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Thirty-Fifth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

Monday, May 11, 1992

The House met at 8 p.m.

COMMITTEE OF SUPPLY (Concurrent Sections)

HEALTH

Mr. Deputy Chairperson (Marcel Laurendeau): Will the Committee of Supply please come to order. The committee will be resuming consideration of the Estimates of the Department of Health. When the committee last sat, it had been considering item 5. Health Services (b) Hospitals and Community Health Services: (1) Salaries on page 87 of your Estimates book $32,015,900–pass; (2) Other Expenditures $4,006,000–pass.

Item 5.(c) Laboratory and Imaging Services: (1) Salaries $13,037,200.

Mr. Gulzar Cheema (The Maples): Can the minister give us an update on the issue of CT scanners, and has his department heard of any major outcry from some of the hospitals? What is the actual policy? Can he tell us that when they were buying CT scanners, did they have in writing that the government would give them a set of CT scanners, because that has been one part of the problem? People are saying there was a possibility that the government would support the CT scanners once the community buys them. I just want to know, what is the truth?

Hon. Donald Orchard (Minister of Health): Mr. Deputy Chairperson, I guess it would take me a little bit to go through my notes and find the CT scanner report and some of the background. I have a good file of background.

To give my honourable friend an answer to his first question, yes, there has been some of the facilities express consternation about, you know, the policy that government has put down: Concordia Hospital, one, Seven Oaks, certainly another hospital, Misericordia and Grace. Outside of the city of Winnipeg, consternation, not to the same degree I will admit, is coming from some of the other areas.

Now, the whole issue goes back to the approval process that we initiated and the conditions we put around approving Victoria General Hospital's scanner. It was to try and prove in fact that you could operate within expected budgets, et cetera, et cetera. When we approved the Victoria Hospital, we set out a series of conditions; I think there were four of them. One of them was that the capital costs had to be picked up by fundraising, and the operating costs, there were conditions attached around the operating costs.

* (2005)

That information was circulated to the hospitals, some, I guess eight or nine of them, and foundations who were expressing interest in fundraising towards the purchase of a CT scanner. It outlined the policy by which government had approved the Victoria installation, but I will be very direct with my honourable friend, there was no implied or otherwise connotation that by simply meeting the fundraising for capital costs that there would be an automatic approval process for the installation of CT scanners, should the respective hospital foundations raise the capital money.

This, I will tell my honourable friend the member for The Maples (Mr. Cheema), I am trying not to waste time in Estimates, that is why I am not reacting to this crisis here for the member for St. Johns (Ms. Wasylycia-Leis). [interjection] If that coffee had got on her, it would have been–

Mr. Cheema: It could have been a health care issue.

Mr. Orchard: Yes, we might have had to call a doctor, Gulzar.

At any rate, there is no question about it, that Concordia, in terms of receipt of that correspondence, some decisions back about three or four years ago that defer I guess an RF unit, there was the belief on the part of the Concordia Hospital that that in fact was approval to go ahead and purchase and that we would fund it. But we never gave any such approval.

In the correspondence we indicated that we were going to do an evaluation of Victoria, and after the evaluation we intended to establish a policy for the acquisition of CT scanners by other hospitals. That, in essence, is the longer term investigation by Dr. MacEwan and others around the CT scanning issue

and resulting in the report that I tabled with the recommendations that we have agreed to. [interjection]

Mr. Cheema: Mr. Deputy Chairperson, I think I am getting a lot of patients in this building. I could certainly see you, Sir, also and see the member for St. Johns (Ms. Wasylycia-Leis) and provide my services. It is possible.

My question is: In terms of the Seven Oaks Hospital, what are the plans for the CT scanner there?

Mr. Orchard: Basically, the criteria for approval were laid out, and, indeed, given the report and given the recommendations from the committee investigating CT scanning installations, we are not approving any further installations anywhere in the province. That has left facilities in a dilemma, because some of them have fund raised, some of them indeed have purchased.

I guess it is fair to say, we have discussions ongoing with those facilities to see exactly what their intentions are, because we have heard mixed reports about business as usual and other indications that nothing has changed with this policy. In times of constrained budget a lot will have changed, because without an operating budget approval for the CT scanning units as installed there is the dilemma of finding operating costs from within the global budget. We have maintained that, if there is that much flexibility in the budget, then they have surplus dollars that can come out of the base, if it is not being used for patient care, because, quite frankly, MacEwan's investigation—and you know we have been through these numbers before, but I think it was 3,600 on the waiting list, 2,400 actually by the time it got analyzed, and of those, two-thirds were on an elective basis and only one-third were three to eight weeks. His investigation did point out that under current configuration we are able to manage the needed requests for CT scanning.

* (2010)

Additional CT scanner installation will lead to a significant drain on an already constrained Health budget. We cannot afford to have global budget dollars going towards technology and taking it away potentially from patient care, because I do not think there is any question that probably each hospital will experience an increase of a half million dollars in operating costs per year, over and above what is incurred on behalf of their patients, upwards of 600 per year.

That half million dollars translates, if I can be so blunt, into an awful pile of cataract surgery or hip replacement surgeries to do imaging. I think the choice that we have to make, as government, is whether that is some choice that we will allow to happen, because if the flexibility is there to find the budget globally from existing resources, then somebody is going to answer the question, well, why is it that you are saying you do not have budget for surgeries and waiting lists in surgeries when you have money for CT scanning or, for instance, when last year you had money to do a top-up on anesthesiology, this year you do not have, but yet you make the claim that you have global money to put into CT scanning and not for anesthesiology upgrade while we get fee schedule reform, which I tell my honourable friend the president of the MMA on Friday last—not this past Friday, but when I was at the Faculty of Medicine—offered to government the opportunity, now that we have the consultant in place, to fast track fee schedule reform to get around this anesthesiology issue.

So I think we have gone quantum leaps with the MMA trying to get things back on track to make the whole. I have always recognized that with the MMA they have dynamics within their organization that are not popular in this fee schedule reform. There are a lot of hard questions yet to be asked for anyone who believes they have spare money to operate CT scanning.

Mr. Cheema: Mr. Deputy Chairperson, I am sure the minister knows and the minister's staff know about this issue of mammogram, and we were even as a member of this Assembly four years ago when we wanted to establish at a very fast track, and once we reviewed what was happening, now the other provinces are having a look at what they are doing. I think that is why the cautious approach is very, very important for health care issues. That is why the CT scan, when the report came out, and so far a few hospitals are concerned, and they have the right reason to be concerned.

I think in future any of the major views of technology must be evaluated, and we are looking for some policy direction in the health care reform package. We want to see the government laying some fundamental rules and regulations that any new technology brought into Manitoba must be approved by the government based on scientific

evidence not on single professional advice, and that had been happening in the past.

Mr. Orchard: That is where we are going to try to come from and that is what we tried to do by bringing together the expert group on mammography to try to give us that kind of guidance.

Let me give you an example of how back when I was an opposition critic, I advocated very strenuously for lithotripsy, because at the time lithotripsy for kidney stone problems was viewed to be the answer for all surgery. You would not have to go in anymore and do interventive surgery. Now we are finding that it is good technology, but probably for only 40 percent of the patients. The patient selection criteria is much narrower than first envisioned.

I want to tell you that when that technology first came out, I used to raise it regularly at Estimate time encouraging the minister, from my role as opposition, to adopt this new technology because I was sold, quite frankly, by one urologist who had my ear and said you have to go for this, we are medieval in our technology. I carried the argument here, and in retrospect I carried it too exuberantly because it was not the proven technology that all of us were led to believe, including the urologist that was advocating it.

That is where a number of people had said, and I believe that we are getting closer to having that capability nationally, is that with new technology we have to have an evaluative protocol to assure us that if we invest in it, it is going to meet real health needs and have a positive outcome in health status.

* (2015)

Mr. Cheema: Mr. Deputy Chairperson, I think it will be very important for the minister to have in his health care package certain strict regulations and rules by which the new technology will take place and have an effect on Manitoba's health care system.

I think those things have to be made very clear. We are hoping that the minister would move in that direction and has a major part of the package.

My next question is very basic. I am under the impression and have some experience personally that when new offices of physicians are being opened, whether they are walk-in clinics, or single, or two offices, why would some of them have their own private lab services which are still co-ordinated by the main branch? That creates the perception that the things which are being done, why are the tests not being done in one place. Why do you want a facility at each and every clinic, and that in part eventually may be multiplying some of the tests which are being done? There has to be some policy.

I know there is a policy in terms of setting up the X-rays and the major technology, but the lab tests on a very primary basis is not being done. I would like the minister to look into that. I think it is quite an important issue.

Mr. Orchard: I am just informed here that with a physician's office we allow the short list of tests to be undertaken, but any extension beyond that into what I guess is known as the long list is only done through an approval process by which needs, i.e., patient care is going to be compromised by not having additional lab and X-ray tests in the physician office groups.

We are pretty stringent—well, we are very stringent on the long-list approvals. The short list is more automatic, and I will take my honourable friend's caution here and get further briefing from the commission on that.

Mr. Cheema: Mr. Deputy Chairperson, I do not want to put some examples that may alienate some individuals, but I think there is a problem. When the offices are being set up, and when you have, for example, an office, and five blocks you have another medical office, but the lab services are being done in both offices. There may be a personal financial interest involved in those things. Some arrangements are sometimes involved, they may not be made public, but there is a perception that in certain cases the financial aspect could be a part of the process.

I think that is not very healthy, and something has to be done in terms of there must be guidelines set up when you are opening a new office. If you have a lab in the area, then why have a second or third or satellite labs? I mean it is good to facilitate patients, but at the same time you do not want to duplicate services. I think that should be taken into account; it is a problem as far as I can see.

Mr. Orchard: Again, in terms of the long list and the X-ray side of it, we have only had one in the last probably year and a half. We did not approve the request to expand on the X-ray side, but maybe we are not talking about the same kind of laboratory tests then.

* (2020)

Mr. Cheema: Mr. Deputy Chairperson, I will talk to the minister's staff and try to explain to them, because I do not want to put some names here, but there is a problem. I think it may not be a major one, but once you start searching for a thing, you always find one after the other. If that can be stopped, I think it should be stopped. There has to be some regulation that even though we are talking about a short list, but the long list also, which lab, for example, in downtown, how many major labs are you going to need? That is the question basically, and whether those labs have any self-interest in terms of and getting their professional, going to a different office at a specific time and getting the test done. Those things are causing some difficulties and I think there is a perception that there maybe financial incentives involved. I think that has to be taken into account that the lab use must be for the best care of the patient and if we can avoid duplication of the services.

Mr. Orchard: I would appreciate if my honourable friend had some discussions with staff on that. I think that would be most productive.

Mr. Cheema: Can the minister tell us about the ultrasound procedures now? For example, in what hospitals, other than the Winnipeg hospitals, for example, Dauphin, Swan River or Thompson, do they have ultrasound?

Mr. Orchard: We have ultrasound in Dauphin, Thompson, Morden, Winkler, served by one unit. A mobile unit in Minnedosa that serves Neepawa, Selkirk has a permanent unit not a mobile and so does Steinbach so that--did I miss any in the distribution outside of Winnipeg?--like Brandon and Winnipeg, of course, and Thompson I mentioned, Flin Flon and The Pas.

Mr. Cheema: Can the minister tell us what is the average waiting period for--not the emergency ultrasound procedures but in terms of the elective ones, what is the waiting period?

Mr. Orchard: We would have to confirm, but my associate deputy tells me probably six to eight weeks at a maximum.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us whether they have put in place the procedure like the Medical Review Committee to review the medical labs and the testing methods and some of the profiles of the tests being done in each and every clinic, to make sure that there is also a provincial as well as national standard of those testing?

Mr. Orchard: My honourable friend might recall last year, last session, we passed amendments to The Health Services Insurance Act. That gave us the ability to audit and verify that we were being billed accurately for lab testing procedures, because we had one circumstance where that was not the case, and resulted in a substantial, well, nearly $1-million recovery to the province as a result of improper billing.

(Mr. Ben Sveinson, Acting Deputy Chairperson, in the Chair)

Now, Mr. Acting Deputy Chairperson, here is the problem with the laboratory, and this is an issue that came up most recently publicly with the Medical Review Committee itself. The major issue around recovery of taxpayer dollars from one of the physicians was around the lab-testing issue. Now, you see, the lab or labs--I am not even sure if there was more than one--acted legitimately on the request for blood work and whatever submitted by a physician. It is not up to the lab--and I think this would be appropriate that they question the physician as to why he is ordering this test for this person over a period of time--but the Medical Review Committee puts the onus on the physician to order appropriate and needed lab tests.

* (2025)

Hence, that is why the Medical Review Committee request for repayment of monies was made to the physician, even though in the one case the physician did not receive the money. The monies were actually paid to the labs but they were for tests ordered by the physician. So it comes down to the Medical Review Committee, rightfully so, says the responsibility for any inappropriate level of testing, the recovery of that is the physician's responsibility who has ordered the test, not the lab, because the lab has no ability to judge whether the test is inappropriate or outside of what would be required for medical reasons.

Mr. Cheema: Mr. Acting Deputy Chairperson, then does not the process and the review of the whole--this particular case, it is very unfortunate the physician whose name has been put in a lot of scrutiny and in terms of his own credibility, which I do not doubt--he is a well known and very committed physician. When his work ethics are being checked by the college--I am sure they do for each and every

person—and when they are satisfied, and if he is providing a specific kind of service, and if in that service you need more testing then, but the Medical Review Committee would say, rightly so, because they have their own pattern, so whom do you fault? To whom do you say, you are wrong, whether you say to the physician or to the patients?

In this case I think the impression has been left through the reports that it is the physician's fault. I think it is unfair, because if you look at the person's profile of his medical care or if this person is providing a special group of people, and if they require more testing, then why were those things not explained to the individual at an earlier stage?

I have not been in touch with this person personally. I do not know him, but what I have read and the information we have got through the media, I think that tells that the medical review process needs to be reviewed in many ways. I think rather than waiting for a long time, for two or three years, I think it should be done on a regular basis.

If there is any fault in terms of not falling within the normal pattern, then the physician should be notified so the physician can tell the patient, I am providing you such-and-such services. Some of them are not covered because they do not fall within the normal pattern. Then patients should be responsible for some of those services. I think those things are going to come eventually, but it is very tough to explain to the physician, when he or she has not benefited personally from the services, why they should be responsible.

Mr. Orchard: Mr. Acting Deputy Chairperson, I think that is some of dynamics behind why the physician in this case volunteered and came forward, because the impression was that he had personally benefited from some $230,000-some-odd and that was quickly established not to be the case.

I think from that standpoint, the honesty question around the physician I do not think is at issue. What is at issue, and here I am guided by the Medical Review Committee because those are physicians on there. They maintain that there should have been—I think this is the point they maintain—sufficient understanding that a diet program that required this kind of extensive laboratory testing would not fall under medicare coverage.

If it was extensive blood testing, let us say to monitor someone on chemotherapy, there you know that that is trying to come to grips with a medical condition that is an insured service, but in this case dieting, quite frankly, is not.

These tests were precipitated because of a type of dieting program, I guess, that has its foundations in the U.S. The physicians on the Medical Review Committee have made the case, and I have to agree with them, that the onus is on the physician to understand what is an appropriate service to be providing for which you are using a taxpayer dollar to deliver the complete service. In this case, they found that the physician should have known that was an improper billing and should have either informed the patient, so that they would have a higher enrollment fee or whatever. I think in doing that—correct me if I am wrong, Frank—the physician would not have contravened the Canada Health Act to manage the diet in that fashion, because it is not an insured service.

* (2030)

I understand my honourable friend's point in terms of the furor around the issue, because everyone's immediate reaction that phoned our office was: what the heck is going on, this fellow made off with this kind of money? You know, we were walking on pins and needles, because we cannot disclose what it was for. I even had a confidential conversation with one of the people in the news media who was going down the wrong path, because he did not have the full background.

That is why in The Health Services Insurance Act, we now have the ability to release the name and the narrowed detail, if the act passes as proposed, to disclose that so the information—bang—is upfront right away, so they do not have this roiling speculation around, some of which can be damaging to the individual practitioner in terms of leaving the suspicion that the individual acted dishonestly rather than simply without appropriate knowledge or appropriate understanding of what could be billed.

Mr. Cheema: Mr. Acting Deputy Chairperson, I find this discussion very, very useful, and it will be very comforting to that person who is involved. I will send the Hansard copy to this physician. I think it will be very positive for him to know that things in this building are not what sometimes has been reported, how the news got out and the way things were.

We are given the impression that for this particular person something really went wrong and he was sort of, you know, taking the money away and

running away somewhere, and I think that would be helpful. The next important issue the minister has raised is, what are the services that are covered and what are not covered? What is a medical necessity and what is not a medical necessity? That is the issue that has to be debated, if they know where they are dealing. If the patient is walking into my office or somebody else's office, they should know what is covered and what is not covered, what is required. That is why I will go back again, protocols are very important.

If there were a protocol, this situation would never, never come to the surface, because the physician would tell the patient, I cannot do those things because those are not the normal pattern of this health care provider. That way a physician is covered, and if the patient wants to get something else done, then maybe they have to look at the other avenues, or buy private insurance. In some cases they do. They have Blue Cross or some other insurance and some company insurances are there. So patients do make use of those services. Physiotherapy is paid by the Blue Cross and other services; Autopac pays that kind of services. The Pharmacare is paid by some companies.

I think those things, when people know them, then they can make informed decisions. I think it becomes very tough for the health care providers to continue to explain in a vacuum, I mean, when they do not know what they can tell a person or not. When they can explain to them that these services are not covered the way they do--for example, if you are filling the forms, then you are charging the patient because that is not covered. If you are providing extra service, that is not covered, so you are charging them. I think it will be very good if there are protocols set up in a major way, and I hope that is a part of the fee reform schedule. The MMA should take a part in that kind of process and make sure that they make a contribution to set up those protocols and will be helpful.

Certainly I think that, once this person reads this evening's Hansard, he will find a satisfaction that the people in this building and especially the minister's office are not out to get anybody, but just a simple question of what is there. When you are in a responsible position, then certainly decisions are made, and within the law and within the regulation you have to make decisions. Sometimes when full information is not provided you are left in darkness. I think that will be very helpful.

Mr. Acting Deputy Chairperson, I will ask the minister: Has there been any more money allocated or more money spent on HIV testing in view of the recent reports? I was under the impression that more and more people are coming forward to get the test done.

Mr. Orchard: We do not have with us this evening the number of tests, but I think we keep those by calendar, not fiscal year, do we not? So I will provide my honourable friend with the 1991 HIV tests.

Mr. Cheema: Can the minister also provide information in terms of the process that was started about two years ago for testing? You have to fill the forms rather than making a whole list. A physician has to make a request; these are the tests you are doing and this is the possible diagnosis. So that way some of the extra tests can be easily eliminated, and I just want to know: Have we made substantial progress in that area in terms of saving tax dollars?

Mr. Orchard: My associate deputy indicates that that took out about $700,000 of testing in its first full year, and we believe that has been reduced from the base of lab testing. It just sticks in my mind, though, just from memory because this goes back more than two years ago when we had our first full year, that it was a higher figure than that.

If it is more than the $700,000, we will confirm that as soon as we get the number. But it had a quite significant impact simply by changing the form for ordering laboratory tests in that it had a significant downward impact on the lab testing budget.

Mr. Cheema: Can the minister tell us if there is a policy by which patients do receive, for example, questions from the Department of Health in terms of how much was billed for a particular service on a random basis, as we are doing for physicians? You send 5 to 7 percent cards back asking the patient, did you go and see this doctor and doctor's charge on your behalf? If you do not agree, please get in touch. Can the minister tell us if that kind of policy is in place for the lab services also?

Mr. Orchard: No, not on the lab side. All we do is when we do our random check--and it is 2.5 percent a year; we tripled it one year--but 2.5 percent random selection, and all it deals with is physician billings. That would be office visits, et cetera. But because normally the individual does not know necessarily what tests were being ordered or what test they went through, we have not placed those on the statement

to randomly selected Manitobans so that they can confirm that, but they do get the opportunity to confirm office visits and any other procedures billed by physicians in a given year.

Mr. Cheema: Mr. Acting Deputy Chairperson, I think it is unfair that only one section of the health care providers is being checked and not the others. One suggestion for the minister is that when a person goes for testing, and the physician or the health care facility gives him or her a form, and that form is taken to a particular lab, the duplication of services can easily be avoided if there is an extra copy there. That copy can be given to the patient, so that when a patient is visiting other doctors he or she can simply tell, these tests were already done, so they can get in touch. You do not have much extra cost. It can be done on a regular basis, and it does not compromise the patient care at all. It does not compromise the confidentiality of the patient either simply because the patient is getting information for him or herself which simply can be relayed to hospital or to the clinic or the walk-in clinics, and I think that could be helpful.

* (2040)

Mr. Orchard: Mr. Acting Deputy Chairperson, there is no question that concept has value. Whether it is achieved through a duplicate or triplicate form, plastic-card technology in its more sophisticated form accomplishes the same thing. Let me tell you a little dilemma though. When I went in to get my plate sewn in my eyeball here I had my tests done at Carman, presented them when I got admitted to the hospital where I got the surgery done. They thanked me very much and put me through the same test again that I had three or four days earlier.

As a result, I think we are coming around that issue now so that we are not doing that kind of duplicate testing. It is inconvenient to the patient. I mean, sure, I am a tough-hided fellow, and I did not mind them taking another chunk of blood out of me, but it was unnecessary because I am generally in good health. [interjection] I am talking physical health. Anybody could never claim to be in good mental health in this crazy racket. At any rate, you know, I maintain and some hospitals will accept laboratory tests up to several weeks prior to admission as sufficient indication of general health status. I think that is a policy that we bring in without compromising anything across the system.

(Mr. Deputy Chairperson in the Chair)

Mr. Cheema: It may take probably a few years for the smart card or whatever name you want to call it, but these basic measures can save a lot of tax dollars, and I think it will not compromise patient care. It can be done the same way the triplicate prescriptions are being done, same way as the lab tests are being ordered. Patients simply go to a hospital or clinic and tell these tests are done. When you know the address, one can simply phone and find out. It is not tough. It does not take more than two seconds. It will take them less time to phone than to fill a form, spend five minutes explaining what they are going to do. Ultimately, sometimes it will take a few days, and by that time the patient may go somewhere else. So I think those things could be helpful, and it can be done.

Certainly, the other issue that the minister has touched on again is the issue of protocols. I keep on emphasizing it is very essential to have the uniform protocol system, what is acceptable, when the primary tests were being done. What is it, four weeks, six weeks? What age group? What tests are going to be required? If you have a set protocol for the whole province that would be very helpful.

Mr. Orchard: In that regard, the College of Physicians and Surgeons has to probably play the lead and central role in the development of that. As my honourable friend knows in terms of reading the Barer-Stoddart Report, that is really a central part of their recommendations as well to develop on the national basis.

Ms. Judy Wasylycia-Leis (St. Johns): The first question under this section has to do with, how is this section different from the branch in last year's Estimates entitled Provincial Laboratory and X-Ray Services?

Mr. Orchard: That is the same thing. The only difference that would be here this year over last year would be Administrative Salaries which last year were part of Salaries under the Health Services Insurance Fund or the Health Services Commission last year. The portion of Administrative Salaries from there would be transferred over to the—specifically to laboratory, in other words, would be attached to the appropriate function of operation here, namely lab and imaging services, phylactic operation.

Ms. Wasylycia-Leis: I have three follow-up questions to the member for The Maples. No. 1, on CT scans, is the minister giving advice to hospitals, given his ministerial statement, the committee, the

work that has been done to rationalize this whole area? I am asking this, because, as the minister knows, fundraising efforts continue in our community hospitals for purposes of raising dollars, I believe, to operate already purchased CT scans. I am wondering if—and that is creating a great deal of questions out in the community, a great deal of confusion, and people are turning to us and asking for advice about the worthwhileness of these fundraising endeavours, and what is the current state of affairs given the directive from government? I am wondering if the minister can just help us to answer those questions in our respective communities.

Mr. Orchard: With the tabling of the CT advisory committee report, naturally some of the hospitals—one that I can think of in particular who had on site and was operating a CT scan, and we were not supposed to know as government, all of a sudden the cold hard reality has come home that government may well be serious because they—see, the Victoria Hospital had their scanner in place, but they did not operate that until we had worked through a system to put some integrity behind analyzing what their projections were and what the system impact would be.

That is not necessarily the case in at least one institution. Now that they have their machine, I think it is, to put it bluntly, a little embarrassing that they are having to go back now to all of those people who donated in good faith. Of course, you can lay blame on government that we created the expectations and all this sort of thing, but the bottom line is, no one in government had ever approved the installation of additional CT scans.

In fact, correspondence was fairly direct. I met with some of the hospital boards back last summer and indicated—one exception, one board chair was not present at that meeting—that we have got a problem coming at us with CT scanning and do not take it for granted that, because you raised the capital money and you buy one, you are going to get funding. That is not in the cards. That is not part of the discussions. We are waiting for recommendations from the MacEwan report, which we got.

To go out and fundraise for operating costs, I guess there is nothing preventing them from doing that, but I will tell you that we are being very diligent. I will go through the process again in terms of analyzing the operating costs of unapproved technology. We are going to find out and determine very precisely what the operating costs for that is, and if there has been a transfer of the global budget from other hospital areas, because we are into global funding, into the operation of a CT scanner, then we are going to consider those funds surplus to the hospital and pull them out of their budget. If they have money for unapproved technology, then they have money that they could be putting into patient services.

* (2050)

I think that my honourable friend has to agree that nearly every hospital will universally be saying, we need more budget to deliver patient services. At the same time, they may well be trying to utilize existing global budget to fund operations of a CT scanner. If they have got sufficient slack in their budget—I am using loose terminology—to operate a CT scanner, then they cannot make very well the case that they need greater operating budget for patient care. Despite the fact that everyone wants one, MacEwan clearly identified that there was reasonable and probably sufficient access to CT scanning technology, certainly in the city of Winnipeg, and outside the city of Winnipeg, Brandon to serve a fairly good chunk of the province, still an adequate opportunity to access the service.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, I am wondering what success the minister has had in convincing any hospital now that has either purchased a CAT scan and is in the process of fundraising for operating the CT scanner, or is fundraising to purchase a CT scanner. What success is the minister having in convincing those hospitals and the boards of those hospitals either to redirect their fundraising efforts to other activities or, I guess in the case of those who have already purchased a CT scanner, to find ways—I do not know what the market is—for selling CT scanners and to get compensation for that? I will leave it at that.

Mr. Orchard: My honourable friend is asking me what success I have had in the last three weeks since we tabled the report. I think it is fair to say none, because I sense that the weekend after our announcement in the House there was the Tri-Hospital Lottery on Sunday, which did a substantial fundraising effort. I appreciate that one of the pleas that they made was, could we not simply hold off this announcement till after that?

That is why I was very careful to acknowledge volunteer fundraising efforts. They are very

essential throughout the guilds and all the other volunteer organizations to support ancillary services that are not funded by government. We in no way want to inhibit that, but there is an appropriate role to focus that so that it meets the most important need. I just went through this very recently. There is substantial pressure in the system to install CT scanning because there is this second-class facility mentality.

I had quite an extensive discussion with a group recently who have an organization fundraising for the acquisition of a CT scanner. I want to tell my honourable friend the exact point I made with them. I said: Okay, you believe that you need to have this CT scanner installed, because you are a facility of some diversified service for the community that you are located in. I said, I appreciate that, but you are going to be looking at probably a minimum operating cost per year of $800,000 for the CT scanner. You might be able to justify about $200,000 a year maybe of operating costs for upwards of 300 or 400 people a year to go out to be scanned with a CT scanner.

I said, the blunt question you have to answer to government is that, if you find the other half million dollars from within your global budget, you have to justify that that is the most appropriate use for scarce dollars. While you are doing that–I simply ask you because we had been talking about, for instance, hip replacements earlier, and cataract surgery earlier. I said to this group, next time you say to me, there is not enough money and my waiting list is too long for hip replacements, I am going to point out, well, now for $500,000 a year of global budget reallocation to CT scanner operation, you could have undertaken at $15,000 per hip replacement surgery close to 300 of those per year–that is the entire provincial program. I am wrong, 30, which is 10 percent of the provincial program.

I said, if you make the case that the CT scanner is the most appropriate one, you are going to have to explain to 30 Manitobans who did not get a hip replacement why you chose CT scanning instead of hip replacement or cataract surgery or any other number of procedures that citizens of Manitoba place some value towards.

So, to put it to my honourable friend bluntly, we are prepared to play a little bit of hardball on this one in terms of technology, because it does not buy the next greatest increase in outcome in health status improvement for Manitobans to have nine more CT scanners in the province of Manitoba at an operating cost of between $800,000 and $1 million each.

Ms. Wasylycia-Leis: On another question, with a question related to one that has been previously asked by the member for The Maples (Mr. Cheema), and it has to do with mammography services. I am raising this question with the hope of getting some advice from the minister. I am quite serious, and I hope he treats it that way.

The member for The Maples referenced this letter that many have received from Pro-Med Associates suggesting that there was a need for a mammographic unit at the Seven Oaks clinic and indicating that there–and they listed dozens of communities that would benefit because they did not have access at present to such a facility in that region.

I am wondering if the minister could give us some advice about how best to respond to this letter, and how do we make judgments in terms of the need from the point of view of utilization review and quality assurance?

Mr. Orchard: I just asked my associate deputy what was the waiting time for a diagnostic mammography, because those are very much covered under the insurance services. I do not have that figure, but we have done some preliminary investigation on mammography. Taking a look at that diagnostic tool, experts have concluded that we ought to do somewhere in the neighbourhood of 45,000 per year. Taking a population of 1 million, 45,000 would be a very reasonable target. We are at that now, so in terms of absolute numbers, we are very close to what experts in the field say would be a reasonable expectation of numbers of services for a population of 1 million, slightly more than 50 percent women.

Now the difficulty is the maldistribution, because some are being inappropriately screened because of advertising push, doctor preference, et cetera. So balance on that the advice that came out of the mammography working group, where they said that under 50 there is no benefit apparent to a screening program. That does not say that a women at age, let us say 40, with a family history and indications that they may be more prone to breast cancer, that we deny that person the opportunity for the diagnostic mammogram.

We are coming to grips with that one, and I guess the advice I would give to my honourable friend is blame government if we say no to it and

congratulate us if we say yes, but we have not made a decision yet. In about six weeks we are going to make a decision, and it will be based on the kind of waiting list and the kind of access for the city, even though it serves a region of the city of Winnipeg. I mean, if there is capacity in the system for the diagnostic mammography that does not compromise waiting, it would be an improper investment to simply add into the system with this capacity already there. That is going to be the background research to a decision that would be made to either approve or not approve.

Ms. Wasylycia-Leis: Just a final question on this area, and it also relates to the question of the member for The Maples (Mr. Cheema) on HIV tests. In addition to providing us with the 1991 tests for HIV, would the minister be able to provide us with the complete results of the Cadham and Red Cross surveys on HIV and AIDS. [interjection] Yes, yes. The last time we discussed this issue there were preliminary results in, and I am wondering if the minister has the final results in and when he might release them.

* (2100)

Mr. Orchard: That came up about this time last year and preliminary results were presented, I think at a Montreal conference, and that is how it became in the news. As I recall it, it was a two-year blind testing trial, and I do not think it is over yet. The intention is, that will become a research document that is public. It will become public when it is complete, but to my knowledge, it is not complete yet.

Mr. Deputy Chairperson: Item 5.(c) Laboratory and Imaging Services: (1) Salaries $13,037,200—pass; (2) Other Expenditures $9,779,600—pass.

Item 5.(d) Emergency Health and Ambulance Services: (1) Salaries $966,100.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us–during last year's Estimates discussion we asked the minister to look into this issue when the patients are being transferred from one hospital to another. In those cases the ambulance cost is not being covered by the hospital and patients are paying some of the amount. So we would like to know why that policy is still in place, because the minister really last time took a great interest that that was an unfair policy, especially when we are transferring patients between the hospitals, not only patients on demand but due to the medical reasons or because they are refused or you do not have any beds—there are a number of circumstances.

Those problems are going to be there more when some of the hospitals are going to restructure their services, and I think that issue is going to come up eventually, so I think it will probably be a good idea for the minister to be prepared on those fronts also, because you will require more transfers once you are restructuring the system.

Mr. Orchard: Yes, we have not changed the policy. We are still adhering to ambulance transfers within a 24-hour return are covered by the hospital global budgets when the patient goes out for diagnostic testing. But a straight transfer from hospital A to hospital B for services is still charged back to the patient.

Mr. Cheema: Mr. Deputy Chairperson, in certain circumstances that is not a fair policy because if there is not a bed in a given hospital for a special service, if a patient is being transferred to another hospital, why should the patient pay?

Mr. Orchard: Well, they pay because, let us say I show up at Carman hospital in the emergency and they diagnose that I have myself an injury that is serious enough that I should be transferred to Winnipeg and I should not go in the car like I have arrived in, I am responsible as an individual to get to the hospital where the care is being provided because ambulance services are not an insured service.

As much sympathy as I have for making the program 100 percent insured, the cost would be in the neighbourhood of probably $25 million. If we insured ambulance service across province—sorry, not $25 million but an additional $12 million, that would bring it close to—well, we provide about $5 million or $6 million now, but it would be an additional $12 million.

Quite frankly, right now, when it is not part of the Canada Health Act and we are being accused as all provinces are of not having sufficient monies to meet Canada Health Act, I cannot see my way to including another level of program and providing additional dollars. Instead, we try to, as much as possible, make everyone aware that private insurance ought to be carried, because we—I mean, it is a straight financial issue, to put it to you bluntly, and I think has been for 20 years.

(Mr. Bob Rose, Acting Deputy Chairperson, in the Chair)

Mr. Cheema: I am not asking to cover everything. My question was very specific, that the person when he goes to a hospital, if after 24 hours or 12 hours or 10 hours or a two-day stay in that hospital, the patient has to be transferred on the basis of medical reasons or on the basis of they do not have a space, then that patient should not pay the money it is going to cost for a transfer of the patient. I think that is the issue. I am not asking that each and every person has to be–specifically when the restructuring of the hospital is going to be done, that issue is going to come up absolutely, no doubt.

Many patients are going to question why I cannot go to a given hospital, and the arguments can be made on both sides. But once you are already in the hospital, once you have stayed there for some time, a day or two or three days, and when you are being transferred, not by your choice, then I think it is unfair that the patient should pay that amount.

Mr. Orchard: The closest estimate we have, narrowing it down to my honourable friend's suggestion of interhospital transfers, it looks like about maybe a $3-million touch, a $3-million impact on budget across the system, a fairly substantial amount of money. That has probably been the main reason why we have maintained the existing policy of within-24-hour return for diagnostic services, that where the treatment can take place in the originating hospital, but the necessity of, for instance, CT scanning or MRI imaging that would cover the cost there, because that is more cost effective than having the technology underutilized than expanded across the province.

Mr. Cheema: Can the minister tell us if the policy is going to be reviewed in terms of some circumstance where you do not need ambulance services? For example, you may need Handi-Transit or some other services where the patient can be transferred from one hospital to another, if we can use those resources and save money for the taxpayers as well as the patient. I think that should be looked at. I am not certain whether we have a policy like this.

Mr. Orchard: Mr. Acting Deputy Chairperson, my honourable friend has hit upon a subject that we currently have as an item for review before the Manitoba Health Board, and I am advising caution to them in this issue because you might recall about–was it three years ago? Remember the swirl of controversy around the mini-ambulance introduction into the city of Winnipeg. Basically, the Winnipeg Ambulance Service was trying to do just that.

There were some patient transfer requirements that did not require the full-service full-size ambulance, and when they tried to bring in the mini ambulance, which did not have full capability but certainly was not an unsophisticated method of transportation, it ran into quite a little bit of flak at the time. I am not even sure if they are running the mini ambulances now, but regardless of that narrowed issue to the City of Winnipeg, the commission board has ordered a review into some opportunity or potential opportunities for alternate transportation.

Mr. Cheema: I think that may solve some of the problems. If the Minister of Health (Mr. Orchard) keeps on throwing things at people, he may injure some of them physically around this table.

Mr. Acting Deputy Chairperson, we will ask the minister to review that policy, I think. Eventually, those things are going to come in. It does not matter whether you do it or somebody else will do it, because if there are going to be substitute services and they are less expensive, cheaper and still effective, what is wrong with that? It is taxpayers' money. If it is going to cost $100 for a transfer of a patient, if it will reduce to $20, so be it.

Mr. Orchard: I thank my honourable friend for his insightful advice.

* (2110)

The Acting Deputy Chairperson (Mr. Rose): Page 87, 5. Health Services (d) Emergency Health and Ambulance Services: (1) Salaries $966,100–pass; (2) Other Expenditures $2,863,900–pass.

Item 5.(e) Capital Construction: (1) Salaries $542,200.

Mr. Cheema: Mr. Acting Deputy Chairperson, I understand the minister has made a promise that he is going to come back with the Capital Construction budget and then we are going to debate this issue. I am simply waiting for the member for St. Johns (Ms. Wasylycia-Leis), because I do not want to pass this because she may have some specific questions, so if the minister can give us some rough time frame when we could see the Capital Construction budget?

Preferably, we would like to see it after the health care package reform. I think that would make more sense. Also, probably there may be good

discussions with the minister's own caucus members, how they are going to divide the pie and see how they are going to divide the health care budget. It is going to be very important, and I think that is why I am very curious to see how each and every caucus member, how each and every MLA is going to react to the health care package. It may have some negative impact on some of your own constituencies.

Mr. Orchard: Yes, I think when I indicated–I am just looking at the watch here, this is the 11th. I think it was towards the end of April, about the 30th or so that we talked about not meeting–maybe it was the 28th of April. It is a long time ago, but at any rate, I indicated that I would have the capital budget by the end of May and at that time I did not expect that we would still be debating the Department of Health Estimates. I am probably going to be into the first week of June now because I have lost a week in terms of developing the capital program, et cetera. But I will simply indicate to my honourable friend that the opportunity will be to debate on the concurrence motion both the capital budget and the reform package, because I would have preferred to be debating the reform package at Estimates and that would have been a much more open forum and opportunity for debate.

The Acting Deputy Chairperson (Mr. Rose): Page 88, Health, (e) Capital Construction.

Mr. Daryl Reid (Transcona): Mr. Acting Deputy Chairperson, I am not sure if there were discussions on this in the past during the Health Estimates debate.

Mr. Cheema: We will not cheat on you. Do not worry.

Mr. Reid: No, I am sure you will not cheat on me, as the member for The Maples has indicated.

My concern is dealing with the hospital that services my community of Transcona. I have had some discussions with the members of the hospital administration there and they make me aware that the new facility, I believe it is a 60-bed facility, is awaiting the grand opening. There is some equipment, I believe, that is scheduled to be delivered to that hospital facility within the next week or two.

Can the minister give me some indication on when we expect that hospital facility to open, when we can expect the equipment to arrive, and what type of service the minister sees that new facility performing for the community?

Mr. Orchard: It will have quite a substantial role for the health care system, a role that was envisioned–and I think maybe it might be appropriate to go back and take a look at the proposal of Concordia Hospital, about 1968, where it was envisioned to be roughly a 200-bed facility. An event in 1969 caused the planning to greatly shrink the Concordia Hospital from plans in 1968. I am not making any political inferences here, but by 1972, the plans for Concordia Hospital had shrunk significantly. Then, in 1978, '79, '80, discussions were ongoing and plans were rejuvenated for another floor on Concordia Hospital, but events in 1981, late in the year, caused those plans to be dashed by 1982-83. We revitalized those plans again in 1988, and now, given the Extended Treatment Bed Review, have nearing completion a 60-bed unit which will allow for, in essence, extended treatment to be undertaken for the Winnipeg hospital system out of Concordia Hospital.

Mr. Reid: Mr. Acting Deputy Chairperson, a lot of words keep getting the go-around here. I notice that the minister is very adept at that. The question I put to the minister though was: Has any decision been made on those facilities on whether we are going to have acute care or long-term care in that particular hospital facility? Has that decision been made yet?

Mr. Orchard: There is going to be both in that hospital.

Mr. Reid: Can the minister give me an indication on what type of a ratio we are looking at for that new 60-bed wing facility as far as acute and long-term care?

Mr. Orchard: Mr. Acting Deputy Chairperson, those are issues that are currently before discussion within the system and will be part of the system-wide reform plan. If my honourable friend had the modest patience to wait, he would find that there is a very visionary role for Concordia Hospital. That is why we as government on three occasions–in 1968, 1980 and again in 1988–have advanced the construction and proposed the construction. Only this time we did not get upset by an election, and we are actually going to be able to complete it before another government comes in to cancel it.

Mr. Reid: Mr. Acting Deputy Chairperson, the minister takes lightly the concerns of the residents

in the surrounding community for that particular hospital. The questions that I posed to him are very serious in nature. They want to have some kind of an understanding on what type of services are going to be made available to them, and that is why I posed those questions to the minister. I would like a straight answer on it so that I can take that back and inform my constituents what type of service that hospital is going to provide for the community.

Mr. Orchard: Mr. Acting Deputy Chairperson, how can my honourable friend as a new member have the audacity to say that I take the Concordia Hospital lightly? It was this government, myself as minister, that invested over a million dollars in a renewed lab. It was this government, myself as minister, that gave the construction go-ahead for 60 beds of additional capacity at Concordia Hospital.

Mr. Reid: It is sitting there empty.

Mr. Orchard: The member for Transcona (Mr. Reid) says, it was sitting there empty. It has not been completed in its construction yet; it is not ready to occupy its patients. It is a hell of a lot further ahead than the time in 1970 when the NDP under Ed Schreyer cancelled the construction plans and revamped them to a downsized hospital that we had to remedy in 1992. It is a far sight further ahead than the 1982 cancellation of the additional floor to Concordia Hospital that the Howard Pawley NDP government cancelled on Concordia Hospital.

When my honourable friend says I take lightly Concordia Hospital, maybe he ought to visit the light role that Schreyer's government and Pawley's government took of Concordia Hospital where they cancelled expansion plans at Concordia Hospital. We have delivered and my honourable friend says, we take it lightly.

Mr. Reid: Mr. Acting Deputy Chairperson, in my discussions with the administration at that hospital, they tell me that there were some programs that were in the works under this minister's tenure as the current Minister of Health, that those programs were put aside and cancelled so they could move forward with other programs on certain promises, and now they find out that some of those promises are not being lived up to, some of those commitments.

When I talk about that hospital sitting empty, I know it is complete and that they are waiting for some direction on what is going to happen with that facility, and so are the people of the community that I represent. They want to know what is going to happen with that hospital. They do not want to have a very expensive facility sitting vacant waiting for this minister to make a decision.

Whether I am a new person or not, I am here to represent my constituents' concerns and wishes and that is what I am attempting to do. By this minister sitting on that decision and not making that decision, he is not doing any of us any good. That is why I wished he would come clean and tell the people of that surrounding community what is going to happen. What type of service is this hospital going to perform for the community–long term, acute care, what type of mix? When I ask for some kind of a ratio, the minister continues to skate around this issue as he has with every other health issue that has been raised by the critic for St. Johns. Why does he continue to skate around these very important issues?

* (2120)

Mr. Orchard: Mr. Acting Deputy Chairperson, I am intrigued with my honourable friend saying that the administration of the hospital has indicated to him that certain promises and commitments were made and then they were backed away from. This is all in this sort of nebulous area. I am really intrigued by my honourable friend's discussions he has had with administration at Concordia Hospital.

Maybe he could give us some of the examples that he has at his finger tips and on the tip of his tongue as to what was promised and what was allegedly promised, allegedly taken away from Concordia Hospital. I am deeply interested in picking my honourable friend's brains because I would like to have some idea of what these bits of information are that have been provided to the member for Transcona (Mr. Reid) by the administration of Concordia Hospital. I wonder if he could be a little more specific than the broad generalities that he just finished talking about. If he has specifics, I would be pleased that he put them on the record so we can discuss them.

Well, what happened to the specifics, Mr. Acting Deputy Chairperson?

The Acting Deputy Chairperson (Mr. Rose): Page 88, 5.(e) Capital Construction: (1) Salaries $542,200–

Ms. Wasylycia-Leis: I am sorry, I was going to say pass, but I just want the record to note that we have many specific questions on Capital and Capital Planning, but as you know, Mr. Acting Deputy

Chairperson, the minister is not ready with his Capital Estimates. He is telling us it may not be until the end of the month of May, and it may be even beyond that time frame.

I am sure that the member for Transcona (Mr. Reid) has many questions to follow up in terms of Concordia Hospital. We are all anxious to know about when the long-promised spaces at Concordia Hospital, the beds promised at Concordia Hospital, the expansion of the Concordia Hospital will be clarified, since this was something promised in the election. It has been mentioned in every set of Estimates since then, and we are anxiously awaiting the details so we can have the debate. Let the record show that we will have many, many questions in concurrence on Capital.

Mr. Orchard: Mr. Acting Deputy Chairperson, I appreciate the member for St. Johns (Ms. Wasylycia-Leis), but the question that I had was not on Capital. Her honourable colleague the member for Transcona (Mr. Reid) indicated that in discussion with the administration of Concordia Hospital, they had indicated to him that certain—he makes the allegation that they—or the statement that they indicated to him, that certain things were committed to Concordia, and then the commitments were reversed on program, not on Capital.

All I was wanting was just to have a tiny amount of example there so that my honourable friend could not again make accusations that he has this inside track with management who are giving him specific complaints and then to disappear and not lay a single specific on the record as to what these programs were. In the absence of that, my honourable friend creates an impression that the management of Concordia Hospital are not happy with their expansion, are not happy with their lab, et cetera because the member for Transcona (Mr. Reid) did not come up with specifics on program. Maybe he does not have any; I do not know. That would be the impression one would have, because I have asked him for specifics and he has remained silent on the issue.

Mr. Reid: Mr. Acting Deputy Chairperson, I will rise to that bait, just for a moment.

Let the record show that there will be questions coming forward to the Minister of Health (Mr. Orchard) at the appropriate time when we move into the section on concurrence and that we will raise the specifics of those with the minister—not for the slightest moment thinking that we will receive straightforward answers to the questions that we pose—and that I am sure that from the minister, who has done this go-around for some 55 hours now in Health Estimates, we will continue to get the same rhetoric that we have received now for the last number of days that we have been in Health Estimates, no specific answers.

Mr. Orchard: Mr. Acting Deputy Chairperson, I look forward to my honourable friend posing some specific questions, because when you pose nebulous questions and nebulous allegations, it is a little hard to provide specific answers to phantoms.

The Acting Deputy Chairperson (Mr. Rose): Item 5.(e) Capital Construction: (1) Salaries $542,200—pass; (2) Other Expenditures $236,100—pass.

Resolution 69: RESOLVED that there be granted to Her Majesty a sum not exceeding $63,732,700 for Health Services for the fiscal year ending the 31st day of March, 1993—pass.

Page 88, 6. Insured Benefits (a) Salaries $5,608,500—

Mr. Cheema: Mr. Acting Deputy Chairperson, I was enjoying the discussion between the member for Transcona (Mr. Reid) and the Minister of Health (Mr. Orchard) and would like to have that discussion again take place some time when the Capital Construction comes. I think that will be a good issue.

Can the minister tell us if there are any insured services under study in terms of whether they are medically necessary or not? Will they be part of the health care package?

Mr. Orchard: Mr. Acting Deputy Chairperson, not specifically of the health care package, but bear in mind that the major opportunity here in terms of the insured benefits, I think, lies in part with the whole fee schedule reform and review, where we expect to have a pretty substantive and wide-ranging review with the MMA on fee schedules and billed services.

As we discussed around this issue maybe last week, probably there is 90 percent commonality across Canada for a number of procedures, and it is really in the last 10 percent, if you will, that there can be investigated the medical necessity test. That is why last year we did remove from Insured Benefits several procedures.

That is going to be an ongoing program where we try and come to grips with as much as possible

meeting medical needs. That means from time to time some difficult decisions. We are prepared to make them and try to undertake at the same time as good an opportunity for discussion with the providers as we can, and then I think fee schedule reform offers us that kind of discussion around service provision.

Mr. Cheema: Mr. Acting Deputy Chairperson, so the minister is saying, if I am interpreting correctly, that the insured services or the study of the insured services, whether some of them will be eliminated or not, they will be part of the fee reform package not the health care package?

Mr. Orchard: Yes. Even at that, I am taking a liberty probably in saying that it is part of the fee schedule reform that we are undertaking with the MMA. I think that a natural outflow from fee schedule reform is really the blunt question as to whether a given procedure–when we do an analysis of benefits across Canada whether indeed we might find the flexibility of not carrying the insurance program on for certain tariffs and certain items, but I am taking a liberty with–the original intent of the agreement on fee schedule reform was to just do that: examine our relative fee schedule and try to bring a greater clarity and a greater purpose to the fee schedule.

I think, whenever you get into that detailed a discussion, the opportunity to look at medical necessity certainly presents itself.

Mr. Cheema: Mr. Acting Deputy Chairperson, I think the minister is very forthcoming with a very politically risky statement. I am not going to hold him to that because I think it is a part of the whole discussion process that everything is on the table in terms of all the insured services and the fee-for-services reform package.

* (2130)

(Mr. Deputy Chairperson in the Chair)

I think that is a very bold step in terms of even discussing those things, as long as people know that everything is going to be on the table to see what the medical profession thinks is a necessity and what are the insured services that taxpayers can pay. I think that is a very, very important question that has to be answered. I would encourage the minister to be very open and frank with people and tell them that this is the way they are going to have a look at the whole system.

My next question is, anything with insured services has a direct link to the physician supply and the maldistribution of physicians. I think that issue has to be also discussed, the number of physicians, the number of practitioners, the number of specialists and all other services. I think that should be part of the package because anything we discuss under this section is a direct link to the services the health care providers do provide either directly or indirectly.

Mr. Orchard: My honourable friend knows very well that part of the recruitment retention package in terms of certain specialties in physician training is directly related in no small way to the opportunity to earn income. Let us be blunt about it. In relative terms, in Manitoba, for instance, anesthesiology has been an underpaid discipline. As a result, we are neither graduating sufficient numbers–and that is not unique to Manitoba. That happens right across Canada. We have a significant problem across Canada in two other disciplines: rheumatology and geriatric medicine.

I will not have these numbers exact, but in discussions I had last week, it was pointed out to me that in a period of time, and not too long a period of time–I think it was less than 10 years, or less than, I think it was, five years–Canada graduated something in excess of 700 pediatricians–I am not going to be held by the number exactly–and less than 50 geriatric medicine specialists. That is at a time when our birth rate was going down in general and the percentage of aging population was going up, and here we were still graduating substantial numbers of pediatricians and insufficient numbers of geriatric medicine.

In part, that has something to do with the opportunity for compensation. There is a relative imbalance in the way we provide remuneration to physicians. There is no question that physician services to seniors are much longer, like much more time consuming in many ways if you are going to do probably a good or an adequate job. There is not necessarily the reflection on that kind of time commitment reflected in the fee schedule. Of course, there is an issue that hopefully we put some direction around as we get into fee schedule reform.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us if the Department of Health is having a look at the method of paying physicians in terms of some countries which are funded under the national health care system having a different

payment method? That different payment method excludes many of the duplication possibilities, excludes many of the problems in the system. It may not be 100 percent successful, but I think it is worth having a look at it in terms of giving a particular physician a responsibility for a number of patients, and then you pay the person on the basis of per patient per year rather than per services or per visit. That will solve some of the problems.

I was talking to Mr. Harvey the other day, and he indicated very clearly that in Australia you are paid by the time in certain circumstances. You spend five minutes or two minutes for certain areas; you are paid from that level. If you are going to do a complete physical, then you are supposed to spend half an hour or 25 minutes, and you get paid by that. If you are going to do more services, you are paid by that.

So that balances the time versus the quality of care plus the other services the physicians do provide, and that in fact will eliminate some of the duplication of services. I think we should have a look at setting up a system where the physician, for example, on a salary basis, will be useful in the system, because whether this minister does or not, eventually that will come to this country—no question about that. Under the fee-for-service system that is ultimately—every country started with the fee for service, and when things went out of control, then they started making sure that the government will have some control.

One of the ways to have control is to have a specific number of patients assigned to a specific number of physicians, and then you are paying them per patient rather than per visit or per services. The only one argument which people will complain about this is whether you are going to restrict the services. Some advocates of patient groups could say that you are telling a patient whether he or she can only see a certain physician, but if given the choice, one or two health care providers in a given area, that could be solved very easily. So I think that could be a good experiment, and that will function at a community clinic concept in a much better and much more co-ordinated way. Those patients will get a quality of care, and also the health care providers would know what the limits are and what they can do within the ability of the taxpayer to fund the system.

I just want to know whether the minister is having a look at that system because some individuals will argue whether the same system as in the United States or even in Ontario—the health maintenance organizations have the system, but you have to have a Manitoba model and a model which will have some of the basics derived from the experience of other countries which have similar funded systems. So I would encourage the minister to look into that.

Outside this building we are all saying that we want to have a change in the system, and we want to have a salaried physician, but I think that process has to have a good look at the whole process and see whether that would really function. Then the patient also has to be educated, and probably then they will have a choice, but still they will be accountable that they will go to a certain group of physicians and get the services. If they are not satisfied, then they can change, but there has to be some limit on some of the things.

Mr. Orchard: You know, looking at it, yes, but I do not think in as broad a sense as my honourable friend is maybe suggesting.

Within our community health districts and throughout rural and northern Manitoba, we support salaried physician positions. There is a determination of numbers, formula based on population, which in effect is doing what my honourable friend says, that for so many thousands of people, we will fund so many salaried physicians and, in essence, expect within the salary commitment that they provide needed health care services to that population in the catchment area, and that works.

Here is our difficulty in Manitoba. Our difficulty is that we have this city right here where roughly 80 percent of our physicians are located. There are about 400 outside the city and roughly 1,600 inside, so 80 percent of our physicians are inside the city of Winnipeg. I think, with few exceptions, probably less than 5 percent, they are all on fee for service in the city of Winnipeg.

You run into the problem of distribution or even factoring out the specialists because you are not going to have a cardiologist or a cardiac surgeon outside of possibly two teaching hospitals. We have cardiologists in Brandon, but other than that, you are not going to have those skilled practitioners probably in any other parts of the province, and rightfully so, because the investment to back up their trained profession is extensive. It is a big investment, and you are not going to make that in a population of one million people or a province of

million people. You are not going to make that in any more places than absolutely necessary.

* (2140)

But even factoring out the preponderance of specialists in the city of Winnipeg, we do have an imbalance in terms of general practitioners. Getting around an HMO-type of concept with fee-for-service family practitioners in the city of Winnipeg, we have not even matured thinking around how we would start talking about that, because I think my honourable friend would appreciate that that is tantamount to a march on the—well, you know I mean that is really controversial, and we are not sophisticated in our understanding of what changes are possible to instigate, to even commence that kind of discussion. In a smaller scale, we offer the salaried physician on basically a mini-HMO throughout rural Manitoba to our health districts, so many salaried positions based on population.

Mr. Cheema: Mr. Deputy Chairperson, while I was discussing the issue, I was merely concerned about the family health care physicians. I think, as the minister has said, many of the northern communities do have the basic salary. Then there is the incentive for fee for service, and then you are not punishing each and every person who wants to work more than the others, but still there has to be some base line.

To give a health care provider a specific area, you are giving them the responsibility to serve that population. That kind of health care has merit in terms of that you are taking away a lot of the perception: first of all, that too many things are being done; second, the physician knows what the government is expecting out of them; and third, I think the patient also knows that they have to be somewhat responsible in terms of having access to services, and that can be delivered.

I understand this is at the very early stage, but it is going to come eventually, because the government will have to have some control in both ways, through the patient as well as to the health care provider. I am not saying it has to be done right away, but I think the thinking process has to start.

That kind of services, if they are effective in northern Manitoba, why can they not be effective in Winnipeg? You are talking about the same people. They are not different people. They have maybe some small difference in terms of age group or some of the other things, but basically human beings in the same age group would have almost the same kind of problems. Then I think the issue is going to come.

The other aspect is whether the government would go to MMA or health care body and tell them, this is what we have. You want to operate within 2,000 doctors, you do it, or do you want to do it within 1,200 or 500? I think there the discussion and everything will start right now. It is not their responsibility, and they may not take that seriously, because we have a system which is very open now. As you try to close the system, then so many things have to be taken into consideration.

I am trying to be very careful; I do not want to alienate my professional group, but I think the question is here: How much money is sufficient for so many people who are providing the health care system, whether you want to be given to five or 10 or 20 or 25 or 30, the numbers have to be decided. Then I think the issue of physician distribution—and the numbers will be really important because then both sides will be talking on the same wavelength, and the financial package will be that one common denominator which will bind the both sides.

Mr. Deputy Chairperson, I hope that I made myself very clear on this issue, in terms of the thinking process for the health care reform, in terms of the physician on a salary basis or a combination of both has to come eventually.

Mr. Orchard: You know it is interesting because recent discussions I have had with health care managers outside the city of Winnipeg, the topic was broached about doing a straight division of the current health care budget. You come out to $1,800 per man, women and child, and you go via the regions of the province and you say, here is your budget, and if you want to buy all of your services—and I will use my home area as an example, the Central Region. If they want to bypass their local hospitals and physicians and buy all their services at the Health Sciences Centre at a higher cost per day for in-patient days and they run out of budget six months into the fiscal year, they have made the decisions.

In discussing the issue, if it were a workable proposition, there are a lot of interesting possibilities in that, because if the budget was controlled on a per capita and age and sex-sensitized basis, then it is the golden rule that sort of comes into play. He who has the gold makes the rules.

If northern Manitoba says, well, our population says that we have a budget—and let us just pick a

figure of $300 million—and we are, quite frankly, going to spend it in northern Manitoba, I think very soon you would have employment opportunities being filled by caregivers. So it is coincidental that my honourable friend broaches the topic because it has been one that I very recently had with managers from outside of the city of Winnipeg as their observation on how maybe we should approach the system.

If you think about it, it is probably worth trying to put a group of experts around to suggest methods—and not on the exact topic that we have just discussed, but I have asked the Centre for Health Policy and Evaluation what sort of analysis they can give me around how effective a given hospital is in providing patient care from their global budget.

I am not going to describe myself very well, but I have asked, can you develop a formula that says: In hospital A, 62 percent of their total budget, their global budget, goes to provision of patient services; in a much more complex hospital, maybe it drops to 50 percent; and maybe in a teaching hospital, because they have a teaching role, et cetera, it might drop to 40 percent. Is it possible to give a percentage rating of budget dedicated to patient care? I think that would significantly help us to understand what drives our costs in the system. They are doing a little thinking around that.

There are only crude measurement tools that are available in the Canadian system right now, but I will just say to my honourable friend that in some of the areas he is suggesting are in need of investigation, we believe we have the opportunity over a several-year window period of time to do those kinds of investigations around funding. The report that I tabled in the House that the centre did in terms of alternate mechanisms for funding hospitals is rather an interesting one.

We have other opportunities to challenge the centre and other expert groups to come around issues of maybe how to rethink our entire method of planning and spending.

Mr. Cheema: Mr. Deputy Chairperson, just a final comment. While I was raising those issues, those are some of the ideas coming out of many groups, and I thought it was worthwhile to explore them. We cannot just make those policies on the spot, because these are very, very difficult questions. Difficult questions take a long time, but then we can always have some answers.

But if you start dealing with the financial aspect and as it relates to health, and if you want to look at Manitoba from a region point of view, north, south, southwest, western region, and try to divide the health care budget, when you are dividing that, then all these things we have discussed and we will be discussing in the future, will all fit into that. Then you are filling those gaps.

* (2150)

Those gaps will be filled by the professional groups, and then they will come with a lot of suggestions also because then—when I said we are talking about the same point of view, the financial point of view—the financial point of view unites many professional groups. When you are dividing the same pie, then they have to come up with the money answers, so that is the reason I think those things are worth discussing and having a good look at how the system could be reformed because, if you start today, it probably would take two or three or four years to develop a system which would really have a meaningful, long-term policy.

So it may not benefit your government, but it will at least benefit somebody else, and taxpayers will benefit eventually from the process. The process has to start, so I will encourage you to look into that issue, I mean, not at this state, but once the health care reform is coming into place, because each and every province, as I said from the beginning, is having a good look at the system, whereas your government is going to do it now. For them it is going to be the model. That is why, when we are saying that your model has to be successful, it is in all of our interests that you have to be successful. Otherwise, not only are you failing yourself, you are failing a lot of other governments that are having a good look at the system.

It is so essential to continue to provide the leadership in terms of the future plans for health care because what somebody has done in 1980, today you will not be doing them because you do not have to. You are cleaning somebody else's mess, but you do not want to leave the mess for somebody else who is going to come in, in six years time.

Mr. Orchard: I appreciate my honourable friend's comments, but you see in my humble opinion that is exactly why we should have these kinds of debates around Estimates. It is an opportunity to bounce different ideas without the risk of having them tied in a negative political way to you as a proponent of an idea.

Ideas and new ideas are needed to challenge thinking throughout the system and throughout Manitoba to come to grips with logical solutions that can make the system continue to work and work well.

I have often said this to my honourable friend, I listen very carefully to the suggestions because we all need to have these open suggestions. Some of the ideas certainly will get tossed aside, that they are unworkable, but nothing ventured, nothing gained.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, a few areas to cover in fairly brief form. First, with respect to Pharmacare, does the minister have the list of drugs that are affected as a result of the change in Order-in-Council pertaining to emergency release drugs or investigational drugs?

Mr. Orchard: Yes, Mr. Deputy Chairperson, I do. I have two copies.

Ms. Wasylycia-Leis: I would like to thank the minister for that list. We will be using it as a reference for concerns that are coming in from different individuals about drugs that they had once been covered for.

On Pharmacare, could the minister indicate, when they changed coverage under Pharmacare by excluding—and I am referencing now the Order-in-Council—allergenic substances used for the use of allergenic diseases, why when that change was made through Order-in-Council did allergenic substances used for treatment of allergenic diseases get covered as well, or if that was an error and could be corrected?

In other words, I will be more specific. We had an individual complain to us and document for us the fact that substances—in this particular case these substances were pollen and house dust—that were once covered under Pharmacare, found herself shortly after this Order-in-Council was passed without any coverage at all under Pharmacare and was told that in fact these substances were no longer covered and were part of the whole list of drugs excluded under Pharmacare.

I am wondering, is there a reason for that, on what basis this decision was made, how does an individual who feels she is dependent upon these vials and getting access to these injections, this material for injection purposes, to prevent serious reaction to allergies and could end up in hospital without the benefit of this, how this kind of substance was part of that whole reduced coverage?

Mr. Orchard: Mr. Deputy Chairperson, let me clarify, first of all on the list that I handed out, those are the emergency release drugs that were covered under the Order-in-Council. There is only a handful of those that are currently being charged for by the manufacturer, clarythromycin being the most obvious one. We think there are maybe four others, but we do not have definitive information and appreciate the reason why we do not is because you do not—

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, I think that the minister may not have heard all of my question, and maybe I rambled a bit.

Mr. Orchard: No, I am going to answer the second part.

Ms. Wasylycia-Leis: Oh, okay.

Mr. Orchard: No, I just wanted to clarify around the emergency release drug list, that at present the vast majority of these drugs are not being charged to the consumers, not being charged by the manufacturer because they have not got the notice of compliance.

Clarythromicin and maybe as many as four others may well be charged in communication, being charged for prior to notice of compliance. We have undertaken communications with the manufacturer to inform them of our policy so that we can hopefully receive some assurance that manufacturers will continue to supply emergency release drugs at no cost until notice of compliance, and inclusion thereafter on the Pharmacare list has been achieved.

Second point, on the allergy materials, there were some that were removed from the Pharmacare coverage because they were over the counter. In other words, nonpharmaceutical did not have to be prescribed, they are over the counter. Some of those were removed from the Pharmacare list. If my honourable friend could give me some details as to which one, we could clarify whether that was the case because I am unaware of any circumstance where a prescription pharmaceutical for allergies was deinsured or taken off the Pharmacare list.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, yes, I can be quite specific to the minister and ask him to look into the situation. It is not a case of a drug, it is part of the list of drugs delisted because they can be purchased over the counter.

This is a case of a substance that can only be obtained through prescription and needs to be purchased in vial form for the purpose of injection to prevent reaction to allergies. The two are, in this case and there may be others, pollen and house dust, which this individual had been prescribed for years, and every three months or so the bill was about $90. Written right on the pharmacy bill is pollen, 5 mils $50; house dust, 5 mils $40.

She is from rural Manitoba. She comes into Winnipeg, goes to the Winnipeg Clinic to see an allergist–if that is the correct word–is prescribed these substances–[interjection] Yes, pollen.

Mr. Orchard: Well, we will have to check that out because I am really unable to answer how you would prescribe pollen and house dust. Maybe if we could get that photostated, please, we will check that out.

Ms. Wasylycia-Leis: I appreciate the minister looking into that. I am assuming that it is something that got covered under sort of the umbrella term, allergenic substances used for diagnosis of allergenic diseases. I realize it is very rare these days for individuals to be getting the form of injection of the substance to which they are also allergic.

That was a common practice in the past. It still is used occasionally. I realize that in some, maybe used sporadically and maybe in some question, there may be some reason for it, but it certainly does not fall under any of this documentation.

The final question on the list of–

* (2200)

Mr. Deputy Chairperson: Order, please. Just one moment, please.

The hour being ten o'clock, could I ask what the will of the committee would be? Continue? Okay, we will carry on then.

Ms. Wasylycia-Leis: A final question pertaining to the number of drugs that were delisted and they do fall into that category of drugs that can be purchased over the counter.

The minister will, no doubt, have received some complaints, and concerns as well, similar to the one I am about to mention. It has to do with calcium and the requirement of, particularly seniors, in our population to be on prescribed fairly high regular dosages of certain kinds of calcium which are now no longer covered under Pharmacare and for which doctors are expressing concern, and of course their patients and clients are expressing concern.

I am wondering if any exceptions have been made to this change in the Pharmacare program so that individuals who absolutely depend upon such things as calcium for their health and well-being, and to keep them out of hospital, and to keep them away from necessary surgery and so on, if there is any exceptions, any procedures made for dealing with those who might not be able to afford the very high, regular dosages of something like calcium.

Mr. Orchard: No, I am informed there have not been any exceptions granted. I cannot even answer to my honourable friend as to whether there are that many requested.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, on a separate issue, I would like to ask about–this is an issue I want to clarify at the outset, that we have touched on here and there throughout this whole Estimates process. It has to do with the waiting list for cataract surgery, hip surgery, knee surgery. I am wondering, the minister has in the past referenced the committee that is being headed up by David Naylor. I am wondering, since all of this impacts on hospital budgets and health care reform, if the minister could tell us when he expects Dr. Naylor and his committee to report and how it fits into the overall health care reform strategy and hospital budgeting process?

Mr. Orchard: Well, I think it is an important component of health care delivery. All too often, our health care system is judged to be inadequate because of the length of the waiting list. Waiting lists, on a regular basis, will be used from time to time to demonstrate a greater need for services in the system.

The most recent example I can give to my honourable friend in terms of the need for an investigation into waiting lists is the MacEwen report. As provincial radiologist, he found out that out of 3,600 people on the waiting list for CT scanning, in fact it was 2,400 long, so that there obviously were a number of people commonly on waiting lists.

In terms of the waiting list, let us deal with some of the specific surgeries that my honourable friend has mentioned. Let us deal with cataract surgery as one example. There may be a dozen practitioners who are maintaining waiting lists. Each practitioner has access to a certain amount of operating theatre time and, on the basis of that, will prioritize their waiting list. That has relevance in terms of the prioritization on the waiting list for physician A, but

it does not have any correlation, necessarily, with the prioritization of waiting list B.

I will give you the example: Let us say physician B might have half the waiting list and the same operating time. It is quite conceivable that less urgent cases are being advanced by physician B simply because of his position for admissions and access of theatre time compared to physician A. In reality, there are patients in more need on physician A's waiting list.

Dr. Naylor is chairing the group with the vice-presidents of medical from St. Boniface, Health Sciences Centre, Victoria; Dr. Israels and Dennis Roch, who heads up our research group that was here for a significant portion of the Estimates. There are a number of objectives, hopefully, going to emerge from the waiting list, i.e., the kind of prioritization so that we can establish relatively uniform criteria for placement on the waiting list by physicians putting patients on the waiting list.

(Mr. Gerry McAlpine, Acting Deputy Chairperson, in the Chair)

That has a pretty significant purpose. It can ensure that Manitobans in need are in fact placed on the waiting list and have a prioritization for accessing the service which reflects their individualized need. That is not necessarily how those individuals may access the system today.

I want to give my honourable friend a specific example, and this came out of my own constituency. A cardiologist had referred an individual to an open-heart surgeon. The first visit that the individual made to the open-heart surgeon, the gentleman was--how do I put this so it does not sound offensive, but he was placed on the waiting list. That was a precondition of him seeing the surgeon. He had no desire and ended up not wishing to undergo the surgery, but yet that individual became someone who was on the waiting list. The waiting list was subsequently, at some point in time, used to try to focus attention on the issue of open-heart surgery, and clearly the objective was to have more resources focused on open-heart surgery.

Well, that is interesting. We need to have some consistency around waiting lists, the type of patient who is on the waiting list, so that we can have an accurate assessment of how well needs--and I emphasize "needs"--are being met. That is the purpose of the Dr. Naylor investigative committee.

* (2210)

Ms. Wasylycia-Leis: I appreciate the lengthy response of the minister and understand how important this whole issue is in the context of rationalization of our health care system, but in the meantime, we have got probably more concerns coming forward as a result of waits in these areas than probably on any other issue. It has been fairly intense lately around this whole question. It has been a particular concern because people have been notified that there is an option. I am not saying, notified by this department, but they have heard through various sources that they have an option of getting the surgery done at a private hospital.

Just to clarify the minister, he may have missed the coverage on this, the Western Surgery Centre is doing cataract surgery, hip surgery and knee surgery. I do not know what they are charging in each instance, but they are providing that surgery. I have had a couple of examples brought to my attention. There was in fact an article in the Free Press as recently as April 1--I assure the minister this was not an April fool's story--indicating that some Manitobans are paying $330 for knee surgery, and that must mean per knee--

Mr. Orchard: Thirty dollars?

Ms. Wasylycia-Leis: Three hundred and thirty dollars [interjection] Would not that--

At any rate, to the minister, this does raise the whole question about our system, the impact of waiting lists on our universally accessible health care system and what it does mean in terms of creating lucrative markets for those who can find a way to offer the service and still make it pay. It does beg the question about how we can ensure that people do not have to turn to this option in the context of changes to our hospital system and funding arrangements in health care reform.

I am wondering if the minister can give us some advice about what we say to these individuals, many of whom indicate quite clearly that the wait for either cataract surgery or hip surgery or knee surgery is clearly impacting on their quality of life and creating difficulties, either in terms of seeing or walking and just plain going around.

So I am wondering if the minister could tell us while this review is going on, while the whole issue of funding to hospitals is sorted out, while issues of centralized waiting lists is pursued, what advice do

we give these people? Is there a role we can play on their behalf, if we think they are a serious case, to get the attention that they need to get moved up on the surgery list? Could the minister give us some help on this front?

Mr. Orchard: Mr. Acting Deputy Chairperson, I presume my honourable friend would want to give them the same advice that she would have given them when she was a Cabinet minister, because these clinics were in place prior to us coming into government, every one of them. They were offering those services while my honourable friend was in government. What advice did you give to these individuals in 1987 when you sat around the Cabinet table, and Western surgical clinic was offering cataract surgeries at roughly $1,000 an eye? That was happening when you were government. I do not know what advice you offered them then.

Whenever I receive a request into my office asking about the scheduling that an individual has with a given physician for cataract surgery and any other kind of surgery, we make inquiries to find out what the circumstance is. We often suggest to the individual patient to consider having their general practitioner refer them to another specialist to see whether they can access the surgical procedure quicker. That is the kind of advice we give.

But my honourable friend might be very cautious in terms of getting into the issue of the Western surgical clinics because if my honourable friend wants to trace the history of that clinic, it came into being after we left government in 1981, while my honourable friend was in government. I do not know what kind of advice my honourable friend offered to them as a Cabinet minister, to those individuals who were going to Western surgical clinic that started up approximately in 1984, what kind of advice she gave them.

(Mr. Deputy Chairperson in the Chair)

But surely that advice might have some sense of consistency from the time my honourable friend was in government to now, when my honourable friend is in opposition.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, first let me indicate that this is a matter of concern for us, whether in government or out of government. Certainly, it was an issue that caused concern and very serious discussion when the NDP was in government, and it still concerns us. That does not make it necessarily easy to solve. I would certainly concede to the minister that it is a difficult issue, but it is an issue aggravated by the funding policies of the day.

So, Mr. Deputy Chairperson, while it was certainly possible for an individual during the time I was in government to get cataract surgery, the whole growth in the private sector, this rapid growth in terms of private centres, private hospitals, private surgery, is a recent phenomenon.

I do not know what the minister claims the history of the Western surgical centre goes back to 1984. It was my understanding that this particular centre has a fairly recent history. I know that it was certainly possible, and people did get private cataract surgery through different avenues in and outside the province when we were in government, but the expansion, the growth through the Western surgical centre, is fairly new.

In fact, I am referring to some coverage when this issue first really became quite newsworthy back in October of 1991 when the media at that time reported that Winnipeg's—this was referencing Dr. Noel Book, who works with Dr. Davinder Singh-Rehsia and his clinic, and the article claims that his clinic was set up on the same site as Winnipeg's first cataract suite opened in February of 1990 by Dr. Daya Gupta at the Western surgical centre.

So maybe there is some history here that I am not aware of or that the media is not aware of. But, regardless, it certainly is clear, and I do not think the minister is going to dispute the fact that as, for whatever reason, whether it is to do with funding policies, whether it is to do with shortage of specialists, whether it is to do with an aging population, whether it is do with more and more people demanding a better quality of life, whatever the reason, there is more of a demand, longer and longer waiting periods and a real lucrative climate for private cataract, hip and knee surgical services.

My question still comes down to: Is it the minister's goal and objective to try to work with the hospitals and develop procedures and centralized surgery lists, or whatever is required, to cut down on our waiting lists so that those who need the service get the service within a reasonable amount of time so that we are not causing people to turn to private services and aiding and abetting this whole private health care delivery system? Does the minister at least share that concern and that goal?

* (2220)

Mr. Orchard: Mr. Deputy Chairperson, my honourable friend is I think mixing a little bit of apples and oranges, and just let me straighten her out. The Brandon clinic offering ophthalmology was doing that prior to 1988, circa '84-85. That is the clinic I was referring to.

Yes, it is my understanding that Dr. Gupta is offering in Winnipeg, through Western surgical clinic in Winnipeg, not only he is offering them now, but there were discussions going back about nine months ago to offer the service in Winnipeg.

The cataract replacement surgery in Brandon was ongoing when my honourable friend was in government.

As I have indicated many, many times when this issue has come up, if we had reduced or levelled or flattened the number of cataract surgeries that were performed in the province of Manitoba, I would say that I would be open to criticism as government, but in fact we are doing about 40 percent more.

I do not have the numbers in front of me right now, but since we have come into government we have increased the number of procedures–I will be conservative–by 30 percent, from 3,500 to 4,500 in '90-91; 1991-92 we do not have available stats obviously yet.

Since we have come into government, we have done a full 1,000 more cataract surgeries per year. That is a pretty significant increase. That is 30 percent more, and certainly the drive no doubt would be to have many, many more candidates for that surgery. That is why we are trying to establish, through the committee chaired by Dr. David Naylor, the appropriate protocols for access to the service.

We are concerned that one might be promised as a patient a result if only they went ahead with this surgery and avoided these waiting lists, et cetera, et cetera, and accessed the Brandon clinic or indeed the Winnipeg clinic and would be not necessarily having their health status either compromised or improved through that access. We want to be very sure of that, because we are providing roughly 30 percent more cataract procedures per year than what we did when we came into government–not less, but more.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, how many individuals are referred by this government to facilities outside of Manitoba–I am talking about within Canada–for necessary hip, knee or cataract surgery? If the minister could give us some figure in terms of numbers of people who need hip, knee or cataract surgery and are referred by this government to a facility outside of Manitoba within Canada?

Mr. Orchard: I do not believe, Mr. Deputy Chairperson, that we make referrals outside of the province for hips, knees or cataracts because the service is available here.

Ms. Wasylycia-Leis: I would certainly be interested if the minister could check this a bit. I have had calls from individuals and all circumstances are different, but I have had, for example, an individual from the North in Manitoba who needed hip or knee surgery and was actually referred to a hospital in Ottawa and had it all covered.

I have another example in front of me pertaining to an individual whose doctor was able to refer her to a facility and a physician in Saskatchewan. I know that the minister has made a lot of comments about Saskatchewan in the last little while, but in this particular example, while the individual would have had to wait a year or two for necessary hip or knee surgery here in Manitoba, was able to get into the Royal University Hospital in Saskatoon in very short order.

In fact, this was an issue that goes back to about January of 1992 when she found out it would take a year or two here in Manitoba for the surgery, was able to get a date at this hospital in Saskatoon for May of 1992, but then, subsequently, was told that that could be moved up a month to April of 1992. Of course, as the minister knows, all of that is covered by this province.

So whether one is referred by the government or by a doctor, the point is, it is a question of necessary surgery being done at facilities outside of Manitoba because the waiting lists are not as long. But it is all covered, and one would assume, in fact, that there might even be additional costs for government if any kind of transportation is paid.

So I am wondering, in light of those two examples, if the minister has any further comments to make on this issue or is prepared at least to determine numbers in this regard and get back to us?

Mr. Orchard: Mr. Deputy Chairperson, we will check and see whether we have paid hip or knee replacements outside of the province of Manitoba, but when we have the service available in Manitoba, we do not refer out of province for the procedure.

I might simply add to my honourable friend that that is exactly why we are having Dr. Naylor and a group of professionals in Manitoba examine the waiting list issue in Manitoba, so that we might have some advice from experts on how to more appropriately manage the provision of service in the Manitoba program.

But we will make inquiries and provide whatever information we can in terms of out-of-province procedures that are paid for.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, with respect to a situation pertaining–it is an issue that links both the issue of private services and our hospital system. Does the minister have any information indicating the incidences when people turn to private services to provide additional nursing support when a member of that individual's family is in hospital?

I raise it because I have had a number of individuals raising with me the concern of feeling that hospitals are so short staffed that they felt it absolutely necessary to go to a private agency to hire a nurse, particularly for nighttime duty in hospital.

I am wondering if there is any kind of research, any kind of information that the minister has indicating how serious this whole issue is and what the source of the problem might be?

Mr. Orchard: Mr. Deputy Chairperson, if any of those additional nursing requests are requested by the physician, they are covered by the hospital budget.

Ms. Wasylycia-Leis: Is the minister saying that if anyone requires additional nursing support the hospital would help the family pay for the cost?

Mr. Orchard: I am saying that if the attending physician indicates that the individual in care needs additional nursing services, that is provided by the hospital budget.

* (2230)

Ms. Wasylycia-Leis: I appreciate that information. That is something I was not aware of. However, I am raising a situation where families believe that their family member in hospital is not getting the necessary attention and on their own make the decision without doctor's recommendation, make the decision to actually hire a nurse from a private agency in order to get the extra care or supervision, particularly between the hours of 11:30 p.m. and 7:30 a.m.

Is the minister at all aware of any growing concerns in that regard, and could he give us some indication of whether or not, as hospitals find it more and more difficult given the current budgetary situation to make ends meet, that they are having a higher and higher ratio between patient and nurse, particularly during the evening shift?

Mr. Orchard: Mr. Deputy Chairperson, I am not aware of any growing phenomenon as my honourable friend indicates in her questions may be happening.

I will share a little personal history with my honourable friend going back to 1975 in October where my mother died in a hospital in the city of Winnipeg. We made the decision that my sister was going to provide that extra nursing support because we wanted our mother to have that.

I suppose one could conclude that the hospital was understaffed in 1975. I did not make that conclusion. We made a family decision that we were going to provide some additional services to my mother in the hospital. The families decide that, they are fully free to do that.

If the physician decides additional nursing is required, that is paid for by the hospital budget, but if families decide, as we decided in 1975, to provide that extra nursing care, we did it on our own. The hospital in question did not say we could not, nor could they have, I presume. The same situation exists today.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, I appreciate that personal history that the minister has conveyed. I just want him to know that those individuals who are raising this issue with us and writing to us are also very committed family members who are doing everything possible within their time and abilities to provide around-the-clock presence at hospital. That does not make their concern any less legitimate. Their concern about ratio of nurses to patients, particularly during the night shift, is one I think that should not be dismissed too quickly, and perhaps is a result of difficult budgetary decisions being made by hospitals.

I had hoped that the minister would perhaps take it upon himself to see if there was a way he could survey hospitals or indicate to us what an appropriate ratio would be for different types of patients, but the hour is getting late and I will not pursue it at length except to indicate that the individuals who have contacted us have stretched their resources to the limit and have still felt that they

were not able to do everything humanly possible for their mother, in this case, and paid for private nurses for 15 days. They were there, the family members were there every day from 8 a.m. to 9 p.m., but could not find a way to be there every minute of the day and felt the only way to ensure that their mother had someone there at her bedside at all times was by hiring someone. I think they raised a legitimate question. What is happening to our system?

Maybe in all cases it is not legitimate; maybe things have not changed all that much from say 15 years ago, but maybe they have and maybe we have to ask those questions and see how hospitals are reacting to some tough financial constraints imposed on them.

I am wondering if the minister could give us any indication about the reasons for the apparent rise in private health care services in Winnipeg and in the province of Manitoba? I will leave it at that.

Mr. Orchard: Like what?

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, I am referencing, and I am sure there are other examples, private services that provide home care, nursing and other services. This certainly seems to be an area of growth in our economy.

I am wondering if the minister can account for that in terms of either change in policies of the government or is there in his opinion a change in peoples, in terms of the needs that they perceive out there that have to be met?

Mr. Orchard: Mr. Deputy Chairperson, I presume my honourable friend wants to revisit the home care policy guidelines debate again. There has not been any change in home care policy guidelines. If individuals are choosing to purchase services from medics and any other of the private providers, that opportunity is available for them to do so.

The criteria for accessing the Continuing Care Program has remained consistent. Paid hours per patient day have remained consistent in our hospital system.

My honourable friend brings up some examples of individuals who have contacted her office. I guess back in 1975 our family could have contacted the opposition and said, here is what is happening and tried to point accusatory fingers, but we chose not to do that because it was our choice to care for our mother in that fashion.

As I have indicated to my honourable friend, in the hospital system, should the physician request additional nursing hours, those are provided within the hospital budget.

In terms of accessing the private services that are available, I am not sure my honourable friend's apparent observation that these have increased quite significantly has accuracy. Those services have been available for a number of years, and I suspect will continue to be available as individual families make personal choices around provision of service.

The Continuing Care Program has been operating with an increasing budget and increasing units of service ever since I have come into the ministry. This year's budgetary approval request is for an additional $7 million to provide additional services.

Ms. Wasylycia-Leis: Just a final question on this whole area: Are our hearing tests an insured service or not?

Mr. Orchard: Hearing is undertaken as a program offered in regions in some of our hospitals throughout Winnipeg and rural Manitoba but is not an insured service.

Ms. Wasylycia-Leis: Just one last question on that whole issue: Has there been a change in policy in addition to the issue of audiometrists that we dealt with last year in Estimates in terms of rural Manitoba and, in addition, to the cutback to the Winnipeg School Division for audiology services? Have there been any other changes pertaining to hearing tests being available in certain parts of the province?

Mr. Orchard: No, the only thing that might vary the level of service capability is, from time to time, a vacancy which we recruit very quickly into, but there may be a temporary service gap. That would be the only reason. There is no change in the program.

* (2240)

Ms. Wasylycia-Leis: Since the minister is saying that audiology services or hearing tests are not insured but there are programs which people can access, if people cannot access a program, does that mean then an individual, if they can find an individual or a facility that can do the test, must pay a certain fee? If so, what would the fee be? Would the minister have any idea?

Mr. Orchard: There is no fee.

Ms. Wasylycia-Leis: I will have to leave that for now. Thank you.

Mr. Deputy Chairperson: Item 6. Insured Benefits (a) Salaries $5,608,500–pass; (b) Other Expenditures $370,200–pass.

Resolution 70: RESOLVED that there be granted to Her Majesty a sum not exceeding $5,978,700 for Health, Insured Benefits, for the fiscal year ending the 31st day of March 1993–pass.

We will now move on to item 7. Health Services Insurance Fund.

We will recess five minutes.

* * *

The committee took recess at 10:41 p.m.

After Recess

The committee resumed at 10:51 p.m.

Mr. Deputy Chairperson: Order, please. Before recess, the committee started to deal with item 7. Health Services Insurance Fund.

Mr. Cheema: Can the minister tell us in terms of the Manitoba Health Status Improvement Fund now. This is one good proposal. Can he give us some indication, did the St. Boniface Hospital–they have set up this new one-stop cancer clinic. Is this is a part of this Health Status Improvement Fund?

Mr. Orchard: Mr. Deputy Chairperson, no, not that specific program. The only one that has been approved for go-ahead funding is the LRDP program at Victoria. The labour recovery discharge postpartum program at Victoria is the only one that has been approved so far.

Mr. Cheema: Mr. Deputy Chairperson, when the minister had the press release, it was made very clear that any hospital which comes up with a new, innovative idea, and when the news of St. Boniface Hospital came out, I thought that the St. Boniface Hospital might have got the money out of this fund. If that is not the case, then they certainly deserve double credit. If they are setting up a system within their own hospital and still not asking for extra money, they are setting up a very unique program, a one-stop cancer clinic program, and that is very positive. I think that will save money in the long run and provide good and effective health care services, and that is very positive.

Certainly the minister says the Victoria Hospital got the funding out of this. Is the birthing centre a part of that funding?

Mr. Orchard: In Victoria's case there were renovations required to bring in the 20 labour and delivery rooms into being. That is what they accessed the funding for. Their containment of budget costs over the next–well, forever, if you will, are pretty significant because of that. They have amalgamated the two units, et cetera, so that they had a pretty cost-effective program which was very much in vogue with the aspirations of today's mother wanting to have a different delivery environment which was much less sterile, if I can use that terminology, and much more homelike in its presentation.

I just want to get my honourable friend so he does not get the wrong potential idea in terms of St. Boniface. I do not know the specifics around the program my honourable friend mentioned about St. Boniface, but it may well be that they introduced that within the global budget without the requirement for a capital investment and significant capital improvement. If that is the case, no support financing would be required.

This Manitoba Health Status Improvement Fund is there to provide support funding to an institution, which they cannot achieve from within their global budget, in order to bring an innovative process or an innovative management procedure or program delivery into their institution, and that to do so would require a commitment of budget dollars, in the case of Victoria, capital commitment which they did not have available any other way. The bottom line on approvals to this is that they do have to improve care delivery and operate at a lesser cost to the system, and in both cases, both the patient and the taxpayer, both the mother and the taxpayer won in the Victoria example, and we hope in any others that we approve out of this fund.

Mr. Cheema: Mr. Deputy Chairperson, one of the activities under this program is: Funding will be administered by the Urban Hospital Council. I think that is a wrong statement. If funding has to be provided throughout the communities, including the minister's own riding and the North and other parts, I think that needs to be corrected, because it should be through the hospital council, or whatever term you want to give to it. I think each and every hospital should have the opportunity to apply for the funding not only the Winnipeg hospitals, but some of the smaller hospitals, and they may have some good ideas.

Mr. Orchard: My honourable friend might recall when we discussed this. At the time of printing of the Estimates, the urban hospital equivalent in rural

Manitoba, the rural health council, was only an idea that we were discussing at senior level of MHO, and at the time of the printing of the book, et cetera, we were pretty reasonably assured, but we were not confident beyond a doubt, that we were going to have an urban hospital equivalent in rural Manitoba. They have the opportunity to access that fund, so that is half the information or however we put that. Certainly there is no restriction on accessing this fund to hospitals with qualifying projects outside the city of Winnipeg or outside of the Urban Hospital Council membership.

Mr. Cheema: Mr. Deputy Chairperson, another very positive statement was that they will not be punished if they are saving money, and they will be able to retain their funding on a global budget, so they will continue to have more innovative ideas. The policy in the past has been as long as you have deficits, you may get some money; if you have a surplus they will be taken away and next year that may be adjusted. The net saving could be used in the hospital system, and that is very positive, and I just want the minister to continue to reinforce that any health care provider who is providing good, effective and efficient health care should not be punished rather than rewarded, and I think this is one way of doing it, giving the hospital and the health care facility an indication that when they bring in good ideas, that will be appreciated by the Department of Health.

Mr. Orchard: Mr. Deputy Chairperson, that is always a really hotly debated issue in terms of how you put incentives in the public sector, because I will make the argument, I believe we ought to do that. As a matter of fact, I would make the case that–and I have often talked about it, except we do not have our minds around the method of how the policy might be implemented–but I have no aversion to having an incentive system to employees within the ministry to come up with better ideas for program delivery right across the system, including in hospitals, and to offer a financial reward to individuals making good suggestions. I mean, it works in the private sector. It should work in the public sector.

In today's environment the dilemma quite frankly is, the first thing you are going to run into is criticism from beleaguered taxpayers out there that, why are you providing an incentive to well-paid civil servants–and the well paid is the perception–for just doing their job? That is what they are supposed to do is come up with these innovative new ideas,

* (2300)

There is a little bit of a communication gap there in how we put more private sector incentives to come up with innovative ideas and benefit thereby as an individual civil servant or someone working within the system having a good idea. I would like to reward those good ideas and encourage them coming forward, because I know there are lots of them out there.

In the case of the Health Status Improvement Fund, savings that accumulate to the operating budget can be retained, and we have maintained the 2 percent figure that one can run a surplus of 2 percent of global budget per year. It is seldom achieved, but it is there in some facilities, and they retain up to 2 percent of global budget in base as a surplus for future needs or for some enhancement of service delivery, as the case may be.

Mr. Deputy Chairperson: Manitoba Health Board $469,300–pass; Manitoba Health Status Improvement Fund $3,000,000–pass; Hospital $946,828,200–pass; Medical $297,941,800–pass; Personal Care Home $256,894,000–pass; Pharmacare $56,268,000–pass; Ambulance $6,221,300–pass; Northern Patient Transportation $2,846,500–pass.

Resolution 71. Resolved that there be granted to Her Majesty a sum not exceeding $1,563,348,100 for Health Services Insurance Fund for the fiscal year ending the 31st day of March, 1993–pass.

We will now move on to line 8. The Alcoholism Foundation of Manitoba, Board of Governors and Executive $154,700.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, the first question I have has to do with the relationship between the work of this foundation and the $250,000 new initiative that the minister has included in his set of Estimates that pertains to drug and substance abuse. I am wondering first of all if the minister could now give us more details about what that new initiative is, when it might be announced and how it fits in with the work of The Alcoholism Foundation.

Mr. Orchard: Yes, it is attached, but no, it is not part of The Alcoholism Foundation specifically. Now, I am going to take a political risk. I hope that in the month of June several things happen. Okay? Again, I sometimes get behind on this, but I am

willing to take this risk because I know my honourable friends here are fully supportive of me taking risks. [interjection] Well, some of the honourable–

Mr. Steve Ashton (Thompson): Is it a long walk off a short pier, or something of that nature?

Mr. Orchard: Well, actually now that the member for Thompson mentions it, at one time I was going to take a walk off the Selkirk bridge which was designed for half the length as a diving board for cars by his bench mate the member for Dauphin (Mr. Plohman) when he was Highways minister. Remember him designing that bridge, and he said they only designed it half long enough. Sorry, Mr. Deputy Chairperson. Just a little levity that the class of John Plohman as Highways minister enjoy every once in a while.

An Honourable Member: It created a lot of jobs for the people of Transcona. Some of my constituents worked on that project.

Mr. Orchard: Well, did they work on the half that was planned or the half that was not planned?

An Honourable Member: Worked on the overall project. It was the whole project.

Mr. Orchard: What was the question again? I forgot the question already. Oh no, I have not.

An Honourable Member: You were talking about your risk taking.

Mr. Orchard: Yes, that is right. Thank you.

An Honourable Member: That might be pretty risky.

Mr. Orchard: I am trying to finish an answer, but they are provoking me.

Mr. Deputy Chairperson: Order, please. The honourable minister please answer.

Mr. Orchard: My honourable friend might be aware that we undertook an extensive consultation a year ago in terms of drug and alcohol substance issues throughout the province.

I have been advised of their findings, and hopefully we will be tabling or presenting in June the findings of their public consultation and announcing a strategy and action plan out of the Healthy Public Policy Division of my ministry, which will as best possible bring together a number of the observations that were brought to the War on Drugs Consultation Committee.

The reason for the $250,000 funding being lodged with the Healthy Public Policy is that one of the observations that was made–and I will use general language so that it fits with many observations by individual groups and individuals across the length and breadth of Manitoba, the feeling, and this happened to us on two other consultation processes–is that there is probably sufficient support available in the community through a number of agencies and government departments, but there is a woeful lack of co-ordination between departments, i.e., the Justice department may well be partners with a given community group through a law enforcement agency, the education system through the boards have quite a substantial range of programs and liaison with the community in their respective school divisions.

The ministry of Health directly has support in the various areas and regions of the province. The AFM has varying digress of presence throughout the province. Family Services, in terms of their dealing with children, offer varying degrees of services and so do their funded agencies.

What was identified by the War on Drugs Committee in the broadest possible terms is the understanding or the observation that we have a significant number of services out there but, as I say, an inability or a current lack of co-ordination between those varying facilities. I think that is a criticism that is appropriately focussed at the AFM, as well as one of the agencies that delivers services. I mean, they deliver services, maybe without full participation with other providers in the community, so that we put a quarter of a million dollars into the Healthy Public Policy area to signal that we intend to bring over the next number of months and years more co-ordination between a multitude of departments directly and their funded agencies as indirect service providers in an effort to co-ordinate those programs. AFM will have a significant role in that co-ordination effort.

So that is why the signal is very clear. It is not narrowed only to AFM as a delivery agent. It is a Healthy Public Policy issue, because it crosses a number of departmental jurisdictions. That is why we put the initiative funding in Healthy Public Policy, but AFM will be a key player in the unveiling of that provincial strategy which I hope we can undertake in June of this year.

* (2310)

Ms. Wasylycia-Leis: I would like to ask a question pertaining to the whole question of the funding arrangements vis-a-vis the AFM and the Native Alcoholism Council of Manitoba. The minister knows that the council has been raising questions recently about adequacy of funding and methods of funding.

I am wondering in the context of the stated goals by the minister himself of moving toward self-help, self-determination models in the aboriginal community and given the inadequacy of the resources and the method of funding to respond presently to substance abuse in the aboriginal community, if he is reviewing this whole area and prepared to significantly revamp funding for substance, alcohol and drug abuse to meet the needs more effectively of the aboriginal community.

Mr. Orchard: Well, obviously that is an issue of discussion and concern. The AFM is probably undertaking the more significant discussion role with the Native Alcoholism Council, but again the issue crosses not only the ministry of Health's jurisdiction, but into Northern Affairs, Native Affairs, Family Services and the Justice system. You know, I guess I am troubled. I do not know whether the issue is solely availability of additional resources to solve the problem.

Certainly that is the first line of defence, if you will, but in this budget we have not got any significant new monies which would be available to the Native Alcoholism Council of Manitoba.

Ms. Wasylycia-Leis: A final question on this whole area. There are obviously different models of dealing with substance abuse, solvent abuse, drug abuse, alcohol abuse. Some of the organizations that are funded through AFM obviously are working on different models, maybe models and approaches that then are new, innovative and maybe effective.

I am wondering in a general way if there is any change in thinking in terms of what is a most effective way as a treatment program to deal with an abuse problem.

Mr. Orchard: Well, that is often very much open to debate. Let us deal with alcohol as the most often abused substance. I think the AFM operates a very good program for alcoholics, but I will also be very blunt.

No matter how good the AFM's program is for getting an individual to drop abusive consumption of alcohol, the important component in staying away from alcohol is the kind of follow-up and support program that is available. I think there is no question that in terms of alcohol, Alcoholics Anonymous, the A.A. movement, has provided that kind of support for individuals after they have had their addiction problem addressed through the AFM or any other agency. It is that network of support that I think makes the treatment and rehabilitation program successful over the long run.

Some of the criticisms that we have, and this applies particularly to the issue of native alcoholism, is that they are not able to access, for any number of reasons, as sophisticated a follow-up program. In other words, a young native youth, for instance, can be cured of an alcohol or a substance abuse problem and can leave a treatment facility clean, if you will, but if they go back to the environment that caused the abusive problem in the first place without the support, without the opportunity for some personal advancement of life style and career and self-worth, sadly the record is they are soon back into old habits.

That is where we are trying to get a better understanding of what is the underpinning of support post treatment which would be most effective. I do not think anybody has got the perfect answer, but I think in terms of one of the more successful movements ever, I think definitely A.A. has proven that that model is pretty supportive.

Even it has its critics, as my honourable friend will know, as you go across the spectrum of disease model versus factors outside of the individual's control, the societal factors. So there is not even unanimous agreement as to how effective A.A. is, but I am not particularly hung up on that argument. I will make the case that A.A. has been exceptional in helping a great number of people, too successful to be written off as not an appropriate model that works.

Again, very significant for the taxpayers, A.A. does not, to my knowledge, access any taxpayer dollars. This is a support group that is self-financing. I am positive it is self-financing. I do not think we provide any financial support, nor do I think any level of government provides any financial support to them. So from that standpoint they are pretty fiercely independent, but they are also quite effective.

Ms. Wasylycia-Leis: My last question, Mr. Deputy Chairperson, pertains—I am sure it will not come as a surprise to the minister—to Bill C-91. I am

wondering if the minister could just tell us what will be the fate of Bill C-91? Will it be proclaimed at some point as it is? Will it appear before the Manitoba Legislative Assembly in some other form but at least in part addressing the original intentions, or will we never see any shape or form of Bill C-91 in our Chamber?

Mr. Orchard: Never is an awful long time, so I think that is not possible.

Before we move on, the member for St. Johns asked about expenditures to go to Edmonton for the NAIT ambulance outside of staff time. Because there has been staff time dedicated, we have expended $3,161.09. This amount represents the cost for Dr. Ip, Bob Rauscher, and both those individuals are departmental staff, and then a Mr. Bert Bryan. He is the director of the Selkirk and District General Hospital. He also travelled to Edmonton with Dr. Ip and Mr. Rauscher. It was not two people from Selkirk–the original intention was to have two people go, but only the one individual went. The total costs for travel and hotel and meals, presumably, to Edmonton was $3,161.09.

Mr. Deputy Chairperson: Item 8. The Alcoholism Foundation of Manitoba, Board of Governors and Executive $154,700–pass; Finance and Personnel $339,700–pass; Drug and Alcohol Awareness and Information $499,900–pass; Program Delivery $9,014,400.

Mr. Cheema: Mr. Deputy Chairperson, I just have one question. The minister established this committee chaired by the member for Fort Garry (Mrs. Vodrey) on drug and substance abuse. I missed the initial part. I just wanted to know if the member for St. Johns has already asked questions. If she has, then I will read the Hansard. That was one of the concerns.

The other issue, I just wanted to make sure that the question asked by the member for St. Johns–we have almost similar concerns, so I did not want to duplicate, given the time limits. I just want to make sure that somebody does not say to me that I did not ask a single question. I have learned that from past experience.

Mr. Orchard: Mr. Deputy Chairperson, I do not know of anybody in this committee tonight that would do such a dastardly thing to my honourable friend.

* (2320)

Mr. Deputy Chairperson: Program Delivery $9,014,400–pass; Funded Agencies $1,999,700–pass.

Resolution 72: RESOLVED that there be granted to Her Majesty a sum not exceeding $10,882,400 for Health for the fiscal year ending the 31st day of March 1993, The Alcoholism Foundation of Manitoba–pass.

We will now move on to line 9. Expenditures Related To Capital (a) Acquisition/Construction of Physical Assets: (1) Health Services Insurance Fund $1,325,000–pass.

Item 9.(b) Capital Grants: (1) Health Services Insurance Fund $55,788,300–pass.

Ms. Wasylycia-Leis: It is fine to have them both pass except I think the record should indicate that we have not received the health care Estimates for capital, that we will be debating them in concurrence. In effect, although our system does not allow deferral, that is what we are doing.

Mr. Deputy Chairperson: Health Services Insurance Fund $55,788,300–pass; (2) The Alcoholism Foundation of Manitoba–no expenditures–pass.

Resolution 73: RESOLVED that there be granted to Her Majesty a sum not exceeding $57,113,300 for Health Expenditures Related To Capital for the fiscal year ending the 31st day of March 1993–pass.

We will now move on to line 10, Lotteries Funded Programs, (a) Health Policy Evaluation and Research Initiatives $174,900.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us, out of this $11,538,900, how the money is being divided, and what is the funding policy in terms of who can apply funding through this program? What is the difference in terms of this program and the Health Services Improvement Fund, because some good ideas may be covered in both phases, so I just wanted to make sure we do not have a duplication.

Mr. Orchard: You see under the Health Services Development Fund, and I am going to stand corrected, but with the exception of renewal of technology. For instance, dialysis machines are an example, the Health Services Development Fund does not fund capital improvements such as we accessed at Victoria Hospital under the Health Services Improvement Fund.

So that is the difference, although if one wanted to get right down to the bottom line, they have very

similar intents in terms of providing funding to achieve new program initiation which is going to either deliver better care or contain costs or both. Of the $11,538,900 in Lotteries programming, the Health Services Development Fund, by far the largest chunk, we anticipate we will need $9 million this year as opposed to $5 million last year.

The Manitoba Health Research Council, we have maintained without increase their funding. I fully recognize that they would have appreciated even a modest increase, but we fairly significantly increased that amount, I believe, two years ago or maybe three years ago now.

But nevertheless, back within two or three years we significantly increased it. We modestly increased it last year and left it level this year. The $416,000 is one of the last years that we have in an agreement that goes back, I think, to about '83 or '82, somewhere in there, where the first– [interjection] '84? '84. The first hospital to access lottery funding for the research foundation, I believe, was St. Boniface, then Health Sciences Centre, and the third hospital was Children's. I think this is the second last installment at Children's. At any rate this is one of the ongoing installments until we retire the commitment made in 1984 to the Children's Hospital Research Foundation.

Health Policy Evaluation and Research Initiatives, again level funding this year, we were not able to increase the funding.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us, are these Lotteries Funded Programs going to be in the same funding limit as they were last year, this year, next year? Or will the funding be variable in terms of the demand or some of the criteria you have set up? For example, the Health Policy Centre is going to need money to upgrade on a long-term basis, so are they going to be covered solely on the basis of lotteries funded, or are they going to be covered under the Health Advisory Network, or are they going to be covered under the Health Services Development Fund, or the other funding possibilities?

I think it is very important because if your government in two years time does not survive, you want to make sure that the Health Policy Centre will survive if you have long-term funding. If it is funding on a year-to-year basis, that will not be very beneficial for the major centres, on the basis of which many policies are going to be coming forth.

Mr. Orchard: Not that I am in any way doubting that two years from now the horrendous possibility my honourable friend mentions would occur, and I know that is not the context that he is posing the question.

We have had this discussion with the Centre for Health Policy and Evaluation. This is a delicate one, because we rely on the Centre for Health Policy and Evaluation to be nonattached to government, in other words, to be beyond the accusation that this is merely another arm of government which is turning out these reports. They have to maintain an academic independence.

At the same time when we are providing a pretty significant amount of their budget, we at the same time are going to put demands and deliverables on the centre to research for government to assist us in the formulation of policy. We are searching, and the board is searching right now with what is the opportunity for continued funding, because I happen to agree with my honourable friend. I do not think there is any question that the centre has already established itself nationally as a very, very sophisticated research centre. My humble opinion is that we can do nothing but get better as we move to more sophistication in our information base and more sophistication in terms of their ability to do analysis on existing data base. I genuinely see them being probably one of the most permanent new entities that I will have been part of establishing as Minister of Health.

The delicate dilemma is how do we continue that funding support from government around deliverables and yet give them the freedom to move outside and bring in outside research dollars as well. It is a quandary where extreme success of the centre might leave us without the ability to get them to do work for us, which I think would be a loss to the province of Manitoba.

There is no question we are going to come to a resolution of that, and let me give my honourable friend some of the areas where I think there is an opportunity for success. I believe that we can probably reprioritize within the ministry of Health and fund directly, by contract, research funding into specific issues directly out of the ministry through reallocation.

* (2330)

If necessary, we do have the fall-back of the Health Services Development Fund, because, unless something absolutely unforeseen happens to casino revenues, we suspect that we ought to be

able to have a few dollars per year to commit to the Centre for Health Policy and Evaluation on specific research projects.

I know where my honourable friend is coming from in this questioning, and it is a concern that government has and that the center has and our concerns are to try to find that mechanism that maintains independence of operation and an environment where no one can accuse them of simply being an arm of government, but yet to build on their excellence and to have that excellent capability available to government in order to provide underpinning of research for informed decision making by government. But we are going to work it through. We have a year and a half or better window to work it through and likely we will have more solid direction as we debate Estimates next year.

Mr. Cheema: Mr. Deputy Chairperson, my concern is very valid and so is the concern of many individuals who see the centre as a major pillar, but you want to make sure that a major pillar will survive no matter what. I think to do that you have to have established a relationship with the Department of Health which is viable and on a long-term and nonpolitical base, and that can only survive if you have a long-term funding policy which is not solely on the basis of a largely funded system which is also at the very primary stage of development in itself. It could change any day, depending upon many things that could happen. You know, I think that is the place where the government can probably make some changes and maneuver without touching some of the basic programs. So that is my concern.

We want to make sure the system will survive, and of course the minister says there is a risk because if this group becomes very successful, then they certainly would have the opportunity to make use of the resources to sell to other provinces. So, I think, if that is the case so be it, but still their main responsibility is to Manitoba. To do that they have to have some kind of moral obligation, and moral obligation only comes if you have solid communication in terms of financial backing. That is where I am coming from. I just want us to make sure that is the direction the government is taking, to make sure the centre will survive in the long run, no matter what.

Mr. Orchard: Well, you know, maybe I am being presumptuous here too, but I believe that their value to all of us already has pretty well assured their continuation, regardless of who governs in the province of Manitoba. The briefing Wednesday about two weeks ago, now that started out and was rolling at eleven o'clock. So it had to be cut off, what?–about 11:20 or thereabouts. I mean, when you start to listen to experts who have an unbiased and impartial observation of the system it turns into an absolutely fascinating discussion, because you begin to see incredible potential for change without compromising the individual's access to quality care.

I mean, we are dealing with a lot of givens in the system that have not ever had the hard light of analysis put on them, and the centre does that in a very realistic way. I think they have already proven that they can provide government with very impartial information on which to base sound decisions. That is valuable to us. That is why we conceptualized and funded the Centre for Health Policy and Evaluation, but more importantly I think that is why it probably will establish itself as a research centre of longevity irrespective of changing political winds in the province.

Mr. Deputy Chairperson: Item 10.(a) Health Policy Evaluation and Research Initiatives $174,900–pass.

Item 10.(b) Children's Hospital Research Foundation $416,700–pass.

Item 10.(c) Manitoba Health Research Council $1,947,300–pass.

Item 10.(d) Health Services Development Fund $9,000,000–pass.

Resolution 74: RESOLVED that there be granted to Her Majesty a sum not exceeding $11,538,900 for Lotteries Funded Programs for the fiscal year ending the 31st day of March, 1993–pass.

The last item to be considered for the Estimates of the Department of Health is item 1.(a) Minister's Salary $20,600.

At this point we request the minister's staff to leave the table for the consideration of this item. Thank you very much for your presence during the past 56 hours.

Mr. Cheema: I just want to take the opportunity and express our sincere thanks to all the staff who have worked very hard and continue to work very hard on behalf of taxpayers of Manitoba in a very, very positive way.

Ms. Wasylycia-Leis: I would like to add my thanks to the staff who have been with us for many long

hours. I am sure we are close to 60 hours this evening. I just wanted all the staff to know that what I am about to do is no reflection on their contribution and their long service to the province of Manitoba.

Mr. Orchard: Mr. Deputy Chairperson, I want to thank my associate deputy minister Frank DeCock for being here for probably 20 of the last 56 hours, but the real thanks has to go to Fred Anderson my ADM of finance and administration who has been here for the whole process.

Fred, thank you kindly. You can now safely say to your wife that we are going to stop meeting like this.

Mr. Deputy Chairperson: We will just give the staff a minute.

Ms. Wasylycia-Leis: I move that line 1.(a) Minister's Salary be reduced to $50.

Mr. Deputy Chairperson: It has been moved by the honourable member for St. Johns that line 1.(a) Minister's Salary be reduced to $50.

Ms. Wasylycia-Leis: I think that probably my motion requires a little bit of explanation. As my friend, my colleague the member for Thompson (Mr. Ashton) has said, one does not really need to explain this for anyone who has spent a good part of the last 56 hours in Health Estimates.

However, for those who are joining us, who have dropped in and out of the Estimates or who are joining us for the first time this evening, I would like to indicate that this is a very serious motion. It reflects the level of concern that we have experienced and felt over the last 56 hours and more as we have attempted to ascertain the agenda of this minister and his department and this government as it pertains to health care issues.

* (2340)

Mr. Deputy Chairperson, let it be noted that by reducing the minister's salary to $50, the minister will still have $50 to cover the user fee if he moves north and gets sick. Let it be noted that this $50 still leaves the minister the ability to mail out 125 copies of his health care reform plan. It should be noted, of course, that only covers postage but given what we have heard to date and received from the minister, we do not expect he will need much more than that.

Let it be noted, Mr. Deputy Chairperson, that $50 allows for payment to the minister of 85 cents for every hour we have spent in Health Estimates. Eighty-five cents I repeat for the member for The Maples (Mr. Cheema), and it should be noted that that probably is about the wage rate that we would all be looking at under the North America Free Trade Agreement.

Let it be noted, Mr. Deputy Chairperson, that $50 would allow the minister to pay for about three months of calcium supplementation if he found himself to be in need of such a large dose on a regular basis and being on fixed income. Let it be noted that $50 would allow the minister, if in another situation in his life cut off of home care, he could still pay for eight hours of nonprofit homemaking service or one hour of help from a private agency.

Let it be noted, Mr. Deputy Chairperson, that $50 will allow the minister to buy 65 coffees in staff canteens and facilities and health care centres in hospitals around this province, allowing him to hear what health care concerns there are at the bedside in the store-front facilities. Let it be noted, that $50 will just about cover purchase of the best book available today on conflict resolution. Let it be noted, that this $50 would cover a small down payment on private knee surgery if the minister was in such a situation as to require surgery but forced to face a long waiting list. Let it be known, Mr. Deputy Chairperson, that $50 would probably cover about five medium pizzas at the new pizza shop at one of our urban hospitals.

So we have been generous in our motion. We have allowed for some change for the minister to accomplish some things that are important in terms of his whole agenda. We have allowed him some few dollars to start thinking about how he will plan to pay for health care services in our ever-changing health care system under a Conservative government, a system that is moving rapidly towards American-style user pay system, but in so doing, we have saved about $20,550 to help deal with some serious outstanding issues in the health care policy area in Manitoba.

We have saved a little more than $20,000 to help go towards some of the organizations that were totally cut off of provincial funding. Some of that money could go to the Manitoba Childbirth and Family Education association and help perhaps pay for a few Spanish-speaking volunteers as labour coaches and companions during difficult isolated child-birth experience. Some of that money could actually go to the St. John Ambulance organization

to help provide necessary training experience and programs in rural Manitoba.

Some of that money, Mr. Deputy Chairperson, would help to sustain and keep alive a very important, well-established mental health program for new Canadians. Some of that money would help go towards the elimination of the $50 user fee for northern patients. Some of that money will help us redress some serious cutbacks in the area of prevention and promotion. Some of the $20,550 can be used to enhance pay equity at a time when the minister has basically handed the problem to our health care facilities and thumbing its nose at the court order decision to live up to legislation in the province of Manitoba. Some of that money could go towards the publication of information, brochures, for all of our retail outlets in the province of Manitoba to inform them about the benefits and responsibilities under Bill 91.

Some of that $20,550, Mr. Deputy Chairperson, could help enhance our community-based health care services, could extend northern and rural health care, could develop prevention programs in terms of alcohol, substance and solvent abuse. Some of these dollars could help seniors deal with the financial pressures of paying for dozens and dozens of drugs delisted and removed from Pharmacare coverage. Some of this money could actually go to lower the deductible for Pharmacare. Some of this money could help deal with the training requirements for LPNs. Some of this money could help our seniors and others who need significant care in their homes and their communities and thereby save so much more in terms of pressure removed, taken away from expensive institutional care.

Mr. Deputy Chairperson, so much more could be said about where this money could go, where dollars could be spent more wisely throughout the Department of Health. We have spent too long at achieving very little. We have spent too many hours at getting almost no answers from the Minister of Health (Mr. Orchard). None of these savings can pay for the pain and agony and suffering that some of us have experienced going through 56 hours or more of Estimates with this Minister of Health.

Most important is that after all those hours and the pain and suffering and agony of going through constant battle with the Minister of Health, we are no further ahead in terms of being able to leave this room, go to our constituents, to the people of Manitoba and say we feel confident that our long-treasured, universally accessible, high-quality health care program is being kept intact, maintained, preserved.

* (2350)

We have ended up, after all these hours and weeks, finding out very little about this government's real plans and real intentions. We know that by ending Estimates this evening we are leaving ourselves with less opportunity to respond to this government's and this minister's plans, which will no doubt happen in short order once we are out of Estimates.

I conclude by indicating to the minister and to all of his colleagues that we will not be any less vigilant outside of this Estimates process. We will be watching and listening for any hint of government plans and intentions with respect to health care. We will be speaking out every time, every single time there is any erosion of our treasured medicare program, if there is any shift away from the fundamental principles which have guided us over many years and held us in good stead and kept in place a system of health care that is cost effective, that is efficient and that respects the fundamental right, the fundamental principle of health care as a right and not a privilege.

Thank you, Mr. Deputy Chairperson.

Mr. Cheema: Mr. Deputy Chairperson, I do have a lot of things to say about this motion.

I think probably as of April 26, 1988, and it has been four years, five budgets and five Estimates discussions, and a number of hours of discussion, in my views and my caucus' views we have never, never been so serious about health care reform as we are today, because we know that we have to deal with the problem, and without dealing with the real issue on a nonpolitical basis, I think we are not only deceiving ourselves, we are deceiving the people who elected us.

This debate, these 56 hours were very interesting. Once people read it, they will have their own opinion depending upon where they are coming from, but, ultimately, Mr. Deputy Chairperson, as I said from the beginning, the success of health care reform is not the sole responsibility of this minister or any particular party. It is all of us, and I personally and my caucus believe very strongly about this issue. We think that we have to come forward with the policy in a bold statement, a bold statement which

people can understand. Given the time and given the right information, people will co-operate to save the medicare system, and it is going to take some time.

It is going to take time from many points of view–and I will continue tomorrow, I have a lot of things to say about this whole thing. I think in my personal life I have never been more serious about anything else than I am today about the health care issue. It is so important to me personally to make sure things are successful, because people say, what can one single MLA or six or seven MLAs in the opposition do? I think we can do a lot of things, and we can contribute in a positive way. That can only be done if we are not afraid, and if we have the courage of our convictions. The courage of conviction comes only with the attitude which is acceptable by the public at large, not a specific interest group or a specific political affiliation, because health care does not belong to any single political party in this country.

Mr. Deputy Chairperson, you start from Newfoundland, the Liberal government; to Nova Scotia, the Tory government; New Brunswick, the Liberal government; Ontario, the NDP government; Quebec, the Liberal government; and then you start with Saskatchewan and Alberta and British Columbia–not a single political party has a monopoly on any issues and any right answers, and we do not have–I do not have the monopoly on all the things. But certainly we are willing to participate in a process and in a very genuine and in a very realistic way to make sure that people understand and they are given the right information.

Mr. Deputy Chairperson, I do not know what was happening before 1988, how the debates were proceeding. In fact, I read to some extent, but not to a large extent, because in my views the issues were always very political. I have seen–and I think we will fail, individual MLAs, if we do not make the system very successful. Who is going to benefit? I have said from the beginning, many times, whoever is the next government is in a very, very political, risky area. We need leadership. Leadership has to be based on three basic principles. Whether you are dealing with your own situation or any situation in life, you have to have experience, you have to have integrity, credibility and willingness to take chances.

Each one of us has to qualify so many things. I think the real issue here is some people are really afraid that this minister may be successful in health care reform. That may be the fear, this insecurity in many areas of many interested groups. I think that is very positive for the public, because when you feel interested groups are fearful and insecure, somebody is doing the right things.

Mr. Deputy Chairperson, so I am going to debate this very important issue. I may not be debating it next year or the year after that. We do not know what is going to happen politically, but I think to justify my presence here and my time and people's time and taxpayers who are paying my salary to work here, we have to be very honest with the whole debate.

I am not going to be trying to make political points here when we have not seen the whole package. We have seen the basic guidelines, basic principles, coming forward as of 1971, 1985, even by the previous NDP administration. They were also thinking of health care reform. Then in 1988, each and every political party had their platform. They wanted to reform the system. A minority government did not allow that because of the political structure we have, the democracy we have. There are pitfalls in some of the things we do here.

Now we have four years of government, and we want the government to come forward with positive and bold steps. When I say positive steps, Mr. Deputy Chairperson, those positive steps are positive steps for the people, not for a single political party or a single political group. So we want to be very careful on this and on the whole issue. When the rest of the country is acknowledging a Minister of Health, when they are sitting around the table 10 or 12 of them, they are wanting to have direction.

So what changes when the minister crosses, when he is flying and coming back to Winnipeg and landing here? Does anything change? I do not think so. I think that process is continuing and that is the issue here, whether we are seeing any integrity and credibility coming from the Minister of Health. I have no doubt about that. I think that is the issue here.

Within four or five years when the rest of the country is looking forward to changes and they want to make changes on the basis of what is happening in Manitoba, so do you want to kill the process? Do you want to kill the head of the house by demoralizing, by having routine motions which have no real meaning in terms of when you have not seen

the whole thing? I do not think so, and not many people think so. They are not. [interjection]

Mr. Deputy Chairperson, I will listen to all of them, but I will continue my remarks. I think what is happening here is one of the best experiments going in Manitoba. I keep on saying that you do not want to kill it and you want to discredit a person on the basis because he is sitting on the opposite side of the House. It does not do any good. So, in a way, I think people are feeling insecure who are opposing the health care reform. They are insecure because the system may change and could be successful.

That is the issue here, and the real picture will come out. It will be very different, and we may not agree with everything that the minister is doing or will do, but certainly that is our right. We can do that, but I am not going to lock the door and say everything inside the door and tell everyone everything inside the door. It is just gone. It is not there. If any member thinks that after spending about 280 hours we have not learned anything, I have learned a lot of things.

Probably if somebody would see, I have been most critical of the minister between '88 and '90, very, very critical. I wanted to see what things were wrong. When you identify the problem, you are trying to find the solution, and the time for solution has come and that is what the debate process is. So I am really astonished that the member for St. Johns (Ms. Wasylycia-Leis) would compare the health care issues, and the comparison she has given is very, very intellectually not compatible with what people think of us as legislative members.

* (0000)

Mr. Deputy Chairperson: Order, please. I would just like to interrupt the member for a minute and find out what the will of the committee would be, the hour now being midnight. What is the will of the committee?

Mr. Ashton: I am wondering if we might want to finish discussions on this particular motion, deal with this motion and then, the Minister's Salary will still be on the order paper tomorrow.

Mr. Cheema: Mr. Deputy Chairperson, this is a very important issue. This is not a piece of paper that one can deal with in five minutes, justify and try to run away from the responsibility. I do not know if my caucus members want to come and speak on this issue. For them, it is a very important issue. I would like them to have an opportunity tomorrow to come and talk. I am sure the member from the other opposition may like to speak. I think it is a very important issue for them to express their views as to how they view the health care system.

Mr. Deputy Chairperson, if it is the will of the committee, we can come back tomorrow and I will continue my speech. If they still want to continue, I can continue to do so now.

Hon. Albert Driedger (Minister of Highways and Transportation): I got some of the comments that were made by the member for The Maples. I just want to indicate that what is happening here is not that unusual. Over the years that I have been involved in the Legislature, which will be 15 years this fall, I was chairman of Committee of Supply at one time and we sat until two, three, four, five o'clock in the morning sometimes and motions were made. I can recall when the member for Dauphin (Mr. Plohman) was Minister of Highways and Transportation, we voted his salary down to the price of a ton of asphalt. That is not that unusual.

I just want to make a few comments now in terms of the fact that we have spent the Estimates process, such as it has been arranged—it used to be an unlimited time—then we set maximums which turned out to be, or minimums which turned out to be maximums or vice versa, and a lot of debate has taken place.

I feel compelled at this stage of the game to indicate that a lot of time has been spent debating the philosophies and the concerns, opposition members versus the Minister of Health (Mr. Orchard). I have gone through various Ministers of Health and some very reputable ones, including this one now, including Mr. Desjardins, Mr. Sherman, and invariably I have found, regardless of the politics of the minister, that every Minister of Health has been very sincere in his concern about providing a good health program, because that is the most important thing in people's lives.

If you look back and I can recall, I realize my age to some degree, when I was a youngster, we did not have any of these programs. We have developed a beautiful system that provides health services for everybody, and we debate how it should be delivered, pros and cons, and are we doing it the right way. But every Minister of Health, irrespective of the politics, has been sincere in what he has done. I got elected the same time as this Minister of Health (Mr. Orchard) got elected, which was in 1977. He has, with all due respect, been sort of one of the

more outspoken ones in the House from time to time, but I have to indicate, and I want to put this on record, that from the time that he took the responsibilities of being Minister of Health, it is almost as if the man has changed. Not his attitude, but his sincerity in terms of being sincere about being the Minister of Health. I have to indicate that I blush by comparison in terms of the dedication that he has put in in terms of knowing the system and being sincere about what he is doing.

I am not trying to pat him on the back. I have lived with this man for 15 years, I have sat beside him in opposition, backbencher and in government, but I have to indicate to you that the motion, if it is based on the philosophy of what the government is doing, I can accept that. I just want to put it on record that Don Orchard, by and large, as Minister of Health, has been the hardest working, sincerest man that I have seen in my political career of almost 15 years. He has done a tremendous job. We have our political differences, we have our personality differences, but one thing I have to indicate is that he is a very sincere individual.

Tomorrow we will vote on this motion that has been put forward and it is based maybe on political differences, but one thing I want to indicate to everybody and I think I would challenge anybody in this Legislature that Don Orchard knows the health system better than anybody does in government at this stage of the game.

Now, the member for The Maples (Mr. Cheema) is in the health profession and the critic; you know, we all have our views and we all take little shots, but somebody that has been that dedicated and been involved in that--I just want to put this on the record, and I think I have a right. We all have a right to speak.

I do this sincerely, because the hour is after midnight and like I say, we have our political things that we play with, but in terms of sincerity. If you look at the process that has taken place in terms of Estimates, records have been set in terms of Health Estimates. Don, my colleague the Minister of Health, has his own way of operating from time to time, but in terms of sincerity--and I will say that whether it is the member for Thompson (Mr. Ashton)--I always give credit when it is due. I am also critical when it is not due.

I accept the motion, the fact that you feel maybe that you have not had the satisfaction, but in terms of sincerity and ability and knowledge of the health system at this stage of the game, I have to indicate, and I will challenge the member for The Maples and certainly the member for St. Johns (Ms. Wasylycia-Leis), that the Minister of Health has been the most sincere individual that I know of in the health system. That is people like the former member for St. Boniface Mr. Desjardins, Mr. Sherman, whoever was there at one time, they never had the intimate knowledge of the system like Don Orchard.

Do not shrink. I feel compelled to say this because of the fact that we have somebody from the rural area could be that kind of a Minister of Health, I think is sincere. I say that in sincerity at this time of night. Aside from that, I think the critics have to agree. The member has a good knowledge of the health system and has done better than anybody I know in terms of providing services for the people of Manitoba. We can have our differences, and I say, listen. Tomorrow we will vote on that and whatever happens will happen, but it is not unusual.

I just wanted to put that plug in for my colleague whom I respect. We have our differences because he is a hard case from time to time, but I think he is a very sincere individual and deserves some credit after all the hours that have been put in, and I think the people of Manitoba deserve a minister like that.

Thank you.

Mr. Deputy Chairperson: Order, please. I guess we are going to carry on the debate for a while by the looks of it.

Mr. Ashton: Mr. Deputy Chairperson, just on a suggestion. I think the Liberal Health critic is indicating he wanted to make sure this motion was not voted on tonight so other people can speak to it tomorrow. [interjection] Okay, because I wish to add no more than about five minutes worth of comments. It is up to the--

Mr. Deputy Chairperson: Sure.

Mr. Cheema: Mr. Deputy Chairperson, it seems like probably we would like to finish it tonight. That is fine with me, but I think the Minister of Highways has missed my whole speech. He has missed the whole point. I think that I discussed all things about the Minister of Health based on the three basic principles. I look at every issue in my life and everything that I do is the experience, credibility and integrity, and I see all the ingredients. That is why I am not going to be supporting this motion at all. I

think that goes against the basic existence of a human being.

* (0010)

When you are seeing somebody who is working hard, you want to derail them. You want to discredit them; you want to get a few headlines here and there; you want to centre your own individuals. I am not going to do that because that is not a part of my personality. That is not good for the people of Manitoba. We need to have a successful system. As I said to the minister, if he fails, he is failing all of us so we want him to be successful in health care reform.

Mr. Ashton: Mr. Deputy Chairperson–

Mr. Deputy Chairperson: Order, please.

Point of Order

Mr. Driedger: On a point of order, and I do not want to cut off the member for Thompson. It is just a clarification.

Is it proper to vote on this motion tonight or is it a motion that is going to be deferred till tomorrow or how does this work? Mr. Deputy Chairperson, I ask your guidance in this. We can keep on debating it.

Mr. Deputy Chairperson: Rule 9 in the Rules book, 65.(9): "Where the Committee of Supply, or a section of the Committee of Supply, is sitting after 10:00 o'clock p.m. on any day

(b)where two members demand that a formal vote be taken, the Chairman or Deputy Chairman of the Committee shall defer the vote on the motion until the next sitting of the Committee of Supply in the Chamber"

So you could have a voice vote, but we could not have a formal countdown vote until tomorrow. That would be deferred until tomorrow.

* * *

Mr. Driedger: Mr. Deputy Chairperson, the member for Thompson (Mr. Ashton) wants to make some comments and I appreciate that. If the Chairperson could explain the process so when the Committee of Supply is called tomorrow, the first order of debate will be the vote on the Minister's Salary.

Mr. Ashton: If there is a recorded vote.

Mr. Driedger: Okay. Then if that vote passes, does that conclude the Estimates or do we then come back into the process here?

So, Mr. Deputy Chairperson, when we finish the discussions today, there will be a vote in the House tomorrow and that will conclude the Estimates of Health aside from the capital which is going to be under concurrence?

Mr. Deputy Chairperson: Order, please. Number one, if there is a vote in the House in the Chamber tonight, in the section of the committee tonight, all we can have tomorrow is a formal vote in the House, voice vote–

Ms. Wasylycia-Leis: –tonight, formal vote tomorrow.

Mr. Deputy Chairperson: That is right.

Ms. Wasylycia-Leis: If a formal vote is requested.

Mr. Deputy Chairperson: That is what I said.

Mr. Ashton: This is only an amendment. There will still be the Minister's Salary motion. If this is defeated by government members, there will be a vote on the Minister's Salary.

An Honourable Member: Again? And the vote?

Mr. Ashton: There has to be, because this is just an amendment.

Mr. Deputy Chairperson: This is an amendment to the Minister's Salary. What we were voting on–

An Honourable Member: We would come back and debate the salary.

Mr. Deputy Chairperson: Then we would come back tomorrow and debate the salary.

Mr. Ashton: So this is not the last vote?

Mr. Deputy Chairperson: This is not the last vote.

Mr. Driedger: It must be the hour of the night. So tomorrow when the motion is called to move into Committee of Supply, we will have a vote, a formal vote, on the Minister's Salary. Then ultimately we come back in here and continue the debate?

Mr. Deputy Chairperson: Order, please. Only if a formal vote was requested. It is possible that this committee will resolve it without a formal vote. We do not know if the formal vote will be requested at this time. This is an amendment to the Minister's Salary. That is what we are dealing with. Once this is either passed or defeated, we will move on to the Minister's Salary. At that time, the debate on the Minister's Salary can again commence and we vote at that time. Do you understand?

Mr. Ashton: Yes, as I said to the Minister of Highways (Mr. Driedger) on the amendment, the universe will unfold as it should.

Mr. Deputy Chairperson, I wish to make a few comments tonight having sat through the last couple of hours of debate, and perhaps try and bring a little bit of perspective particularly to the last two speakers, because I think people have lost sight of what this motion is traditionally, what it signifies on behalf of an opposition party, and indeed to the Minister of Highways and others and to the Liberal Health critic, what it says–the only way we can say anything about health care and health care reform in this province.

Let us begin by looking at what this signifies. I remember times when I was on the government side and I had difficulty with this tactic. We in opposition, Mr. Deputy Chairperson, cannot add anything to a budget, we can only delete. In this particular case, it is traditional to move a motion in terms of Minister's Salary when an opposition party is dissatisfied with the performance of a minister, because it is a way of saying that we have no confidence in that minister, and it is a way of doing it in a way that does not impact on the rest of the department.

We are not reducing hospital care; we are not reducing home care; we are not reducing the Alcoholism Foundation of Manitoba. By this we are making it very clear that what we are doing is the only thing available to us in the form of a substantive motion, and that is to deal with the Minister's Salary.

We have moved other motions, and I say this to the Liberal critic and I hope he will record this. We have done this with other areas through motions that would not have had a substantive impact but indicated that we were dissatisfied with the minister's lack of information before the committee. Once again, those were not substantive motions. So that is what it is in a political sense, and that is what it is in a tactical sense.

I just want to get some reality back to this glowing tribute that the Minister of Highways and Transportation (Mr. Driedger) was putting on the record. I believe the Minister of Highways and Transportation is an individual of some integrity, and I have come to respect him over the years, but, Mr. Deputy Chairperson, let us start with an obvious fact.

This minister–and I am saying this from 10 years' experience and having sat in the chair that the Chair is sitting in right now, when this minister was sitting in the opposition critic's chair. I have seen this minister as Health critic and I have seen this minister the last few years and let us not anyone get any illusions here, the Minister of Health (Mr. Orchard) has not mellowed.

Let us go one step further, the Minister of Health, when I was first elected, was the most political member, the most partisan member that I had run into in this House. Let us go to Question Period today. I ask any objective observer, and I really wish the Liberal Health critic would take the time to do this, who was the most partisan minister in the House today? It was the Minister of Health.

The Minister of Health–to the Liberal Health critic–will be the first one to admit it, so let us get that out of the way, too. The minister has not undergone some miraculous conversion since becoming Health minister. This minister is partisan; he always has been and he always will be. If there is any doubt about that, I just look at the evidence of this committee. Any time a member of the opposition asked a question, I will give you the standard answers of the Minister of Health: Well, when the member for St. Johns sat around the cabinet table. That is one. In my case he cannot do that. I was not a member of the Pawley cabinet, so it is usually: Well, the member for Thompson never sat around a cabinet table, so he does not know.

* (0020)

In the case of the Liberal Health critic, the Liberal Health critic is nowhere near sitting around a cabinet table, has never sat around a cabinet table, so if he is critical of the minister, he has no idea. Of course, if he supports the minister, which he often has done in these Estimates period, then we hear all these glowing tributes in return to the Liberal Health critic. I say, let us get this illusion out of our way. The minister is not only political, the minister has politicized the Estimates debate on the Department of Health more than anyone else in this committee, and I ask you to check Hansard.

I will go further, Mr. Deputy Chairperson, to talk about interesting comments in this committee, because what I found more interesting than that was now the minister, entrenched in his position as Minister of Health as much as any minister can be subject to cabinet shuffles and the whims of Premiers and politicians, the minister now accusing the opposition of being political. For what? For asking questions about his health care programs?

Let us not forget how this Minister of Health came into office in 1988. Did the Minister of Health–and I say this to the Liberal Health critic–say in 1988: We will support the NDP in terms of health care reform? Did the Minister of Health say, we are willing to look at significant changes to the health care system?

There were two things that were the key elements of the Conservative campaign in 1988, and our Health critic has referred to both of them. Number 1, the Conservative opposition said they would impose a moratorium on bed closures for budgetary reasons. I ask you in context of these Estimates and the events currently undergoing, whatever happened to that promise? Was that political. Was that made out of ignorance? Let the public be the ones to decide on that, but I ask this minister who lectures us about what we are proposing in terms of health care to remember his comments.

The second–I think this should be even more important to the Liberal Health critic, because I believe he should reconsider his vote–does he also recall in 1988, the Minister of Health (Mr. Orchard) and the Premier (Mr. Filmon), the then Leader of the Opposition, promising a health action plan for 1990? I remember that because I was Health critic in 1989 and 1990, and I asked the minister where it was and he said it was coming. It is now 1992, and it is still coming. We have had a disappearing campaign promise on bed closures, and we have had a never-yet-to-appear promise on a health action plan.

Let this minister not criticize members of the opposition for asking questions on health care. Let not the Liberal Health critic lecture us in terms of the role of this minister, because this minister has always politicized the issue of health. He has done it as critic, he has done it as Health minister and he has done it during these Estimates.

I say to the Minister of Highways and Transportation (Mr. Driedger), he hit the nail right on the head when he talked about sincerity. You know, the Minister of Health (Mr. Orchard) may be a lot of things. I have always said, and I said this when I was Health critic, and I have said it again in these Estimates. I will continue to say it and it is not easy sometimes when you hear the minister put forward the kind of arguments he does when you raise matters. I raised concern about the $50 user fee in Northern Patient Transportation, and he then attempted to argue that myself or others were against additional physician services in Thompson, a very entertaining debating device, Mr. Deputy Chairperson. I could have done that with the minister anytime, twisting arguments around to say that. What is he planning on doing? Eliminating Northern Patient Transportation program completely, is that what he is doing? Is he planning to pay for the physicians by taxing northerners in this device? You can get into all these great debates.

I chose to come here and argue based on the specific examples of people who contacted me and said they were being impacted unfairly. What did the minister do? He responded with these kinds of circuitous arguments–these circular arguments that he has become an expert at. You know, that is the sad part, Mr. Deputy Chairperson, and something I do not think this minister will ever understand. When things are done, whoever has been involved with that deserves credit. In my own constituency, in the case of kidney dialysis, in 1989 when that was put in, a lot of people worked very hard for that, and I know the minister in argument likes to play politics with that and he has.

I ask the Liberal House critic (Mr. Cheema) to look at his statements in terms of those, but I said the Kidney Foundation, the Department of Health, the local hospital all worked very hard on that, and I was pleased to be able to work with them. I do not take credit for that because it was a group effort, and whatever role the minister might have had in that the minister should be part of that group effort and the kind of support and kind of reaction that should be given to something that is positive like that.

I raised the concern in Health Estimates in 1989 about physician services in Thompson. I live in Thompson. My family lives in Thompson. I am concerned about physician services. So are my constituents. At that time there were nine physicians. There are currently around 20. There are a lot of people who deserve credit for that. It includes the hospital board in Thompson. It includes the department, and indeed if you want to give any credit to the minister in terms of any role he may have had, I will do that. I have always said I will do that, Mr. Deputy Chairperson. Unlike the minister, whom I have never known in the 10 years I have been in this Legislature to give anybody any credit other than himself and in a lot of cases give himself a lot more credit than he deserves, and in some cases to give himself credit where no credit is deserved. That is what I say about sincerity here.

That is what I say to the Liberal Health critic (Mr. Cheema): I will support positive initiatives. That does not mean that I am going to support a $50 user fee on Northern Patient Transportation when I know it is wrong and it is hurting people and it is unfair. I will support positive initiatives in terms of health care reform, but I know that I am not, and our caucus is not, going to support the ad hoc sort of arrangement we have seen currently, the kind of major decisions that are being made when health care professionals are–not interest groups, I am talking about health care professionals who are saying, be careful. You are not dealing on the basis of what really needs to be done. That is the message for the minister.

You know, every time an opposition member asks a question or expresses a concern it is not based on politics in the sense he understands it, because I believe that is the only thing the minister understands, that kind of politics. When I raised the concern about the $50 user fee or when our Health critic raises the concern about health care reform, Mr. Deputy Chairperson, it is because we are concerned about the future of health care in this province.

I said, let us talk about sincerity for a moment. Let us talk about the kind of answers we receive in the House from this minister. Are those sincere answers? There is a lot of debate. There is a lot of rhetoric. There are a lot of political shots, a lot of personal shots, Mr. Deputy Chairperson.

Mr. Orchard: It goes both ways.

Mr. Ashton: The minister says it goes both ways. The minister who has supposedly mellowed, and I do not buy that, he is the one who is trying to achieve, supposedly should be trying to achieve, support for whatever initiatives this government is taking, but he has confronted not only opposition critics, he has confronted every significant player in the health care system. Mr. Deputy Chairperson, that is not being sincere. It can be a lot of things. This minister is well informed about his department. I have never said he is not. This minister is a good debater. I have never said he is not. I enjoy debating with the minister a lot of times, but I tell you in health care I do not.

I sat here for 44 hours two or three years ago and I found it a very useless experience because I did not go in wanting to debate and debate and debate. I went in with some specific questions and wanting some answers, and I found it frustrating that every time I asked a question I got rhetoric in return. When I look at these Estimates the last 60-odd hours have been the same process. There has been no sincerity in the answers–none. There have not been answers in many cases, and every time the minister has been pressed, and every time we have gotten frustrated, oh, well, that is because the opposition is playing politics. That is what the minister suggests. The opposition is playing politics? I ask you, Mr. Deputy Chairperson, the opposition or the minister?

I say this to the Liberal Health critic because I cannot believe that the Liberal Health critic could not support this motion. This is not playing political games. This is about the health care system of Manitoba.

I say to the Liberal Health critic, and I say this not politically: If we are going to have health care reform in this province, we need a minister that is not going to confront but is going to co-operate, that is not going to have a closed policy on answers to questions but is going to have an open policy, who is not going to duck responsibility for decisions that he ultimately, as Minister of Health, has to make. He has to understand, he has to accept responsibility.

That is what this motion is aimed at doing, is trying to strip away the veneer of the debate, to strip away the–

Mr. Driedger: This is politics.

Mr. Ashton: This is not politics, to the Minister of Highways and Transportation (Mr. Driedger). This motion is aimed–and the only way we have as an opposition saying that this minister does not have the confidence of the New Democratic Party in terms of health care policy and health care reform. No ifs, no ands or buts.

Mr. Deputy Chairperson, you will note that we have not moved motions of this type on every minister. I do not think we are going to do it on the Minister of Highways and Transportation. The Minister of Rural Development (Mr. Derkach), we would think twice. With the Minister of Health (Mr. Orchard), he of all ministers has lost the confidence, not only of opposition members–but we really are unimportant in this whole thing–but of the many people out there who are concerned about health care in this province.

* (0030)

To the Liberal Health critic, that is what this motion does. If he has trouble with the way it is worded, let

him amend it. If he has an alternate motion to express that, let him do it. But, if the Liberal Health critic and the Liberal Party do anything other than express lack of confidence in this minister, I think they do us a disservice, because what they do is they accept the course on which the minister has embarked on.

I say to the Liberal Health critic, do not confuse the issue of health care reform with the actions of this minister. Because if you go along with the kind of idea that the minister is putting forward, that only he can pilot health care reform through this province, you are buying into the whole problem once again. The bottom line is for the Liberal Health critic, please think about it overnight. Come up with something else if you do not like this.

But understand, and I will say this, Mr. Deputy Chairperson—this particularly is not political—I really believe that many other people in the Conservative caucus could pilot through health care reform in a better way than the minister. They may not be as well prepared as the minister. They may not be as good in debate, but if they are less combative and more co-operative they certainly could not damage the prospects for health care reform any worse, and they could only do better.

It is only through motions such as this we can send this kind of message. So the bottom line, just to conclude, is yes, this message is very clear. We, in the New Democratic Party, our caucus, have lost confidence in this minister. Out of the 62 hours of Estimates which we feel has been wasted in a large part because of the lack of co-operation with this minister, we have only one option remaining to us, to move this motion, to ask the committee to support it and send a clear message to Manitobans that this is not the way to proceed with health care reform.

Mr. Orchard: Mr. Deputy Chairperson, I am intrigued with my honourable friend, the member for Thompson's (Mr. Ashton) observations. You know, my honourable friend for Thompson says that New Democrats support health care reform. I am intrigued. I am interested. I am really, really, deeply interested because I feel somewhat dismayed and cheated during this 56 hours of Estimates or whatever the numbers come to, because I have not heard anything that positive from the critic.

Your critic has not said that the party supports health care reform. When we have tried to identify what, in fact, the New Democrats believe in, we have not been able to determine that. I even went so far this afternoon in trying to entreat the New Democrats to just give us a little hint, a little clue as to what they really believed in.

I said okay, if you do not like the policy of this government in terms of health care, then give us a hint. Which province from Newfoundland to B.C. do you find more appropriately positioning itself in development of health policy? You know, I never got an answer. So I said, okay, let us get away from the policy. Let us not even talk policy, because we do not want to talk policy at Health Estimates with New Democrats, because we do not want to put them on the spot.

I said okay, you do not like our funding policy. So I said, well, give me a little hint. Give me a little hint, I said to the New Democrats, give me a little hint. Which province, from Newfoundland to British Columbia, do you like the funding policy better than the funding policy of this government? I figured they would say—well, we knew they would not say it would be Saskatchewan, and we kind of knew they would not say it would be Ontario, but we wondered if maybe, if it might be Alberta. Well, no, there was a little article in a newspaper this weekend about Alberta. We thought it might be British Columbia, but it looks like the New Democrats are going to reduce their acute care beds by up to 25 percent over a period of time because that is what closer to home says, the royal commission report, so I am in a real quandary to know what New Democrats believe in when they say they believe in reforming the health care system.

We are certainly not sure and, you know, what I really would have enjoyed was having the discussion paper, The Action Plan for Health Care Reform, at the Estimates process, because as I said in Question Period today, it would have allowed my honourable friends in the New Democratic Party to stand up and say, well, this is no good. Then someone could have asked the logical question, well, if this is no good, what would you suggest as a New Democrat to be better? Then we would have this open debate so Manitobans would understand what New Democrats mean when they say they support health care reform.

My honourable friends are going to have an interesting time as we approach this. I want to end my little dissertation here with two observations. I want to offer a quotation, and I am going to give you this quotation, and then we are going to have a little

guessing contest as to who said it. This is a direct quotation: We are struggling against a nightmare, and that nightmare is the disintegration of medicare. The nightmare looms over all of us if we don't succeed in reforming the system.

An Honourable Member: Don Getty.

Mr. Orchard: Obviously, somebody said Don Getty. Well, somebody might say Bob Rae. Somebody might say the new Minister of Health in New Brunswick, but this was Ontario Health Minister Frances Lankin. I want to tell you something. I very much enjoy working with Frances Lankin, and we come from quite different backgrounds. She is a member of the union movement. That is where she has been in her private life, but I want to tell you when you come around the health table as Ministers of Health, she does not approach it from a narrowed partisan process that has philosophical attachments, because she understands the challenge in the system.

I have to say I look forward to meeting my counterpart in Saskatchewan. I look forward to the first meeting we can have with the Saskatchewan Health Minister, because I bet you the Saskatchewan Health Minister would love to have this budget to present to the people of Saskatchewan. The Saskatchewan government would give their eyeteeth to present a Health budget like this one, but that is where I am having trouble.

That is why I want my honourable friends, the New Democrats, to give me a province, give me a hint, which province has better policy. Because I do not know what you stand for, give me a hint--and maybe you do not know what you stand for as New Democrats. Give me a little hint as to which province is closest to what you stand for, and then I could maybe sort of find out where you are coming from.

The second thing, well, we talk about budgeting. Give me a little hint. Which province do you like the budget better in? Is the Saskatchewan model better, Ontario model better? Give me a little hint, that is all I am asking.

Now, my honourable friends say they are doing this motion to try and draw attention to the fact that they did not get the answers they wanted in the Estimates process.

An Honourable Member: We did not get answers, period.

Mr. Orchard: Well, my honourable friend says they did not get answers. The member for Transcona (Mr. Reid)--

An Honourable Member: Yes, and I will repeat it. You did not answer the specific questions--

Mr. Orchard: You did not get answers tonight, because my honourable friend from Transcona this evening asked some questions about some policies that the administrators of Concordia Hospital had said were promised by government and then pulled back by government. I asked my honourable friend, you know, I am having a little difficulty answering this question. Could you be specific about which policy? Do you know what the member for Transcona did? He fell mute and silent, because he does not know what policy he is referring to.

Now, you see, I am being criticized by New Democrats for not being definite in my answers. Well, you know, you cannot answer a phantom question. What policy was this that this administrator, alleged administrator at Concordia Hospital--what possible policy is it that he shared with the member for Transcona (Mr. Reid) that is causing such difficulties? It does not exist, Mr. Deputy Chairperson. That is where I keep coming from. The member for St. Johns (Ms. Wasylycia-Leis) kept on bringing up these phantom people whom she talked to, who were telling this, that and the other. The member for Thompson (Mr. Ashton), the same kind of phantom people who do not want to co-operate with government on health care reform.

Well, I want to tell you: there are two solitudes out there. There are the New Democrats in isolation as caucus members and philosophical socialists; and then there is the real world. I want to tell my honourable friends that as my honourable friends in the New Democratic Party want to say we do not have an attachment to real people in health care, they are wrong.

I have got to give my honourable friend, the member for The Maples (Mr. Cheema)--and I am probably going to ruin his political career, but I am going to tell him that he has got his eye on the ball and he knows what has to be done. He is not afraid to challenge the direction of this government with reasonable criticism and good questions. I have not had the same kind of approach from the New Democrats.

Now, my honourable friends the New Democrats say, well, you know, we are sending this little signal;

we are going to make $20,550 available for other purposes in the system. I want to make a little deal with my New Democrats.

* (0040)

I want to take a look at how we could use the $140,000 plus that they were over budget in their median communication, with all the stuff they sent out two years ago and last year, $140,000 over budget. I want them to put that towards hip surgery because 10 more Manitobans would get hip surgery, 100 more Manitobans would have cataract surgery, if my honourable friend for the New Democrats would just give their $140,000 budget overrun for propaganda to the people of Manitoba.

Instead of stealing it from health care, give it back to the people of Manitoba and let some people have hip surgery and cataract surgery, instead of stealing it from them with a propaganda machine in the New Democratic office. I mean, you want to talk about those kinds of monies. We will get into those kinds of monies. We will get into them in spades and we will have those kinds of discussions and talk.

But in the meantime, I am quite satisfied that my honourable friends are satisfied with the time we have spent in Estimates. I am quite pleased with it, and I am prepared, Sir, with your will and compassion, to move this vote on tonight, and we will see where the cards may fall tomorrow.

Mr. Deputy Chairperson: Order, please. That concludes the debate. It has been moved by the honourable member for St. Johns (Ms. Wasylycia-Leis) that line 1.(a) Minister's Salary, be reduced to $50. Shall the motion pass?

Some Honourable Members: Yes.

Some Honourable Members: No.

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

Some Honourable Members: Yea.

Mr. Deputy Chairperson: All those opposed to the motion, please say Nay.

Some Honourable Members: Nay.

Mr. Deputy Chairperson: I declare the motion defeated.

Ms. Wasylycia-Leis: I would like to request a recorded vote, please.

Mr. Deputy Chairperson: You need two members: the honourable member for Thompson (Mr. Ashton) as well?

Mr. Ashton: And the member for Transcona (Mr. Reid).

Mr. Deputy Chairperson: A formal vote has been requested.

I must advise the committee that, according to Rule 65.(9)(b), when Committee of Supply or a section of Supply is sitting after 10 p.m., "where two members demand that a formal vote be taken, the Chairman or the Deputy Chairman of the Committee shall defer the vote on the motion until the next sitting of the Committee of Supply in the Chamber". Therefore, a formal vote will be deferred until the first order of business tomorrow.

Is it the will of the committee to rise?

Some Honourable Members: Rise.

Mr. Deputy Chairperson: Committee rise.

EDUCATION AND TRAINING

Madam Chairperson (Louise Dacquay): Order, please. Will the Committee of Supply please come to order.

This section of the Committee of Supply is dealing with the Estimates for the Department of Education and Training. We are on item 5. Post-Secondary Adult and Continuing Education and Training, page 42.

Will the minister's staff please enter the Chamber.

Item 5.(a) Executive Administration.

Ms. Jean Friesen (Wolseley): Madam Chairperson, we were talking before we broke at five o'clock about the overall policy for community colleges, and I wanted to continue with that. I think it is a crucial time in both the economic history of the province and in the condition and governance of the community colleges, and so I want to spend a little while longer on that.

The minister, in her last reply, talked about policies for women, for aboriginal people and for older members of the work force. She talked about the goals that she had set out for the community colleges in this area, and I wonder if I could pursue that a little and ask about the success levels, the evaluation of the colleges performance in meeting these goals. To what extent have the colleges succeeded in attracting more women throughout their programs? To what extent do they know what the need is in terms of enrollment demands and in the level of unemployment amongst women?

Similarly, for aboriginal people, the minister set out a series of goals dealing with both governance and with participation as students, but I think we would need to know not just the goal but the evaluation of the policy. To what extent have aboriginal people been increasing their participation in community college life, and also to what extent does this meet the needs of that community, particularly in view of the changing population structure and the increasing and horrendous unemployment in northern Manitoba?

Similarly, with the older population, to what extent are we able to meet the need of those people who need training on the job or who have been displaced as a result of a variety of reasons and are looking for new employment opportunities?

Hon. Rosemary Vodrey (Minister of Education and Training): I am informed that for Red River Community College approximately 689 students are aboriginal students. Of that number, 55.6 percent of those students graduate, so that would be the graduation rate at Red River Community College.

At Assiniboine Community College, I am informed there are 185 aboriginal students and a graduation rate of about 88 percent. At Keewatin Community College, I am informed that there are about 1,107 aboriginal students. The graduation rates at KCC appear to vary widely for those aboriginal students depending upon course, and so I do not have a percentage at this time of the graduation rate of that number of students.

For women, we do not keep statistics as they relate to women in the same way as I have for the aboriginal statistics, but there has been an effort to recruit women particularly into the nontraditional trades, and the results have been what has been considered modest at this point. But the Canada-Manitoba Labour Force Development Agreement, which I have referenced several times, does target the area of women and women particularly in the nontraditional trades as a specific area for effort in the near future.

Ms. Friesen: What I am trying to get at is to relate the performance of the community colleges to the labour force development strategies. I know that the actual written papers are not in final form yet, but the question I am really getting at is, of the 689 people, for example, who are part of the intake of Red River Community College plus the ones at Keewatin plus the ones at Assiniboine, what kind of a dent is that making in the aboriginal unemployment issues?

What proportion of the age cohort is it taking up? How is it actually making any inroads into the training and unemployment issues facing aboriginal people? I mean, are we addressing, for example, one-tenth of that problem, .25 percent of that problem? Do you have any sense of the scale at which we are beginning to make some changes?

* (2010)

Mrs. Vodrey: Madam Chairperson, I am informed that the aboriginal share of the labour force at this time is approximately 5 percent, but the staff report predicts that in the year 2000 about 20 percent of the new entrants will be aboriginal Manitobans. At this time, I am informed that for all of the PACE division programs including colleges, the number of native participants is approximately 4,203. That is a percentage of all participants of about 22.6 percent. Of the money devoted to native education, of the total, it is approximately 26.6 percent.

So at this point, we certainly recognize the issue that has been raised in terms of the training and the future employment for aboriginal Manitobans. At this point, we believe that we are somewhat ahead of the target of new entrants which has been predicted in the year 2000. It is certainly one area which will be of continual effort for the PACE side of the department.

Ms. Friesen: In those calculations, would not the department want to take into account that, whereas it may only be 5 percent of the work force, overall—I think Winnipeg 2000, for example, said that 64 percent of that proportion was unemployed and that in certain areas of the province, in fact, it reaches 90 percent. So it is really a step beyond that issue I am getting at, and I am wonder if the minister still believes that the department is ahead of target.

Mrs. Vodrey: I certainly will acknowledge, as does the department, that this is a very complex issue. The role of the Department of Education and Training and our goal is to make sure that we have prepared a trained work force for when the economic development, particularly in some of the rural and the northern communities at this point, is available, and when that base is further developed.

I think that we have seen our goal. A very important part of the overall goal is to make sure that we have this trained work force. We have been devoting our efforts in a large share to the training

of aboriginal Manitobans proportionately in terms of numbers and dollars to try and make sure that training is available for them, and so that there will be a readiness for economic development.

Ms. Friesen: I am still looking in the context of the overall policy being presented to the community colleges at what I think is a crucial time. In reading these Partners for Skills Development, there are a number of directions there which are suggested for community colleges. This is a report of two years ago, and I wonder what has been accomplished in following those directions, how many of those directions the government accepted and how many they rejected.

In particular one of them that we had not addressed so far was, at a very clear direction of this report, to suggest that the community colleges needed to greatly increase their intake of high school graduates, those who are immediately graduating from high school. We have talked about other target groups, so I wonder if the minister could comment on that one particularly and then the policy directions suggested on pages 36 to 41 of that document.

* (2020)

Mrs. Vodrey: Madam Chairperson, well, the labour force strategy that I have been referencing will be developed with a great deal of attention paid to the staff report, and in some of the areas that we have moved already, just to update the honourable member, it was recommended that we move to regional centres and that has happened in relation to the colleges. We also have paid a great deal of attention to what we are calling the foundation of education in that K-12 area which will prepare students for future learning. Then we have expressed concern, and concerns have been expressed to us regarding the number of sequential students or sequential learners who move from the high school programs into the community college.

I would like to say it is a recognized issue and that we have encouraged through the new programming at colleges for those grads to be considered for acceptance into some of the new programs at the community colleges. We also recognize that these strategies must be very comprehensive.

In other areas, we are moving toward college governance, which we have discussed earlier today. That was specifically referenced as a recommendation within the report, and we have also moved in the area of adult literacy and adult literacy programs.

Ms. Friesen: Can I follow up on the specific question that I asked, which the minister made some reference to, and that is the recommendation which is quite clear in the report that colleges must attract a larger share of high school graduates into diploma and certificate courses? She says that the new programs at Red River Community College in particular will take this into account, but what is the specific goal and how will you be able to evaluate it?

Mrs. Vodrey: Madam Chairperson, well, the labour force strategy will provide us with a long-term framework. It will, as one of its main goals, consider the issue of sequential students moving on to the community colleges. The strategy has not yet been announced, so it is very difficult to comment until that strategy has, in fact, been announced. Its success then will be measured following the announcement when we are able to actually then look at the initiatives discussed and the numbers that follow through from those initiatives.

Ms. Friesen: Then can we come at it another way? Manitoba has the lowest proportion of 18- to 21-year-olds in community colleges. I believe it is about the same proportion as Newfoundland. Setting aside the labour force development goals that the minister will be putting into place, we are in the process of developing new patterns and long-term goals for community colleges. Is it the policy of the government to expand the community colleges, in particular by moving towards a Canadian average of 18- to 21-year-olds in the community colleges? Can we look at it from that perspective?

Mrs. Vodrey: The issue of sequencing, there is no doubt, can be improved, and if we are able to improve it to the national average or beyond, that would be very good for this province. In looking at some of the ways that we are trying to improve those numbers, we are looking at, first of all, the unit credit funding for vocational education in the high school level which will allow then young people to take a single credit and have some experience in a vocational area where before they would have had to take a whole program and, therefore, sometimes were discouraged from that specific type of training.

We are also looking at the new programs and the new and really quite attractive programs within the college to attract young people. Those programs

should lead to employment, and they also, as we move to the issue of college governance, will become more responsive to the local community areas in which young people may live. Then young people may decide that those college programs are, in fact, more attractive to them and wish to take part in them.

The issue of apprenticeship is also another major issue which, with my colleague the Minister of Labour (Mr. Praznik), we have been looking at very carefully, and the issue of articulation within apprenticeship, so that people studying in various apprenticeship trades are then able to move into different programs and, perhaps, in different geographical areas.

In addition, we are also looking at the issue of co-operative education which will allow young people studying to also have some opportunity to work at this practically within the workplace. I come back to saying that, I think, one of the major issues, the big picture issue, is for us to look at developing the sense of a training culture, and that the training culture becomes attractive to young people who are leaving high school and to make the colleges seen by both students and their parents as valued places, places that they would like to be, with course content that will, in fact, be important to them and lead to employment.

* (2030)

Ms. Friesen: Madam Chairperson, what I was also getting at with this question was the recommendation on page 38 of the same report, the Partners for Skills which was for a change in the proportion of post-secondary students in Manitoba as apportioned at the moment between universities and community colleges.

I have asked the minister this question in the House before, but I wonder if I could pursue it a little further. There is a very direct recommendation here, it seems to me, that Manitoba again should be looking at a system much closer to the national average. We and Saskatchewan are very much the extremes on this, and having a very small proportion of students in community colleges with waiting lists, enrollment problems, whereas we have very large and expensive universities with open enrollment. I wonder, again, at this crucial time in changes in community college education, what policy directions the minister and her staff are taking in this regard?

Mrs. Vodrey: Madam Chairperson, I am informed, first of all, that our college system is, in fact, an average size in Canada, not so large as some of the larger provinces but average in its size, but we do acknowledge the sequential issue that has been raised.

In dealing with the sequential issue I referenced a number of ways in which we are attempting to deal with that. We also have to deal with the numbers at community colleges in relation to market demand and also a fiscal responsibility which is required.

One other area that I think would be important to add into the list of issues which we are considering is that of articulation between the colleges and the universities. That is certainly one issue that I think needs to be studied through the university review for co-ordination so that colleges again become a more attractive place to study for young people in particular.

Ms. Friesen: Madam Chairperson, I am not quite sure what the minister means by average. Some of the provinces have almost equal portions of post-secondary students in universities as compared to community colleges. Manitoba has a very small percentage. Unfortunately, I do not have the numbers in front of me, but I did ask the minister a question in the House on this, using the exact figures I believe.

A very small percentage of the post-secondary education enrollments in Manitoba are in community colleges; a very large percentage are in universities. Provinces such as Alberta, British Columbia, I believe even New Brunswick, Prince Edward Island is another anomaly I think, but a number of other provinces tend towards a 50-50 distribution of those post-secondary enrollments. I think this is the kind of thing that the Mauro report was talking about, the Partners for Skills Development.

Mrs. Vodrey: Madam Chairperson, I think it is important to say that, first of all, we are not attempting to create specifically a shift from one to the other, but we are really attempting to, No. 1, make sure that the needs of students are met and, No. 2, that we are developing the thinking into a training culture. Just to clarify in terms of the system in other provinces, I am informed again that the four large provinces do have a larger capacity within their community college system, but that our system is really not significantly smaller than any of the other provinces.

The issue of capacity which the member has been raising is really one that has been a very longstanding issue from the time of the former government. We are trying to look at the issue of capacity in the light of the Mauro report, and the Mauro report did not recommend specifically new resources, but a redirection. The redirection does take some time and some planning, and that is the part of the process at which we are in at this time.

* (2040)

Ms. Friesen: Madam Chairperson, really what I am looking at is should Manitobans be spending the kind of money that they are spending in universities or should it be put into community colleges? Why do we have, for example, students who are in university because they cannot get a place at the program of their choice in community colleges? I do not know how extensive that is. I do not know if the minister has numbers on that, but it seems to me an odd use of resources and one that is unusual in the context of Canada. So it is that reallocation, that reapportioning of priorities and resources that I am looking for some direction from.

Mrs. Vodrey: Madam Chairperson, I would just like to say again that we are working on a strategy. It is premature to announce that strategy at this time until it is fully formulated. I am not sure if the honourable member is suggesting that we redirect money from the universities into the community college program, but I will say that I will be announcing the university review. Within the university review, perhaps one of the considerations may be the role and the function of the university and the role and the function of the university in relation to the community colleges.

Ms. Friesen: It is that latter that I am suggesting that the whole area of post-secondary education is one that needs to be considered together. It seems to me that Manitoba and Saskatchewan, both of them have unusual apportioning of places in universities and community colleges. There may be reasons for that within the economic and population structures of both provinces, but I certainly think it should be part of a university review and is the kind of guidance and direction which I think ought to be coming from the department to the community colleges as well.

The minister has talked about training culture, and I know that is one of the current buzzwords particularly in large and small "c" conservative circles. I think most Canadians would support a training culture which increased the amount of money and the commitment of the private sector of corporate Canada to training, education and development. I think it is becoming well known across Canada that private enterprise in Canada and North America generally, certainly, has not borne its share of that responsibility in the way in which European, Japanese, and particularly German corporations have. Although it is by no means the only reason, it is certainly one of the reasons that we have fallen behind so dramatically in industrial activity.

I think from the perspective of a Department of Education, one of the things that we should be looking at perhaps even more so is the educational climate, the educational culture. The minister has talked about making the community colleges more attractive to students. Given the waiting lists at a number of colleges, I am not sure that is actually the issue.

It does seem to me that one of the areas that a Minister of Education responsible for community colleges should be concerned about is the educational support services and the educational culture within the community colleges.

Unlike the community colleges in Alberta, British Columbia and Ontario—I accept that they have far more resources than we do, they have still set out to make a community college a structure which has services for students which are attractive to that 18- to 21-year-old group, for example, the kinds of things that certainly in Ontario has obviously meant student residences—that may not be the way to go for Manitoba—but the support services, the creation of an educational climate, a climate of learning within the community colleges that is not just short-term job oriented, but has the opportunity to make the community colleges become those centres of lifelong learning, which I am sure that this government wants as well. When the community colleges are places where you are predominantly part time, you go for very short periods of time, you are taught by a faculty who are increasingly short-term faculty, how do you develop that loyalty to an institution and how do you create that climate of learning as well as a training climate?

Mrs. Vodrey: The issue of a training culture is a word that I recognize has been used significantly and frequently. I do think that it is a very important word in its meaning to allow those people studying to both enjoy and to learn and to also feel motivated

in terms of the training programs and that it is a lifelong learning. The issue of training becomes equally important in terms of a very specific goal for some individuals.

Within that training culture and where part of that training culture will take place within the community college, there does, of course, have to be a climate for learning. The climate for learning can be partially set and is, in fact, partially set within our community colleges through the student support services which are offered by the colleges. There is counselling available, and I think that we each recognize the importance of that kind of support, especially for people who are perhaps returning or older workers who are becoming retrained or for those participants within the community colleges where they have not had those kinds of supports for their learning previously.

The proof of the fact that this is working is that the community colleges do have a very high job placement rate. In many cases it is well over 80 percent. We also have very high graduation rates within the community colleges. I believe that is offset with places like Ontario, where we have a number of students, they have much larger institutions and we have about a third of the students dropping out within the first few months of a program in which they might be studying.

* (2050)

Ms. Friesen: What I was looking at was the policy direction that the minister and the Mauro report wanted to take, which was to increase the number of 18- to 21-year-olds and the translation of those into college students. I think one of the responses you often get from families particularly is that they will look at universities rather than community colleges, because they perceive that the social side of university, the sort of peer-learning side of university is much better developed than it is in the community colleges.

Whereas I will agree with the minister that there are some student support services in the community colleges, I think it would be fair to say that the perception of student life is not the same as it is for universities. It may be one reason that people are choosing universities over community colleges, not necessarily to the benefit of the Manitoba economy or necessarily to the students themselves. So it was that kind of policy direction for the colleges that I was looking at.

Mrs. Vodrey: Madam Chairperson, well, at this point again, I have to say that it would not be possible to do a quick fix to any of the issues that have been raised today. I have discussed some of the issues which we believe we will be putting in place which we are working towards, issues such as articulation between colleges and universities, issues relating to articulation and apprenticeship. Certainly, there is a need to have young people and their families see the colleges as a place where they would like to attend. We also have to work with the high school guidance counsellors and career counsellors also so that there is a recognition on their part that colleges are, in fact, a place to attend.

We do have the difficulty in comparison where the universities have been an open system and colleges have had a fixed capacity, and it will take some time in terms of the course development and the encouragement of students to move young people, particularly sequential learners, which I think the member is discussing in particular, into the college system. But I would want to be very careful and not suggest that the colleges were inferior in terms of their student life in particular. They do have strong student organizations. They also have a recognition that there is a very good employment record following training at community colleges, that employment, as I said, tends to follow.

I would contrast that again to some of the difficulties experienced by the universities in which there is a dropout rate within the university system and recognize it when we begin to talk about the universities. We will also have to discuss some of the supports available to students within the university system. Again, within the college system, we have attempted to support students through Student Support services, and finally I would say that the movement to governance, I think, will also, we expect, have another significant impact.

When colleges can become more responsive to their community areas, to the needs of their community areas, where young people see employment may follow within their community areas, then an additional sense of attraction, I believe, will follow from the governance model.

Ms. Friesen: I wanted to follow up on the issue of articulation. It is one obviously that is much better developed and for different reasons in Quebec and British Columbia, Alberta and Ontario to a lesser extent. My sense is, from the minister's raising of this issue, that she is looking for a much–in fact,

the initiation of some articulation measures would be good news. But, as I see it now, and I have talked to people both in the community college system and in the universities about this, there is no incentive for either group to move toward any kind of articulation.

First of all, does the minister share my sense that the articulation, the links between the universities and colleges, the opportunities for transfer of credits should be much more extensive at all levels and through many different programs?

Second of all, if she does share that goal, what kind of incentives and what kind of policies is she directing toward, in this instance here the community colleges—we will look at the universities later–to develop those links?

Mrs. Vodrey: Madam Chairperson, we certainly recognize that articulation is a desirable objective. Certainly, the colleges would value this, and the universities have not necessarily historically valued this. However, there is a growing voluntary sense that this may in fact be an important way to go. I have met with the university presidents, and it seems that one of the important starting places is to establish the climate for the articulation discussion even to take place. I look for the university review to look at this in more detail and look at what they may determine may be steps to formalize. In addition, it is very difficult to look at this specifically, because in fact we need to have some of the information that will flow from the review to give us information for the overall context.

I would like to say that there are some agreements already in place, and we can talk about some of those specific agreements for the community colleges when we reach each of the community colleges in detail. I would raise one though by way of example: the Swampy Cree Tribal Council agreement with Brandon University and KCC, which is the business administration diploma which then may be articulated into the business administration degree.

The issue of incentive, money does not seem to be the incentive, but at this point it seems to be the incentive of a type of progress which would be available to the student. Students may attend a community college, for instance, complete the diploma course, get a job and then either proceed on to a degree program or for some students to continue working and work on the credit courses for the degree program while they are in fact working at the diploma level.

Ms. Friesen: Madam Chairperson, we talked about the links to the universities, and I want to look at the links to the government's economic strategy. We have a cabinet committee chaired by the Premier (Mr. Filmon), I gather, looking at economic strategies for Manitoba. We have a labour force development strategy somewhere in process. Where do the community colleges fit into this overall economic strategy?

* (2100)

First of all, is there an economic strategic document? I am thinking in terms of the one that Newfoundland has produced, for example, a population of about half the size of Manitoba, but they have a publicly presented document which looks at regional development, at labour force training, at strategic goals, in particular areas of Newfoundland's economy. I do not see anything like that for Manitoba, and I do not see it emerging.

I wonder how we are developing policies for the community colleges, which are looking at technological development, at articulation, at making inroads into our unemployment and training issues without that overall strategic sense of where the province is going?

Mrs. Vodrey: I think that the starting place is to say that the human development is really a very integral part of the economic development which is being asked about right now and that the skills development which the Department of Education is responsible for is again a very integral part of the economic development.

We are looking to assist in the economic development through this human development, through this skills development again through our college programming. We believe that our college programming will contribute to the economic health of both the province and also the private sector. We also encourage the private sector to become involved in training through programs such as Workforce 2000.

Again, we are looking at college governance which I continue to reference because college governance provides for more community participation in terms of the economic growth and what is required within the local market area.

Again, I have talked about the labour market strategy, and the labour market strategy which we

are in the process of developing will set out the broad framework for the colleges and for the training directions within this province. The member is right when she references the economic board and when she references the work done by other colleagues in government in terms of economic development and the response.

The leadership of the Department of Education and Training is to make sure that we do have the trained work force. In looking at that also we have to look to the Canada-Manitoba labour agreement which will be signed in the near future. That references the role of industry and labour and what kind of a role they might play. We can look at many kinds of scenarios, for instance, potentially regional boards to assist in terms of tying training to economic development.

Ms. Friesen: But the minister's answers deal predominantly with process. I am asking, trained for what? Where is the economic development plan or even discussion paper which, for example, takes account of the fact that the only growth area in terms of population is the area surrounding Winnipeg? Where is the plan that takes those kinds of things into account? What are we going to be training people for?

We are in a process now of setting the community colleges off into governance and not much over a year from now, at a time when they have to be looking at the kind of capital that they are going to have in place, the kind of technology that they are going to be looking at, the jobs that are going to be needed and I do not see a direction coming from the government either in specifics or in the overall context of direction. Process I understand. Could the minister give us a sense of where that process is going?

Mrs. Vodrey: Again, I would like to remind the honourable member that the Department of Education is one part, one piece of the whole economic development strategy.

I have attempted to outline over the past while exactly what our response is and how in the training of human resources we are looking to assist in the economic development, but she may find that some of the other information she is seeking in more detail may also be available through questioning in some of the Estimates of the other departments.

Again, I have said to her that our focus is on looking at the human development. We are looking at the demands of the marketplace. We are looking at the enrollment of students within certain programs which give us an informal signal of training required, but we also work together, as she has said, as a government. I work with colleagues in other departments as the strategy is being determined. We also are looking at our own labour market strategy, which I have referenced several times this evening, and which I have told the honourable member I will be announcing as soon as possible. We are looking to put together all of these parts, and I think perhaps she may wish to question some of my colleagues for some other specifics.

Ms. Friesen: I certainly will do that, but I assumed that the minister had a context within which she was working. At one level, obviously, you are talking about market-driven training, so that is a response to existing conditions in the Manitoba labour market, whether it is in Winnipeg or whether it is outside of Winnipeg.

* (2110)

One of the other obvious features of current economic conditions in western society is that in fact the jobs come to where the trained labour force is, and so the creation of the trained and educated labour force in certain strategic areas is a crucial aspect of any kind of economic development policy, and an important part of that, obviously, is the community colleges and the universities. So that is what I am looking for from this department.

Yes, at one level market-driven training in response to local demand, but it seems to me that also the government should have a responsibility and a plan to develop the educated labour force in advance of certain types of industries, because that is what brings them here, that is the attraction.

Mrs. Vodrey: Well, the Department of Education does have labour market demands that we have looked at up to the year 2000. We have invested training resources in those key industrial areas.

I reference for the member areas such as aerospace, where we look to attract further aerospace industry; the health industry, where we look to attract further health industry and technological work. Then I reference the area of sustainable development, telecommunications in the area of agriculture. Those are certainly some of the areas which I think she will find helpful when she looks at a trained work force being able to draw industry into this province.

The demand is also created through that and through, as I said previously, students and their program choices. Students also, by virtue of their program choices, give us a sense of the demand of what is required.

Secondly, we have employers who also forecast for us what their needs will be.

Thirdly, we have the federal government purchasing training spots within the community colleges, and then we have the marketplace in general, in which we can look at the marketplace and also forecast where that training would be. So I believe that this does provide a context for the training of Manitobans.

Ms. Friesen: Could the minister then, in the areas that she has identified, give us an idea of how many places there are each year in each of those programs, so we get a sense of the priorities of the government?

Mrs. Vodrey: Madam Chairperson, the details of those numbers are available under other specific appropriations, and I wonder if the honourable member would be willing to wait until we reach those specific areas for the numbers?

Ms. Friesen: Is the minister referring to specific numbers under each college, or are you also including Workforce 2000 in this?

Mrs. Vodrey: Madam Chairperson, yes, also Workforce 2000.

Ms. Friesen: Again, looking at the overall economic direction of the government and the way in which community colleges are playing a role, I want to come to the other side of the ministry's program which has been to cut places at community colleges, and we have had this debate in the Legislature a number of times in Question Period. It seems to us obvious that two years ago this ministry cut nearly 1,000 places from community colleges and reduced the appropriation for community colleges I believe by about–was it $10 million?–no, 10 percent. I do not have those numbers in front of me.

The minister's response is always, we added new programs this year. It seems to me that the numbers are still not up to where they were two years ago, and that, in spite of the minister's suggestions that we might be looking at an expanded community college program in Manitoba, we are not even at the place we were two years ago.

(Mr. Ben Sveinson, Acting Chairperson, in the Chair)

One of the bottom lines for any department of this government should be, how are we stronger? How are we fulfilling the needs of Manitobans in a better, more appropriate way than we were four years ago? It seems to me in the area of community colleges that we have lost ground.

Mrs. Vodrey: I would like to start by saying that the member seems to be talking simply about the quantity, and I would say back to her that it is not just the quantity but the quality of programming. In fact, there were some programs eliminated over the past few years. Those programs were programs of low demand and also low employability, which is a great concern for Manitobans.

Yes, we have gone through a restructuring. That restructuring, I believe, brings us to programs of higher demand and greater employability. I am informed that we are now back to our level of two years ago for full-time equivalent students. We believe that at this time we do have a stronger mix of programming, that we have a better contribution in terms of the programming, and some of the weaknesses of the past programming were, for a period of eight years, that programming simply did not change and was not responsive until the restructuring.

* (2120)

I would like to draw the member's attention to some of the new programming that I would like to read into the record.

Red River Community College, new programming: electrical and electronics, industrial electronics, CNC operator, expert systems, avionics technician, composite technology, business accountancy, business administration, total quality management for Red River Community College.

At Assiniboine Community College: business administration, finance and sales management, and the Parkland Southwest Regional Centre.

At KCC: business administration, small business management, computer applications, hospitality management, forestry technician, pulp and paper technician.

Then I would like to talk about the new and expanded programming.

At Red River Community College: the post-diploma program in geographical information services, a new program; post-diploma in

biomedical engineering, a new program; manufacturing assessment service, an expanded program; development of learning technologies, a modification of a previous program; post-diploma in technology management, a new program; post-diploma in electrical electronic technology, an expanded program; telecommunications technology, an expanded program; developmental service, an expanded program; civil engineering technology, both a modification and an expanded program; motor vehicle mechanic, a modification and expanded program; business administration, expanded program; technology preparation, a new program; advertising art, a modified program; business accountancy, an expanded program; and applied sciences, a new program.

At ACC: the agribusiness rural enterprise, a new program; heavy duty equipment electronics technology, a new program; business administration year one, an expanded and a modified program; media production technology, new program; sustainable shelter specialist, new program.

At KCC: the instrumentation electronic technology technician, year one, a new program; computer technology, a new program; computer technician, a new program; a facilities technician, a new program.

I am advised that the difference in student numbers that the member references is, yes, 2,000 students. Basically the reduction is in the extension enrollment, and the extension enrollment is a lower demand. We believe that is due to the recession.

Ms. Friesen: The minister argues that the cuts that this ministry made two years ago were because of low employability. Would the minister be prepared to table some evidence to that statement, essentially showing the programs that were cut and the absence of employment in those areas?

Mrs. Vodrey: Mr. Acting Chairperson, I am informed that all of that information was tabled last year, all of it in detail and she might like to ask her colleague for it.

Ms. Friesen: I was not aware that particular information related to the absence of employment. Does it demonstrate the absence of employability?

Mrs. Vodrey: Yes, I am informed it does.

Ms. Friesen: One of the areas that the minister has talked about has been the way in which the community colleges are preparing Manitobans for the future. But as I look overall, what I see is a drift, and it seems to me, Mr. Acting Chairperson, that what we have is a recognition of a number of issues in part as a result of a number of reports, in part coming from individual colleges themselves, in part coming from specific and immediate issues of the recession. Since 1988 it seems to me that the community colleges have for a number of reasons remained stagnant, certainly in terms of numbers and the way in which they are educating young Manitobans.

We have looked for a labour force strategy from the government, certainly at least since the 1990s when their own report suggested that one should be done immediately. It is still not here. It seems to me that the department will be scrambling even to get it out by the fall if they are starting from scratch at this stage. In process we see is a university review. In process some consideration of articulation. There seem to be so many areas of community colleges which at a critical time—I will not say crisis time but certainly critical time—in their history that so many areas are left pending.

The minister is new to this portfolio. I will not make this a personal issue, but I wonder if she could respond to the fact that here is a department which since 1988 seems to have done very little and, by the governance bill last year, has brought things very quickly to a head, and that the community colleges, within a very short period of time, are going to be forced onto their own resources in a very unpredictable economic climate at a time when the population of Manitoba is changing, the regional structure is also changing, and there does not seem to be the economic direction from this government that one would expect. I wonder if the minister would like to comment on that.

Mrs. Vodrey: Well, the member has asked me this evening, several times, about a strategy. So I would refer her to the book, Building A Solid Foundation For Our Future: A Strategic Plan 1991-96, from the Department of Education and Training.

In terms of that strategy, we have looked at and attempted to demonstrate and achieve our mission through: "Increased levels of literacy skills and other basic skills such as critical thinking and problem-solving. Increased rates of program completion for students. Increased number of graduates from our education and training system with marketable work skills. Increased number of graduates with the ability to be enterprising, to

persevere with hard work, to take risks and to be diligent in all efforts. Increased levels of knowledge and skills in science and technology. Increased knowledge of, and concern for, the environment.... Greater integration of components of the education and training system . . . . Increased public confidence in education and training programs."

As the public becomes more knowledgeable about the training programs offered and what they lead to, the "Increased participation of all partners in education and, in particular, increased participation of women, aboriginal people, immigrants and other underrepresented groups."

* (2130)

I have this evening discussed the strategies, the process strategies that the member has referred to them as, ways in which we wish to attempt to deal with those underrepresented groups. All of those particular strategies are also measurable. Through the process of the strategic plan we will be looking at measuring them.

Now, in relation to the college in specific, as part of the government's ongoing activities in strengthening the Manitoba economy by developing the skill levels of our labour force, an extensive review of community college programming was undertaken in 1991. I think it is important to underline again that this was an extensive review, that the aim was then to focus on effective long-term approaches to meeting our labour force needs as I have spoken about tonight, rather than on the short-term, quick-fix measures which were very common during the period of the '80s.

Now the review resulted in a redirection of programming from those less effective programs, and I have talked about those as being tabled last year to ones which would be more effective in addressing the labour market matches than this, to identify the mismatches. The college programs were identified and evaluated based upon enrollment levels, a measurable method, graduation rates, job placements, projected demand for graduates, as well as the programs costs and their effectiveness.

Some programs were eliminated, as the member referenced, things like recreational vehicle technology and hairstyling and clerical bookkeeping, but many were added including technology and business management programs, computer-related programs, programming related to our aerospace industry and expanded programming within rural and northern Manitoba.

In 1992-93 we are proposing a further expansion of $2.5 million to college programming in areas which will contribute to the economic development of our province all within the framework of the strategic plan. We believe that this will result in the training of an additional 640 students in 1992-93.

So I say back to the member that this is a period of phenomenal growth. This growth has provided a linkage from the labour market to the economy. It has put training on the economic agenda for this province. We have established regional centres which provide a responsive training community. We have attempted to strengthen small business programs. We have implemented new programs and I have read those into the record. We have provided support for economic programming.

So I refer her back to the area of the '80s where there was very little change, where there was a short-term quick fix, and I bring her forward now into the '90s. I bring her forward to the strategic plan of this government and of this department, and I reference to her each of those areas which, within the framework of the strategic plan, I think speaks very specifically to the linkage between training and economic development in this province.

Ms. Friesen: Mr. Acting Chairperson, it seems to me that what the minister calls strategies I would call goals and ideals, and I do not see the specific programs in effect to meet those particular goals and ideals. What she calls an additional 600 places to me seems to be a replacement, perhaps partial, perhaps full, depending upon how you determine the number of training days, for example, in the community colleges.

I think there is a difference of opinion of what exactly a strategy and a plan is, and it seems to me you can hardly claim that you have a provincial economic strategy when you do not have a labour force strategy in place; when you do not have any strategy for the replacement of faculty in colleges over the next ten years, when indeed it is acknowledged that a large proportion of that faculty will be retiring; when you do not have any knowledge or analysis of the way in which your programs are addressing the issues of aboriginal unemployment and aboriginal training needs. Certainly they are addressing them more extensively than they have been in the past, at least in some areas, not all areas of the province but in some areas. The minister

does not seem to have any way of evaluating the impact that they have on the unemployment issues throughout Manitoba for aboriginal people.

So it seems to me goals and ideals, yes, and I think many of them are ones that most people in Manitoba would share, but I do not see the strategy and the planning and the direction for all three community colleges that will move them in that direction. I suspect we will have to disagree at this point on that.

I wanted to ask the minister about the impact of federal policy on community colleges, particularly the situation that is recognized across the country of the reduction of post-secondary support from the federal government. That is one level of question, and I think the second part of that would be specifically the impact of the reduction of purchases of places at community colleges by the federal government. What impact is that having upon the planning for the Manitoba government?

Mrs. Vodrey: Well, I agree that we will have to disagree on the semantics of "goals and objectives" versus "strategic planning." To the specific question, there is no direct impact of the EPF funding on colleges. The provinces have been forced to accept a reduction while providing continued support at the post-secondary level.

Now, I am informed that, between 1986 and 1989, the direct purchase was reduced 39 percent and the federal government does propose a further reduction of 28 percent over the next two years, but the funds will be available through local labour force boards to make purchases, so we do not predict a significant impact. The money will still be in the province, but the colleges will have to be more entrepreneurial in terms of the money flowing to their programs.

Ms. Friesen: I am not sure I understand the last part of that. Does that mean that the three colleges will be competing for a finite amount of federal money?

* (2140)

Mrs. Vodrey: Though it is not intended that the colleges will compete one against the other, in The Colleges Act the colleges had defined geographic areas and it is intended that the local boards will also have defined geographic areas and that there will be a funding allocation to Winnipeg, to rural Manitoba, and to northern Manitoba.

Ms. Friesen: I am not sure then what the minister means by becoming more entrepreneurial, and I am adding, in search of those dollars. That is what I understood. What did the minister mean by that particular new process?

Mrs. Vodrey: Yes, entrepreneurial in the way to provide quality programming, to look at the skills in demand, to look at the client focus needed, entrepreneurial in providing those programs which have been determined by those who have the funds to put into the programing, and who have identified the skills in demand in those areas--by way of example, Indian bands.

Ms. Friesen: So a finite amount is to be available to each of the local development boards within the three designated areas for the three community colleges, as I understand what you are saying. What is the basis for the amounts in each of the areas? Is it a historic basis or is it one that is based upon current unemployment levels? What is the basis for the funding amount?

Mrs. Vodrey: Yes, first of all, I would like to say that these boards are simply in the proposal stage as a potential, but we understand that the funds available would be based on unemployment levels and that it would be a federal decision.

Ms. Friesen: I know it is not an agreement which has been reached yet, but the minister's staff are involved in negotiations with the federal government and have been for some time over the labour force development boards. I wonder if the minister could give us some account of the length of those discussions, perhaps the stage they are at now and when she expects some resolution.

I believe we are, perhaps if not the last, one of the later provinces to sign an agreement, and I wonder if there is some explanation from that from either the federal or provincial side.

Mrs. Vodrey: To bring the member up to date, I can tell the member that the entire matter is now being considered by me as minister and by my department, and that I hope to have an announcement within the next while, within the next few months.

Ms. Friesen: Mr. Acting Chairperson, could the minister explain why we are one of the later provinces to sign one of these agreements?

Mrs. Vodrey: I would like to say again that this is a very complex topic, and it was necessary for the former minister to meet with the federal minister in

December. Our province has required some extra time, because we have been looking very carefully at mutual priorities and, in particular, our province has been targeting the industrial sectors. These have not been considered, not been prioritized, by other provinces so we have taken our time to do an extremely thorough job. We look forward to the completion of the agreement.

Ms. Friesen: Do I understand the minister to say that Ontario has not been prioritizing industrial strategies? I am not sure of the contrast that you are drawing between the Manitoba potential agreement and the agreement of other provinces.

Mrs. Vodrey: Mr. Acting Chairperson, I think it is important to note that I am not attempting to speak for Ontario in any way. The comment was not directed specifically to a province in particular. We are looking for ours to be very specifically a made-in-Manitoba agreement, and we have had to work carefully with our local CEIC. We have been somewhat slower. We have been very thoughtful. We are attempting to do what is right for Manitoba and what is right for Manitobans.

* (2150)

Ms. Friesen: One of the purposes of these federal-provincial agreements, of course, is to bring together labour, government and business. I wonder if the minister could tell us what part labour has had in advising on or developing these programs.

Mrs. Vodrey: First of all, labour has a representative on the Canada-Manitoba Labour Force Development Board, and in fact is a co-chair of that board. The model being put forward to the provinces simply mirrors the federal board, so the labour input has been at the federal level on that federal board.

The agreement itself is a bilateral agreement, government to government. It is not an agreement between stakeholders; however, when the structure is in place, then labour and industry will come forward as equal partners following the agreement.

Ms. Friesen: The minister indicated that she would be reaching a decision within a few months. Does she have any intention, in the intervening period before the agreement is in place, to consult business and labour?

Mrs. Vodrey: Well, I will remind the member that this is in fact a government-to-government agreement. However, in the development of the agreement, we have paid attention to the needs of Manitobans, both labour and industry, but there will be a consultation with Manitobans before any boards are put in place.

Ms. Friesen: I think the composition of those boards is of some interest to what is sometimes called the stakeholders, and I wonder if the minister is proposing to make an agreement that is the best for Manitoba and for Manitobans, why she would not take advantage of an opportunity of the next couple of months to consult with both business and labour in Manitoba to ensure that all minds are brought together on this and to ensure that there is a widespread acceptance of the agreement which is put in place. What can be lost by consulting at this stage?

(Madam Chairperson in the Chair)

Mrs. Vodrey: I am somewhat confused by the member criticizing the government for not signing and yet asking for further consultation to delay a signing. I am also informed that consultation at this point within the government-to-government agreement would be a violation of the agreement. I can assure her that when the agreement is reached and before any boards would be functioning, there would be consultation regarding the make-up of the board, the structure of the board, perhaps the number of the board, and the boards are the decision-making bodies. I think that is the place where the member would like to see consultation occur, when there is actually an effect to the agreement.

Ms. Friesen: I think one of our concerns is the actual composition of those boards and who does the appointing to those boards. That is where I am interested in having some consultation and input from business and labour at this stage. The minister indicated that she had a few months at this stage, and that she was not going to make up her mind immediately. It seems to me that part of that process of making up one's mind in the best interest of Manitobans might be some consultation on that.

Mrs. Vodrey: I would ask the member to listen again, because I have been saying the same thing several times now. At the moment the agreement must have the approval of government. When government has approved the agreement, we will then be looking at the structure of the boards, the make-up of the boards, the number of the boards, and I have assured the member that consultation will take place for that particular stage. I have also

assured her that the boards are the decision-making bodies, and that because of that, consultation will occur.

Ms. Friesen: Madam Chairperson, is the minister then saying that the composition of the boards and the method of appointment is not part of the agreement? Is that something then which is going to come afterwards?

Mrs. Vodrey: I cannot state strongly enough that this debate is asking me to reveal what is in a proposal stage. I would like to stress again that this is a proposal stage in which we are discussing, but this proposal stage, in fact, each province basically operates by the same standard agreement within each province, and the agreement has guidelines. The guidelines are that business and labour should be represented on these boards.

At this point, I think it would be very important simply to say that this is a proposal not yet approved by government.

Madam Chairperson: Item 5.(a) Executive Administration (1) Salaries.

* (2200)

Mr. Reg Alcock (Osborne): Madam Chairperson, before we get into some of the details of this area, perhaps I could just ask the minister a very simple question just to clear some administrivia out of the way, if you like. Does the department have written policy on the education and training of deaf persons?

Mrs. Vodrey: Yes, I am informed that we do not have a specific policy for deaf adults. However, the disabled are a priority group within the labour force development agreement, and we do have, as the member knows, specific services available at Red River Community College and also programs, the deaf literacy program and the interpreter program, by way of example.

Mr. Alcock: Perhaps the minister could just clarify that. You mean there is no written policy in the Department of Education on the education and training of deaf persons in this province?

Mrs. Vodrey: We have a belief in the department that education should be based on the needs of Manitobans, and we do have a target of particular groups for particular attention. I am informed we do not have a written policy for the education of deaf Manitobans. However, we do have many projects underway for the education and training of deaf people in Manitoba. I reference the K-12 program specifically at MSD, in the colleges: the deaf interpreter program, and the New Careers program, training the Deaf Human Services Worker.

Mr. Alcock: Madam Chairperson, I am a little confused by this. So the department does not have written policy, then how does the department make decisions? Do they have written beliefs? The minister says that they have beliefs about what happens with people. I mean, how are staff to be guided when they are approached by people for services? Is this something that you just sit around and kind of come to some kind of belief about this, or do you have some guidelines that allow people to make objective decisions about what is available to them? Is that obnoxious?

Mrs. Vodrey: Madam Chairperson, well, within the written document which I would refer the honourable member to, Building a Solid Foundation for our Future: The Strategic Plan, we have a mission statement which within the mission statement embodies in a written-down form, the key values for the Department of Education.

Those key values—I would just like to reference them for the member: guiding principles of excellence, providing a climate for education and training that fosters dedication and determination; creativity, initiative and high achievement; and then equity, ensuring fairness and providing the best possible learning opportunities for Manitobans, regardless of background or geographic location—all Manitobans. Certainly the deaf population falls within that.

The guiding principle of openness, being receptive to ways of thinking and acting that result in ongoing renewal and meaningful involvement of people in decision making.

The guiding principle of responsiveness, meeting the education and training needs of individuals by taking into consideration personal background, individual characteristics and geographic location.

The guiding principle of choice, providing alternatives to meet diverse learning needs and interest.

The guiding principle of relevance, providing education and training that is current and meaningful to students.

The guiding principle of integration, connecting components within and between education and training and social and economic systems in order

to increase the effectiveness and the efficiency of programs and services.

The guiding principle of accountability, ensuring that the expected educational outcomes are realized through effective and efficient use of resources.

Then I take the honourable member on a page or two pages where we talk about a method of implementing our priorities. The following quality indicators, which are tangible and observable, will demonstrate that we are achieving our mission. Again, I reference the issues of increased levels of literacy, the increased rates of program completion, the increased numbers of graduates from our education and training system, the increasing number of graduates with the ability to be enterprising, the increased level of knowledge and skills in science and technology, the increased knowledge and concern for the environment, the greater integration of components of the education and training system, the increased public confidence and awareness in the education and training programs, the increased participation of all partners in education, and in particular, the increased participation of women, aboriginal people, immigrants and other underrepresented groups, of which I would believe the deaf community the member references would become a part.

* (2210)

Mr. Alcock: I have heard all sorts of press releases from this government, and they all sound very good and they all give one a warm feeling. The question is a little more basic than that.

It is: If I were a deaf person in this province or if I were the parent of a deaf child in this province, I would want to know what sort of services I could access, what sort of responsibilities I am taking on in doing so, what sort of additional supports are available from the province. If I lived outside the city of Winnipeg and felt that my child must go to the Manitoba School for the Deaf, that would involve some kind of residential support. If I was a deaf adult and wanted to upgrade my literacy skills, I might have all sorts of questions about what programs are available and what specific supports are available to me.

The minister has told me that thus far all I can get that will guide me in making my career choices is a statement that will let me know that I have somehow succeeded if I have increased my knowledge and concern for the environment or if I have had an educational experience that is meaningful. Perhaps we could be just a tad more precise.

Is there nothing in this department that exists that would assist a parent in determining an appropriate placement for their child or becoming aware of what sort of supports are available to them?

Mrs. Vodrey: I would like to remind the honourable member that discussion on deaf education K to 12 does not fall within this appropriation, but in fact should have been discussed in the appropriation 16-3(d) and (g).

However, in terms of the education for deaf adults, I would like to tell the member that I have met with the deaf community. The deaf community representatives did not raise this particular issue, however I will be meeting with that community again. I hope to have ongoing discussions with communities that have issues which they would like to bring to the Department of Education and Training and to the minister. I am certainly open for discussion.

Mr. Alcock: I am pleased that I have now been informed about the minister's schedule of meetings; however, that was not the question. The question is very simple. I referenced K to 12.

Mrs. Vodrey: I would like to remind the honourable member that discussion on deaf education K to 12 does not fall within this appropriation but, in fact, should have been discussed in the appropriation 16-3(d) and (g).

However, in terms of the education for deaf adults, I would like to tell the member that I have met with the deaf community. The deaf community representatives did not raise this particular issue; however, I will be meeting with that community again. I hope to have ongoing discussions with communities which have issues which they would like to bring to the Department of Education and Training and to the minister. I am certainly open for discussion.

Mr. Alcock: I am pleased that I have now been informed about the minister's schedule of meetings. However, that was not the question. The question is very simple. I referenced K to 12 because the minister referenced K to 12, but the department offers a number of programs some of which are accessible by deaf persons. These involve questions of interpretation as well as support. All I am asking is, is any of this written down?

Mrs. Vodrey: I come back to the place where I started. There is no such comprehensive list. I would remind the member that the issue has not come up during my previous discussions with the deaf community. However, as I said to him in my last answer, I am certainly prepared to consider it. I am certainly prepared to discuss it with the deaf community to determine if this is what their wishes are as well, in any direct, face-to-face discussions with myself and members of my department.

Madam Chairperson, I am also informed that in the booklet titled Inventory of Labour Market Programs and Services in Manitoba, there is a section called Vocational Rehabilitation Services in Manitoba: Designated Agencies, and through these agencies, inventories of programs are available.

Mr. Alcock: I am pleased that the minister is prepared to meet with the deaf community and respond to their requests. However, again, that is not what I was asking the minister. What I was asking the minister for, very simply, was whether or not the department had a policy manual. Other departments seem to have policy manuals that guide decisions by staff in the department. So let us broaden the question: Does this department have a policy manual?

Mrs. Vodrey: Madam Chairperson, well, I will tell the member again, and this time perhaps he will hear me. I did say to him that there is not a policy written down in this specific area that he has requested because, as I had told him, that issue to this point had not been raised as an issue of specific request. However, he has asked what kind of policies we do have written down, and I am happy to provide him with an example of some of those policies. The GMA manual, the General Manual of Administration, the FAME manual, the Students Record manual, the Student Financial Assistance manual, the FRAME manual and the Strategic Plan, which I have referenced this evening, and within the Strategic Plan with goals and objectives and with a specific process outlined which applies to all Manitobans, including special groups of Manitobans, and I think they are also referenced as specific groups within that manual.

Mr. Alcock: Well, Madam Chairperson, the minister is now saying that there is no written policy relative to deaf persons in this province. Then was the previous minister lying to me when he accepted an order for return or an address for paper for the production of such written material?

* (2220)

Mrs. Vodrey: Could I ask the member to repeat his question for me, please?

Mr. Alcock: Almost a year ago, Madam Chairperson, I put on the Order Paper an address for papers requesting copies of all written policies in the Department of Education relative to the education of deaf persons in this province.

The previous Minister of Education, the Minister of Finance stood in his place and said, yes, they were only too willing to accept the address for papers and that copies of same would be coming forthwith.

So, a year ago, it was the position of the government that such materials existed. It is now the position of this minister that such papers do not exist. Now, was the former minister misleading me when he accepted that order for return? The House leader for the government, the Minister of Finance (Mr. Manness), was he being less than forthright with me when he accepted that address for papers? Was he pretending to things that do not exist or has there been a change now and such policy has suddenly ceased to exist within the department?

Mrs. Vodrey: Well, at this point I am afraid I do not have the knowledge of exactly what the member's request was to the former minister and to the House leader, but I will tell him that I will be happy to meet with the House leader and the former minister to determine how they understood the request that was put forward by the member.

Mr. Alcock: I am certain that if the minister does have those conversations or if she wishes to go back into Hansard she will see exactly the discussion that took place and the conditions upon which the order was accepted. I would ask her to do that and bring that information back to this session.

Now I am a little concerned, Madam Chairperson, that the department is ill-prepared for these discussions. I would have thought that a matter like that, the department would have anticipated it coming up and we would be prepared to have a discussion.

You will recall when I opened this question I said this was a piece of administrivia. It was not a large policy item just a small administrative piece that I hoped to get out of the way but given the fact that the department is unable to discuss something as

limited as that perhaps we should–would the member for Wolseley–should committee rise at this point?

I would move, Madam Chairperson, that the committee rise until such time that the department is prepared to have a discussion.

Madam Chairperson: It has been moved by the honourable member from Osborne (Mr. Alcock) that committee rise. Is that the will of the committee? [Agreed]

Call in the Speaker.

IN SESSION

Madam Deputy Speaker: The hour being after 10 p.m. this House is adjourned and stands adjourned until 1:30 p.m. tomorrow (Tuesday).

Legislative Assembly of Manitoba

Monday, May 11, 1992

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