in our province.

Now the minister decided to purchase the Pan Am Clinic. He has not been able to demonstrate what positive benefits will accrue to the clients of the system with the purchase of the clinic. Now he has made some statements rhetorically, but no evidence has been coming forward as to what benefit Manitobans have as a result of the purchase of the clinic. He has purchased a relatively old building, one that has been depreciated. He has purchased some relatively old equipment, and he has purchased some relatively old operating theatres. He is going to be spending something in the neighbourhood of $3.3 million on renovations in order to bring it up to a standard that he wants to see it at.

* (00:00)

Now, Mr. Chair, the minister has never been able to tell us why he could not have achieved the same goals of doing more procedures in that same facility, leaving that facility as a private-run facility. He has never been able to demonstrate to the public or to the papers, to the news media, nor to the Opposition, what other benefits he is going to be able to show

Manitobans that his purchase is going to give them.

In the former administration, there was a cap put on the number of procedures that could be done at the Pan Am Clinic. If the minister had wanted to, he could have simply taken that cap off or increased the cap, allow for more procedures to be done, and allow that facility to continue as it was. So, because he has not been able to explain that, he cannot ignore the fact that Manitobans will be suspicious of what his hidden agenda is with respect to the Pan Am Clinic.

Now, Mr. Chair, I have to concur with my colleague from Charleswood that we will oppose this bill, because it does nothing to address the interests of patients in Manitoba. The minister has not been able to demonstrate how we are going to improve our system. Now, we can talk in philosophical terms about whether we support public health care publicly funded or a private system publicly funded, but the reality is we have a system in this province which is not private. We have a system in this province that does have a couple of private entities delivering services to help, to complement the current system, but what the minister is doing here is fighting a phantom issue, because it does not exist in this province.

I know my colleague from Charleswood has many questions to ask tonight of the minister with respect to this bill. I think those are important questions, and I am hoping before the end of the evening I will get a better understanding of why the minister is really going in the direction he is with respect to this legislation.

Mr. Chomiak: A couple of points. Did you not hear what they presented? Person after person cited report after report that said when you run a private system beside a public system the waiting lists go longer. You have not been able to present one report that says otherwise, point one.

Point 2, Mr. Chairperson, if this bill is only about private hospitals, which the member just indicated, then what are you opposing? You cannot have it both ways. You cannot say, oh, you are closing your mind to private clinics, but then the bill, the member admits the bill only deals with private hospitals and that is what it does deal with, private hospitals. The member admits it, and you are opposed to it. So you cannot have it both ways.

With respect to Pan Am, it is very clear, again I go back to the presentations. Some of the presentations talk about what goes into a private clinic, profit, around 15 percent, administration, management. That is why the American system is more expensive, 28 cents on the dollar versus 13 cents on the dollar for the Canadian system. It is straight administrative costs. That is why the French system that you so put up the flagpole, cannot provide any evidence for, has higher taxes, has a 13% employer tax, and you only get 80% coverage. You have to pay 20 percent. So, if you have a $50,000 operation, you put down $10,000, and do not tell me there are no waiting lists.

Mr. Chairperson, there are a number of issues to differ on, but members opposite should argue, provide me with the evidence and provide me the details to support your position. You have not been able to do that, throughout this entire debate. All you have talked about is Maples Surgical Centre and France, but the studies show otherwise. All we are saying with this bill is we want to prevent the introduction of private hospitals in Manitoba. As I have said over and over again in the House, when I went to the Health ministers meeting, the members forget there was this little bit of a controversy in Alberta about a year ago, just a teeny-weeny bit of a controversy. It was a huge controversy. There is controversy in Ontario.

We are trying, in Manitoba, we are not closing our minds. We are not going down the ideological path of private, private, private. We are saying we have contracts with private facilities, we are taking the longest-standing, the oldest, the most efficient, the most respected private clinic and melding it into our system, and in addition we have our public system. So we are trying to be innovative. Members opposite say one way: private, private, private. They do not even have studies to back it.

So there is a difference in the viewpoints. That is correct. It was very clear at the committee hearings tonight. Presenter after presenter

said look at the experience of the previous government. They tried to privatize home care, and when they did the public said that is not the way we want to go in Manitoba. That was also reflected in the presentations tonight. In addition, the cost of the home care experiment was beyond the public system. It cost more, because that is what study after study has shown, the administrative costs, the profit costs.

I do not want to mix up a number of issues here because members are going back and forth. This bill deals with the limitation on third-party payment, which is a problem in the Canada Health Act, and this bill deals with private hospitals and definitions to ensure that it is very clear what a private hospital is in Manitoba.

The members said they do not agree with private hospitals, then why do they oppose this act? I do not understand, but members seem to be adopting an ideological line in this regard and that is why we are having difficulty.

The Member for Charleswood (Mrs. Driedger) refers to Roy Romanow, the Romanow commission. The Romanow commission is examining, the Romanow commission was in Sweden. I understand Sweden, which was the old flag that had been run up the flagpole by members opposite, Sweden has put on hold its privatization effort. Why? Because the things happened in Sweden that were found in the Centre for Health Policy and Evaluation study, creaming, fast procedures. Yes, they did more procedures, but they were to the detriment of the public system. The public system was left with the more expensive procedures.

So, yes, there is much to discuss, there is much to study and there is much that we are doing, but I think rather than going down the only private route in Manitoba, which members opposite encourage, we are being open. We are saying, we are maintaining contract with the private clinic. We are taking a private clinic and moulding it into our system. We have more flexibility than any other jurisdiction, I suggest, in the country, except we are not going to enter into a contract or purchase every clinic that comes into Manitoba because, as it said in the *National Post* article: Costs skyrocket when you do that. Costs skyrocket when you do that.

So, Mr. Chairperson, I think this is a pragmatic bill that members opposite are choosing to oppose, based I think on ideological reasons. I think the evidence is quite contrary to the member's position. The act itself–the amendments themselves are not overly ambitious–but we are obviously having this debate.

Mr. Derkach: Mr. Chair, the minister started out with raising three points that he said he would contradict my comments on, but, in actual fact, the minister's actions speak louder than his words. He has, as minister, disallowed, for example, the Godley clinic from doing procedures which, normally, a private clinic should be allowed to do. Now he blames the WRHA for that, the Workers Compensation programs.

An Honourable Member: No.

* (00:10)

Mr. Derkach: Now he says no, Mr. Chair. But as I say, his actions speak louder than his words. They simply do not get access to those files. That is a philosophical bent. That is an ideological approach that we do not agree with. I have never seen our Government advocate for a privately run health system in this province. Minister after minister, during our 11 1/2 years of government, supported and advocated for a public health care system, but the Pan Am Clinic was in existence long before we came into government, provided services to Manitobans.

I will tell you of a personal experience where we had an issue in our family that needed to be attended to. We could not get into the publicly funded system, but we could get into the Pan Am Clinic–paid for publicly. It did not cost me a penny, but it was a system that augmented, that complemented, the public system that we have in our province. So, Mr. Chair, there was not ever a problem that I recall in having a private system like the Pan Am Clinic work alongside of our publicly funded health care system.

Now the minister says, then, we should support this bill, because all it does is speak to the private hospital, except that the minister has put a twist into this bill. He prohibits any overnight stays in any of these clinics. Now, if

the minister is really open-minded about the delivery of health services in our province, then he would simply say, well, if that is allowed, if we are really interested in the safety of a patient, the care of a patient, then we will allow for those cases to stay overnight, provided that the care is there.

What we should be concerned about is that the adequate care for those people is there. It is still a publicly funded system. It is still paid for by the taxpayer. There is no difference in that respect, so therefore we should allow for that clinic, in cases where your hospitals are full. Is it better for a person to be cared for where that person has had the surgery or do we move him or her to a hospital, perhaps, where that person has to lie in the hallway? *[interjection]*

Now, Mr. Chair, the comments we hear around the table are driven simply by ideology, not a practical approach to what we face in this province. There has never been a problem with the Pan Am Clinic in Manitoba. I say to them– *[interjection]* Yes, for that matter, for any of the–

Mr. Chomiak: Well, you were fined by the feds, and you had to bring in legislation, Len.

Mr. Derkach: Mr. Chair, the minister says something about legislation. We put a cap on the Pan Am Clinic. Yes, we put a cap on the Pan Am Clinic, but that cap could have been lifted.

An Honourable Member: You were being fined by the federal government.

Mr. Derkach: Now we are getting into a different issue, Mr. Chair. Provided that the procedures done in that system are funded in the same way that procedures which are funded in any other facility, then those procedures were not questioned by the federal government or anyone in authority. What we addressed was the issue of having people being able to jump queues, people being able to go there and pay for their procedures when they could not get them done in other facilities.

So that was not incongruent with what the philosophy was of a publicly funded system in our province. So the minister again is looking for excuses in this particular instance to justify his position with respect to this bill. But I have spoken to a lot of people in the health care system who simply do not understand what the thinking behind the purchase of the Pan Am Clinic really is. No one in government, neither the minister, the Premier (Mr. Doer), nor anyone else who has spoken with regard to this issue has been able to explain the benefits of purchasing a Pan Am Clinic for $7.3 million and what benefit it will have to Manitobans.

Mr. Chair, at the same time, I do not know what this bill is going to do for Manitobans as well, except that it fulfils the minister's agenda, an agenda which is wrong-headed, an agenda which will restrict access to health care, which does not have the good intentions that we should have with respect to our patients. Instead, it will disallow patients who perhaps have been injured in the workplace, who have been injured and want to get back to work, they will not have access to treatment perhaps in a private clinic where they can get back to work earlier than they normally could.

The minister shakes his head at this, Mr. Chair, but that is the reality. So I guess the minister and I disagree. In terms of the approach, we will continue to disagree, but there is no way that the minister can really explain how his system is going to be more beneficial to clients in Manitoba. He points at studies that have been done and without wanting to embarrass the presenter, we could have shot holes through the report that was done, but that does not do any good to anyone.

The minister says: We are clinging to a French system or a Swedish system, but there is evidence in this country itself where the private system is working hand in hand. When I say the private system, I am talking about private clinics. Not hospitals, not private hospitals, not privately funded. I am talking about a publicly funded, privately administered system which works hand in hand with our public system right across this country, delivers services to patients in a very effective way.

Then he tries to justify his position by saying that he is opposed to a privately funded, privately administered system. Yet he sends his

patients to those systems, whether they are in Ontario, or whether they are in the United States, Mr. Chair. So, yes, we have a difference of opinion.

An Honourable Member: And you support that.

Mr. Derkach: Well, the minister says: and you support that.

We had to do that when we were in government. But he was the one during the election campaign who said we will close the door to North Dakota. We will close the doors. We will put Grafton out of business, he said. But unfortunately, when he got into government he realized that he had to use the system. He had no choice but to use it. So, Mr, Chair, the minister has not fulfilled his commitments in that respect.

Mr. Chairperson: Question then.

Mr. Derkach: I have no question for you. I just–

Mr. Chomiak: Mr. Chairperson, with all due respect, one of the problems with going to general questions is precisely what happens, we get into these long repeat over the same arguments and we do not move this along. Now, I am not–it is relatively late, or relatively early, on Wednesday morning. We have a lot to go through. I suggest we should start dealing with the–well, you know, why do we not start dealing with some of the issues related to the bill so that we could expedite the matter? We are going to have plenty time to debate the various ideological differences.

Mr. Chairperson: No further questions?

An Honourable Member: Actually, there are lots of questions.

Mr. Chairperson: Are there?

What is the will of the committee? To continue with questions at this point in time or to proceed with clause by clause and deal with questions at that point in time? No comments? Is it the will of committee to proceed to clause by clause?

I have put it to the committee to move to clause by clause, and I do not think I had unanimous consent to do so. Far be it for me to want to squelch the previous agreement to pose general questions at this time, unless I have unanimous agreement to move on. We will continue with general questions.

Mrs. Driedger: Does the minister understand that publicly funded private clinics are allowed under the Canada Health Act?

Mr. Chomiak: Yes.

* (00:20)

Mrs. Driedger: Could the minister then tell us why he is so adamant in his purchase, for instance, of the Pan Am Clinic to remove something that is totally allowed under the Canada Health Act, that he moves to purchase that? Yet we see this minister still continues to use other private clinics like the Western, certainly has not been seen to be moving through this bill to either buy the Western Clinic or to change it into a private hospital. It does not seem to be in the range of discussion.

I wonder why the minister, on one hand, is saying that publicly funded private clinics are allowed under the Canada Health Act, that is okay, but he is going to buy one of them and pull it out of that even though it has functioned well, and then he is going to allow others to remain in the system.

How is it that he is so comfortable talking out of both sides of his mouth on this issue?

Mr. Chomiak: I am not so ideologically bound as the member is in her position. I want to have a variety of pragmatic responses. The justification for Pan Am was very clearly laid out in the Pricewaterhouse report.

Mrs. Driedger: Certainly the Pricewaterhouse report was done well after the announcement was made to purchase the clinic, so the decision was made well before that. Then the firm was told that Government needed a paper trail and then let us get one in place. The fact of it was the big announcement for the clinic was made and

then the due diligence was done well after the fact. I mean, everybody knows that.

I am very curious as to why the minister appears to be so hung up on who provides care within the system. For some reason he has such an opposition to the private clinics, the publicly funded clinics, so much of an aversion that he wants to now rename them private hospitals just so that he can control and manipulate the whole debate and environment around the issue of publicly funded private clinics.

Mr. Chomiak: The member just contradicted her previous question when she said we were so utterly opposed to private clinics that we did not want to deal with it. We are maintaining the contract with the private clinic. We are purchasing Pan Am to have an option to do a different approach to health care, and we are going to have the public system. There are three different paths, three different options that we are looking at.

Mrs. Driedger: On June 14 of this year in Hansard the minister said, and I quote: What we wanted to do was to prevent all kinds of private for-profit clinics coming in in order to try to save medicare and maintain the integrity of the system. Can the minister tell us how publicly funded private clinics compromise medicare in his view?

Mr. Chomiak: I cite all of the reports cited by people who appeared before this committee. Person after person cited reports and studies that indicated the difficulties that could be encountered, Mr. Chairperson.

Mrs. Driedger: Certainly the minister needs to have a stronger argument than that. He is putting a bill forward. He has got a very strong stance in this particular area, and he does not seem to have a good answer really for how publicly funded private clinics compromise medicare. He is out to save medicare and maintain the integrity of the system. I mean, we have had three publicly funded private clinics in Manitoba for three years now. They have done 3500 surgeries a year. In the year 2000, all they cost our system was $2.8 million out of a $2.4-billion budget. They served Manitobans really well.

I would like this minister to explain to Manitobans how these three clinics, that only spent $2.8 million out of a $2.4-billion budget, harmed medicare, and how they hurt the integrity of the system? Can he explain that to Manitobans?

Mr. Chomiak: Mr. Chairperson, first off, the member's numbers are wrong. She is using one year of $2.2 million on a $2.4 base, and that was not the actual base of the actual expenditures. That point aside, as I indicated in the Price-waterhouse, we will be doing more procedures to more people under the action plan that we are devising.

Mrs. Driedger: In this whole debate, the minister has always talked about private clinics being for-profit clinics. I would like him to tell Manitobans how publicly funded private clinics actually make a profit. Seeing as he always alludes to this: Can he explain to us how that can actually happen?

Mr. Chomiak: Mr. Chairperson, I think they are generally referred to as facility fees.

Mrs. Driedger: Does the minister not have the power to set up contracts with private clinics?

Mr. Chomiak: The answer is self-evident.

Mrs. Driedger: Well, certainly the minister does have power to set up contracts with private clinics, so I have to wonder what causes him some great concern. He can determine how many there are in Manitoba. He can enter into contracts with some if he wanted to. He does not have to enter into contracts if he does not want to. So he actually can control them without bringing in a bill, and then skewing the whole issue by calling everything private hospitals now instead of private clinics. He has the power to control them, to regulate them, to contract with them on an annual basis for how many surgeries he is going to do in a year. He could do less one year and more another year, depending on the need out there.

So I have to wonder why is he so worried about this. Why is he so worried about trying to save medicare and maintain the integrity of the

system, when he has absolute control over publicly funded private clinics?

Mr. Chomiak: Yes.

Mrs. Driedger: I think the minister, I mean, if he is so passionate about this subject and goes the length of putting Bill 25 forward, I think it would be nice for Manitobans to have a little bit more of an answer like that.

Certainly, this minister can control all of this system, and he can determine, as I said, the number of clinics in the province. He can actually set contracts on an annual basis. How does this compromise medicare, and how does this compromise the integrity of the system? The minister has been on record saying this, so I want to know from this minister how something that he has total control over like this, how he actually sees it that it can need his input to save medicare and maintain the integrity of the system by wanting to bring in a bill like this?

Mr. Chomiak: Mr. Chairperson, the bill deals with profit hospitals and charging people's friends for faster access.

Mrs. Driedger: In the last three years in Manitoba, can the minister indicate where people were paying for faster accessing for care in this province?

Mr. Chomiak: Three years ago, the Province was cited by the federal government–

Mrs. Driedger: No, today.

* (00:30)

Mr. Chomiak: No, the member said three, the last three years. Three years ago, the Province was cited by the federal government for a violation of the Canada Health Act by virtue of people being forced to pay facility fees, and they were fined on a monthly basis. Ergo, the Province brought in a bill, not dissimilar to the legislation that we have brought before us today, Mr. Chairperson, to deal with that particular issue.

Mrs. Driedger: Well, the minister sounds pretty high and mighty on all of this, but all through the '80s, two of these clinics, or perhaps even three, operated under an NDP government. User fees were being paid by patients, and they were totally ignored by an NDP government in the '80s.

It is true that come the mid-'90s the federal government decided to pay more attention to this issue. The federal government, after meeting with the ministers across the country, the health ministers, decided that they were going to deal with this issue. What they ended up doing, then, is addressing the issue of user fees that were being charged to patients.

We acknowledge that. This is not anything we are hiding, and, in fact, I believe the NDP even voted for the legislation that was brought in at the time.

So for the minister to sound so high and mighty about all of this is a little bit strange. Certainly the Province was fined $68,000 a month, and, in fact, the legislation was brought in so that for the past three years we have had publicly funded private clinics. It was the Tories that created the situation where user fees were taken out of the system, and, in fact, the fees were paid through public funds.

Certainly the NDP supported that legislation back in the–*[interjection]*

Mr. Chairperson: Order, please. If the captains would like to have a conversation, they could go to the other end of the table.

Mrs. Driedger, continue, please.

Mrs. Driedger: Thank you, Mr. Chairman. So certainly we have had three publicly funded private clinics that the minister is in full control of. He has an opportunity to decide if he wants two in the system or four in the system, but he gets all excited about this issue, and it becomes quite hard to understand how he feels that he has to bring in a bill to save medicare and maintain the integrity of the system when he had control over that. It is just so unclear to many Manitobans how these three clinics that have been around for a long time have actually harmed the system when, in fact, many Manitobans have absolutely benefited from them.

So, then, we have the minister who goes out and decides to buy one of these clinics, nationalize it rather than just raise the cap and allow more surgery to be done. So one has to wonder, well, why would somebody do that? They have a good track record. They have a good history in Manitoba. I mean, the Pan Am Clinic was only costing $670,000 in the year 2000. That is hardly going to harm medicare, and out of all three clinics, I mean, 3500 surgeries took pressure off the hospitals for $2.8 million out of $2.4 billion, and the minister is going to save medicare from these awful publicly funded private clinics. People are asking: Why did the minister not just raise the cap? Why did he buy the clinic? He is in control of these clinics.

Could the minister tell us how he feels that a bill like this is needed when he had all of this control and did not even need to go this route but is still bound and determined to go this route? Can he tell us how bringing in a bill like this is going to help patient care in Manitoba? How it is going to improve patient outcomes? How it is going to improve access to care, when really all he is doing is shutting down innovation and preventing access to care and also compromising patient safety?

Mr. Chomiak: Mr. Chair, most of what the member said is wrong. This bill deals with limiting overnight stays in private clinics for normal procedures, and it deals with third-party payments.

Mrs. Driedger: The minister has accused us, June 14, in Hansard of advocating a two-tier system where the rich can pay and get faster service. Can the minister tell us where in Manitoba that happens?

Mr. Chomiak: Mr. Chairperson, I certainly do not want to have private public hospitals in Manitoba where people can pay money to go to the front of the line or jump the queue. That clearly is not something that we want.

Mrs. Driedger: Well, certainly the minister even in the op-ed piece today, which I have to say I read and found to be one of the most manipulative pieces of writing I have seen out there in a long time, certainly the minister knows full well that in the past three years there have been no user fees in Manitoba. There is no queue jumping in Manitoba, but he continues to infer our there that these things are happening, and he is going to protect Manitobans from the bogeyman because the bogeyman is going to come and create a two-tier system where the rich can pay and get faster service.

I would like this minister to indicate where, in the last three years, after the Tories changed the legislation to prevent that from happening, he is finding it in existence in the last three years in Manitoba.

Mr. Chomiak: First off, I do not believe in the bogeyman, Mr. Chairperson. Secondly, this bill is being introduced to prevent private hospitals coming into Manitoba and people paying user fees to jump the queue.

Mrs. Driedger: The minister needs to explain to Manitobans because he uses this out there all of the time, talking about a two-tier system where the rich can pay and get faster service. I think if the minister is going to use that, and we are talking about a bill that applies today. Where, in today's system, do the rich pay and get faster service in Manitoba?

Mr. Chomiak: We have been operating a system now for almost two years.

Mrs. Driedger: On June 14, in Hansard, the minister accused us of advocating for a two-tier system where the rich can pay and get faster service. He made an accusation about me and my colleagues, that we are advocating for a two-tier system, where the rich can pay and get faster service. I think this minister owes us an explanation as to why he said that, and where, in Manitoba, this could possibly happen, because he is inferring that that is something that is out there, when he knows full well that what we are supporting is publicly funded private clinics. There are three in Manitoba, well, two, now that he has moved in, and that is all we are talking about.

We are not talking about anything outside of that in this discussion. Yet the minister goes out there, and infers that the Tories are supporting some kind of a two-tier system where the rich can pay and get faster service. He knows full

well under the Canada Health Act that user fees are not allowed, so, the rich in Manitoba cannot pay and get faster service. Although we certainly find that people are leaving this province to get service for their children, for their elderly parents, in the States and Alberta and into other provinces, can this minister tell us where, in Manitoba, the rich can pay and get faster service? He knows there are no user fees allowed, and there is no queue jumping.

Mr. Chomiak: The member opposite has said we should reopen the Canada Health Act. The member opposite has said we should look at user fees as Roy Romanow has suggested. The member opposite said we should emulate France, where they have a 20% user fee. The member opposite has said we should go to the Swedish model that uses for-profit hospitals. I think that the member's statements speak for themselves.

* (00:40)

Mrs. Driedger: Certainly this minister tends to twist the kind of questions that are asked. I saw it numerous times in Estimates when one asked questions about something the minister will automatically assume that there is a support for it, just because a question was asked. Then he deflects when a question comes his way, and becomes defensive about it, when he has accused us, June 14 in Hansard, of advocating for a two-tier system where the rich can pay and get faster service. I think the minister owes us an explanation as to where in Manitoba that could possibly happen.

Mr. Chomiak: In addition, it is interesting that members opposite say they are innovative. What is their innovation? Well, we want private clinics paid for publicly, and by the way, fund Dr. Godley when he comes in, and fund the next clinic that comes in and fund the next clinic that comes in. If you were to read the *National Post* and read what Evelyn Shapiro had to say, it was very clear. It is quoted by Evelyn Shapiro, who is a professor at the University of Manitoba. I know, maybe she does not live in France, but the fact is that she clearly indicates that the policy advocated by members opposite would have skyrocketing costs, firstly. Secondly, studies show that waiting lists increase when you operate private system beside a public system.

Members opposite have not put one scintilla of evidence to contradict that. Not one scintilla of evidence, not one study. They have had months to come up with studies.

The member comes up with a study from the Montréal Research Institute that says: Well, you cannot compare to the United States or internationally. But not one study. Now, the Centre for Health Policy and Evaluation is wrong. The Alberta Consumers' Association is wrong. The Harvard *New England Journal of Medicine* is wrong. Evelyn Shapiro is wrong. The people that presented tonight are wrong. I think the member's comments speak for themselves.

Mrs. Driedger: I think the minister's comments, the comments he is making, certainly speak for himself in what he is now implying about the World Health Organization, a highly accredited and acknowledged organization that looks at health care systems around the world. They are the ones that put France at No. 1 for having a health care system in the world. I am the messenger, and this minister has such a knack for trashing the messenger, when, in fact, it is the World Health Organization that has rated France No. 1, not me. They used the criteria that they use. They have rated Italy as No. 2. They have rated all of these other countries, and we are rated No. 30. Is the minister sitting here now saying that the World Health Organization is not to be an organization that does good, valid work, that they in fact do not know what they are talking about? The way the minister is talking, he is certainly, I think, discrediting the work of the World Health Organization.

While he can make all kinds of comments about me, I mean, I am the messenger in this. I am not the one who invented France as having the best health care system in the world; the World Health Organization did that. Yet the minister appears to be degrading here what their findings are.

But this is sort of typical for this minister, where he will lash out, he will become defensive, he will fearmonger, and lately we are seeing skewing debate by changing, for instance, in this legislation, definitions. I have to really wonder with all of that if the minister really thinks he is actually helping Manitobans get better care.

Mr. Chomiak: Yes.

Mrs. Driedger: I think if the minister were to listen to people out there, they are not feeling that they are getting better care now at all in Manitoba. In fact waiting lists under this Government have gone up. Hallway medicine is still in existence. We are hearing from patients day after day who are complaining about our health care system and are waiting for this minister to put in a plan so they can see an improvement to the system. All he can do is get defensive and trash the World Health Organization. I say shame on him for doing something like that when people all over the world hold them in high esteem. They certainly have valid criteria for how they look and judge different health care systems, and they have no stake in it. They look objectively at what is happening around the world. Their intent is to try to see to it that health care systems across the world can improve. That is why they are doing the work they are doing.

The minister likes to talk about creaming. I have to wonder if the minister really understands what day surgeries were set up to do. Day surgeries and surgical centres were not set up to do complex surgeries. They were set up to do what day surgery centres can do, and that is generally minor surgeries. The minister even acknowledged the Pan Am, for instance, as being efficient and effective as a private clinic, but now that he wants to change the legislation he sort of does not look at the value of what the Pan Am was doing. Well, they were doing what publicly funded private clinics, day surgery centres, do.

Now, the minister, when he wants to, talks about creaming, you know, creaming off the easy cases and leaving the public system to pick up the complex, more expensive cases. That is what day surgery centres were set up to do, so that the hospitals could actually do what they were meant to do, complex, expensive cases. It is interesting because when he talks about that perhaps he is not aware that the College of Physicians and Surgeons is the one that determines what surgical centres can do for day surgeries. There is a very thorough list in all of the various specialities. So when the minister talks about creaming that is a bit absurd, because the College is the one that makes the decisions as to what procedures can and cannot be done and set the criteria within the clinics for the procedures that doctors are able to do. For the minister to be talking about creaming, I mean obviously he does not understand the health care system then very well.

One almost has to take it a little bit of a step further. I mean, Doctor Postl has indicated that the private surgical centres are more innovative, more efficient and cheaper. He said that to the media. So I will take Doctor Postl's word on this. If we are looking at day surgery centres doing what the College says they can do, that is hardly called creaming.

It is interesting, too, when all the money is coming from the same taxpayer. I mean, is it not better that the surgical centres do the type of surgeries they can do at a cheaper cost and leave the hospitals to do what they do best? I have to assume this minister does not fully understand what day surgery centres are supposed to do.

But it is interesting because there is a hospital in Sweden, Sankt Göran Hospital, that has indicated to a comment, a similar comment made there about a situation: They said that that is absolutely false. When you have private clinics and hospitals, they are saying that is absolutely false when anybody is making the accusation of creaming off the easy cases. There are people out there who, I think, can actually dispute many of the comments that this Minister of Health is making.

I am concerned with his moving forward on the bill when we see the health budget so high in Manitoba. We see it go up by 22 percent in two years. It is now $2.6 billion. It is almost 40 percent of the Budget. It is the highest per capita spending in all of Canada, and I do not think we have seen the serious effects of the baby boomers hitting the system. I do not think we have seen where Pharmacare is going to go yet. We have not seen anything about technology yet because those are all going to increase. So, then, rather than look at innovations in the system, what the minister does is go out and buy an old building and old equipment with the Pan Am Clinic rather than just raising the cap and maybe spending that $7.3 million for providing patient

care in Manitoba. Now we see a bill where he absolutely shoots down any possibility of anybody wanting to be innovative in the system out there.

I do not think we are going to see very many people who are going to want to come to Manitoba or even be in Manitoba and try to be innovative in this province because they can see what is happening here. All the other provinces are moving ahead. Other countries are moving ahead and Manitoba is moving backwards, and yet the minister has had opportunity to address the value of private clinics, but he absolutely refuses. One has to wonder: Does the minister not feel he is abdicating his responsibility as a leader to thoroughly look at this?

* (00:50)

Even Roy Romanow is looking at it. Publicly funded private clinics are allowed under the Canada Health Act. So I have to ask: Where is the minister's accountability to look at creating efficiency in the system, or is he just so committed to just dumping more and more money into the system which was somewhat inferred earlier, and he thinks that is all he has to do to improve the system? I mean, when he talks about being pragmatic, being pragmatic might have been to at least talk to Doctor Godley to see if there was an opportunity for something happening and then if he did not want that, he could have said no. He has that opportunity. He could have avoided so much pain and aggravation by dealing with this in a very honest and forthright way at the beginning. Instead, no, he ducks the issue, and it just escalates into where it is now. To me, that is not very pragmatic.

An Honourable Member: Are you done on your 20-minute question–

Mrs. Driedger: If the minister wants to respond, I can wait to go on to the next one.

Mr. Chomiak: Most of what the member says is wrong, Mr. Chairperson. I cite an article that I am willing to provide to the member which talks about the creaming of that very hospital that the member referred to in Sweden and the fact that they recently passed legislation of the government banning any further expansion of the private health care role. Sweden is now re-examining its own system. What the member actually went through is mostly inaccurate and is a rehash of statements the member went through earlier.

Mrs. Driedger: Why does the minister think that the College of Physicians and Surgeons approving overnight stays is something that he is not willing to, I guess, honour? I mean these are the experts in this system that actually as a body can decide that overnight stays are allowed. I understand that overnight stays were approved by them from The Maples Surgical Centre, so I would have to wonder. Here we have experts, a group of doctors, who thought that overnight stays could be allowed. Could this minister indicate why he would not be listening to the College of Physicians and Surgeons and supporting as they do overnight stays?

Mr. Chomiak: The by-laws that I think were cited by the member opposite refer to day surgeries.

Mrs. Driedger: I suppose the minister is taking day surgery in a very strict definition when in fact if he wanted to be truly innovative, day surgeries are generally minor types of surgeries, but what is to say they could not be done 24 hours a day? I do not think we have a minister then with a very open mind and seriously looking at innovation in Manitoba when he had an opportunity.

Now Doctor Postl indicated that the Pan Am may want overnight stays. Can the minister indicate with this bill now: Is the Pan Am going to be considered a hospital of some sort? I do not know what sort, but if Doctor Postl wants overnight beds in the Pan Am Clinic, does it now have to become a hospital?

Mr. Chomiak: If Pan Am were to have overnight stays that were contrary to the provisions in this Bill 25, it would have to be designated a private hospital. *[interjection]* Pardon me, a public hospital.

An Honourable Member: Be careful here.

Mr. Chomiak: I have heard the word "private" from members opposite so long, it just keeps spinning around the room.

Mrs. Driedger: I guess I just have a little bit of trouble with that particular answer, but I do not suppose I am going to get much more out of this minister in answering that question.

The Health Minister has indicated that relationship to not allowing overnight stays, that after 11 o'clock at night, if there is a patient still left in a clinic, that that patient will have to go to a hospital. The minister then said, well, there is enough capacity in the hospital to handle all of this.

But he railed earlier tonight that all these beds were taken away, and now he is saying there is enough capacity in our hospital system. Which way does he want it?

Mr. Chomiak: Mr. Chairperson, the member is mixing statements and is not actually comparing proper statements, so I am not sure what the member's question is.

Mrs. Driedger: Well, certainly the minister has indicated publicly that at 11 o'clock at night, if patients are in a clinic, they are going to have to move out of the clinic. Even if they only need to be there for a little while because they are nauseated, they are going to have to move out and go to a hospital. Publicly, he indicated that there was enough capacity in the public system, in the hospital system, to accommodate patients. So, obviously, he is implying that there are enough beds in the system.

Why, then, does he then rail against the Tories time and again for following the trend across North America of creating more day surgeries, closing hospital beds, and then railing against the closure of beds in the system, and now he is saying, well, there is enough capacity in the system.

I mean, which is it? Is there enough capacity in the system, or is he going to continue to rail that the Tories closed too many beds?

Mr. Chomiak: First of all, Mr. Chairperson, the member is wrong in terms of the 11 p.m. It is for normal procedures. For normal procedures, you should not have to stay after 11. It does not preclude people staying after 11 p.m. under health circumstances, so members opposite have been "fearmongering" on that one.

An Honourable Member: But you did not explain that, Dave.

Mr. Chomiak: I did. In fact, to the Member for Roblin-Russell (Mr. Derkach), I explained that in the House. If one reads the act, it says "normal." The Member for Charleswood, who interprets legislation so broadly, ought to look at that word.

The second point I would like to indicate is I would like to open more beds in the public system. I would like to open more beds in the public system. We would open more beds tomorrow in the public system if we had the staff. We do not have the staff, but I would like to open more beds in the public system.

Thirdly, the issue of capacity is we have capacity in the system for additional surgeries. We do not need another surgery centre. We do not need another three or four surgery centres. I do not know what members opposite would advocate, but if they advocate contracts with The Maples–*[interjection]* Members opposite indicate that with every single surgery centre that comes into the province, we have to enter a new contract. Evelyn Shapiro of the Centre for Health Policy and Evaluation says, quote: That would skyrocket.

So, generally, Mr. Chairperson, that is my response to the member's questions.

Mrs. Driedger: Does the minister actually think that any doctor out there is going to be brave enough to keep a patient after 11 o'clock at night for fear of a $30,000 fine when he has to defend that with–oh, this is just temporary; this is not happening on a regular basis. He is presumed guilty until he proves himself innocent.

Does the minister really think doctors out there are going to buy into that?

Mr. Chomiak: Mr. Chairperson, they have been operating like that in Manitoba for 20 years.

Mrs. Driedger: They have never been threatened with a $30,000 fine.

An Honourable Member: Just $5,000.

Mrs. Driedger: Oh, no, not $5,000. It is $30,000 in this one.

I mean, maybe he does not know too many doctors, but I think the minister is very naïve if he thinks doctors are going to think–oh, I will believe the Minister of Health; I will be able to talk my way out of this.

I do not think there are very many doctors who are going to even be–they are not going to be brave enough at all to stay past 11 o'clock, which means you are going to see less surgeries being done. That is absolutely for sure, because he has put a big threat in here.

* (01:00)

In fact, there is huge intimidation in this bill, that some of the inspectors can waltz in and all they need is a certificate and you are guilty until you can prove yourself innocent. An inspector can come in just like that, and I think the minister is very naïve if he thinks a doctor is going to leave patients there past 11 o'clock at night with a threat of a $30,000 fine. That is just not going to happen.

In the minister's news release re: Bill 25, he says: An important goal of this legislation is to close the door on two-tier medicine in our jurisdiction. Can the minister tell us exactly where two-tier medicine is in our jurisdiction?

Mr. Chomiak: Mr. Chairperson, we certainly want to ensure that people do not pay money to get to the front of the queue.

Mrs. Driedger: Well, the minister knows that that is probably one of his lamest answers tonight. There is no two-tier medicine happening because there are no user fees. There is no queue jumping.

I mean, if we want to look at two-tier, 30 percent of health care in Manitoba, in fact in Canada, is already private. I mean, it has been for 40 years. That is not new.

But, I mean, what about third-party payment, then, for WCB, RCMP, military, MPI? These people are now going to be serviced through the Pan Am Clinic, a public clinic, and they are going to get in there and they are going to–I heard him the other day say they get expedited services.

So now are we going to see WCB, MPI, RCMP, military, all who are being paid by third parties jumping the queue and getting expedited services in the Pan Am Clinic, a publicly funded clinic now that is going to be owned by the people of the province? Is that not two-tier?

Mr. Chomiak: Mr. Chairperson, did the member not advocate that we do that with Maples?

Mrs. Driedger: I think the minister again is getting defensive and really avoiding this particular question. I mean, I can sit here all night. I am prepared to do that and continue asking these questions. So, if the minister wants to do cute little answers, we could be here for a long time yet, and I am not sure his colleagues will be very happy with him.

But he said in his news release: An important goal of this legislation is to close the door on two-tier medicine in our jurisdiction. Now, that was in his news release that he put out. What door is he closing, because the two-tier door in Manitoba has been closed for three years? So what is he talking about?

Mr. Chomiak: That is an important goal and we want to ensure that people are not able to pay money to jump the queue.

Mrs. Driedger: In the absence of fundamental reform, what we are seeing with this Government, I think, are some pretty poor answers tonight to some of these questions. We are seeing the Province spend $7 million a day, $4,800 a minute, $80 a second on health care in this province, and we are seeing a minister who is not even addressing the issue of how to spend that money better and more efficiently.

I have one final general question for the minister, and that is related to home care because he likes to bring up the home care issue. But we do know that a year ago he did sign a contract for having the private system provide probably a fairly significant amount, in terms of people and dollars, of home care service.

How is that any different from looking at collaboration between publicly funded private clinics in our hospital system right now? How is that any different than what he did with the

home care contract that he signed that brings in private companies to provide home care in Manitoba?

Mr. Chomiak: I answered that question last year and I answered that question today in the House, that the contract that was signed a year ago was an extension of a contract that members opposite had entered into that provided backup home care services and was a continuation of the backup provision of home care services that were provided.

Mrs. Driedger: Can the minister not see the same possibility with clinics, too? I mean, the clinics, we are talking a small amount of services in the scheme of things. Can he not see the same benefit to having a few publicly funded private clinics doing exactly the same thing?

It is almost like a backup system that he just talked about with home care. Does he really, truly not see the benefits, because it is almost identical. Why is he so against one and willing to go along and not change the other?

Mr. Chomiak: I do not know where the member has been, but I have said on numerous occasions that we are continuing the contract with Western Surgery. We have had the contracts with the surgical centres for the past two years, so I do not know what I am missing, but I keep saying that to the member opposite and she keeps not hearing certain things. That is the way things go in this committee.

Mr. Chairperson: No further questions? Okay. We are over the general question phase.

During the consideration of a bill, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Clauses 1 and 2(1)–pass. Clauses 2(2) to 3(1).

Mr. Derkach: A Question. Clause 2(3). I would like to ask the minister, as it relates to "surgical service."

Mr. Chairperson: Order. Mr. Derkach, I wonder if it would be possible if we could pass clause 2(2) then, if your question is on 2(3).

Mr. Derkach: If you would like to.

Mr. Chairperson: Okay. Clause 2(2)–pass. Shall clause 2(3) pass?

Mr. Derkach: Well, no.

Mr. Chair, I have a question for the minister, as it relates to "surgical service." In the definition here, it says it means "the alteration of the human body manually or through the use of an instrument or the introduction of an instrument into the human body, when the procedure is carried out with the concurrent use of

(a) a drug to induce sedation, or

(b) local, regional or general anaesthesia,

to a degree that requires the monitoring of vital signs, but does not include a surgical procedure that is exempted in the regulations."

Now, Mr. Chair, further in this act it also defines a private hospital. My question to the minister is: Would this definition go so far as to include a procedure that is done to someone who is being treated at home for a procedure?

Let us say that it is someone who is under the palliative care definition and is in a home, requires the introduction of a surgical instrument into the body, but is confined to a bed in his home, because later on in the definitions in 19(2) "'private hospital' means "a house or building in which one or more patients are received and lodged for medical treatment or for care and treatment for childbirth, but does not include a hospital as defined in *The Hospitals Act*."

Mr. Chair, that, to me, seems that if it is a private home where patients are cared for, perhaps in a palliative sense or perhaps someone who prefers to be in a home setting rather than in a hospital environment, that in fact could be considered under his definition.

* (01:10)

Mr. Chomiak: First off, under the definition of "private hospital" it says: "house or building in which one or more patients are received and lodged for medical treatment." That would

preclude the definitions and the information that the member talked about. That would preclude your own home. That would preclude a birth in you own home. That would preclude your getting palliative care in your own home. That would preclude your getting palliative care in your parent's home. Okay.

We have got legal advice on this, because as I indicated in the House on many occasions when the Member for Charleswood (Mrs. Driedger) was raising these issues, we were very precise and we were quite aware of the implications of these definitions. We have sought legal advice. So the definition of "private hospital," which is a definition under The Private Hospitals Act, which is a separate act from the Manitoba Health Services Insurance Act, has a specific meaning and specific definition.

In addition, the regulations permit exclusions under all categories, under a variety of categories, and we intend to maintain the pre-existing regulations that are contained in the acts that deal with those issues. In addition, the by-laws of the surgical service, the by-laws as contained in the College of Physicians and Surgeons act, talk about procedures that are performed in premises the College of Physicians and Surgeons have authorized, which then means that "surgical service" is precluded from being defined because of that definition with the College of Physicians and Surgeons. It is getting very late, but I think I have gotten all of those aspects right.

I may not have explained it as clearly as I would like, but suffice to say that, in fact, when we first started reviewing this legislation, we went through all of these areas point by point, item by item, issue by issue. Nothing that the members have raised was not looked at and would not be dealt with either by the definition in the act or by exclusion in the regulations or by pre-existing regulation, that already exists.

Mr. Derkach: Mr. Chair, I have to trust that the minister will clarify in the regulations what he means by surgical service and what is exempted, because further in this act he talks about an inspector who may enter any premise.

Now, I would assume that that inspector would have the right to enter a premise where he suspects that there is activity going on which is prohibited under the act, which could be a private home for that matter.

Does the regulation exclude a private home or a residence, and is it explicit in that regard?

Mr. Chomiak: The act excludes a private home from being entered by the inspector.

Mr. Derkach: Can the minister please point me to the section where it excludes the private home?

Mr. Chomiak: Amendment 63(3) says: "enter a hospital, surgical facility or other health care facility." That is with Entry and inspection, page 3 of the act, 63(3): An inspector may at any time enter a hospital, surgical facility or other health care facility, and "house" is excluded from the act by virtue of the other definitions.

Mr. Derkach: Mr. Chair, in a senior citizens' home where, in fact, that is a premise where a patient could be treated, yet it could be a facility that could be considered under the definition of a private hospital depending on what procedures are going on in some of the rooms in a personal care home: My question is, is it going to be considered a private home, or is it then going to be considered a private hospital?

I ask these questions for information purposes only, not to try and trick the minister into anything. My concern is about private senior citizens' homes or public senior citizens' homes.

Mr. Chomiak: It would not follow that the definition of a surgical service operated in a personal care home, either private or public, could be defined under this act or fall under the auspices of the act because it is not a surgical facility.

Mr. Derkach: But, Mr. Chair, under the definition of a private hospital, it could be a facility where one or more patients is lodged for the purposes of medical treatment or care.

So, in that sense, it could fall within that definition. In terms of surgical service, it could also fall under that category, I would think, because a surgical service could be provided to somebody who is in the care of that facility.

Mr. Chomiak: You cannot look at definitions in isolation from other definitions. A personal care home would not be deemed a private hospital, and the inspector only has authority to enter into a hospital surgical facility or other health care facility that is defined. So it would not fall within the definitions of a private hospital or a hospital under the act.

Mr. Derkach: I have one more question in this regard, Mr. Chair, and it has to do with a specific facility, that being the Morgentaler abortion clinic, which, in fact, could, which does provide surgical services. It could be considered a private hospital because it does provide for the care of people in that setting.

Would you consider the Morgentaler Clinic a private hospital if, in fact, they are equipped to keep patients for overnight purposes in a case of emergency?

Mr. Chomiak: Mr. Chairperson, I do not see it as any different than the Pan Am Clinic or Western Surgery Centre which have beds and have had beds since their inception for overnight patients but do not keep patients overnight.

Mr. Derkach: So what the minister is telling us is that it would not fall under the category of a private hospital then as defined in section 19(2).

Mr. Chomiak: No.

Mr. Derkach: Mr. Chair, I think it is a vague definition of a private hospital, with the greatest of respect to the minister. In my humble opinion, it should probably be clarified to ensure that facilities like that are not going to be considered under the definition of private hospital, because it certainly leaves the impression that it could be, in my view.

Mr. Chomiak: Mr. Chairperson, if read in isolation, I think one could interpret that, but if read in the context of all of the acts and the definitions, I do not think it is as much of a problem.

Mrs. Driedger: Could the minister tell me that if a specialist is doing a procedure in their office, like a urologist or gastroenterologist or respirologist–they are doing cystoscopies or scoping and then doing a biopsy and prostate biopsies–would those be considered surgical services, particularly if the doctor has perhaps given a bit of sedation or local anesthesia and is monitoring their vital signs? Would that be considered a surgical service in a doctor's office?

* (01:20)

Mr. Chomiak: No.

Mrs. Driedger: How does it not when it fits all those criteria?

Mr. Chomiak: They will be exempted, as I indicated earlier, by the regulations that presently exempt them, Mr. Chairperson. Those regulations that presently exempt are going to be continued in the new legislation. That is what I have indicated.

Mrs. Driedger: Are those procedures that are exempt the same ones that are considered by the College of Physicians and Surgeons as procedures that can be done either as day surgeries or in doctors' offices? Is it the College that makes that determination, or now do we have Government determining what procedures can and cannot be done?

Mr. Chomiak: Mr. Chairperson, the College will make that determination.

Mrs. Driedger: Where would it indicate that the College is responsible for deciding what those surgical procedures are? If a new one comes along, is it the College that then adds it to the list, or do we actually have Government making some decisions here about what procedures are or are not done in a doctor's office or in a surgical centre?

Mr. Chomiak: By regulation, it has already been looked at by the College, the draft has. It will be determined by the by-laws of the College. If they make changes, then our provisions would change accordingly.

Mrs. Driedger: Does the minister always have to get the College's permission to add or delete from that list then, or do we have Government now taking on the role that I would have thought normally physicians would? Does the Government have a right then to take away or add to that list?

Mr. Chomiak: It is done by by-law, dovetails under the by-laws of the College of Physicians and Surgeons.

Mr. Chairperson: Clause 2(3)–pass; clause 3(1)–pass. Clauses 3(2) and 4.

Mrs. Driedger: The particular clause "no collection from others for outpatient services in a surgical facility," can the minister indicate in this particular area, because the way it is written it could be interpreted that tray fees are now no longer allowed when a physician does a surgical procedure.Can the minister indicate whether or not tray fees are allowed or disallowed under this clause?

Mr. Chomiak: This definition stays the same as the current definition of out-patient services under the current by-laws. So there is no change.

Mrs. Driedger: So can the minister confirm then that tray fees are still in place and allowed in doctors' offices where in their treatment rooms they are doing such procedures as cystoscopies or prostate biopsies or any other number of procedures that the minister will allow tray fees to continue to exist?

Mr. Chomiak: As I indicated in the House to the member, the existing criteria vis-à-vis the tray fees will continue.

Mrs. Driedger: Can the minister tell us where the definition of tray fees can be found?

Mr. Chomiak: Is the member aware what tray fees are? I am not being facetious, but–

Mrs. Driedger: I am very well aware of what tray fees are, and I am wondering, though, where in all of the legislation a tray fee is defined because I do not know that.

Mr. Chomiak: Out-patient services refer to routine medical and surgical supplies which cannot be charged for.

Mrs. Driedger: Can the minister tell us where we could find the definition, under what legislation or regulation, or where the definition of tray fee can be found.

Mr. Chomiak: The definition of out-patients services that cannot be charged for are regulations that were 222/98.

Mrs. Driedger: Under which act?

Mr. Chomiak: The Health Services Insurance Act.

Mr. Chairperson: No further questions?

Mrs. Driedger: Can the minister indicate who sets tray fees? Do doctors just tend to set their own prices?

Mr. Chomiak: The MMA has recommended guidelines.

Mr. Chairperson: Clause 3(2) and 4–pass; clauses 5(1) to 6–pass; clauses 7 and 8–pass; clauses 9 to 11–pass; clauses 12 to 14–pass. Clauses 15 to 17.

Mrs. Driedger: Can the minister just answer one particular question here? If something is not considered a surgical procedure, or, I suppose you could have some surgical procedures, but they would not be called a surgical procedure if they are exempt in the regulations. But some of this becomes very confusing. I mean, if something is not considered a surgical procedure, therefore tray fees could be charged and a patient could stay after 11 p.m. and fines cannot kick in. Would that be a logical assumption to make in following through with the way these clauses are written?

Mr. Chomiak: It is not likely that there would be any occasions for those kinds of procedures to be charged for if they were not surgical facilities.

Mr. Chairperson: No further questions, Mrs. Driedger?

Clauses 15 to 17–pass. Clauses 18 to 19(4).

Mrs. Driedger: I guess I would just like to reiterate a comment that my colleague here has just made, about the definition of a private hospital. This is almost pretty much a stand-alone clause in this whole bill, and this is the one that gives me huge concern as it relates to midwifery. Now, I do understand that there could be some feelings that you do not want birthing centres, but, certainly, this definition as it is used, and it can be used alone, it does not

have to apply to any other clauses in here, is wide open to misinterpretation.

* (01:30)

But not only this, there are a number of other definitions through this act. I do have to wonder if there did turn out to be a court case in any of this, whether any of it is going to stand up to litigation, because that is certainly going to be the test, not with the lawyers who wrote and interpret it, or the Health ministers, because Health ministers come and go. Are they all going to interpret it the same way? I think a judge is going to be the one that is going to end up interpreting this in the end, and to me, there are too many holes in a lot of these definitions. I do not know if the minister is prepared to look at it before this bill goes through, but I really do have to wonder if these definitions are all going to end up standing up to litigation, should that point ever happen, and it could happen, particularly in the area of tray fees.

Mr. Chomiak: First off, the definition does not differ significantly from the definition that was in place since the 1920s, with respect to the use of the words, although it adds "surgical service," and it reduces it from four beds to one, Mr. Chairperson. So, in that respect, the words themselves have been interpreted, probably, since the 1920s.

The second issue, it is very evident on its nature, that "a house or building in which one or more patients are received and lodged for medical treatment" is very clear, Mr. Chair. You do not receive and lodge yourself in your own home. That is evident on the record. It is just common sense with respect to the definition. In addition, there is also the ability of the minister to exclude, or include it anyway, by regulation. Perhaps not.

Mr. Chairperson: No further questions?

Clauses 18 to 19(4)–pass. Clauses 19(5) to 19(11).

Mr. Derkach: Mr. Chair, 19(8) says: "No licensee and no medical practitioner shall provide a surgical service, as that term is defined in The Health Services Insurance Act, in a private hospital."

Is this not redundant, because we do not allow private hospitals in Manitoba, in accordance with this act? Is this not a redundant clause, then? And the other concern I have is, by expressing this within the act, what happens in a case, rare as it may be, should it ever happen that we have an emergency service that is required by a patient, and he happens to be in what might be deemed a private hospital? I am thinking of somebody who is suffering a heart attack, where a physician may have to do a surgical procedure via needle to keep that person alive, and he has to do that to save that person's life and he happens to be in what could be defined, by an inspector, as a private hospital.

Does the doctor, then, have the choice of either doing this or not doing it, and seeing this patient die because the doctor may be fined $30,000? Rare, hypothetical perhaps, but, in this world, things like this do happen.

Mr. Chomiak: The question is: If a doctor has a patient, and he or she has to perform a surgical service on that patient, in a place that could be defined as a private hospital, would they be precluded from doing that procedure by virtue of this act? I do not think they would be precluded. I think that they could undertake it, because it seems to me that the definition of private hospital, which means one or more patients are received and lodged for medical treatment, would preclude that definition from occurring.

Mr. Derkach: I ask the minister: Would it not be then more advisable for him to remove this clause from the bill because he already has it covered under the private hospital definition? This particular part of the act then simply instils, if you like, a tremendous fear in a surgeon being put in a position where he or she may have to provide a service that could be perceived to be illegal. I think we are putting ourselves in a trap when we put clauses like this in the act, especially when earlier in the act we have already covered the definition of a private hospital and the fact that we do not allow for them.

Mr. Chomiak: Now, 9(1) that the member is referencing refers to The Private Hospitals Act, not The Health Services Insurance Act that was dealt with earlier.

Mr. Derkach: I am not trying to be in any way obstructive here. I am just looking at situations. Let us be practical about this. Whether you are a licensed practitioner in Manitoba or a surgeon or a doctor you could be put into a position within this province where you have to do an emergency medical procedure in an emergency. You could find yourself in a facility that could be considered a private hospital. Now all of a sudden you are putting that medical professional into a very precarious situation because he or she then is either faced with doing the procedure and exposing him or herself to a fine and other discipline, I would assume, or taking a chance and saving this person's life. Then we put the onus on that individual to try to prove his case.

I think, if we have any compassion for the people who work with patients and save people's lives in this province, I would recommend to the minister that this section be removed.

* (01:40)

Mr. Chomiak: I fail to understand the member's concern insofar as the place that the service was rendered would have to be defined a private hospital, and I cannot think of an instance or an exception where that would occur under the circumstances in the scenario the member has pointed out.

Mr. Derkach: The minister has to accept the fact that there could be a situation where we do have a facility in this province which could be deemed a private hospital because if he says that could never happen in the province of Manitoba, then why do we have this bill in front of us at all? Secondly, if he has already covered the issue of a private hospital in his definitions, and it is not allowed in the province of Manitoba, then I say to him 19(8) is redundant and should not be part of the bill.

Mr. Chomiak: We will come back. We will discuss it with you at third reading.

Mr. Chairperson: Should we put that on the record?

An Honourable Member: It is on the record already. It is in Hansard.

Mr. Chomiak: It is on the record.

Mr. Chairperson: I had not recognized you yet, so, honourable minister.

Mr. Chomiak: Oh, I am sorry. Mr. Chairperson, I will endeavour to ensure that this matter, this specific reference to subsection 9.1 in this act is reviewed prior to third reading in terms of legal interpretations and opinion. I will discuss it with the member prior to a third reading.

Mr. Chairperson: Clauses 19(5) to 19(11)–pass; clause 20–pass; enacting clause–pass; title–pass. Shall the bill be reported?

Some Honourable Members: Yes.

Some Honourable Members: No.

Voice Vote

Mr. Chairperson: All those in favour of the bill being reported, say yea.

Some Honourable Members: Yea.

Mr. Chairperson: All those opposed, say nay.

Some Honourable Members: Nay.

Mr. Chairperson: In my opinion, the Yeas have it.

An Honourable Member: On division.

Mr. Chairperson: The bill shall be reported on division.

* * *

Mr. Chairperson: That, I believe, concludes the business of this committee. Meeting adjourned.

COMMITTEE ROSE AT: 1:45 a.m.

WRITTEN SUBMISSION PRESENTED BUT NOT READ

For the Standing Committee on Municipal Affairs regarding Bill 25

Don't Make the System More Inefficient

Everywhere you look there are signs that the system is getting more inefficient. The following are some of the examples:

1) Hospitals are more inefficient

In 1999-2000, 3 percent fewer patients were treated in our hospitals than in 1998-99. One would think that if the number of patients was decreasing then the accumulated patients days would also decrease. It did not. Instead the average length of stay in our acute care hospitals went up from 9.6 to 9.9 days.

(Source: Annual Statistics 1999-00 and 1998-99)

Dr. Brian Postl stated in the *Winnipeg Free Press* that there is still evidence that hospital stays are longer in Winnipeg than national averages. "We could save 20 percent of our bed days if we could get to the best practices of other jurisdictions."

2) Waiting lists are growing

Many of the waiting lists are growing longer and hallway medicine is still common.

(Source: Numerous reports including those in the media)

3) Lower socio-economic people are less likely to receive specialized care

A new report was released this spring by the Manitoba Centre for Health Policy and Evaluation (MCHPE). "One might expect that in an area where health is generally poor, people would need more health care". They did not find this when it came to specialist care and "high profile" procedures, like MRI scans, coronary angioplasties, coronary bypass surgery, and hip and knee replacements. Rates are higher in areas with the healthiest residents.

4) Fewer specialists are available

In 1999-2000 there were fewer specialists in Manitoba than in 1998-99 in the following areas: Internal medicine, cardiology, general surgery, cardiovascular surgery, plastic surgery, urological surgery, orthopedic surgery, radiology and obstetrical gynecology. The overall number of specialist physicians is down by 13 in 2000-2001, but until the government produces the 2000-2001 statistical report we will not know which specialty these losses occurred in.

(Source: Annual Statistics 1999-00)

Costs Grow Rapidly

The cost of health care has skyrocketed; the health care budget increased by almost $470 million or 22 percent over the last 2 years.

(Source: Budget 1999-00 and 2000-01)

Manitoba is an example of a province where untargeted increases in overall government health spending is ineffectual. We have the highest per capita provincial government spending (Source: CIHI). This has caused a growing dissatisfaction with the health care system, and yet there is no open discussion as to how the health care system could be fixed.

Health Care Spending in Canada

Forecast public health care expenditure per person averaged $2,198 in Canada in 2000. Average private spending was $896 per capita. Across the provinces, the private share varied from less than one in five dollars in Newfoundland to almost one in three dollars in Alberta. In the territories, the vast majority of health care funds come from the public purse.

(Source: National Health Expenditure Database, CIHI)

Limited Discussion

In spite of all of these difficulties, every time someone wants to talk about the system, the current government will suggest that we are trying to Americanize the system. No one wants this.

Solidarity Principle

Among industrialized democracies, only the U.S. has yet to implement the solidarity principle. This principle was well documented by Wagstaff and Van Doorstaer in 1992. The solidarity principle expresses the need for fairness in both access to care and contribution of funds. Specifically, the access to all of the

publicly funded care must be equally accessed by all individuals, rich and poor, and the system is financed through progressive income taxes.

Survey after survey has demonstrated that our attitudes toward the type of health care we want for our families and ourselves is changing. We have had a publicly funded and administered system for the past few decades, but accessibility to timely appropriate care has become difficult as waiting lists grow.

The health care system is the No. 1 concern for Manitobans and a tinder dry political issue for all politicians on both the federal and provincial levels, but one thing Canadians can agree on is that we want a thriving, robust health care system that we can once again be proud of.

The Clair Report

Last year, Québec completed an extensive review of their health care system and the resulting account was dubbed the Clair report for its chairperson. This report made several recommendations including having the government encourage private-sector investments in areas such as long-term care accommodation, diagnostic laboratories and day surgery clinics while ensuring appropriate regulation of these services. These services would still be paid for through public dollars.

Roy Romanow

In April, Prime Minister Jean Chrétien appointed the Commission on the Future of Health Care in Canada to be headed by former Saskatchewan Premier Roy Romanow.

The man assigned to chart the future of medicare says he's no longer concerned about Alberta's new private health law stating: Bill 11, "I think, may be less of a concern . . . with respect to the Canada Health Act than it was when it was initially introduced." (Hard to believe after the initial controversy).

In fact, he has also said that there could be some "feathering in" of privately provided services; that the tradition of free, publicly funded and administered services might be combined with a larger role for the private sector.

Improving the Canada Health Act

Medicare is a universal medical insurance program which was initially created in Saskatchewan and then implemented in the rest of Canada in 1969. It enables Canadians to obtain medically necessary services and hospital care. The Canada Health Act was created in 1984. It enshrines the principles of today's medicare system, which are: Public administration; comprehensiveness; universality of coverage; portability and accessibility. Still, not once has it been openly re-examined to see whether the legislation still applies to today's changed realities in health care.

There are several good reasons for doing this:

1. There has been exponential growth in terms of what health care professionals can do and what people can do for themselves to improve their length or quality of life. There have also been vast changes in virtually all aspects of society, technology and demographics over the past 17 years, and these changes are likely to continue at an increasing pace.

2. Comprehensiveness: The health care insurance plan of a province must insure all services that are "medically necessary." However, the act neither mentions the quality of services to be provided nor gives a detailed list of what services will be insured; provincial governments define these. Thus the range of insured services varies among provinces and from one year to the next. According to the Canadian Medical Association, 23 services are provided in some provinces and deinsured in others, including gastroplasty, psychoanalysis, ear wax removal, penile prosthetics, et cetera.

3. Accessibility: Insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. No one may be discriminated against on the basis of income, age, health status, and so on. However, queuing is allowed to such an extent in some areas causing prolonged suffering and disability with the loss of employment and independence.

4. None of the principles focus on outcome or attainment of the highest possible level of health (increased life span, reduced disability).

5. Many important aspects of health care in other countries are not mentioned. These include home care, community care, medication and dentistry.

Having said this, there is no requirement to open the Canadian Health Act to allow for private providers as this is already allowed. Private payments began before the Canada Health Act and continue to today. In fact, 30 percent of health care in Canada is already paid for privately.

Improving Health Care through Private Delivery

Many health care providers (e.g., physicians, physiotherapists, dentists and pharmacists) are private in Canada. Further privatization of the delivery of health care implies greater reliance on individuals and institutions outside government for the production and provision of health care services, most of whom we already know and trust. We must then ensure that they are regulated in a manner where information regarding the quality of their care is available to the public.

Other countries have had much success in this area when appropriate regulations and incentives are in place. In France (the country rated No. 1 by the World Health Organization; Canada was rated 30), the health care system is based on competition and the freedom for patients to choose their own doctors and treatment centres. Sécurité sociale, the compulsory health insurance plan, finances or reimburses for health care or pharmaceuticals provided or purchased.

The government of France has created a framework for health care in which public and private hospitals co-exist to provide the population with easy access to the required services. Both public and private hospitals and clinics are subject to government approval for their location, their development and major medical equipment (MRI, lithotriptors, scanners, et cetera.). Beyond this, there is an accreditation/ evaluation process in which the results are published.

The results of the French system speak for themselves; they have virtually no waiting lists (three to four weeks is considered a long wait and is rare) and their system costs them $200 per person per year less than the Canadian system. (Source: CIHI) France achieves a higher disability adjusted life expectancy. (Canada 72 years, France 73.1 years. Source: WHO) Beyond this, the French system is fairer to the poor as French citizens personally pay less through private insurance or out-of-pocket payments.

Isn't it time Manitobans re-evaluated their health care system and looked to where other countries are having success in delivering timely and high quality care? Will the Minister of Health please withdraw this bill and allow an open debate as to what the future of health care should be?

How Canada Compares

In 1998, Canada was fifth among the 27 OECD countries in total spending per person on health care. But most had a higher share of spending from the public sector, as shown below. Estimates are adjusted for differences in prices (purchasing power) between countries.

(Source: OECD Health Data 2000)

Linda West RN, MBA, PhD