Third Session – Forty-Second Legislature

of the

Legislative Assembly of Manitoba

Standing Committee
on
Social and Economic Development

Chairperson
Mr. James Teitsma
Constituency of Radisson

Vol. LXXV No. 5 - 6 p.m., Monday, April 12, 2021

ISSN 1708-6698

MANITOBA LEGISLATIVE ASSEMBLY
Forty-Second Legislature

Member	Constituency	Political Affiliation
ADAMS, Danielle	Thompson	NDP
ALTOMARE, Nello	Transcona	NDP
ASAGWARA, Uzoma	Union Station	NDP
BRAR, Diljeet	Burrows	NDP
BUSHIE, Ian	Keewatinook	NDP
CLARKE, Eileen, Hon.	Agassiz	PC
COX, Cathy, Hon.	Kildonan-River East	PC
CULLEN, Cliff, Hon.	Spruce Woods	PC
DRIEDGER, Myrna, Hon.	Roblin	PC
EICHLER, Ralph, Hon.	Lakeside	PC
EWASKO, Wayne, Hon.	Lac du Bonnet	PC
FIELDING, Scott, Hon.	Kirkfield Park	PC
FONTAINE, Nahanni	St. Johns	NDP
FRIESEN, Cameron, Hon.	Morden-Winkler	PC
GERRARD, Jon, Hon.	River Heights	Lib.
GOERTZEN, Kelvin, Hon.	Steinbach	PC
GORDON, Audrey, Hon.	Southdale	PC
GUENTER, Josh	Borderland	PC
GUILLEMARD, Sarah, Hon.	Fort Richmond	PC
HELWER, Reg, Hon.	Brandon West	PC
ISLEIFSON, Len	Brandon East	PC
JOHNSON, Derek, Hon.	Interlake-Gimli	PC
JOHNSTON, Scott	Assiniboia	PC
KINEW, Wab	Fort Rouge	NDP
LAGASSÉ, Bob	Dawson Trail	PC
LAGIMODIERE, Alan	Selkirk	PC
LAMONT, Dougald	St. Boniface	Lib.
LAMOUREUX, Cindy	Tyndall Park	Lib.
LATHLIN, Amanda	The Pas-Kameesak	NDP
LINDSEY, Tom	Flin Flon	NDP
MALOWAY, Jim	Elmwood	NDP
MARCELINO, Malaya	Notre Dame	NDP
MARTIN, Shannon	McPhillips	PC
MICHALESKI, Brad	Dauphin	PC
MICKLEFIELD, Andrew	Rossmere	PC
MORLEY-LECOMTE, Janice	Seine River	PC
MOSES, Jamie	St. Vital	NDP
NAYLOR, Lisa	Wolseley	NDP
NESBITT, Greg	Riding Mountain	PC
PALLISTER, Brian, Hon.	Fort Whyte	PC
PEDERSEN, Blaine, Hon.	Midland	PC
PIWNIUK, Doyle	Turtle Mountain	PC
REYES, Jon	Waverley	PC
SALA, Adrien	St. James	NDP
SANDHU, Mintu	The Maples	NDP
SCHULER, Ron, Hon.	Springfield-Ritchot	PC
SMITH, Andrew	Lagimodière	PC
SMITH, Bernadette	Point Douglas	NDP
SMOOK, Dennis	La Vérendrye	PC
SQUIRES, Rochelle, Hon.	Riel	PC
STEFANSON, Heather, Hon.	Tuxedo	PC
TEITSMA, James	Radisson	PC
WASYLIW, Mark	Fort Garry	NDP
WHARTON, Jeff, Hon.	Red River North	PC
WIEBE, Matt	Concordia	NDP
WISHART, Ian	Portage la Prairie	PC
WOWCHUK, Rick	Swan River	PC

LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON SOCIAL AND ECONOMIC DEVELOPMENT

Monday, April 12, 2021

TIME – 6 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. James Teitsma (Radisson)

VICE-CHAIRPERSON – Mr. Josh Guenter (Borderland)

ATTENDANCE – 6   QUORUM – 4

Members of the Committee present:

Hon. Ms. Gordon, Hon. Mrs. Stefanson

MLA Asagwara, Mr. Guenter, Mrs. Smith (Point Douglas), Mr. Teitsma

APPEARING:

Hon. Jon Gerrard, MLA for River Heights

PUBLIC PRESENTERS:

Bill 56 – The Smoking and Vapour Products Control Amendment Act

Ms. Katherine Legrange, Treaty One Nation
Ms. Deborah Smith, Brokenhead Ojibway Nation
Mr. Arlen Dumas, Assembly of Manitoba Chiefs
Mr. Mike Sutherland, Peguis First Nation

Bill 67 – The Public Health Amendment Act

Ms. Darlene Jackson, Manitoba Nurses Union
Ms. Shannon McAteer, Canadian Union of Public Employees

Bill 10 – The Regional Health Authorities Amendment Act (Health System Governance and Accountability)

Ms. Darlene Jackson, Manitoba Nurses Union
Ms. Brianne Goertzen, Manitoba Health Coalition
Ms. Michelle Gawronsky, Manitoba Government and General Employees' Union
Mr. Cory Baillie, Doctors Manitoba
Ms. Sherry Nield, private citizen
Ms. Leah Wiebe, private citizen
Ms. Lori Amedick, private citizen
Mr. Colin Mehmel, private citizen
Mrs. Ashley Rawluk, private citizen
Mrs. Jen Dyck, private citizen
Mrs. Elizabeth Dyer, private citizen
Ms. Ashley McKague, private citizen
Mr. Ken MacDonald, private citizen
Mrs. Liz Miller, private citizen
Ms. Trish Rawsthorne, private citizen
Ms. Irene Sheldon, private citizen

WRITTEN SUBMISSIONS:

Bill 56 – The Smoking and Vapour Products Control Amendment Act

Dino Flett, Garden Hill First Nations

MATTERS UNDER CONSIDERATION:

Bill 10 – The Regional Health Authorities Amendment Act (Health System Governance and Accountability)

Bill 56 – The Smoking and Vapour Products Control Amendment Act

Bill 67 – The Public Health Amendment Act

* * *

Mr. Chairperson: Good evening. Will the Standing Committee on Social and Economic Development please come to order.

Our first item of business is the election of a Vice-Chairperson. Are there any nominations?

Ms. Gordon, perhaps turn your video on. Or I can ask nicely for MLA Asagwara to nominate Josh Guenter. Or we can be patient. Oh, Minister Gordon, would you like to nominate somebody as Vice-Chairman–Chairperson, sorry.

Minister Gordon. Minister Gordon, are you able to hear me? Please give me a thumbs-up. That is a no.

Minister Gordon, our first item of business is the election of a Vice-Chairperson. Are there any nominations?

Hon. Audrey Gordon (Minister of Mental Health, Wellness and Recovery): I have a nomination, Mr. Chair.

Mr. Chairperson: Go ahead.

Ms. Gordon: I nominate Josh Guenter for Vice-Chair.

Mr. Chairperson: Mr. Guenter having been nominated, are there any other nominations?

Hearing no other nominations, Mr. Guenter is elected Vice-Chairperson.

This meeting has been called to consider the following bills: Bill 10, The Regional Health Authorities Amendment Act (Health System Governance and Accountability); Bill 56, The Smoking and Vapour Products *[inaudible]* Act; and Bill 67, The Public Health Amendment Act.

I'd like to inform all in attendance of the provisions in our rules regarding the hour of adjournment: a standing committee meeting to consider a bill must not sit past midnight to hear public presentations or to consider clause-by-clause of a bill, except by unanimous consent of the committee.

Now, we've received written submissions from the following people, and we've distributed those to committee members: Sherry Nield, private citizen, on Bill 10; Chief Dino Flett, Island Lake First Nations, on Bill 56.

Mr. Clerk, were there any additional to those three? Okay?

So does the committee agree to have those documents appear in the Hansard transcript of this meeting? *[Agreed]*

Now, prior to proceeding with public presentations, I would like to advise members of the public regarding the process for speaking in a committee.

In accordance with our rules, the time limit of 10 minutes has been allotted for presentations with another five minutes allowed for questions from the committee members. If a presenter is not in attendance when their name is called, they'll be dropped to the bottom of the list, and if the presenter is not in attendance when their name is called a second time, they'll be removed from the presenters list.

So the proceedings of our meetings are recorded in order to provide a verbatim transcript. Each time someone wishes to speak, whether it be an MLA or a presenter, I first have to say the person's name. That is the signal for the Hansard recorder to turn the mics on and off.

Also, if any presenter has any written materials for distribution to the committee, please send the file by email to the moderator, who will distribute it to all committee members.

I thank you for your patience and we will shortly proceed with public presentations. I did have a proposal for the members, and that was out of respect for the few people who have signed up to speak to Bill 56 and 67, compared to the many who have signed for Bill 10, that we proceed to hear the presentations for Bill 56 and then for 67 and then go to Bill 10 after that.

Is there leave for the committee to proceed in that manner? *[Agreed]*

Thank you. Then we will do so.

So, let's see if I can find my list here. I think you only gave me Bill 10's list here. Oh–is it all in here? There we go. All right.

Bill 56–The Smoking and Vapour Products Control Amendment Act

Mr. Chairperson: So, beginning with Bill 56, The Smoking and Vapour Products Control Amendment Act.

I will now call on Norman Rosenbaum, private citizen, and ask the moderator to invite them into the meeting. Mr. Rosenbaum, I–when you appear–well, I'll just be patient. But I'll ask that you unmute yourself and turn your video on so that we can see you.

All right. Mr. Rosemaub *[phonetic]* does not appear to be present, so we will get back to him. We'll drop him to the bottom of the list.

Now, I will call Katherine Legrange, from Treaty One Nation. Katherine Legrange, if I can ask the moderator to invite them into the meeting and then ask them to unmute themselves and turn their video on.

Welcome to the meeting, Ms. Legrange. You can proceed with your presentation. You have 10 minutes.

Ms. Katherine Legrange (Treaty One Nation): I won't take too long, I promise.

[inaudible] and good evening. My name is Katherine Legrange. I'm the executive director for the Treaty One Nation government. I would like to start by acknowledging the Treaty 1 Anishinabe land that this hearing is being held on this evening.

Treaty 1 was signed at Lower Fort Garry by First Nations chiefs and representatives of the Crown in August 1871 after days of ceremonies and negotiations. The Treaty One Nation government consists

of seven First Nations in Manitoba, nations whose combined population makes up approximately 33,000 citizens.

Our collective government is mindful and respectful of each individual nation's laws and customs, including their elected chiefs, councillors and knowledge-keepers. The governing council of the Treaty One Nation government has asked me to present the position of the collective on Bill 56 and the proposed amendment to The Smoking and Vapour Products Control Act.

* (18:10)

The Treaty One Nation is strongly opposed to the–is strongly opposed, rather, to the proposed amendment that seeks to apply the act to areas currently under federal jurisdiction. The Pallister government's overreach in attempting to enforce legislation on First Nations land is not only unethical but a breach of the nation-to-nation treaty signed in 1871 and of the Canadian constitution that protects and affirms First Nations treaty rights.

Furthermore, the provincial government's effort at amending the act via Bill 56 is also a direct violation of several UNDRIP articles, including Article 3, the right to self-determination. By virtue of that right, we freely determine our political status and freely pursue our economic, social and cultural development; Article 4, the right to autonomy or self-government in matters relating to our internal and local affairs, as well as ways and means for financing our autonomous functions; and Article 5, the right to maintain and strengthen our distinct political, legal, economic, social and cultural institutions, while retaining our right to participate fully in the political, economic, social and cultural life of the state.

The amendment in Bill 56 not only shows the Pallister government's lack of relationship building with Treaty 1 First Nations, but also the lack of meaningful consultation and consent of First Nations in Manitoba. The Treaty One Nation government is not encouraging smoking, vaping or the sale of products. In fact, several First Nations have chosen to pass bylaws limiting or restricting smoking on their reserve lands. However, it must be noted that this choice was made by those First Nations' leadership while considering several different factors such as health, infrastructure and revenues.

This evening, we are asking Mr. Pallister and his caucus to, firstly, educate themselves on Treaty 1 and the Treaty One Nation government as they live and work in Treaty 1 territory; secondly, instead of trying to impose laws outside of their jurisdiction, we invite them to attempt to build a relationship with the Treaty One Nation government and our 33,000 citizens. These 33,000-plus citizens are a strong force in this province and throughout Canada. Lastly, the Treaty One Nation government is prepared to do whatever it takes to assert our rights as self-governing First Nations people and challenges the amendment in order to protect our treaty rights and sovereignty.

I am grateful that two Treaty 1 chiefs are here to present their position on behalf of their respective nations, as well as Grand Chief Arlen Dumas on behalf of the Assembly of Manitoba Chiefs. I look forward to hearing from them and from the other presenters.

Miigwech and thank you for your time.

Mr. Chairperson: Thank you, Ms. Legrange, for your presentation.

Do members of the committee have questions for the presenter?

Hon. Audrey Gordon (Minister of Mental Health, Wellness and Recovery): I do have a comment. I would like to thank you, Katherine Legrange, for your presentation on behalf of the Treaty One Nation and for sharing the Treaty One Nation's position on the amendment that will be made to the bill. I have a long-standing relationship with First Nation communities and Indigenous peoples in the province. I respect your comments and will take them to heart.

I do want to say that while we are moving this legislation through this committee and do have jurisdictions to pass laws of general application to protect and promote the health of all Manitobans, the Province also recognizes and respects that First Nations maintain the right of self-government on-reserve and will assure–I'm here to assure you that you do have the ability to pass bylaws that override these provisions if you see fit.

So we've talked a little bit before about paramountcy and the ability for First Nations and Indigenous groups to pass bylaws that align with your views on smoking, so–and vaping. And you've said already that there are communities that have passed bylaws. This will certainly make it easier for the–those communities and others who would like to regulate smoking on their reserves to be able to do so without passing bylaws.

So, I thank you very much for your comments, and they will be taken under consideration. Thank you for your time tonight.

Mr. Chairperson: Ms. Legrange, would you like to respond at all to the minister? Up to you.

Ms. Legrange: No. That's fine, thank you.

Mr. Chairperson: Any other members with questions?

An Honourable Member: I have a question.

Mr. Chairperson: Ms. Smith, go ahead.

Mrs. Bernadette Smith (Point Douglas): Question for Ms. Legrange: you heard the deputy–or, you heard the minister speak about consultation, respect and that she has a working relationship with First Nations.

Do you know any First Nation communities of the 63 that have been consulted on this bill? *[interjection]*

Mr. Chairperson: Sorry. Ms. Legrange, I have to say your name first. *[interjection]* Sorry, Ms. Legrange, I have to acknowledge you first, and then let you respond.

So, go ahead, Ms. Legrange.

Ms. Legrange: Thank you.

No, not that I'm aware of, and certainly not with the seven First Nations of the Treaty One Nation.

Mr. Chairperson: Are there any other questions from members of the committee?

An Honourable Member: Another question.

An Honourable Member: Yes.

Mr. Chairperson: Mrs. Smith.

Mrs. Smith: I actually have a few questions.

Were you aware that the Canadian Cancer Society has withdrawn their support for Bill 56 because of the lack of consultation with First Nations?

Ms. Legrange: Yes, I was aware of that.

Mrs. Smith: Were you aware that we asked the minister during debate time to withdraw this bill until proper consultation with First Nations happened?

And here we are in committee stage without consultation with First Nations, which shows a lack of–disrespect to these communities and, you know, the autonomy to be able to bring this forward like the other eight First Nations have, if they so choose to.

Ms. Legrange: Yes, I was aware that it was brought up in question period, and I appreciate the opposition party's efforts to make aware–make the government aware that they have not meaningfully consulted nor obtained consent from any of the seven First Nations of Treaty 1.

Mr. Chairperson: Mrs. Smith, we've got about 30 seconds left. Go ahead.

Mrs. Smith: Last question: if you can say anything to the minister today, what would your message to–be to her about creating meaningful relationships with the seven First Nations that you work with?

Ms. Legrange: I would say that in order to have meaningful consultation, you need to invite us to the table. We have not been invited to the table thus far.

Mr. Chairperson: Okay, that concludes the amount of time that we have available to us for questions. I thank you very much, Ms. Legrange, for coming to committee and for making your presentation this evening.

I will now move to the next witness. And I will call on Chief Glenn Hudson from Peguis First Nations and ask the moderator to invite them into the meeting.

They appear not to be ready in the meeting yet, so we'll drop their name to the end of the list, and instead I'll go to the next witness on my list here, which is Deborah Smith from Brokenhead Ojibway Nation.

Deborah Smith, I'd ask the moderator to invite you into the meeting and also ask you to unmute yourself and turn your video on.

Welcome to the meeting. I encourage you to proceed with your presentation. You can start when you're ready, you have 10 minutes.

Ms. Deborah Smith (Brokenhead Ojibway Nation): Thank you. Boozhoo. *Ojibwe spoken.*

Translation

Hello, my relatives. My name is Eagle Woman, and I'm from the Caribou Clan. And I am from the Brokenhead Ojibway Nation.

English

I want to first acknowledge the lands on which this committee hearing is taking place. The lands of my ancestors on Treaty 1 territory. It is my honour to greet you all this evening on behalf of the community, the people of the Brokenhead Ojibway Nation.

* (18:20)

I will be sharing with this committee Brokenhead's position on bill c-56 and at the outset, I want to make it clear that bill c-56 is a direct violation of our nation-to-nation relationship with the federal government and bill c-56 is also a violation of the United Nations Declaration on the Rights of Indigenous Peoples and an attack on our sovereignty as First Nations people.

By way of background, I would like to provide some context in terms of our community and existing bylaws that we have enacted as a self-governing, sovereign First Nation. Brokenhead Ojibway Nation is an Anishinabe nation, as represented by its duly elected chief and council that is governed according to its customary laws and practices. BON entered into treaty with Her Majesty the Queen–the–and–of the Dominion of Canada in or around 1871, commonly known as Treaty 1.

Among other things, Treaty 1 recognizes certain obligations of Canada to the First Nations and reserve lands for Brokenhead's exclusive use and benefit. Brokenhead has governed itself and its reserve lands and citizens pursuant to its customary laws and practices, as well as duly enacted bylaws pursuant to the Indian Act. Bylaw No. 001-2007R, a bylaw to regulate smoking within Brokenhead Ojibway Nation lands, was enacted in or around 2007 and regulates smoking in public places on Brokenhead Ojibway Nation's reserve lands in a manner that balances a variety of interests, including economics, health and alleviating poverty and unemployment on Brokenhead Ojibway Nation lands.

The bylaw allows certain designated smoking areas on Brokenhead Ojibway Nation through various methods of regulation by the Brokenhead Ojibway Nation council, including in the public area in a building where gaming activities are situated.

We view the actions of Manitoba as another example of the undermining of our acts of self-determination. The Manitoba government has stated that it has tabled this bill for health reasons. However, the actions of the Manitoba government are nothing short of continued economic warfare, imposed under the thin veil of a public health concern. I say thin veil because your government has made it clear that First Nations are on our own when it comes to matters of health.

I remind you and your Premier's public statements on December 3rd, 2020. He stated loud and clear that the health and welfare of Indigenous Canadians is the principal responsibility of the federal government. Premier Pallister claimed that this policy of providing priority vaccines for First Nations punished and short-changed Manitobans on their share of the vaccines. Your government has never met with me about COVID-19 or any of the health issues facing my people.

I want to also draw your attention to other areas of jurisdiction and the rights that First Nations have and are protected under the Constitution Act of Canada. Section 91(24), Indians and lands reserved for Indians, the Canadian Constitution of 1867, which is a source of fiduciary obligation of the federal government, because at that point, First Nations were made wards of the state, and this section of the constitution obligates the federal government to act in our best interest.

Section 35 of the Canadian Constitution of 1982 states that the existing Aboriginal treaty rights of the Aboriginal people in Canada are hereby recognized and affirmed. And it may be noteworthy to advise you that subsection (1) of section 35 has further–was further affirmed through the Sparrow case of 1990. The Supreme Court of Canada states that Canada and the provinces have a fiduciary obligation to act in good faith. It is a matter of fair dealing with a group of peoples who have special rights and a special history in Canada.

The actions of the provincial government with respect to bill c-56 appears arbitrary and not engaging with First Nations as partners. Brokenhead Ojibway Nation and other First Nations have constitutionally protected rights to self-government under section 35 of the constitution. I would further offer the Province to educate themselves on established and developing First Nations case law that define our rights and jurisdiction, including the Sparrow, Haida Nation and Mikisew court cases.

In summary, I would like to reiterate, then, the Brokenhead Ojibway Nation has exercised its authority to enact a bylaw to regulate smoking within Brokenhead Ojibway Nation lands to serve the community and its members.

The Province must be mindful to not continue to engage in the mistakes of the past. This means the promise–Province must respect the sovereignty of First Nations in Manitoba. Also, we must be involved as people that have a stake in the outcomes that will impact upon our ability to exercise jurisdiction and self-determination in economic activities in our communities.

First Nations have treaty agreements in place with Canada. In the court decision R v Van der Peet of 1996, Canada must reconcile with the fact that First Nations were here first. And, in my opinion, this ruling should be equally applicable to the provinces.

First Nations are currently engaged in a process that will recognize its ability to exercise authority and jurisdiction in child protection and in health. That will serve both on- and off-reserve members, and the Province must be willing to recognize these new realities.

It has been determined that the provincial governments–as good practice and in good faith–must exercise duty to consult in a meaningful way with First Nations. I will state that no meaningful consultation regarding bill c-56 happened with Brokenhead Ojibway Nation chief and council.

Further, it is well known that Manitoba has the worst duty-to-consult policy in Canada, and we must look forward and begin to define what is meaningful for First Nations within this framework.

The above statement and concerns would reflect the Province's willingness to move forward in the spirit of reconciliation, and for the Province to acknowledge The Path to Reconciliation Act; moreover, section 4, subsection (c) where it states: establishes immediate and long-term actions that are responsive to the priorities and needs of Indigenous nations and Indigenous peoples.

Moreover, also, those set out in the calls to action of the Truth and Reconciliation Commission, and, in our opinion, more directly, specifically to call to action No. 45, subsection (iv): Reconcile Aboriginal and Crown constitutional and legal orders to ensure that Aboriginal peoples are full partners in Confederation, including the 'recognation'–recognition and integration of Indigenous laws and legal traditions in negotiation and implementation processes involving treaties, land claims and other constructive agreements.

Mr. Chairperson: Ms. Smith, just to let you know, you've got about 30 seconds left.

Ms. Smith: Okay.

We will continue to assert our Aboriginal inherent rights and our legislative rights to govern our people. I'm calling on your government to meet our obligations to First Nations to act in a reconciliatory manner and to change your relationship with First Nations to reflect the nation-to-nation and treaty relationship.

Miigwech.

Mr. Chairperson: Thank you much–thank you very much, Ms. Smith, for your presentation.

You opened with some words in Ojibwe, and I was wondering if you would be able to provide a translation of those words for the benefit of our Hansard recorders and also for my benefit. I'm genuinely curious as to the sentiment you expressed.

Ms. Smith: So I said, hello, my relatives. My name is Eagle Woman, and I'm from the Caribou Clan. And I am from the Brokenhead Ojibway Nation.

Mr. Chairperson: Thank you very much for providing that. I appreciate it.

Do members of the committee have questions for the presenter?

* (18:30)

Mrs. Smith: I have several questions.

I want to thank you, Chief Smith, for coming to present and really outlining what a relationship would–a true, meaningful relationship would look like with First Nations and government.

So my first question is: I've heard that you weren't consulted; Ojibway or Brokenhead Ojibway wasn't consulted. Do you know if any of the other 62 First Nations were consulted on this bill?

Ms. Smith: Thanks for your question. No, I'm not aware.

Mrs. Smith: Were you aware that the cancer care society withdrew their support for this bill because there was no consultation with First Nations, what they–which they originally thought that there was?

Ms. Smith: Again, thank you for your question. No, I was not aware until today.

Mr. Chairperson: Mrs. Smith, further questions?

Mrs. Smith: Yes, I have about three more.

Were you aware that we called during debate for the minister to withdraw this bill until there was meaningful consultation with First Nations, but here we are in committee stage, you know, going full speed ahead without any meaningful consultation?

You know, the minister talks about creating meaningful relationships with First Nations. I know the minister is new to the portfolio. As a new MLA, is

this a good way to start a relationship with First Nations?

Ms. Smith: I would have to say no, it's not a very good way for any type of relationship with First Nations, and I think, in my presentation, I spoke to, you know, some options, I think, that are available to the government in terms of, you know, really looking at that relationship and also going back to some of the pieces of legislation or acts that have been passed with respect to reconciliation. And I thank you for–and you and your party for raising that and asking them to withdraw the bill until a proper consultation could happen.

So, thank you.

Mrs. Smith: Chief Smith, if you could tell the minister anything, you know, moving forward–like I said, you know, the minister is new to her portfolio; she's a new MLA; she's talked about having meaningful relationships in the past with First Nations. Now that she's in government, what would a true, meaningful relationship look like with First Nations?

Ms. Smith: Well, I think my colleague from Treaty 1 said it best, and I think, you know, you want to have a relationship, invite us to the table. We were never asked to come to that table, and I just want First Nations–the Province, to recognize that, you know, First Nation governments are nations and we want to have that nation-to-nation relationship. But also, I strongly believe that the Province has to educate themselves on what, exactly, our treaty relationship is and also, you know, what are, you know, our rights within, you know, our territories.

So, again, inviting us to the table.

Mr. Chairperson: Mrs. Smith, was that No. 3? I can't remember.

Mrs. Smith: I have one more question, last question.

Mr. Chairperson: Okay, go ahead.

Mrs. Smith: So my last question just revolves around Brokenhead Ojibway First Nation setting up their own laws.

Do you feel that other First Nations should be able to do the same without the, you know, stepping–overstepping or overreaching, you know, jurisdiction into federal jurisdiction and trying to, you know, really set laws where they shouldn't be?

Ms. Smith: Of course–oh, sorry–of course, I believe that First Nations have that right and that, you know, jurisdiction, and I would encourage any of the other 62 First Nations to do that.

Brokenhead has exercised that right several times, and, you know, I think that that is, you know, federal jurisdiction, and the Province has no business overstepping that jurisdiction.

Mr. Chairperson: Minister Gordon, you've got 30 seconds.

Ms. Gordon: Thank you, Mr. Chair, for the opportunity to speak. I did have my hand up immediately after Chief Smith spoke, but I was not recognized.

Thank you, Deborah–Chief Deborah Smith–for your comments and for your presentation tonight.

I do want to correct the record. Immediately after the amendment to the bill was distributed in the House for public viewing, we immediately wrote to all 63 First Nations chiefs and band councils, inviting those individuals to begin what we saw as a very extensive, three-phase–prong engagement process. We also wrote to the three grand chiefs.

Last week, we had a very good discussion with Grand Chief Settee. Unfortunately, the other two grand chiefs were not able to attend–

Mr. Chairperson: I'm sorry, Minister Gordon. That is all the time that we have allotted. I'm afraid we've come to the end of questioning for this person.

Ms. Gordon: Thank you. And we do have those correspondents on file–

Mr. Chairperson: Yes, I'm sorry, minister, but we're going to have to move to the next presenter.

And so if I can now call on–and first of all I do want to thank Ms. Smith–Ms. Deborah Smith–for coming and for giving your presentation and for answering the questions.

We'll now move on to the next presenter, which is–oh. Actually, before I do that, I've been advised that Mike Sutherland has asked to make a presentation on behalf of Chief Hudson, which is presenter No. 3 on the list who is not able to make a presentation at this meeting.

Is there leave of the committee to grant that request? *[Agreed]*

Okay. And we'll get to him after we go to the final witness on Bill 56, which is Grand Chief Arlen Dumas from the Assembly of Manitoba Chiefs.

I'll now call on Chief Dumas and ask the moderator to invite him into the meeting. And I ask that Chief Dumas unmute himself and turn his video on. There he is. It is very good to see you, Chief Dumas. Welcome to the committee meeting, and I encourage you to proceed with your presentation. You've got about 10 minutes.

Mr. Arlen Dumas (Assembly of Manitoba Chiefs): Thank you. It's Grand Chief Dumas.

I'd like to speak on the bill, Bill 56. The Smoking and Vapour Products Control Act is yet an unjustified intrusion of the Province of Manitoba on the jurisdiction of First Nations. Bill 56 is not about smoking and health, though that is how the government has decided to spin it. What the bill actually does is attempt to legislate in an area where the Province has no jurisdiction by ignoring the constitutionally protected rights that First Nations have.

Putting this bill under health is extremely disingenuous. And it's disingenuous of this government to claim that the purpose of this bill relates to health and all Manitobans. But this very government has proven time and time again that it does not consider First Nations to be included as Manitobans.

When the COVID-19 crisis hit, what–where was this government to *[inaudible]* the province. Why did Premier Pallister claim that it would be unfair to Manitobans for First Nations living in this province to get a separate supply of vaccine under the federal vaccine and distribution plan? Why has Premier Pallister stated that the health and welfare of Indigenous Canadians is the responsibility of the federal government?

First Nations have constitutionally protected inherent rights to self-government. These rights have been recognized by the provincial government in the past. The reason why the exemption from the smoking ban on reserves exists was explained in a letter dated June 11th, 2004, from the provincial government. The act recognizes First Nations governance jurisdiction within their communities and, as such, the smoking ban will only apply to areas where the Province has clear jurisdiction and will not apply to reserves.

Not only has this government decided to ignore our First Nations inherent right to self-determination, but it has also decided to ignore the bylaws that certain First Nations in Manitoba have passed under the Indian Act. We see this bill for what it is, and it is not about health or smoking. This bill is a signal that this government does not respect the constitutionally protected rights of First Nations.

* (18:40)

What makes the situation particularly egregious is that–this government withholding the VLT–holding the VLT revenue hostage that First Nations in this province desperately need. If the chiefs do not agree to the smoking ban, Manitoba Liquor and Lotteries has threatened to deactivate VLTs and the termination of VLT site-holder agreements. Instead of engaging in nation-to-nation discussions with any of the First Nations in this province, this government has attempted to pass legislation unilaterally without consultation and outside of it, its–outside of its jurisdiction, with a substantial financial threat if there is no compliance. It is shocking that this government is resorting to this type of behaviour.

Furthermore, the Supreme Court of Canada has established exactly what consultation is and how it should be brought forward. Having somebody talk at you and send you an arbitrary letter after clandestinely planning to circumvent the jurisdiction is completely disingenuous. If you're going to consult with people, you need to do exactly that. You need to sit down; you need to have a conversation and not try and figure out precarious ways to get around meeting with First Nations' governments and addressing these issues.

I can tell you myself, as Grand Chief, on numerous occasions we have attempted to have meaningful and participatory conversations with this government on a variety of issues, and despite those efforts, there's been no effort made to actually speak and talk with First Nations' governments in a meaningful way. And in listening to Minister Gordon's comments about having a meeting on Friday that magically appeared, that's not consultation, and that, unfortunately, is exactly the reason why I was unable to attend that meeting because I would normally–it would be used as a form of consultation to pad the record as to whether or not you consulted with First Nations, and it's unacceptable.

We–I demand that this bill be struck down because what you will actually facilitate is, due to the 'unforceability' of this bill, you will actually cause a lot of criminal activity to begin. You will actually force people to actually push boundaries that don't need to be pushed. If you truly wanted to address this issue in a meaningful way, our chiefs are more than reasonable. We have shown, through our own processes, that we respect health issues, that we

address these issues on our own right, and we certainly don't need anyone else coming to dictate to our communities what we can and can't do.

If you want to have a meaningful solution to this issue, then you need to come to the table and we need to talk as equals, not to be talked down to, especially from a government that obviously is not well-versed in what consultation is and are not well-versed in what our rights and jurisdictions are in our territories and in our communities.

So, thank you very much.

Mr. Chairperson: Grand Chief Dumas, thank you so much for your presentation.

Do members of the committee have questions for the presenter?

Ms. Gordon: Thank you, Grand Chief Dumas, for joining us this evening and for your presentation. I value and appreciate your feedback and consider you to be a friend. It's–you're someone I have a deep respect and admiration for and really appreciate hearing your comments.

Unfortunately, due to schedule conflicts, you were not able to join us last week for the meeting. We had a very good conversation with Grand Chief Settee and hope to continue to, as you say, Grand Chief Dumas, to come to the table and have meaningful and respectful conversation.

I do want to ask you if you are aware of this type of exception or exemption that exists in our Bill 56 appearing in any legislation across Canada, in any other jurisdictions, if you–are you aware.

Mr. Dumas: Sorry, I can't speak on behalf of other regions, minister. *[interjection]*

Mr. Chairperson: Minister Gordon, go ahead.

Ms. Gordon: I do also want to put on the record that it was not the–CancerCare Manitoba's position on Bill 56 was not a request made by our government. So whether they put out a statement in support of or withdrew a statement is–that was not initiated by our government.

I also would like to say once again that we respect First Nations and Indigenous peoples' right to self-governance, and the legislation does not–there's no intention in terms of this legislation to remove your right to establish bylaws or to have paramountcy over this–the repealing of this section of Bill 56.

So I do want to put that on the record, and to once again say we have written to all 63 First Nation chiefs and band councils–the grand chiefs as well, as Chief Dumas has alluded to–and we are open to engaging and having meaningful and respectful conversation.

Thank you, Mr. Chair.

Mr. Chairperson: Grand Chief Dumas, would you like to respond?

Mr. Dumas: Yes, certainly.

Again, consultation is a very specific issue, having a conversation is something otherwise. And, you know, the merits–the legal merits of consultation are what will bring this issue forward. And if you want to have a meaningful discussion on consultation, then we should do that; therefore, you'd miss some of the obstacles that are going to come about and reduce the conflict that will come about from this legislation.

So again, I implore the government to actually strike this bill–and so that we can actually have consultation in a meaningful way and talk about things on how we can collectively move forward.

Thank you.

Mr. Chairperson: Thank you, Grand Chief Dumas.

Mrs. Smith: I want to thank you, Grand Chief, for coming to present.

So, I have a question on meaningful consultation. The minister talked about, you know, sending a letter. And I know the minister is new to her portfolio, I know she's a new MLA, she's new to government, you know, but she's talked about having good relationships with First Nations.

We asked the minister during debate time to withdraw the bill and to go back and consult with First Nations, but here we are, you know, in committee stage, you know, rolling–steam ahead, you know, without proper consultation, trying to call a meeting a couple of days before committee so that, you know, again, you outlined it, can say that there was consultation that happened.

So, can you, you know, just talk about what it would mean if the minister would withdraw this and actually do meaningful consultation with First Nations.

Mr. Chairperson: Grand Chief Dumas, you've got about 40 seconds.

Mr. Dumas: It would be incredible, and it would be a good–show of good faith to First Nations in Manitoba

that there is an actual appetite to work together collaboratively to address this issue and to address the peripheral issues associated. And I think it's the right thing to do.

Again, I said talking at somebody, or sending a letter to somebody is actually not consultation. Consultation is actually a prescribed legal process that everybody needs to agree to. And in order to do what's right for everybody, we need this legislation struck down and we need to have meaningful conversations and consultation with people.

Mr. Chairperson: Okay, that concludes the time that we have for questions for you, Grand Chief Dumas. I thank you very much for coming to committee tonight for presenting and be willing to answer the questions also from members.

We'll now move to the next presenter, which is that substitution that I spoke about earlier.

All right. I will then call on Mike Sutherland to join the meeting. I ask the moderator to invite them in.

Mr. Sutherland, I ask that you unmute yourself and turn your video on.

Oh, but he's not present. Okay. We'll drop him to the bottom of the list and hopefully be able to get back to him.

Bill 67–The Public Health Amendment Act

Mr. Chairperson: We'll now get to the presenters for Bill 67.

So the first presenter that we have for Bill 67 is Darlene Jackson, from the Manitoba Nurses Union.

* (18:50)

So I call on Darlene Jackson to–and ask the moderator to invite them into the meeting. And I ask Ms. Jackson to to unmute herself and turn her video on.

Welcome, Ms. Darlene Jackson, to this committee meeting. Thank you very much for appearing this evening. You may now begin with your presentation. You have 10 minutes.

Ms. Darlene Jackson (Manitoba Nurses Union): Good evening, committee members. My name is Darlene Jackson, and I am the president of the Manitoba Nurses Union. I'm here today to speak on behalf of the Manitoba Nurses Union regarding Bill 67, The Public Health Amendment Act.

As you know, this act would amend the current Public Health Act to give the chief public health officer the ability to issue orders restricting individuals' capacity to work at more than one health-care facility during an epidemic.

First of all, this bill is yet another example of the effects of a profound and long-standing lack of investment in the long-term-care sector in our province. According to a recent investigation by the CBC, nearly 50 per cent of the COVID-19 deaths that have occurred in Manitoba have been among residents of long-term-care facilities.

While some have pointed out that Manitoba is not unique in terms of this issue, its own culpability was clearly and shockingly underscored in terms of the tragic and unprecedented losses of life in many of Manitoba's personal-care homes. These losses were the grave consequences of a government's failure to resource, monitor and ensure the provision of adequate and life-saving care to its long-term-care residents.

The most pronounced example of this failure was what occurred at the Maples Personal Care Home in the fall of 2020. The media exposure and scrutiny associated with this event forced this government to respond, which it did by calling an investigation in what had occurred. I could go on at length about the many shortcomings outlined in the investigative report, but the report outlines those exhaustively for you.

The reality is that nurses have been aware for quite some time that the acuity of residents in long-term-care facilities has been steadily increasing but without a corresponding increase in resourcing. Greater numbers of residents with significant chronic health issues, Alzheimer's, dementia and chronic health conditions put growing strain on the limited number of staff in these facilities. These staff members then struggle to provide the care they know the residents need and deserve.

MNU for years has been calling for increasing the number of nursing-care hours per resident per day in the long-term-care sector. The urgency of and justification of that call has never been more substantiated than it has been throughout this pandemic.

This pandemic has changed our lives, and arguably, nothing has been more severely affected than our long-term care of our elderly. Prior to the implementation of the single-site order, nurses frequently held down multiple part-time positions at multiple

facilities in order to obtain an equivalent semblance of full-time employment.

Early in the pandemic, the government issued the single-site order supposedly as a means to reduce risk of transmission by staff from site to site. A similar restriction was contemplated for nurses working in both acute- and long-term care sectors due to the fact that there was a multitude of outbreaks in acute-care centres, which have ostensibly have been–could have been imported into long-term-care facilities. However, in this case, that plan was abandoned after a brief trial period. Just weren't enough nurses in Manitoba to 'susain' care if the same precautionary measures had been imposed on nurses concurrently holding positions in both long-term-care and acute facilities.

While we're on the subject of government suggestions that health-care staff import infections into facilities, we feel it's necessary to highlight the outcome of another initiative that was undertaken. It is our understanding, in the recent past, COVID-testing swabs were performed on some 1,800 occasions on nurses and other health-care workers in the long-term-care sector. Of those tests, only two were subsequently confirmed to be COVID-positive.

Given that information and the lack of any significant data to 'provude'–prove its necessity, we question the rationale behind the continuation and expansion of the single-site restriction and its codification into The Public Health Act.

We know there are significant and profound nursing shortages that exist that do not allow for some practical applications of this restriction beyond the public health sector–or, the personal-care sector, excuse me. Yet the amendment now includes acute- and home-care nursing.

Furthermore, the amendment condones a suppression of collective agreement rights of nurses under the standard of reasonableness. But we asked, reasonable as a–determined by who? What recourse is available to a nurse when they believe that conduct is not reasonable or there is a dispute as to whether the conduct is reasonable?

Rather than introduce legislation amendments with limited and transitory impact, patients would be far better served by government focusing on and introducing lasting and meaningful improvements to the long-term-care sector; incentivize nurses to return to PCHs; introduce measures to ensure gainful, full-time employment can be achieved without the necessity to take on multiple part-time jobs; inject appropriate funding for resourcing into these facilities so that nurses are not run off their feet and can actually take a moment to provide necessary care and meaningful human interaction to their patients and residents.

The reality is that the long-term-care sector and its evolving needs have been neglected for far too long. The neglect has directly resulted in the unprecedented loss of far too many lives. Simply put, those residents' lives were cut short and their loved ones lost them too soon.

There is a pathway to tangible improvement, but it needs real and sustained action, not short-term illusory measurements, that truly deal with the grave issues. The bill is not an answer to the–Manitoba's long-term-care issue.

Thank you for your time and consideration.

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

Do members of the committee have questions for the presenter?

Hon. Heather Stefanson (Minister of Health and Seniors Care): Can you hear me okay? Okay, great, just–

Mr. Chairperson: Yes, we can.

Mrs. Stefanson: Yes, just not a question, just a comment.

Darlene, just wanted to thank you for taking the time out of your–what I know is a very busy schedule and presenting to us this evening the views of your members. Really appreciate you taking the time and look forward to the continued dialogue that I know that we have shared so far.

Mr. Chairperson: Ms. Jackson, would you like to respond to the minister? Up to you.

Ms. Jackson: I know we've spoken about this issue, specifically with regards to the funding for long-term care, Minister Stefanson. So, thank you for bringing me into those meetings and speaking with it about this.

Mr. Chairperson: Other members with questions?

MLA Uzoma Asagwara (Union Station): I want to thank Darlene for a really great presentation. Your insights are valuable and also want to thank you for fighting so hard on behalf of those you represent throughout this pandemic and before this pandemic.

I would like to touch on something that has sort of come up as a theme already in terms of consultation. I am pleased to see that obviously you and the minister have been in communication. We know that meaningful consultation is critically important to informed decisions being made.

Can you advise, Ms. Jackson, as to whether or not the–your union was–and your members consulted about the creation of this bill?

Ms. Jackson: No, there has been no consultation.

We were informed of it about the same time as the public was, and I continuously say that in order to provide the best possible patient care in this province you need to bring the health-care experts to the table, and that's the nurses in this province; those front-line nurses need to be spoken to; they need to be included in these conversations.

MLA Asagwara: Thank you, Ms. Jackson.

So, along with there being a theme already here this evening about the importance of meaningful consultation, there also seems to be a bit of a pattern emergence–emerging on the part of the government whereas maybe they're constructing consultation as asking people for their opinions after the fact, after legislation has already been drafted, after it's already been put forward and essentially long after the period where meaningful consultation could've and should've taken place.

And so I'm wondering, although you've laid out some really great pieces of information in your presentation, I'm wondering if you could articulate, Ms. Jackson, for us what meaningful consultation should have looked like, at what stage it could've been taking place and what it should look like moving forward.

* (19:00)

Ms. Jackson: Well, that's a great question because I do speak about bringing nurses to the table, ensuring that those front-line providers have had their say. And you're right, it means more than just finding out about a bill when it's been drafted. It means actually having some consultation prior to the bill being drafted.

And we've put it out there, the Manitoba Nurses Union has put it out there many, many times that we are more than happy to assist and provide solutions. That's what nurses do: they bring a problem, they bring a solution with it. And I think Shared Health has been witness to that, just with all the redeployments and nurses that have come forward to speak about what could work better, how do we make this situation tenable.

And I really wish that we were brought into the discussion prior to the drafting of the legislation.

MLA Asagwara: Thank you, Ms. Jackson.

You did touch a little bit on–I believe in your comments in your presentation–about collective bargaining. We know that hasn't been available to health-care workers now for the entire duration almost, under this government.

And I'm wondering if you can talk a little bit about the impacts of that lack of collective bargaining in the midst of a piece of legislation like this being brought forward, something that would impact the employment of these workers should these decisions be made under this legislation.

Mr. Chairperson: Ms. Jackson, you have 15 seconds.

Ms. Jackson: We've long advocated for larger EFTs to ensure that people have a living income where they work, and that is nothing different than what's on the table right now with our bargaining proposals.

It's all about retention, recruitment and having a living income for nurses.

Mr. Chairperson: All right, that brings us–thank you very much, Ms. Jackson, that brings us to the end of the time for questions for you. I want to thank you for appearing at the committee this evening and for your presentation and your willingness to answer the questions from the members.

So, we'll now proceed to the next presenter. So, I'll call on Shannon McAteer–I'm not sure how to pronounce that–McAteer–and ask the moderator to invite them into the meeting.

And I ask Shannon to please unmute themselves and turn their video on.

There you are, I can see you now and I'm sure you'll be happy to let me know how to pronounce your name, Shannon–your last name, at least. But you've got 10 minutes to proceed with your presentation. Thank you.

Ms. Shannon McAteer (Canadian Union of Public Employees): Thank you. It's Shannon McAteer.

I'd also like to acknowledge that I am coming to this meeting from Treaty 1 land here in Winnipeg and I represent CUPE, which is the Canadian Union of

Public Employees. We represent about 37,000 members here in Manitoba, and more than half of that are within the health-care sector, both public and private.

This current–the amendment to Bill 67, I think we should acknowledge that this order with–it's currently an order that has already been in place for a year–the restriction of working single site has been in place for a year already. And that has had a profound effect on the staff.

CUPE, as well as the other unions–my colleague Darlene had already mentioned about the staffing ratio or the funding ratio, the care-hour ratio, whatever we want to call it that–we have also been calling for years for that to be increased. We've also, for many years, been talking about the fact that there is a crisis in the staffing levels in long-term care. And that has been around for, goodness, more years than is acceptable to be talking about it.

And the term working short has become part of the vernacular, it's a term that everybody knows about, everybody talks about the fact that, well, we're working short today because that's the norm, not the exception anymore.

Unfortunately, this has led to the horrible situation that happened during the pandemic at Maples personal care home. But there was others as well; Maples just happened to hit the news. There was other personal-care homes that were also struggling just as much during that time.

And this amendment does speak to the fact that it would expand it not just for personal-care homes but to the acute facilities as–or, the hospitals, as well as other health-care facilities, with no definition of what these other facilities would be.

And again, as Darlene had mentioned, the government had done this–they did a pilot of it last summer–from July 'til September, I think it was–restricting working between the acute facilities and the personal-care homes. And it was the government that–or, the employer that stopped that pilot because it wasn't working and it was creating other staffing issues within the system.

So, currently, if staff work–especially in the support sector, we still have many, many members and employees that work more than one position, sometimes three or four, to even get close to full-time hours.

Now, these span between the private and the public, so the benefits and the pensions that are connected to those positions, they're not always the same and they're very different.

So, if I am currently restricted from working at a personal-care home, I am technically put on a leave of absence from my other employer, which means I have to–if I'm going to maintain my benefits, I have to prepay them, and that's both the employer and the employee's portion, and under the HEB rules, which the majority of the health care–the public health-care workers under CUPE belong to HEB, you can only do that for one year. And, again, we are already at that one-year mark.

So, it's concerning, and staff are losing income. This is affecting their income. They are not able to work both their jobs so they're not able to work the hours that they normally work. They're only allowed to pick up two–what we call an equivalent full-time, so 1.0 is a full-time position–so they're allowed to work up to 1.3 EFT, but then anything after that, it's not guaranteed that their hours will be made up. And that is affecting families. It's affecting everybody in–especially in this horrible pandemic that we're in right now. It's really affecting, as well as the stress of working in COVID, the stress of, like, their financial situation. We hear it all the time. The uptake for EAP has gone up hugely during COVID, and not in any small part to the financial stress that the members and the staff are under.

Also, during this pandemic, when the wave two occurred, the employer came out–or the government came out with an exemption list so that, because of the staffing situation, because of the crisis, there's now exemptions that you can work at two personal-care homes if you're on the exemption list.

So, we're restricting staff, but yet we're having exemptions when it works for the employer or the government, but not allowing the employees to return to their–both of their positions or three positions, whatever the case may be.

I don't think we can under–or downplay the impact, the psychological, physical and emotional impact, that this pandemic has had on the employees, the staff, the members that have been working in the last year under stressful and horrendous conditions. And, again, I want to highlight that those–some of those conditions existed prior to COVID. This is not just COVID-related. The staffing crisis has been around for far too long.

I'm going to just comment for a second about the–we keep talking about meaningful consultation, and

it's almost becoming a buzz phrase, where it's–and I hear it a lot–I hear it a lot from individuals that I speak with, from the government and from the employer, and I can tell you we–our latest outreach to the government was officially in June of 2020. We sent a letter to the then-minister of Health about the staffing ratio and many other–staffing crisis and many other issues within long-term care, specifically within Manitoba.

We never even received a response, a callback. We never received anything. So, MNU, I understand, has had a conversation with the minister; we have not even had a response to get our concerns heard. So I just wanted to point that out.

The government is also, during this–for going–COVID–they've got the–a few incentives, a few–pandemic pay. There's so many different terms that are being used for it, the first one being the 14-day admin pay, and then–for individuals who did not have sick time, and then the second most recent one would be the caregiver amount. And they were great announcements; they sounded wonderful. The problem is is when the implementation came in, the number of individuals who actually qualified was very small, and we actually have grievances pending around that.

So, the staff are feeling undervalued and under-heard, and now we're talking about adding another year of this restriction of working at single sites. And it's causing a huge burden. I'll say it's an additional burden on the staff.

* (19:10)

So, we are–CUPE, much like my colleague, are calling on the government to not–not to make these amendments. We don't need to make these amendments. There's other solutions that can happen; the vaccines are rolling out; maybe not quick enough, but they're definitely rolling out.

There's other things that we can do here. We don't need to affect individuals' income. We don't need to affect their benefits. We don't need to affect their home life by restricting them to working at one site.

And I think I'll leave it there.

Mr. Chairperson: Thank you, Ms. McAteer, for your comments this evening.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: Just wanted to thank you, Shannon, for taking the time out of your schedule for tonight and for coming here and presenting, and for your feedback on behalf of your members. Appreciate you taking the time.

Mr. Chairperson: Ms. McAteer, any response for the minister?

Ms. McAteer: No, thank you.

MLA Asagwara: I want to thank you, Shannon McAteer, for your presentation and for sharing the insights that you've garnered from your members.

You highlighted some really key areas, some issues and areas of concern that are really important to be addressed. I was certainly–and I thank you for also voicing that you folks haven't gotten a response from the minister's office on the issues that you've brought forward, and I would certainly encourage the minister's office to reach out to you folks and bring it to the table on this issue.

I'm wondering, Shannon, if you could share whether or not you think it was a wise decision for the government to bring this bill forward, given all of the issues that you've outlined that apparently haven't been addressed at all, with the order as it currently stands.

Ms. McAteer: No, I don't believe it was a wise decision. The–we negotiated last–goodness, like three or four months ago now–what was–been come to be known as a memorandum of agreement No. 2, regarding redeployment and this fact that staff would receive financial incentives for being redeployed or having to work in a different facility or in a different shift, but the personal care home staff were left out. They are not–were not included because of the caregiver, that they–because they were qualified for the caregiver amount, but that amount ended in January and they're still not included.

So, no, I don't believe it's a good idea to extend this–or bring this bill forward at this point.

MLA Asagwara: Thank you for that information.

I'm also wondering if you could share your thoughts on what actions the government could take. What could the Minister of Health do in–you know, instead of this piece of legislation, over the next one year, because it is a time-limited piece of legislation.

What actions could be taken within the year to actually address the issues that this bill is purporting to address?

Ms. McAteer: I think the first thing we need to do is they need to sit down with the front-line workers, the people who are actually performing these services and providing this care to the residents, and–because I'll tell you–they've got great ideas and they can probably solve most of this–these issues right now. But I think the biggest thing is we need–there needs to be funding put in place to support the staffing levels so that there's adequate staffing levels at every personal care home.

MLA Asagwara: Thank you so much for that. I'm really glad to hear you touch on staffing. That is something that, and you're right, was an issue before the pandemic and certainly has been an issue during the pandemic. And there are concerns about beyond this pandemic.

So I'm wondering if you have any thoughts on how this piece of legislation, given what you know workers are going through, might impact the recruitment and retention abilities in regarding–in regards to staffing?

Ms. McAteer: I can tell you it's already affecting recruitment because we have individuals–members–who are being denied positions because they would have to quit the job at their other personal-care home in order to take it.

So, it's–the current order is affecting recruitment and retention, and if someone is going to be restricted, why would they want to take a job at a facility if they can't work anywhere else within the personal care home system?

MLA Asagwara: I just want to reiterate my thanks to Ms. McAteer for taking the time in the evening to share and to present and to bring forward some really important feedback, suggestions and to amplify the voices of your members. So, thank you so much for doing so. We appreciate it; I appreciate it, and I hope that you take good care and stay well.

Mr. Chairperson: Honourable Mr. Gerrard, we have 30 seconds.

Hon. Jon Gerrard (River Heights): Okay. Thank you very much for your presentation, Shannon McAteer. Were you in any way consulted before the public health order was put in place originally?

Mr. Chairperson: Ms. McAteer, a short response please.

Ms. McAteer: Like before the order that's in place was enacted? There was–we were told that that was going to be coming, so, not consulted; informed.

An Honourable Member: Yes. Thank you.

Mr. Chairperson: That concludes–thank you, Honourable Mr. Gerrard–that concludes the time that we have for the questions for this particular witness.

Bill 10–The Regional Health Authorities Amendment Act (Health System Governance and Accountability)

Mr. Chairperson: We will now proceed to the next set, which is under Bill 10, and a familiar name tops the list. Darlene Jackson from the Manitoba Nurses Union.

So I'll now ask the moderator to admit Ms. Jackson into the meeting, and I'll ask Ms. Jackson to unmute herself and to turn her video back on.

And the floor is once again yours for 10 minutes.

Ms. Darlene Jackson (Manitoba Nurses Union): Thank you. Once again, my name is Darlene Jackson, I'm the president at the Manitoba Nurses Union which represents more than 12,000 nurses in our province. Our mandate is to improve working conditions for nursing as this allows them to provide the quality, safe patient care that they are dedicated to providing. Nurses are deeply committed to our patients across the province in every regional health authority, and we know that there are important differences in every region.

There are key aspects of The Regional Health Authorities Amendment Act that we believe will impact our members' ability to provide the patient care that they believe is necessary and appropriate. This proposed act is entirely top down, not bottom up, and begs the question: why does this act even keep the word regional in regional health authorities?

We are concerned that this bill prioritizes fiscal matters over patient care. We recognize the need for careful management of health-care dollars, but this bill's creation of accountability agreements and expectation of strict adherence to them by each health–of the health authorities places fiscal concerns above the needs of patients. It binds the hands of those in charge of health authorities and limits their ability to adapt and respond to the changing needs of residents living within their region.

The fact is that health-care needs of residents are not always predictable. Forcing regions to a strict adherence of budgets will be a means to a loss of flexibility. We are concerned about the elimination of capacity of regional health authority to address the

particular needs of their residents and the loss of the local regional lens.

There are several examples, but I'd like to highlight one for you. The current act states in 23(1) that a regional health authority is responsible for providing for the delivery of–delivery of and administering to health services to meet the health needs of its health region in accordance with the act and the regulations.

The Regional Health Authorities Amendment Act changes this to: a regional health authority is responsible for administering and delivering, or providing for the delivery of, health services in its health region in accordance with the act; the provincial clinical and preventative services plan and the regional health authorities strategic operational plan.

This will have serious implications as most Manitobans understand that the health-care needs of those in the North are completely different from those needs in Winnipeg. A true regional health authority should be empowered to account for local and regional needs in the health-care services they deliver. Under the RHA amendment act, this ability is lost. We already see this evidenced in Shared Health's Clinical and Preventive Services Plan.

We are concerned about the standardization of care and services across all health care–health authorities. Our view of this is similar to what I just mentioned about RHAs. Although standardization may increase consistency and predictability of costs, it also reduces flexibility and can lead to service delivery that doesn't account for the particularly–particular needs of the individual patients. We are concerned that the reduced consultation with other organizations and the public in drafting of important plans–this RHA amendment act instead sees them as conducted as directed by the minister–RHA amendment act 23(3) and 24(2).

* (19:20)

Is the minister really the appropriate person to determine which stakeholders in the various regions of the province are the most important and appropriate to consult? This language undoubtedly opens a door to the possibility of less rigorous consultations or expedited consultations.

An additional change is this act is the–for the elimination of the local health involvement groups, which affect the public's ability to participate in health-care planning and provide feedback on services.

We are concerned about power being concentrated in the hands of the minister and the provincial health authority. Overall, this bill appears to clearly diminish the powers of regional health authorities, subject them to planning and oversight of the new provincial health authority and enhance the power of the Health Minister.

To conclude my remarks this evening, I, on behalf of the Manitoba Nurses Union, state our 'opposation' to the–opposition to this bill for the following reasons.

In this bill, we see that fiscal restraint is 'priorterized' over patient care. Regional health authorities see diminished abilities to respond and tailor their services to the needs of the residents living within their boundaries. In this bill, we see increased standardization of care that deprives patients and health-care providers of the flexibility needed to address individual care needs.

We see a lack of clarity and vagueness regarding consultation with stakeholders, as well as the discontinuation of public input that was done by the local health involvement groups. We see a higher position given to the provincial health authority centred in Winnipeg and the concentration of power in the hands of the minister.

In addition, we feel that information must be provided around the purpose and intent of standards committee and contend that blanket refusals of access to information or records should not be included in the legislation.

Thank you for listening to my presentation.

Mr. Chairperson: Thank you so much, Ms. Jackson.

Do members of the committee have questions for the presenter?

Hon. Heather Stefanson (Minister of Health and Seniors Care): Just–no questions, just wanted to thank Darlene for once again taking the time and–to articulate the views of her membership and just thanks for taking the time this evening.

Mr. Chairperson: Ms. Jackson, any response to the minister?

Ms. Jackson: No, I have no response.

MLA Uzoma Asagwara (Union Station): Yes. I would echo the minister's sentiments there. Ms. Jackson, it's wonderful that you made the time to

present on this bill as well. Appreciate you bringing the concerns of your membership forward and advocating on their behalf.

I just have one question. You know, in this–we're in this pandemic, we've been in this pandemic now for over a year, and we're going to be in this pandemic for quite some time to come.

Given the–what we've seen during this pandemic, the impacts it's had on communities, the issues that have been amplified during this pandemic, how–just how much more pressing–or is it more pressing–the issues that you outlined here very well today–how seriously does this minister need to reflect on this bill, given everything you've seen during this pandemic?

Ms. Jackson: I think there has to be very serious reflection on this bill.

We're seeing in the North right now outbreaks that are unprecedented, and trying to keep on top of those outbreaks in very remote rural communities takes a tremendous amount of effort, and from what I have been told, the RHAs–the northern RHA is absolutely thinking outside the box on how to deal with those.

And under this amendment, it does not really allow out-of-the-box thinking. So, I think it's so important to ensure that there is some type of autonomy within the regional health authorities, because every region has a different issue that needs to be dealt with and different patient issues that need to be dealt with.

Mr. Chairperson: All right, any other members with questions?

Hon. Jon Gerrard (River Heights): Yes. I think one of the things which is very disturbing–and you have pointed this out–is the lack of local input.

I suspect, from your experience, you've got some examples of how valuable that local input has been and how it has worked in the past, and I just want to give you an opportunity to talk about that, and again, thank you for being here and presenting.

Ms. Jackson: We've always, in the North, had much, much community support and community, I guess, consultation.

Part of the issue in the North–and I'm going to speak to that because that's what I'm really familiar with–is the–we have reserves that are within our catchment area because the North is a huge catchment area, but are–some of them are funded both provincially and federally, some of them are totally federally funded.

But one thing I have to say is that the RHA in the North is very committed to bringing those individuals to a table, listening to their concerns. And we understand that there are populations that need a different direction in health care, that need to have issues specific to them dealt with.

So I will say that the RHA has been very, very receptive into–in having that consultation with many of those individuals, with many of those communities and they understand how important that is to ensure that every northerner receives the care they need and the care they deserve through the RHA.

Mr. Chairperson: Honourable Mr. Gerrard, a follow-up question?

Mr. Gerrard: Yes, thank you and, I mean, your experience in the North is particularly important because we need to be able to give care to everyone all over Manitoba and, if we can't effectively form these partnerships, then it's, you know, it's a detriment to everything we're trying to achieve.

So I just want to say thank you very much for your comments and your insights.

Mr. Chairperson: Ms. Jackson, any closing remarks?

Ms. Jackson: No. Thank you very much for taking the time to listen to my presentations.

Mr. Chairperson: All right, thank you very much, Ms. Jackson, for appearing once again before committee this evening. We thank you for the time that you put into this and your willingness, also, to answer the questions of our members.

So, we'll now move to the next presenter. I'll call Brianne Goertzen to come into the meeting and ask the moderator to invite them into the meeting.

And I'll ask Ms. Goertzen to unmute herself and turn her video on.

There you are, Brianne. I see you once again. It is good to see you and I invite you to begin your presentation. And you've got 10 minutes.

Ms. Brianne Goertzen (Manitoba Health Coalition): Good evening, and thank you to the members of the standing committee for having me.

My name is Brianne Goertzen and I am the provincial director of the Manitoba Health Coalition. The Manitoba Health Coalition is a non-profit, non-

partisan health care advocacy organization that advocates for the preservation, the expansion of universal health care in the province.

While we are a relatively new organization, we are affiliated with the Canadian Health Coalition, a national organization which has been active since 1979. We believe that health care must remain public and is a right.

Our organization is concerned with a variety of areas contained within The Regional Health Authorities Amendment Act (Health System Governance and Accountability). We would like to take our time today to highlight the following areas of concern: centralization of power, the loss of local input and the clearing of the path to privatization and continued service cuts and reductions.

There are a number of examples from other provincial jurisdictions that have followed similar legislative changes which have been to the detriment of health care, including to the patient and to the front-line workers that provide that care.

The first area of concern that we would like to highlight is the further centralization of authority in the Minister of Health's office at the expense of the regional health authorities. As we have all learned during the pandemic, health-care decisions can become highly politicized when the decision makers hold political office. We can look no further than our neighbours to the south to see examples where political ideology drove public health decisions in places like Florida.

Even here at home, our own government has been criticized for taking victory laps for the handling of the first wave when it would have been better served preparing for the second wave, though we all love Chicken Chef. So forgive us for being concerned that this government is currently contemplating legislation which would further empower the Minister of Health and Seniors Care (Mrs. Stefanson) at the expense of the experts in the regional health authorities when it comes to the provision of local health care.

It wasn't so long ago in Manitoba that it was the Progressive Conservatives who, as champions of rural Manitoba, championed local decision-making and feared the centralization of power here on Broadway. But this proposed governance structure laid out before us in Bill 10 ensures all roads lead to Broadway, right up to the Minister of Health and Seniors Care's desk.

Additionally, it is clear in this legislation that the minister's directives must be followed by the provincial authority, Shared Health.

* (19:30)

Our question is: What if that directive is contrary to the provision of quality patient care? What protections are offered by way of a whistleblower or will we just see resignations of top officials when political interference reaches fevered pitches, as we have seen elsewhere, such as in Manitoba Hydro?

The one-size-fits-all approach contained in Bill 10 not only hampers provincial health authorities through additional red tape and approval processes but this bill eliminates, with no clear replacement, the local health involvement group. Local health involvement groups, as operational in the regional health authorities, act as–our act–are established under section 32, wherein a regional health authority shall establish local health involvement groups to explore and provide advice to the board of the authority on issues that impact the delivery of health–local health services.

Bill 10 eliminates this advisory group. As demonstrated through the Nova Scotia example, the one-size-fits-all approach has resulted in slow-to-respond central body. The unique needs that are located throughout the province are not being brought to any decision makers within the authority structure and certainly is absent from the minister and Shared Health level.

In fact, we would argue that this bill is going in the exact opposite direction. We should be looking for more regional involvement and we should be looking to hear from more everyday, regular Manitobans about their experiences in the health-care system.

Adding to the complications with the elimination of the local health involvement groups is the current makeup of the boards of regional health authorities, where appointees are far more likely to come from the business and corporate sector than they are from health professions or community organizations. When your appointments lack both health-care experience and community organizational experiences, you start losing sight of the issues facing the communities in which the appointees are making decisions for. Instead, decision making becomes a numbers game and you lose sight of the lived reality on the ground.

The current legislation exasperates this problem by both removing local voices and ensuring that cost

savings are the No. 1 criteria on which all decisions are made.

One has to look no further than the recently tabled budget, which actually included a cut to acute care during a pandemic, to see how committed this government has been to rolling back long-term care spending.

This leaves me to my final point. It is clear to us that Bill 10 is designed to clear the path for further privatization within our public health-care system. The centralization of health-care service decisions in the minister's office and the elimination of oversight from medical and health-care providers and service recipients will place cost savings or the promise of cost savings at the centre of decision making. This isn't what Manitobans want and it's certainly what we don't want during the third wave of a global pandemic.

So even if you don't share concerns, we would implore this government to just stop with the health-care reforms. Our health-care system and the person–people who work in it are under unprecedented stress. They do not need to fear this government is going to further implement unpopular and ill-fated reforms; to fear whether this government plans to move them once more or worse, privatize their work and leave them unemployed. This is not what Manitobans want you working on.

Provide health services, get people vaccinated, keep COVID under control and keep Manitobans safe. That's what we care about.

Thank you.

Mr. Chairperson: Thank you, Ms. Goertzen, for your presentation.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: Well, I just wanted to thank Brianne for taking the time and presenting on behalf of the Manitoba Health Coalition tonight. Appreciate your comments. I took some notes here and thanks again for taking the time.

Mr. Chairperson: Ms. Goertzen, any response to the minister? Up to you.

Ms. Goertzen: I look forward to an email response from her.

MLA Asagwara: I'd like to thank Brianne Goertzen for that solid presentation. It was very, very thorough in a very compact and concise amount of time. Your expertise really comes through and I do have a couple of questions because I think that you can really help shine a light on some areas of concern of this bill that I think the general public would benefit from hearing your expertise on.

So, if you wouldn't mind, could you talk a little bit about the privatization concerns that you have and why those concerns need to be understood by Manitobans.

Ms. Goertzen: I think what's really interesting and really important to point out within this bill is when you centralize the power and the decision making, you're essentially creating one authority with the minister.

And so when they house all the decisions, they can actually decide where the service provision is going to go. So, if they wanted to contract out say, for example, to Dynacare, which is a private provider, it becomes easier for them to do such a thing.

If we look to different provinces like Alberta, they have cleared the path for this in similar legislation. And so that is problematic when you've thinking about access to care. And, again, I'll point to the States that does have a privatized health-care system: an inability to access care amongst all its residents. And I think what Canadians, and especially Manitobans, have repeatedly shared amongst public polling is that they value and they respect that our public health-care system is public and that they can actually frequent a hospital with their health card and not have to worry about the amount of dollars in their bank account. What we don't want to see as an organization is for this public good to be further eroded in order to set the conditions necessary to privatize.

MLA Asagwara: Thank you for that, Ms. Goertzen. I'm also wondering if you can talk a bit about–because I know that the Manitoba Health Coalition does a tremendous job of incorporating data, local data, research and evidence in formulating reports and information that can be very useful–is incredibly useful–in developing health policy.

Can you talk a little bit about the data and the research that you've been able to access during this pandemic that would raise further concerns in regards to Bill 10?

Ms. Goertzen: I think the inability to actually access timely data from this government is something to note in this pandemic. I think what we really all want, and I think the government representatives can agree, is that transparency and accountability matters, and in

order to have accountability and transparency, folks need to be able to access consistent data, clear data, in order to provide clear analysis on what that data actually shows.

I think when you start having this practice of withholding information or strategic release of information, it sets amongst the population a little level of fear, at least amongst myself, when it comes to seeing the information in a timely manner. And when we're talking about this pandemic and we're talking about people's needs for information, we need to hear what's going on and we also need to know that those decisions are actually being made by health-care professionals. And what Bill 10 ensures is that health-care professionals can make those recommendations; however, at the end of the day, the final decision rests within the minister's office.

MLA Asagwara: I just want to reiterate my thanks to you, Brianne Goertzen, for taking the time to share invaluable information and insights with the committee and generally with Manitobans. You provided some really great, concrete, tangible information that's important, and I certainly hope that the minister will incorporate that into her decision-making in regard to Bill 10.

So thank you, Brianne Goertzen, for taking the time.

Mr. Chairperson: Brianne Goertzen, any response?

Ms. Goertzen: Just thank you very much for having me.

Mr. Chairperson: Any other MLAs with questions?

An Honourable Member: Yes.

Mr. Chairperson: Honourable Mr. Gerrard.

Mr. Gerrard: This bill gets rid of the local advisory groups or councils. Do you have any idea why the government would've decided to get rid of these local groups and councils?

Ms. Goertzen: While I can't assume to know exactly what the government was thinking in the elimination of the 'links'? one could say that it is to ensure that the dissenting voices did have a space to voice criticisms or–and/or critical experiences within the health-care system.

I think it's really important for folks to understand what's happening within our health-care system–the good, the bad–in order to be informed when we are making decisions such as this very overarching piece of legislation, which will adversely impact the ability to access health care in various regions within the province.

Mr. Chairperson: A follow-up, Honourable Mr. Gerrard?

Mr. Gerrard: Yes. Thank you for your comment. There's concern about limiting access to information that applies to advisory groups. In what other way will the access to information be limited?

Mr. Chairperson: Ms. Goertzen, just 10 seconds.

Ms. Goertzen: I think it was already spoken about within Darlene Jackson's comments. But when we don't have the ability to FIPPA in a timely manner, you actually lose the ability to have a critical analysis of the–of something that's happening in a timely manner.

Mr. Chairperson: Brianne Goertzen, I thank you very much for coming to committee tonight and taking the time to prepare and present your presentation and also for answering all the questions of our committee members. So thank you.

We'll now move to our next witness, and I will call Michelle Gawronsky, the president of the Manitoba Government and General Employees Union, and ask the moderator to invite them into the meeting.

And I would ask Ms. Gawronsky to unmute herself and turn her video on, hopefully.

Ms. Michelle Gawronsky (Manitoba Government and General Employees' Union): I'm not sure if you're going to be able to see me.

***** (19:40)

Mr. Chairperson: I can hear you, but I cannot see you yet. You need to turn your video on.

Ms. Gawronsky: You can hear me. There we are.

Mr. Chairperson: There we go. I think we've got it now.

Michelle Gawronsky, it is good to see you and you have 10 minutes. Go ahead with your presentation.

Ms. Gawronsky: Sorry about that. I'm bouncing between offices to try and hit more than one committee room, so–and I have to say it's not fair to put me after Brianne. Just saying.

But–good evening, Mr. Chairperson and honourable members. As the moderator said, my name is Michelle Gawronsky, president of the

Manitoba Government and General Employees' Union. And thank you for the opportunity to present on this bill tonight.

The MGEU represents over 32,000 Manitobans who live and work throughout Manitoba in a wide variety of workplaces, including members in health care at workplaces like Addictions Foundation of Manitoba, Selkirk mental health care centre, Manitoba Developmental Centre, Cadham lab and many members from a number of regional health authorities as well, just to name a few.

Our members are battling the COVID-19 pandemic every day. Hospitals and personal-care homes were at the centre of most serious impacts of the virus, and our members and their colleagues across the province have answered the call for public service. They are craving stability and predictability. You can't imagine what life has been like for them at work.

The pending changes in the health-care system do not provide peace of mind. I hear stories from health-care members regularly, and I would like you to put yourself in the shoes of an employee of one of these workplaces. You've gone to work every day under extreme stress while providing care at a bedside, addictions treatment or mental health services for those in need, personal care and acute care in hospitals. Now these looming changes are coming at them, and it's taking a toll on people.

This is after the government introduced Bill 28, which impedes their right to free and fair collective bargaining and has restricted health-care budgets while the need for services vastly increases. After that, Bill 29 was introduced, a needless exercise that forced employees to reselect which union they wanted to represent them. Next, the VIRGO report was released, which on its face looked positive but, without significant investment in addictions and mental health services in Manitoba, the report findings and recommendations won't lead to better services.

Most recently, with no clarity or clear communication with those who provide these services, the government has now introduced Bill 10. The bill does nothing to clear up the uncertainty or the anxiety felt by our members. In their view, it is creating more chaos in a health-care system that is already stressed and stretched to the max. When it comes to the regional health authorities and their involvement in the health-care system, local decision making has been erased from the process.

The previous act included local health involvement groups that would provide a regional or local perspective on health care and what works and doesn't work in that area. This was one of the main reasons RHAs were created in the first place, I believe. I presently sit on one of those organizations and I know first-hand how my community is, again, going to lose in health care when we don't have a voice.

This top-down style is very similar to the experience of health employees involved in the health transformation experiment. There is a lack of meaningful consultation with the people who use the system and those that provide the care. I know.

The bill raises many questions about what the future holds for all of these organizations and the valuable services they offer Manitobans in a time of need. Take AFM, for example, an agency that has been around since the 1950s, helping countless families struggle with addictions. Relationship with donors and volunteers are being lost or are at risk. Staff have been left in limbo and uncertainty for years. Our communities are in the middle of an addictions and meth crisis that demands attention and expansion of these services, not a cutting or a privatization of these services.

We have some questions related to the bill. Which service providers will be impacted? Will front-line services be cut? Will employees be forced to move? Will they be retrained? Will they lose their jobs? They have many, many questions and they'd like some answers. We're all looking for answers.

We want to work co-operatively with you as you make changes that will affect the lives of these members and Manitobans accessing health care, mental health care and addiction services. In order to do that, we would help to–it would help to understand what these changes will mean and how they will be incorporated over the next 18 to 24 months. Manitobans need to know what's going to happen to their health care.

Thank you very much.

Mr. Chairperson: Thank you so much, Ms. Gawronsky for your presentation.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: I just wanted to quickly say, Mr. Chair, thank you, Michelle, for coming out, taking the time this evening and presenting on behalf of your members.

Mr. Chairperson: Ms. Gawronsky, any response for the minister?

Ms. Gawronsky: No. Thank you very much, and minister, definitely look forward to some further talks and being able to have some discussions with you on how things are going to move forward. Definitely offer myself up.

Mr. Chairperson: Okay. Further questions?

MLA Asagwara: Thank you so much, Michelle, for that presentation and so–for so eloquently articulating the concerns of your membership, the impacts that this bill can have and the impacts that we've seen of the health transformation to date.

I really encourage the minister to take you up on that availability in terms of meeting. I've been very fortunate to have important conversations with you and heard the concerns of your membership and know what a strong advocate you are.

I really don't have any questions. I think you did an outstanding job of outlining the concerns, and I sincerely hope the minister takes you up on your offer to meet and to work collaboratively, meaningfully, consultatively, address those concerns in entirety.

Ms. Gawronsky: We're willing to work with anyone that is going to promote health care in Manitoba, so, thank you.

Mr. Chairperson: Other questions?

Mr. Gerrard: Yes. Michelle, thank you for coming and for being so passionate about health care and people.

You cite some examples where you were involved with local decision-making and local input. Can you tell us a little bit about how that worked and why we're going to miss it so much?

Ms. Gawronsky: Absolutely, Mr. Gerrard. Thank you so very much for that.

I chair the Vita & District Health Centre Foundation; I have for a number of years. And my husband, before his passing, chaired it for 20-some years. He was also chairman of our board–our local board–before the RHA's inception in the '90s, where the facilities were forced to join the regional health authorities. I remember it very, very well.

At the time when we used to have the foundation and we had a publicly seasoned board of directors, the health care in our community grew by bounds. We knew what was going on. We knew as a community what we needed to do to work with government to be able to promote health care in our area.

When the regional health authorities came in, the powers were taken away from the local community and even–there was no further discussions with places such as ours, like the foundation, where we have raised hundreds of thousands of dollars over the years to–for the health care, for equipment, for the facilities, for furnishings. We built a house for the ambulance folks. We built doctors' homes. And all of that has gone by the wayside, and now we get a–now we're meeting with–we're called stakeholders now, and in there they inform us on what is going to happen within the community, within the guidelines of what they're allowed to share with us. Even that is going to stop.

And I find it a real crime and a real shame that communities who live and breathe in the community and need their health care in those communities are going to have no say, have no interest–or no involvement in that. You know, it is a real shame.

Mr. Chairperson: Any other questions from members of the committee?

An Honourable Member: Yes. Just one last comment.

Mr. Chairperson: Go ahead.

Mr. Gerrard: Yes. Thank you. And I think that story has played out in many other sites around the province, and it's a sad reflection on what has happened. So, thank you very much for sharing that.

Mr. Chairperson: Ms. Gawronsky, any final words?

* (19:50)

Ms. Gawronsky: Just one thing, Dr. Gerrard.

One of the things that my husband did as the chair of the board was protected the funding of the foundation with the then-minister Praznik. He was the minister that signed the regional health authorities. And the funds in the foundation were kept, unlike St. Pierre and Ste. Anne and some of the other smaller communities where the regional health authorities swallow the bank accounts. That money has been protected and it will continue to be protected for the citizens of the Vita facility.

Mr. Chairperson: All right. I thank you very much, Ms. Gawronsky, for your presentation, for taking the time to join us tonight at committee, and for also answering the questions of the committee members.

We'll now move onto the next presenter, and I'd like to call Dr. Cory Baillie, the president of the Doctors Manitoba, and ask the moderator to invite them into the meeting.

And I would ask Dr. Baillie to unmute themselves and to turn their camera on. There we go; I can see you now. So, welcome to the meeting, and you have 10 minutes; you may begin your presentation.

Mr. Cory Baillie (Doctors Manitoba): Thank you very much, Mr. Chairman and committee members.

My name is Cory Baillie, and I'm the elected president of Doctors Manitoba. Thank you for the opportunity to present on Bill 10.

Doctors Manitoba is the voice of the medical profession. We have more than 4,000 members, including practising and retired physicians, residents and medical students.

Doctors Manitoba exists to strengthen and support the whole physician so that physicians have what they need to deliver exceptional care to all Manitobans. This includes facilitating constructive engagement between physicians and the health system as they work together to improve care for patients.

Bill 10 proposes many changes to the health system as part of the government's restructuring agenda. I appreciate the opportunity to share the views of Manitoba's physicians on some aspects of the legislation and health system changes.

Members of this committee may know this is the third time that Bill 10 has been introduced in the Legislature and the first time that Bill 10 has come to the committee for public comments.

When Bill 10 was first introduced in 2019, Doctors Manitoba raised serious concerns that the minister would be empowered to unilaterally declare that a physician had overbilled Manitoba Health with no ability to appeal or resolve disputes about billing in a fair way.

We appreciate that, after hearing from physicians, the government agreed to amend Bill 10 to restore fairness to this process. The change will ensure that physicians continue to have the right to share their side of the story in a billing audit to resolve disputes. We're pleased at the changes incorporated in Bill 10, now before the Legislature.

It's our hope that this dispute is now behind us and we can move forward. Before we do, I'd like to take a moment to share why this is important when dealing with what is truly a very complex process.

Most Manitoba physicians earn the majority of their income from fee-for-service billings, where a procedure or a visit is billed to Manitoba Health in accordance with an agreed tariff. With over 6,000 tariffs, billing and reviewing billing submissions is a meticulous process. Doctors Manitoba offers extensive guidance to physicians to support accurate billing.

As was recently confirmed by the Office of the Auditor General, the vast majority of physician billings–over 99.9 per cent–were accurate. It's entirely legitimate for provincial auditors to flag billing submissions as a potential overpayment, but it's important to note that in almost every case the matter was resolved after physicians provided additional documentation to back up their billing submission.

Government auditors are generally not medical experts. We agree with the Auditor General's recommendation that government auditors, who often have no medical background, should receive formal training to ensure their audits are efficient and effective. We agree that audits should be undertaken in a timely way.

As we look into the future with Bill 10, Bill 10 is intended to facilitate the restructuring of health care in Manitoba. As health-care professionals who know their patients best, Manitoba physicians are interested in working with the health system leaders to improve the system to provide the best possible outcome for Manitoba patients. Changes to the system, however, require the input of physicians working in the system.

We saw what happened during the first round of restructuring in Winnipeg. Physicians were not consulted about the changes to ERs and other hospital services. This created challenges as changes were implemented, including very last-minute changes for Concordia Hospital. Asking for and listening to input from physicians from the start could have prevented many problems.

Doctors Manitoba appreciated the opportunity to recently connect with members of the Transformation Management Office about effectively engaging physicians in system change. Our main message is simple; doctors want to offer constructive feedback about changes. Doctors Manitoba can help government engage effectively with physicians. Please, let us help.

As the government prepares for further restructuring changes to the health system, we ask government to engage physicians in the plan and recognize us as allies in providing care to patients; this will only improve the decisions being made and, most importantly, the outcome for Manitoba patients. Doctors Manitoba, as the voice of Manitoba's physicians, is ready and willing to work with government.

As we now consider health care during the pandemic, the pandemic's reinforced the value of consulting and working with physicians. We've appreciated the opportunities to connect recently with Minister Stefanson and with Minister Fielding; both ministers reached out to us for advice from physicians.

In the lead up to Budget 2021, we offered advice about addressing the growing surgical and diagnostic backlog caused by the pandemic response, or the pandemic pilot as Premier Pallister has called it. It was very positive to see that the government's included $50 million in Budget 2021 as a strong start to addressing this challenge. But with over 10,000 cancelled or postponed procedures, this will take not only a financial commitment, but also collaborative planning between health system leaders, physicians and other stakeholders to catch up and keep up.

We're actively engaging with our members to get their advice about what the barriers and solutions are to addressing the backlog. We know that research from Deloitte showed that an investment over $65 million is required to address the pandemic backlog in Manitoba from just the first wave of the pandemic, for priority wait time procedures. Additional investments will be required, but the $50 million is a substantial investment and a good start to addressing the backlog. Manitoba physicians want to work with the government to ensure that this $50-million investment can be rolled out quickly and in a way that benefits patients across Manitoba.

Another top pandemic concern amongst physicians is the immunization rollout. With the third wave now starting in Manitoba, our hospitals are at risk again. This time, we have a medical workforce that has already been stretched for many months. We value the medical leadership guiding the prioritization of the vaccines, and physicians want to help speed up getting the vaccine to those Manitobans most at risk of severe illness or death from COVID-19.

We're helping with the public vaccine resource to let Manitobans know that doctors trust and support the COVID vaccines. At manitobavaccine.ca you can learn more about the vaccines, see answers from doctors to common questions, check to see when you'll be eligible and sign up to get notified when it's your turn to get the shot. Over 177,000 Manitobans have checked their eligibility and more than double that number have visited the site overall.

Research here and from other provinces reinforces that physicians are the most trusted information source about the vaccines and the most desired location to get the shot. Doctors are best positioned to address hesitancy about the vaccines. Everyday we see missed opportunities to immunize at-risk Manitobans.

We know that the government and the vaccine task force have faced a great deal of criticism lately about the vaccine rollout; not all of this criticism is fair or valid, but the goal of immunizing more Manitobans faster, especially those at high risk, is top of mind for Manitobans' physicians. We submitted recommendations to the Vaccine Implementation Task Force about how physicians can help reach more Manitobans with the vaccine.

Hundreds and hundreds of physicians have signed up to provide the vaccine to Manitobans; they take medical direction seriously and want to immunize those most at risk. The main limiting factor is there– in the ability to immunize more Manitobans is Manitobans' access to vaccines. Allocating more vaccine to medical clinics will help; the jurisdictions that are leading the world at getting vaccine to arms quickly and immunizing more of their citizens, like Israel, Chile, the UK and US, all use medical clinics as a more significant part of the vaccine rollout.

* (20:00)

Using familiar, existing immunization infrastructure works; using physicians, the most trusted voices in health care, helps. This includes the use of MRNA vaccines, like Pfizer and Moderna, in doctors' offices. Governments, health officials and vaccine manufacturers have all found ways elsewhere to address concerns about storage, transportation and training.

Physicians remain ready and willing to help. We see both fear and hesitancy in our patients every day. Physicians are in the best place to address our patients' concerns and deliver the vaccine so we can reopen our economy safely.

In conclusion, I'd like to thank you for the opportunity to present on Bill 10 and the challenges

our health system faces. Doctors Manitoba looks forward to being an active and engaged partner in improving Manitoba's health system.

I'm happy to try and answer any questions committee members may have. Thank you for your time.

Mr. Chairperson: Thank you very much, Dr. Baillie, for your presentation.

We'll now move on to questions from the committee. Do members of the committee have questions?

Mrs. Stefanson: Cory, thank you very much for your presentation tonight. Very thorough and certainly want to thank you and all your members for everything you're doing in these unprecedented times.

We certainly look forward to having that continued dialogue and working with a collaborative relationship with Doctors Manitoba moving forward. So, thanks again. I know how busy you are–as others are here tonight who have been presenting–and just really appreciate you taking the time out of your schedule to bring forward many important points tonight.

Mr. Chairperson: Dr. Baillie, any response for the minister?

Mr. Baillie: Thank you, Minister. Look forward to continued collaborations with the government.

Mr. Chairperson: Are there questions for the member?

MLA Asagwara: Thank you, Dr. Baillie, for taking the time to present to us this evening–really appreciate your thorough presentation. This is a very helpful document that you've provided with–provided to us, rather.

I do have a quick question. Just in regards to–in the document, it says that you did meet the ministers recently–Minister of Finance (Mr. Fielding), Minister of Health–and that you've seen changes as a result of these consultations. Can you articulate what those changes are?

Mr. Baillie: The meetings with Minister Stefanson and with the–Minister Fielding, recently–we were engaged with the–Minister Stefanson when she first took over as minister to reach out to us and ask concerns that we had.

We were engaged with Minister Fielding in the prebudget consultation process. We also discussed with Minister Fielding about surgical recovery and recovering from the pandemic.

Mr. Chairperson: Other questions from committee members?

Mr. Gerrard: Yes. Thank you for your excellent presentation.

Just–in the context of understanding the vaccine rollout now, the system is working with Shared Health and so on, you mentioned that you would be able to deliver, in many cases, Pfizer, Moderna vaccines under very cold conditions. Obviously, they've got to be stored in doctor's offices.

Let me give you an opportunity to, you know, tell us a little bit more about that.

Mr. Baillie: Thank you, Dr. Gerrard.

We're confident that physicians would be able to use the MRI–MRNA vaccines in their practices. We know that this is being done in many different locations, both inside Canada and in other countries, and we're confident that the logistics and training that would be required to utilize MRNA and physician practices could be achieved.

Mr. Chairperson: Other questions from members of the committee?

An Honourable Member: Yes. One more.

Mr. Chairperson: Go ahead, doctor–honourable–sorry, Honourable Mr. Gerrard.

Mr. Gerrard: I know, on–in the write-up on your background and your interests on the Doctors Manitoba site, there's a mention of your interest in the potential of artificial intelligence and virtual medicine or health care in the future.

In terms of where things are going, let me give you an opportunity to talk about that and how it would fit in to this realm of Shared Health and RHAs.

Mr. Baillie: You know, that–thank you, Dr. Gerrard. That certainly is a very interesting question. You know, I think we have seen a landmark change in virtual health since the onset of the pandemic. We look forward to working with government to be able to ensure that virtual care will be able to be available for Manitoba patients as we emerge from the pandemic and have it continue on as a long-term tool for physicians to care for Manitobans.

Mr. Chairperson: Thank you very much, Dr. Cory Baillie, for your presentation to us this evening and

for taking the time to do so and also for answering the questions from members of the committee.

We're now going to move to the next presenter. So, I'm going to call Sharon *[phonetic]* Nield, private citizen, and ask the moderator to invite them into the meeting.

And I ask Ms. Nield to unmute herself and turn her video on. And there you are. I can see you now and so I, just on behalf of the committee, I want to welcome you here this evening and give you the opportunity now to commence with your presentation. You have 10 minutes.

Ms. Sherry Nield (Private Citizen): Thank you. My name is Sherry Nield and I have been type 1 diabetic since I was 12, and I'm now 73. Type 1 diabetes is an autoimmune disease.

Bill 10 refers to the Peachey report which says that care for older adults is the No. 1 priority. I live by myself in a rural area, so monitoring my chronic condition is very important which is also a priority in Bill 10.

The Peachey report also discusses using technology. That is very important to me. I currently don't qualify for a continuous glucose monitor or an insulin pump. The government has recently committed to covering people up to age 25. I wouldn't qualify and cannot afford either one of these important instruments on a senior's income.

People of all ages can be hit with this disease but it is most commonly diagnosed in someone's late teens. Once you get it, it never goes away and you have to do whatever you can to preserve your health.

On Saturday, unbeknownst to me, my blood glucose tested at 17 around 5 o'clock p.m. Normal is between 4 to 8. I gave extra insulin in the injection before my meal to compensate.

By around 10 o'clock p.m., it was 2, which is dangerously low. If I had a continuous glucose monitor, it would have notified me of the glucose changes and I could have corrected it before such extremes happened.

Unlevel glucose is what causes heart disease like hardening of the arteries, which I've had triple bypass for; kidney failure, which I just found out is starting to happen with my kidneys; and blindness because of brittle veins in the retina. And I want to add, too, that I also have rheumatoid arthritis, which is another autoimmune disease.

HealthDay news states diabetes' impact on health, heart health, appeared to be the largest single cause of lost years. The researchers also found that type 1 diabetes younger than 50 are dying in large numbers from conditions caused by issues in management of the disease, diabetic coma caused by critically low blood sugar and ketoacidosis caused by lack of insulin in the body.

I had heart surgery seven years ago and my hospital stay was nine days rather than four to five days because of the difficulty regaining my strength from the damage done to my body from diabetes. This disease doesn't just require a pill a day to fix the symptoms. It requires numerous injections, finger pricks, counting, estimating, being aware of how your body feels every moment of every day. I never have a break from all the responsibilities that come with it, noting that it has been 61 years.

A continuous blood glucose monitor would be a tremendous addition to keeping my health going in a positive direction while being less of an expense to the health-care system.

* (20:10)

Diabetes didn't leave my body when I turned 25. No, it stayed in my body and kept slowly gnawing at every organ and nerve ending in my body. I've worked hard to make a living for myself and my kids and have tried my best to keep my health so I can be of benefit to society.

Extending the policy that's been announced so that seniors like me can access this monitoring technology would help me now and would align with the goals of Bill 10. It would help me prevent emergencies right away and would help the complications I have from deteriorating further.

There was a clinical trial and in this trial it randomized–clinical trials looked at the effects of continuous glucose monitors or CGMs in seniors and type 1 diabetics. The study included 200 participants, half of whom got to use a CGM and half of whom used a standard finger prick for six months.

In the finger-prick group, 10 participants had severe low blood sugar events, including five that had seizures or loss of consciousness. In the CGM group, there was only one severe low blood sugar event and it did not involve a seizure or loss of consciousness.

This study also showed a statistically significant reduction in low blood sugar overall in the CGM group, including reduction in mild and moderate lows.

The finger-prick group, 10 per cent of seniors had a severe low in six months; CGM group, 1 per cent of seniors had a severe low in six months. Other adults, particularly those with long-standing type 1 diabetes, are prone to hypoglycemia and hypoglycemia unawareness. In addition to acute changes in mental status, severe hypoglycemia can cause seizures, falls leading to fractures, cognitive impairment and cardiac arrhythmias, resulting in sudden death.

What costs more dollars for our health system? Seizures that lead to fractures? Cognitive impairment and cardiac arrhythmias or continuous blood–sorry–or continuous glucose monitors that can prevent many of these seizures?

Thank you.

Mr. Chairperson: Thank you very much, Sharon *[phonetic]* Nield, for your presentation.

Do members of–oh, before I proceed to questions, I just did want to let committee members know that the presentation that we received in writing from Ms. Nield is considered a brief or a handout and not a written submission.

We'll now move to questions. So, anybody with questions?

Mrs. Stefanson: Sharon *[phonetic]*, I just want to thank you for sharing what is, I know, a very personal story with us tonight and, of course, it offers more of an education to all of us, I think, about not only your own personal story but, obviously, this is a story of many, many Manitobans.

And I know we had decided, you know, we wanted to move and, you know, take a step in the right direction. Obviously, lots of more work to do and I really just appreciate you taking the time out of your schedule and sharing this with us tonight. I look forward to getting a copy of your presentation.

Mr. Chairperson: Ms. Nield, any response for the minister?

Ms. Nield: Thank you for taking the time to listen.

Mr. Chairperson: Other questions for the presenter?

MLA Asagwara: I just want to thank you, Sharon *[phonetic]* Nield, for taking the time to present to us this evening, for providing your presentation in writing, as well.

It's certainly–really causes one to pause and think very deeply when we hear personal stories and it takes a lot of energy and it takes courage to share your own personal journey and your own story. And so I sincerely thank you for that and, you know, we've been advocating for greater accessibility to the devices that you've mentioned to make sure that all folks with diabetes don't have any barriers to accessing what would make their lives better in terms of navigating this disease, and in many cases is a life-saving access to these supplies.

And so, thank you so much for sharing with us and providing us your own personal story alongside this information. And I hope that you take good care and, you know what, don't hesitate to reach out. I'd like to connect with you beyond committee if you have more questions, concerns that you want to share and reiterate.

Mr. Chairperson: Sharon *[phonetic]* Nield, any response to MLA Asagwara?

Ms. Nield: No, just thank you so much for understanding.

Mr. Chairperson: Very good. Are there other questions from members of the committee?

Mr. Gerrard: Yes. Thank you, Sherry. Wonderful to see you here, and thank you for your presentation. I mean, it highlights something which is not as well understood, and that is that it's a severe hypoglycemia, the low blood sugar, which is often very, you know, dangerous and catastrophic.

I think you also make the point very well that having really good health care with a continuous glucose monitor is–costs a little bit, but it's–provides better health care and it saves a lot of dollars in hospital visits and broken limbs and so on. And so it really is good for health care and good for fiscal management, too.

So, thank you very much for your presentation.

Mr. Chairperson: Sharon *[phonetic]* Nield, any response to Honourable Mr. Gerrard?

Ms. Nield: I Just want to mention that the difference between the finger pokes and the strips and a continuous glucose monitor is only about $300 a year difference. So I just want to make that point.

Mr. Chairperson: Thank you very much Ms. Nield. Any other questions from members of the committee?

And seeing none, I want to take the–yes. I want to take the opportunity to thank you, Ms. Nield, for coming to committee tonight, for sharing your story and for also taking time to answer some of the questions from our members.

I will now move on to the next presenter. And I'd like to call on Leah Wiebe and ask the moderator to invite Leah into the meeting and ask Ms. Wiebe to unmute herself and turn her video on.

Ms. Leah Wiebe (Private Citizen): There we go. Hi.

Mr. Chairperson: Hi there. We can see you now. And so I just want to give you the opportunity to make your presentation. You have up to 10 minutes. Thanks.

Ms. Wiebe: My name is Leah Wiebe. Some of you may know me from back in the day when I started a petition for insulin pumps. I live in the RM of La Broquerie, and Bill 10 states that the health system should be patient, focused and equitable, but by putting an age limit on CGMs is not–is just–sorry–is not just unfair, it's discrimination. My life is just as valuable as a 54-year-old as someone who is 24 years old. There are not age limits on other life-saving devices like pacemakers, etc.

Type 1 diabetes is an autoimmune disease. I was 21 years old and pregnant when I was diagnosed with type 1. It was not just gestational diabetes. I had a hard time getting my blood sugars under good control. I started on an insulin pump when I was 34 years old and started on a CGM when they first came out. My doctor is so impressed by how well I have managed to keep my A1C under 6.8 for this many years.

Where the CGM helps me the most is it alerts me before I am going low or high and I can deal with it before either happens. I have not had any diabetes complications in my 34 years of having type 1 diabetes, and I believe it's because of my insulin pump and the CGM.

The cost of testing my blood by finger pokes and getting a tiny glimpse into what my sugar is costs me $300 a month if I test 10 times a day with the strips. The cost of a CGM is also around $300 a month, but only one is covered under Manitoba pharmacare, and that is the blood testing strips. The CGM gives a full picture with predictive results to help prevent severe highs and low blood sugars. After 34 years of finger poking for blood it is becoming difficult to get blood.

* (20:20)

In Bill 10–sorry, Bill 10 also states the health-system transformation is about modernizing the system to make it more patient-focused and ensure the delivery of care is safe, accessible and equitable, providing Manitoba families with access to the right care at the right time and the right place. CGMs are devices that save lives and save taxpayers money in reduced hospitalizations for severe hypoglycemic and hyperglycemic episodes, kidney failure, transplants, amputations, eye disease and cardiovascular disease.

Bill 10 also states the health system should be patient-focused and equitable, but putting age limit on CGMs is just unfair; it is discrimination. Again, my life is just as valuable as a 54-year-old as someone who is 24 years old. There are not age limits on other life-saving devices like pacemakers and other ones. CGMs are an affordable way to prevent complications that cost the government much more than the cost of paying for CGMs in the first place.

It feels like those of us who are over 25 are forgotten despite the fact that we must live the longest period of time without access to these–this great technology. The budget proposal is to limit access to these devices to those under 25. Preventative care for elders is very inline with Bill 10's objectives.

Thank you for your time.

Mr. Chairperson: Thank you very much, Leah Wiebe, for your presentation.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: Thanks again, Leah, for your presentation tonight, certainly hear you loud and clear as to where you're coming from, and it is why our government did want to take, sort of, a first step towards moving in the right direction here. But certainly hear what–where you're coming from tonight and really appreciate you taking the time to share your very personal story with us tonight.

Mr. Chairperson: Leah Wiebe, any response for the minister?

Ms. Wiebe: Thank you for listening.

MLA Asagwara: Thank you so much, Leah Wiebe, for sharing your story. Thank you for shining a light on your experience.

You are one hundred per cent correct; your life and your health as a 54-year-old is just as important and valuable as someone who's 24. You know, this is a really important issue and hearing your story attached to the cause and the issue at hand really helps to amplify the concerns around it that I think, you know, folks who didn't have as much of an understanding certainly are getting that understanding now, and it's due in part because of folks like yourself who share their own experiences and continue to

champion this really, really important aspect of our health care.

So, thank you.

Mr. Chairperson: Leah Wiebe, any response to MLA Asagwara?

Ms. Wiebe: Thank you very much. And like I say, I've been a foster parent to two children as well, and sometimes when you're a diabetic, it's hard, you know, I mean it's hard enough fostering–love those girls both, had one since she was three days old, she lived with me 'til she was 18; the other one was five, and she lived with us 'til she was 20. And, you know, it's a lot of work taking care of those children, never mind having to deal with my own health issues.

And once I got that insulin pump, it's like my whole life changed. And now with this CGM, I'm not worried about having lows. I've had one severe low blood sugar where I passed out and needed medical attention immediately, but that was before the CGM. You know, so. I'm thankful. I'm thankful that I've done good with this, so.

And thank you for listening.

Mr. Chairperson: Other questions for the presenter?

An Honourable Member: Yes.

Mr. Chairperson: Honourable Mr. Gerrard.

Mr. Gerrard: Thank you very much, Leah, for coming tonight and talking about–

Floor Comment: Hi, Mr. Gerrard. Do you remember me?

Mr. Gerrard: Yes.

Floor Comment: You were a big supporter of it back then.

Mr. Gerrard: Yes, and still am, so, and one day we will get it at every age.

So, yes, I think you tell the story beautifully and you've done well, you're an example and you make the point very well that the health-care system should about–be about providing equality, and that's where we've got to go.

And thank you for saying that so well. *[interjection]*

Mr. Chairperson: Leah Wiebe, any response to Honourable Mr. Gerrard? Sorry.

Ms. Wiebe: Just thank you very much for listening.

Mr. Chairperson: All right, and seeing no further questions, I also want to thank you, Leah Wiebe, for coming here tonight and I thank you for your service of fostering those two girls that you spoke about is–that's a beautiful thing and touching for me. I know I grew up with foster siblings and it was awesome to have that as well. So I thank you once again for coming tonight and for presenting.

And we'll now move to the next presenter.

I just–before I move to the next presenter, I just want to let you know I let the committee know that presenter No. 17, Paul McKie from Unifor, will not be presenting to us this evening.

We are now going to move to the next presenter. So, I'm going to call Lori Amedick, private citizen, and ask the moderator to invite them into the meeting.

And I ask Lori to unmute herself and turn her video on.

I can see you there now. Welcome, Lori, to this committee meeting. You now have the floor and you can make your presentation for up to 10 minutes.

Ms. Lori Amedick (Private Citizen): Thank you very much.

Hello, everybody. My name is Lori and I am the mother of a nearly 24-year-old daughter, Ally, who was diagnosed with type 1 diabetes at the age of nine. She is working as a front-line health-care professional and could not attend this evening, as she is currently working in the hospital.

I am here to share my grateful approval of Bill 10, specifically in relation to the age discrimination present within the recent expansion of diabetes coverage in Manitoba, as well as how this has impacted her patient experience and how the principles of Bill 10 highlight the need to expand current diabetes coverage in Manitoba.

Ally currently uses a CGM and an insulin pump, though she is unable to afford the supplies for these devices and will be forced to resort to old-fashioned methods of management: 10 finger pokes a day minimum and five to six needles a day. She is incredibly thankful for the recent expansion of coverage for young type 1s and asked me to share her sincere thank yous this evening, though she is unlikely to benefit from the program for long, if at all.

Bill 10 is largely proposing modernization of the health system to ensure it is more patient focused, as well as to ensure the delivery of care is safe, accessible

and equitable. In terms of diabetes coverage in Manitoba, the government has recently announced plans to cover continuous glucose monitors and insulin pumps for those age 24 and under, despite the fact that diabetes does not go away at any–pardon me–does not go away at any age and despite the fact that there is no evidence to indicate that this is an effective policy decision.

In terms of safety, Ally has described many times how difficult it is to keep her blood sugar stable while attending to her patients. Without access to CGM, she must remove PPE during unpredictable moments, which puts her and those around her at risk.

Her CGM also lets her know real-time data and alerts her to both high and low blood sugars. This allows her to correct these potentially deadly episodes before they require costly medical interventions. The average cost of a hospital stay is $7,000 in Manitoba and there is evidence to show that 10 per cent of diabetics are hospitalized each year, not including hospitalizations related to diagnosis.

Without all-age coverage, Ally will soon return to finger pricks and needles and will no longer have the benefit of her CGM and pump. Her partner and her will need to wake up each night, sometimes several times, to check her blood sugars. While she is at work and busy in the hospital, she will have to remove PPE in order to finger prick and give a needle. Ultimately, she will likely have to err on the side of caution, keep her blood sugar slightly elevated in the hopes of avoiding extreme low blood sugars, which then will expose her to expensive health complications in both the short- and long term.

Please believe me when I say that that is not a positon that a health-care provider or anybody should be in Manitoba. She is a health-care worker employed within the Manitoba Renal Program. Yes, she should not have to be in that situation.

* (20:30)

According to the Kidney Foundation, Manitoba has the highest rate of kidney disease in Canada with an average price tag of $60,000 each year for dialysis treatments. Manitoba's current dialysis budget is over $90 million. Coverage of CGMs has been shown to reduce complications such as kidney disease and therefore reduce the need for costly expenditures associated with dialysis.

In terms of accessibility, the cost of these supplies to keep type 1's alive every day is unaffordable to many. Ally, despite being a well-paid professional health-care worker, is unable to afford these supplies.

Many Manitobans are forced to ration their diabetes supplies simply because there is no alternative. The principles of Bill 10 would encourage accessibility for type 1 diabetics through the use of preventative services, CGMs and insulin pumps.

In terms of equity, the current age cap of 25 certainly creates barriers for the majority of diabetics in Manitoba, yet there is no evidence to support this decision. Ally, a relatively soon-to-be 25-year-old, is already dreading her 25th birthday. A day on which all of her peers are looking forward to celebrating, she is faced with tremendous uncertainty as to how she is supposed to be able to afford to live.

Diabetes does not go away and it certainly will not go away when she's turned 25. There is ample evidence to show that funding of CGMs and insulin pumps drastically reduce acute emergencies and hospitalizations by up to 50 per cent. There is also evidence to indicate that they reduce long-term complications such as heart disease, vision loss, stroke, amputations and kidney disease.

As an employee within the Manitoba Renal Program, she understands the importance of keeping her blood sugars within range, and is dreading the day she must stop using a CGM and insulin pump because, like many Manitobans with T1, she simply cannot afford to continue.

Under Bill 10, given that modernizing the health system indicates that care should be equitable, there is currently an age cap for services which is not evidence-based. Bill 10 also outlines providing care at the right time. In terms of diabetes coverage, prevention is key. Providing care at the right time is as soon as possible to ensure that acute emergencies and long-term complications can be avoided.

CGMs and insulin pumps are absolutely vital to this, and the fundamentals of Bill 10 support the expansion of coverage for CGMs and insulin pumps to all ages–an outcome that both my daughter and I hope to see become reality.

Given the new Shared Health authority will be responsible for preventative services, it is incredibly important to revisit the current eligibility criteria for coverage for CGMs and insulin pumps in Manitoba alongside discussions of Bill 10.

CGMs and pumps save lives, and they have certainly saved my daughter's life on many occasions.

Diabetes truly is a 24-7, 365 illness which cannot be prevented, but the complications of diabetes can be prevented.

With the implementation of Bill 10, I ask that you please consider expanding covering to all ages to ensure that this policy aligns with the government's progress within the health-care system. CGMs and insulin pumps are vital to preventative care for one of the leading illnesses in Manitoba: diabetes.

I would like to conclude by sharing a short story of how my daughter's CGM has impacted her–both her as well as her partner. She had had a busy day, pre-COVID. She was at her niece's birthday party, and as I'm sure you can imagine, she was exhausted after spending the day caring for a group of seven- or eight-year-olds.

Now, Ally was using a CGM at the time. She went to bed that night with her sugars in range and steady. In the middle of the night, her CGM alarmed her that her blood sugars were dropping quickly and soon would be at a dangerous level.

She only woke up because her CGM alarmed her. It is likely–and we strongly believe–that she would not have woken up that night without her CGM. At that point, her blood sugars were dropping so quickly that she physically could not get out of bed or grab something to treat the low. Thankfully, her partner was also alerted via the alarm on her CGM as well as the alarm on her own phone via the CGM follow app.

He was able to treat the low and no medical intervention was required. Without it, Ally would certainly have been hospitalized that day.

I am here today to advocate alongside my daughter and type 1 diabetics in Manitoba. With a discussion and implementation of Bill 10, it is truly vital that all ages coverage for CGMs and insulin pumps be introduced now. Bill 10 is meant to modernize the health-care system and allow for safety, accessibility and equity; principles that are certainly lacking within the current health-care system, in terms of diabetes coverage.

The longer we wait as a province to fund these critical devices for all ages, the less patient-focused of a system we will have and the less financial benefit we, as taxpayers, will see.

I sincerely thank you for listening this evening and I look forward to continued discussions.

Mr. Chairperson: Thank you, Lori Amedick, for your presentation and also for your story of–on behalf of your daughter, Ally.

Now I'll ask the members of the committee if they have questions for the presenter.

Mrs. Stefanson: Thank you, Lori, for sharing Ally's story, really appreciate you taking the time to do that tonight. It's obviously why we felt it's an important thing to take a step in the right direction.

I know that there's–most other provinces are not covering the CGMs as of right now and are looking into it. So we have taken that first step to move, what I think is, in the right direction, but there's certainly–we recognize that's there more work to be done. And so we appreciate your advocacy and we look forward to continued dialogue.

Mr. Chairperson: Lori Amedick, any response for the minister?

Ms. Amedick: We'd just like to say thank you and we need those changes sooner versus later.

Mr. Chairperson: Other questions for the presenter?

MLA Asagwara: Thank you so much, Lori, for sharing your personal story and the story of your daughter, Ally. Again, it's so important for us to hear the personal experiences of folks to better understand–for the general public to better understand these issues on a human-to-human level.

So thank you so much for taking the time tonight and for very generously sharing your own experience and information with us.

Mr. Chairperson: Lori Amedick, any response for MLA Asagwara?

Ms. Amedick: Thank you.

Mr. Chairperson: Other questions for the member?

Mr. Gerrard: Lori, thank you very much for your presentation and for sharing the story of Ally.

One of the things that you raised, which I think is not as much appreciated as it needs to be in Ally's story was that when her blood sugar had dropped precipitously, she was not able to help herself because of the impact of the low blood sugar. And so it is so critical to be able to have that CGM and to have it linked with a partner so that, in fact, somebody can be helped, prevented and know–it was just wonderful that it was there and that the disaster was prevented. But it certainly illustrates how, you know, on a knife-edge sometimes somebody with diabetes has to live

and let's hope that it won't be too long when there's CGMs and insulin pumps available at all ages.

Mr. Chairperson: Lori Amedick, any response to Honourable Mr. Gerrard?

Ms. Amedick: Yes, I would like to say thank you and we are convinced that if she did not have a CGM that she likely would not have woken up the next morning. Unfortunately, that's reality with type 1 diabetics.

My daughter will tell you that there is not a night that she goes to bed that she doesn't wonder if she's actually going to wake up in the morning. It's a real fear.

Mr. Chairperson: Are there any other questions?

Seeing no other questions, I want to thank you, Lori Amedick, for coming to this meeting tonight and in the absence of your daughter, who's also doing invaluable work that we very much appreciate, I want to thank you for your time and for your willingness to present, and also your willingness to answer questions from members of the committee.

We're now going to move on to the next presenter. It's Colin Mehmel, and I'll ask the moderator to invite them into the meeting. And ask Colin Mehmel to please unmute yourself and turn your video on.

I think I can see you there now, so welcome to this committee meeting this evening. The floor is yours. You may present for up to 10 minutes.

***** (20:40)

Mr. Colin Mehmel (Private Citizen): My name is Colin Mehmel, and I am a type 1 diabetic.

Now, according to the government, Bill 10 is about providing safe, accessible and equitable health care while improving efficiency, providing the right care at the right time. The government's aim of providing the right care at the right time is well realized by providing CGMs to all insulin-dependent diabetics.

Mr. Vice-Chairperson in the Chair

For those of you who don't know, a CGM is a device that continuously measures blood glucose levels, providing better glucose control and more effective and more thorough data for diabetes management. According to several European studies previously provided to this government, this level of care provides savings and greater efficiency to the governments that adopt it, reducing diabetic health emergency stressors and chronic complications. Realizing these savings by introducing CGMs will help the government achieve one of the goals stated in Bill 10: improving the sustainability of the health-care system.

Providing coverage to–providing coverage for CGMs to insulin diabetics of all ages will also help individual Manitobans. Like many Manitoban adults, I am part of the gig economy and do not have the luxury of employer health benefits. CGM coverage would give me the economic freedom to better manage my disease and would allow me to grow my business opportunities, providing economic security for myself and my family.

Paying for my CGMs during the pandemic has eaten into my savings and compromised my economic and health security. Managing a chronic condition with outdated finger-prick technology makes it harder to earn a living. Staying awake for hours at the end of a long day to make sure sugars are optimal before I go to sleep, worrying about blood glucose levels during the night and trying to wake up on target so I can start my day and be productive is a huge stressor, and it takes time away from my family and my business. CGM coverage would provide me with the financial freedom to manage my disease and have resources left over to grow my family.

As I said, I'm using my savings to pay for CGMs during the pandemic and its resulting business slowdown. While I was able to afford the right care at the right time, my care has not been equitable. I was only able to have this quality of care using my own limited resources to pay for this monitoring, and many other Manitobans don't have that option.

I am confident that the goal of this government is not to try to bankrupt diabetic Manitobans trying to access the best current care. But that is what is–that is the decision currently faced by diabetic Manitobans. They have to choose between their economic prosperity and their health. This lack of equity seems contrary to the spirit of Bill 10, as outlined by the government. So too is providing age-based coverage discrimination.

This government has created age restriction–age-restrictive programs for insulin pumps and CGM coverage. I'm not sure why Manitoba limits diabetic care based on age, and I'm not aware of any other condition that is subject to age-restricted coverage. Insofar as I know, cancer care, stroke recovery, cardiac care, other neurological care is not limited by age, but diabetic care is. In my opinion, this is not equitable. Including adults in current medical

coverage–in current medical technology and covering it seems equitable and ethical.

I hope that the government is sincere in implementing Bill 10 and its commitment to provide improved access to health services and consistent clinical standards, regardless of where the service is provided. Because I paid for my CGM, I was able to get good health advice from my endocrinologist remotely during a pandemic. This care was not available to all Manitobans, who couldn't just send their data electronically to their health-care provider.

And I hope that the government, under the stated aspirations of Bill 10, will continue–will ensure that equitable care is provided to all insulin-diabetic Manitobans, providing them with the health advice a CGM affords regardless of their location and regardless of the limitation of in-person appointments due to pandemic restrictions or geography.

I hope that the government will come to understand and agree that every diabetic Manitoban should be able to sleep safely without having to go to bed fearing a catastrophic health outcome because the government will not provide access to current technology. I hope that the government will also come to appreciate that for insulin-dependent diabetics, providing a CGM is preventative medicine. Helping diabetics like myself keep the use of their eyes, limbs and cognition will provide huge savings to the Province.

And, please, in the spirit of the efficiency laid out in Bill 10, help diabetics to also save the Province money.

Since CGM technology allows for comprehensive diabetes management data to be shared with an endocrinologist or other health-care provider anywhere in the province, as I said this will help make quality health-care coverage not dependent on geography, which is very critical.

Thank you.

Mr. Vice-Chairperson: Thank you, Colin, for your presentation.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: Thank you very much, Mr. Deputy Chair. And thank you, Colin, for your presentation tonight, really appreciate you taking the time out of your schedule to bring forward your personal experience with diabetes.

And certainly I have, sort of, talked about this before but, you know, obviously we'll keep the dialogue going. And very much appreciate you taking the time out of your schedule this evening.

Mr. Vice-Chairperson: Thank you, Minister Stefanson.

Mr. Mehmel, do you have any comments for the minister?

Mr. Mehmel: Thank you, Mr. Deputy Chair.

Yes, I know that the government has taken some steps in the right direction, and I really look forward to continuing the dialogue with the government on this really critical health issue.

And I just want to stress that the data that we have submitted does show that CGMs pay for themselves and also improve the quality of care. And I think that these things are reliable, and the sample size is good. And I really hope that those are going to be taken into consideration as we go forward.

Mr. Vice-Chairperson: Okay.

MLA Asagwara: Just want to say thank you, Colin Mehmel, for your presentation, for sharing your personal story and for really clearly outlining the personal impacts–financially and otherwise, that having to pay out of pocket for CGMs has had on yourself and your family and many, many Manitobans as well.

Again, you know, it certainly helps to better illustrate the realities of lack of access when we hear personal narratives, and not just–and we know that each person's experience is unique, and so the more folks that we hear from the better, to better understand why this issue is so important.

So, thank you for taking the time and for sharing your story and this information with us.

Mr. Vice-Chairperson: Mr. Mehmel, would you like to respond?

Mr. Mehmel: Thank you for those comments.

Mr. Vice-Chairperson: Okay.

Honourable Mr. Gerrard, do you have any questions?

Mr. Gerrard: Yes.

Thank you for your presentation. And, I mean, you illustrate so well why this is good, just not in terms of health care, but it's good for the economy because of your ability to, not only start a business but

to keep it going, and how much easier that will be, or is, with a CGM and insulin pump.

I'm curious about one aspect. You said that, you know, the record of the blood glucose levels would be transmitted to the specialist. Does that require a cell phone or Internet access, is that importance, would that limit access in some parts of Manitoba?

Mr. Mehmel: When–with the technology, they include a service to be able to provide the data to health-care professionals. Usually, while people often use a smartphone device that is Internet connected–in order to do that there are usually other reader devices that could be provided if someone is without that technology.

But I would–but I believe Internet access would be required for those individuals, yes.

An Honourable Member: Yes, okay. Thank you.

Mr. Vice-Chairperson: All right. Are there any further questions?

All right. Thank you, Colin, again for your presentation. Very much appreciate you coming forward.

We will now move on to–all right, I will now call on Ashley Rawluk, and ask the moderator to invite them into the meeting.

Please unmute yourself and turn your video on.

Hi there, Ashley. Welcome here.

* (20:50)

All right, you may begin your presentation. Go ahead.

Mrs. Ashley Rawluk (Private Citizen): Okay, thanks. My name is Ashley. I was diagnosed with type 1 diabetes 12 years ago at the ripe old age of 25. Twenty-five years old, the cut-off age of the newly announced pump and continuous glucose monitor program.

The recognition and the provision of these tools for young adults and children is really, really amazing but, unfortunately, the constant burden of living with diabetes is a life sentence. Despite having some insurance to help with my medical costs, I still pay about $4,500 out of pocket every year for my medical supplies, which include a CGM and an insulin pump. I spend a significant portion of my income yearly on these costs, but at least I have the ability to do that; many type 1 diabetics over the age of 25 can't.

CGMs are crucial to the successful management of diabetes, and Manitobans of all age deserve access and is–to provide evidence-based clinical and preventative services plan that is patient-centred and driven by quality and measurement, along with the incorporation of digital technologies. CGMs provide the evidence-based preventative digital technology that allows for better control, lowering the incident of severe low blood glucose and long-term complications from elevated blood sugars.

The data from CGM provides 288 glucose values per day; every five minutes, it provides you a blood sugar value. It's like a video. It provides a constant stream of information on glucose levels, trends and overnight data, all for the cost of about $3,600 per year. Finger-stick blood glucose readings are more like a photo. They provide you a single snapshot. You know your blood sugar's seven because it's seven and holding steady, seven and rising, seven and dropping.

After the age of 25, the provincial government will return to providing support for the 10 finger-stick readings a day. It's about a cost of $3,300 per year.

Now, let me put this into perspective. We're Manitobans, we want to get the best bang for our buck, so for just $300 more a year, the provincial government can purchase a 24-hour video that is proven to prevent immediate and long-term complications and it will save the health system far more than the $300-a-year investment. It's really, comparably, it's a very poor outcome for a similar amount of money.

Type 1 diabetics of all ages need access to CGMs. I'm going to throw around some numbers here just to help support that. The outcomes of poorly controlled diabetes are truly devastating. They're also extremely costly to the health-care system.

Here are some of the potential complications and their associated costs: dialysis for kidney failure, Winnipeg Health & Wellness Magazine puts that at about $60,000 annually; diabetic foot ulcer, the Diabetes Action Canada pegs that at almost $23,000 per hospital stay; a major amputation is almost $49,000; PubMed says that an incident of diabetic ketoacidosis or DKA will cost about $20,000 if the patient ends up in the ICU.

These complications and their associated costs do not disappear at age 25, and that investment of an additional $300 a year to provide access to CGMs for diabetics for their life will really save in the long-term. Type 1 diabetics of all ages need access to CGMs.

I'm going to shift over to talking about pregnancy. Diabetic mothers are considered high risk and need to maintain particularly tight blood sugar control to avoid complications to their own health and to the health of their unborn child. Poorly controlled diabetes prior to becoming pregnant or during pregnancy can result in miscarriages, malformation or stillborn babies. And as the child grows or the baby grows and develops, your insulin requirements increase throughout your pregnancy in response to changing hormones.

I am really fortunate. I have two healthy children. They're age two and five. I was pregnant with both children when I was age 32 and 35. During this time, I didn't have a CGM but I was able to have healthy pregnancies with the support of a great medical team and about 12 to 15 finger pricks a day. I also gave myself countless injections of insulin to, you know, correct any fluctuation in blood sugar.

A 2017 study by Feig et al. found that the use of CGMs during pregnancy in patients with type 1 diabetes is associated with improved neonatal outcomes, likely attributed to reduced exposure to maternal hypoglycemia–hyperglycemia, sorry. They recommend that CGMs should be available to all women with type 1 diabetes prior to and during pregnancy.

In 2009, Statistics Canada reported that the average age of a first time mother is 29.4 years old in Canada. The cap at age 25 takes away access to CGMs at a time when it is particularly crucial to diabetic women who are considering starting a family. Type 1 diabetics of all ages need access to CGMs.

I'd like to share a personal experience where I had a severe low blood sugar. I'd like to say it was my only one prior to getting a CGM, but it's just one of many, which is the reality of living with diabetes. At the age of 34, I was home alone with my daughter, who was almost two. We laid down together in the afternoon for a nap. My blood sugars were holding steady when I laid down. Quinn *[phonetic]* woke up but I didn't, thanks to a severe low blood sugar. My husband, Ben *[phonetic]*, wasn't supposed to come home early but he had a strange feeling when I didn't answer the phone.

He found us in the bedroom. I was unconscious and Quinn *[phonetic]* was awake, playing next to me. Despite administering glucagon, I wouldn't regain consciousness. He called the paramedics and I was hospitalized.

For years I was terrified of low blood sugar while sleeping, so I set my alarm every night to wake up and manually check my blood sugar. I also became very anxious to sleep without Ben *[phonetic]* or for him to go to work, which is often out of town. Ultimately, he quit his job because we kind of became crippled with the fear that I would have a severe low overnight or when I was home alone with our children.

Today, if I have low blood sugar, my CGM will alarm and I can treat it before it becomes an issue. The CGM also sends my blood sugar data to my husband, Ben *[phonetic]*, who can help ensure that I am treating low and, you know, it's great peace of mind, too, to be able to look at his phone and know that my blood sugar is in a target area that's safe.

I've never had a severe low since getting my CGM and my family is less stressed with the ability to monitor remotely. The risk of severe blood sugar is always there, regardless of your age. Type 1 diabetics of all ages need access to CGMs.

Mental health is becoming an increasingly–we're becoming increasingly aware of how important mental health is, and diabetes certainly takes a toll on your mental health. The effort and energy that goes into managing my diabetes, it literally never stops, no matter what stage of life.

Insulin, the hormone I need to stay healthy in the long term, can also kill me right now. Being your own pancreas is mentally exhausting. I'm certain that I would have died during some of my past severe lows if it wasn't for help from Ben *[phonetic]* and other emergency professionals.

I think about diabetes more than my families, my friends, my jobs. It's the first thing I think about when I wake up every morning and it's constantly on my mind. High and low blood sugars and their potential complications cause me mental anguish and feelings of humiliation, shame, bitterness, anger, fatigue, sadness. Type 1 diabetics have increased likelihoods of depression and anxiety, and I'm definitely impacted by this.

However, having access to a CGM has eased the mental burden of diabetes so much. The provision of real-time blood sugar alarms and the ability for my family to monitor remotely–my blood sugar remotely and allows me data that empowers improved control. It's–I can't even tell you how much it's improved my life. Type 1 diabetics of all ages need access to CGMs.

This is just a few examples of the benefits that CGMs provide. There's plenty of evidence-based research that identifies CGMs as a necessary tool for all diabetics, not just children and young adults.

Government of Manitoba must include supports to diabetics of all age, ultimately reducing spending on severe low blood sugar incidents and long-term complications resulting from elevated blood sugars.

Thank you.

Mr. Vice-Chairperson: Thank you very much, Ms. Rawluk, for your presentation.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: I just wanted to say, thank you, Ashley, for sharing your personal story tonight and really appreciate you taking the time to share that with our committee.

Mr. Vice-Chairperson: Thank you, Minister.

Ashley, would you like to respond?

Mrs. Rawluk: I'm just happy for the opportunity to speak on behalf of my fellow diabetics.

***** (21:00)

MLA Asagwara: Ashley–thank you so much, Ashley 'Rawlchuk'–sorry Rawluk, for taking the time to present to us tonight.

It's a real privilege to be able to hear such a personal story. I'm grateful to hear that you–your children are healthy and that you had two healthy pregnancies. A lot of effort, clearly, went into maintaining your health, and I'm very glad to hear that you had a strong team supporting you through both of your pregnancies.

I really appreciate–and I want to make sure that I specifically speak to the fact that you talked about mental health and the impacts on your mental health, that of your family and for many folks with diabetes here in Manitoba who don't have access to the supplies that they need. That's a really important part of this dialogue, and it's something that I think gets overlooked, sometimes, in some of the details.

So thank you so much for not only sharing your personal story and some data-based information, but also bringing something up and into this conversation that is really, really important for us to not only not forget, but to make sure that we understand it to be integral to why folks like yourself are advocating so strongly.

So, thank you.

Mr. Vice-Chairperson: Ms. Rawluk, do you have any further comments?

Mrs. Rawluk: No. I appreciate the comment. Thank you.

Mr. Gerrard: Ashley, thank you so much. You tell an amazing story and it's really important.

I didn't realize until a number of years ago that depression was as common as it is among people who have diabetes, and we tend to think of, you know, the heart disease and the kidney disease and the foot ulcers, but depression ranks right up there.

And it's really important–and probably there's a lot of money saved by preventing depressions. And keep on telling your story and keep on your CGM.

Thank you.

Mrs. Rawluk: Thank you. I appreciate the opportunity.

Mr. Vice-Chairperson: Any further questions?

Mr. Gerrard: No, just thank you for coming tonight and you did very well.

Mr. Vice-Chairperson: Okay. Thank you again, Ashley, for your presentation and thank you for taking the time.

I'll now call on Jen Dyck and ask the moderator to invite them into the meeting.

Please unmute yourself and turn your video on.

Hi Jen. Welcome here. I'll ask you to begin your presentation.

Mrs. Jen Dyck (Private Citizen): Hi. My name is Jen. I live in Winkler and I've been a type 1 diabetic since I was three years old, and I'm now 30.

Bill 10 states the health system transformation is about modernizing the system to make it more patient-focused and ensure the delivery of care is safe, accessible and equitable, providing Manitoba families with access to the right care, at the right time, in the right place. The new Shared Health authority will be

responsible for preventative services and developing clinical standards.

Mr. Chairperson in the Chair

Continuous glucose monitors, CGMs, are devices that save lives and save taxpayers money in reducing hospitalizations for severe hypoglycemic and hyperglycemic episodes, kidney failure and transplants, amputations, eye disease and cardiovascular disease.

As a medical transcriptionist in our local hospital, I frequently type reports and see first-hand the repercussions, physically and financially, of uncontrolled blood sugars. As a type 1 diabetic since I was three, I frequently had low blood sugars that resulted in ambulance calls.

The entire time I have used a CGM, I have never had a severe low or been admitted to a hospital. The costs of testing my blood sugar, my finger pokes and getting a tiny glimpse into what my sugar is costs me $300 a month if I test 10 times a day.

The cost of a Dexcom CGM is also $300 a month, but only test strips are covered by Manitoba Pharmacare. The CGM gives a full picture with predictive results to help preventative–severe high and low blood sugars.

An example of how this has saved my life was a couple weeks ago. I did a finger poke because I cannot afford a CGM right now, and my sugar was a perfect 6.2. I got ready for bed and, while showering, I got shaky, confused, disoriented and couldn't stand. I quickly had to get out and I checked my blood sugar, and in just 15 short minutes, my blood sugar had dropped drastically to 2.9.

If I had a CGM, when I checked it the first time, I would've seen that it was 6.2 with two straight-down arrows warning me that my sugar was crashing. I would have suspended my insulin delivery and drank some juice, and I would've avoided the severe low blood sugar that leaves me feeling drained and sick.

The previous two years that I had a CGM, I maintained an A1C, which is an average glucose level between 4.7 and 5.2. My endocrinologist–who is in Winnipeg, because that's the closest one to where I live in Winkler–was so confident in my ability to maintain good blood sugars that instead of driving out to Winnipeg, missing a day of work and finding child care for a day every three months, he moved it to every six months and then to every nine months.

In 2017, a study of 325 women with type 1 diabetes examined the differences in outcomes between those wearing a CGM versus those relying on finger pricks during pregnancy. Pregnant women with type 1 diabetes are a high-risk population who are recommended to strive for optimal glucose control, but neonatal outcomes attributed to maternal hyperglycemia remain suboptimal.

For those in the study who were wearing a CGM, neonatal health outcomes were significantly improved, with lower incidences of large or gestational age, fewer neonatal intensive care admissions lasting more than 24 hours, fewer incidences of neonatal hypoglycemia and one-day shorter length of hospital stay. The study concluded that all type 1 diabetics who are pregnant should wear a CGM.

For those of you who aren't aware, uncontrolled blood sugars during pregnancy result in both birth defects and miscarriages. I know first-hand how true this is. I was fortunate enough to have access to a CGM for both of my pregnancies, and I had two healthy pregnancies that resulted in two seven-pound healthy babies that required average hospital stays with no NICU admissions. My sister, on the other hand, did not have access to CGMs for both of her pregnancies, and she had two almost-11-pound babies, one that required an admission to the neonatal intensive care unit in Winnipeg.

Bill 10 states that the health system should be patient-focused and equitable, but putting an age limit on CGMs is just–not just unfair, it is discrimination. My life is just as valuable as a 30-year-old as someone who is 24 years old. There are not age limits on other life-saving devices.

CGMs are an affordable way to prevent complications that cost the government much more than the cost of paying for a CGM in the first place. I am asking you to remove the age limit of 25 on CGMs and cover them for all Manitobans to ensure the delivery of health care is safe, accessible and equitable.

I have a friend who has a sensory deficit, so he can't use the electronic methods to appear before the committee today, so I'm going to read a statement from him:

My name is Brian *[phonetic]* and I'm 74-years old. I've had type 1 diabetes for 63 years. Because diabetes is progressive, I've gone through a lot of the issues that come with the disease such as retinopathy, neuropathy and susceptibility to infections at what I imagine was a great financial cost to the health-care system. Through this, all I've ever wanted was to live

as normal a life as I could despite having to live it four hours at a time between insulin injections and finger-prick blood tests.

All of this has been very invasive and painful. It's difficult for nondiabetics to imagine how painful finger pricks can be when you have diabetic nerve damage and have to do numerous tests every day. After years of diabetes, recognizable signs of insulin reaction, low blood sugar, disappear. Picture trying to operate blood letting device to determine your blood sugar in the middle of the night while only partially awake and confused by the low blood sugar.

Since the introduction of CGMs, my ability to prevent low blood sugars by early detection has increased dramatically. Having the ability to take readings as many times a day and night as necessary without painful and inconvenience–and inconvenient blood testing has finally allowed me some degree of normalcy in my life.

* (21:10)

Unfortunately, I am at a stage in my life where I am on a fixed income, and the CGMs are not cheap. I am very pleased the government has decided to cover the cost of CGMs for people up to age 25, but if you excluded others, could result in much larger costs for preventable medical issues.

In a lot of ways, as a proud Manitoban who worked and paid taxes for over 50 years, I feel like I am being treated like a second-class citizen, and that as a senior I don't matter.

As I read that statement, I already identify with parts of it, and it scares me to think that this could be my future without access to the current technology. But what you need to remember is that this isn't just a hypothetical future for me. This is a current reality for many Manitobans right now.

So I'll ask you again: Will you please remove the discriminatory age of 25 on CGMs?

Mr. Chairperson: Thank you, Jen Dyck, for your presentation.

We'll now proceed to questions. Do members have a quest–members of the committee have questions for the presenter?

Mrs. Stefanson: Just a comment, Jen.

Thanks for sharing not only your story but the story of your friend, Brian *[phonetic]*, as well, and sharing what, as you say, is your reality. And obviously, just thanks for taking the time to present to this committee tonight. I think we've learned a lot from your presentation and from some of the other presentations tonight.

Mr. Chairperson: Jen Dyck, any response to the minister?

Mrs. Dyck: Yes, thank you for listening.

And I hope that all of our presentations will show you how important it is for coverage for everyone.

Mr. Chairperson: Other questions from the members of the committee?

MLA Asagwara: Jen Dyck, thank you so much for taking the time to present this evening and thank you for sharing your time to–with a friend of yours, for Brian *[phonetic]*, for amplifying his voice and his experience as well. It's very generous and thoughtful of you to do so.

You know, this is a really important issue. I think you did a really important thing by also contrasting your experience with pregnancy and that of sister's, based on the access to CGMs. That's a really–it's a really important marker for people to be able to better understand just how significant the impacts can be for folks. And I appreciate that, you know, you've taken the time to be here and shared so many different aspects of your own experience with us this evening, so thank you.

Mr. Chairperson: Jen Dyck, any response to MLA Asagwara?

Mrs. Dyck: Yes, thank you for listening and taking the time too.

And yes, the difference in pregnancy, the CGMs, I just–I can't even imagine trying to survive a pregnancy with healthy–like, a healthy pregnancy without the CGM. It's needed.

Mr. Chairperson: Okay, other questions from members of the committee.

Honourable doctor–or, Mr. Gerrard.

Mr. Gerrard: Thank you, Jen, a beautiful presentation.

One of the things which you talked a little bit about, and maybe you can expand a little bit, when your blood sugar goes down, you talked about being disoriented and confused, and, I mean, that sounds, you know, dangerous.

Maybe you can talk about, you know, what that feels like and why it's so important to avoid it.

Mrs. Dyck: When my sugar drops, it will often drop just very quickly and I don't have symptoms that I can feel until I am confused and disoriented, and my husband will often notice and then he'll try to get me something, like some juice, something to help me bring my sugar up. It's very stressful. It is scary to be so disoriented that I don't know where I am or what I'm doing.

My husband took a different job so that he wouldn't be working out of town, so that he would be home every night. Yes, it affects everything.

Mr. Chairperson: Other questions for the presenter?

Okay, seeing none, I want to thank you, Jen Dyck for coming virtually to this committee this evening and for making your presentation, for taking the time to prepare it and to share your experiences and Brian's *[phonetic]* experiences with us. So thank you for taking the time to answer the questions that we as committee members had to ask of you.

We'll now move to the next presenter, and I'll call on Elizabeth Dyer and ask the moderator to invite them into the meeting. I ask Elizabeth Dyer if she can please unmute herself and turn her video on.

All right. Elizabeth Dyer, I think I see you there now. You can proceed with your presentation. You have up to 10 minutes. Go ahead.

Mrs. Elizabeth Dyer (Private Citizen): Hello. Yes, my name is Elizabeth Dyer. My 14-year-old son was diagnosed with type 1 diabetes when he was 12 months old, as–just as a baby. I'm honoured to be able to speak with you tonight, and I was thrilled with the recent announcement for coverage for continuous glucose monitors up to the age of 25 and also extending the coverage of insulin pumps to 25.

I would like to ask for this coverage of both CGMs and insulin pumps to be extended to all ages of insulin-dependent Manitobans.

When my son was first diagnosed, we tested his blood sugar manually with a finger prick at least 10 times a day. More often than not, we would exceed the 10 paid-for strips because it was just not enough to get the full picture of how his tiny body was reacting to the insulin we had to give to him four to six times a day. As careful as we were, he suffered from many low blood sugar induced seizures. His first one was at 18 months old–multiple hospital *[inaudible]* calls.

He was lucky enough to start using his pump when he was five, and this was life-changing for him. This gave him freedom with his food. He didn't have to decide between a snack or an extra injection. But more importantly, it meant that we could disconnect or suspend his insulin delivery if he was suddenly dropping unexpectedly or decided to be more active or was in the middle of an illness or a growth spurt–this is my son Quincy *[phonetic]*–which both cause drastic changes in insulin needs. This is not possible with normal daily injections.

Our life really changed, however, when he started using a CGM. He rarely is able to feel fluctuations in his blood sugar and has never woken up overnight when his blood sugar is low. Before he had a CGM, we would need to set our alarm multiple times a night to check on his blood sugar, as some of his seizures did happen overnight. Every night and morning I would walk into his room and I would have a moment of terror and hold my breath, hoping he had not had a seizure that I had not heard and slipped into a coma–and he would still be breathing.

Now his CGM is connected to apps on our phone. It shows us not only what his blood sugar is in real time with a reading every five minutes, but how it is trending. We know if it will stay steady for the next while or if it is about to crash to a severe low or skyrocket to a high blood sugar, both of which are dangerous. It will alarm us when this happens, so we no longer need to set our alarms overnight.

Recently, as an added bonus, based solely on his CGM data, his pump will automatically shut off insulin delivery if his blood sugar is predicted to go low. This greatly reduces the risk of overnight low blood sugar emergencies.

We can also share with his team virtually–his medical team–the data from his CGM, making sure–making it easier to adjust his ever-changing insulin needs. These devices have saved his life countless times and it improves all of our mental health. Having this technology is crucial for people of all ages, especially those who are caring for young children, living alone and don't feel the fluctuations in their blood sugar. Even for people who normally do feel their changes in their blood sugar, sometimes, due to no fault of their own, things can change quickly, leading to catastrophic outcomes.

Excuse me I'm just going to–sorry, everyone.

Okay, so if–however, if that person is wearing a CGM, it is possible for loved ones to follow their blood sugars via an app on their phone if they notice that their blood sugar has dipped to a dangerous level.

And if they are unable to reach the person, there is time to intervene, and it can be set up to call 911.

My husband also has type 1. He was diagnosed after our son at the age of 37. For the most part, he manages his diabetes very well–excuse me. I'm so sorry. Toddlers. I'm so sorry.

So, for the most part, my husband, he manages his diabetes very well without the use of a CGM or pump, but yet has had a number of very terrifying, sudden low blood sugar episodes: three seizures, one while at the grocery store with our son, one while walking to the bus alone in -30° weather; three ambulance calls; two hospital admissions and many more close calls.

***** (21:20)

One terrifying moment happened when he was holding our six-month-old baby. I was in the next room and we were chatting back and forth and he got quiet. I thought nothing of it, but a few minutes later, I walked into the dining room and he was sitting on the floor slumped against the wall and he was still holding our baby, but he was barely conscious. It happened so fast, he hadn't even been able to tell me what was happening. Had he been wearing a CGM, we both would've been alerted and had time to act before it got to that point. We are very lucky I was home at the time and he and our baby were both okay.

If you would allow me, I would like to read a statement by a friend in Winnipeg who wanted to present tonight but, due to diabetes-related health issues she is experiencing right now, she was unable to. So, the following are her words: My name is Shandra MacNeill, and I'm a professional artist, former executive director for arts organizations, on-and-off-again special needs caterer working on my sports nutritionist diploma, sometimes *[inaudible]* diabetic, diagnosed at 17.

Due to my diabetes, I now have extensive autonomic nervous damage, increasing serious mobility issues and have almost died from diabetic-related medical events at least eight times. I have had five eye surgeries, a very expensive trip to the Mayo Clinic and one very successful kidney transplant. These are merely the highlights of my life with diabetes.

Soon after my diagnosis, it became clear that I did not respond consistently to insulin. The basis of this life-saving treatment is being as consistent as possible with all the variables you can control so you can establish a functional and beneficial relationship with insulin. What this means is that for over 20 years, I have tested manually 10 to 14 times a day to determine the momentum of my blood sugars and the current effect on–insulin is having on me.

I had to sort this out for myself before the technology of the CGM was merely an idea. I watched impatiently as it developed and became a reality and available to Canadians. As a self-employed artist, I had to wait until my career was established before I could even begin to think about affording the safety and diagnostic aid which would allow me to react and treat my sugars, helping me minimize the window that they would sit in dangerously high levels leading to the quite catastrophic damage I now live with, work with and remain determined to overcome.

That said, I estimate I've lost half of my professional and personal life to this disease's effects. I'm not in the most privileged of circumstances, but I'm near the top of the list and yet the technology has not been available to me for most of my life.

Managing without this technology has rendered my life a constant struggle to defy a level of physical misery and hardship that, up to this point, I have never bothered to describe so that I may not be slowed down or discouraged by it. I would rather use the tools available at this time to overcome it.

Heartfelt stories aside, this simply makes financial sense for the government to cover both pumps and sensors for all ages, not just up to the age of 25. A kidney transplant surgery as well as pre- and post-care on top of dialysis costs versus a machine that, for me, costs less than the test strips I have to use each month.

I urge this government to allow for the best of these tools to end up in the hands of people like me, both early enough to avoid the kinds of damage I contend with, but also to allow those like myself the opportunity to slow the effects of this terrible disease and restore the control and health in their lives.

So, thank you so much for letting me tell Shandra's story and for listening to my own. If Shandra would've had access to a continuous glucose monitor as soon as they were available, her life, I'm sure, would look much different now and the Province would've saved hundreds of thousands of dollars. She is just one example of many. I know covering these devices for all ages will not only keep Manitobans out of the hospital now but in the future by cutting down on long-term complications, such as what Shandra has had to face.

My worry is that if these are not covered after the age of 25, my husband and my son will face these same health issues, especially for my son, as someone who was diagnosed so young. When he is 26, the financial choices he should be facing are if he is going to make a down payment on a house, start his own business, apply to grad school or start a family, not how will he pay for his future if he needs to pay for the devices that keep him alive.

He should have the freedom to go to sleep without the fear of possibly not waking up, the freedom to lead a productive and healthy life. These life-saving tools should be made available to all Manitobans who need them, not just those who can afford them, and up to the age of 25. Diabetes does not go away at the age of 25.

While debating the changes to the health-care system with Bill 10, I ask the government, please do not delay in covering these devices 'equitiby'–equitably to all ages.

Thank you so much for allowing me the opportunity to speak tonight.

Mr. Chairperson: Thank you so much, Elizabeth Dyer, for making your presentation and also for sharing Shandra's story with us as well.

And I can assure you on behalf of the committee that there's no need whatsoever to apologize for your toddler. I think I can speak–just based on the smiles that I saw all the way around the table and via Zoom–that that was no trouble at all.

So, we'll now move on to questions, and do members of the committee have questions for this presenter?

Mrs. Stefanson: Thank you, Mr. Chair, and I know you know full well what that's all about–and I do too. I remember those days fondly when my kids would participate in some of the things that I was working in. So, always great–tell Quincy *[phonetic]* he did a great job tonight.

And obviously, just want to say to you thank you for presenting tonight on behalf of your family, your son, your husband as well as your friend Shandra. You brought forward some very important points, and very much appreciate you taking the time out of your family time and your schedule to present to committee this evening, really appreciate it.

Mr. Chairperson: Mrs. Dyer, would you like to respond to the minister?

Mrs. Dyer: Yes. Sure. Thank you so much and I would just like to say to all of you and the minister for hearing our stories today and previously. I know a lot of you have taken times to have meetings with us and we really appreciate it, so thank you.

Mr. Chairperson: Thank you, Mrs. Dyer, yes we did–I can say personally that did very much enjoy that.

Other questions from members of the committee?

MLA Asagwara: Hi Elizabeth. It's good to see you. Thank you so much for sharing your story and that of your family and Shandra as well.

You know, we've connected before and it's always great to hear you speak on this issue. You always share something unique every time, and so I appreciate that, you know, it's late now on a Monday evening that you're making the effort to present and that you continue to be a tireless advocate for so many people. It's invaluable work and I want to thank you so much for continuing to do it. And we're listening.

Thank you.

Mr. Chairperson: Mrs. Dyer, would you like to respond to MLA Asagwara?

Mrs. Dyer: Sure. Just again, thank you so much. It–I can't tell you how much it means to have people listen like you do and it's very obvious that you care about all of us.

So thank you so much.

Mr. Chairperson: Other questions for members of the committee?

Mr. Gerrard: Hi, Liz, and thanks for coming, and you spoke very well. Your son is quite a lemonade salesman, among other talents.

One of the things from Shandra's story that is so–sort of compelling, in terms of the argument, is not just the complications but the fact that she feels she's lost about half her professional life. And just thinking about that and what that means and what a CGM and insulin pump can do that give somebody half their professional life. And that means an extraordinary amount to that person and of course it also contributes to the economy and contributes to wellbeing of a lot of other people as well.

So thank you for sharing that story, and sharing the story of your husband and your son.

Mr. Chairperson: Mrs. Dyer, any response for Honourable Mr. Gerrard?

Mrs. Dyer: Yes. Thank you. Hi, Dr. Gerrard.

***** (21:30)

Yes. When I was speaking with Shandra, she–just in the last year, she's been able to use a CGM–not a true CGM–so she uses the flash system so she doesn't have access to the alarms. But she said even just using that technology it felt like she was stepping into the future and she could, for the first time, have an idea of what her number was going to do. And I think especially for vulnerable people, such as herself, people that have had life-changing health problems such as she has, it's very, very important that the province supports people like her.

Mr. Chairperson: Thank you very much, Mrs. Dyer, for your presentation.

Are there any other questions from members of the committee?

And seeing none, I am going to thank you once again for taking the time to continue to advocate for your family and for people like them, and for appearing before the committee this evening. Wish you all the best.

We will now move on to the next presenter on our schedule, we have Ashley McKague, private citizen. So I'll call on Ashley McKague and ask the moderator to invite them into the meeting. And I ask Ashley to please unmute herself and turn her video on.

All right. There. I can see you.

So, welcome to the meeting. You have 10 minutes to make your presentation. Please go ahead.

Ms. Ashley McKague (Private Citizen): Great. Thank you so much, Chair, and everyone in attending tonight for hearing all our stories.

My name is Ashley McKague, my daughter Anna *[phonetic]* is four years old and was diagnosed with type 1 at age three. So her average blood sugar was around mid-eight, which–it would put her at risk for all those awful complications that we heard tonight.

Exciting news, we got a insulin pump at the beginning of February and already in a very short, short amount of time, around two months, it's dropped from mid-eights to mid-sevens. So, like, a full percentage point which, you know, may mean something, maybe 1 per cent isn't a lot in diabetes, it now means that she is not at risk for long-term complications. So my four-year-old, if we maintain this and even get lower, I think we can get lower with her pump and CGM together, she can be healthy and not have all these–the kidney, the heart, the eyes, all those things for her whole life.

Saying that, at equity lots of folks have talked about is huge. Getting a pump right now, we want all ages. We also need to look at pump criteria, which is really, really important. So, right now, for the pediatric pump program, a lot of folks don't realize this, you have to have really good blood sugar–relatively–to get it. Right now at the DER-CA clinic in Winnipeg, a lot of kids have over 10. So Anna *[phonetic]*, even at mid-eight, that's–that was not great but a lot of them, she was better than half the clinic. Kids in Manitoba have really poor blood sugars–and adults–but specifically kids. And so, to get a pump, you have to be under 10.

So at–we know so many families that can't afford a CGM and how this all relates it's like the chicken and the egg, you need the CGM to get better blood sugars to get the pump. So, because I could afford to pay out of pocket $300 a month, I was able to keep Anna *[phonetic]* in a good blood sugar range, and we were able to get the pump and now with the pump it's even better. So together it's key.

So really need to look at the criteria for the pump program and CGM going forward, even for the expansion to 25 it shouldn't be that you have to have great blood sugars to get a pump. In Alberta, you have to have really bad sugars to get a pump. So everybody–the pump is going to help.

We know so many families that are trying so hard, so hard. I spoke to one mom, her child's blood sugars are consistently over 12, all the time. Her daughter is going to be in big trouble–not when she's 80, like when she's 20 because her blood sugars are running so high all the time. If you don't have the technology often they'll run kids really high blood sugars at school or in life as an adult because you don't want to dip down as a senior. So a lot of folks in Manitoba are running their blood sugars high on purpose because they don't want to risk a severe low. That's scary. That is so scary. The severe low is scary, but the long-term implications are so scary also.

So once we had the CGM and the pump we were able to get it down, we're able to make a huge impact and I was finally able to breathe. Some people have talked about mental health, so without a CGM, parents, adults, seniors, like, you're waking up, you're pricking, you're not sleeping, you're not able to do your best job at work, do your best job in life due to all of that, right? And as a adult, that's super hard.

Now I know I can sleep; I'll know the alarm goes off. Right now, I have her pump–like it's a whole digital thing, and you can see it–oh, maybe not. But I can see, so she was running a little bit high, so I was able, on the pump, to adjust it even while she's sleeping to give her a little bit more insulin now.

So, electronically, it's just amazing and it shouldn't just be kids that get this. Saying this right now, not all kids are even getting this. So we really need to look at the whole pump program as a whole and make it equitable for everybody to get this life-saving technology.

And we can't have hoops, we can't have hoops to jump through. Diabetes, already a million hoops, you're always watching, you're always on it. If we make hoops to get the CGM and pump program, then it's not going to be–we're not going to be helping as many people as we can. So we need to look at this really carefully and look at the barriers in place.

And Bill 10 is talking about equitable access. So, yes, we need it to open up the age restriction but we also need to look at what the barriers are even if you are that age and you can't receive that technology.

Thank you.

Mr. Chairperson: Thank you, Ashley McKague, for your presentation and for sharing your story and also telling us about your daughter, Anna *[phonetic]*, and her experiences.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: Thank you very much, Mr. Chair, and thank you, Ashley, for your presentation tonight. Very informative on many fronts, so really appreciate you taking the time. I know we're getting into later in the evening when you've got little ones at home and so certainly I appreciate you taking the time out of your schedule away from your family to present tonight.

Mr. Chairperson: Ashley McKague, any response to the minister?

Ms. McKague: Thank you for listening. Thank you for your time.

Mr. Chairperson: Are there questions?

MLA Asagwara: Hi Ashley, it's good to see you again. Great to see you. I know you're going to continue to advocate on this really important issue and I really appreciate you talking about eliminating barriers to access, and not having hoops to jump through. And folks with diabetes already navigate jumping through so many hoops related to health. I think that that is something that is so important. I think you know that I'm a big proponent of eliminating barriers and making things as accessible as possible, and you just articulated beautifully how and why that's so important and what we need to consider in regards to access of diabetes supplies.

So, thank you so much for taking the time. I hope you get some rest tonight and I hope you take good care.

Mr. Chairperson: Ashley McKague, any response to MLA Asagwara?

Ms. McKague: Yes, just thank you. Yes. And it's just important to keep in mind with any program of what the qualifications are. So thank you for recognizing that.

And I will sleep well because I know, I know she's safe with her CGM.

Thanks.

Mr. Chairperson: Other members of the committee?

Mr. Gerrard: Thanks so much, Ashley, for coming in and telling us your story and telling us about Anna *[phonetic]*. You probably had other observations to share with us about Anna *[phonetic]* before and after the CGM, whether her behaviour has changed, whether other things have changed. Maybe let me give you an opportunity to talk a little bit about that. *[interjection]*

Mr. Chairperson: It's okay, Ashley, I've recognized you now, you can answer the question.

Ms. McKague: Thank you, Dr. Gerrard. Yes. There's been a huge change. So before the CGM, like we were running higher and she was–when she runs higher she gets very grumpy, very irritable. At daycare, things were much more difficult, she would just–she was not listening, there were issues with things like that. School-age kids I know have–I know another family that their child is doing very poorly in school. So, she was three; so she was in daycare but, of course, that early learning is important too and just getting along with kids, she was having difficulty with that.

So, having the CGM, being in balance at daycare, I know she's safe. I know that early childhood educators are able to watch her number all the time and see if she needs some fast acting sugar if–she needs to–if we need to give a little more insulin at lunch, different things like that. So that's really important. And she's

able to learn and play get along with everybody. So, yes, definitely a positive behaviour change on her; and then going forward as far as learning, heading into kindergarten next year.

* (21:40)

The other really important thing is with her pump; again, we can set different rates at different times. So, in the morning, we have a lower rate of insulin than the afternoon. I don't know if folks know about that–at the pump. And so, as an adult, too, like, when you're having your day, not just for kids, you can really kind of manage it a lot better; so then you're not running so high, because with that needle you have to inject it once for your 24 hours and that's your whole 24 hours. It's always the same, right?

So, yes, thank you for that.

Mr. Gerrard: Thank you for sharing.

Mr. Chairperson: All right, I'm not seeing any other questions from members of the committee, so once again, Ashley, I just want to thank you for coming out this evening, for making your presentation and I wish you all the best.

We're now going to move to our next presenter. We'll now call on Ken MacDonald and ask the moderator to invite them into the meeting, and ask Mr. MacDonald to unmute himself and to turn his video on.

All right, I think I can see you there now, Mr. MacDonald. You are free to proceed with your presentation, you have up to ten minutes.

Mr. Ken MacDonald (Private Citizen): Thank you. I'm in the RM of Springfield which is on Treaty 1 land. I'd like to thank the ministers for their announcement in extending the current insulin pump program to age 25. I'd like to share my experiences with that program and how I think Bill 10 could improve it, especially when I read the findings of the Peachey report that Bill 10 references. Ashley mentioned the barriers to accessing a pump through the program, and that's what I'll be expanding on.

When my son was diagnosed and still in the hospital under 24-hour watch, we were taken for training in how to administer insulin. And that's done at DER-CA, which is the acronym for Manitoba's pediatric diabetes clinic, and it's located at HSC. They administer the pediatric insulin pump program.

And I asked, well, what about getting an insulin pump, and our educator looked at just and just, she shook her head and said it could take years before you get one. And I was pretty surprised, but I learned there would need to be multiple clinic visits to access the program–and I'll refer you to page two and three of the 2019 Pump Program Annual Report that I presented tonight, and that's–it details the qualification process which is now in place in order to get an insulin pump.

So, in addition to those qualifications, which I would term barriers, there are hidden barriers that you have to read between the lines. So, completing each of the qualification steps has to be done at the clinic in Winnipeg, that's the clinic for all of Manitoba. They've added some virtual options but the training has to be done in person at family expense, and that's also burdensome when managing a chronic condition, that you would have to fly in from The Pas or anywhere if you want a pump. So, I appreciate that the Peachey report prioritizes consolidating services closer to home, with attention to travel burdens.

So, after a year–after half a year at the clinic, I learned it would take us at least another year to complete all the steps, and that was as accelerated as we could make it. So for us, that would have meant anywhere from eight to 12 visits with a specialist doctor and a diabetes educator, and it depends on how they allow you to move through the process, and there was no guarantee that we'd be approved.

I'd like to point out the current Manitoba Health policy with regards to the Pediatric Insulin Pump program. I've included that in my handout as well. And the process there says only that patients have to be under 18; that's it. DER-CA originally started with those criteria when the program started in 2012, and it's added additional criteria, adding a lot of time and expense to the process. It used to be basically immediate, and now it takes over four years on average from the time of diagnosis to get a pump.

These added criteria–or what I would call barriers–don't conform to the current Diabetes Canada clinical practice guidelines. The clinic wasn't able to provide me with any research evidence to support the steps they'd introduced, especially a completely subjective psychosocial assessment of our whole family. There's no evidence that they could provide me to show that a psychosocial process could predict or assist in using an insulin pump.

So, patients like us worry about meeting the criteria and shifting subjective goalposts, worry about the pumps that won't be renewed; we had an unhealthy patient-provider relationship at that clinic. To me, this all led to a breaking point and we considered moving

as a family from Manitoba to care for our son. Our son was miserable and he was doing worse and worse as he's very needle-aversive.

So I phoned the next nearest clinic, which is in Grand Forks hospital down in North Dakota and I asked what's the process of getting an insulin pump? We'd like to get our son an insulin pump. And they said *[inaudible]* an appointment and see about getting him one. I was pretty shocked and I asked, well, don't I need to see a specialist? What's the timeline? And they said, well, send us your CGM results, and you'll see a pediatrician, a dietitian and a diabetes educator and be on your way.

So we drove to Grand Forks for two days of back-to-back appointments. Our son had his new insulin pump in two days, all conforming to the American Diabetes Association practice guidelines.

So, I'd like to mention their reaction in Grand Forks on hearing what was happening in Manitoba. They said if they provided care like we do in Manitoba, they would lose their American Diabetes Association accreditation. Diabetes Canada has clinical practice guidelines and they say they're suggestions and they don't offer an accreditation.

So, in Grand Forks they said their goal was to have young patients equipped with a CGM and an insulin pump on diagnosis before they left the hospital. Now, I'm a firm believer in public health, but I appreciated that Grand Forks clinic prioritized efficiency and quality to save me money and provide value. I'm lucky I can afford it. But what they're doing costs a fraction of what our insulin pump program costs the public for us here.

We don't have to look to the US, and we probably shouldn't, but we can also look to Ontario. They formed local dietitian and diabetes educator. There are 83 such teams all over Ontario so that in communities as small as 5,000 people, people can get care in their community. Those teams have access to a specialist endocrinologist if required, but those teams are definitely not operating at top of licence as they provide care in the community.

It's firmly within–I sincerely appreciate the gesture of raising the age of the current program to age 25, but I would like to be frank. It's a program operating independently of oversight in that the pediatric pump program was due to be reviewed in 2015, but, to my knowledge, it hasn't. The previous annual reports indicated that patient consultation would occur, but, to my knowledge, there hasn't been any patient input into any of these additional qualifications or barriers that the clinic has added.

So, in the nine years since the insulin pump program was introduced, they've added many years and billable hours to the process. And neither is the process operating to its original stated capacity. They said they anticipated a 30 per cent uptake, but they've never had people up past 20 per cent of people in the program. They only serve 105 pump patients, and after expansion that you've announced, that might only come to 150, which would indicate that only 2 per cent of the type 1 patients in Manitoba would get a pump through the program. So I don't see it as an accessible or an effective program.

The overall blood glucose levels of patients at the clinic are high enough that complications are guaranteed. And when we voiced our concerns about that in saying that's why we want a pump, we were told by a provider there, don't worry; those complications could be 20 years down the road. I can't look at my nine-year-old, think of him as a 29-year-old with kidney failure and not worry. The clinic doesn't see patients past 18, and I felt they didn't see far enough down the road. And I don't think expanding that clinic's reach to see patients to age 25 is a good solution.

Bill 10 talks about developing clinical and preventive service plans. My use of a CGM and an insulin pump are all about using the best clinical advice and preventing emergencies every day. That's not an overstatement.

So I would welcome Bill 10 if it would finally bring some oversight to the clinic that runs the insulin pump program. I think this program embodies much of what the Peachey report, via Bill 10, is looking to change in our health-care system.

The top-stated priorities for the new Shared Health are very pertinent here; using remote monitoring, using technology to deliver health's primary value proposition. I love that term. Let's get to it. As giving care this close to home, giving consideration of different health-care practitioners working together, just like our neighbours in Ontario have done in forming care teams in local communities, and I just hope however we move forward, the voices of patients as stakeholders can be heard.

Thank you.

Mr. Chairperson: Thank you, Mr. MacDonald, for your presentation and for sharing all that information with us.

Do members of the committee have questions for the presenter?

Mrs. Stefanson: Thanks very much, Ken. Very informative and obviously well thought out.

***** (21:50)

You put some–a lot of thought and time and effort into that tonight. So really, really appreciate that. And also just, you know, appreciate the time that you've taken away from, you know, your family and your schedule to present at committee tonight. And I've taken some notes here, and so, you know, look forward to following up on some of those things.

Thank you.

Mr. Chairperson: Mr. MacDonald, any response for the minister?

Mr. MacDonald: Yes. I wanted to say that when I joined the call to expand the pump program to all ages, I saw that as a good way to, kind of, move towards a healthier way for Manitobans to access pumps. I really didn't want to get into, like, a head-to-head of complaining about the clinic. That's not my overall intention.

But entrusting them with an expansion, I think, is the wrong move, and I think it's counter to Bill 10's objectives. So I wanted to share my experience of why we took our care to Grand Forks so that we could remain in Manitoba.

Mr. Chairperson: Thank you, Mr. MacDonald.

Other questions for the presenter?

MLA Asagwara: Hi, Ken. Thank you so much for presenting. You know, every time I hear you speak, I learn something more. And, you know, tonight was no different. You continue to shine a light on aspects of access to diabetes supplies in Manitoba that, you know, aren't being talked about enough, quite frankly. So, thank you so much for providing that information and for the work that you continue to do in this area. And I look forward to, you know, ongoing dialogue in terms of advocacy on this issue.

So, thank you.

Mr. Chairperson: Mr. MacDonald, any response for MLA Asagwara?

Mr. MacDonald: Yes. I thank you very much. Like, shining a light is something that's not done in this area very much. In fact, I asked almost everybody in the major diabetes organizations in Canada what I could say about the clinic here. They never want to say anything negative. They never do it. They always just want to say the happiest possible thing. And one person said to me, well, don't quote me but, I guess what you could say is the clinic is operating independently of current clinical practice guidelines. So that's a pithy little thought, and it needed some unpacking.

Mr. Chairperson: Thank you, Mr. MacDonald.

Other members of the committee with questions?

Mister–you–you're–yes. Okay.

Then we'll go with Honourable Mr. Gerrard.

Mr. Gerrard: Yes. Thanks, Ken, so much for talking about that and talking freely and openly. You know, there's a lot of good things that have come historically from the diabetes clinic here for kids, but sometimes over time it helps to have a look at it again.

And I've always found that, you know, people like yourself, concerned parents, can contribute a tremendous amount to improving medical care and health care generally. And so, keep up the good work and thank you for your presentation today.

Mr. Chairperson: Mr. MacDonald, any response to Honourable Mr. Gerrard?

Mr. MacDonald: Yes. I *[inaudible]* we got this technology, so, thank you.

Thank you to the committee.

Mr. Chairperson: All right. I'm not seeing any other questions from members of the committee. So, I do want to thank you, Ken MacDonald, once again for coming this evening and for making your presentation.

And we will now move on to the next presenter. I'd like to call Liz Miller and ask the moderator to invite them into the meeting.

Liz Miller, I'd ask that you would unmute yourself and turn your video on.

All right. I can see you now. So, you may proceed with your presentation. You have up to 10 minutes. Go ahead.

Mrs. Liz Miller (Private Citizen): My name is Liz and I'm speaking today about type 1 diabetes and the preventive services plan in Bill 10.

Type 1 diabetics in Manitoba need coverage for continuous glucose monitors to be equitable and accessible for all ages in order to prevent complications. And that time is now. There should be no age restriction on this coverage.

I've been a type 1 diabetic for 15 years, and I'm 31 years old. Type 1 diabetes is a chronic autoimmune disease that is for life. This disease can have serious short and long-term complications if daily blood sugar levels can't be managed; complications such as diabetic ketoacidosis, which costs about $6,500 when treated on a step-down unit and costs about $20,000 when treated in ICU; dialysis, which costs about $60,000 per patient per year. A note that Manitoba's current dialysis budget is over $90 million. There are 1,845 people with kidney failure receiving dialysis in Manitoba. Also, Manitoba has the highest rate of kidney disease in Canada.

There's also heart disease, which the average cost of a triple-bypass surgery was around $10,000 per patient back in 2005.

Amputation, where the main in-patient cost for treatment of a diabetic foot ulcer, is about $22,000 per hospital stay and about $48,000 if a major amputation is required.

There's also low-blood-sugar seizures, which often require hospitalization, and the average cost for a hospital stay in Canada is $7,000.

These complications of diabetes cost the Province money, but they can be prevented. Continuous glucose monitors are devices that are vital to managing blood-sugar levels and preventing these complications. There are so many factors that affect blood-sugar levels. You could take the same dose of insulin each day and because of these factors, end up with different results. Some factors are, like, stress, which can make blood sugar rise instantly. Even the temperature can affect blood sugar if your body is sick. Different activities can cause rises or drops in blood sugar; like, walking can lower blood sugar; lifting weights can raise blood sugar. There are other factors as well.

Constant insulin adjustments must be made based off blood sugar data. With a continuous glucose monitor, you actually have the proper data to make these adjustments and can make adjustments before your blood sugar goes out of the normal range. With a CGM, you can see where your blood-sugar level is coming from and where it is headed. With finger-prick testing, you can't see this range of data and you can only see where the blood sugar is at one stationary moment.

My CGM alerts me when my blood sugar is low or high so that I can take immediate action to treat it. My CGM has wakened me up at 2 a.m. to alert me that I was low. Without this alert, I would not have wakened up and could have gone into a low seizure. My CGM has also alerted me in the night when I've been high, and I've been able to take my insulin at that time so that I can wake up in the morning with a normal blood-sugar level.

These–yes–so these low and high alerts that CGMs give, they, of course, also help me during the day as well; at night is particularly scary. My husband also can get these alerts, and he doesn't even have to be near me; he can be, like, across town; he can be anywhere and still get these alerts if I'm high or low.

I currently have CGM coverage through my insurance at work, so without that coverage I would not be able to afford a CGM. I do worry about losing my coverage, and I don't know what I would do if that happened. A CGM is so critical in living a safe life and preventing complications for children, adults and seniors with type 1 diabetes. CGMs need to be covered by the Province for type 1 diabetics of all ages, and that time is now.

Please extend the coverage of CGMs to Manitobans of all ages. Type 1 diabetes does not stop at age 25. The disease does not get easier to manage, and complications need to be prevented for all ages now.

Thank you.

Mr. Chairperson: Thank you, Liz Miller, for your presentation.

We'll now move to questions. Do members of the committee have questions for the presenter?

Mrs. Stefanson: Thanks, Liz. Just quickly to say thank you for your presentation; very well presented and thought out tonight and informative. So, really appreciate hearing your story and for you taking the time out of your schedule to present to committee tonight.

Mr. Chairperson: Liz Miller, do you have a response for the minister?

Mrs. Miller: Yes, just thank you. Thank you so much for listening.

* (22:00)

Mr. Chairperson: All right. Are there other questions for the presenter? Mrs. Smith–I should maybe let you know that MLA Asagwara had to step aside for a moment. Perhaps you have a question for the presenter?

Mrs. Bernadette Smith (Point Douglas): Sure. Thank you so much, Mr. Chair.

I just want to thank Ms. Miller for her presentation and sharing her personal story, and I'm so glad that you get yours–your CGM covered through work, but I'm happy that you're advocating for others to get that same coverage through the government.

So important, you know, as you outlined through your story, to have these so that others can, you know, get the alerts that they need to make sure that their health is in *[inaudible]* and that they can, you know, maintain a good life.

So, thank you again for your presentation.

Mr. Chairperson: Liz Miller, any response to Mrs. Smith?

Mrs. Miller: Yes. Thank you.

Mr. Chairperson: Other questions from members of the committee?

Mr. Gerrard: Thank you, Liz. Sometimes hearing about what happened before and what it was like after you got the CGM and the pump–what age were you when you got the CGM?

Mr. Chairperson: Ms. Miller, you can respond now.

Mrs. Miller: I was almost 30 when I got my CGM, and about half a year later I got an insulin pump.

Mr. Chairperson: Follow up, Dr. Gerrard?

Mr. Gerrard: Yes. Tell us what it was like before and what it was like after and–just to give us a comparison.

Mrs. Miller: So before my CGM, it was definitely–it was constant finger pricks and I was always really worried about my blood sugar and just, like, what it was going to do. I would test and I would see a number, but I wouldn't really know what would happen, like, an hour later.

And with the CGM, just, like, complete mental relief and better data so that I know what's–I can see what's going to happen in an hour and I can just make sure that my blood sugar is going to stay steady.

And with the insulin pump, like, not having to do multiple injections a day is just so freeing. And, like, not having to worry about, like, waking up every morning at 7 a.m. to take insulin. Just knowing that my pump, it will do that for me, which is amazing.

Mr. Gerrard: Okay. Thank you.

Mr. Chairperson: Thank you, Ms. Miller, for sharing your story and your experiences with it. It is very much appreciated by all the members of this committee–and also for answering the questions that were posed to you.

So we're going to move to the next presenter. I'm going to call on Trish Rawsthorne and ask the moderator to invite them into the meeting. And, Trish Rawsthorne, I'd just ask that you unmute yourself and turn you video on.

All right. I'm not seeing you yet. Make sure–

Ms. Trish Rawsthorne (Private Citizen): Okay.

Mr. Chairperson: Trish Rawsthorne–yes. Oh, there we are.

Excellent. I see you now and I welcome you to this committee meeting. Now you have the opportunity to make your presentation. You can take up to 10 minutes.

Ms. Rawsthorne: Great, thank you very much. My name is Trish Rawsthorne and I'm presenting on Bill 10.

As a citizen of Winnipeg and a former nurse and a clinical research manager, a former caregiver for two relatives–and I have had over nine years of lived experience in long-term care with these two relatives–I appreciate the opportunity to speak to this committee on Bill 10 from my own experience in health care, most recently in February 2019, following major surgery at Health Sciences Centre.

In my nursing career of over 40 years–16 of those years as a general duty nurse, and then to head nurse in the respiratory hospital, to supervising many of the nursing departments in the Health Sciences Centre, including the ICUs, SICU, emergency–I have experienced several changes in health-care management.

The first style involved a president of a–of the Health Sciences Centre who knew everybody by name and assumed the responsibility and accountability for

all that happened, to make it their responsibility to fully expect that all managers would be as responsible and to correct and prevent errors or omissions, and he was there to support their efforts and make the needed changes.

The next management style involved adding administrators to each of the four hospitals–the general, women's, children's, and the rehabilitation and respiratory–which further created a silo effect among staff and in each of the hospitals against one another. This style did not last for long at all.

Next was the creation of the regional health authorities. And by this time, I had moved on to a staff position at the University of Manitoba helping to create the Manitoba Inflammatory Bowel Disease Clinical and Research Centre. We worked out the Health Science Centre Bannatyne campus, so I was an outsider looking in at this new management style that did not seem to understand the inner workings of health care, nor did the needs of other–of both the patients and the staff, but focused too much on efficiencies over patient care, and ignored staff suggestions who knew how to provide care. This created an atmosphere of distress and fear that exists today.

It is under this management style that I had my surgery in 2019, and the changes I saw within Health Sciences Centre was dramatic and very disconcerting to me as a patient. I appreciated the joining of the surgical team around me to say who they were and why they were there and what was going to happen. That demonstrated to me expectations of accountability and responsibility; it was reassuring and calming to me, the patient.

However, while recovering on the surgical unit, I noticed several essentials were missing:

(1) I only saw one health-care aide who offered me a basin to wash on the first morning and a facecloth and a towel. I never saw another health-care aide after that except the odd one hurrying down the hallways.

(2) I saw a nurse at midnight each night for an injection and–to prevent blood clots, and a nurse in the mornings to check my wounds on the–days 1 to 3. Walking the hallways, I did not see staff sitting around, so they must have been with patients.

The third one was I saw a daily accumulation of used facecloths, towels, gloves, alcohol wipes strewn on the floor, and an ever-collecting mound of debris and dust. I only saw a housekeeper once in the four days. I made a point of checking out on day 4, as I thought I might be subjected to an infection if I stayed around with the accumulation on the floor.

(4) was an elderly gentleman who was my roommate on the day of my surgery. His family indicated clearly to the nurse that he did not speak English nor understand it. Despite this, the staff spoke to him in English. Only one resident used their phone to ask him a question in his language, and his reply was recorded on her phone.

During the middle of the night on day 2, he needed a blood transfusion, and the nurse carefully ran through the instructions for this patient to notify the staff of any possible reactions to the blood. It was clear that someone had to watch over this gentleman as he received his blood during the night. That person was me.

There are translation services available, but not at 2 a.m. in the morning. It would have been very time consuming to get the patient to the phone at the front desk. There are advancements in technology that could be present at the bedside of the patient to facilitate translation and avoid serious incidences.

(5) One day, I was walking in the halls and came upon a nurse explaining to a First Nations young man in a wheelchair that he needed to get his prescription filled. And it was clear to me that the fellow likely did not speak English, and he was not from the city. I could only hope that the transportation driver would know to get his prescription filled before he returned to wherever he lived.

What was missing at all of these changes in management–in how health care is managed, is the fact that health care is about people and it's less about dollars and less about cutbacks. It works best when there is–those who work in health care are consulted about what they do and asked how care can be improved upon.

* (22:10)

Rarely does this happen, and it creates several things: an unsatisfactory working relationship between health care staff and management; as well as influencing a patient's impression of health care when completing surveys that are sent out after post-discharge; and a serious lack of accountability and responsibility for anything that happens in health-care facilities.

There ought to be a serious consideration in the composition of boards of directors for both health-

care facilities and for long-term care facilities, including supportive housing and assisted living to include those with lived experiences of patients, residents and staff members for the region's specific needs and for their health care facilities.

I would ask that reviews of current and future changes to the health care by government involve input from those who are involved and affected by care in urban and rural communities–management, all levels of staff, patients, caregivers, volunteers–as they all see and experience health care differently.

Returning accountability and responsibility to the health-care facilities would do a lot to improve relationships between the facilities, patients and the public. It would give a voice to those who have experienced problems, as well as those with excellent care.

The sharing of breast–best practices is always a great way to improving health care or long-term care and to look at ways to increase efficiencies. I would ask that reviews of current and future changes to health care by government involve all those involved and affected by health care, including urban and rural involvement, management and all levels of staff, patients, caregivers, volunteers, as they experience it differently.

They all have a vested interest in providing great care and want to improve care for all.

Thank you.

Mr. Chairperson: Thank you, Mr. Clerk, for drawing my attention–Trish, thank you so much for your presentation.

Now–ask if there are–anybody who–members of the committee who wish to ask any questions?

Mrs. Stefanson: Thank you, Trish, for sharing your own experience in health care, and certainly appreciate your perspective and thanks for sharing your views and the importance of reaching out to those who work in the system, those who have used the system–certainly appreciate your comments on that and for taking the time tonight to share all this and being very patient as it's getting a little bit later into the evening.

So–really appreciate you waiting and being able to offer your views to us this evening.

Mr. Chairperson: Ms. Rawsthorne, any response to the minister?

Ms. Rawsthorne: Yes. Thank you very much for listening to it, and I appreciate your input. And I hope you appreciate input from the public as well.

Mr. Chairperson: Thank you, Ms. Rawsthorne. Any other question from members of the committee?

An Honourable Member: Question.

Mr. Chairperson: Mrs. Smith.

Mrs. Smith: Ms. Trish, I'd like to thank you for your presentation and of course for sharing your experience and knowledge of your years as a nurse, and of course, you know, becoming a patient yourself.

My mom was a health-care worker for over 25 years, and certainly–2018, she retired because she saw exactly what you were seeing, you know, the lack of care for patients and patients not being first and, you know, being asked to do more with less time. And she started getting dizzy spells because she was being asked to do so much.

And, you know, with big hearts, you know, you get into this field because you want to help people. And she just felt that she wasn't able to do that with, you know, the resources–the depleting resources–that she was being given.

So, my question to you is, do you think that, you know, this further consolidation is going to make it better or worse for patients in Manitoba in the health-care system?

Ms. Rawsthorne: I appreciate the comment, and your insights, and I wish your mother had stayed in health care. But I understand why she didn't.

I have one comment to your question, and that is, when a foundation on a bed is broken, laying another mattress on top is not going to help fix it.

So I think we need to go back to fixing what the problems are and allowing those who want to come forwards with needed changes and how to do it best should be listened to. And then if we together can make a concentrated effort to look towards patient care and be person-centred about that care, as that gentleman who could not speak or understand English. We need to do that so that we do not have incidences of critical nature with these patients.

Mr. Chairperson: Further questions from members of the committee?

Mr. Gerrard: Thank you, Trish, for presenting and for taking the time to talk very clearly about your experience over many years.

My impression is that part of the message that you're trying to send is that where you've got a president who knows at the Health Science Centre what's happening and knows the people it can make a big different. That no matter what structure you have up top that you need to have a significant amount of local input at the level of which care is actually being given, and local oversight and local accountability.

So I think it's a pretty strong message and, you know, I'll–we'll give you a chance to comment a little further on this.

Mr. Chairperson: Trish Rawsthorne, your response to the member.

Ms. Rawsthorne: Yes, you're quite correct, Mr. Gerrard. When I first started working in 1970 I knew the difference between good care and bad care, because as a general duty nurse I actually was first involved as a student nurse in a nursing home. And I saw that the care in a nursing home was not what it should be. When I got to work in the respiratory centre, that was excellent care. When I moved throughout and towards the general hospital that became lesser.

But the overall management, I could walk down the hall and he would know my name and he would ask me how we were. I'll just relate a brief episode that has stuck in my mind for all these years. There was an incident very similar to serious incidences that we know about in the newspaper. And the first thing that happened was he called every single manager of every single department into the auditorium and he said to them, this will never happen again, and I need all of you to tell me how we are going to make a change and prevent this from happening again. And that was the message.

And as soon as we came to him and said this is what we'd like to recommend and how we could prevent any critical incidences or deaths or whatever that we'd never want to do, is to have somebody who appreciated our efforts to make that happen.

Mr. Chairperson: Thank you very much, Ms. Rawsthorne. We've actually come to the end of–or actually beyond the end of the time allowed for questions. So I'm going to have to cut you off there. But I really do appreciate the time that you've taken, and I encourage you to continue to be in touch with members of the committee also. And thank you very much for answering the questions that were posed to you in this evening.

I will now move onto our next presenter, it's Irene Sheldon. I'll ask the moderator to invite Irene Sheldon, private citizen, into the meeting. And, Irene Sheldon, I'd ask that you would unmute yourself and turn your video on.

Oh, I think I can see you there. All right, welcome, Irene, to this meeting. You are now welcome to proceed with your presentation, you have up to 10 minutes.

Ms. Irene Sheldon (Private Citizen): Hi. Thank you very much for having me.

I'd just like to say that today is a very special day for me; it is my eight-year-old's birthday today, so thank you for spending it with me. It's also the fourth–sorry, I hear myself and it's confusing me–it's also the fourth year since his diagnosis with diabetes. So he was diagnosed on his birthday when he was four years old and tomorrow he will have had long–had diabetes longer than he hasn't had it.

Mr. Chairperson: Sorry to interrupt you, Irene. But–sorry to interrupt you, Irene, but we are getting some feedback somehow. I'm not sure if there's anything you can do to mitigate that.

Ms. Sheldon: I don't actually know–

* (22:20)

Mr. Chairperson: It's like we can hear–are you listening to the broadcast of yourself perhaps or something along those lines? But we're kind of hearing you twice.

Ms. Sheldon: I am not, but I'm listening to it on my phone. How do I get it back on Zoom?

Mr. Chairperson: Yes. You'll have to turn that–turn one of them off. Yes. Okay.

All right, we paused your time, so you can start whenever you're ready. I think we can hear you now.

No, we're still getting the echo. Are you able, maybe, to turn your phone off and just use the computer?

Ms. Sheldon: Ha. Yes. This'll do it.

Mr. Chairperson: All right. There you go. You can go ahead.

Ms. Sheldon: Great. Thank you.

Okay. So, Stanley's *[phonetic]* birthday is today. He's eight years old. He was diagnosed four years ago on his fourth birthday, so he is–he's now had diabetes

longer than he hasn't had it, which is not something that I had to deal with when I was his age.

Ashley spoke a bit about the insulin pump qualifications process, and we were one of those families that she was referencing. We were diagnosed four years ago, but we got the pump 10 months ago, and that was three years of struggle.

I understand diabetes and how it interacts with his body. I weigh all of his foods before I give them to him. I pre-bolus. We choose good foods from the glycemic index. I got accommodation from my work for the last three years to go down to his school and daycare to give insulin injections. I watch his sugar all night long. In the end, it was the CGM and hard work and luck that got us through the door to the pumping program.

We actually qualified at one point and then we had an A1C that was higher than what they allow and we disqualified and we had to go through the qualifying process again while we were on the wait-list for the pump classes. So it was very heartbreaking at the time.

Even though target blood sugars for a diabetic are not as good as a non-diabetic, so I worry about the effects that 20 years of battling this illness will have on the rest of his organs. The pancreas is not something that we typically see or talk about, so I think sometimes we forget how significant it is to the functioning of bodies.

When Stanley *[phonetic]* was diagnosed, we were covered under one private insurance company, which covered $500 per year per person, which was about a month of his medical care, and it didn't cover any pump or CGM supplies.

There's many factors that affect your blood sugar, like insulin on board, exercise hormones, carbohydrate intake. Stanley *[phonetic]* has co-diagnoses of autism and ADHD, so for him, one of the factors that he deals with that is very significant for him is excitement. An example of how this plays out is for his fifth birthday we got him a piñata and he was so excited about it that every time he talked about it, his sugars would just, like, go through the roof and, like, stay there.

It's impossible to control–I don't know–a child's excitement. You want them to be excited, but it affected his physical health until he broke open the 'piata' a week later and then everything went back to normal.

We started pumping in June of 2020, and it's only now with the access of the CGM and the pump that we were able to get our first target A1C of under, like, 7.6, which is normal-ish. It's a bit high, but it's normal. And for the first time ever, we were able to see, like, a target range, and it wasn't next to the words increased risk for long-term health complications.

Target blood sugar also means that he's able to engage and pay attention in school in a way that he cannot do when his sugar is high. I think the ripple affect that diabetes has–like–not just–like–on every piece of your life it touches, I think we don't really always see how much reach it has.

Stanley *[phonetic]* doesn't consistently feel his lows. It might be because he has low proprioceptive awareness due to his autism, but he'll say he feels fine and the CGM is telling us that his blood sugar is 2.0, which is very, very dangerous, and it can be very surreal to be talking to him and he says he's fine when you know that his body is starting to shut down. It's only the data from the CGM that has alerted me to many similar lows that, without treating them, we would have had to call an ambulance or administered glucagon, which is a rescue drug that shocks the body into releasing sugar into the system from the liver.

So, I'm so grateful that we have access to the CGM and the pump. They have increased our quality of life in a way that I can't measure, and the things that many people take for granted. Like, now, he can eat when he wants to eat and stop eating when he's full, and change his mind and have seconds. He got to eat some ice cream today. I can send him to school and know that the teacher will be alerted if he's heading towards an emergency situation.

And I can correct his high blood sugars without having to worry about how many meals he's gotten that day, and how he's going to associate that with the food that he's eating, and his overall long-term psychological health.

I can monitor him appropriately at home when he is sick in a way that I couldn't without the tools. And I have hope that this better control will mean that he's not dealing with neuropathy or eye damage when he's my age, like other type 1s that I know in my peer group.

All of the data from the CGM that is collected from the insulin levels that he's getting, the carbs that he's eating, his blood sugar trends, we share that all with Stanley's *[phonetic]* doctors and nurses through the online platform that's associated with it. And it's

been very valuable during the virtual medical appointments, but also during troubleshooting with the clinic. When Stanley *[phonetic]* is sick we don't have to bring him in, we can just upload it and call them and say have a look.

Other apps can be used to call a parent or a friend when his blood sugar drops to dangerous levels, so somebody can do a wellness check. And it's super valuable for people who live alone.

So it would mean so much to know that he's going to have access to this standard of care when he turns 25, to not have to worry about what comes next, to not have to choose between these essential tools or retirement, to be able to just let him know that this is something that he doesn't need to worry about and he can focus on the other things that eight year olds want to think about.

The financial burden of paying for these tools out of pocket would be huge and impossible for our family once Stanley *[phonetic]* is no longer covered under our private insurance. I am a single mother living in the low-income neighborhood, and the monthly cost of Stanley's *[phonetic]* diabetes supplies is more than my mortgage payments. But these tools keep the risk of him developing long-term complications lower and they help us avoid emergency situations now. So, for us, it's worth it.

Every time we avoid a DKA situation when he has the flu, the health-care system will save the approximately $7,000 it would have spent if he went to the hospital. Keeping his organs healthy now will mean that he won't have to rely on government-funded programs, like dialysis in the future, and his body stays healthy. His chances of getting a job that will afford him the private health benefits that he needs will help him access the tools he needs to live longer.

So it feels great to see equitable health being written into this bill, but it must mean that coverage of medical needs would not have an age discrimination built in. It feels good to be able to tell Stanley *[phonetic]* that policy makers are discussing this disease and they want to help where they can. But when he asks me why it stops when it turns 25, I don't have a good answer to that question.

So this year marks the 100th year since insulin was discovered in Canada, and before getting it that–before that getting a T-1 diagnosis was a death sentence. It no longer is because we have the tools to manage it, and I am hopeful that there will be a cure in his lifetime, But having access to appropriate tools in the meantime would mean a lot to us.

So, thank you for taking the time to talk about this and your consideration, I know it's been a very long day.

Mr. Chairperson: Thank you, Irene Sheldon, for your presentation. And I think I can speak on behalf of all the members of the committee that we would like you to pass on birthday greetings and a sincere happy eighth birthday to Stanley *[phonetic]* when he wakes up tomorrow I guess.

But now we'll move on to questions and see if there's any questions from members of the committee.

Mrs. Stefanson: Thank you, Irene, and thank you for sharing Stanley's *[phonetic]* story and happy birthday to Stanley *[phonetic]*. Quite a way to spend his birthday, I guess, tonight waiting to speak at committee, but I really appreciate you taking the time and your patience to be able to be here and present to us tonight. You brought up a lot of very valid points, and just really appreciate you taking that time.

So, thanks again.

Mr. Chairperson: Irene Sheldon, any response for the minister?

Ms. Sheldon: Yes. I kind of wish he could be here actually. Like, so when the finger-prick challenge was happening and he saw people doing the videos and he was, like, cheering them on, like representation matters. So to hear that this is being considered and talked about, like, I don't know, it's–I'm very grateful. So thank you so much.

Mr. Chairperson: Thank you, Ms. Sheldon.

Other questions from members of the committee?

* (22:30)

MLA Asagwara: Hi, Irene, it's good to hear from you and happy birthday, Stanley *[phonetic]*. Happy eighth birthday. Very, very generous of you to give up your time tonight to share personal experience and lend your voice to this really, really important dialogue.

You know, you just mentioned the finger-prick challenge that many of us participated in, that those are really great ways to expand awareness and understanding of the issues that you're advocating for. And, you know, I appreciate any opportunity to hear from you and from folks in the community about this matter.

So thank you so much for taking the time, and I look forward to connecting in the future on this, for sure.

Mr. Chairperson: Irene Sheldon, any response for MLA Asagwara?

Ms. Sheldon: No. Thank you very much for all of your support. I see it.

Thank you.

Mr. Chairperson: Any other questions from members of the committee?

Mr. Gerrard: Yes. Irene, thanks so much for coming, and happy birthday to Stanley *[phonetic]*.

You said something which I think is notable, interesting and worth telling us a little bit more about. And that is that you said that it's much easier to monitor Stanley *[phonetic]* at home when he's sick. Tell us a little bit about that and why it's so important.

Ms. Sheldon: So, there have been–so, when he gets sick–like, I don't know, his sister will get sick and she'll be sick for five minutes, but his immune system just doesn't seem to battle things the same way. And so when he gets sick, his blood sugars go up, he develops ketones and once he starts throwing up, you have to go to the hospital.

But until he reaches that point, I'm able to monitor the sugar and give a ton of insulin because I can watch it and make sure I didn't overshoot. It just allows me to be a little more aggressive in treating those ketones.

And if I ever run into a problem where I don't feel confident, I can upload it and then call the clinic and they can look at it and be like, oh, I see what you're talking about, have you considered this, or this might be your problem. It just gives you, like, an extra tool. And we have spent eight hours in the waiting room of a hospital waiting for some ketones to go down while he was in severe pain.

I don't know, and just to be able to, like, avoid those situations and deal with it at home is just better for everybody. *[interjection]*

Mr. Chairperson: Thank you. Sorry, Honourable Mr. Gerrard.

Mr. Gerrard: I think it's tremendously important because, when you are sick, your glucose can go all over the place; you may not be eating, you may be excited. And being able to control that or have some control over it so you can manage it better, I think that's a very important point.

Thank you.

Mr. Chairperson: Irene Sheldon, would you like to respond, once again?

Ms. Sheldon: Yes. Thank you very much for taking your interest.

Mr. Chairperson: All right, I'm not seeing any further questions from members of the committee. So then I'm going to thank you, Irene, for coming out and for staying up–on your son's birthday, no less–and sharing your story with us and we very much appreciate your time. And so thank you on behalf of the committee.

I'm going to allow the clerk to give me a moment to explain something and then I'll be back. Just give me 30 seconds.

Okay, a somewhat unusual circumstance for the committee, but especially if people on the line could listen. Apparently there is somebody who has joined the call via phone number, but we don't know who the phone number is, it ends with 5712. And the nature of committee means that we're not actually able to hear from that person until we know who they are, and that puts a little bit of a Catch-22.

So we're asking that that individual email the moderator to let them know who they are, calling in from that number, and hopefully they're able to do that. We'll grant a couple minutes, I guess, for that to be done.

And in the meantime, I do have two other presenters that we're going to go back and see if they're available on the line, to see if they're able to make their presentations.

Bill 56–The Smoking and Vapour Products Control Amendment Act
(Continued)

Mr. Chairperson: So the first one is Norman Rosenbaum. I'll call on Norman Rosenbaum and ask the moderator to invite them into the meeting.

Unfortunately, Norman Rosenbaum does not appear to be in the Zoom call either, so I will strike his name from the list.

And then I'm going to ask once again, Mike Sutherland, on behalf of Chief Glenn Hudson, if he's available to make a presentation if he's on the line. We're not seeing him on the line either.

And perhaps it would be wise to recess for two or three minutes just to give Phone Number -5712 an

opportunity, or–that's–is that the will of the committee just–let's just do two minutes. That should be sufficient, and then we'll get into bill by bill, clause by clause.

The committee recessed at 10:36 p.m.

____

The committee resumed at 10:37 p.m.

Mr. Chairperson: All right, we've received confirmation–oh, I'm going to bring the committee back to order. I know I'm a little bit early. So I suppose we can take a look and see if everybody's still able to be with us.

The honourable Minister Stefanson's video is off. There she is.

And Honourable Mr. Gerrard, are you back, and are we able to get going again? Otherwise we can give it another minute.

But I have received confirmation of who's on the phone, and it is, indeed, Mike Sutherland, so we're going to get to his presentation shortly.

Floor Comment: Hello.

Mr. Chairperson: All right. Well, then we're going to–yes, it's okay, we're going to go ahead, and I thank the moderators for allowing Mike Sutherland into the meeting.

And I guess I can give you now the opportunity to present now. No? Okay?

Floor Comment: Hi. Do you hear me?

Mr. Chairperson: Sorry, one moment, please. I'm just conferring with the clerk.

All right, I'm going to–just going to pause–for a pause for 10 more seconds to make sure that the honourable member, Mr. Gerrard, has the opportunity to take his full two minutes that I gave him. Those two minutes are now up, and so we can now continue.

And it's acceptable to accept phone testimony for this meeting, so I'm going to give the floor to Mike Sutherland and welcome him to the committee meeting.

You have up to 10 minutes to make a presentation. Please proceed.

Mr. Mike Sutherland (Peguis First Nation): Hi. Thank you very much, Mr. Speaker.

On behalf of Chief Hudson, we bring greetings and give thanks for this opportunity to present here this evening on Bill 56.

Peguis First Nation is the largest First Nation in Manitoba, the population of about 10,000, and is a member of Treaty 1 nation. We are here today in direct opposition of Bill 56, which seeks to remove any federal jurisdiction to The Smoking and Vapour Products Control Act on reserves in Manitoba. Pallister government's attempt to impose provincial legislation in First Nations oversteps their jurisdiction and infringes on our treaty relationship with the Crown.

As a sovereign nation, Peguis will continue to determine jurisdiction over our lands and business, particularly on-reserve. We will continue to uphold our nation-to-nation relationship with the federal government, without interference from the Pallister government.

The COVID-19 pandemic highlighted the need for leadership. My council and I worked quickly to establish protocol for safety measures for Peguis First Nation that were successful despite the PC government's interference. We will do the same for our citizens when it comes to smoking and vapour products in our community.

We do not need the provincial government's oversight and intrusion in our operations. This is merely another attempt to divide Manitobans and appeal to their voter base.

* (22:40)

Therefore, we wish to make it clear that Peguis First Nation does not support this amendment and we ask that the bill is revoked.

Miigwech and thank you for your time.

And I read from the note that Chief Hudson provided me to present here tonight. Thank you.

Mr. Chairperson: Thank you very much, Mike Sutherland, for sticking with us so long and for being able to share that presentation on behalf of Chief Glenn Hudson. We very much appreciate it.

We'll now go towards questions. Do members of the committee have questions for the presenter?

Hon. Audrey Gordon (Minister of Mental Health, Wellness and Recovery): Hi there.

Thanks so very much, Mike Sutherland, for your presentation on behalf of Chief Hudson. I appreciate

you staying with us and being patient as long as you've had to tonight, and very much value and appreciate the feedback you have provided, look forward to working with your First Nation in the weeks and months ahead.

And thank you again for your very thoughtful comments.

Mr. Chairperson: Mike Sutherland, any response to the minister?

Mr. Sutherland: No. I just want to give, you know, thanks for this opportunity and it is quite an interesting evening. I've represented Peguis First Nation in many other bills in the past, however, in person. But due to the nature the pandemic, I fully understand and was willing to wait the evening to prevent–present our comments in regards to this bill.

And, you know, I know leadership really takes it seriously when it comes to smoking and the health of our people, but we also take it more seriously when it comes to the intrusion of our jurisdictions and our First Nations communities.

And I think that if there was more time for proper consultations in regards to this bill, things may have been different. But for the lack of consultation and the Province moving forward without really coming to sit with Peguis First Nation in regards to this bill, we have to oppose it in regards to protecting our treaty and our Aboriginal rights.

Thank you.

Mr. Chairperson: Thank you, Mr. Sutherland.

Other questions from members of the committee?

Mrs. Bernadette Smith (Point Douglas): Thank you, Mr. Sutherland, for coming and presenting.

In debate, the minister had mentioned that she'd actually consulted with Peguis First Nation. So has Peguis First Nation been consulted with, and do you know any other First Nations of the other 62 that have been consulted on this bill?

Mr. Sutherland: No, I'm not. I'm not a hundred per cent sure. I know Brokenhead First Nation was talking to–chief of Brokenhead, Chief Deborah Smith, was talking to Chief Hudson.

The consultation–like, I'm the consultation co-ordinator for Peguis First Nation, and talking to us and sending correspondence is not a consultation. I mean, when we take consultation, we take it seriously and it goes to our constituents–the people of Peguis–whether the consultation be in Peguis, Selkirk or Winnipeg. We have 10,000 members or more residing all over southern Manitoba, and we do numerous consultations throughout the year, and it's all done through my office. So, there was no real form of consultation provided to Peguis First Nation other than correspondence and some talking to leadership.

And when we consult, leadership does not consult on the behalf of its nation; consultation happens with the people of Peguis First Nation, and that way the community leadership understands the direction that comes directly from its people.

Thank you very much.

Mr. Chairperson: Thank you, Mike Sutherland. I understand Minister Gordon may have a follow-up question, is that true?

Ms. Gordon: I do. Thank you very much, Mr. Chair.

And I would like to correct the record that Hansard will not show the comment that the critic has stated from debate. What Hansard will show is that I shared at debate that I had a conversation with Peguis First Nation leadership regarding the youth hubs and our work that will be undertaken with the group in terms of development of a youth hub. And that is what Hansard will show, so I'd like to correct the record in regard to the critic's incorrect statement tonight.

Thank you, Mr. Chair.

Mr. Chairperson: Thank you, Mike Sutherland.

Any response to the minister? It's up to you, of course.

Mr. Sutherland: No, that's fine.

Mr. Chairperson: Okay.

Are there questions from members of the committee?

An Honourable Member: Question.

Mr. Chairperson: Mrs. Smith, go ahead.

Mrs. Smith: Mr. Sutherland, are you aware that during debate I called on the minister to take this legislation and go back to the drawing board, talk to First Nations and consult with them first before even drafting legislation and bringing forward. Then after, you know, saying that the–she sent out letters to the communities, she's had a conversation with one chief of the 63 First Nations.

Do you think that this legislation should be going forward, considering that this minister–and she's new to her role, I get that. She's, you know, a new M-E–MLA, she's new to government, you know, maybe she doesn't understand the role–

Mr. Chairperson: The time. Time check, Mrs. Smith. We're over time.

Can you quickly wrap it up?

Mrs. Smith: Do you think that this legislation should go forward?

Mr. Chairperson: Mike Sutherland, a brief response, if you may.

Mr. Sutherland: I can't answer that because I don't know the full, I guess, what's been done and what needs to be done. When consultation happens with our community the formal process is done through our office and we set up the meetings. And that talking and conversing to us is not a form of consultation. We take consultations, as I said before, to the community.

If this bill needs to be passed and it affects the sovereignty *[inaudible]* then, yes, a formal consultation has to go through and done properly. And then through that consultation you will find the responses from the First Nation community that you consult with, and then you take it from there.

Thank you.

Mr. Chairperson: Thank you, Mike Sutherland, for that response and for taking the time to stay up for committee and to participate even if only by the phone. We very much appreciate the efforts that you went through and the time that you spent with the committee in answering questions from the members of the committee, as well.

So that concludes the list of presenters that I have before me.

* * *

Mr. Chairperson: In what order does the committee wish to proceed with clause-by-clause consideration of these bills? What order would the–should we do the bills?

Minister Stefanson has a suggestion. Go ahead.

Hon. Heather Stefanson (Minister of Health and Seniors Care): Yes, numerical is fine. That's fine.

Mr. Chairperson: Numerical order. If that's–is that agreeable to the committee?

All right.

Bill 10–The Regional Health Authorities Amendment Act (Health System Governance and Accountability)

(Continued)

Mr. Chairperson: Then we will proceed with numerical order and we're going to begin with clause-by-clause consideration of Bill 10.

First, does the minister responsible for Bill 10 have an opening statement?

Hon. Heather Stefanson (Minister of Health and Seniors Care): I do, Mr. Chair. Just very, very briefly. Bill 10 will amend The Regional Health Authorities Act–

Mr. Chairperson: Sorry. One moment. Sorry. Apparently, for Hansard's sake I need to again say: thank you, and now, Minister Stefanson, you can proceed. So I give you the floor, Minister Stefanson.

Mrs. Stefanson: Very briefly, Bill 10 will amend The Regional Health Authorities Act and a number of other acts consistent with the blueprint for the health system transformation to provide the legislative framework to support the transformation.

In particular, Bill 10 supports the health transformation principles of improved and effective health services, role clarity and accountability for Shared Health, CancerCare Manitoba, and the five regional health authorities; the seven major organizations that provide health services to Manitobans. Clarifying the respect of roles of organizations involved in the delivery and administration of health care are foundational to the success of the overall transformations.

Thank you, Mr. Chair.

Mr. Chairperson: We thank the minister for that opening statement.

Does the critic from the official opposition have an opening statement?

Please proceed, MLA Asagwara.

MLA Uzoma Asagwara (Union Station): Bill 10 amends The Regional Health Authority's Act to consolidate administrative services related to health care, and to centralize the delivery of certain health services across Manitoba.

Shared Health is designated as the provincial health authority and given numerous responsibilities, and under this bill, each health authority must enter into an accountability agreement with the minister and

prepare an annual strategic and operational plan for the minister's approval. They must also obtain the approval of the minister to acquire certain equipment. This bill also eliminates the Addictions Foundation of Manitoba, which will directly harm Manitobans who are struggling with addictions.

***** (22:50)

This bill is about the Premier (Mr. Pallister) and his Cabinet giving themselves widespread authority over the health-care services Manitobans depend on. Bill 10 tightens the Pallister government's grip over health regions and gives the minister the power to take away any authorities they have as she sees fit.

Bill 10 gives the minister broad regulation and policy-making powers to reshape regional health authorities and health agencies. Part three of the act gives the minister broad powers to vary and create regional health authorities, meaning she could amalgamate health authorities or even collapse all of the health regions into one through regulation and without consulting Manitobans. This is not accountability.

The Premier (Mr. Pallister) and minister should lay out their plans for such reforms up front, but they would rather make massive changes to our health-care system in a back room where Manitobans cannot hold them to account.

Bill 10 exempts huge portions of health regions' activity from freedom of information. Section 23.1(4) creates an exemption in FIPPA for records, including opinion or advice, and I quote, "prepared solely for use by a standards committee".

This is concerning, as we have no idea about the scope and mandate of these committees. The transformation functions of Shared Health could now easily be moved inside a standards committee, removing their activities completely from public scrutiny.

This is not acceptable, and it's incredibly concerning for all Manitobans. The Pallister government decimated our health-care system since they took office and continue to cut during a pandemic. Giving the minister more power over health authorities will only worsen the quality of care Manitobans receive.

I'd like to thank all of the presenters for providing their valuable input on Bill 10, and I sincerely hope that the minister will listen to Manitobans and stop cutting the health-care services Manitobans need.

Mr. Chairperson: We thank the member.

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

Also, if there is agreement from the committee, I, the Chair, will call clauses in blocks that conform to pages, with the understanding that we'll stop at any particular clause or clauses where members may have comments, questions or amendments to propose.

Is that agreed? *[Agreed]*

Clauses 1 through 3–pass; clause 4–pass; clause 5–pass; clause 6 through 9–pass; clauses 10 through 12–pass; clauses 13 through 16–pass; clauses 17 through 19–pass; clauses 20 through 22–pass; clauses 23 and 24–pass.

An Honourable Member: Can I ask–sorry.

Mr. Chairperson: You may.

MLA Asagwara: Okay. Can I–I think I actually missed something, that–

Mr. Chairperson: I'm so sorry. I'm a little bit–I see a five-page script ahead of me and I'm in too much of a hurry, perhaps.

MLA Asagwara: Is it possible–may I ask for leave to revert back to clause 3?

Mr. Chairperson: MLA Asagwara is asking for leave to revert to clause 3–is that agreeable? *[interjection]* One moment, please.

All right, we've now got everything straightened away and I, as Chair, have been suitably chastised and I will slow down so that everybody can follow along and keep up.

All right. We will continue on now. Shall clauses 23 and 24 pass?

Some Honourable Members: Yes.

Some Honourable Members: No.

Mr. Chairperson: I hear a no. MLA–

Shall clause 23 pass?

An Honourable Member: No.

Mr. Chairperson: No? I hear a no on clause 23.

MLA Asagwara: I'm just wondering if I can use this opportunity to ask the minister a few questions regarding this clause? Yes? Okay, wonderful.

So, section 23.1(1) establishes the standards committee powers, including to take actions or systemic changes that should be made to improve the

quality of patient care or services provided by a health authority, health corporation, health-care organization or health-care provider.

This is an especially broad authority, and the concerns that I have are that this could include virtually any organization, action or plan that is about better health care.

So, I'm wondering if the minister could provide clarity around what her intentions are with giving such broad powers to standards committees that we now know, based on this legislation, would be exempt from FIPPA?

Mrs. Stefanson: So, these standards are actually in place now, and what these are doing is just–this is actually on the advice of the Ombudsman, and expanding the–providing for the protection of those–of the information, right? Exactly.

Mr. Chairperson: All right. Further questions, MLA Asagwara?

MLA Asagwara: Okay, so I suppose, you know, when I think about the fact that exemptions–certainly, we know that exemptions might be made for different regulatory authorities, like the college of physicians or nurses.

The concern with this bill is that the way that it's written–like I've already said, it kind of so broadly–it's so broadly written that it essentially is saying that virtually any unit or any organization or action or plan could be imbedded in a standards committee and thereby exempt from FIPPA, and that's what the concern is.

So, can you address that specifically?

* (23:00)

Mrs. Stefanson: So this has been–this makes it–actually it hasn't been this explicit in the past in terms of the protections in place, and so this just specifies that more and puts further protection in place.

And again, this is supported by the Ombudsman and was something that they wanted.

Mr. Chairperson: Shall we continue with clause-by-clause then?

One more question.

MLA Asagwara: Can the minister explicitly state whether or not she intends to define the transformation organization office, a subunit of that organization or similar unit as a standards committee?

Mrs. Stefanson: No. The standards committees are appointed by the provincial health authorities.

Mr. Chairperson: Are we prepared to continue now with clause-by-clause?

Clause 23–pass; clause 24–pass; clause 25–pass; clauses 26 and 27–pass; clauses 28 and 29–pass; clauses 30 and 31–pass; clauses 32 and 33–pass; clauses 34 through 39–pass; clauses 40 through 43–pass; clauses 44 and 45–pass; clause 46 through 49–pass; clause 50–pass; clauses 51 and 52–pass; clauses 53 through 55–pass; clause 56 and 57–pass; clause 58–pass; clauses 59 through 61–pass; clauses 62 through 64–pass; clause 65–pass; clauses 66 through 70–pass; clause 71–pass; clause 72–pass; clauses 73 and 74–pass; clauses 75 and 76–pass; clauses 77 through 80–pass; clauses 81 through 83–pass; clauses 84 and 85–pass; clauses 86 and 87–pass; clauses 88 and 89–pass; clause 90–pass; clause 91–pass; clauses 92 through 94–pass; clauses 95 through 97–pass; clauses 98 through 101–pass; clauses 102 through 105–pass; clauses 106 through 108–pass; clauses 109 and 110–pass; clauses 111 through 114–pass; clauses 115 through 117–pass; clauses 118 through 120–pass; clauses 121 through 124–pass; clauses 125 through 129–pass; clause 130–pass; clauses 131 through 133–pass; clauses 134 and 135–pass; enacting clause–pass; title–pass. Bill be reported.

That concludes clause-by-clause consideration of Bill 10.

Bill 56–The Smoking and Vapour Products Control Amendment Act
(Continued)

Mr. Chairperson: We'll now proceed with clause-by-clause consideration of Bill 56.

Does the minister responsible for Bill 56 have an opening statement?

Hon. Audrey Gordon (Minister of Mental Health, Wellness and Recovery): Mr. Chairperson, very briefly, commercial tobacco remains the leading preventable cause of premature death in the world, and smoking kills more than 2,000 Manitobans every year.

There are growing concerns on the negative impacts of vaping, such as promoting nicotine dependence in our youth and lung damage and other potential long-term health impacts of inhaling the chemicals in vapour products that are still being assessed.

You can read more in the Health Canada vaping website for additional information.

The Smoking and Vapour Products Control Act currently provides that it does not apply to a place or premises occupied by a federal work undertaking or business or on reserves, except for prohibitions in the act respecting the smoking and vaping of cannabis.

This exception is unique in Manitoba legislation, and based on the results of an interjurisdictional scan in Canada, it means that the health protection measures relating to the harmful activities of smoking and using e-cigarettes are not applicable across Manitoba.

Bill 56 will repeal this exception so that the act will apply across Manitoba, subject to legally recognized exceptions. This amendment is intended to provide equitable access to healthy, smoke-free and vapour-free enclosed public places and workplaces for all Manitobans, and support the denormalization of smoking and using vapour products for children across Manitoba so they're not encouraged to engage in these harmful activities.

Thank you, Mr. Chairperson.

Mr. Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

Mrs. Bernadette Smith (Point Douglas): I do, Mr. Chair.

Bill 56 is yet another example of the Pallister government bringing forward legislation that impacts Indigenous communities without first consulting with those communities.

As we've heard from every single presenter on this bill tonight, I hope that the minister listened intently and will scrap this bill and, in the future, will learn from this experience that consultation with First Nations does matter.

Under the Smoking and Vapour Products Control Act, areas within federal jurisdiction are exempt from the rules respecting smoking and vaping and the advertising and sale of tobacco and vapour products.

This bill removes the exemption. The act now allows–now applies across Manitoba, subject to other legally recognized exemptions–exceptions–sorry. This impacts Indigenous communities, yet the Pallister government did not consult them at all before introducing this bill.

This is damaging to the relationship between Manitoba First Nations and the Pallister government, and this isn't a good start for this minister in establishing a relationship with First Nations.

While First Nations will still be able to have their own bylaws in place regarding smoking and vapour products, it is disappointing that they are not—that they were not consulted on this bill, and that VLT facilities will be tied to this bill, as we heard from Grand Chief Arlen Dumas.

Of course we know that reconciliation and consultation with Indigenous communities has never been this government's priority. We have a Premier (Mr. Pallister) who unapologetically uses racialized language to create division between Indigenous and non-Indigenous Manitobans. He and his caucus only support the right to protest when it's a cause they support, and they are trying to use legislation to shut down any protests they don't agree with, particularly by Indigenous peoples.

* (23:10)

This government is clearly not committed to reconciliation when they won't even talk to Indigenous communities about bills that affect them during the draft stage. And sending a letter to First Nations and calling a meeting a few days before a committee meeting is not meaningful consultation, and is disrespectful to First Nations.

It is notable that the Canadian Cancer Society has removed their support for this bill because the Pallister government did not first consult with First Nations and they respect the consultation with First Nations, which this minister should also do.

I'd like to thank all of the presenters for providing their valuable input on Bill 56, and I hope that the minister will listen to Manitobans and begin to build a meaningful relationship with Indigenous communities by recognizing them as true partners and their inherent right to self-determination. This is not a good show of respect by the minister to First Nation communities.

Miigwech.

Mr. Chairperson: We thank the member.

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

Clause 1–pass.

Shall clause 2 pass?

An Honourable Member: Pass.

Some Honourable Members: No.

Mr. Chairperson: I hear a no.

Mrs. Smith: This bill has failed to consult with First Nations who will be impacted by this, and we will not support it.

Mr. Chairperson: Any other members wishing to speak at this time?

All right, then we will vote on clause 2.

Voice Vote

Mr. Chairperson: All those in favour of clause 2?

Some Honourable Members: Yea.

Mr. Chairperson: All those opposed, nay.

Some Honourable Members: Nay.

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

An Honourable Member: A recorded vote, please.

Mr. Chairperson: Mrs. Smith, sorry, I have to recognize you before you ask.

Recorded Vote

Mrs. Bernadette Smith (Point Douglas): A recorded vote, please.

Mr. Chairperson: A recorded vote having been called.

Well, for the information of all the members of the committee, recorded votes take place in a similar way to those in the Chamber. All those in favour on the committee will please raise their hands and the clerk will then count–and rise and count the hands out loud and then, similarly, will do the opposition.

***A COUNT-OUT VOTE** was taken, the result being as follows:* Yeas 3, Nays 2.

Mr. Chairperson: Clause 2 is accordingly passed.

* * *

Mr. Chairperson: Clause 3–pass; enacting clause–pass; title–pass. Bill be reported.

Bill 67–The Public Health Amendment Act
(Continued)

Mr. Chairperson: We will now move on to Bill 67 clause-by-clause consideration.

Does the minister responsible for Bill 67 have an opening statement?

Hon. Heather Stefanson (Minister of Health and Seniors Care): I do, Mr. Chair.

Very briefly, this bill will amend public–The Public Health Act to explicitly address the authority of the Chief Provincial Public Health Officer to issue public health emergency orders prohibiting or restricting the movement of health-care staff between personal-care homes and other health-care facilities and between home care and health-care facilities.

This authority is currently included in the more general public emergency order-making authority that is provided to a chief provincial public health officer in The Public Health Act. This authority has been used by Dr. Roussin to ensure–to issue the current public health emergency orders restricting staff movement at personal-care homes, which are still in effect.

The proposed amendments will also enable the Chief Provincial Public Health Officer to make orders to address employment matters arising from public health emergency orders prohibiting or restricting the movement of health-care staff.

The amendments will enable Dr. Roussin to continue the order re: personal-care home operations issued under The Emergency Measures Act to deal with employment matters arising from the public health emergency orders restricting staff movement at personal-care homes after that order expires on April 15th, and other such orders, if necessary, in response to the pandemic.

The amendments are intended to be used in the current pandemic and will be automatically repealed in one year.

Thank you, Mr. Chair.

Mr. Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

MLA Uzoma Asagwara (Union Station): Bill 67 amends The Public Health Act to enable the chief public health officer to make orders during an epidemic that prevent people from working at more than one hospital, personal-care home or other facility.

During the COVID-19 pandemic, our health-care system was pushed to the breaking point and we saw the importance of all Manitobans being able to access quality care close to home. An unacceptable number

of COVID-19-related deaths occurred in our personal-care homes, clearly demonstrating the deep, systemic flaws in the way we care for our elders.

During this pandemic, the Province tried to implement a one-site rule for personal–sorry, for PCH staff, but these staff were so under-supported that this was impossible for some PCHs who had to apply for exemptions to the rule just to have enough staff to take care of their residents.

Now, this is the direct result of the Pallister government's deep cuts to our health-care system, including cuts to personal-care homes. A one-site rule during a public-health crisis is an excellent idea in principle, but it won't be practically possible under the Pallister government's cuts.

Currently, a single-site order is in place under the powers of section 67 of The Public Health Act, so the powers proposed by this bill already exist and could be used in future epidemics and pandemics. Additionally, this bill applies to hospitals, personal-care homes or other facilities–that's a direct quote–and it is still vague as to what could be considered one of these other facilities.

And I was pleased, actually, to see one of the presenters echo the concern around this language–Shannon McAteer spoke to this specific issue. And I was really relieved to see that folks are picking up on this language and amplifying their voices and other people's voices around concerns for this.

You know, we're disappointed that unions were not consulted in this bill, despite the impacts this bill will have on them and their members. Manitobans deserve a government that takes their health seriously and makes the appropriate and necessary investments, not one who makes cuts at the expense of Manitobans' health.

I'd like to thank all of the presenters for providing their valuable input and participating in the democratic process. I hope that the minister listens to the suggestions and feedback that Manitobans provide.

Mr. Chairperson: We thank the member.

During the consideration of this bill, I'll 'sow' the enacting clause and title are postponed until the other clauses have been considered in their proper order.

Clause 1–pass; clause 2–pass; clause 3–pass; enacting clause–pass; title–pass. Bill be reported.

The hour being 11:19 p.m., what is the will of the committee?

Some Honourable Members: Committee rise.

Mr. Chairperson: I thank you all for your participation this evening and for the good harmony that we could have between the members. Meeting is adjourned–committee rise.

COMMITTEE ROSE AT: *11:20 p.m.*

WRITTEN SUBMISSIONS

Re: Bill 56

We, the First Nations of Island Lake residing in the Garden Hill, St. Theresa Point, Wasagamack and Red Sucker First Nation, do hereby affirm that we have never relinquished our inherent right to govern ourselves and continue to maintain the freedom and spirit of the First Nations Self-Governance as practiced by our ancestors.

We the members for the First Nations of Island Lake, do hereby declare the right to exercise and assert our sovereignty of self-governance and self-determination by opposing the Province of Manitoba's attempts to insert itself into our inherent First Nations jurisdiction through Bill 56.

Island Lake First Nations have never rescinded our rights to govern ourselves and therefore we stand by our inherent sovereign right to nation-to-nation relationships with the Crown in Right of Canada as was recognized in the signing of the Island Lake Adhesion to Treaty 5 in 1909. It is the Crown's responsibility to fulfill its obligation such as to provide the Medicine Chest as per the treaty process.

The Province of Manitoba is violating our Inherent and Treaty Rights that are affirmed in Canada's 1982 Consitution that have been protected by many Supreme Court of Canada rulings. Therefore, we reject and will not affirm any attempt by the Province of Manitoba to violate our jurisdiction and our right to enact our own laws for the health and wellbeing of our people.

Sincerely,
Chief Dino Flett

Representing Island Lake First Nations

[Written submission removed - by leave]

[Written submission removed - by leave]

[Written submission removed - by leave]

[Written submission removed - by leave]

The Legislative Assembly of Manitoba Debates and Proceedings
are also available on the Internet at the following address:
http://www.manitoba.ca/legislature/hansard/hansard.html