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MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Fifth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

Tuesday, April 21, 1992

The House met at 8 p.m.

COMMITTEE OF SUPPLY
(Concurrent Sections)

HEALTH

Mr. Deputy Chairperson (Marcel Laurendeau): Good evening. Will the Committee of Supply please come to order. The committee will be resuming consideration of the Estimates of the Department of Health. When the committee last sat, it had been considering Item 1.(c) Evaluation and Audit Secretariat: (1) Salaries.

Mr. Neil Gaudry (St. Boniface): Mr. Deputy Chairperson, this afternoon I received a letter from one of my constituents and a copy went, I believe, to the Minister of Health (Mr. Orchard). We will put some of the comments on the record.

His letter says: I am writing this letter to you to raise what I believe to be a deficiency in the public health care system in this province. The case involves my father, currently 75 years old. He is in need of a hip transplant and is currently on the waiting list for surgery at the Health Sciences Centre. The surgery had been originally scheduled for September after about a two-year wait, but with the recent delay, I understand resulting from lack of funding, the surgery has been delayed to December.

To be fair, the gentleman called me this afternoon, and he has been given a date of October 7.

I understand that the principal criterion defining emergency versus elective surgery in this sense then is the issue of mobility. Simply, if the person is immobilized by the hip, they go to the A list, if you will. To be truthful, my father is technically mobile. However, there is a quality issue that, in my opinion, should be considered. For example, my father is an Anglican priest and has been forced to curtail many of his activities, performing services for only a certain period. He can endure the pain of standing on his feet for only a short period. He has done most of his ministry to seniors, both those shut in and not, performing a valuable service unpaid to society. He is unable to do this as frequently.

It continues: I could continue the litany of examples, but I trust that my point is made. Because he is technically mobile, he is on the B list. Here, in my opinion, are two ironies to the situation. First, I have a 92-year-old grandmother in a nursing home, virtually a vegetable, who would be operated on tomorrow if she were to break a hip. A productive member of society has to wait. A second irony is that the cost will be the same for the operation if it is done now or later, so why delay it? Finally, while I would prefer the operation being performed locally, there are other options available out of province which our medicare system will not fund, so my father and those like him continue to rely on expensive, potentially damaging medications and wait.

I am concerned with cost constraint and cost control. I pay substantial taxes–

* (2005)

Mr. Deputy Chairperson: Order, please. Can I ask you to pull up the mike? The answer is not very clear.

Mr. Gaudry: I am concerned with cost constraint and cost control. I pay substantial taxes and laud the efforts to keep them reasonable. However, I also concern myself with where the money is being spent. I certainly advocate spending the dollars where they make a difference to society. I fail to see where delaying so-called elective surgery provides any net gain to society where the individual concerned is a productive member putting something back into that society. One final note about my dad. He does not complain, he endures. He happens to be a veteran and saw so much suffering in the war that he feels lucky that he is not worse off. I believe that many examples such as my dad are out there.

My request is simply this. Change the priorities from taking care of the budget to taking care of the people. My dad will probably not live another ten years, but society owes it to him and to those like him to make those years the best they can be. I am looking for special treatment for my dad, you bet. He and those like him deserve it. The inevitable response from the officialdom will undoubtedly be,

sure, but who is going to pay for it? Most of us, myself included, who watch our loved ones suffer the humiliation, the personal embarrassment and anxiety needlessly, would pay more taxes if it would make the difference. I hope that you can help make the difference.

Would the minister comment on the process for this kind of request from constituents who request on behalf of their parents?

Hon. Donald Orchard (Minister of Health): Mr. Deputy Chairperson, that is not an unusual letter the Minister of Health gets in the province of Manitoba today, five years ago; that a Minister of Health gets anywhere in Canada, today, five years ago, the difference being that it is getting probably more commonplace that these letters land on ministers' desks.

Let me give you the dilemma. I have every sympathy with the individual for whom you are bringing that case forward. Ten years ago, maybe I am wrong in my years, but there was a time when medicare came in that this individual would not have had a service which could be accessible under any program to help alleviate the suffering from joint deterioration, hip and knee. That is one of the absolute quandaries that ministries of Health are facing in this province and across Canada, because we have an insured system which has brought, as a new procedure which we will pay for under the health plan, such technological innovations as joint replacement. It was not there, I do not believe, as an original insured service 20, 25 years ago when the system came in. It was, quite frankly, probably not considered.

* (2010)

This is joint replacement, hips and knees, today. We are going to be faced over the next decade–and this gets us into the issue of pharmaceuticals. There is another area where there are going to be very narrowed and potentially effective pharmaceuticals coming on the market. I do not have the prices in front of me. I thought we might get in this debate when we reached the Pharmacare line. This new generation of pharmaceuticals is several tens, if not several hundred dollars, per dose. Under an insured health care system, once they are there, there is an automatic expectation that they should be made available to those to whom the process, the pharmaceutical, the procedure is prescribed. That is why, right across Canada and, indeed, North America, we are faced with an incredible dilemma of costs in our health care system.

Take the compassion aside. Take the obvious desire that this family has, this individual has, to have their mobility reinstated. That is very, very natural. The difficulty that it puts the system of health care provision is that reinstating that mobility is now proposed in terms of medical need. It is no doubt going to alleviate suffering, increase mobility, increase quality of life. Many procedures will do that, all of which are going to be demanded of the taxpayers.

I have often said, the changing technology and the basic miracle medicine that we can now practise in North America and Western worlds will continue to drive our costs, so that we truly will not be able to afford a publicly-funded, universally acceptable health care system. I do not think I am stating something that is alarmist; I think I am making a statement of fact.

In this particular case, the family say, well, raise the taxes, and I mean, they are sincere, because they would believe that would be appropriate if that is what would be required to cover the cost of this operation. But, boy, I will tell you, one of the messages we get when we detach ourselves from the individual circumstances across this nation and this province, no exception, is that the citizens across this country are saying, we are already being taxed at too high a rate.

We cannot deficit finance the system, because that also is a significant challenge and problem that all of us acknowledge. We cannot continue to deficit finance current consumption. I mean, all it is is a tax on our children and grandchildren.

So it is one of those dilemmas. The way we manage it is we provide budgetary allocation which will allow a maintenance of program at a minimum and, hopefully, some expansion annually in terms of the program. That does not allow access to the system as quickly as a number of individuals who are prescribed the procedure are able to access the system. I mean, there are significant waiting lists in both hips and knees.

* (2015)

There is some inconsistency in that waiting list that we found out when we took a look at the process at Health Sciences Centre with them undertaking their annual budget and more dollars within the nine months of the 12-month funding year. Some doctors have significantly higher procedure waiting

lists and, hence, longer waiting times. Although the suggestion is made from time to time that maybe your constituent here ought to seek a reference to another physician, hopefully to access the system quicker with a physician who is not as busy as possibly the one he has been referred to, but that is a partial solution, because all the other physicians are under the same constraint of accessing operating time.

I guess, I have to indicate to my honourable friend that amongst the many demands on the system that are made for elective surgeries and for funding of any number of very worthy and worthwhile programs, we have in general terms placed more money at the disposal of those programs over the last few years. There have always been requests for a greater level of funding, and that will never go away. That will be here as long as we have a publicly funded health care system. It has been traditional for 20 years; it will continue.

It is part of the resource allocation decisions that we are asking physicians to try and come around the issue on behalf of their patients because this government, and I speak apolitically here, does not have the unlimited funding ability to provide the surgical capacity to deliver all of the knee and hip surgeries that are certainly being recommended across the province.

Mr. Gaudry: Could the minister tell me who establishes the priorities for the surgery, for example, at the Health Sciences Centre?

Mr. Orchard: I am going by what I understand to be the system. We allocate a global budget figure to the Health Sciences Centre. From that, they will divide that budget amongst the many program areas that they have over at the Health Sciences Centre, part of which is an orthopedic surgery program which involves knee and hip replacement.

The orthopedic section will receive an allotment of, I believe first off, surgical theatre time, access to the surgical theatres and, of course, part of the global budget. That process is undertaken by senior management coming around the global budget issue and making the allocation as they best can, given the clear indication that there has not been, nor will there probably ever be, an infinite budget which they can access, so that they, the professionals, in terms of management and physicians, try to make the best allocation resources decisions that they can around the global budget that is provided to the facility.

Mr. Gaudry: For example, this man had been on a waiting list for two years, and then he was given a date of December. Now in the last week he has been given a date of October 7. Is this because they are doing more surgery lately, or is this that he has been established as a greater priority than he was the other time?

Mr. Orchard: I cannot answer that, but I would suspect that the December date, the individual may well have been part of the decision process which said they would suspend knee and hip operations for the last three months of the year, although December is the fourth month. About the end of November they had utilized their budgetary allocation decided on the first of the year on knees and hips, and they ran into the end of December actually with over-budget allocations, allocations beyond what was originally budgeted at the start of the fiscal year.

* (2020)

I cannot indicate whether that clearly is the reason, and if I have a letter in the office I will try to make that determination, but I would suspect that this individual's surgery no doubt was cancelled in December because of last year's circumstances of doing the program and more in nine months versus 12. The rescheduling, and this one I am more clear on, would have been made by the physicians in terms of a prioritization of the patient load that, I believe, seven surgeons or eight–it is somewhere in that number of orthopedic surgeons doing hips and knees at the Health Sciences Centre–they would make an effort to prioritize their patient waiting list to make sure that the most urgent needs are cared for first, or are served first, and they have developed their internal assessments so that there is some hope for consistency in that approach at the Health Sciences Centre.

I might add to my honourable friend that that is one of the issues that we are asking Dr. David Naylor and the head of surgery–am I using the right terminology at Health Sciences Centre and St. Boniface?–the vice-presidents of medical at Health Sciences Centre and St. Boniface; and Dr. MacKenzie at Victoria General Hospital to come together along with assistance from Dennis Roch, out of this area of the department to try and develop some consistency around selection of appropriate candidates for the surgery and prioritization along the waiting list between facilities so that there is some consistency.

Another thing that we find is that sometimes the waiting list can be not necessarily accurately reflective of the waiting because, for instance, when we investigated cardiac by-pass surgery a couple of years back, we found that even though there were only two hospitals offering the program, we found common patients on both hospital waiting lists and that may well exist here too.

Mr. Gaudry: Yes, I thank the minister for his answer, and I will give him a copy of the letter so he knows which one we are talking about.

Changing–not gears, because I will go too fast–the minister knows very well that we have met several LPNs in the last six weeks to eight weeks and met some again last week from St. Boniface. Their concern was the fact that, to me there are rumours that they want to close down the LPNs in St. Boniface and do away with them. Can the minister indicate what is going to happen with the LPN, firstly for my own St. Boniface Hospital?

Mr. Orchard: I guess we could go over this ground for the fifth time in these Estimates and about the tenth time in the House, but that is all right. I have all kinds of time. The issue came up at St. Boniface because of a discussion in, I believe, late November 1991 at the board level at St. Boniface, where consideration was given to curtailing enrollment in the licensed practical nursing course as offered at St. Boniface.

I believe members from the MALPN were either at the meeting or were informed of that meeting. That led to a significant concern over the issue, a press conference by the association in mid-December. I answered at that time that I was aware that the issue was being discussed at St. Boniface Hospital at the board level, but they had not asked for direction from government or approval from government even though government is not necessarily the final decision-maker there.

Subsequent to that discussion and some, I think, requests for information, et cetera, the issue did not conclude with the closure of the school of LPN nursing, and they will be accepting graduates for the foreseeable future. Now, there is no–I will try to be as direct as I can–commitment for permanent operation of the school, but plans for the closure of the school for the interim time have been deferred, and students are being accepted into the program.

* (2025)

Mr. Gaudry: I will ask one more question, because my associate here has asked me if I was taking over. Mr. Deputy Chairperson, to the minister, has the minister arranged a meeting with the LPNs in the near future?

Mr. Orchard: When that question did not come up this afternoon, I provided an answer without being asked. I indicated that I am attempting to set up–I wanted to have a meeting as soon after their Thursday general meeting of the membership back about three and a half, four weeks ago. My time schedule has simply not allowed me to get together, because we have been in Estimates and I was away for that week.

Yes, I want to meet as soon as possible. As a matter of fact, my appointments–my secretary and I discussed it again and she is attempting to fit the schedule in the very near future.

Mr. Gaudry: One final comment. Yes, the fact that in the last couple of days the honourable member, well, the official Leader of the Opposition (Mr. Doer), has been waving the flag to me that there is going to be a layoff of some 500 employees in St. Boniface. I was wondering if the minister maybe can indicate to me where those 500 jobs are going to be affected in St. Boniface in the health care services?

Mr. Orchard: You have a rumour that I have not heard.

Mr. Gaudry: I just wanted to put it on the record, because I do not think anybody wants to see 500 jobs lost in the health care, and I think the minister himself, and all my other colleagues in the Legislature.

I thank the minister for his reply.

Mr. Deputy Chairperson: Item 1.(c) Evaluation and Audit Secretariat: (1) Salaries.

Mr. Gulzar Cheema (The Maples): Mr. Deputy Chairperson, I do have a few questions. I was sort of worried there the member for St. Boniface was really taking over. Everybody wants to be a Health critic, and I would love him to have this portfolio.

Can the minister ask his staff to get this information ready for the Health Services Commission Estimates? Discussion on the waiting lists in various hospitals of the various surgical procedures, because that has been an issue that comes up many times. Each and every person has his own waiting list and each and every person who is affected by the delay in surgery has a number of other reasons to ask for. I think it will be worthwhile to have the full discussion on how the waiting lists

are taking place, and if there is any co-ordination and how this system can be improved. I think it will require some modification to the staff.

My question on the issue of the nursing education, that part of this evaluation branch is to provide support to the minister's Council on Nursing Education. During the last week's debate in the nurses' union, it was clear that they wanted to know where the nursing profession is going. Even though I did not get any particular sense from the floor also whether which direction they wanted us to ask him questions, because it was probably not very clearly defined in my own mind, I just want to ask the minister: What is this government's policy in terms of the nursing education, whether the minister's own policy direction is to go along with to have the BN by the year 2000, or is there a different approach by the Minister of Health?

* (2030)

Mr. Orchard: The nursing education issue is one which is a very complex one. There is a whole dynamic of requirements that are impacting on the system. Move to community care–that is why we are moving for instance with the registered psychiatric nurses towards a new curriculum in both the two-year and the four-year baccalaureate program, because we see in mental health and we have the lead time and the window of opportunity to craft an educational course which is reflective of the move towards community-based care.

I do not think there is any question that that will require a differently trained nurse in psychiatric nursing, and the association has taken up the goal and the challenge and has been working with government for over two years, probably two and a half years, to try to get some sense around the educational programs for psychiatric nursing.

We had to agree to disagree about this time last year, budget time, with the consolidation of Selkirk school into Brandon, but it was done with the overview that we work on an enhanced education system for psychiatric nursing in Brandon, both diploma and baccalaureate. I think, although I would not be so naive as to say everybody is 100 percent happy today, there is considerably less concern about the future of psychiatric nursing today than there was a year ago with the consolidation of the schools, because the rumours abounded then as they did in '84-85 when the Portage School of Psychiatric Nursing was closed that government had the psychiatric nursing profession in their sights and were going to remove them from the health care system.

Well, I think we have clearly indicated that that is the exact opposite of the agenda of the government in terms of psychiatric nursing.

I will try to deal with the nursing issue in general, and generalities are all I can offer, I think to maybe try to get some sense of where we are heading. When I came into government in '88, amongst many issues there was the overriding issue of a report which was endorsed by MARN as our professional body for registered nursing in Manitoba, acceding to BN entry to practise, year 2000, and the regular and constant request of government, both the previous government and of course myself as the new minister as to whether we were going to adopt that goal of entry to practise BN, year 2000.

I was unable and am still unable to endorse that as a goal for registered nursing. However, what we have done in the past four years is set up what is a process which I do not think necessarily was there in the past to try and bring as much professional expertise around the training program as possible so that we develop curriculum, training program and capacity to meet future needs.

The key question is: What are the future needs? I mean, what kind of trained nursing professional do we need five years out, 10 years out in the Manitoba health care system? The best guess that we are trying to put to paper is the survey that we launched in January, which we hope will indicate what kind of care professionals are needed according to the facilities assessment of health care five years out or the managers of the facilities assessment five years out, so that we can then commence planning with the respective associations the appropriate curriculums, No. 1, and the appropriate graduate or enrollment capacity, so that we can take that cyclical up and down out of nursing recruitment.

That is not a perfect process, but it is really the only process that I know of that can maybe give us some clear direction on where nursing as a profession ought to set its goals in terms of curriculum and graduate capacity.

One thing I want to avoid, and I started alluding to it before the break at five o'clock. I think there are a lot of people who are now questioning, asking the very direct question: What happened to the shortage of nursing? As we sat in Estimates two years ago, there was no question that we were being told almost weekly, if not daily, that there is a

shortage of nursing, that they are leaving the province, that conditions for nursing are terrible.

Part of it, I will admit, was build-up to the contract negotiations, and that is fair. I mean, that is the kind of dynamic that we will always have. You are not going to avoid that. What we did do in June, I think of '90, was we launched in co-operation with MARN an advertising campaign on television to try to encourage individuals into the nursing profession.

Within two or three months of the new contract coming in, all of a sudden we did not have a nursing shortage in the province of Manitoba. I think probably, without exception, vacancies that were there before the new contract was signed are no longer vacant. Thompson, I understand, had some recruitment problems, and they do not have recruitment problems now.

What is happening–and this is a very real problem. I have had phone calls from concerned parents who have daughters or sons that are in the nursing programs, and they are questioning, you know, where did the job opportunities go, because we understand new graduates are not facing a buoyant job market, and I think that is right.

It is not only the fact that maybe the shortage was overstated two years ago, but I think economic conditions has a lot to do with it. More nurses are coming back into the labour pool. Maybe the spouse has been laid off or is unemployed or between jobs. The sheer financial pressure of families are bringing, I think, maybe more nurses into the work force, and secondly, those that are already in the work force are taking more hours of work or as many hours of work as they can. Clearly, the shortage is no longer there.

Now let us speculate. Would there be a shortage, if the economy was booming and there were lots of job opportunities in the private sector? I think you might see, as has happened in the past, nurses opt for careers outside of nursing–real estate, whatever–because they are skilled people. But right now we do not have a shortage of nursing that I have been informed of in the province of Manitoba.

I think there are applicants for jobs, vacancies on a pretty regular basis, but that is quite a different contrast to two years ago. If at all possible, and I say if at all possible, I would like to be able to develop some sense of two, three, four and five years out as to what our needs are going to be and the market survey demonstrating what our training needs are going to be. If government is going to have a role in providing the training and if the professional associations are going to have a role in terms of encouraging people to take nursing as a career option and train for it, there has to be some attachment to employment and the needs of the system.

The system is not going to perfectly identify those needs, but we are certainly hoping the survey gives us a good, decent indicator so that we can use that information in our planning of educational capacity, and, indeed, depending on what the survey says, it may well guide us in terms of the type of professional training that is needed, whether there will be the emphasis by the system in one area or another on BN versus diploma versus LPN versus nurse's aide.

Mr. Cheema: Mr. Deputy Chairperson, in his opening statement, the minister made a remark on the mix of services and the mix of health care providers. Can the minister tell us now how the role of nurses will fit into the new community-based program, because some changes have to be made? More specifically, is the province thinking of having the role of RN as a nurse practitioner? Alberta has made those recommendations and they are saying probably within two to three years, they may have a specific definition of nurse practitioner. To do that, as I understand, our Canada Health Act or the regulation under the act does not really allow that so far, because they think that the health care provider who is going to be paid on a fee-for-services has to be a physician or in a similar category.

So there may be some changes that have to be made. I just want to ask the minister, what are his government's views on the role of nurse practitioner in Manitoba in the future?

* (2040)

Mr. Orchard: I want to tell my honourable friend that I had heard the terminology but, I have to be very blunt, I have never had a reasonable explanation of what a nurse practitioner was and what their role was until, as luck would have it, I am at Agape Table this fall and while I am there, an individual, a woman, came over to me, introduced herself as a nurse practitioner. She had trained as a nurse practitioner out of Ontario, and apparently the professional designation no longer exists in Ontario, I think is what she indicated, and she no longer had a professional role which utilized her training skills as a nurse practitioner.

Basically a very interesting conversation, and this individual made the case that the nurse practitioner

as she was trained would offer a significant amount of pre-patient screening for instance in the physician's office, and considerably enhance the ability for quality patient flow through the office because they were doing certain things. Now, that intrigued me, and although there are many issues on the go, this one has not been specifically fast-tracked or identified, but I have made enquiries within the ministry as to whether the nurse practitioner role should be investigated, similar to nurse-anesthetist, because nurse-anesthetists practice just to the south of us here in the United States.

I think in a reformed health care system offering more community care, I do not think there is any question that the nursing profession will pick up a much larger role. I do not think that is even questioned. The one thing that we do not know, and this is always the classic $64 question, is what sort of training standards various care providers ought to have in providing those community-based services, because I just want to remind my honourable friend that one of the very interesting recommendations coming out of the British Columbia Royal Commission on Health Care was their observation that one of the greatest concerns or one of the greater concerns–I will not say greatest–they could foresee in the health care system and its affordability and its ability to deliver services is the overprofessionalization of care giving.

That clearly sends a pretty direct message, I think, to all of us that, as we move toward, say, community-based care that we do not insist on, for all cases, an unaffordable professional trained individual. That is going to require quite a little bit of discussion and insight into how we staff and how we deliver care in the community. That being said, I see a fairly insignificant enhanced role for the nursing profession in community care.

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

Mr. Cheema: I have a few other questions, but I have to make a phone call, a very urgent one. If the member for St. Johns (Ms. Wasylycia-Leis) would like to ask a couple of questions, I will be back in two minutes if it is possible. Would that be okay?

An Honourable Member: Sure.

Mr. Cheema: Otherwise, I do not want to lose the floor.

An Honourable Member: No, go ahead.

Ms. Judy Wasylycia-Leis (St. Johns): I am never short of questions. I would be happy to ask a few questions at this point and also take the opportunity to indicate to you that we are hoping to move through some lines this evening so we can get to some of the major areas of public concern and controversy.

Let me go back to an area that we touched on this afternoon and ask if the minister has had time to review the Urban Hospital Council working group that is working on staff mix and ask him how that fits into the MALPN study and all other reviews and endeavours in this whole area of nursing, education and staff mix in our facilities.

Mr. Orchard: My staff inform me that they were unable to put together that information, but we will have it for Thursday. So if that would be acceptable to my honourable friend, we can have that sort of discussion even if we have to revert back temporarily.

Ms. Wasylycia-Leis: Since we are dealing with this whole area of evaluation, I am wondering if the minister can give us an indication of the impact and the evaluative process that would have been undertaken presumably with respect to the recent fairly sizable increase in personal care home rates.

Mr. Orchard: You mean the per diem? [interjection] We went through the calculation as has been done since 1974 or whatever to establish the per diem. The per diem is established to leave something in the neighbourhood of, give or take, depending on the days, the length of the month, because it varies between a 28-day month and a 31-day month, approximately $110, $115 above the pension.

You start from the basic starting point; then you set your per diems based on sole source of income being pensions. That is the way it has always been done, leaving the individual with somewhere in the neighbourhood of, for average figures, $115 maybe $120 per month for personal needs.

Ms. Wasylycia-Leis: I appreciate that explanation. What accounts for the fact that such a significant increase occurred in one period of time? Is it the fact that there was no regular increase on a year-to-year basis or that there was a change on the pension side to account for the jump from roughly $20.50 a day to $25.25 a day?

Mr. Orchard: April 1, 1992, the rate is $24.90–do we have the schedule that goes back? That represents 35 cents a day. It has not been $20 as

a per diem probably since maybe '85 or '86. The increase has been quarterly now for about seven years, I think. It used to be adjusted on an annual basis, but now the process when I came into government in May of '88 was that it was adjusted on a quarterly basis. That had been the process for three or four years prior to that on the criteria of allowing so much minimum disposable income.

* (2050)

There has not been an increase overnight from $20 to $25. Here are residential charges in effect since July 1973. They started at $4.50 in July of '73, and now 20 years later are $26.30. To give you an example: They have increased by 25 cents quarterly to 35 cents quarterly in the last little while.

The last time it was $20 would have been in November of '88, actually August of '88–1990.

Ms. Wasylycia-Leis: Perhaps it is just my own confusion around this issue. I am certainly not trying to raise an issue here that the minister has to worry about in terms of a hidden agenda. All I am trying to do is understand the current Order-in-Council, which set the rates in the beginning of May of 1992 at $25.25 a day, and then going up some 35 cents a quarter.

My question is basically, prior to this Order-in-Council and the increase for May of 1992, the last increase by Order-in-Council was February 1989, where it went up to $20.50 a day.

Mr. Orchard: There would have been an Order-in-Council circa this time last year to set the rates. I have brought in one Order-in-Council per year, and we try to bring in that Order-in-Council so that it is passed, I believe, by March 31, so that there is a month of notice time until the effective rate increase, I believe, on May 1 of each year, and then thereafter every three months there is a quarterly increase reflecting one month after there is a quarterly increase in the pension.

That is the circumstance that has been–as I say, that was the process that was in place when we came into government in 1988 of quarterly increases reflecting. That was brought in shortly after the federal government changed the pension to a quarterly increase. I think that goes back seven or eight or so years ago.

Mr. Cheema: Mr. Acting Deputy Chairperson, the issue of the RNs, I would like the minister to look into the issue of nurse practitioners from Alberta. The proposal has been made to the Minister of Health in Alberta, and it is my understanding that the role of a nurse practitioner in Alberta might take two or three years for them to have really a nurse practitioner as a practising part of the health care team in Alberta.

There is one more issue there: whether the nurse practitioner is going to be paid fee-for-service per patient, or are they going to be on a salary basis? I think that is where the Canada Health Act comes in. There may be some changes that have to be made or some kind of amendment, or the regulation has to be changed in terms of are they going to be paid fee-for-service, and specifically when we are going to have a mix of services.

You do not want to add on services. You are going to have the role of nurse practitioner, a very specific one, and especially in a community clinic setting. They will be screening patients and doing a specific job, so that job should not be added on, as has been in the past. You release a patient, and the three health care providers who were serving the patient in the hospital, they are doing the same thing in the community.

That does not really save any money in the long run, so I think those things have to be qualified and make sure that their role is specified, and I would like the minister to look into the issue from Alberta because they have done substantial research and work on the issue.

Mr. Orchard: Yes, we will try to get some details from Alberta that maybe we can share later on in the Estimates process. I will stand corrected if I am in error here, but I do not think that the Canada Health Act is an issue here, because I think anyone who is considering–let me put it this way. With the discussion I had at Agape Table with a nurse practitioner, that individual, when employed as a nurse practitioner in Ontario, was in a salaried position. There was no fee-for-service connotation at all to the discussion I had, and I have never heard that broached before.

I would never give consideration to nurse practitioners coming into the system as a fee-for-service potential arrangement. It would be under the basis of a salaried position, like for instance, in most of our community clinics–no, I should not say this, but a goodly number of our community clinics have salaried positions even, let alone the other care professionals that they have there. I do not think that is an issue; however, I will see whether it is. I will try to seek advice on that.

Mr. Cheema: When the system is changing and if those things are not taken into account at the beginning, those things become an issue in the long run. I think that is why it is so important to have a clear idea on the role of nurse practitioner and how that role will fit into our system because, as the minister has said, and many people are asking, there even has to be compensation changes for the physicians.

(Mr. Deputy Chairperson in the Chair)

So if we are going to have add-on services on what we are already paying, then it is not worth it, so it has to be a specific role, a defined role, and should be a substitute to some extent, not an add-on cost to the system. When the system is in the community care, those roles have to be explored and a very essential one it has to be because, when so many patients are going to come to the community, their visits to the physician probably are going to increase if we do not have another alternate midway system put in place.

I think that is why it is so essential to look into that aspect from the beginning, so that you do not end up in a system where you are paying three times the normal stay in the hospital, the same thing, as many people have said, when you release a patient into the community who would need 24-hour high-care services, so basically it is costing the same money as it would cost in the hospital, because all those services were never meant to be a total replacement. They were supposed to be a substitute for some of the services. I just want the minister to realize that is a practical problem that has to be taken into consideration.

Mr. Orchard: That in a way is reflective of the discussion we are into in terms of midwifery, because that can be a valuable replacement service and I have stated, I think quite clearly, that my consideration of midwifery as a professional discipline of choice for women is that it be made available, not as an add-on cost, but as a replacement cost to the system.

The same kind of criteria would apply to consideration of nurse practitioner, or for that matter any other new professional discipline that might come into the system. They have to replace a regime of service in a more economic fashion. That is the only way that I think we can have some sense of ensuring that the patient receives care and that the taxpayer is not unduly burdened.

That is always tough because when you get into these kinds of discussions, there is always someone on the higher level of tier delivery in training who believes that their opportunity to provide services and earn income are being compromised by the additional skills being offered by nurse practitioners, or BNs versus RNs versus LPNs versus–and I mean it is right through that whole spectrum of training turf protection.

* (2100)

Mr. Cheema: The reason is that the many individuals and the many organizations are really worried. They are saying, well, each and every person is talking about community care, and when you do not define it properly and you do not have the system put in place where each and every group has a specific role and at lesser cost. Otherwise, we will end up in a major problem and we may end up spending the same amount of money. So I think those things are a very real concern.

You want a different system, you wanted a system which more efficient, that will cost less, but the roles have to be defined from the beginning. Otherwise it may take another five years to change what we have started now. So I just want the minister to know. Many health economists are saying that is a real possibility. That is why people are not jumping right away. Let us start the community care without doing all the research, without putting everything in place, making sure that the health care provider who will fit into the program will have the training, they have a future in the long run, and have something to fall back on. So I think that those are the very real and major concerns because it could cause ministries to fall very easily if you have 200 patients released in that community, and 200 of them are seeing a physician every day, and it is costing more than would have cost in the hospital in the long run. So I think those things have to be taken into account.

My next question is in terms of midwifery. The minister has made some comment about the issue of midwifery. Can the minister give us an update where we are in Manitoba at this stage?

Mr. Orchard: Mr. Deputy Chairperson, as we dig out the status on midwifery, I want to just indicate to my honourable friend that community care and community-based services have a wide range of interpretation and understanding. There is no question that in some individual circumstances the provision of care in the community for independent living is probably more costly than an institutional

care regime. We have made the choice in some cases that this is an initiative we are going to take because there is a quality-of-life factor there that cannot be replicated in the institution, and recognize that these are costs that are probably higher than institutionalization would be.

Those are exceptional cases. I think where you will see the movement of patient from our high-cost institution to lower-cost institution in community, I think you will find that there is an assessed need of the patient that is very adequately met in the community and, in fact, that the admission to hospital or the occupancy of an institutional bed in an acute care hospital or otherwise is inappropriate. There is more cost-effective care delivery in the community which, as well as being more cost effective, is also very much superior care and more desirable to the individual.

Now, midwifery, let me just flip down to the bottom line. Right now, the working group that was struck in June of last year has four subcommittees formed. They are practice, curriculum, legal and consultation.

Currently the working group is identifying and exploring key issues pertinent to the introduction of midwifery in Manitoba and consultation is occurring with experts in the field from Ontario and Alberta. Discussions are underway between the chair of the Manitoba working group and key individuals in Ontario and Alberta and health and welfare Canada to explore the possibility of a national workshop to address issues of shared importance such as portability of midwifery qualifications.

We are hoping that the working group in the subcommittees will be receiving their input from the key stakeholders as well as the public and will be submitting a report to me in fall of '92 as to whether we implement and, if so, how we implement and what sort of process they would recommend to us.

Mr. Cheema: Mr. Deputy Chairperson, after the report in the fall, when can we expect the legislation to be brought forward after the consultation to make sure that midwifery becomes a legalized practice of health care professionals in Manitoba?

Mr. Orchard: Mr. Deputy Chairperson, I cannot give my honourable friend that kind of indication because I do not know what sort of recommendations the report is going to make to me but, as I indicated to my honourable friend earlier on, one of the preconditions I put on this is that it become not an add-on to the cost of the system, but rather a replacement of service which has all of the regular attachments to it of assuring safe and quality care delivery so that I simply am unable this evening to prejudge what sort of recommendations we would make.

I will say this to my honourable friend, that the reason we are proceeding with a working group is with the obvious desire to bring in midwifery as a care option in the province of Manitoba that we think has an opportunity to contain costs in the system and provide a birthing method of choice that a number of women in the province of Manitoba have expressed an interest in and the desire to have available to them. I share that desire.

Mr. Cheema: Mr. Deputy Chairperson, one of the functions under this secretariat is to draft a new health discipline legislation. Can the minister tell us, are we going to receive during this session The Mental Health Act II, the community component which was supposed to be coming forward, because when we are changing the system as the minister would see it, there is going to be a need to have a community mental health regulation put in place to make sure that the reform becomes effective in the community.

Mr. Orchard: No, Mr. Deputy Chairperson, we are not anywhere close to having that sort of legislation. I have to say to my honourable friend that the pressures on my staff over at the Mental Health Division are such in terms of advancing the mental health reform process that I think they are putting modest effort only into the consultation and meeting process on part II amendments that we discussed last year.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us if he is bringing any other legislation during this session in terms of the health care professionals, not only physicians, but the other health care providers? So many of them have expressed their intentions that some of the regulations are very old, that some of them may need some amendments and some of these changes. We are hoping the minister will bring such a legislation so that those concerns can be heard and the changes can be made. Without real change in health care delivery in terms of the health care providers, it will be difficult to get the best possible care eventually, because when we are changing so many things, you have to make sure that the health care professionals are also along the same line.

* (2110)

Mr. Orchard: Mr. Deputy Chairperson, it is my intention to advance amendments to the professional acts of dentistry, optometry, this year, and hopefully they will be introduced very shortly. I just indicate to my honourable friend that the pattern for amendment was the pharmacy professional act that we passed last year, a process involving a more effective disciplinary screening process and then the option of the public hearing process and of course often increase in fines because they are out of step, but basically the path laid down with the successful pharmacy legislation will be emulated as closely as possible if not identically in both dentists and optometrists, in terms of their professional act.

Then my honourable friend is aware of the minor amendment that we are making to The Denturists Act to remove me as the person responsible for advancing complaints against individual members.

Mr. Cheema: Mr. Deputy Chairperson, a final question on this section is can the minister tell us if there is any internal audit going on in any of the major branches within the department?

Mr. Orchard: You are asking for something other than the normal audit process that they go through, like whether we have any special audits ongoing. I will have to seek advice on that.

For this fiscal year, we propose major audits for mental health, environmental health, a registration system, administration and finance, continuing care and personal care home panelling. Those are the five areas that we are proposing major audits on.

Mr. Cheema: Mr. Deputy Chairperson, a final question. As a politician you always say "final," but it is never the final one.

Can the minister tell us what is the complement in terms of the affirmative action at the senior level within the Department of Health, in terms of how many visible minorities, how many women's groups, and how many aboriginal people have reached the middle management or the higher management levels in the Department of Health?

Mr. Orchard: I will give you a summary of target group representation as of March 1992, and bear in mind that in some of these areas the designation is by choice of the individual. If an individual chooses not to be in one of the categories, they are not; 76.8 percent of our total employee complement is female, 4.6 percent is native, 3.1 percent disabled, and 3.5 percent visible minority.

Mr. Cheema: Mr. Deputy Chairperson, are we meeting the target set by the Department of Health in all those areas?

Mr. Orchard: I guess, yes and no, not that I am wanting to make light of the issue. We are significantly over the long-range target. I do not know how we have a long-range target of women, 50 percent, in the ministry, but that is what it is, or I guess that is across government. We are significantly above that, but we are below by approximately one-half on native. We are better than one-half way there for visible minorities, and we are slightly under the half in terms of physically disabled.

Ms. Wasylycia-Leis: A few more in this area—I am still confused, I must say, about the personal care home rate increase. The Order-in-Council that was passed on April 8, 1992, refers to amendments to regulation 506/88R, and that regulation brings us up to date to February 1, 1989, at $20.50 a day.

Mr. Orchard: Mr. Deputy Chairperson, I do not know why my honourable friend would not have access to the regulation that would have been passed effective for the '91-92 fiscal year.

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

There has been regulation passed each year. This year the rate is 35 cents per quarter. Last year it was 55 cents per quarter because all residents received a GST rebate which we factored in to leave disposable income roughly at the—well, it ranges, depending on the month, from a low of just under $100 to over, well, one month $175, but that is an exception. The average is closer to $120. It works out to a yearly average of $118 projected for this year. It was $141 last year; it was $130 the year before; it was $128 the year before; it was $122 the year before that; it was $120 the year before that, $133 before that.

Last year was exceptional in that even with a 55-cent quarterly increase versus anywhere from 25 to 35 that it has been over the last few years, the average disposable income last year went up, even with the 55 cents which was reflective of leaving that kind of average income in the individual's pocket. The decision was made for policy reasons that we would increase the per diem reflecting the GST rebate, the argument being quite frankly the same as it has always been—I do not think it has changed significantly—that all the individuals' shelter, food, pharmaceuticals, and all their needs are covered,

and the per diem is only approximately, maybe–it would not be a 20 percent offset of the total costs, somewhere between 15 and 20 percent of the total offset of costs.

There is obviously an Order-in-Council missing in my honourable friend's files, because the Order-in-Council last year reflected 55 cents per quarter. I believe, if I am not mistaken, the first triggering of that, because of sheer timing and getting Treasury Board approvals and whatnot, I think, was June 1 instead of May 1. It was one month delayed last year.

Ms. Wasylycia-Leis: I appreciate the patience in correcting my information. I had simply looked at the regulation listed on the covering page of the Order-in-Council indicating 506/88R being the most recent regulation. I will ask the minister afterwards, and perhaps we can clarify that.

* (2120)

Mr. Orchard: Mr. Acting Deputy Chairperson, that covering letter, I think, has to be incorrect because I have passed that Order-in-Council every year about this time of the year to make the new regulations, in fact, and always accompanied by a letter to the personal care home facilities indicating what the new per diem rates will be, because this is a source of income to the personal care home program. I do not know why that would say 88 because I know I have passed one each year, maybe not at exactly the same time but at approximately this time of the year.

We will try to straighten that out for Thursday as to what was the reason for that reference in the covering department. I never noticed it when I brought it in.

Ms. Wasylycia-Leis: Just a couple of other questions. Based on the role of this branch in terms of analysis and evaluation, can the minister indicate what the increase in supplies is expected to be for health care facilities this coming year?

Mr. Orchard: I do not know whether we have an estimate–can I provide that information on Thursday?–because I think clearly there is going to be a difference between the estimate and what we are funding. I do not think we are going to be in a position to fund the complete supply increase, I think that is fair to say, but I will try to provide firm information on Thursday.

Ms. Wasylycia-Leis: The minister references a concern that I have raised in the past and obviously is part of my question now, and that is with the roughly 5 percent increase that the minister says is going to hospitals. It does get back to my question and ties into what analysis has been done by this branch in terms of impact, how hospitals will handle a 5 percent increase if one accepts what the minister said previously, that out of that must come pay equity adjustment, and I am still waiting for the minister's figures on that.

Out of that must also come the regular adjustments for increments, reclassifications, adjustments, benefits and so on, as well as, of course, any negotiated settlement, not to mention the increase to cover inflation vis-a-vis supplies and hospital equipment. So all of those figures are important in this whole exercise, and we look forward to the minister's information because, as it now stands, it would appear that in fact the government has not moved much from its position of zero percent for wage increases as a basic guideline when one considers all those different factors.

Could the minister indicate how soon we could expect to get some of that information and be able to have some understanding of just how serious the situation will be with respect to our health care facilities?

Mr. Orchard: My honourable friend wanted a projection on supply costs, and I am going to try to get that for her, but I did it at the risk of getting my honourable friend back on the process of let us deal with hospital budgets tonight and the next request being the exact dollar that we are providing every hospital. Clearly the roughly $53-million increase to the hospital line is representative of approximately a 5 percent budgetary increase on the hospital line. I mean, that is irrefutable. You cannot get away from the mathematics of that.

It is, as I have indicated to my honourable friend, not what the hospitals requested. They want more. We are unable to provide them more, but for relative comparison, approximately 5 percent more to be allocated across the board for all purposes in the hospital system of Manitoba, be it increments, be it pay equity, be it supplies, be it salary increases, be it on and on and on. Approximately 5 percent of the disposal of the hospital line is a significant improvement over, for instance, Ontario, which has provided a 1 percent increase this year, and I mean it is real, and Saskatchewan who has given a

preliminary indication of about 2.6 percent less in the hospital budget.

Now, Ontario and Saskatchewan are not magically devoid of the increments, the supply costs, the salary negotiations, the operating costs because they are in Saskatchewan or because they are in Ontario. Ontario has pay equity, which has been significantly underfunded by decision of the government. They have provided approximately $24 million or $25 million to the entire hospital system in Ontario as a contribution towards pay equity.

We have been significantly more generous in our base line funding so that, when it comes to a relative comparison, I will put our funding this year and past years, our funding commitment to our hospital system, in comparison with anybody else, but clearly, from the standpoint of monies available, we are asking hospitals to provide us with options as to how they can provide patient care with limited budget dollars. We do not have unlimited money to put in. We do not have $106 million additional to put into hospitals; we only have $53 million. That is going to mean some management choices. We have talked about those management choices in Estimates before, and some of the policy directions that I think are to be explored will be explored in terms of managing our hospital system.

I think one of the issues that came up last week at Seven Oaks Hospital was a management decision that did not compromise the volume or the quality of patient care, but it achieved a significant saving to their budget. Those are the kinds of management initiatives that the ministry has gone through. We collapsed Health Services Commission into the ministry of Health into one operating ministry of Health. That led to 55 fewer staff at the end of the exercise–tough decisions. There were people we knew, people I knew personally, some of them. Those are never easy decisions, but I will say to you today, it did not compromise our ability to manage the health care system as the ministry of Health.

I believe similar decisions can be made in our funded institutions without compromising patient care, and that is what we are asking to do because we cannot afford operating budgets which have built-in savings that can be achieved without compromising the patients' access to quality care.

Ms. Wasylycia-Leis: With respect to this overall branch, is this the part of the department that is responsible for the consolidation of all of the numerous, too numerous to mention, studies that are out and about as a result of this government's initiative?

Mr. Orchard: In large part, yes, but not exclusively.

* (2130)

Ms. Wasylycia-Leis: Could the minister explain, with all these studies out in the field–and obviously it is getting difficult to keep track of them since the minister has some trouble recalling even some of the studies he released in his own press conference–why at this point the minister would even be considering a parallel body to the Urban Hospital Council and even considering establishing a rural hospital council, as he indicated at his last press conference on this matter?

Mr. Orchard: I guess I would have to ask the simple question: Why not? I think there is some sense that only the big boys–the old boys' club, as my honourable friend calls them–get to provide advice around the issues. There are many managers and board members who have expressed the concern to me: What are we? Are we chopped liver because we are not Winnipeg or Brandon? They want to be in on the process of decision making. We agree.

It is taking a little longer to set the process up, because we are talking about a more diversely spread out group. It is relatively easy to get together the CEOs of our Winnipeg hospitals and the CEO of the Brandon General Hospital; but, if you start talking about a rural hospital council, each facility is not going to have representation. It is going to go by region and hopefully with the balance of representation from the region.

It is into the discussion that we talked about earlier on today. We have to have a forum of discussion around delivery and care issues which go beyond the narrowed focus of the individual facility in rural Manitoba, be it long-term care, be it acute care hospital. There has to be a greater integration with our regional services in those communities.

It has to be a greater opportunity for co-operation between communities, so that regions of the province can advance plans for care delivery which provide a wider spectrum of services to their citizens closer to home. That will mean, in some cases, moving those services from the city of Winnipeg to rural Manitoba and to northern Manitoba. To come around that issue, and clearly that has been recommended by many people, there is a process

by which–and we went through some of the steps of it earlier today of making that happen.

Now it is not going to happen very directly if every single institution zealously guards its role without consideration of change, of dynamics, of reform in the health care system. It is so very easy for a Minister of Health to say no to any given individual institution for a request which is beyond the guidelines for the area because in making decisions there are always guidelines, if you will, that the ministry establishes for various service provisions.

It is easy for a Minister of Health to say, no, I am sorry, as an individual community, you do not qualify. It makes the job an awful lot tougher if several communities get together and present us with a shared-community plan, and that is where we are trying to have the communities move in co-operation.

We think there is a great opportunity for success in that process. A counterpart to the Urban Hospital Council can be very, very instrumental in bringing the leaders together in a decision-making forum–the leaders from rural and northern Manitoba in a decision-making forum.

Ms. Wasylycia-Leis: A counterpart to the Urban Hospital Council for rural Manitoba does not appear to be consistent at all with the interim report of the rural task force report. I will certainly be interested to see the final report, to know whether or not that is a recommendation of the rural task force, part of the Advisory Network.

(Mr. Deputy Chairperson in the Chair)

I will also be interested to know when we get to the line on Lotteries-funded programs, how an urban administered initiatives fund–I forget the exact name–will benefit rural Manitoba. The minister knows I have raised that before, and I am anxious to hear some comments on that.

Let me ask a couple of final general questions on this area. It seems that after every year that we go through Estimates there is a change in this branch in terms of people who are heading it up. The minister has gone through a lot of heads at this branch.

Last year we asked about some of those individuals. I will ask it again since we obviously have gone through another change in four years. If I am not mistaken, the minister has gone through David Pascoe, John Wade, Kathleen Scherer, Connie Becker and now the new head is Denis Roch. I am just wondering what accounts for this rapid turnover.

Also commensurate, or consistent with that question, what has really been accomplished by this branch, in concrete terms?

Mr. Orchard: New leadership.

Ms. Wasylycia-Leis: Well, thank you. I would really like to thank the minister for that very enlightening answer. I do not think the minister has taken it very seriously, but it is a serious question.

In essence this branch basically comes close to $1 million a year, and I think it is only appropriate for us to ask what have we for the $1 million that is spent annually on evaluation and policy work.

Mr. Orchard: As I indicated earlier, some of the areas in which we want to undertake a major audit were outlined earlier. The audit function is rather important to assure that the aims and goals of the ministry are being achieved with the budget allocation that is there.

We call on this group to do evaluation of outside agencies from time to time, where we have requests for additional funding and where they have the ability to provide that kind of evaluation they do. The reason for the combination though, of internal audit and evaluation with the policy group, is to have that linkage between policy direction and understanding of outcome or the various programs that we have funded.

You can do a monetary audit and evaluation to assure yourself that line X in the ministry, which was supposed to spend $637,000–$499,000 of it for salaries and $138,000 of it for supplies–you can have an evaluation which puts on an accountant's hat and says, yes, they spent this much money on salaries and they were under budget in terms of their supply line as allocated; therefore everything is alright.

Well, yes, from a purely accounting standpoint they have maintained the integrity of the budget process and the expenditure process, but by combining evaluation, as in the policy research area, we can then make the determination that in fact the goals of that funding have been achieved in part or in whole and can suggest improvements or changes that can happen. So it is more than simply a clinical number-crunch function. It is number-crunch with an evaluation as to the outcome.

Now that is new. It is going to take us some time to mature the process so that it works well, but that is sort of the intended marriage of purpose that we are attempting to achieve here.

* (2140)

Ms. Wasylycia-Leis: There is one area I had overlooked that I would like to raise briefly, and that is the question of legislation. Under Activity Identification, the question of health discipline legislation is referenced.

I would like to know specifically on the timetable with respect to the whole schedule for legislation pertaining to dental auxiliaries and the whole list of professional associations that we have talked about in the past, as well as to know what is the full list of legislation for the Health department we can expect for this Session.

Mr. Orchard: The dental auxiliaries are not part of any legislative package. As I have indicated to them for the last couple of years, we are awaiting–I am even going to get I believe it is the Law Reform Commission report on how we might best handle a significant number of demands in terms of professional legislation which, not that I want to categorize, but which fall outside of those who already have it, like physicians, dentists, optometrists, pharmacists, so that there will be no legislative initiatives in terms of dental auxiliaries.

The denturists' modest amendment is before the House. I will be bringing forward legislation which changes the professional acts of dentists and optometrists to essentially emulate the pharmacists' act that was provided last time around. There are amendments to the Manitoba Health Services Commission, and the bill had not gone to print as of discussion with you last week, where I sought your advice, because the legislation, as originally envisioned, was to deal with the changed reporting structure from the amalgamation of commission and ministry of Health.

The legislation is, I think, going to print either later this week or the first part of next week and will incorporate, in one bill rather than two bills, the amendments which deal with the amalgamation of the ministry but also will deal with the issue of disclosure, of physicians being asked for return of billings or improperly billed services as decided by the Medical Review Committee.

That will be probably the largest bill, the most comprehensive bill–big in size but not necessarily–principally only a couple of principles in there, changes essentially–well, it accommodates the reform.

Now, we are bringing in some amendments to The Mental Health Act which will give us compliance as mandated by the Supreme Court decision out of the Ontario case. Those will be not large amendments but nevertheless essential amendments, and we are trying to ready ourselves for a couple of others. In the case that I do not succeed, I would use the ministerial discretion in not sharing those with you because then that would create an expectation that we may not be able to deliver on.

I am always sensitive to not doing that, and particularly I am sensitive to some of the timetables that as legislators we have imposed upon ourselves, in that we do not present, as has happened in the past, and I will not point any accusatory fingers, but there has been a complaint in the past that too much legislation comes in toward the end of the session and does not get reasonable discussion.

We are attempting to avoid that, and I am hopeful that the amendments that I have referenced to my honourable friend are printed and maybe even before the House before the end of this month. I know that they will be the kind of thing that my honourable friend will, even sight unseen, recommend to her caucus and achieve speedy and quick passage, so we can better the delivery of health care in the province of Manitoba.

Mr. Deputy Chairperson: Item 1.(c) Evaluation and Audit Secretariat: (1) Salaries $804,100–pass; (2) Other Expenditures $137,900–pass.

Item 1.(d) Finance and Administration: (1) Salaries $2,399,700–pass; (2) Other Expenditures $1,628,400–pass.

Item 1.(e) Human Resources: (1) Salaries $983,300–pass; (2) Other Expenditures $89,300–pass.

Item 1.(f) Health Information Systems: (1) Salaries $3,705,400.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, I would like to ask just a question or two on the status of the Health Advisory Network interim report on Health Information Systems, or whatever it is called.

First of all, could the minister indicate when we might expect to see the final report, and secondly if he has a plan of action to begin to address some of the concerns outlined in that report?

Mr. Orchard: We have very, very significant discussions around how we take the recommendations in that report and develop them into a workable solution for information systems across the health care system.

I think there is a reasonably legitimate observation that solutions to date have not allowed the achievement of that. I want to tell my honourable friend that this is an area that I am genuinely troubled with. Because, for lack of better terminology, I find that in the past, okay–I do not think what I am going to say is necessarily the case today–but I think in the past there was a lack of sort of the honest broker, if that is the appropriate phraseology, to provide advice to government on how to implement and what to implement in terms of information systems.

I make that observation because I can recall very clearly one of the major accounting firms, I was at a reception when I was in opposition. I was invited to a reception that they were holding, and they were kicking off a new consulting arm of their accounting business.

This new consulting arm was to provide impartial advice on information systems to any and sundry potential clients including government. I thought that was an excellent move at the time because, without wanting to find fault with any of the major suppliers, because I understand the marketplace and their drive to attach sales of hardware and equipment to information systems.

I mean, there is a dual motive there. If you sell the information system and it can attach your product line, you are a double winner. That seemed to be the nature of information system development in the '80s.

Now there is the advent of open architecture and a number of–and again I am out of my league in terms of the technology–but there is open architecture and open communication systems which are not proprietary to a given supplier of hardware and software.

That has led to a generation of new advisers who can provide systems solutions which are not necessarily tied to the acquisition of equipment. It is along that line of advice that we are trying to place the advice and the observations by the task force, which I have to say was composed of some quite prominent individuals and knowledgeable individuals. I am trying to take that report and background it on the open architecture and the new ability to communicate between platforms and try to craft a workable policy across the health care system because, boy, let me tell you, this whole area frightens me.

* (2150)

I mean, you can end up with literally tens of millions of dollars spent, and my experience has been, unfortunately, that the goals of achievement are seldom met, and you end up with systems which have created deficits in the various institutions. Of course, there is the finger pointing of the agreement with Unisys that cost them versus, you know, unpredictability in terms of their implementation.

I am giving a very long answer, but this is a very complex area, and I openly admit to my honourable friend that I am out of my league in understanding what to do here. I am very much guided by the advice of the task force, and we are actively seeking the kind of independent planning advice which is not attached to a proprietary sales organization, and we believe that we have potentially that kind of expert advice available to us and are in the process of actively pursuing the initiative of information systems in government or in the health care field with these individuals. I know that is a long answer to my honourable friend, but that is about as briefly as I can put the issue.

Ms. Wasylycia-Leis: I think we certainly recognize the complexity of this whole area and the difficulties to find easy solutions or quick solutions to the problem–[interjection] and economical solutions, I certainly would concur with that.

I also concur that there were serious problems before that were never addressed, before this minister's time, before this government. They were not addressed by the previous NDP government, but this minister has had four years, and yet we see very little sign of things changing or improving or some attempt to get a handle on the fact that hospitals all continue to do their own thing.

I am wondering, why has there been such a delay in terms of getting something going in this regard? Why has there been no movement specifically on what I believe to be the case in just about every other province, and that is the establishment of MIS guidelines?

Mr. Orchard: Before we fall off this congenial atmosphere that we have been cultivating diligently all day today, I want to point out to my honourable friend that I think that when I came into government, I had approximately three or three-plus years and

twenty-plus million dollars to spend on an agreement that I inherited. That took up roughly three of the last four years or two and a half of them, for sure.

In the interim period of time, recognizing that the inherited process was not necessarily going to lead to the best solution or the most usable solution across the system, we established the task force on Health Information Systems and engaged, if you will, independent expertise within the province of Manitoba to provide us with some guidance.

That was done. I am in possession of the report. From that report, we are internally, and with engaging what expertise as I have indicated to my honourable friend earlier this evening in my previous answer, obtaining expertise on how we can move. For instance, MIS guidelines, yes, those are part of the recommendations and are going to be part of the end goal.

A very interesting piece of information that I have recently acquired from a source–I consider it to be North American in its understanding, i.e., a significant presence in the U.S. system–they are of the belief that the MIS project at Misericordia is a part of and, I am informed, is considered to be a very good information base in terms of health information systems.

That view came from an expert that I recently had the opportunity to undertake discussions with whose predominant expertise has been the U.S. system where information systems are much more mature, but not in the applicable form to the Canadian system because appreciate that their information systems are very much a financial information system so that they can account for every aspirin of an inpatient service. I mean, that is where a significant amount of their accounting and information system resources are placed, but the observation was made by this individual who now is undertaking a presence in the Canadian marketplace that the MIS guidelines are pretty reasonable guidelines.

That, to me, was a piece of information that came from what I consider to be that sort of outside observer without vested interest that is very valuable to guiding us on where we go, and maybe takes us where we do not have to reinvent the wheel, as always we tend to do when we embark on these information systems. We always reinvent the wheel, it seems.

Ms. Wasylycia-Leis: Let me just pursue for a moment just specifically the MIS guidelines, because on that the interim task force report is very clear and very definitive, indicating that the MIS guidelines appear to be a sound basis for management of health care Manitoba, that they can be implemented through existing health information systems, computerized or manual, that implementation is modular, department first, then global so that the implementation cost may be spread over several years and so on and so forth, ending up with a recommendation that the Health Services Commission approved the MIS guidelines for implementation across all Manitoba health care institutions.

What is the drawback in terms of not moving on that immediately, or why has there been this delay? I am not an expert. Just on the basis of this report and what little I know about the area, I am wondering why the directive has not gone out and the work has not begun on the establishment of MIS guidelines across all health care facilities in Manitoba.

Mr. Orchard: Well, no particular reason except that is all part of the process that we are embarked upon. I indicated to my honourable friend that we are moving not as quickly as a lot would like to see possibly, but there is a saying that haste makes waste. I can always remember advice from that venerable bastion of slow pace, the former member for Ste. Rose, on his Main Street Manitoba Program, where he constantly cautioned opposition members urging him to announce the guidelines on the Main Street Manitoba Program that he was moving cautiously.

There is a heck of a lot more investment and more potential for mistakes in moving too rapidly without a system-wide goal on information systems, so that we are taking a reasonable amount of time, some would say an unacceptably long amount of time, in the hopes that when we develop the guidelines and the plans they will meet the future needs of the system and will be as applicable as believed by the Health Information task force, and will have the ability to be implemented within finite resources available for the appropriate outcomes that we hope to achieve.

Mr. Deputy Chairperson: The hour being ten o'clock, what is the will of the committee?

Mr. Orchard: We better pass a bunch more.

Mr. Deputy Chairperson: We will continue for a while.

Ms. Wasylycia-Leis: I am wondering what, and I know this will probably be restructuring accounts for this, but I would like to know specifically what is the roughly $3-million expenditure under total Other Expenditures that has been added from last year's Estimates for this line.

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

* (2200)

Mr. Orchard: Last year, under the reorganization, what was shown in this area was the staffing costs. The costs of computer time, et cetera, were left within the commission budget. This year the increase reflects the total accounting under this line of not only staffing costs as was there last year, but computer costs of in excess of $3 million.

It is a simple transfer of the costs of computing time from the commission where it appeared in as part of the administration budget, I would presume, at the commission line directly over to here. It is a lateral move of existing spending with only whatever increase–there is no increase on that line even. It is just simply a lateral move from administration line under the commission over to this line. Only staff were moved last year, now the computer time and costs are moved as well.

Mr. Cheema: Mr. Acting Deputy Chairperson, can the minister tell us about us this system in terms of different hospitals which the previous administration put in the system? I think that they made a major mistake in terms of having a system in each and every hospital with no co-ordination, and now they are trying to solve the problem and spend a lot of money. Now we have nowhere to go.

So basically, now, what kinds of things are being put in place to make sure we do not end up in a similar situation, and how much actually is it costing each and every hospital? That would be interesting to find out because services, if we can not utilize from the hospitals, what is the use of having a central communication when the system does not co-ordinate within each of the hospitals?

Mr. Orchard: I guess my honourable friend has identified part of the problem that comes with the agreement ofthe NDP. I mean there is a lot of finger pointing going on around that agreement. I simply do not, as much as I used to, relish in that; I mean, that was my forte. I loved to beat up on the NDP whenever they appeared to make a mistake and whatnot, but I am not into that now because what we have to do now is make our current investment of over $30-million work to the best advantage of the system.

Now, some of the inability to develop a system-wide approach has been identified, and there are various reasons for that, all of which are historical and really not germane to guiding us on how we approach the solution for information systems as presented by the Health Advisory Network Task Force Report. I am exceptionally cautious in terms of finding fault with the supplier. Unisys is a valued supplier in Manitoba and a valued industrial presence in the province of Manitoba. They will continue to have an equal opportunity to provide additional services and/or equipment to our health care system. They are moving towards open architecture in other areas of development.

Where we are trying to move is to take the report of the Health Advisory Network which I believe has some pretty significant and good recommendations. I mean, our senior people have looked at the task force report, and I do not think I have significant difficulties with any of the recommendations that are there.

Now, having said that, our next obligation is to attempt to focus sort of the best intellectual power we can put around the issue to develop that system for the future, which has the ability to communicate, as we all would like to see, but more importantly, which is based on–how do I word this?–is based on a system of information which has a utility to the Province of Manitoba as the funder in understanding what we do in the system and how it affects patient care, outcome of patient care, general improvement of health status, which I can see is an absolutely essential component of future information systems so that the information is not merely just stacks of paper with numbers and statistics, et cetera, but that there is a usable analysis from those that can guide us as senior administration for the health care system in general and can guide individual managers of our facilities in making appropriate funding and program decisions based on outcome.

(Mr. Deputy Chairperson in the Chair)

I think that there is an opportunity to use the Centre for Health Policy and Evaluation in terms of assisting us in developing the information development which would lead to their ability to analyze and give us a real outcome analysis of what we do. That ability is not perfectly there right now–I do not think it is there in any system necessarily–so that we are moving cautiously. I think the goals that

we have are not dissimilar to my honourable friend's goals or indeed the goals as set out by the members of the task force. We will get there, and as I have openly admitted, we are probably not going to get there as quickly as some would like us to be, but in this case, I think we will make in the long run the best decisions with the prudent and consultative approach we are taking.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us, do we have a system where, for example, the Manitoba Health Services Commission, if they would like to have access to any information at any given hospital in terms of the patient occupancy rate and on a day-to-day basis, and monitor each and every hospitals in terms of user of the facility so that the information can be provided and some directions can be given? Those things are going to be very important in the future when you are going to rechannel some of the patients from an institution to another institution. Also, when the community component is going to come, those things are going to be very essential because basically the control has to be at one place where the changes can be made, and I think the technology is going to come.

I am aware that the Health Services Commission do have information for their own use and all the practical purposes and where the Health Policy Centre is going to drive all the information. I am just asking if there is a system which does communicate within the community hospitals?

Mr. Orchard: No, we can not access a terminal in the commission and pull up information from a hospital in Winnipeg in terms of occupancy rate, but each hospital does have that information, and it is readily available by direct contact of our staff with their counterparts in the various hospitals.

Where we are deficient in our information capacity, like the occupancy rate, the length of stay, those sorts of admissions, discharges, those sorts of statistics are readily available. What we do not have for quick and easy comparison is program costs so that we have the opportunity, for instance, to compare the cost of the gall bladder procedure in hospital A versus hospital B versus hospital C with accurate sophistication. I think that is a needed goal in terms of our health care system.

I will make the case, and I do not think I am wrong, that a hospital, for instance, in my area, Carmen or Winkler or Morden, I believe, will undertake a number of surgical procedures at a lower cost than at Victoria, Grace or Seven Oaks who will undertake the same procedure at a lower cost than St. Boniface or Health Sciences Centre. Without having that kind of quite definitive information, we cannot make the complete program reform allocation of funding. We can get a pretty good handle on it In terms of moving the cost with the patient, but we do not have an accurate comparison so we can go directly at the individual hospital's budget so that we are assured that we are not compromising other areas of the hospital or whatever when we say this is what should be able to be moved with the patient. We will eventually have that kind of sophistication, but we do not have right now, no question. [interjection]

* (2210)

Mr. Cheema: Mr. Deputy Chairperson, the minister responsible for Urban Affairs (Mr. Ernst) will really be the best person for anything but not a good physician. That I can tell–[interjection] Exactly.

Can the minister tell us, about 16 or 18 months ago, there was a conference in Manitoba arranged by the Health Services Commission, and a lot of noise was made. The question was raised inside the House by, I think, Mr. Doer; his question was smart card. Such a terrible thing was coming in, and now each and every province is taking a good look at the whole system.

In fact, Ontario is going implement some of the smart card systems in terms of information data which will facilitate some of the process of application was access to the services. Now, can the minister tell us where are we in Manitoba in terms of the smart card coming into action in our health care delivery? Is the government serious to implement such a system, or are they still considering? What are the reasons why they have not made up their mind?

Mr. Orchard: Let us get right down to business. Yes, the plastic card technology, a year and a half or so ago when we hosted the national conference, I do recall vividly those cries of concern by the Leader of the opposition party.

I cannot even remember whether it got him a headline at the time, but that really does not matter now. [interjection] No, no, I mean I always mention this to my honourable friend the member for Concordia (Mr. Doer) because he is a headline hunter, there is no question about it.

At any rate, we were advised, basically, by the findings of that conference, and this advice went to

all provinces that in terms of implementation of the plastic card technology, smart card or any variation of it, because there are a number of them, that we move with some caution because it is very much an emerging technology field. There are advancements almost monthly.

But I will say to my honourable friend that I recognize an opportunity here, and I will share sort of a vision of the future. I will put a caution on it because it has a big price tag. I would dearly like to see Manitoba lead the way–and we have not got our minds around the issue–in terms of bringing in plastic card technology across the system: physicians' offices, any other professional offices and pharmacies which routinely provide services which are billable to the health care system, so that we can develop a system which allows the plastic card as an identifier of an individual requiring care.

Let me just use this specific example: Dr. A will know that patient C had seen a physician at a walk-in clinic six hours before and had this series of tests done. That would automatically lead the second physician to be asking very appropriate questions of the patient as to what, et cetera. That is one example of better patient care that can emanate from it.

There is the issue of confidentiality. I think there is sufficient technological sophistication to our systems, and I will use the example: Everyday, I think that our banking systems in Canada probably handle more individual transactions on a daily basis than we ever would in terms of sheer volume of information and number of times that the system is accessed. They have a security system which bars access to the system according to need-to-know.

I have not heard of a time when that security system in the bank has compromised the confidentiality around the individual's banking records. If there is one thing that is almost as confidential as your health records, it is your financial records.

So I am confident that the ability to technically handle the information volume, to technically protect the confidentiality aspect, exists. The difficulty is, and I will be very direct with my honourable friend, finding the capital dollars to implement. To assure oneself of that, in the operation of the system, it is going to make our whole health care system more effective in its care delivery. Those are sort of the unknowns to date.

But I will tell you, I can see some tremendous advantages with the expertise we have in the Centre for Health Policy and Evaluation and their ability to analyze the data that we currently have been collecting at the Manitoba Health Services Commission. I mean, they have made some marvelous analyses of that data to guide us in an informed and scientific way into policy decisions.

With an information system that goes across the health care system, with appropriate information collected, I can see ourselves being a very excellent research laboratory for the world, in terms of how publicly funded health care systems can work to improve and enhance health care services and to give some definitive answers as to what the effectiveness of new programs are, because they could be almost instantly tracked and monitored.

So, to me, there are a significant number of advantages. If I had my way–and I do not, very obviously--I would be rushing rather rapidly into a province-wide system, not the pilot project as recommended by the experts. But I am guided by an abundance of caution, and we are moving diligently in trying to see where the new technology has a role in the Manitoba health care system.

Mr. Cheema: Mr. Deputy Chairperson, I think all these areas are worth exploring because you do not want to be left behind when every other province is going to do it eventually. When the information age is changing and so much analysis is going to be required, so many things are going to depend upon this kind of very new techniques–as long as patient confidentiality is kept in the highest priority.

I do not think anybody would like to see that taken away, it does not matter who is in power. Even the people who are designing their own records, they are concerned. As long as the issue is kept in mind, it is worth exploring because it has a tremendous advantage of access. While duplication of services have the–I think eventually when we look into the issue of services delivery from the physician or hospital offices, eventually things are going to come when the system will have to be in a way that some patient responsibility has to be involved in the health care delivery.

Then I think the issue is going to come. I would like to discuss that in detail that you have to have areas where a specific number of physicians will be assigned to a specific number of patients. That is a possibility and that is happening in Great Britain and in other countries, as well as in the industrialized

nations. Some people would say you are going to restrict the patient. That is not true, because the patient will still have a choice of two or three or four or five physicians. There I think those techniques are going to be very, very useful because you are working within a group of systems and how the information can be exchanged at a very rapid rate, and the issue of the compensation package of the physician can be evolved through the whole process in a very meaningful way.

The other issue which we raised, the issue of patients signing those when they are visiting a doctor, that can also be implemented through the same thing, simply giving your code to each and every person, or say, when you are the present in a certain office, you have to punch those codes, and specific patients will be assigned a specific number.

* (2220)

So there will be far less chance of any duplication of services, possible abuse by the patients or by people who do not have cards and they may be using somebody else's number, and that is happening. It is difficult to detect because when somebody comes into your office, you do not want their driver's licence at the same time, but eventually it is going to come, that you have to have two pieces of ID to identify yourself, and if you are a minor, then your family or somebody will have some identification.

It may not be a problem in a family practice or a community clinic office, but it could be a problem in walk-in clinics. It could be a problem in major hospitals, and that is coming. Eventually, people are going to look at that issue. That is not to restrict services, but to use services more effectively, more efficiently and to make sure that services are given to the people who are supposed to get them, not somebody else. I think that is the issue.

The issue of technology, a smart card, is going to be the future. There is no question there. Somebody who says that, you know, it will be not acceptable simply is probably living in another age or on another planet. It has to be part of the new system, and I think the exploration must be made. The initial cost is going to be there, but that is with anything you start. Eventually, the paperwork is going to be saved, so much of the storage space. So many things are going to be saved by having that kind of technology, especially when the system, which is publicly funded and publicly owned, will have more control with these kinds of things, rather than the individual office setting up the things.

Then the issue of office protocols, the issue of referrals, the issue of testing, the issue of having access to Pharmacare, the issue of comparing the national debt, all those things will become very easy. I think that is the one problem the minister should also discuss with his provincial counterparts, as long as they can also have the implementation of those programs at the same level. It is going to come. It is a matter of time. I just want the minister to know that. These are very, very real issues, very practical ones, and it is just a matter of time as to when they will come in.

Mr. Orchard: Mr. Deputy Chairperson, I do not have any argument with what my honourable friend has put on the record because I think that the future he describes is going to be with us, and I know that he shares the common concern and caution that has been given to us by the experts, of making every effort to assure that confidentiality is maintained in the system.

I believe that can be done. The example I used in terms of banking transactions, I mean, they operate a multitude of branches. You take a look at the number of branches that are operating in the province of Manitoba. That is more individual outlets than we will ever have in terms of health care, in my humble opinion. So I think that can be achieved.

One of the issues that my deputy reminds me is being discussed at the provincial level, because every province, like Manitoba, is approaching the issue, and one of the things that the deputies have identified as an issue for resolution is the conjoint development between provinces, because if we want to share patient information or have an individual who may be going across Canada, it might be well advised to have the opportunity for a physician to understand the individual's condition when out of province, so that they do not prescribe improper information or whatever.

So there is that aspect, but that really takes you into quite a sophistication, and we are probably, even with mature information systems, going to rely on the phone call to our central–a B.C. physician phoning our central area, if he has any concerns.

Mr. Deputy Chairperson: Item 1.(f) Health Information Systems: (1) Salaries $3,705,400–pass; (2) Other Expenditures $3,491,400–pass.

2. Healthy Public Policy Programs (a) Administration: (1) Salaries $961,000.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, first of all, a general question on the whole area of Healthy Public Policy–I notice somewhat a discrepancy between the chart as presented at the beginning of our Estimates book and the actual description on page 29. I am wondering where aboriginal health falls as delineated on the chart, and where are the resources allocated for aboriginal health?

Mr. Orchard: That initiative is still part of Healthy Public Policy.

Ms. Wasylycia-Leis: The reason for my question was that I do not see a reference to aboriginal health issues or resources allocated for that area in the descriptive part on page 29, or in any of the breakdowns of this whole section which is not consistent with the chart, which clearly, at the top of the list, reference is made to aboriginal health care.

Mr. Orchard: Mr. Deputy Chairperson, let us separate program from reorganizational direction. Under Healthy Public Policy, aboriginal health is one of the initiatives that we feel can be appropriately accommodated under Healthy Public Policy and under that ADM responsibility. In establishing aboriginal health, which will be essentially a new initiative, we have undertaken a series of consultation with the aboriginal community, and from that consultation, have some direction around the program. We will be moving hopefully by mid-year to active recruitment of an individual to assume the leadership role within the Healthy Public Policy division for aboriginal health.

Ms. Wasylycia-Leis: Could the minister indicate where in this whole section such an individual would fall? Would there be a separate section on aboriginal health, or would such a person be reporting to the ADM?

* (2230)

Mr. Orchard: We have an SY available for the position, and what is under current discussion is the reporting structure–the sense being right now that the reporting mechanism will be directly to the ADM, because it is envisioned that the aboriginal health position will cross the department. It will not be an issue narrowed only to consideration under Healthy Public Policy. I mean, there are issues in acute care, long-term care, et cetera. So that the current thinking, unless it changes, is that there would be probably a direct reporting relationship of the individual when hired to the ADM.

Ms. Wasylycia-Leis: Could the minister give us some idea about the type of person he is looking for in terms of filling that position and that, of course, ties into the general policy directions or vision with respect to this whole area?

Mr. Orchard: Mr. Deputy Chairperson, naturally, we are looking for an individual who has understanding of health services, the delivery, et cetera. Obviously, what is needed is an individual who would have credibility in the community they are working with.

We are, I guess it is fair to say, rather interested in the applications to the position when it is advertised because, as we sit here tonight, we think there will be a great deal of interest in that position.

Ms. Wasylycia-Leis: In terms of the overall mission statement of the department, the department references the goal of improving and promoting the health status of Manitobans and to reduce inequalities in health status.

Could the minister give us his definition of what those inequalities are or his description of that statement?

Mr. Orchard: I think the most succinct description that I can give is the emerging evidence that even in a publicly funded health care system, with no barriers to access, there is a pretty clear correlation between access to that system and socioeconomic status. I do not think it is any secret, but the aboriginal community tends to have, in many instances, a lowered health status than other Manitobans.

Certainly, in terms of infant mortality and a number of other key indicators, they are significantly at a disadvantage compared to, for instance, the middle-income, non-native Manitobans. That has been a historic relationship.

There are gradients that have been well researched in other countries that we think probably are applicable to the Canadian circumstance and the Manitoba circumstance, those gradients involving the health status as it relates to the economic and the income gradients of individuals.

What we are embarking upon with the Canadian Institute for Advanced Research is the population health study which, with permission from Stats Canada achieved, and with utilization of the analytical capability of the Centre for Health Policy

and Evaluation on our health statistics, we hope to be able to establish and verify that relationship, in the Manitoba context, of socioeconomic status and health status and access of the health care system. We think we will find some interesting correlations which we suspect but will be able to definitively identify with scientific analysis and research.

That leads us to the next step in terms of the then creation of public policy which would be targeted, rather than across the board, but targeted in terms of health promotion or specific educational programs or specific policy initiatives of support at those groups which are shown to be disadvantaged in terms of their access to and service from the health care system as currently structured.

I want to point out to my honourable friend that when I start getting a greater understanding of this relationship of income and health status, I get more and more concerned about the viability of the Canadian and North American economy, because there is absolutely little question that probably our greatest public policy initiative to improve the general health status of Manitobans and Canadians lies in our ability to have a vibrant and growing economy which is providing the kind of meaningful and rewarding and monetarily rewarding jobs that a growing economy can provide.

That would probably be one of the best health policies we could ever implement. More and more research is pointing to the direct linkage of the health of the nation's economy to the health of their citizens.

When we get into these debates about resources and dedication of resources to our social program underpinning, those are all very laudable public undertakings that governments of many political stripes have attempted to assure are in place and are effectively delivering service.

The challenge that we have is that the funding of those programs does not undercut the ability of the economy to continue growing, continue making investment and creating new jobs, and maintaining our competitive position in the global marketplace. That is the delicate balance I think that the whole debate nationally is going on right now, for instance, around health care.

We could, I think, clearly dedicate 50 percent of the provincial resource to the provision of health care and still find a number of people who would say that is not enough. In doing so, we would probably have to remove entire departments of government which are providing services to underpin the growth and the economy. If one were to be an outside and casual observer to such a proposed direction of government spending, one might call that–what is it?–penny-wise and pound-foolish, or whatever, that we are cutting off our nose to spite our face.

Some of the direction that we are attempting to make strong linkages with is in terms of socioeconomic status and health status, because we think there is an opportunity with the understanding of that relationship to very much focus the government programs and initiatives to assure that we underpin those target groups which we feel today are inappropriately accessing the health care system.

Ms. Wasylycia-Leis: The minister has certainly touched on an area of broad debate. I do not know if we have the luxury of time or energy at this late point in the evening to get into it. But I think it is worthy of a short response since, in fact, there are many who question whether or not this government does understand the linkage between socioeconomic status and health status and question the wisdom of a government that has basically maintained a hands-off approach in terms of the economy and has done little in terms of actively addressing the growing unemployment situation, unprecedented poverty levels, increasing numbers of people being added to the welfare rolls, more and more people turning to food banks, more and more young people out on the streets turning to prostitution, to drugs, to suicide, to a whole host of very difficult life choices.

* (2240)

There is clearly, we acknowledge, a linkage between the economic situation in a society and the health status of its citizens. We question whether or not this government understands that linkage by its hands-off approach to economic activity, economic development, job creation, preservation of important social programs and supports that help families make it through these very difficult times.

Certainly, when it comes to aboriginal people who, as the minister has acknowledged, face some of the worst living and working conditions of any group in our society, there is a very clear correlation between their economic status and ill health.

I am wondering where the minister intends on beginning to address that whole issue of socioeconomic status of our aboriginal people and the linkages with their health needs.

The minister talks of one person and hiring an individual to begin to address this whole issue and this whole policy area. Where is the minister beginning that focus? Is it with respect to aboriginal people in our urban centres? Is it with respect to aboriginal people on reserves? Is it all of our aboriginal community? What will the be the priority, what will the focus of this minister and this government in beginning to address this most difficult area?

Mr. Orchard: The process we are currently on. But let me just take the gloves off just a wee little moment here, because we were having quite a nice evening before my honourable friend ventured into grounds where people of her political persuasion ought not to be.

I want to tell my honourable friend that the solution of Howard Pawley and the NDP around job creation and solving the unemployment problem of the last recession was to create the Jobs Fund. The Jobs Fund spent $200 million a year.

There is a little anecdote that I will share with my honourable friend, particularly with the two newcomers that are here, one from the Liberals, one from the NDP. Go back to Hansard, the first year that the Jobs Fund was created, and read an exchange over several days between the Minister of Natural Resources then, Al Mackling, and the then member for La Verendrye, Bob Banman, because here are the circumstances of the phoney Jobs Fund.

The Jobs Fund was created. All ministries had to allocate money to it from within their budget. In Natural Resources, they had commenced a tree-planting program in the eastern region of Manitoba, a reforestation program, very environmentally friendly. It was employing a number of people with a budget of, I do not know, several hundred thousand dollars, probably close to a million. All of a sudden, after being on the job about three weeks, every one of these people got a layoff notice. They were raising this issue with their MLA, Bob Banman.

Well, you know what happened to them? They were laid off because the Jobs Fund had demanded of the Minister of Natural Resources, Al Mackling, some budget from within his allocation. Where did he get it? He got his budget by laying off and cancelling the reforestation program, laying off those people so the money could go to the Jobs Fund to hire people to paint fences, to mow grass and pound up these green and white Jobs Fund signs all across the province.

It was the phoniest sham I have ever gotten into, but that was the NDP solution to unemployment in the province of Manitoba in 1982-83. The only thing that I want to ask my honourable friend is, where are the jobs from the Jobs Fund today?

They invested $200 million a year and more for several years. Where are the permanent jobs? Where is the depth and strength in Manitoba's economy that the Jobs Fund, this proactive Howard Pawley-New Democratic Party government left a legacy for in Manitoba? Where are the jobs today?

I will tell you where they are. They are in the annals of the history books because none of them exists today. There is not a single job from the Jobs Fund that exists today. The fences have all been painted, the grass has all been mowed and regrown, the Jobs Fund signs, if you can find some, are faded and gone.

We have no permanent legacy of underpinning in the Manitoba economy. What we do have is a legacy of debt where every single year for every year the $200-million Jobs Fund was in place, I now have $20 million pulled out of my Health budget every year because of the Jobs Fund of the NDP.

That is the interest on the debt created by the $200 million Jobs Fund. Every year, we pay $20 million out of my Health budget. It has robbed health care in Manitoba, that good old Jobs Fund that Howard Pawley and the NDP put together.

So when my honourable friend comes to me and lectures me about having no idea of how to stimulate the economy, I say, I do not need your advice. That is a failed philosophy of every NDP government that has ever tried to do anything in Canada, a failed philosophy. They have invested money in building airplanes and making Chinese food to canning beans. It has got everything to do with health care.

My honourable friend the member for Burrows (Mr. Martindale) says, what has this got to do with health care? As I have indicated time and time again, the best health policy we can get into is a secure and stable job and creation of new wealth in the province of Manitoba and the nation of Canada. (a) It is the only way we are going to sustain the tax base to pay for our social services including health care; and (b) employed people access the health care system a lot less frequently. That has everything to do with health care, and if my

honourable friend does not understand that, maybe he should start talking to some experts who do.

Now, you want to talk about what you do to make the link between a job and health status? You know what you do? You create an environment where the creation of wealth is a welcome initiative by those who are best at it in the private sector. You create a taxation environment, not by raising tax after tax after tax that the NDP did during the Howard Pawley years, but rather, freezing, lowering and eliminating taxes wherever you can, which we have done for five consecutive budgets.

You do not rack up massive deficit after massive deficit. You try to control that through the control of expenditures within government, which we have done, because deficits simply add to the interest bill that detracts from economic development policy, health care policy, and any other initiative of government.

You fundamentally put an attitude out where you make the business community aware of the marvellous opportunities in terms of personnel, investment climate, taxation regime, understanding of the future, market positioning in the world and international market, the kind of skilled people we have, the absenteeism rate, the power, the hydro, the cheap electricity rates, all of those advantages, by harnessing the natural resources through an information campaign in the private sector which is ongoing right now, and above all, an attitude wherein government demonstrates clearly that it understands the needs of the investment community, the wealth creation community, so that we let people who are adept, skillful and very good at creating wealth, know that Manitoba is a good place to be. Jobs Fund, phooey!

Mr. Cheema: Mr. Deputy Chairperson, it is certainly a stimulating dose for tonight's sleep.

I just wanted to put some comments on the record in terms of the issue of poverty, and the connection of poverty with illness and the prevention of illness and many diseases. I think it is not a secret that homelessness itself has become a disease in some parts of this country. There was a study that came out of Toronto and I can provide copies to the members of this committee, and I think I gave some to some members already.

It clearly correlates the connection between poverty and the many illnesses, starting with teenage pregnancy, drug abuse, alcohol abuse, family violence, and sexually transmitted diseases. Those things are coming up and the argument has been made in that article that all those things, they are not only eating the health care services, they are also eating our economy in many other ways because it goes into social services, it goes into the community services, you are draining the disability funds, you are draining pensions. So basically, it is just like a sponge, it keeps on attracting everything by osmosis, and the money is just draining.

* (2250)

I think the argument has been made all across the world right now, the issue is that the best thing for a person who has physical and mental well-being is to have a good environment and good environment has a lot of meanings. As a person we are controlled by many forces. Even if one force is not right, then we are in big trouble. When the immediate force of economy is not right, it does not matter what we say, what we do, nothing can be achieved. I think that is the argument people are trying to make.

That is why the NDP philosophy is failing in many ways and the world is seeing the light that that does not work. You have to provide people the kind of environment, a healthy environment. Some are lucky, they are born in that circumstance; some are not, but the governments have the responsibility to try to provide an environment with a healthy economy. Everything else goes along with a good environment. I think that leads towards a healthy person and a healthy family, and that helps in the long run if each and every person in Manitoba would have a job we would have a lot less problems right now.

In many ways, the indirect draining on our economy because of the circumstances where we are, I think that is the argument I made in my budget speech, that I would not deal with the health care budget differently than I would deal with my own budget at home.

If we are going to balance our own books, why do we not balance the books of the government? That is the taxpayers' money; it is your money either way. I think the argument has to be made.

It is no secret that there is a correlation between poverty and economy and health as in the Third World countries' infant mortality rate. All the violence and the abuse and all those things–we have an example in this country, the native community is suffering from many of those things. It is a very, very realistic comparative right here. We

have it at the end of the road here, only a few hundred kilometres away from Winnipeg.

The best thing is to try to provide a healthy environment, a healthy economy, but that takes a long time to provide those things. If you want to really clamp the system, then try to live not within your means and you will see within a month or two months where you are going. I have difficulty with those terms.

I think we should try to give people as much as possible a good environment, put money back into their pockets, so they stimulate the economy, everybody is participating, they use less services. Then whatever we have we give to the people who are not privileged, and certainly they need some help. It is a very, very complicated thing. You cannot deal, any government, any department any more in a single issue. It is all interconnected by the end of the day. It all affects each of us. I think it will take a long, long time to correct the mistakes of the past.

It is a very, very difficult situation. When people know that $550 million per year goes out of Manitoba as taxpayers' money somewhere else where you have no control, how would you feel? If you have a $50,000 debt personally and your income is only $80,000, how would you live? I think that is what the situation is right now–a very difficult one, but most people do not know on the street. They think that everything is fine. Go and borrow and then everything is going to be fine.

Somebody, I do not know which member said from the NDP caucus, I would stand to be corrected, that no word is a bad debt. I do not know who said that but I will qualify it, I will ask the member for Inkster (Mr. Lamoureux) because he was telling me, I can confirm that. But I know somebody said there is no word such as bad debt. I think that kind of thing is very, very unfortunate. People know that nothing can be achieved without a healthy pocket for anybody, and the government is no different from the individuals. Societies are made that way.

It is so important, a solution is essential. I know I am going probably too much in this direction, but I think it is very important because the health promotion and healthy environment is related to the economy, too, in many ways.

If you are feeling good at heart, or you are feeling good around your surroundings, you will have less mental problems. You will suffer less anxiety, depression, all those things which drain the system. You will have less family problems that will help you in many other ways.

Everything is so much connected. With the technology that we have today, we have tackled diseases in a major way, but some of the basic things we are forgetting. Those are the basic things of which we have a control and we are failing ourselves. I think that is where the total restructuring of the family thinking has to come back eventually in this country, if we are to compete with the rest of the world.

We are in a very, very difficult situation–24 million people, 10 percent unemployed, 10 percent senior citizens, the Cold War ending, with the European market coming very strong, with Third World countries opening up their system, 4 billion people are coming into the economic power. We will have a difficult time to compete if we are not smart enough pretty soon.

I think we will have a difficult time to maintain the present standard of living. I mean that is part of health, too. Is it not how you live, what you think, what you do, how your ideas are in your life? I just want to put my comments on the record. I think they are not just picked up from the air. That is the experiences of millions and billions of people around the world.

It is very sad to see that in Toronto and industrialized nations you have people who do not have a home to live in. Homelessness has become a disease. Why it has become that is because of so many problems of the past. If people do not start addressing those issues, we will have more of those problems in the future. The situation of aboriginal people is a very clear indication of how much suffering they have gone through. We can blame anyone we want right now, but to change the whole system it will probably take 10, 15 years, because you have to change the whole attitude of structure. You have to change the whole system.

When individuals say that we can change everything tomorrow they are probably dreaming. It takes your own child, to raise for 15 years, to train him and then at the end of the day you do not know which way he is going to go. That is true, and we want to change something which has been put into place for 300 years. So when I see all these fancy words, you know, we are having the open things–I have my reservation. It is going to take a long time, not within our lifetime. But I would like the minister to notice those observations which are

people-oriented observations, and they are related to our day-to-day living, thus ultimately health, because no definition of World Health Organization will fit if you are not physically and mentally healthy.

Ms. Wasylycia-Leis: With respect to Healthy Public Policy Administration, I noticed that the ADM position is still filled on an acting basis. Can I ask, was there a competition for that position and, if so, what happened?

* (2300)

Mr. Orchard: Mr. Deputy Chairperson, we did undertake a competition, and after the competition we found that our internal resources were as good as we could put in place, and hence the position was offered to Ms. Sue Hicks on an acting basis approximately four months ago now, or thereabouts.

I will indicate to my honourable friend that one of the difficulties that we have experienced from time to time is our professional compensation levels. Sometimes they do not make us competitive, and so we have been, I think, exceptionally successful in terms of recruitment internally of people who have been with the system for a number of years and understand the workings of the system.

Ms. Wasylycia-Leis: Is the minister saying that by not being able to offer higher salaries for these positions, this government may not be able to attract as highly qualified individuals as they might have liked?

Mr. Orchard: Not that I want to get into the highly qualified, et cetera, we have run into the obstacle that where we have found an individual with whom we would want to advance discussions on employment we have often found that their salary demands simply exceed what our range is. Without the authority to go further, we find our best quality is in terms of internal recruitment because one never has an assurance that even though the credentials or the C.V. may indicate a worthy candidate for the position, always with someone coming from external to the province or the provincial Civil Service, you are dealing with an unknown quantity and you are going by interview skills and recommendations and C.V.s. We have not been disappointed any time that we recruited internally.

Ms. Wasylycia-Leis: Could the minister indicate why the position was only offered on an acting basis to Ms. Sue Hickes?

Mr. Orchard: That is not unusual. I think my deputy was an acting deputy for about a six-month period of time. I think Miss Havens was in an acting position for a number of months. I would just caution my honourable friend that there is nothing to be read into that. That is what we have tended to do with most of our senior positions, that I have tended to do with most of my senior positions over the last four years.

Ms. Wasylycia-Leis: Could the minister indicate what these ten or so positions are in terms of professional/technical capabilities for this branch? What do they do?

Mr. Orchard: Mr. Deputy Chairperson, I will provide that. Incidentally, Ms. Sue Hicks is here as our acting ADM of Healthy Public Policy, for any of those who have not met Sue Hickes.

We have one ADM; eight medical officers of health, in the regions primarily; the aboriginal health specialist, which is vacant and we will be recruiting for earlier on; and then a senior policy analyst.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, I was going to suggest, and I did consult with the member for The Maples, that we adjourn at this point. I am wondering, with apologies to Ms. Sue Hickes, who has just settled in, I am wondering if the minister would agree to an adjournment, given the lateness of the hour.

Mr. Deputy Chairperson: What is the will of the committee?

Mr. Orchard: They so much enjoy the entertainment as well as the debate value here. As much I would love to carry on interminably, if my honourable friends think we have accomplished—maybe we could slip a couple of lines through before we adjourn though.

Mr. Cheema: Mr. Deputy Chairperson, we will co-operate. We will go a few lines ahead.

Mr. Deputy Chairperson: Item 2.(a) Administration: (1) Salaries $961,000—pass; (2) Other Expenditures $164,300—pass.

Item 2.(b) Health Promotion, Protection, and Disease Prevention.

Mr. Cheema: Mr. Deputy Chairperson, can we wait until Thursday?

Mr. Deputy Chairperson: Is it the will of the committee to rise?

Some Honourable Members: Yes.

Mr. Deputy Chairperson: Committee rise.

FAMILY SERVICES

The Acting Chairperson (Jack Penner): Would the Committee of Supply please come to order. I understand that we are dealing with item 6.(c) on page 63 of the Estimates. Shall the item pass?

Ms. Becky Barrett (Wellington): Mr. Acting Chairperson, when the committee last sat, I had asked the minister a question on the Seven Oaks Youth Centre staffing decrease and wondering if he has the answer to that question.

Hon. Harold Gilleshammer (Minister of Family Services): Mr. Acting Chairperson, yes, that was due to some workload adjustment at the centre. As a result there were some staff changes.

Ms. Barrett: Mr. Acting Chairperson, can the minister state how many youths are currently at the youth centre and if it is a decrease or an increase from last year?

Mr. Gilleshammer: Yes, I am told there is an average occupancy there of 25 which from a number of years ago has been downsized from a time when there were between 60 and 70 youths that were at the Seven Oaks Centre, but in recent months, in the area of 25.

Ms. Barrett: Can the minister tell us what the average stay in the youth centre is currently and compare it to a year or so ago?

Mr. Gilleshammer: The average length of stay is 21.4 days. I am not sure I have data here on previous years, but I believe–and let me just check. That average has been coming down as a number of young people who are there are sent along to treatment centres and other accommodations.

Ms. Barrett: Mr. Acting Chairperson, is that then the same reasoning for the reduction in social assistance and related costs which are down a little over $1,000 this year from Estimates from last year. Is that because the individuals are staying a shorter period and there are fewer of them in Seven Oaks?

Mr. Gilleshammer: The figures would be lower in terms of the expenditures there with decreased enrollment and shorter time spent there.

Mrs. Sharon Carstairs (Leader of the Second Opposition): Sorry for being a few minutes late, so I hope I do not repeat anything that has already been asked.

With regard to the Suche report and particularly its references to Seven Oaks, can the minister tell us what is the state of the primary recommendation with regard to Seven Oaks which was the immediate establishment of a management team?

Mr. Gilleshammer: I can say to the critic that in the very near future, we will be releasing the Suche report and our recommendations or the government position on the recommendations. I would hope to be able to do that before the end of the month.

Mrs. Carstairs: Can the minister tell me if that means that he has not accepted recommendation No. 16, that an immediate management review of Seven Oaks be conducted?

Mr. Gilleshammer: Well, I guess I am just thinking whether we want to start into a discussion of the Suche report before we have formulated and announced our response to the Suche report. I can tell you that we have spent the last six weeks or so within the department looking at the recommendations and putting in place some action with a number of the recommendations and at the same time responding to the Ombudsman's report which was brought out just a few months ago.

We have a formal response that is almost completed. I would hope, and I have stated that we expect to do that before the end of the month which is next week.

Mrs. Carstairs: Well, thank you, I look forward to that, but this is a very significant document. This is probably going to be our only opportunity to ask detailed questions about what Mrs. Suche, who is after all the minister's appointee, had to say about the Seven Oaks Centre.

One of the very serious issues which she raises is that Seven Oaks offers no treatment. The children who meet the admission criteria are some of the most damaged children in the system and should not be housed without treatment, that it is supposed to be a minimum 30-day holding facility. In fact, according to her, there is one child who has been there for 284 consecutive days without any treatment whatsoever. Now, can the minister give us any idea if issues of that magnitude are being addressed?

Mr. Gilleshammer: Yes, just before you arrived the critic for the NDP had asked us about the average length of stay. I had indicated it was 21.4 days, and that the number of children being housed there was now around 25. So, in effect, we have done two things. We have brought the number of children at Seven Oaks down from a high of 60 or 70 a few years ago to around 24 or 25 at this time,

and we have also decreased the average length of stay as these children are moved into other facilities.

The fact still remains that we do have children that before they can go to any other treatment centre have to reach a more stabilized position where someone can, in fact, work with them and get them on the road to treatment. We are in a position with Seven Oaks where, I think, in the long term we have to make some decisions on what is the most appropriate place for some of these children, and in some cases it would be an institution for children who have some real deep psychological problems.

At the present time, the mental health system does not have a place to accommodate them. The youth corrections system does not have a place to accommodate them, and we have a number of treatment centres that deal with children that need extensive treatment, but until–and I hate to use the word "stabilize" and I am searching for a better one–these children do stabilize, where they are not a threat to themselves, are able to enter some of the treatment centres, we are charged with retaining them because they are either a danger to themselves or a danger to others.

* (2010)

One of the issues, I think, that Ms. Suche speaks to is appropriate treatment for adolescents with mental health problems. This is an issue that I think has been before government in the '80s and the '70s and which has not been brought to a final resolution. These are children that the hospital system, by and large, says we do not have a place for them or appropriate programming or treatment. Others are saying the same thing, and as a result, they are housed for a time in Seven Oaks. As I indicated, the average length of stay now is 21.4 days, but you are absolutely right, there are a couple of individuals that have been there for almost a year. One of the things we look at from time to time, I believe, is even out-of-province placement to find the appropriate treatment for them.

So the Suche report deals with a lot of issues. We have worked very hard over the last six or seven weeks, and we are going to make a presentation, I hope, next week with our formal response to what we are doing in the short term and what we are doing in the longer term.

I can tell you that we have been also working on the Ombudsman's report. He had brought to us a report–I am just looking for the date–on January 9 and we have made some changes within the medical unit regarding his recommendations. We have also been addressing program issues that he drew to our attention and also administrative issues. I can go into more detail on those if you would like, but I will wait for a subsequent question.

The issue of Seven Oaks is part of the Suche report and part of our response will be dealing with some of these items. We have taken some action, and I hear what you are saying, that you feel that there will not be another chance to discuss this. Some of those things have not been finalized as yet, but they will be finalized, I think, by next week when we make a response if we are able to do it that quickly. Perhaps with other questions, we can answer some of these issues.

Mrs. Carstairs: Let me make it clear that I do not put any of the blame for the condition of Seven Oaks on this present minister. I was asking questions about Seven Oaks in 1987 when Muriel Smith was the minister and that was the other party. My frustration goes back that long, when I first learned first-hand what the facility was like and what it was housing and how I considered it to be a major violation of any Charter rights of these kids whatsoever.

So, if I appear a little agitated, I do not want the minister to accept it personally because it is not a personal attack on him whatsoever, but I am dismayed at the kind of language that he is using.

First and foremost, you cannot stabilize a child without any treatment, so to stabilize a child at Seven Oaks when there is absolutely no treatment facility available at Seven Oaks is a ludicrous use of the term. Secondly, to talk in the same breath about youth corrections is one of the problems that Seven Oaks has had since its inception. The children who are admitted to Seven Oaks are not criminals. They have not committed any criminal act; otherwise they would be in the correction system. One of the things that Colleen Suche points to so very clearly is the very fact that their union has orchestrated them towards the corrections end of the scale instead of the social service end of the scale, is indicative of the way that institution has been treated in the past and something that has to end, the sooner the better.

If the minister is unable–and I can understand that he has not had the report all that long–to go into details, and I would have liked to have him afford the critics the opportunity of perhaps a more detailed briefing than normal when the report is finally

decided, the government's reaction to the whole Suche report and in particular the Seven Oaks portion of that report.

Mr. Gilleshammer: Mr. Acting Chairperson, I have no difficulty with that, that we can certainly provide a more detailed briefing for the critics and would be happy to arrange that. I use the word–and I am going to not react to your comments, but, I guess, try and focus on my meaning of them–when I use the word "stabilize," I am thinking of a few children there that are, unfortunately, long-term residents where the child is so self-destructive–and some of the things that have been explained to me about children who are trying to hurt themselves and destroy themselves in terms of pounding nails into their flesh and eating glass and it goes on and on. Before any of the treatment centres are in a position to enroll those children in a program, the child has to be somewhat willing to enter into that treatment program.

I am saying that this falls on Seven Oaks because of lack of other facilities in the province, that these are children that the hospitals are not able to accommodate and who turn to Seven Oaks to, I guess, bring some stability or bring some behavioural changes to the child before the child goes into the treatment program. It is probably a very unfair expectation to put on staff at Seven Oaks who are there to deal with a wide spectrum of children who are brought there by the police or come from other institutions because there is no other place for them to go. It would be, I guess, easy for me to say it should not be our problem, it should be a Health department problem. That does not solve it, and we are going to try and solve it over the next few years and find appropriate treatment and appropriate placement for these children.

I do not mean to use the word "stabilize" in any derogatory sense whatsoever, but given the treatment resources we have in Manitoba at this time, that child has to be accepted at a treatment centre on the basis that there is some indication that the child is prepared to work with those people, whether it is at Knowles or Children's Home or Marymound or wherever. Fortunately, most of these children are only there for an average of 21 days. We are dealing with two or three who are there for a longer period of time, and we have to find some solutions for them. At the present time they do not appear to exist in Manitoba.

I know in one case that we were talking about, there was not a solution and we were looking outside of the province. The other thing is, it is very, very difficult for the staff who, I think, work under a lot of pressure. I say to you from working in the school system, we were always nervous about children getting injured at play or on the school grounds. We had supervision here, we had supervision there. These are children who need 24 hours of supervision, in some cases not by one person but by two people. You have a staff who is very concerned that some incident would happen while that child is in their care.

I also referenced that the corrections system does not have treatment facilities either. This was not meant to reflect that this was part of the justice system or our corrections system, yet it is the only place where children are brought by the police when they are under age and either are a danger to others or a danger to themselves and need to, if not have a time out, at least have some custodial care.

* (2020)

So if you are saying to me that we do not have the full spectrum of treatment facilities in care in Manitoba, I say, yes, for a few children we do not. It is an issue that is before this department and before government that we have to work at to find I suppose very specialized treatment for self-destructive and severely damaged children who are brought into care.

Again on the question of a briefing, I would again say that we would be pleased to do that.

Mrs. Carstairs: I just want to put on the record very clearly that I do not think it is fair to the staff and it is not fair to the children to expect behavioural changes to take place in an environment in which there is no therapy. There is no behavioural therapist in that centre, never has been. There is no one who can modify that child's behaviour, so to literally having them in a time out where they can continue what could be excruciating, self-destructive behaviour–and that kind of self-destructive behaviour does not just go on at Seven Oaks.

I was at Marymound one day where a girl had used a mirror to rip up her arms and her legs. This is going on in our community, tragically, but I do not think an institution without any therapy whatsoever is the place to put that child.

I would like to know why there was a reduction in staff years when, if anything, Miss Suche pointed

out that there was a lack of staff, and that was one of the reasons for the low morale at the Seven Oaks Centre.

Mr. Gilleshammer: Mr. Acting Chairperson, we addressed the staff reduction a few minutes ago, but I will mention again, it was a workload adjustment. We have some 43 staff positions there with an average of around 24 children. There has been a dramatic reduction of children who are in Seven Oaks over the last number of years, where I believe in the mid-'80s we had 60 to 70 children there and we, the department, has consciously brought that down to where the average now is around 24 children, and the length of stay has been reduced to an average of 21 days.

Mrs. Carstairs: Yes, but that does not address the Suche report which after all was only submitted in February of '92, and she says: Staffing levels are inadequate in many instances. Less frequently, but certainly not unusual for some facilities is the risk of physical harm. Many facilities are single-staffed for up to 120 hours every month. Working alone can be frightening. The use of–et cetera; the rest does not actually address that issue.

In that the government was going to hopefully make some fundamental changes to Seven Oaks, why was this the time it was decided that they would cut a staff person?

Mr. Gilleshammer: Mr. Acting Chairperson, one of the staffing adjustments that we use there from time to time is using staff years from within the department to hire term staff at Seven Oaks as it is deemed necessary. If there is a change in the enrollment there downward and it goes down to 20 clients, then through the term staff we can adjust that. If there are more children brought into care there, we can adjust it upward through the use of part-time staff.

Now, I do not know of any guideline which indicates what the appropriate number of staff positions there would be for 20 children or 24 children or 26 children, but we do have some flexibility within the institution to use some of our term staff on a part-time basis to add counsellors as we need them.

Mrs. Carstairs: We can pass this.

The Acting Chairperson (Mr. Penner): We are on item 6.(c)(1) Salaries–pass; 6.(c)(2) Other Expenditures–pass. The amount of $1,901,900–pass.

Item 6.(d) Family Conciliation: (1) Salaries $714,600.

Ms. Barrett: A couple of comparisons in this area from last year's Estimates. In the Expected Results last year, there was a statement that said that there would be full or partial parenting agreements in 60 percent of the mediation cases. That appears to have been left out of the Expected Results from this year, and I am wondering if the minister can explain that deletion.

Mr. Gilleshammer: Mr. Acting Chairperson, I would like to introduce the acting director in this area, Sandra Dean, who has joined us.

The Expected Results for this year are similar to last year.

Ms. Barrett: So that when there is the statement, there is "reinstatement to access to be accomplished for 60 percent of the cases" that includes then the parenting agreements as well as the mediation cases?

Mr. Gilleshammer: That is correct.

Ms. Barrett: Last year in the Estimates it stated that you would provide family conciliation to approximately 1,600 families including 170 court-ordered assessment reports, and last year there was no discussion of number of mediation cases that would be dealt with. This year you have substantially increased the results to 230 court-ordered assessment reports, 650 mediation cases, and 2,000 families with absolutely no increase in staffing. I am wondering if you can explain that.

Mr. Gilleshammer: Mr. Acting Chairperson, I am told that there was a backlog of cases before this area of the department, and the department has been working diligently to update this and have had a fair degree of success.

Ms. Barrett: So the increase of 400 families and 60 court-ordered assessment reports from last year to this year, with no increase in staffing, is as a result of working through a backlog?

* (2030)

Mr. Gilleshammer: I say that there were cases before the department that they have been successful on. We have not had any request through the department to add staff, and we have been able to handle more cases.

Ms. Barrett: That is a very substantial increase in caseload with no increase in staffing. I find that very interesting. This Family Division of the Court of

Queen's Bench, is this related to the Domestic Violence Court? Is this part of that at all?

Mr. Gilleshammer: No.

Ms. Barrett: Can the minister tell me approximately what kind of activities are undertaken in the 650 mediation cases that are listed in this year's results, and why there was no comparable statement about mediation cases in last year's Estimates?

Mr. Gilleshammer: Mr. Acting Chairperson, maybe I could do this best by just talking a bit about what is being accomplished here.

By definition, mediation is a structured, short-term intervention to assist families to develop a parenting plan to maintain a continuing relationship amongst children, parents and extended family and to protect children from parental conflict.

This is a preferred intervention for resolving custody and access conflicts, and a number of families have received services through this particular branch of the department, with the courts actually referring a portion of the clients to mediation as well as lawyers referring people to this area of the department. Self-referrals make up a little over a third of the workload here. So these referrals, by and large, come from three sources then: from the courts, from lawyers and the third being self-referrals.

Ms. Barrett: I do not mean to keep harping on the same issue of the increase in the number of assessments in families that are being dealt with by this branch, but the court-ordered assessment reports, for example, is over a third higher this year than it was last, and there is, what, a 25 percent increase or a 20 percent increase in the number of families that are going to be dealt with through this Family Conciliation Services.

If there is no increase in staffing, the only way I can see that this increase can be undertaken is if the type of mediation and services that are being provided are required to be less intense, less lengthy in their implications or that through sheer weight of numbers and lack of resources the effect is that each mediation or each contact with a family is shorter than it used to be and perhaps shorter than it really should be.

Mr. Gilleshammer: I am told that two of the reasons why they are able to provide more service more efficiently is to do more prescreening for mediation and to get involved at an earlier stage and, secondly, to do shorter reports on the activities that they have been involved in. So government is not often accused of being more efficient. It appears that maybe in some small way we are more efficient here with the same number of staff that are covering more cases. I think the prescreening, in particular, is one of the reasons why they are handling more cases.

Ms. Barrett: So the prescreening would be as a result of the referrals from the courts, the lawyers or the self-referrals that the staff would prescreen as to whether these cases or clients could actually benefit from family conciliation and some of them might then not be seen. Is that what the minister means by the prescreening?

Mr. Gilleshammer: I think there is a determination made of the type of service they need and the type of continuing ongoing treatment or counselling that is needed. So I think it is fair to say that if there is early intervention, some of these cases are resolved successfully at an earlier stage.

Ms. Barrett: Can the minister tell me how many mediation cases there were last year?

Mr. Gilleshammer: In 1990-91, there was a total of 594 cases. In '89-90 there were 749 cases, and in '88-89 there were 722.

Ms. Barrett: Does the minister have any explanation for the fairly precipitous drop between '89-90 and '90-91 in the mediation cases seen by the Family Conciliation branch?

Mr. Gilleshammer: Mr. Acting Chairperson, in the screening process some people are screened out at an earlier stage and do not show up in the figures in 1990-91.

Ms. Barrett: Can the minister give me an example of where a family or a client might be referred and through the prescreening process and seeing these cases at an earlier stage it is determined that they are not necessarily required to come to conciliation, to whom or to what agency they would be referred if they are not seen by Family Conciliation?

Mr. Gilleshammer: In cases where there had been some violence as part of the relationship, they may be and will be referred to other agencies. Where perhaps the need was for marriage counselling of a sort, they could be referred to other counselling agencies.

* (2040)

Ms. Barrett: Would these cases that are referred to other agencies get preferential treatment at these other agencies?

Mr. Gilleshammer: The arrangements are most often done by the clients, and they would have to present their case to whomever is doing the counselling and be served either on a wait list or, if they are given preferential treatment, that would be as a result of the need. For instance, some of the clients would be referred to the Evolve Program. There is a wait list there, but there is also now another counsellor of course to take on some of those cases. With marriage counselling, there are quite a variety of options, and they would be responsible for setting that up themselves. It depends on, I suppose, what arrangements they made.

Ms. Barrett: So in effect the prescreening process could say to a client or family, I am sorry we cannot provide the Family Conciliation services for you, but we suggest you make individual application, and then a series of options would be given to the family or the individual and then they would be asked to make those arrangements themselves. If that is an accurate description of the prescreening process, can the minister give us some indication as to what the criteria would be for choosing or not choosing to provide the services of Family Conciliation to a family or an individual?

Mr. Gilleshammer: I think you are asking what their judgment is, and they make a professional judgment based on the cases that come before them. I am told, if there is some concern that further counselling be found in the short term, that there is the ability to facilitate getting the client involved with another agency.

Ms. Barrett: I am not sure I understood the minister's last portion of his last response. If there is short-term counselling required, then an individual or a family would be recommended for another service, or if it were only short term that Family Conciliation would be involved.

Mr. Gilleshammer: If the family would find some difficulty in making those arrangements themselves, or if there is some urgency to it and need assistance, they would be facilitated by the staff in this area of the department.

Ms. Barrett: So can I extend from that then that the families and individuals that Family Conciliation sees are the ones who are, to be very general about it, in crisis and that the ones that the Family Conciliation feels can more likely handle the weight that will be inevitable, virtually inevitable, by being required to go to another agency, those cases would not be seen by Family Conciliation. Is that a generally accurate statement?

Mr. Gilleshammer: Mr. Acting Chairperson, the clients that the Family Conciliation assists are children mainly who are affected by divorce and separation. Those families who are looking for marriage counselling are referred to other agencies, and similarly where there has been some violence involved, or potential violence, the clients are referred to other agencies. So the prescreening, one of the aspects of it is to determine the nature of the service that clients are looking for.

Ms. Barrett: Assuming that the range of cases and problems and issues that potentially come before Family Conciliation has not changed much in the last couple of years–and that is potentially a major assumption, but just assuming that–then one of the reasons for the ability of the Family Conciliation staff to handle upwards of a 35 percent increase in court-ordered assessment reports and a 20 percent increase in families is that they are screening out some of the cases that they would have potentially seen in prior years and offloading, if you will, onto other agencies and to other agency wait lists. Those people that in past, they may have been able to take the time to see but due to staffing constraints their screening process is eliminating whole categories of people that they may have seen in the past.

Mr. Gilleshammer: Mr. Acting Chairperson, maybe, if we could, it would be helpful to focus on the objective of Family Conciliation and that is, and I will just read this to you: "To ensure the availability of a range of dispute resolution services and counselling support to families that are disrupted by separation or divorce, and where continued parenting of the children is of primary concern."

Maybe it is fair to say that the Family Conciliation branch is more focused on that objective rather than getting into the situation where they are acting as a marriage counsellor or dealing with individuals who are susceptible to violent behaviour.

* (2050)

I think there is maybe a more focused approach in providing some dispute resolution services to these children and the parents who are in conflict. The prescreening is allowing maybe an earlier recommendation for some individuals to acquire

their service elsewhere and being able to focus more specifically on what the objective of Family Conciliation is.

Mrs. Carstairs: I think I am among those who would like to see all divorces involving particularly the custody of children totally removed from the hands of lawyers, so I have to commend the conciliation efforts which go on in this particular branch of the department, but I think there is a great deal of confusion as to exactly what this branch does. I have had some people tell me that in fact it is a reconciliation branch.

I think if I am reading the minister correctly, what he is saying is that is not the function of this particular department at all, that the function of this department is that one has accepted that there is a marriage breakdown.

Now it is to ensure that services are available to the couples, not for the couples' protection quite frankly, but to ensure that the children have access to both parents if that is in fact the recommendation, how that access is mediated, and the primary function is the protection of the child's rights. Is that a correct assessment?

Mr. Gilleshammer: Yes, you have stated that very well. I would go on to say unfortunately all of us probably know someone who has been divorced and has children, and it always amazes me that such a very, very high percentage of those cases there are children who are caught in the middle. The children become very confused in terms of sometimes feeling they have to be on one side or the other, and unfortunately with parents they sometimes precipitate that thinking with the children and in fact use the children in their anger to get back at their former mate.

It is unfortunate those things happen, but I am more aware of it now than I was 10 years ago seeing it happen to friends and colleagues and neighbours and so forth. It is the children who are so often caught in the middle, and we have so many cases that come forward where that is true.

Mrs. Carstairs: The minister indicated that some of the referrals in fact come from lawyers. Under what circumstances would a lawyer refer people to this form of conciliation? My experience is they like to shoot it out at the O.K. Corral.

Mr. Gilleshammer: Mr. Acting Chairperson, I guess I am not going to get involved with lawyer bashing, but it appears that lawyers more and more are seeing this as a credible service. They are also aware that there are court-ordered assessments, that more and more are taken into consideration in adjudicating cases, and as a result–I forget the figures I gave you earlier, but there are more cases which are being referred by lawyers.

Mrs. Carstairs: Is there any fee for service for this particular form of conciliation?

Mr. Gilleshammer: The answer is no.

Mrs. Carstairs: Has there ever been any consideration that such a fee for service should be put into place?

Mr. Gilleshammer: As we get into more difficult times with budget, with the arrival of the Finance minister, I think we have to look at ways of generating revenue. There are people who access service from this department who can well afford to pay for a service that they would pay for in the private sector. So, while that idea has not been advanced too far at this point, it is something that I have had some thoughts about within the last year, and you know I think if I follow through there is a suggestion there that we look at some services for revenue generation, and I would be prepared to do that.

Mrs. Carstairs: Obviously it would have to be based on an ability to pay, but it seems to me that they are paying extremely high legal bills, most of these couples, and here is a service which is an extension of that legal service for which they are paying nothing. I think that this one is probably more valuable to them, quite frankly, than sometimes the high-priced legal talent that they are paying for, and it is nonconfrontational. That is the beauty of what is being done in this particular branch.

This is also a branch that through things such as court-ordered assessments, decisions are sometimes made with regard to restraining orders. I certainly have seen recommendations done by staff of this branch which say that this parent or the other parent should not have access to this particular child. That is the recommendation of the court-ordered assessment.

Is there any follow-up done by this particular branch or any information package provided. I am thinking primarily of women here, who have a restraining order but who–and I know the Justice minister does not like it when I say it in the House, it is not worth the paper it is written on, but in fact, Dorothy Pedlar went on to say exactly the same thing, that it is not worth the paper it is written on

unless agencies are going to ensure that there is follow-up. Is any of that kind of thing done by this branch?

Mr. Gilleshammer: On the issue of restraining orders–and we are getting into the issue that you raised in Question Period today–institutions have to have policies set about who they are going to admit to their premises. School divisions have done this. In almost any school you go to now there will be a sign asking visitors to report to the office, and it is incumbent that the person in charge of the building ask, who are you and what do you want? I am sure in almost every school in Manitoba, we have had this case where a parent has come to either visit a child or take a child where they are not in a position to do so.

* (2100)

Now on the part of the institution, if they have not been informed that one of the parents is under a court order, they may in fact accommodate that person. Daycares are the same. Boards are now looking at their policies to determine who can enter their premises and go through the same thing. So with respect to daycares, the advice that we have been given is, if there is a restraining order to honour that and to not allow contact.

Restraining orders, however, have not been regarded as the serious document that they should be. We have all sorts of cases where people do not take them seriously. Now I think that our schools and our daycares, in particular, are in a position where they have to very much understand what their responsibility is, that they cannot simply turn a child over to a stranger or to a parent if they know there has been a restraining order. If they fail to comply with that, then they in fact run the risk of being in trouble with the courts.

Mrs. Carstairs: I am really concerned about a case, and it is not a particular case, it is a hypothetical case, if you will, in which a woman has been through a family conciliation process. She has met with officials. She has had a court-ordered assessment. There is, in fact, a restraining order. The restraining order is violated. Can she then turn to this particular branch to go through further conciliation or is that totally outside of the jurisdiction of this particular branch?

Mr. Gilleshammer: The approach can be made to Family Conciliation up to a point. Where it becomes a legal issue, then the redress for that would have to come from the courts. If the family is feeling they need more assistance and cannot wait for the court to adjudicate, another source of service that we have found is the Ombudsman's office, that there may be an appeal to the Ombudsman if in fact there is a feeling that they have not had fair treatment.

Mrs. Carstairs: I just want to be clear in my own mind here. The couple is in a divorce situation. They have gone to the court. The judge has ordered an assessment. They come to this branch for the assessment, or the assessment is in fact ordered by the court and the court orders the branch to do that assessment. The assessment is then reported to the court. The court makes a decision. At that point there is no further involvement of this particular branch.

Mr. Gilleshammer: Usually, no.

The Acting Chairperson (Mr. Penner): Item 6.(d)(1) Salaries $714,600–pass; (2) Other Expenditures $101,700–pass.

Item 6.(e) Family Dispute Services (1) Salaries $281,400.

Ms. Barrett: Mr. Acting Chairperson, again a comparison of the Expected Results from last year's Estimates book to this year's Estimates book. Last year there was a discussion of provision of legal information and support to 400 women whose spouses have been charged with domestic assault. That item is no longer in the Estimates book as the Expected Results of this session. In the Activity Identification last year there was a sentence that stated: administers the Women's Advocacy program which provides legal information and support to women whose spouses have been charged with assault. I am wondering if the minister can explain the deletion of those two items.

Mr. Gilleshammer: Mr. Acting Chairperson, I would like to introduce Marlene Bertrand, who has joined us at the table for this last section.

The Women's Advocacy unit within this department has been transferred to the Department of Justice and that was one of the recommendations found in the Pedlar review.

Ms. Barrett: The staffing level has shown a fairly substantial decrease in the Adjusted Vote 1991-92 from the Estimates of '91-92 particularly in the professional technical area with the Estimates for last year showing eight staff years and this year four and next year four. I am wondering if the minister can explain that difference in staffing level.

Mr.Gilleshammer: Yes, I am told that was the staff transferred to the Department of Justice with the aforementioned program.

Ms. Barrett: The minister gave, last week, a listing of grants to external agencies. I attempted to do a comparison from last year to this year and have a couple of questions on apparent substantial decreases. I am wondering if I could give the minister those apparent decreases and have the minister explain, as he has in other areas, where I have gone wrong and in some cases where I have not gone wrong.

* (2110)

In the Crisis Lines the YM/YWCA of Winnipeg Inc. has $206,600 this year and I think last year it was $316,100. Under Crisis Offices on the same sheet, Swan River Committee on the Abuse of Women, this year $14,000, last year $38,600, and quite a number of the shelters have had substantial decreases in grants last year over this year. Now that perhaps may reflect the change in the funding formula and also may be a reflection of the Fee Waiver Grant to Shelters, but if that is the case, I would not mind having that clarified. I did not see what the figure for last year for Thompson Crisis Centre was. So if the minister could clarify some of those grant changes for me, please.

Mr. Gilleshammer: Mr. Acting Chairperson, you were asking about the Crisis Lines, and the Ikwe Inc. last year had a grant of $202,200, that has gone up to $208,400. The YM/YW of Winnipeg Inc., last year it was $200,500, this year it is $206,600. With the Thompson Crisis Centre Inc., last year their grant was $101,400, this year it has gone to $104,500, but the member is correct that there is a restructuring that is taking place with the crisis centres and that the department has worked with the shelter directors and the boards to come up with a more equitable funding level for the shelters by adjusting the grants and the per diems. The system we had before, it appeared, favoured certain crisis shelters that were very, very busy and the grants were changed to a lower level and the per diems were increased.

I think this has met with the approval of the shelter directors, although I have not personally talked to them. I did see the Brandon shelter director's comments in the Brandon Sun which were very, very supportive of the changes. I believe the director of the Selkirk shelter is the chair of their group, also very supportive of the changes. We think that by making those adjustments that all of the shelters will feel that they have sustaining funding and not have to rely on the per diems to the same degree.

Ms. Barrett: I, as the minister knows, have spent a fair bit of time in discussion with the minister on this very issue and am very pleased generally with the information I have been able to get about the change in this fee structure. My understanding is that there are three general kinds of shelters: small, medium and large, for lack of better terms.

Can the minister give to us the formula that reflects on each of these different sizes of shelters? I know that generally it is more of a reliance on a grant and less on a per diem, but I think there is some variation–is there not?–between the three different types of shelters in the province.

Mr. Gilleshammer: Mr. Acting Chairperson, yes, I can give you some information on that. In fact, we have four levels of shelters now: small, medium, large and extra large. But that does reflect the size of those shelters. Of these four levels, core grants are based on shelter size and bed-night utilization. The extra large, of course, is Osborne House. It has 45 beds and 10,000 and more bed nights. The large shelters would be Ikwe and the Thompson Crisis Centre Incorporated, 25 beds between 4,000 and 6,999 bed nights. The medium shelters are 20 beds, between 2,500 and 3,999 bed nights–this would be the Westman Women's Shelter. Then the small which are 10 beds, up to 2,499 bed nights: The Flin Flon/Creighton Crisis Centre Inc., the Eastman Crisis Centre Inc., Parkland Crisis Centre Inc., the Portage Women's Shelter Inc., Selkirk Co-operative on Abuse Against Women Inc., the South Central Committee on Family Violence Inc., and The Pas Committee for Women in Crisis Inc. The sizes are certainly reflective of the number of beds, but also the number of bed nights.

Ms. Barrett: I appreciate that. Can the minister explain the balance between operating core grant and per diem for each of these small, medium, large and extra large? I assume that the balance between the core grant and the per diem changes depending on the size of the shelter. Is that a correct assumption, and if it is not, would the minister please correct me and provide that balance?

Mr. Gilleshammer: Mr. Acting Chairperson, the core grant is based on those figures that I gave you before of the number of beds and bed nights. All of

the shelters increased the size of their grant, but with the smaller shelters there was a more significant increase in that core grant.

I will give you some numbers that might help explain it: Osborne House will have a core grant of a little over $387,000; the two large shelters–and they are not quite identical, but in the area of $220,000; the one medium shelter around $200,000; and the smaller shelters around $154,000 as a core grant. Again the factors were the number of beds and the number of bed nights; all of them received some increases, but the smaller ones had the more substantial increase.

Ms. Barrett: Is the per diem the same for all of the shelters?

Mr. Gilleshammer: Yes, the per diems are identical with the exception of the northern allowance.

Ms. Barrett: Can the minister explain what the fee waiver grant to shelters is?

* (2120)

Mr. Gilleshammer: When clients do not qualify for social allowance payment there is a pot of money that the shelter can draw on to accommodate those clients, those per diems.

Ms. Barrett: I would like to ask a few questions on the second stage transition housing portion of the external agency grants. There is some overlap, such as Eastman Crisis Centre and Portage Women's Shelter; and the Selkirk Co-operative and the Southcentral Committee that appear both as a shelter and a second stage; and Thompson, I guess, as well. Then there are organizations such as Samaritan House Ministries, Women in Second Stage Housing and the Swan Valley Crisis Centre that are not under the shelter list but only the second stage transition housing. Can the minister explain the distinction between those two groupings?

Mr. Gilleshammer: Some of the shelters in their development of a continuum of service have also moved into providing second stage transition housing for clients. I think five of them have MHRC housing, and I believe it was Samaritan House own their own building.

Ms. Barrett: I am aware of the program at Women in Second Stage Housing. I am aware of the shelter programs provided by the shelters, but what is the difference between the shelter programming and the second stage transition housing programming as provided for example by Eastman Crisis Centre? Is there another physical plant or another set of apartments, or what does it look like, the program, the second-stage program for Eastman as opposed to the shelter program?

Mr. Gilleshammer: Mr. Acting Chairperson, the service provided is similar. In some cases they have purchased their own buildings separate from the site of the crisis shelter. One of the announcements in that press release was that our new funding allows for a follow-up worker to each of the shelters. One of the things that has happened is that these shelters have grown in different ways and, in some cases, the services they have provided are slightly different as well. I am just trying to think of the community that uses the shelter for night service for some of our child welfare cases. I believe it was in the Flin Flon shelter. So there are peculiarities associated with a number of the shelters.

I know when I visited the Brandon shelter and talked to the director there, one of the thrusts they are involved in is developing some curriculum for the Grade 5 level that deals with family violence, and they are piloting some curriculum in, I think, one or two of the schools in Brandon. When I say that they have all developed sort of some different interests and I suppose responded to local concerns and issues, that they have not all grown in the identical fashion.

Ms. Barrett: It sounds as though second-stage transition housing encompasses a very broad range of programming and situations. At what point do you differentiate between a shelter program and a second-stage/transition housing program, for example, Eastman Crisis Shelter? Is there a time point after which if a family staying at Eastman that they go into the second-stage transition? Is there different programming? Is it a different physical location or is it all three? What parameters does Family Dispute Services put around determining what is second stage and what is shelter programming?

Mr. Gilleshammer: The answer to that may be different in one situation from another situation. I know in my visit to the Thompson shelter that they had the second stage housing literally attached and nearby. In some cases the second stage housing is quite separate from the shelter. I think that is the case in Steinbach. Those judgments are made by the staff who work in those shelters and through quarterly meetings and other discussions with the

staff, I think, there are some general parameters that are being formulated. By and large, you will find differences that respond to the community needs where they have developed differently.

* (2130)

I might say, too, that second stage housing is regarded as sort of an outreach and when a woman leaves the shelter it provides an extended period of support so that there is continuing contact. If the direction that individual is going is going to be separate from her family there are additional supports put in place.

Ms. Barrett: I am in full agreement with the idea that shelters in second stage and transition and all of those programs need to be flexible and responsive to the communities' needs and they will change over time. This is a comparatively young area of service provision and unfortunately one that we are going to need more of rather than less of I am afraid in the next while.

I have a couple of questions about the press release that the minister issued on April 10 that spends that half a million dollar amount of money. There is $121,400 to assist shelters in responding to the needs of children through counselling and preventive work and then $143,300 toward funding follow-up workers at shelters. Those two items in particular, I would like to ask a question on. Are those figures divided up evenly between the shelters? Are they divided up differently among the different shelters? How is that money allocated to the various shelters?

Mr. Gilleshammer: Before I get into that, you know your observation that shelters were different in different locales was really brought home to me when I visited both the Osborne shelter and the Westman shelter, where supposedly few people know their location, and some care and concern is taken to maintain that. By contrast, I know that one City Council had to pass a variance to allow a new shelter to be built. Of course, it became the subject of public discussion within the community, and you had groups who appeared before council opposed to its location. I am sure there are very few people in that community who would not know where that shelter existed. Of course, in a small community it is much more difficult to sort of hide the location of that shelter.

You were asking about the manner in which those numbers were broken down with the shelters: The first amount was $121,400 to assist shelters in responding to the needs of children. So often the mother who comes to the shelter brings children along, and I certainly saw that at Osborne House here. This is going to allow the shelters to provide, in some cases, much-needed counselling for those children.

The funding is divided up on the following basis: that the funding will account for one SY at Osborne House, with a full year cost of $25,000; one staff year at Ikwe, the same cost; half a staff year in Thompson and Westman; and a quarter of a staff year in Eastman, Flin Flon, Parkland, Portage, Selkirk, South Central and The Pas.

In dealing with the shelters, we have tried to reflect the size of the shelter and the number of children and mothers that come into care there.

With the other sum that I had here a minute ago, it was $143,300; again it is worked out so that shelters will have one follow-up worker for each shelter. Five of the shelters already had a follow-up worker, so the $143,000 is for one worker at the remaining six shelters.

Ms. Barrett: That $143,300 is in effect a top-up so that all of the shelters have one follow-up worker, so that not every shelter got that money. Only the shelters that did not have a follow-up worker got that money, and the ones who did not got a full staff year out of that $143,300. Is that accurate?

Mr. Gilleshammer: I did not think you said what I said. There is now going to be one follow-up worker in each shelter. Five of the shelters already had follow-up workers; the other six did not, so that $143,300 is dedicated to those others so they now too will have a follow-up worker.

I just might say it has been an interesting exercise to try and accommodate all of the shelters with the changes in the basic core funding and the per diems as well as this new funding, but I think the department staff have made an extraordinary effort to work with the shelter directors to change the playing field so that everybody is accommodated. At least at this stage I have not heard the concern that somebody got more than I did type of thing. There has been a lot of work done with the shelters and I think, generally, they have been pleased with this initiative.

Ms. Barrett: Yes, we did say the same thing. I just said it a little more convolutely than the minister had.

A couple more final questions on this, if I may. The minister's statement also says: additional

funding of $145,300 to implement a more flexible application of length of stay for women in shelters.

Does this mean that the minister has followed the Pedlar commission report, and requests and suggestions on the part of many people in the field to increase the shelter stay from, I believe it is 10 days or 21 days, I cannot remember–I think it is 10 days without additional specific dispensation to an average allowable maximum of 30 days?

Mr. Gilleshammer: I think I know the answer, and if I am wrong, my staff will correct me. The length of stay was at 10 days before. The average length of stay was within that number. This new funding will allow some shelters or all shelters the flexibility to accommodate those cases where the stay is in excess of the average.

I am just trying to recall a figure. I think the average length of stay was around seven days before. This new funding will allow some flexibility to accommodate some clients, some people seeking service here, to stay for a longer period of time. It does not shift that dramatically but it does, through the second stage housing and other services, allow them to provide service for a longer period of time.

Ms. Barrett: I will not take the time now to reiterate the concern that I have raised before with the minister about the need for attempting to shut down the revolving door, where families come in and leave the shelter, and go back into the situation and come back in on an average of, I have heard, six times.

I think one of the reasons for that is that there are very few places, often, for women to go. Second stage and transitional housing will assist in that. A longer period of time allowed in the shelters might also assist in that by giving the families the additional time away from the abusive situation to get some more counselling and that kind of thing. So I commend the minister on the beginning of this process but suggest that is only a beginning and the door is still revolving a little too fast for my liking, and I think many people's liking.

* (2140)

Is this a pot of money that shelters will apply for? Is that how it works or is it pretty much that if a family wants to stay the 10 days there, the shelter does not have to make application to Family Dispute Services to get that additional funding?

Mr. Gilleshammer: Mr. Acting Chairperson, the branch will be working with the shelters on an as-needed basis through the fee waiver to accommodate individual shelters that have extenuating circumstances.

Ms. Barrett: I thought I had this clarified and something the minister said makes me think I do not. In the External Grants it says the fee waiver grant to shelters will be $124,200. In the press release it says $145,300 to implement a more flexible application. Is there some discrepancy between those two figures or how do they relate to each other then?

Mr. Gilleshammer: Mr. Acting Chairperson, the $145,300 referenced in the press release is additional money that would be used to accommodate those shelters that present a case to the department.

Ms. Barrett: A final question on a couple of the words in the press release. The minister in his press release talks about grants. Now, grants to the Evolve program and a grant to the North End Women's Centre, Women's Post-Treatment, and Fort Garry Women's Resource Centre–are these funds ongoing? Will they be part of the Core grant, the Core funds that Evolve can count on next year from the department or is this something that is a one-, two- or three-year grant that will then lapse at the end of a time period?

Mr. Gilleshammer: This would be regarded as permanent funding to those groups. The only caveat I would put on that is we do go through a budget exercise year by year. Other ministers might have different priorities; there might be totally different circumstances within the province. So as far as this budget goes, it is part of this budget. We have not communicated this on the basis of a one-time funding grant, but who would have ever thought that a government would remove the RCMP from Reston, but it happened. So those are decisions that are made year by year.

You had your final question.

Ms. Barrett: I actually was going to make a comment, a final comment. I do not mean this in a facetious manner at all, but it is something that really struck me when I saw the press release. I just wish the Minister responsible for the Status of Women (Mrs. Mitchelson) was in the House this evening, or in the committee this evening, because I and my caucus colleagues took some heavy criticism for a suggested acronym for the changing of the Manitoba Advisory Council on the Status of Women, because it had the sound of violence.

I wish the minister would read the verb in the first sentence of his press release.

Mr. Gilleshammer: I will have a look at it.

Ms. Barrett: To refresh the minister's mind, the word is "attack." I just would like–and I am not being facetious–I do think that this is an important symbol, that we have to always be very careful of, that language does have ramifications and does have value and meaning, and that the government has stepped up its "attack" against domestic violence was an interesting juxtaposition of words.

I would like to finally say that I think that, again, while it is a only a beginning, it is a beginning. I applaud the minister and his staff for having made these changes and look forward to them being only the first step in what I hope is a much larger series of resources provided to all of these programs, because they are essential if we are going to make a change and make a difference.

I have no questions on this.

Mrs. Carstairs: First of all, I want to add to the minister's opening remarks of welcoming Marlene Bertrand to the table. When I first became involved in family services back in 1986-87, I met Ms. Bertrand when she was then the head of Osborne House. I cannot think of an appointment of any individual better qualified for the position than this particular individual in terms of her knowledge, her expertise and her compassion. I hope that does not do her any harm.

Having said that, I want to speak about one shelter that, like the Service de Conseiller, is not covered. That is Maison Teresa, which offers a service in French to women who have been abused. Can the minister tell us why this group has not been considered for funding, as it seems an appropriate service to be provided in the second language?

Mr. Gilleshammer: Mr. Acting Chairperson, the allocation of funding within government, within departments, always leads to difficult decisions. Program expansion is difficult and we have to look at the needs that are out there. At the present time, the feeling is that we have enough shelter beds in the urban areas.

We do have the capacity within the existing shelters to provide service to the Francophone community in this, and we also are able to get assistance from Pluri-elles if need be. So while we have announced a 10.4 percent increase with the new funding model and the new initiatives, we have not chosen at this time to add to the shelter system.

* (2150)

I think the member is aware that in many communities we have community crisis offices and crisis committees. I was once told that the dream of every office and every committee is to create a shelter in that community. Again, we have to make judgments on the number of shelters we already have.

Over the last, I guess, four years, we have gone from three shelters to 11 shelters. We have addressed a major issue that the shelter directors and the boards have brought to our attention, and that is the need for some adjustments in the funding model.

So that is the package for this year and the decisions that we made to enhance the programs with this particular budget. It is difficult to say where the whole area of Family Dispute Services is going to go in the next year, in the next five years, but I am told that the total bed nights are levelling off and part of this is due to some of the good initiatives in the Department of Justice.

So I am sure that all of us would want to see the issues dealt with by other departments and by families and by society succeeding to the point where perhaps we can look at reducing the number of beds in the shelter system that we have in the province.

Mrs. Carstairs: Well, we will all yell hallelujah when the day comes when in fact there can be a reduction in shelter beds, but the comment that I made earlier about the Service also applies to la Maison, and that is, when people are under stress they tend to go to their first language. Ikwe is certainly finding that they are working more and more with their clientele in aboriginal languages. When a woman whose first language is French in this country and in this province needs the shelter support system, she too would feel more comfortable if she could get that service in French and not in an English establishment.

So should the day come when the minister either has to expand to other shelters, as they have had to do, going from three to 11, or even if they are looking at decreasing beds, which we would certainly welcome in some of the existing shelters, then perhaps he can look to providing some of that funding to a shelter which provides the other

language of this country as the language of choice to the people who go there.

Mr. Gilleshammer: I would accept the member's advice, and when decisions are made that is certainly one of the factors that we would have to look at.

Mrs. Carstairs: I welcome very much the initiative which puts money into the counselling of children. What I want to know, however, is, will the counselling of children also become one of the mandated services provided by the follow-up worker? Counselling of seven days duration, while good and useful, is quite frankly the tip of the iceberg as far as these children are concerned if we are to stop the cycle.

We know very clearly that young men who have watched abuse in their home are the ones with the greatest proclivity to indeed abuse as adult males. So if you are going to change that cycle, this counselling becomes an important component, also to provide some comfort to the children, obviously, who have been in an explosive situation and have been removed from that.

What will be the outreach work for those children on a continual basis?

Mr. Gilleshammer: Mr. Acting Chairperson, I think that is one of the challenges before the department, to work with the directors and with the boards. As I indicated in an earlier answer, many of these shelters grew and developed in different directions to respond to local needs.

I think that we are going to continue to have the directorate within the department dialogue with the shelter directors and boards on a regular basis. We will be very interested in the input that they have, but I certainly agree that there has to be that continuum of service.

Hopefully, some of the funding that we have put into the shelters is going to allow that to happen. I think, you know, given the staffing size of the various shelters, and I had that here a minute ago, some are going to be able to do that, perhaps better than others. But, you know, just like small communities have to find different ways of providing that service, I think small shelters are going to have to look at their staffing components and work with the department to provide the best service that they can.

There has been a dramatic, I think, increase in the funding in this area, in the number of shelters that have come onstream. The board chairs have indicated to me in the past, and I think the organization of shelter directors as well, that they want government support and support by way of staff training.

Again, I think the board development manual is very important. When I have met with the shelter directors and the board chairs in the past, they needed to have the relationship evolve to another level where boards took a very active interest and direction and gave direction to the shelters.

I have seen in the almost two years that I have been in office a change there. I had one board chair come back and say how much they have changed in their shelter from the first day I met them, that there needed to be demands placed on staff and on directors, and the board really needed to know what was happening, because ultimately they were responsible if there was a large debt that was run up or if there was something wrong in the shelter.

So I think while we are very pleased, and I am pleased with the attitude of the critics as far as the development of the shelters has gone, there is still more work to do in terms of seeing that there is a level of service being offered in all of the shelters that is improving year over year with more funds and more staff.

There also has to be, I think, a staffing plan and program that they have to work on. I am sure that we are going to see, with guidance from the department, a maturing of those shelters to offer more services to the women and children that come into care.

Mrs. Carstairs: My final question: Will there be an advertising campaign this year on the issue of domestic violence?

* (2200)

Mr. Gilleshammer: At this point we have not planned for one.

The Acting Chairperson (Mr. Penner): Item 6.(e) Family Dispute Services: 6.(e)(1) Salaries $281,400–pass; 6.(e)(2) Other Expenditures $82,400–pass; 6.(e)(3) External Agencies $3,818,900–pass.

Resolution 47: RESOLVED that there be granted to Her Majesty a sum not exceeding $103,805,100 for Family Services for the fiscal year ending the 31st day of March 1993–pass.

The last item to be considered for the Estimates of the Department of Family Services is item 1.(a) Minister's Salary $20,600. At this point I would

request that the minister's staff leave the Chamber for consideration of this item.

Ms. Barrett: I do not intend to make the motion that I did during the last Estimates process to reduce the minister's salary.

I would, however, like to put a final few comments on the record sharing some of the concerns that I have expressed as a representative of my caucus and of many of the groups and organizations that I have met with since last we dealt with the Estimates in Family Services department.

Very briefly, some of the major areas include the heavy reliance or that 80 percent of the increase in the Department of Family Services going largely to increased volume for social assistance recipients.

I am not opposed to giving people who require social assistance that assistance at all. I do, however, think that when it is connected with the decrease in employability enhancement programs, other education and training programs that have taken place in the Department of Family Services and in other departments, it is a sad commentary on the priorities of the government that they will accede to their legislated and mandated basic provision of the necessities of life but have not chosen to provide resources that will enable people to break the cycle of poverty and to not require social assistance.

Another area that has been of concern to us, and will I am sure continue to be of concern, is the whole issue of child daycare. The ramifications and the implications and the fallout from the minister's actions of last April in making changes to the fee structure and the funding formula for child daycare in this province are only now beginning to be felt. I am afraid that over the next year, between this year's Estimates and next year's Estimates, we are going to see some serious problems in the child daycare field, and they are problems that could have been avoided had the minister not chosen to make the ideologically based changes to the fee structure that he did.

I have some major concerns over the potential problems with the whole area of Child and Family Services. Specifically, I still have major concerns and questions regarding the restructuring of the Child and Family Services agencies in the city of Winnipeg, but I am particularly concerned about the impact that structured care continuum will have on the service provisions for these agencies and other agencies that are attempting to provide services in an increasingly narrow financial climate and an increasingly needy clientele.

Finally, and this is an area that we will be getting into in the debate in the House, is the whole issue of the Children's Advocate. There will be time in the House and in the public hearings to debate this issue. Again, very serious concerns not about the concept of the Children's Advocate, which is something that has been asked for and suggested for 10 years now, but the method of implementation that this government has chosen to undertake in this very important regard. I think that perhaps the impact of the Children's Advocate legislation as the minister has brought it forward will be far less positive than it might have been had he chosen to follow the full recommendations of Judge Kimelman, Reid-Sigurdson, the Aboriginal Justice Inquiry and Ms. Suche.

Again, there have been a few positive notes, most recently the additional funding for Family Dispute Services, but on the whole a budget in a department that showed very little innovation in a time when innovation is required, and minimal support in addition to the basics that the government was required to put into this budget.

With those comments then I will be prepared to pass the Minister's Salary.

Mrs. Carstairs: Mr. Acting Chairperson, I just want to put a few remarks on the record about the direction, quite frankly, not only of this department but a number of departments in this government, because it all seems to have the same orientation. That is, there seems to be a fear, which I do not quite understand, of the arm's length agency. It is reflected in the action of the Minister of Culture, Heritage and Recreation (Mrs. Mitchelson), it is reflected in the actions of the Minister of Justice (Mr. McCrae), and it is reflected in the actions of the Child and Family Services minister, when they take volunteer boards and they disband them because they do not trust the volunteer boards, or, more importantly, they do not like the fact that the volunteer boards feel that they can, on occasion, criticize government.

I think that criticism of government, from that source, is quite frankly much less suspect than the criticism that comes from opposition parties, because that obviously has an ulterior motive, whereas the arm's length boards do not have an ulterior motive other than the provision of better

service in the areas for which they are providing that service.

That is why I am so distressed, quite frankly, at the minister's approach to the Children's Advocate, and why I will, and my party will, fight him all the way on the methodology by which he wishes to establish such a Children's Advocate.

Judge Kimelman first recommended a Child Advocate in 1983. It has been recommended by the AJI, by Reid-Sigurdson, by the Suche report. In each and every one of them, they talk about an arm's length relationship with government not a line agency of government. I think the government's, and the minister's in particular, constant reference to an Alberta piece of legislation as if it was perfect belies the fact that there is no perfect legislation anywhere.

It behooves us as legislators to make legislation we are introducing in this province better than what is offered in other provinces, not just to meet the standard of what is offered in other provinces. A Children's Advocate that reported to this Legislature, in the same way as the Ombudsman reports to this Legislature, whose appointment comes by the approval of all three parties, is something which I think is sadly lacking in the minister's approach to the Children's Advocate.

But I think it is a reflection, quite frankly, of his attitude towards the disbandment of the Winnipeg Child and Family Services agencies. Many of the functions that he now sees as centralized could have easily been centralized without making the agencies into one. All that they have done by amalgamating those agencies is to remove volunteerism, which was an important component of the effective organization of those agencies.

Like the member, I am also concerned that so much of the budget went into social assistance increase, but I recognize that in a recessionary period, obviously, large sums of money were going to be, to a much greater degree, required by the government to be spent on social assistance.

I think it would be healthy for everyone to remove all of the employable enhancement programs from the ministry of Child and Family Services. I do not think they belong there. I think that we have to restructure the administration so that there is a training component, an ongoing training component.

* (2210)

My greatest concern is always for young people, in the sense that a person who is on social assistance for 10 or 15 years all too often has lost their dreams. When we put a young person of 18 on social assistance, we should be offering them an opportunity still to dream. As long as we have a mentality that social assistance will look after them and they can somehow be pieced away, then we will not meet their needs nor our needs for the future.

Earlier in Question Period today we talked about the fact that there was a 30 percent unemployment rate and a 25 to 30 percent drop-out rate in senior high schools. All of us know that, quite frankly, a young person without a high school diploma today is a young person that will probably find themselves more unemployed than employed. I think we have to change the focus of how we deal with those young people. If I had the optimum, I would not allow a single young person to go on social assistance unless they also were getting training at the same time so that there would be some guarantee that they were encouraged to dream.

As to the changes in child care, one of the areas that concerns me the greatest is the removal of the salary enhancement funding. I think that will only lead to a stagnation of improvement in salaries for child care workers in this province and will say to young people that this is a service which is not highly valued. They will turn from it and will not choose it as an occupation.

I find it fascinating that in the field of education we have determined that everybody who teaches must have a degree, at least one, sometimes two, sometimes three, sometimes four, and yet the teacher in a Kindergarten program takes a child straight out of a child care program. The person in a child care program may be getting an average wage of $18,000 a year and we consider that adequate. That child has a magical birthday, we put them into a classroom and the salary for that particular person may be $30,000-$32,000. We seem to think that is acceptable. I do not think we place nearly enough value on the care given to our children between the ages of birth and five years.

I think that all the literature now will clearly show that that is the time when the greatest amount of learning goes on. That period of four or five years, a child learns more than at any other five-year period in their lifetime. It seems quite unbelievable, but that is where the growth occurs and unless we continue to encourage qualified and highly skilled

people into the care of children in child care settings then we are not doing our children the justice, quite frankly, that our children deserve.

Finally, I look forward to the minister's approach to residential care in general, but in particular to Seven Oaks. I spoke earlier this evening about my concern about that institution, and I again say that this not to be laid at the feet of this minister. This has been an ongoing situation for a great number of years.

It does not meet the needs of the children. We had the minister's staff and department looking very carefully at legislation for vulnerable persons. Well, I would suggest to the minister that if there can be a Charter challenge of a mentally retarded person whose Charter rights have been denied, then a child who has been incarcerated only because that child wishes to self-destruct, with no court orders, with no treatment program, with no quality care in the sense of helping to make that youngster better but only providing custodial care, which is all we provide, could in fact result in a very serious and major Charter challenge, because I think the rights of that individual child have been totally and absolutely violated.

With those remarks, I too will be prepared to pass the Minister's Salary.

Mr. Gilleshammer: I am not going to enter into debate at this stage on some of the issues raised. I would thank the members for the time we have spent on the Estimates, and I appreciate the attitude of both of the critics. I would say that my department will spend some time reviewing the comments that were made in the Estimates process to fully understand some of the questions and criticisms so that we do not miss anything that members were trying to bring to our attention.

I am again not going to enter into debate into the Child Advocate, but I know we will get an opportunity to do that. I think there is good evidence that the practice in Manitoba works. I would urge the two critics to try and understand the service component that the Child Advocate will provide as opposed to the service that the Ombudsman provides in coming in after an event to determine whether someone has been improperly dealt with.

The final point I would mention is we did take the opportunity to brief the two critics on The Vulnerable Persons Act. I met with the working group this morning to indicate that the drafting of that legislation is so complicated that we are not going to be able to bring that legislation in this session. We have made a commitment that we will proceed with it as soon as we can when the drafters have that comfort that they have done a job which reflects the working group's recommendations.

Thank you.

The Acting Chairperson (Mr. Penner): 1. (a) Minister's Salary $20,600–pass.

Resolution 42: RESOLVED that there be granted to Her Majesty a sum not exceeding $7,221,800 for Family Services for the fiscal year ending the 31st day of March 1993–pass.

This completes the Estimates of the Department of Family Services.

Seeing the hour is after 10 p.m., call in the Speaker. Committee rise.

Call in the Speaker.

IN SESSION

The Acting Speaker (Mr. Penner): The hour being after 10 p.m., the House is adjourned and stands adjourned until 1:30 p.m. tomorrow (Wednesday).

Legislative Assembly of Manitoba

Tuesday, April 21, 1992

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