LEGISLATIVE ASSEMBLY OF MANITOBA
THE STANDING COMMITTEE ON LAW AMENDMENTS
Thursday, 6 June, 1985

TIME — 8:00 p.m.

LOCATION — Winnipeg, Manitoba

CHAIRMAN — Mr. P. Eyler (River East)

ATTENDANCE — QUORUM - 10

Members of the Committee present:

Hon. Messrs. Cowan, Desjardins, Evans, Harapiak

Hon. Ms. Hemphill

Hon. Messrs. Lecuyer, Parasiuk, Plohman, Storie

Messrs. Adam, Ashton, Corrin, Eyler, Filmon, Fox

Mrs. Hammond

Messrs. Hyde, Johnston, Malinowski, Manness, Mercier, Nordman

Mrs. Oleson

Messrs. Orchard, Santos, Scott, Steen

WITNESSES: Bill No. 2:

Dr. Paul Shuckett, Association of Independent Physicians

Dr. Richard Matkaluk, private citizen

Dr. Henry Krahn, Association of Independent Physicians

Dr. Jeremy Gordon, Association of Independent Physicians

Mr. Walter Kucharczyk, private citizen

Dr. Henri Marcoux, private citizen

Dr. Gilbert Bohemier, Manitoba Chiropractors' Association

MATTERS UNDER DISCUSSION:

Bill No. 2 - An Act to amend The Health Services Insurance Act.

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MR. CHAIRMAN: Committee, come to order. We are hearing representations from the public on Bill No. 2, An Act to amend The Health Services Insurance Act. I have a list of approximately 10 people.

The first person on the list is Dr. Paul Shuckett.

DR. P. SHUCKETT: Mr. Chairman, before I begin, will it be permissible to add an additional name to the end of the speaking list?

MR. CHAIRMAN: Certainly, the Clerk will get the extra name to make a presentation.

DR. P. SHUCKETT: Dr. Gordon will have the name, okay?

Mr. Chairman, I am an ophthalmologist, an eye doctor, and I have a subspecialty in Pediatric Ophthalmology. I deal in my practice with children.

I was born in Manitoba and educated at the University of Manitoba, both at an undergraduate level and in medical school. For four years I was a graduate student in Economics at the University of Minnesota prior to entering Medicine. After completing my residency in Ophthalmology at the University of Manitoba, I did an additional year's training in Pediatric Ophthalmology at the Eye and Ear Institute in Pittsburgh.

At the time of the completion of my training in 1980, I contemplated returning to Canada, and specifically to Winnipeg. Although I knew that the financial rewards for my work were far greater in the United States and in other parts of Canada, I felt I had a duty to the people of Manitoba, as well as a desire to return to my family and roots, and come home. I knew that the rewards here were circumscribed, but I felt that I could provide the kind of practice that I had been trained to do and provide the rewards that I knew were available in other parts of Canada and in the United States by practising outside the Medicare scheme and extra billing those patients with the ability to pay. In point of fact, I extra bill about two-thirds of the patients that I actually see. The amount that any patient may be extra billed over a year might range from $10 for one visit up to $40 for several visits over the course of a year. I automatically waive my full fee for those who are on Social Assistance, those whose fees are being paid by a third party, etc., etc., etc.

Since the patients pay directly to the clinic business manager, I, in fact, do not know what the patients end up paying, as some patients merely remit their MHSC claim cheque. In fact, our clinic has a practice of not submitting its bill to the patient until six weeks after the patient is seen, so they have received their MHSC cheque before our bill is received by them. I continue to see patients who have kept the money that MHSC has paid them and fail to remit their fees to us. In fact, we do not fail to see patients who have kept hundreds of dollars from our clinic. I cannot see how this practice in any way represents a barrier to access of appropriate health care. In point of fact, any patient who is making an appointment with us is informed of the extra fees that we charge and if they cannot or will not pay, we waive the extra fee.

My patients have the freedom of seeing me or not seeing me. There are other ophthalmologists who are not practising outside the scheme. The patient gets a bill and knows what my fees are and is well aware of what the true cost of medical visits are because of this. I contrast my practice to that of the Provincial Government. Several months ago, they instituted a $15.25 extra billing fee for patients in chronic care facilities. Their definition of the ability to pay was an income of greater than $1,825.00. The Provincial

Government is short of cash, so they can extra bill anyone and this is "okay," but if a private practitioner does this, there is a "barrier" to health care. It is obvious to me that extra billing is permitted when it is to the benefit of the government's own pocketbook, but is opposed when the proceeds go to another party.

As an opted-out physician, I am always aware of the fact that the public may have some adverse feelings toward my practice and toward physicians in general. As you recall, the Hall Commission, in its review of Medicare, found that people were opposed to extra billing. This is much akin to asking people if they would like to have a free lunch or pay for it. The answer is obvious.

In another survey, people were asked whether they would be willing to pay an extra fee if they had the freedom of choice in terms of physicians. With the appropriate phrasing of this survey, people were in fact positive with their response to the practice of extra billing and opting out.

We are well aware that lawyers have a tariff fee, but some choose to charge less than that, and some charge significantly more. People are willing to pay more because certain lawyers have better skills and expertise in certain areas. As physicians, we are to be denied this under the rules to be instituted by this bill.

It should be noted that Britain has had a two-tiered medical scheme for the last 30 years. I refer, of course, to the National Health Service which provides free "medical care" to its population. In particular, with regard to Ophthalmology, they provide cataract surgery. It is a joke that in the National Health Service, the patient is booked for cataract surgery, but the long waiting list reduces the queue by a significant percentage because the patients die before they get their surgery. The response in Britain has been the setting up of private insurance and private health schemes. I find it ironic that labour unions in Britain are fighting for private medical insurance as part of their fringe benefits in settlements. This is a direct result of the inability of the closed health system to provide adequatecare. I fear that this same type of underfunding will develop in Canada with time, as it has developed in the United Kingdom, but unfortunately the second route, the ability to use outside funds for health care, is to be closed by this bill.

The constraints of financing have already reared their ugly heads in the provisions of health care in Manitoba. There is no doubt in my mind that certain decisions, made even in the last few years, have restricted the availability of first class health care to Manitobans and the sole criteria, of course, has been cost.

Recently the Health Sciences Centre in Winnipeg purchased a new computerized tomographic x-ray machine paid for by the government, of course. This is a very expensive machine and it consists of two parts, a computer and a scanner. The patient sits in the scanner and the computer develops the x-rays. The Health Sciences Centre obtained outside funding from a donation for a second scanner which could be hooked up with a computer, as the computer was designed to be used with two scanners at once. The Health Services Commission rejected the use of the second scanner because it said it would cost too much to operate the machine.

It is known from other national surveys that Manitoba is tremendously behind the national average in terms of the provisions of computerized tomography. The costs considerations alone have prevented this machine from being utilized fully at the Health Sciences Centre.

I work in a large multi-specialty clinic in which we have the largest group of obstetricians practising in the city who are responsible for almost 1,000 deliveries, births a year. They, as well as our internal medicine experts, have need of what is called a diagnostic ultrasound machine. This machine is available only at a few hospitals in Winnipeg, and the waiting list for its use are too long, months at a time when it's elective. We felt it would be advantageous to our patients to provide this service and we have, at our own cost, purchased a machine. It has been in use for several years, filling an obvious need for the people of Manitoba. To date, the Health Services Commission refuses to compensate our clinic for this service. It is flagrantly obvious the only reason for this is cost, and the unwillingness for the province to pay for it bodes ill for the future of medical care in Canada and in Manitoba, in particular, when patients are denied adequate access to proper facilities.

I practise in a very fast moving, highly-technological area of medicine. Ophthalmology has seen significant advances in the treatment of various diseases with procedures which save or restoree vision and enhance the quality of life for all Manitobans. In particular, the treatment of glaucoma has changed radically in the last few years. The introduction of laser glaucoma surgery has made profound inroads in preserving vision, decreasing the need for hospitalization, expensive surgery inside the eye and long-term use of multiple potentially hazardous drugs.

We, as a group, have been negotiation with the government, through the Manitoba Health Services Commission, for adequate fees for these procedures. The government has been very hard-nosed about this to the point of ludicrousness. They are willing to compensate us performing a potentially risky, highly-skilled procedure for the sum which is unbelievable - $57.00. Manitoba has been very lucky to have one of its ophthalmologists spend several years training as a glaucoma specialist in the United States and England. This person returned to practice in Manitoba three years ago with great hopes and expectations. Unfortunately, he has been hamstrung by the inability of the Commission and the MMA to come to any fruitful agreements. Because of this stalemate, and because his future is tied to glaucoma work, he has made arrangements to leave the province within the next six months.

Manitoba is a have-not province with regard to ophthalmologists. We have a relative shortage of ophthalmologists and those who are in practice demographically are relatively old. The relatively low level of fee schedules, in terms of office practice, compared to other areas of Canada, can be attested to by the relatively high percentage of ophthalmologists in Manitoba who have opted out of the Medicare scheme. Approximately 40 percent of the fully qualified active ophthalmologists are opted out.

A second factor to bear in mind is the fact that the University of Manitoba has lost its accreditation in the training of new ophthalmologists. Because of problems at the Health Science Centre and other inadequate facilities for training, this has come about. When we

combine the combination of a loss of extra billing and the relative lowering of attractiveness of fee schedules in Manitoba, and a loss of a training facility for new ophthalmologists, we make Manitoba a relatively unattractive place for the future of ophthalmology.

My expectation is, without changes in both these regards, 10 years from now we'll be facing an untenable position in which Manitoba will have very low expenses for ophthalmology because there won't be any.

Thank you very much.

MR. CHAIRMAN: Are there any questions for Dr. Shuckett?

Mr. Mercier.

MR. G. MERCIER: Dr. Shuckett, what was the recommended fee for the procedure you were discussing with the laser beam?

DR. P. SHUCKETT: Initially, when the procedure was introduced in Manitoba, there was an interim fee recommended - and I can't remember the exact number, but I think $250 rings a bell. That was when the fee was first introduced provisionally about four years ago, but then the Commission decided that was much too high and they countered with a fee of $113.00. The fee of $113 was to include six weeks of post-operative care. A calculation done by my colleague who does this procedure, who is the glaucoma expert, concluded when one took into account the number of visits which are required post-operatively with this $113, including six weeks of post-operative care, the fee for the procedure worked out to about $25 and he felt, because of the risks and the paperwork involved, he would do the procedure for nothing. So the problem has been one of negotiation with the Commission and it's been stalemated for several years now.

MR. G. MERCIER: Did a group ophthalmologists purchase a laser machine?

DR. P. SHUCKETT: There is one laser owned privately in the Province of Manitoba.

MR. G. MERCIER: What is going to happen to that with the fee schedule that is being set by the Health Services Commission?

DR. P. SHUCKETT: It's interesting because that machine has been paid for by private funds, by a clinic through a Foundation, and they will be maintaining their facility, but there will probably be no other facility provided at this point, privately.

MR. G. MERCIER: Is there any guarantee that machine will be retained and not sold, in view of the fee schedule that has been approved by the Health Services Commission?

DR. P. SHUCKETT: Well, fortunately for the users of that machine, it has another use, and that's in terms of laser surgery for retinal detachments. Now, the fee for the laser surgery for retinal detachments, which required probably equal amount of time and less post-operative care, is significantly greater than the fee that has been proposed for glaucoma. The problem has not been the fee for the laser surgery, as existed in the fee schedule in the past, the problem has arisen because of these new procedures and the very very hard-nosed approach that the Manitoba Health Services Commission has approached it.

Now the problem arises when you have physicians, such as a glaucoma expert, who confine their practice to a certain area and find that they're stonewalled in their practice because they can't get adequate fees for their work.

MR. CHAIRMAN: Mr. Orchard.

MR. D. ORCHARD: Dr. Shuckett . . .

DR. P. SHUCKETT: Can I add something to that? There is another laser machine which I should mention, it's called a yag (phonetic) laser machine, which I did not specifically mention in my presentation. That's a machine that's used after cataract surgery to open up a membrane, let's put it that way, and the same private Foundation that provided the group of ophthalmologists with this machine has provided them with this yag laser machine. There is no other yag laser in the province; no public facility has the yag laser at the present time. Again, the fees proposed by the Health Services Commission for the yag laser are so ludicrously low the clinic is actively looking for a purchaser and getting rid of it.

MR. D. ORCHARD: Dr. Shuckett, on the first machine that you were describing, are services provided, in the clinic with that machine, currently covered under the MHSC fee schedule?

DR. P. SHUCKETT: The machine itself is being covered for retinal surgery, with an adequate fee; but for glaucoma surgery, the fee that's been proposed is $113.00. Now the Commission has been trying to negotiate an extra fee, and to be perfectly frank the Commission has been trying to propose an extra fee to help those who own the machine to pay for it. But, again, when you add up the professional component to this it's entirely inadequate.

MR. D. ORCHARD: Now, the glaucoma procedure at $113 is deemed to be inadequate, has the MMA supported the ophthalmologists' position that that is an inadequate fee?

DR. P. SHUCKETT: We've been negotiating, through the MMA, for three years on this item, and we have gotten nowhere.

MR. D. ORCHARD: And the MMA is indicating to the Health Services Commission that the fee of $113 is inadequate and should be raised?

DR. P. SHUCKETT: Right, we've been negotiating this.

MR. D. ORCHARD: You've expressed some concern about the loss of the training facility at the Health Sciences Centre for ophthalmology. What impact will that have in terms of recruitment of ophthalmologists in Manitoba?

DR. P. SHUCKETT: In point of fact, in the last 10 years only one ophthalmologist has come here who wasn't, at least, partially trained here. It's a known fact that physicians tend to practise where they train, especially at the end of their training. If they are in a specialty they'll stay where they train.

In Manitoba we've had a relatively successful program in the past, in terms of retaining trainees, especially in the last 10 years.

With the loss of a training program this ability to attract ophthalmologists to Manitoba will be lost, and I can't see how we can attract people here unless they have social or geographic ties to Manitoba.

MR. D. ORCHARD: Now, with the loss of the training facility, where is the next closest geographic school for ophthalmology?

DR. P. SHUCKETT: Geographically west, Saskatoon, it's a very very small program, they accept one resident a year, and that is in fact inadequate for their needs. They have had a very difficult time retaining ophthalmologists in Saskatchewan, specifically, Saskatoon. It's interesting because Saskatoon is where the training program is, and Saskatoon is not bad in terms of the number of ophthalmologists. Regina, which is not that much smaller than Saskatoon, has a tremendous shortage of ophthalmologists.

And, again, it's a simple reason the training program exists in Saskatoon and there's a relative attractiveness to it; here in Manitoba we have the same problem. Brandon which, even of itself, is not a huge city but services a large portion of the population of Manitoba, has only three ophthalmologists who are actively practising, and need a significantly larger number but, because it's not a centre, it's had difficulty in attracting ophthalmologists.

MR. D. ORCHARD: Then, from Saskatoon, is Alberta or Ontario the next closest school?

DR. P. SHUCKETT: Right, then we go to Alberta and then going east - my geography in Ontario is not terrific - but I think that London, Ontario would be the next closest stop.

MR. D. ORCHARD: Now, with the loss of the training facility, are you aware of any loss of some of the training personnel, some of the physicians that provide the instruction and the residency?

DR. P. SHUCKETT: Well, one ophthalmologist who was a former head of the department is leaving the province.

In terms of the facilities provided at the Health Sciences Centre, at the General Hospital, some of the facilities are being closed down. These facilities were providing care to patients at the Health Sciences Centre, ambulatory care.

Most of the ambulatory care facilities at the General Hospital will be closed as of this month in ophthalmology. Surgery will still go on at the General Hospital, but the out-patient facilities, the ambulatory care facilities are gone.

MR. D. ORCHARD: Is your clinic able to, in some way, fill the gap on the out-patient aspect?

DR. P. SHUCKETT: I can only speak for my personal practices in pediatric ophthalmology and, because of the nature of the Children's Hospital and the nature of its operation, we have elected to continue our out-patient services at that hospital.

At the General Hospital, which I don't work at actively, there were several types of clinics. There were general out-patient facilities and very specialized clinics. Now the very specialized clinics, most of the directors of these clinics have gone to great pain to make sure that these patients have been placed, because most of them were followed for years in private ophthalmologist practice.

In terms of the other out-patient facilities, the clinics were disbanded and the patients were told to go to their family doctor for referral to an ophthalmologist, and fight the queues into the offices from that point.

MR. D. ORCHARD: You mentioned earlier on in your presentation the ultrasound machine that is in the clinic that you practise from.

DR. P. SHUCKETT: Right.

MR. D. ORCHARD: Are diagnostic procedures with the ultrasound machine in the clinic covered by MHSC fee schedule now?

DR. P. SHUCKETT: No they are not.

MR. D. ORCHARD: Now, presumably then, when that is used, the patient is paying for that directly.

DR. P. SHUCKETT: We had been billing the patients, and the radiologists who practise at our clinic, have been billing for the professional part of it, for their interpretation of the results. In point of fact, we have not been demanding payment from our patients at this point because the costs would be considerable for the patients and we have been absorbing it up to this point.

MR. D. ORCHARD: Would you anticipate continued usage of that machine then?

DR. P. SHUCKETT: No, I think that it is coming to a head and the situation will have to be rectified. I think that, either we are going to have to start to get paid for the use of the machine, and the provision of the facilities and the service to the people of Manitoba, or we are just going to get rid of it.

MR. CHAIRMAN: Are there any further questions? Mr. Orchard.

MR. D. ORCHARD: Now what is the process? Is that a negotiation with MHSC to have that diagnostic procedure included?

DR. P. SHUCKETT: There are fees for many things that physicians do in a fee schedule. Diagnostic ultrasound nowhere exists in the fee schedule, so we can't get paid for something that does not exist in the fee schedule. We have been attempting to establish fees for ultrasound for years, but the ultrasound facilities are only in hospital right now, and the only way you

could get paid, I gather, is on a sessional basis through the hospitals. We have been unable to establish fees for this.

MR. D. ORCHARD: Thank you.

MR. CHAIRMAN: Are there any further questions for Dr. Shuckett?

Seeing none, then I would like to thank you, Dr. Shuckett, for coming here tonight.

DR. P. SHUCKETT: Thank you.

MR. CHAIRMAN: The next person on my list is Dr. Richard Matkaluk.

DR. R. MATKALUK: I'd like to thank the members of the committee for the opportunity to speak tonight, and I'd like to direct my remarks to some problems that I feel exist with Bill 2, as it relates to my specialty which is dermatology, and specifically as it will ultimately relate to the entire population of Manitoba.

At the present time the American Academy of Dermatology recommends that there is one dermatologist for every 35,000 to 50,000 people in the general population; therefore using the upper figure of one in 50,000, a province the size of Manitoba should have approximately 20 dermatologists. At present there are 12 certified specialists in dermatology in Manitoba; three of whom are over the age of 65.

Training for dermatology is not available in Manitoba. In Canada it is available only in British Columbia, in Ontario, and in Quebec. Clearly, we're facing a critical shortage of specialists in this area, and I feel that the government at this time should be trying to provide incentives to attract more specialists into Manitoba.

What the actual situation is, in terms of financial compensation, could be better construed as a deterrent for physicians to come to Manitoba. At the present time, the fee schedule for dermatology ranks ninth out of the 10 provinces, with only Quebec showing a less favourable fee schedule. And if we look at the fee schedule for 1984 for the five western provinces, from British Columbia through to Ontario which may be more representative, and we pick out a couple of office categories, I'll give the illustration of a complete examination.

The fee schedule for those five western provinces in 1984 varied from $20.60 to $40.21; the lowest fee was in Manitoba; the highest in British Columbia. The fee for British Columbia is 95 percent above the fee that exists in Manitoba.

If we combine those five provinces, the average fee in Manitoba is 31 percent below the average. Similarly, for a subsequent visit, the fees range from $10.55 to $17.60, and once again, the fee in Manitoba is 31 percent below the mean.

Clearly, without training facilities in this specialty and other specialties, such as ophthalmology that Dr. Shuckett has pointed out to you, we have to do something to attract specialists to the province, as he's already alluded to. People locate their practices, either because they're from an area, or because they're trained there and they've liked the environment, or because there are good practice opportunities available.

Although I've already told you there are good practice opportunities available in Manitoba in terms of demand, the situation exists that there are also practice opportunities and good ones available in Ontario, in Saskatchewan, in Alberta, and in British Columbia, all of which provide a more favourable environment for the newly-trained specialists.

Legislation such as this, which restricts the income of highly-trained specialists, will only serve to deter people from possibly locating in Manitoba. At the present time, waiting lists are long and they're continuing to grow. There's a real threat to a superior quality of health care in Manitoba and I don't see that threat being posed by the small amounts, such as $5 or $6 that are billed by myself and other specialists to the patients that can truly afford it.

Once again I'd reiterate what Dr. Shuckett said, that if somebody can't afford it, if they're on welfare, if they're on Children's Aid, if they're unemployed, those fees aren't charged.

I can't see how that small fee I charge my patient can ultimately be expected to limit the access of ordinary Manitobans to quality medical care. But I can see how a lack of manpower that legislation like this can foster and worsen can prevent access to quality medical care.

I think that the problems facing Medicare are much too complex to be solved by a two-paragraph legislation that singles out physicians as a group in society to be subject to unilateral price controls and to infringe on their rights.

I would encourage the government to re-examine this legislation and in the spirit of co-operation with input from not only physicians, but other health care personnel and ordinary Manitobans, to try and establish a more comprehensive solution that might fairly address some of the many problems that exist in Medicare.

Thank you.

MR. CHAIRMAN: Are there any questions for Dr. Matkaluk?

Mr. Mercier.

MR. G. MERCIER: Doctor, how many years did it take you to become a dermatologist?

DR. R. MATKALUK: I was . . .

MR. G. MERCIER: After high school.

DR. R. MATKALUK: After high school - 12 years.

MR. G. MERCIER: Where did you do the final training?

DR. R. MATKALUK: I did my final training in the States, in Cleveland, at the Cleveland Clinic.

MR. G. MERCIER: Training in dermatology, I take it, is not available in Manitoba or . . .

DR. R. MATKALUK: Just the three provinces I outlined: Ontario, Quebec and British Columbia.

MR. G. MERCIER: This is a question - if you don't want to answer it, fine. I would quite accept that. I take

it that you went through a residency period in the final years of dermatology.

DR. R. MATKALUK: That's correct.

MR. G. MERCIER: In your final years in residency, would you care to indicate what the average salary was?

DR. R. MATKALUK: Well, the salary where I was was $18,000.00.

MR. G. MERCIER: Is that for 12 years of training?

DR. R. MATKALUK: That's correct.

MR. D. ORCHARD: Doctor, I missed the numbers of dermatologists in Manitoba right now.

DR. R. MATKALUK: At the present time there are 12, and three are over 65, so I would imagine they probably will be retiring shortly.

MR. D. ORCHARD: Are you aware of how many of the 12 who are practising, how many may use the extra billing provision presently?

DR. R. MATKALUK: Six of twelve.

MR. D. ORCHARD: Six of twelve. Now you give a range in the fee schedule from $20.60 to $40.21 in B.C. Do you have the other provinces of the five western that you . . .

DR. R. MATKALUK: Yes, that fee schedule was for a complete exam and the five provinces - going from Ontario - were $28.50 in Ontario; $20.60 in Manitoba - these are 1984 figures - $27 in Saskatchewan; $21.50 in Alberta; and $40.21 in B.C. The five-province average is $27.00.

MR. D. ORCHARD: I think that's all the questions I have at the present, Mr. Chairman.

MR. CHAIRMAN: Are there any further questions? Mr. Nordman.

MR. R. NORDMAN: Doctor, what would be the average extra billing that would be made?

DR. R. MATKALUK: In my practice, for a complete exam I bill $28, which is very close to the five-province medium of $27.00.

MR. R. NORDMAN: So actually you're extra billing about $7 and some odd cents?

DR. R. MATKALUK: Yes, I'm billing less than I would receive in Ontario or British Columbia; and more than I would receive in Saskatchewan and Alberta.

MR. R. NORDMAN: Further to that, how many of these 12 are in Winnipeg?

DR. R. MATKALUK: All 12 are in Winnipeg. There was recently a dermatologist in Brandon. He's left for New Zealand.

MR. R. NORDMAN: Fine, thank you very much.

MR. D. ORCHARD: Doctor, could you indicate whether you've made any efforts with MHSC to have the fee schedule looked at and possibly adjusted?

DR. R. MATKALUK: We made strong efforts through the MMA to have the fee schedule reviewed but, unfortunately, when you're a group of 12, in a group of 1,400 with a democratic process, it's hard to have a very strong voice.

MR. D. ORCHARD: In other words, you're saying that you haven't had any success?

DR. R. MATKALUK: That's correct.

MR. CHAIRMAN: Are there any further questions?

Seeing none, then I would like to thank you Dr. Matkaluk for coming this evening.

DR. R. MATKALUK: Thank you.

MR. CHAIRMAN: The next person on my list is Dr. Henry Krahn.

DR. H. KRAHN: Mr. Chairman, ladies and gentlemen, I would like to thank you very much for allowing me to come here tonight.

I would like to present to you three things. One, there is a great worry in my soul that if this act is passed the way it has been drafted, that our excellent Medicare system, as we have it today, will be very rapidly deteriorating.

I would say the complaints that I hear about health care services in this province are rarely anything to do with medical services, but usually have to do with hospital services, and I would like to contrast with you for a second. The type of service that is being provided by our hospital services, which I think is inadequate; and the type of service that I think the public generally has agreed, is quite acceptable as far as the medical services is concerned.

Finishing that, I would like to just present to you the difficulties that you have when you have a new procedure that is brought into the health care field that is really of a revolutionary nature and how difficult it is in Manitoba to get a fee established for such a procedure.

Lastly, I would like to make some very presumptuous, but very modest suggestions, as to how I hope this act could possibly be amended. To begin with, I would like to take you through a day of a typical urological surgeon, which is today.

A patient gets admitted at noon yesterday for a very radical kidney operation today for a malignancy. She has a test done on a CT Scanner at the Health Sciences Centre in October 1984, on a machine - and this is no guff - that is a relic. It is a machine that is a museum piece at the Mayo Clinic. I know this for a fact because my daughter is a med student over there and I've been there and I've seen the machine - and on this machine a wrong diagnosis was made.

Finally, because she was continuing to do unwell, it was apparent that there were difficulties; she had a CT

Scan done on an up-to-date machine at the St. Boniface Hospital, which took five weeks to book. There were some problems with this and then we had to repeat this so that a needle could be placed in this lesion to draw off some tissue for examination, which took about another two weeks, and all of this was finished on May 17th.

For the last while this lady has been in contact with me and the admitting office, almost on an hourly basis, hoping that she could get in and have this thing attended to. She's a 48-year-old lady with a young family. She's a nurse.

As of noon yesterday, there was still no indication from the hospital that they could accommodate her for the surgery, which I was hoping could be done today, but she finally did get in; and then there's a tremendous rush to get all the things done, the blood that's required, and so forth, to make it possible for her to have the operation this morning.

The other case is just as bad. A 22-year-old young man with a malignancy in his testicle who, from the time that the diagnosis was made, waited five weeks before he could have a CT Scan at the St. Boniface Hospital to find out if there was any spread and whether there should be further surgery. Again, it was noon yesterday and he still didn't know whether he was going to get in, but he did get in and he finally had his surgery today.

It's very frustrating for everybody. The surgeon is targeted as being the one that should be able to get things moving. We are very much like lawyers. Patients unload on the surgeon and he becomes their advocate and they expect us to get them through this mess, but it is extremely frustrating and very difficult.

I have umpteen patients with malignancies like that that I could show you if you like. This happens all the time. We are very cash short in our hospital system and something should be done to unjam this; even if it means that one has to bend a little bit on dogma or on one's beliefs to allow extra money to come in from other sources. The problem, as far as beds go, is purely one of blocked beds by geriatric patients which, in every hospital in the city, represents at least 20 percent of our bed allotment.

If something could be done to get these geriatric patients into the proper place, then there would be all kinds of room for patients to be admitted at least; and surely if we're having to provide such substandard service with really only one CT Scanner in the province because the other one should be forgotten, then surely we should allow some charges to those who can afford to pay to get money into the system and get this thing unplugged.

In Medicine, that option has always been there, but now we are told that option will no longer be there. I can very quickly see that the frustrations, as far as medical services are concerned, will become just as severe and just as crippling as they are in the health care system.

As far as new fees are concerned, it's almost a joke. We have, in the last two years in my specialty, found a way to remove stones from kidneys and from ureters, without putting people through a mammoth operation with six weeks of recovery before they can go back to work. As far as the advantage to the public is concerned, it's an immediate economic advantage. With this new technology they can have their thing done and practically leave the hospital and go back to work. This is a very high impact economic benefit to the citizens of this province.

The procedure was introduced by one of my colleagues at the Health Sciences Centre, a bright fellow that learned this thing at the Mayo Clinic and since then all of us have taken courses elsewhere and this fellow, Hosking, by now must have done at least 200 such procedures and we still, in two years, do not have a proper fee for this thing. There is an interim fee which is $300.00. If he removes the stone by making an incision, he gets somewhere around $400 to $450, depending on slight changes and variations in the operation and that takes him an hour.

If he does it with this new technique, it takes him three hours and he gets paid $300 and we can see no way of getting this thing unjammed. It's not a problem of the Medical Association. The Medical Association has come out full force and said that this is unreasonable and a decent fee ought to be established for this. It is a problem of the Hospital Commission.

When it comes to another procedure which is allied to this, called ureteroscopy, which is an instrument that we can now pass all the way up into the kidney, we could operate on stones for a fee of around $375.00. The patient would be in the hospital for about seven days minimum, usually 10, and go back to work in six weeks.

With this instrument we can do all of this, but the open operation takes an hour, or maybe even less, and yields $300-plus. With this, we are currently offered a fee of somewhere around $100, which is about $33 an hour. We have office expenses also. We cannot be in the black because my office expenses exceed that on an hourly basis and there's nothing left for it, it's missionary work. This keeps going on and on and on and we cannot get anything done about it.

As far as my modest suggestions are concerned, I think the intent here is that they want to control the medical profession totally. But that very often means that there will be people standing in line for the procedures, which they have to stand in line for in the hospitals but not for medical services at the present time and thereby cut costs, but that means accessability will be reduced.

I think that extra billing, in some form, ought to be allowed. I'd be very interested in what the exact definition of extra billing is going to be in this act. For instance, if I do a bladder examination in the hospital, I get paid $42.50. If I do a bladder examination in my office, where I buy the $10,000 instrument and I provide the nurse and I provide the sterilizing and the room and all of that, I get paid $42.50.

Now would it be considered extra billing if I charged $15 for my instrument, for my nurse, and so forth, over and above the $42.50? As I read the act, this would be considered extra billing. There would be no tray charge; nothing would be allowed, which would mean - and this is happening in many, many of our procedures now - that all of our procedures will end up being done in the hospital and of course you'll get the control that you want. You'll be able to say, we're only going to do this many bladder examinations in 1986 - and maybe that's what you want. I kind of think that's your intent.

I think that we shouldn't hoodwink the public about this. I think there should be the opportunity for people

to continue to get private medical care and there should be some incentive that a lot of this could be moved out of the hospital setting and be done much faster and much more appropriately that way.

The other modest suggestion is that when there is a new procedure - and we've heard of others besides the two that I wanted to bring here today - that the doctor who has this new procedure is not in the fee manual. Let him provide this thing as an uninsured item, if he wants to, and charge a reasonable fee. This will put some pressure on the goldarn government to get this thing unstuck, so that they'll talk to us and make some financial arrangements with us, so that we can feel encouraged to do these things and to develop new procedures. We're all going to be very big losers if this doesn't happen.

Finally, just to contrast how this can be different, I had a patient that I saw last fall who had a fair amount of difficulty with his waterworks and not enough that I thought he needed an operation. So he visited his daughter in Lancaster, Pennsylvania, which I understand is a town about the size of Brandon; and this patient got plugged while he was there, was admitted to the hospital. He had some heart problems. They did some standard x-rays and found that he had a lump on one kidney and he had a type of cardiogram - and I work out of a hospital that is noted for its cardiology - I'd never seen anything like this, as far as the technology was concerned. He had his CT scan and this thing turned out to be a cyst and he had his operation and the whole thing was wrapped up in eight days, to show you what it would be like. If that very same patient had this mishap here in Winnipeg, it would have taken me six weeks.

Thank you.

MR. CHAIRMAN: Are there any questions for Dr. Krahn?

Mr. Orchard.

MR. D. ORCHARD: Thank you, Mr. Chairman.

The aspect of the bladder examination, Dr. Krahn, undertaken in your office. I take it that that, when done in your office, that you do charge something above the $42.50?

DR. H. KRAHN: We're not allowed to. If you are an opted-in doctor you are not allowed to charge one cent more than $42.50.

MR. D. ORCHARD: Okay, yes. I realize if you are an opted-in doctor, but right now, if you so desired, without the legislation, you could charge sufficient to cover off your fees.

DR. H. KRAHN: That's correct.

MR. D. ORCHARD: The resolution of the kidney stone fee schedule for the new procedure, I take it, and I think you indicated in your presentation that you had the full support of the MMA in the negotiation with MHSC.

DR. H. KRAHN: That's correct.

MR. D. ORCHARD: And how long have those negotiations been going on, Dr. Krahn.

DR. H. KRAHN: Two years.

MR. D. ORCHARD: And are they close to settlement right now?

DR. H. KRAHN: Not anywhere near close.

MR. CHAIRMAN: Are there any further questions?

Mr. Lecuyer.

HON. G. LECUYER: Dr. Krahn, referring to the same example and you're referring to a piece of equipment for bladder inspections, whereby you say if it's done in the hospital, for instance, will cost $42.50 for that service, and you will get the same amount, whether it's done in your office or in a hospital. That's one particular example of equipment but, of course, there are many other equipment for other specialized cases. Would there not be merit, for instance, in having all of the specialized equipment in the hospitals so that not every doctor is required to buy these pieces of equipment; but, on the other hand, the doctors, as in your case who have to use that type of equipment, would have slated days or hours whereby your patients would meet you there and you can have access to that equipment. The alternative is that you and everybody else has to buy the same piece of equipment and, understandably, it has to be paid.

DR. H. KRAHN: The problem is that as soon as you bring this into the hospital you very often find that your needs are not a high priority need as far as the hospital is concerned. It may be that some heart surgery is taking all the bucks and there will be no equipment flowing in your direction. So you're limping along with practically no equipment and you're very severely handicapped.

If I have a patient, right now, that comes from rural Manitoba I can, in at least half the patients, depending on the psychological make-up of this person and so forth, and if it's going to be simple, I can do the whole thing, the office visit, the consultation, the examination; rap it all up; get my letter out and it's done.

Now the system that you're suggesting would mean that he'd have to come back for a second examination which would then have to be booked in the hospital, which would probably be something, if it's anything like the hospitals that I'm in, at least six weeks or two months or more down the poke. Why do you think we are doing these things when they're losing money on them in the office. We are also perfectly stable people, we're not crazy. We wouldn't be doing this for $42.50 in the office if we get $42.50 in the hospital if there weren't reasons for it. And the reasons are that it's so goddamn difficult.

MR. CHAIRMAN: Are there any further questions?

MR. D. ORCHARD: Mr. Lecuyer made a suggestion about having this equipment in reasonable enough supply that all doctors would have access to it, presumably, and be able to provide the patient rapid service; but you've indicated, earlier on in your presentation, Dr. Krahn, that such is not the case, that the hospital system is backlogged and, in effect, is

rationing the level of service to your patients and presumably to other physician's patients.

DR. H. KRAHN: That's right.

MR. D. ORCHARD: Now, we mentioned an average figure of 20 percent in terms of block beds in the hospitals, I presume those are chronic care patients, or chronic stay patients that are occupying acute care beds, so that your access to a bed, hence to the surgical theatres, is restricted by that chronic care patient in the acute care bed. So that your suggestion is that if you're going to deliver a quality level of medical service to your patients, that if you rely on the hospital to do it, you may be able to provide a quality service, but not in a quality time. And your suggestion to the committee tonight then is that if you are willing to invest in the equipment, the space, the manpower and, presumably the knowledge of providing some examination, such as, the bladder examination in your office, that there should possibly be two fee schedules; one for the hospital scene where the space equipment manpower to support your practice is paid out of hospital budget, and another fee schedule which would recognize the investment and the additional cost to you as a physician, if you do it in your clinic?

DR. H. KRAHN: And that is not a unique thought either, because the fees are broken down in many fields, like radiology, and I think in lab also, to a professional component, and an overhead component. All that would have to be done is that there would be a professional component which, if this legislation passes, that would be something that couldn't be extra-billed, but that the overhead component, that that would not be considered extra-billing.

MR. D. ORCHARD: I missed that. You're saying that the overhead portion wouldn't be considered extra-billing?

DR. H. KRAHN: That would have to be a definition that would allow this overhead component, that it could go ahead.

MR. CHAIRMAN: Mr. Desjardins.

HON. L. DESJARDINS: Dr. Krahn, it is a fact isn't it that you're on the Executive of the MMA?

DR. H. KRAHN: Yes.

HON. L. DESJARDINS: Isn't it a fact that the MMA has always resisted the concept of a two-fee structure; a higher fee when the physician had a major capital expenditure, and a lower fee when the equipment is supplied by the hospital?

DR. H. KRAHN: I do not recall that. We've had a differential in fees in some specialties, like radiology, which happened during the time of the price controls and . . .

HON. L. DESJARDINS: We're talking about now though, presently.

DR. H. KRAHN: I don't believe so.

HON. L. DESJARDINS: Maybe we should both check, that's not the information that I have.

MR. CHAIRMAN: Mr. Steen.

MR. W. STEEN: Dr. Krahn, you made reference a few moments ago to having a patient visit you in your office and you received a fee of 42.50, I believe. You mentioned that you required a nurse to assist you on that. If you did the same procedure at the hospital, what type of personnel would you need, just a single nurse? Could you give me an example of what you think it is costing the taxpayer of Manitoba to have you do that procedure at the hospital as opposed to your office?

DR. H. KRAHN: That same procedure in the hospital is staffed with at least two nurses, a clean-up person who is not full time in that room, but there are enough of them that as soon as the patient is taken out of the room that they are in that room in a very short time to make place for the next one. There are people who look after the instruments there, at least four or five people involved in such a thing; whereas in the office it is one person, that is, myself and the staff that I have.

MR. W. STEEN: But perhaps, Doctor, with the procedure in the hospital, it can be done so much quicker because there are two nurses rather than one. There are clean-up people where your nurse would have to clean up your office and so on, or do you say that it is still much more expensive to be done in the hospital?

DR. H. KRAHN: Oh, an awful lot more expensive to be done in the hospital.

MR. W. STEEN: That's fine.

MR. R. NORDMAN: When it is done in the hospital, is there a hospital charge besides to the patient, or how does that work?

DR. H. KRAHN: Well, if there is a patient who is going to have a procedure done equivalent to this and it is an uninsured service, it's a person who comes from south of the line, something like that. They charge what the hospital levies, and I presume this is based on something that has been worked out and not just a figure out of thin air. It's somewhere around $175 and then the professional component is added to that. That's probably a good way of showing you the difference in cost.

MR. CHAIRMAN: Are there any further questions?

Seeing none, I would like to thank you, Dr. Krahn, for taking the time to come tonight.

The next person on my list is Dr. Jeremy Gordon.

DR. J. GORDON: I, too, would like to thank the committee for allowing me, on behalf of the Association of Independent Physicians, to have the opportunity to address you with our concerns about Bill 2.

Our group is a group of 94 physicians who have come together to defend the rights of independent physicians. Some of us are specialists, some generalists, some urban, and some rural; all of us united by a desire to preserve what is best in medicine and Medicare.

We strongly believe that the independent contract between a doctor and his patient for delivery of medical services should be maintained. We believe the best way to preserve this contract is to encourage its continuation. The passage of Bill 2 in our opinion will begin the destruction of this independent contract. The freedom of a physician to charge a fee for his services is a cornerstone of the contract.

The state, in the shape of the NDP Government of Manitoba, has argued that in order to protect the weak and give them proper access to a physician that Bill 2 must be passed. The state has said that in order to be fair to everyone, there must be no more freedom for an individual to make his health a financial priority and purchase the kind of treatment that he or she thinks he needs.

The state has decided that in passing this law that promises made to all physicians only 16 years ago are to be broken. The state has decided that the new value for medical services will be whatever fees the state determines. What began as an inducement for doctors to join the insurance plan, that is Medicare, that is discounted fees for services, at the time in 1969, 15 percent less than the going rate. This was an inducement because the government was going to pay the tab for the services rendered. What began as an inducement is now becoming a mandatory fee.

Doctors who are not in the plan set their own fees based on market values. For example, right now my fee is $87 an hour for those who can afford it. The government, as soon as this bill is passed, has decided that my value is $69 per hour. I can tell you that is 9th out of 10 in the provinces of Canada. Only Quebec is lower than us and that is largely because they've got captive doctors - purely French speaking.

In our view, instead of increased access to doctors and lowered costs and protection of the Medicare system, the opposite will occur with their deteriorating medical system, lowered morale of health care practitioners in the general public and general dissatisfaction as has occurred in other countries, such as Sweden and U.K., that has adopted state medicine.

Bill 2 is the opening but very necessary gambit in the plans of the state to control medicine, in particular, to control everything to do with doctors and their services. There is an old proverb: he who pays the piper calls the tune.

I would like to illustrate with two little vignettes, what I believe to be the problems besetting Medicare at this time, and the dilemma facing those politicians who are charged with the responsibility of running Medicare.

Mr. Jake Epp, the Federal Minister of Health, was talking to me about a problem. He described a problem last week to me. He described a small town, and he said, "Look what happens. A new doctor comes into a small town and starts working. Pretty soon he's earning about two-thirds of the income of his colleagues. What happens to the old doctor already in the small town? His income goes up, too. The incumbent has increased his workload and the new doctor is earning a very satisfactory kind of income. There was no increase in the patient population, just an unexpected increase and a demand for medical services."

Second story: the patient goes to the doctor for a trivial complaint, for the umpteenth time. The doctor tells the patient, "Look, I can't do anything more for you, why do you persist? Why are you coming to see me for these services?" The answer came back, "Why shouldn't I? After all, the service is free." The doctor has told the patient, "No, these services are not free."

I think these difficulties that I have just illustrated can be summarized in a few sentences. The demand for medical services has grown to a point where governments no longer can afford to support them financially, and there does not seem to be a natural limit to this demand. Unless governments come up with new resources they will be forced to tackle the problem of increasing demand and try to find solutions to curbing it.

If one adds to the above the coming problems attendant on the expected burdens of an aging population, then we can all clearly see what a pretty pickle the government finds itself in at this time.

The AIP believes that the Government of Manitoba has avoided the central issues of mutual responsibility for the costs of medical services between a patient and doctor.

Medicare, as we all know, is not, nor ever has been, free. There is a finite limit on the amount of government money available for Medicare through taxes or other sources.

We feel that there has to be a public debate on these issues, in order for doctors and public alike to understand for themselves, and resolve their concerns about this disturbing truth. Are people afraid to face the fact that Medicare is not a limitless resource? Is this simply a myth propagated by people in the past, by politicians and, to some extent, by the medical profession itself?

What is needed? We think government task forces just will not do. We think that this is something that has to be brought out into the open and that the population of this province has to be told. We think that you should all trust in the natural courage and common sense of the people of this province. This is not a time to be cowardly and hide behind public opinion surveys that tell you what everybody wants. Believe me, if you ask people if they would like to have a free automobile, you'll get 99 percent saying yes. If everybody was asked, do they want to have medicine free from any kind of extra charge, everybody will say, yes.

So using that kind of information is absurd. No one likes bad news, but if it is bad news, then I think it's better to hear it and then get down to facing the problems and trying to solve the difficulties co-operatively.

Now, let's get back to the example that I introduced. The new doctor in the small community generates enough work for himself to make a good living. Before he arrived the needs of the town were apparently being met by the incumbent. What is going on? Is the increased demand due to the actions of the new doctor? Is he causing the increased need for services; or are the causes unclear at present? Perhaps more research needs to be done to establish the facts.

It would seem obvious to any common sense person that the causes probably lie in the interaction between

the doctor and the people of that town, between the expectations of the townspeople for medical services and the doctor's expectation of providing these services and making a comparable income to his colleagues.

The AIP thinks it's clear that, at this time, neither the doctor, nor the patients, are concerned about the costs of the services that are demanded and rendered. A reasonable man might enquire as to why there is no sense of responsibility for the costs involved. The answer seems to be clear; there has been a deliberate policy of presenting to the general public the idea Medicare is free and unlimited.

We have to admit to all that this is not true. As long as the GNP of the country remained high, then we all could get away with this deception, but now when the national money pie is shrinking in size, then the slice representing the costs of Medicare is proportionately larger. At the same time, the costs of repaying the huge loans governments have borrowed on our behalf, has grown to a point where they consume a quarter of every dollar raised by the tax system.

Now we have respected politicians expressing their concern about runaway costs and pointing to potential crunches in the near future when the Medicare system has to cope with an increasingly aging population.

The AIP, and by now every interested person in this province, realizes the NDP government has already decided on its solution to the problems of providing medical services to the general public with shrinking resources.

The answer is to control doctors. If you control doctors from working hard, then bingo, all our problems will be over. Stop doctors from seeing so many patients; stop them from ordering tests to make their diagnosis; stop them from admitting the sick to hospitals as much as they do; stop them from using the latest equipment; discourage new techniques; stop training as many medical students; reduce the number of specialists in training. The government wants to be able to tell doctors where to practise and how to practise. All this in the name of solving the Medicare problem.

The AIP applauds the government for trying to tackle a difficult situation. However, the proposed solutions must properly be evaluated for their effects before being accepted holus-bolus. With all due respect, it's hard to have complete confidence in the solutions made by the same guys that put you in the manure in the first place.

The AIP has serious reservations to the proposed changes in the delivery of Medicare. They can be summarized as follows: firstly, establishing controls over doctors means abolishing certain rights of doctors and patients. The right to make decisions with the patient about his/her treatment will be eroded by the demands of the state.

Secondly, the right of a doctor and patient to make a contract for services requested and rendered is to be abolished. This is a fundamental right practised by every Manitoban every day of their life. Would any other group in society put up with the loss of this traditional right? Mr. Green, the other day, who helped to bring in this Medicare to this province, said that he's fought all his life for the rights of electricians and plumbers and the working man, but he thinks that these people should have the same rights as doctors and lawyers, and vice versa.

In our opinion, this government feels it can do this to doctors because it experiences doctors, as a group, as already civil servants. Already, as the boss, they feel they can do whatever they want. After all, he who pays the piper calls the tune, as I have said before; hence, the arrogant disregard of our rights as fellow citizens. Why not portray us as bad people, greedy and uncaring, with distortions about our salaries and our motives? To hell with our rights. All that is necessary is the appropriate smear in the press.

What we are aware of is the erosion of our rights today, which is unchallenged, will make it easier for other groups to lose their freedoms in the future. History has many tragic examples of this. Trying to solve problems by trampling on the rights of a minority is always wrong, whether the minority group is temporarily unpopular or not. The AIP was shocked that no one in the Legislature voted against such a proposal on these grounds.

Thirdly, the solution proposed by the NDP, namely, state medicine - that is doctors as state employees with regionalization, strict control over the numbers, locations, services of doctors - this kind of solution has been tried in other countries and found wanting. With that failure inevitably comes the developments of a two-tier system. A significant number of the population eventually get fed up and rebel against such a system and demand a better system even if they have to put money towards paying for it. We think that this is unnecessary; we think that the present kind of system would avoid that.

Fourthly, the solution proposed in Bill 2, namely, control over the medical activity of doctors, will undermine the professional independence of physicians. The tradional role of the doctor as the servant, advisor and advocate for the patient will be lost.

Our primary allegiance as doctors will be expected, by the government, to be to the funding agency. The name of the game will be to control costs and the kingpin will have to be the bureaucrat in charge of carrying out government policy. We will become the gatekeepers, the apologists for other people's decisions. We predict the current experience of a deteriorating system will continue.

Fifthly, the solution proposed by the NDP is an ideological one. We respectfully point out that rigid adherence to ideology runs the risk of being a complete failure. A wise man does not keep all his eggs in one basket. We have already tried to make these points to the government. What we have polled for is a more prudent approach. We suggest that a smorgasbord of approaches be considered in a public forum where all parties concerned have the opportunity to contribute. We're in favour of solutions that emphasize flexibility, pragmatism and competition between various methods of delivering medical services, including preserving a direct contract between doctor and patient where it's required.

Sixth, the solution avoids confronting people with the questions about how much medical attention do we want; how much do we want the state to control medical treatment; what constitutes health care; what are the costs of a service that offers health care, meaning the pursuit of health, whatever that means; what are the costs of a service that offers care of sickness? How can we afford the system we want? Do we have to

accept higher taxes to pay for it? Is there an upper limit to the support we can expect from government in our pursuit of health? Do we have to divide the pursuit of health, which is obviously an admirable pursuit, from the treatment of sickness? Can we accept the principle that much of the work of doctors should be done by other professionals? Will this result in a cheaper and more effective service, or not?

The AIP membership has always been willing to participate in such an exhaustive inquiry. These questions are too important to be left to the biases of government officials or government dominated committees.

Will the passage of Bill 2 contribute to this particular process of investigation of public inquiry, of a resolution in the public's mind as to what is Medicare and what it can do, what it can't do, what are its limitations in these days of a shrinking dollar? I think not.

Will the bill affect the introduction of new techniques and treatment into Manitoba? We feel that this will be undermined. Already you have heard that entrepreneurs, people who take risks, will be discouraged. It will be up to the bureaucracy to introduce new ideas, and this is always a risky business. Without trying to blame or put down the bureaucracy, their kind of decision making is slow and cautious.

What of the $1.2 million quoted as being sequestered in Ottawa? We feel it's a small price to pay to save Medicare. Medical care will deteriorate at the expense of fostering the delusion that Medicare provided universality of care. Only if you suffer from a common illness or live in Winnipeg or a big city, can you hope to get equal attention. If you live in a remote place or suffer from a rare illness requiring specialized care, you will not. If you live in Brandon and require a CAT scan, you will not receive as good attention as if you lived in Rugby, North Dakota, a much smaller centre. The fine imposed in the province is highly questionable in its legality and if this was any other area of provincial jurisdiction, there would be screams of protest from the provinces and determined efforts to contest its legality in the courts. $1.2 million compared to the sums the state spends everyday to pay in interest on debts on past borrowings is very small. How much is the NDP prepared to spend on an advertising campaign to advertise its successes in the hope of electoral advantage? How much has the state spent on projects like McKenzie Seeds or Manfor or Flyer Buses? What promises or reassurances that if the government's policy is proved disastrous, that they will take any personal responsibility for them?

It is our concern that new technologies and procedures are being developed at the inverse speed at which bureaucracy proceeds. New illnesses spring up all the time - AIDS, legionnaires' disease, environmental illnesses come to mind. Doctors and all governments can't stop developments of new illnesses or the developments of new technologies to deal with them. This is a most rapidly moving time. Medical knowledge, all knowledge, seems to double every five years. Can we keep up with this? How are we going to find the money to keep up with this and give the people of Manitoba the kind of medical services they deserve if there isn't going to be a chance for new money to come into the system?

These events that I have described will not slow down in order to oblige slow-moving government bureaucracies to catch up with them. Everything in future is going to go through the Manitoba Health Services Commission which will control all. By necessity, it's cautious and has to be constricted by considerations weighted against risk. Entrepreneurs are needed to take risks. You have to create a climate where these people are welcome in medicine as well as in business in this province.

We are worried about such things as the implications of our medical insurance against malpractice. If our hands are tied in providing the most appropriate medical care, will the state protect us from lawsuits that prove that the patient did not receive the best and the most up-to-date care?

The AIP feels like a fish in a lake contaminated by PCBs, acid rain or mercury. Our vitality, initiative and will to continue is being sapped by this act, but no one seems to pay any attention. We know we are the first victims, but no one appears to be able to hear our warnings.

Our objections to this act are that it's unfair, discriminating, and limits our basic freedoms and those of our patients. As Mr. Green said, the same rule should apply to plumbers and working men as to lawyers and doctors. It's the forerunner of changes that will undermine the independence of all doctors and their patients; it's the forerunner of state medicine which has produced unwanted results in other countries and which we advise against producing here. It won't produce the described results, rather the opposite; it won't enhance accessibility or decrease costs; it'll discourage innovation, productivity, superspecialization, new techniques and technology; it's anti-physician in its bias, which is in concert with current bureaucratic thinking that doctors are what is wrong with Medicare. I think that's an extremely day for Manitoba when this kind of thinking is allowed to become law.

Thank you.

MR. CHAIRMAN: Are there are questions for Dr. Gordon?

Mr. Mercier.

MR. G. MERCIER: Dr. Gordon, to the best of your knowledge, is any consideration being given in this whole extra-billing debate that has gone on federally and provincially as to the possibility of establishing a committee that might be composed of doctors, of government officials, of even laypersons, who could rule on the acceptability of the amount of extra-billing, as to whether or not the extra-billing proposed is excessive, as a possible solution to this problem, because we continually hear from doctors who make very strong and what appear to me to be valid arguments that fees established by the Health Services Commission do not cover the cost of certain procedures. I suppose, in their defense, they don't have the money to do that in every case. Is that type of procedure being discussed; is that type of procedure a process one that you think would be an acceptable solution to this problem?

DR. J. GORDON: We would be glad to do that. The answer is, no, that has not been our experience, but it's something that we would welcome. We sympathize

ery much with the government's dilemma in this articular situation, having to find the money to fund ledicare, and looking down the road is very worrying, nd we absolutely sympathize. However, what we've alled for is an analogy to a mixed economy; in other ords, let's not just go down one road, because what we're wrong. Let's look at a variety of approaches n order to try and solve these kind of problems, very ery difficult and phony problems, and why shut one loor at the moment when you may be glad, in fact, vant to open that door again in a few years time when he funds simply aren't there?

MR. G. MERCIER: Is there a procedure now Dr. Gordon or a patient to complain about excessive over billing?

DR. J. GORDON: No, there isn't. We would certainly welcome such a provision. You know, the patient can have the freedom to just simply not pay the bill and, obviously, if there was a dispute though between physician and patient, we will be glad to have something like the lawyers do, where there is someone that you can go to and have the bill checked out. We would be extremely willing to do that. We certainly don't want to be apologists for any wrongdoing or any rotten apples in our barrel.

In my experience, people follow in my practice very widely, and that is that we charge according to people's ability to pay without any question. I mean it's really a very easily conducted and fair way of trying to establish the fee and I, in my own practice, find that if people have overestimated themselves that pretty soon that shows up, in either their ability to pay, or things that are said, and the fee is then adjusted again.

MR. CHAIRMAN: Are there any further questions? Mr. Orchard.

MR. D. ORCHARD: Dr. Gordon you mentioned earlier on that if you ask - public opinion is the point you were making - that public opinion is basically against extra billing and when you ask an individual, do you want to pay extra for medical services, the question naturally begs the answer that you're going to get a, no. Now, given your opposition and some of the problems you foresee with this legislation, what should the question be to the citizens to make them aware of the problems that you perceive with the ban on extra-billing?

DR. J. GORDON: Well, I would suggest that the public simply hasn't been presented with the facts and that, once it was presented with all the facts, there would be a tremendous debate in the public with all sorts of different shades of opinion. But what I would hope for, at the end of it all, would be some kind of mixture of solutions to be tried out in order to try and understand what might be the best way. So I think that if people were given choices, some of them would opt for a completely covered situation as there is now, and some would want the opportunity to make health care a priority.

Some citizens might even call for an increase in insurance schemes to allow them to insure against their medical services in the future. I mean there's all sorts of possible schemes being tried out in different countries. The HMO's are being tried out in Ontario. There are things called DRG's, Diagnostic Related Groups, which are being tried out in the States where there is a fixed fee for a procedure and that, when this is applied, it does encourage efficiency because that is all that a person would get for doing, say, a herniorrhaphy or something like that. So that there are a whole bunch of possible solutions, including community clinics, nurse practitioners, and everything else under the sun to try and solve these difficulties.

What we say is, let's have a mixture of things and, if you like, give the job entirely to the state, when the state could be flush and we'll get everything we want; or the state could be broke, in which case you know we're going to have some problems. The kind of things that I think of are surely things that would warm the hearts of someone who believes in a welfare state and in socialism, because it would, of necessity, mean that the rich are going to subsidize the poor. Those people who can afford to pay a bit extra would pay so, and that would lighten the burden for those people who don't have the money.

MR. D. ORCHARD: You made reference to countries that have a two-tier system where theoretically the system we may well be moving into now, with the ban on extra-billing, doesn't provide the level of care that the citizens demand, that a change to the sytem be made. Under this legislation, I believe that would be impossible because there is no ability under this legislation to practise outside of the plan and charge anything in addition to the preset fee schedule.

DR. J. GORDON: Well, I'm very concerned about this. I started my medical practice in 1963 with my father. He's a family doctor back home in Wales. I spent six years in Wales under the national health system. In those days, I could see a change happening. My father and people like him, who started the whole thing going in 1948, worked their butts off. I mean, he would do 30 house calls a day and to offices every day, and work on Saturdays and go out on house calls. I joined him and we started to introduce things like appointment systems and some sense of limitation - I mean, my generation began that. We were saying: hey, wait a minute. We just don't think that the kind of money warrants this. I made $5,000 the last year I was in Britain for my year's work.

Now, the point that I am making is that even in those days the doctors worked damn hard to make the system work, but as time went by and the younger generation came in, the doctors began to act in a different kind of way. What they started to demand was lower working hours, overtime, holiday pay, state help with their staff, and pretty soon people started to say, "Well, wait a moment, I don't even get to see the doctor any more. The receptionist tells me what to do, tells me to take two aspirins or something - or the nurse."

Gradually, over a period of time, something that I believed when I left Britain was absolutely impossible to happen, there began to develop a very extensive insurance scheme in Britain involving 20 percent of the population and largely involving not just specialists, because there were obviously a few specialists available right off the bat. I mean it was two-tier system always,

but gradually it went from, say, people having their operation done, because they simply couldn't wait four or five years on the waiting list to have it done. What happened was that people started to use family doctors also in this scheme because of the service that deteriorated, which was something that I found really remarkable, because there was no sign of that on the horizon when I left in 1969.

So I am saying to you that gradually, as government funds dried up, as hospital facilities became deteriorated and less money was put into them, so the development of private hospitals, money from the state came into the system; that now 20 percent of the population of Britain is covered by private insurance and trade unions are asking for it as part of their package.

MR. CHAIRMAN: No further questions.

I would like to thank you, Dr. Gordon, for coming tonight.

Before proceeding, I would like to remind the members of the committee that questions are for clarification. The details of the brief has been presented. I have been fairly lenient tonight on the procedure so far, but I would ask the members to restrict their questions to more of the detailed nature of the presentations.

Mr. Mercier.

MR. G. MERCIER: Mr. Chairman, if I could make a comment.

I believe the committee can only deal tonight with Bill 2. The Attorney-General isn't present with respect to the other bills before the committee, and I note that Mr. Evans from the Land Titles Office is patiently waiting to deal probably with a couple of the bills later on. I wonder if it would be in order for the committee to perhaps allow Mr. Evans to leave and indicate that anybody else who is here with respect to any of the other bills, other than Bill 2, could probably leave; that those matters won't be dealt with tonight.

MR. CHAIRMAN: Is it agreed? (Agreed)

We will be dealing only with Bill 2 tonight for presentations.

The next person on my list is Mr. Walter Kucharczyk.

MR. W. KUCHARCZYK: What happened to you, Mr. Chairman? I see, for the first time, smiling since you were elected.

MR. CHAIRMAN: Order please.

MR. W. KUCHARCZYK: Mr. Chairman, esteemed members of the Executive Council, it is very rewarding to see that there are nine Cabinet Ministers here. That means it is open season on the doctors as it was on the oil industry in 1974.

Ladies and gentlemen of the committee, I will not go into the details of Bill No. 2 from the point of view of the medical profession, per se, since they know they are pains. However, I know the pain as well; what happens when government in its "own wisdom" has an open season on certain groups. I will refresh your memory. There is a gentleman here who had been in the House at the time.

Back to April 1, 1974, the Government of the Day came to the conclusion that the petroleum industry was making too much money, so they implemented very nice wording, "provincial incremental tax." Walter's income, including Chevron and California Standard and others, gone through the window 28 percent per month. It doesn't matter how small we were, how big some were. That's how we got heat. Mr. Turner, of course, he wasn't behind Mr. Schreyer. He fell immediately in his steps and said, "Well, we are not getting enough money, so we'll make it deductible from income tax." So Walter has to pay again to Her Majesty, in the right of the Dominion of Canada at the time, income tax on the money that Mr. Schreyer already collected in the name of Her Majesty the Queen provincially. Now, why I am I mentioning that? Then, of course, income tax came.

You, today, have power, as Mr. Schreyer had. However, very unfortunately we peasants, back in the old country, used to say, "Whoever has a rake always rakes towards himself, never away." Then what happens? Mr. Lyon comes with a big promise — (Interjection) — to power . . .

MR. CHAIRMAN: Order please.

MR. W. KUCHARCZYK: Mr. Chairman, would you call to order the Member for St. Johns, please? I don't mean that seriously, of course not.

When we became buried in industry through the wisdom of the government, I felt very sorry for the medical profession, even though it is only about 5 percent of the total who are being affected, more or less, of your proposed bill. Perhaps since there are members of the Executive Council right here know what will be discussed in caucus, you give thought that you are not a God-given gift to humanity. People know what is good for themselves in a way that sometimes is pretty hard to grasp. So give people a chance. After all, if you don't put that bill through for the next election it's not going to decide anything one way or another. However, you will be in the history of Manitoba, of Canada, one who continues democracy, and I will come to it. Because when you really look at this bill, what you're trying to do here is to paint all of the medical profession, in the form of the fees, with the same brush. Mr. Schreyer tried to do it, and Mr. Lyon didn't do any better either. A number of the industry, small guys, couldn't survive, didn't have enough money behind them, and besides legislation was retroactive, pulled out and went to Alberta. By the way, it later came back. However, at the time, it was a mistake made by the Crown, very regrettable indeed.

Now we all, I assume, are supposed to learn by mistakes, at least that's what I was told. A partly hypothetical example: Assuming that you will make another mistake and go ahead and proceed with the implementation of Bill No. 2, think for a second, please. Years back some of you might remember Dr. Pinfield, one of the outstanding pride of Canada, internationally recognized neurosurgeon. When a member of the Polish Bureau of the Soviet Union took sick, the Soviet medical profession came to the conclusion that it was only Dr. Pinfield who could do the job. Can you imagine how quickly they organized a direct flight on a military plane

to Moscow, and a successful operation had been performed?

Now, for a second, as I said before, heaven forbid, if your Bill No. 2 will be passed, if you would have a doctor here of his calibre, and you used the same paint brush and the same quality of paint, I don't think you could bury yourself deep enough from the embarrassment of your mistake of the power.

Now, the Minister of Education is here and I have to be very careful what I'm saying. I think it's self-explanatory, she's a most gracious lady besides being Minister of Education. Now, time and time again, I see we have young Cabinet Ministers, I think they have a guilty conscience, they expect that their statements pertaining to the Highways Department would have to be censored by the Minister of Education, but she's too busy.

Now, when it comes to phone calls, there is something I took up with a gentleman of government and, up to now, you here in Manitoba - and I don't think anywhere else in Canada - give credit to the medical profession for assisting the patients, or human beings, whatever the case might be, on the phone. Now, I have been told it is very hard to control unethical doctors. Well, my God, after all, that word is burning because I take for granted that every doctor is ethical.

Time and time again you have examples, well-known or publicized - at least the press is not too busy then - when some doctor directs, without the case of military, or case of RCMP, or some other police force, how to assist an individual, over the phone, whether that be delivery, whether that be extreme bleeding through an accident and yet, in this country of Canada, in this Province of Manitoba, being realistic, that's a capitalist state; and you don't expect people to be patriots, to do something for nothing, or deliver their services because of the colour of the eyes. And I respectfully submit that Mr. Minister won't be interrupted right now by the Minister of Energy and Mines, so he would give undivided attention to it.

Mr. Minister, I will repeat again, Sir.

HON. L. DESJARDINS: No, I heard you.

MR. W. KUCHARCZYK: Oh, thank you very kindly, I'm very sorry, I forget your ability, Sir, that you pay attention even to simple people like me. Thank you.

Maybe you give undivided attention because, as I have been told, well, nobody else does it. Well, Manitoba is proud to be in Canada first in many ways, and I am known to say that politically. I remember the days when the today Minister of Health came out with his experience on a number of the issues, but if I would start to talk about the issues I might get a black eye from somebody - and they told me it's non-political. Now then, I hope that point of the telephone, the issue is well made. I see some of you are impatient, so I will come to a further point that I made out.

I heard a quote - I forget the name of the outstanding lawyer of Great Britain - by saying, "Power tends to corrupt and absolute power corrupts absolutely."

SOME HONOURABLE MEMBERS: Oh, oh!

MR. CHAIRMAN: Order please.

MR. W. KUCHARCZYK: Mr. Chairman, with due respect, sir, it's in modern days that one of the lecturers who comes from England to Canada. No, sir, it's not that far back, no.

Now then, if you try to create a utility out of the medical profession, then you are going to wipe out something that you worked so hard up to now to achieve. People hold you in high esteem, so why are you attempting to commit suicide through Bill No. 2? Just think about it.

Time and time again we are criticizing the Soviet system - after the Second World War, of course, because we don't need them anymore - and I tell you, the medical profession is held in the Soviet Union on a much higher pedestal than you demonstrate by drafting even this Bill No. 2 which is, in my humble opinion, an insult - an insult to yourself, whoever experienced that road, and an insult to the medical profession.

Just to give you some points that maybe some day you will be thinking before you have a third reading of it - I hope never. If you permit doctors to charge outside but the same rate, say, which is something to think about, as you are giving right now to the medical profession, and some doctors will not charge as much as your rate is, what are you going to do with the difference in the money? A figure of speech - $20 an hour - and the doctors say, no, I'll just charge you $10, but Medicare has to pay $20.00. What are you going to do with the difference? Have you thought about it? No, because you were too busy with Bill No. 2 to take complete control. I will be very brief; just be patient for a minute.

I only know that in principle, not exactly, but in principle, what you are trying to do through this Bill No. 2, there is only one country, to my knowledge, in the world - that's Afghanistan - that has a ratio 1 to 2. The Cabinet Minister gets twice as much as a working man. That's a very unique position down there. At one time the people steared wrong with Mr. Schreyer, but our situation here is just entirely different - that wasn't applicable - but indirectly your Bill No. 2 supports indirectly Afghanistan, and we are too far away from every point of view; I don't need to give you a lecture on that subject. Time and time again, when you walk into the Legislative Assembly, you see the sign in the Latin language.

It says, "Patria cara carior libertas," which stands for fatherland is dear; freedom is dearer. I repeat - patria cara, carior libertas - fatherland is dear; freedom is dearer.

Mr. Chairman, you are here, so am I, sir, because of the philosophy of Caesar way back, right? And the Minister of Urban Affairs - and may she ever remain as a guideline for people of Manitoba and Canada - Mary Beth Dolin, she also came here and contributed unmercifully to this country the highest esteem I can ever pay to her. I wish my English would be better and a richer vocabulary. And yet by choosing the country with the freedom, as such, you turn around and you are denying, through your power, the freedom that you choose here and yet you weren't able and neither was I - Stalin was in power then, eh?

Well, there is the Member for St. Johns, he can deliver you a lecture, maybe for six months constantly, as long as you have something to drink, right?

SOME HONOURABLE MEMBERS: Oh, oh!

A MEMBER: He already gave that speech at the nominating meeting . . .

MR. CHAIRMAN: Order, order please.

MR. C. MANNESS: Come on Walter, let's go.

MR. W. KUCHARCZYK: I'm finished, Mr. Manness, in about two or three minutes, that's all.

I feel kind of hurt. Somebody said that the Member for St. Johns gave a speech at the nomination meeting. Well, I was going to come. That statement that was made which will linger in many minds, eh, I feel sorry for those people that belittle the issue, what the Member for St. Johns said. I don't think he meant to be derogatory because today in the Globe and Mail, on Page 10, you have the horrible story about the alcoholism situation right here in Canada. The Soviet Union set the precedent; they increased the drinking age to 21 and the liquor commission opens at 2:00 p.m. during the working days. Now, what is more important, health or profit? Maybe the Cabinet will decide about it, etc., I thought, since the suggestion developed on the spur of the moment.

In conclusion, I will only say that despite the fact that we live in a capitalist system, be guided by welfare of people, physically and mentally, and those dedicated people from the medical profession, I think I have to trust them the way unfortunately I have to trust some elected members, not all of them - some. Without any doubt, seeing that the Minister of Health is in an excellent mood, even though he has two portfolios, I'm pretty sure that he one day will say I was on the beginning of the nightmare known as Bill No. 2, but I just woke in time and the nightmare disappeared like a fog when sun and winter comes.

Thank you.

MR. CHAIRMAN: Are there any questions for Mr. Kucharczyk?

MR. W. KUCHARCZYK: I guarantee you there will be no questions at all.

A MEMBER: You've covered everything.

MR. CHAIRMAN: No questions?

On behalf of the committee then, I would like to thank you for taking the time to come here tonight, Mr. Kucharczyk.

MR. W. KUCHARCZYK: And I thank you for the new title, although I have a Ph.D., profound hater of deadbeats.

Thank you very kindly.

MR. CHAIRMAN: The next person on my list is Mr. John Nicolson.

Dr. George Habib. Dr. A. Macrodimitris. Dr. Henri Marcoux.

DR. H. MARCOUX: Mr. Chairman, Honourable Ministers, Leader of the Opposition and members of this committee, concerning chiropractors, Bill 2 is a tip of an iceberg in the continuing shoddy treatment of my profession and our patients. Recent history supports this fact and this history has repeated itself many times before, so I will repeat some of the recent history concerning this.

A lot of Manitobans have been seriously affected and are pretty angry by the decision the government has made in reducing MHSC benefits under pretext of correcting the inequities in chiropractic care. Every Manitoban now has a single benefit limit of $144 a year. The intent, we know, is to save approximately $1 million or more per year. This subsequent increase following the 20,000 letters this government received, is inadequate and our patients are not appeased as yet, although the singles seem to appreciate the increase.

The underhanded manner in which this was perpetrated on our patients and on my profession has left us with a strong determination to regain the little control we have, not only as a profession but also as guardians of chiropractic. We also have the responsibility to represent our patients in this manner because the government has not.

On February 1, 1985, Mr. Harvey of MHSC sent a letter to all chiropractors advising them, that as of January 1, 1985, chiropractic benefits would be cut back to make things more equal for Manitobans. Limits as they existed, $102 for a single, $204 for a family of two or three, $306 for a family of four or more, to be used as a family saw fit, no longer applied.

Our President, Dr. Dunn, was notified by Mr. McCaffrey of MHSC, approximately four weeks before and told that the government would cut back to the limits, change the policy on chiropractors opting out of Medicare where these would, by law, not be permitted to charge more than what MHSC pays per visit - that's extra billing.

Further, Dr. Dunn was asked to keep this absolutely quiet and not to react publicly until it was announced openly by this government. Dr. Dunn reluctantly agreed in keeping with the Manitoba Chiropractors' Association traditional spirit of co-operation - an obvious naivety, I might add - in our dealings with this government and its agencies.

The MCA Board thought is was an unusual request. We did not understand it at first, no consultation, no chance to get feedback, no opportunity for contributing other possible solutions, and no choice was given to us to help this government decide on what is best for everyone, given the profound implications for chiropractic and our patients.

But this is not new. MHSC has never negotiated in good faith for the good of all, but instead has always told us, after the usual make-believe motions of negotiating, that what we would get, period, and this is not only as it applies to fees. Consequently we have fallen seriously behind, not only in fees, but in a natural growth of the profession and in patient benefits.

Instead of being recognized by NDP governments as contributing significantly to the health of Manitobans, we continue to be treated as if we are a burden. I find this incredible. In my home province, where my profession and I work hard to help restore the health and maintain healthy Manitobans, we are treated with profound disrespect, a disrespect that I for one will no longer endure, nor will I tolerate.

Manitoba chiropractors are the lowest paid in the world while they treat the largest percentage of the

)pulation per capita than any other area or jurisdiction the world. MHSC fee increases have not even kept) to the rate of inflation. Example: 1969 - $4.25 from ur $6.00 fee; 1985 - $8.77 per visit from our $19 fee; 10 percent increase in fee in 15 years and a 300 ercent increase in inflation.

Although we started on par with the MDs in 1969, ıey are currently about $4 ahead of us per basic visit) which they can add other fees. Further, our fee :hedule for examinations in other procedures are not ven considered as these relate to the realities of ractice. This is not the case with the medical rofession. This relates very poorly to high overhead osts, 60 to 75 percent of gross income. Costs for ension plans, holidays, seminars and expenses typical f any other small business professional and then one ıust pay taxes. Chiropractors are staying in Manitoba)r reasons other than money.

Chiropractors are hurt and angry at this deplorable ituation. Chiropractic work is very exacting, very emanding and is a strong effort physically and motionally. We deserve to be paid fairly for the work re do, a principle this government must respect and as not. Whenever we ask for more money, we are lways accosted with the cold financial statistics that ıake us look like we are money hungry, that compared) the average Manitoban, we are doing extremely well, manipulation further reinforced by showing hiropractic revenue at higher levels per year with no ccounting for high overhead costs.

No mention is made about how we are not average ınd of the long hours, the hard work and the awesome esponsibility of caring for people who are sick. No :onsideration is given to our right to fee for service ıs small business enterprises. Furthermore, we are ılways aligned to the medical profession in our ncreases and yet we are paid considerably less and ıot fully insured under MHSC. The situation would be nore tolerable if the government would allow extra)illing given the limitations imposed upon us, or at least)ay decent fees for the services we render Manitobans.

Manitobans who utilize chiropractic health care do ;o mostly at their own expense, while those who utilize nedical care do so totally with MHSC support; a true liscrimination in a province that advocates universal ıealth care. My profession has always acted with 'espect, integrity and politeness in dealing with the ıovernment and its agencies. The MCA has been :onscientious in resolving its problems and keeping an excellent standard of professionalism in Manitoba. Because of inappropriate fee schedules, the :hiropractors of Manitoba have financed not only the ıovernment in its health care, but also financed the nedical profession to the tune of millions of dollars)ver the last 15 years. This has been done at our expense and detriment. We have no more to give.

Further, this government and its agencies have rarely, if ever, consulted us prior to making decisions affecting the future of chiropractic care and our patients. This must come to a stop and it will.

In the current situation, the government has broken its part of the contract with the Manitoba Chiropractors' Association and the people of Manitoba three months prior to its expiration. The legal and political implications speak for themselves.

In 1980, when I opted out of Medicare, I met with the Leader of the Opposition, who is now the Premier of Manitoba, I made him aware of the seriousness of our situation. I also informed him about how our patients in the chiropractic profession had been neglected by the Schreyer and Lyon governments. Mr. Pawley agreed that this situation was deplorable and yet his government continues with the same policy towards us and our patients. This government and its agencies act as if they are not accountable to anyone for their actions.

The number of Manitobans who have utilized chiropractic care since 1969 must number well over 70 percent of the population. Many families employ chiropractic as their main source of health care because of our holistic approach. These thousands of people will now find themselves forced to do without or to employ medical practitioners, who in turn, will charge MHSC, Pharmacare, use hospitals, refer to surgeons, etc., thus incurring costs far greater than the $1 million this government is trying to save.

The independent New Zealand Commission on Chiropractic in 1979, an independent study, international and chiropractic, found that chiropractic was not only an important health care profession, but that chiropractors were indisputably the experts on spinal manipulative therapies. This report further established chiropractic as an essential service in any health care scheme.

Canada's Royal Commissions on Medicare and on health care, have all strongly recommended proper inclusion for chiropractic care. This implies consideration and respect and like Justice Hall, have called for an end to discrimination against chiropractic. When will this government start handling its responsibilities towards chiropractic health care?

Removing the right to extra bill for chiropractors causes the profession to be locked into a system functioning on blatant discrimination, inadequate fees and continuing government inconsideration. This does not allow us our survival clause for a situation which, in the last 15 years, have proven can and do happen. Especially ludicrous is the fact that Section 12 of The Canada Health Act does not include chiropractic. The Federal Government gives no monies towards chiropractic care. Allowing extra billing in no way reduces federal money to Manitoba. Are we being sacrificed to keep the medical profession in their place politically?

This government does not have the maturity, the capability, and the ability to be the guardian of chiropractic. Including us in Bill 2 is a discrimination of the highest order and spells a very severe blow to chiropractic care in this province. Furthermore, it renders us completely vulnerable to any agency discrimination and we would have no recourse. Why does this government insist on including us in its policy of universal health care by the removal of extra billing, when we are not universally covered or insured by MHSC? In my opinion, universal Medicare is not advanced by Bill 2.

Bill 2 is a desperate attempt to deal with rising costs and is useless in dealing with the real issues facing health care in Manitoba. Do you think that removing extra billing and saving a few million dollars in provincial monies will make a big difference in health care expenditures when Medicare spending is absolutely out of control? The truth is, that universal Medicare is pie in the sky, as long as Medicare spending is out of control

and that's what it is in Manitoba, and in Canada for that matter. As long as our society fights disease and maintains the attitude of ignoring health, we will be the losers.

The present attitude this government has penalizes health care professionals and patients, especially chiropractic patients, by survival cutbacks instead of reducing usage of Medicare by Manitobans. I realize that cutbacks are often necessary in governments, but what's wrong with creating healthy Manitobans who will not require Medicare to any great extent, but instead will use Medicare for health purposes? The fact remains that there is no relationship between the health and wellness level of Manitobans and the amount of money spent for so-called health care through Medicare. And also, there is no relationship between the sophistication of medical care and a level of health care anywhere in the world.

The U.S. and Canada have the most sophisticated medical facilities in the world and yet at least 18th down the list of healthy countries. Medical sophistication saves lives, that's quantity; but does not contribute significantly to health as a resource, I mean quality. Medicare supports primarily one side only of the health care picture, the necessary crisis intervention of sick people by medical practitioners. Nothing is done to maintain health and to prevent diseases.

Coming back on expenses for Medicare and other changes will do little to alter the ultimate demise of universal Medicare. Medical expenses for Medicare have no alternative but to keep escalating as our society gets sicker and sicker. Increasing the number of medical graduates has not changed this picture. In fact, society wants to cut back on new medical graduates.

The transformation of this situation resides in a firm commitment to alter the direction of health care so that disease care is no longer in control. For this to happen, you need to look at health care in the true sense, that of caring for health as opposed to caring for disease. Medicine, unfortunately, does very little for the care of health. Governments need to look elsewhere to find solutions for the creation of healthy citizens, and finding means of helping people create health as the natural resource that it is.

Chiropractic can play a major role in developing a plan to maintain health and prevent disease, so can other professions. This government, or the next government, need to look into this very soon if we are going to benefit from universal health care, if we don't go bankrupt first.

It is important to change our approach to the current problems and include all the healing arts for their input into developing a concrete plan. This is especially true about chiropractic.

Chiropractic is holistic and concerns itself with correcting and straightening the human frame, the body's state of nutrition, the body's fitness and a person's attitudes toward life. These are the essentials for good health in the human body. Any plan to create healthy Manitobans must and would have to include these essentials. Not using chiropractors to help in this problem is not realistic. In fact, we are the second largest healing art in the world. We don't use drugs or surgery and we are here to stay. We are scientific; we are well-trained; we are very effective in our area of health care. Any plan to save Medicare must make people healthy. That means the emphasis would have to be on health, not diseases, and that must include chiropractic.

Including chiropractic health care, the government must do so in a fair and just manner. Services available to our patients must be in keeping with what public facilities are available for the proper diagnosing and treatment of chiropractic patients. Fees paid must be fair, equitable and relate realistically to the economy.

Binding arbitration for chiropractors is certainly necessary to compensate for the passing of this immature legislation as it is now written. If this Legislature insists on pursuing this course, it must remove chiropractic from its grip and give the profession strong protection against unfair government control. This government must finally make its move to right the wrongs it has imposed on the chiropractic profession and our patients since 1970.

Thank you, Mr. Chairman.

MR. CHAIRMAN: Are there any questions for Dr. Marcoux?

The Member for Burrows.

MR. C. SANTOS: Dr. Marcoux, you made a link between chiropractic medicine and holistic approach to health.

DR. H. MARCOUX: Yes.

MR. C. SANTOS: In what sense is this link established?

DR. H. MARCOUX: The word holistic is a chiropractic word. The authenic spelling is with a "w," not h-o-l-i-s-t-i-c. Holistic is spelt with a "w." Holistic means that inevitably the work that you do with patients who are sick or well relates to the entire human being. For instance, when you work on the skeletal system, the spine and the skeletal system of the body, you affect 70 percent of the human being, especially as it relates to the nervous system. So what happens is the body generally functions better. If, on top of that, you add a sound nutrition and a level of physical fitness, and a way of dealing with life through attitudes and counselling and so on, people automatically regain their health if there is not an irreversible process. So our concerns are with the whole man, and always have been, and always will be. We have no choice, this is how it is with chiropractic.

MR. C. SANTOS: Mr. Chairman, it has been said that people become what they eat; in other words, our diet has something to do with our health. If you are training for chiropractic medicine, are these people required to take some courses in nutrition and diet?

DR. H. MARCOUX: Yes, chiropractors are very well trained in nutrition. We are not nutritionists, but we are trained in clinical nutrition and in the application of diet and things of that nature for the correction of the disorders in the human body, as well as, the use of vitamin therapies and other such therapies.

MR. C. SANTOS: Viewing the whole human being as not merely the material part of our physical body, but

there is a moral aspect or a spiritual aspect to the human being, do you have other preparations for dealing with the spiritual side of man?

DR. H. MARCOUX: The basic training in chiropractic college is the same, essentially, as it is in medical training. There is a course in psychology and in psychiatry. Although we are not trained to be counsellors in relation to psychiatric problems, we are trained in the knowledge and in the general counselling procedures involved in lifestyle counselling and, in general, related to attitudes. If we run into someone who needs psychiatric care or more professional counselling from, say, a psychologist or a family therapist or some of that nature, we don't hesitate at all to refer those people for that type of professional care.

Plus some chiropractors take an avid interest in couselling and other things that relate to the psychological mechanisms of the human being, especially as it exists in the psychosomatic concepts. The mind and the emotions relate together quite distinctly and, in fact, all emotions are physical, so a great number of our patients who come in with muscular skeletal problems are, in fact, complaining about emotional problems that are manifesting physically. We need to be very aware of this and we need to deal appropriately with those situations from a holistic position and we do that very well.

MR. C. SANTOS: In Latin they have a saying: mens sana en corpore sano - a sound mind in a sound body.

DR. H. MARCOUX: I agree.

MR. C. SANTOS: Thank you.

MR. CHAIRMAN: Are there any other questions?
Mr. Storie.

HON. J. STORIE: In your remarks, Dr. Marcoux, you had talked about the relationship to chiropractic medicine and the other healing arts. I'm wondering whether in your presentation you are making an argument, or making a case, for having others of the healing arts included as insured services, talking about nurse practitioners, about naturopaths and herbalists and nutritionists and physiotherapists and psychologists. If that were to happen, would it be your view that the costs of our medicare system would eventually be less onerous than under the present system?

DR. H. MARCOUX: Your question is vipercated - it speaks with forked tongue. Pardon my language, it's two questions you might be saying. First of all, I was not eluding to the . . .

MR. CHAIRMAN: Order please.

DR. H. MARCOUX: I was not eluding, in any way, to the inclusion of other disciplines under Medicare, I don't think that is my domain to decide. But I was referring specifically to the inclusion of other health professionals in developing a plan for developing healthy Manitobans. Every discipline in the healing arts has something to contribute - every displine - that includes reflexologists, massage therapists, physiotherapy, nurse practitioners, everybody has something to say about how we prevent. The prevention of disease and the maintenance of health is a far bigger challenge than to treatment of disease, especially since we do very little of it, except in the holistic professions.

MR. CHAIRMAN: Are there any further questions?
Mr. Storie.

HON. J. STORIE: Just one further question, Mr. Chairman. Do you see any inconsistency, any inequity in the fact that chiropractors are at least partly insured, and that yet other of the healing arts are not insured at all?

DR. H. MARCOUX: Well, you are referring to those healing arts that are not involved medically? The medical profession, as a healing art, with all its auxiliaries and adjunctive therapists, is basically covered by Medicare. Nursing is looked after and so on. What are you referring to specifically?

HON. J. STORIE: Well, frivolous nutritionists, reflexologists.

DR. H. MARCOUX: You know, if there is adequate training and they are contributing something, I would see no objection to any government looking into the feasibility of including them if they are providing a good service, especially as it relates to maintaining people's health. But I am not sure what the direction of your questioning is because I haven't referred to any of those things.

HON. J. STORIE: Well, I suppose the direction of my question was that you talked about the medical model as the sole model for the insuring of health care services. You are making the point, and I think there are certainly merits to your argument that we profess a concern for an interest in preventative medicine. My question was simply whether it would be your view that, including all kinds of other preventative therapies would, in effect, lower the cost eventually of the Medicare system.

DR. H. MARCOUX: You are asking me to outline my plan for what would be cost-reducing for MHSC or Medicare, any kind of Medicare system. Well, I will tell you something, I have a book coming out in about six months exactly on that subject. It will be called "The Survival of Health" and it deals with that, a complete plan. I hope you buy the book.

MR. CHAIRMAN: Are there any further questions?

DR. H. MARCOUX: I will even give you a complimentary copy.

HON. J. STORIE: And you autograph it for me.

MR. CHAIRMAN: Order please. Are there any further questions?
Mr. Scott.

MR. D. SCOTT: Thank you, Mr. Chairman. A question to Dr. Marcoux.

It's my understanding, and this is a follow-up to your comments where you are saying that in no other province do chiropractors receive such terrible treatment as they have in Manitoba.

Are chiropractors covered under Medicare in any province east of the Province of Ontario? Are they covered in Nova Scotia, New Brunswick, Prince Edward Island, Newfoundland?

DR. H. MARCOUX: No, nor in Quebec.

MR. D. SCOTT: Nor in Quebec. So how do you come up with an accusation that they are so terribly treated here in Manitoba when you are one of five provinces that even allows coverage for chiropractors under Medicare?

DR. H. MARCOUX: In Ontario, chiropractors get a basic fee from OHIP for which they can balance-bill to their fee schedule. In Saskatchewan, the chiropractors, apparently, or 50 percent opted out, but I understand there is going to be a change similar to what's happening here, and chiropractors there are getting $10 a visit - I think it may be a little more. In Alberta, chiropractors can balance-bill or extra bill. In B.C., they do not extra bill; I understand there are also some changes taking place there that would have allowed them to extra bill, but apparently it will not come through, but they are getting over $10 a visit. We are getting $8.77 a visit. Their fees are shoddy, as well, but ours are worst than theirs are.

Outside of Medicare, our fee schedule is considerably different. It has kept up with inflation and it's basically realistic. Manitoba has traditionally kept Manitoba chiropractors at a very low salary on the basis - and some of it is a pretence - that we can make up the difference when the patients have expired their Medicare visits, which in some cases took a long time. But just how much can you tax those normal fees that we were charging? So it waters the whole thing down.

Any chiropractor in Manitoba practising outside of Manitoba would immediately, without any other consideration, double his income immediately, triple it if you were going to Ontario and Quebec, and even up to quadruple it in the United States, depending on the area you work in and how much you charge for your fees. I am saying there is a leverage there that allows for fees to fluctuate.

We are not asking here, I mean, I am not speaking for the profession, I am speaking for myself. For me, I am not asking for exorbitant fees, I am asking for a fair fee. I think that a fair fee would be approximately 75 percent of my fee schedule, or at least something that I could negotiate with, but there has never been any negotiating because we have never been taken seriously. My feeling is that we are consciously, purposefully put down or kept down as a profession, and I think that's complete bias, complete prejudice and not acceptable. In fact, from my position, that is so unacceptable that this is going to stop. That's my commitment, this is going to stop for sure.

MR. D. SCOTT: You mentioned chiropractory at the forefront, I guess, of holistic medicine. I wonder what kind of controls you have in your society or organization to, I guess, monitor, one could even say, in other medical professions virtually police the activities of the members as to what they are serving people, what kind of qualifications they have to be able to claim to offer medical services which they are offering.

DR. H. MARCOUX: Well, I will answer your question, but I just want to clarify a term. The word "preventative medicine" belongs to the medical profession; we use "preventative health care." To just make the distinction, medicine is a discipline and chiropractic is another. So within that context, chiropractors are trained in chiropractic institutions. Before coming to Winnipeg, or to Manitoba, or in any jurisdiction, you have to write a licensing board which is governed by the university. It's the same basic science boards that medical doctors write, plus essentially the same type of exams for clinical sciences. Then a provincial association, which is governed by an act, such as it is in Manitoba, further examines this new graduate, or this incoming graduate, to grant them a licence at which point they are acquainted with the rules and regulations of practice in the province.

The act that we have in Maniotba, and I am proud to say the act that we have now, is undoubtedly the best act in Canada governing chiropractic practice, and the act gives us, as an association, a very good leverage into handling disciplinary problems, which we occasionally have as any other profession does. But we handle our problems astutely, and we handle them completely, and we handle them very well. So the level of unethical behaviour and disciplinary problems in Manitoba is very low and, furthermore, has always been low.

MR. D. SCOTT: How many persons in the past, say, five years, have you refused permission to practice, or taken your licence away for practising?

DR. H. MARCOUX: In the past five years?

MR. D. SCOTT: Yes.

DR. H. MARCOUX: To the best of my knowledge, there has not been one practitioner in Manitoba who has been suspended.

MR. D. SCOTT: Thank you.

MR. CHAIRMAN: Are there any further questions? Mr. Orchard.

MR. D. ORCHARD: Dr. Marcoux, you mentioned in your presentation the recent change to your number of visits that you are covered under Medicare to your patients. Could you give me an indication, in your practice, an approximation, as to how many of your patients are affected by the change in the number of office visits where it's been lowered for the individual and the family package has been changed, and they now have to pay for those visits themselves?

DR. H. MARCOUX: Given the type of practice that I have - and there are different types of practices, there

re acute care short-term care practices and there are ›ng-term care practices - my practice is a long-term are practice, and so about 80 to 90 percent of my atients are affected.

Some other practices, where they treat only with acute roblems, like a person comes in with pain in their ack, you get a cursory examination - and I will explain ıat - you get a cursory examination and local treatment › relieve the pain of the back. The problem in the pine is still there. It's basically unaltered, but there's ymptomatic relief. That's like giving an aspirin. That ⁄pe of care is the type of care that a lot of chiropractors ave been doing in this province - like I suspect over 0 percent of the practitioners - so in their practices ıey would not be too effective. But in my type of ›ractice which is corrective long-term care, like getting ‹t the cause and working with nutrition and lifestyle ınd fitness and all that kind of thing, it's 80 to 90 ›ercent.

MR. D. ORCHARD: Then obviously your patients will ıot be terribly pleased with that change in billing, ›ecause that took anywhere from 16 visits away ›resumably from an individual patient.

DR. H. MARCOUX: A lot of patients that I deal with ıre wage earners and you know, are workers, labourers ınd that sort of thing, and they function under a estricted income and they have to put out the extra noney often either from their savings or work extra to ıet the money, to get the care that they need to have ıs you would if you were to see a dentist. Mind you, :hiropractic expenses are nowhere near as high as ıental expenses.

MR. CHAIRMAN: Any further questions? Seeing none, ınd Dr. Marcoux, I would like to thank you for coming onight.

The next person on my list is Dr. Gilbert Bohemier.

DR. G. BOHEMIER: Good evening, Mr. Chairman, Mr. Minister and members of the committee.

Before I get into my presentation, which is the official ›resentation of the Manitoba Chiropractors' Association, I'd like to take this opportunity to thank Dr. Marcoux for his colourful and forceful presentation ınd I think the committee should know that, although ıe was here on his own behalf, his comments and his ‘eelings and certainly his sentiments are felt deeply as ‘eelings of frustration throughout the chiropractors of Manitoba and their patients as well.

The comments I have to make with respect to Bill 2 will be brief and are supplementary to the remarks ‹hat were made by our Association President, Dr. Greg Dunn, when this committee last met on Tuesday, May 28th. During that address, our association president made a strong submission advocating our profession's exclusion from Bill 2.

Through our discussions with government in the past months and in our submission to this committee, we have tried to make our case to the government for exclusion. The Minister, himself, may touch upon this later, but it is my intention in speaking to the committee tonight to advise them that since our president's address last week, there have been discussions between the Minister and our association. We have made a step forward.

The Minister has advised that the government recognizes the reasonableness of our position and has now acknowledged to our president and our solicitors that he is prepared to enter into a series of negotiations with a view to establishing a compulsory binding arbitration scheme for the chiropractic profession. We welcome this undertaking by the government and commend them for taking a positive and forward approach to the legitimate concerns that we have raised. This is a small but significant step forward for our Association and for the government. And I speak for the association when I say that we are optimistic, that in an atmosphere of fairness and co-operation, we can achieve an accord.

While we appreciate the recognition by the government of our position and their willingness to now negotiate a compulsory binding arbitration scheme, we maintain at this time, that the chiropractic profession be excluded from the scope of Bill 2. While we are optimistic about our impending negotiations with the government for a binding arbitration scheme, its terms are crucial to us and they are going to be the subject of some hard negotiations. Given that, it is our position that we should be excluded from Bill 2 at this time, in order to preserve the bargaining position that we have, entering into these negotiations.

If the government should pass Bill 2 in its present form, the Minister will have taken away from our association, our present and only method of determining and negotiating a reasonable fee schedule for our association and, in turn, for the chiropractic patients of this province. He will have taken this method away from us without having in place an agreed alternative in the form of a compulsory binding arbitration scheme.

We wish to be clear that our exclusion from Bill 2, would not be permanent. Indeed, it would be our position that we would agree to be included in the scope of a prohibition on extra billing as soon as our compulsory binding arbitration scheme is in place. But until that time, we urge the Minister and the government, not to disrupt the respective bargaining positions which we will come to the table with. I remind the members of the committee that our exclusion from Bill 2, will have no, absolutely no effect, with respect to penalties, in the form of loss of transfer payments from the Federal Government pursuant to the Canada Health Act.

In conclusion, I again extend our appreciation to the government and to the Minister for their recognition of our concerns and their offer to negotiate a compulsory binding arbitration scheme with us. We only ask that those negotiations get off to a positive start and that the government not upset the status of the parties to the negotiations before we even get to the table.

Thank you.

MR. CHAIRMAN: Are there any questions for Dr. Bohemier?

Mr. Orchard.

MR. D. ORCHARD: Dr. Bohemier, the last time the committee met, Dr. Dunn made a lengthy presentation and laid out some of the concerns of the association.

Tonight I just want to make sure that following the negotiations the Minister has had with you, that you're speaking on behalf of the association and Dr. Dunn this evening?

DR. G. BOHEMIER: Yes, I am.

MR. D. ORCHARD: And that your association still believes that an exemption from Bill 2 is desirable from the association's standpoint until such time as you complete negotiations, that I presume have just started recently, on a form of compulsory binding arbitration, at which time you would be prepared and your association would be prepared to be included under the provisions of Bill 2?

DR. G. BOHEMIER: Yes, in principle our association, as Dr. Dunn said in his speech last week at this committee meeting, is not against Bill 2, nor is it against the inclusion of chiropractic in Bill 2, except under the conditions as they are.

We would want to be included under Bill 2 in the same way, in the same honourable fashion, that the medical profession had the opportunity of being included with many months of negotiations and a binding arbitration package put together.

MR. CHAIRMAN: Are there any further questions? Seeing none, Dr. Bohemier, I would like to thank you for coming here tonight.

The last person on my list is Dr. Tom Fischer.

That completes my list of people who wish to make presentations.

Bill No. 2, what is the will of the committee on how to proceed? Clause-by-clause?

Mr. Orchard.

MR. D. ORCHARD: Mr. Chairman, I wonder if before we go clause-by-clause on Bill 2 if the Minister might provide answers to some of the questions that have been posed from the people who have been presenting briefs to the committee.

HON. L. DESJARDINS: I have no objections. It's rather unusual, but I have no objections if that is going to help to expedite things.

MR. D. ORCHARD: It has come up both last Tuesday and again tonight about really what extra billing means. Right now we have a concept, we believe that if an office visit is, let's say, reimbursed at the rate of $10 from MHSC and if a physician charges $12, that extra $2 is clearly extra billing. But there has been some additional areas brought up this evening and last Tuesday. I know when the Minister closed debate on the 24th of May, he indicated that with regard to the question relating to extra billing for services provided in doctors' offices versus hospitals, this is something we are looking at, but there is not going to be a change.

HON. L. DESJARDINS: Excuse me. Would you mind repeating the last question? I missed your question.

MR. D. ORCHARD: Well, I'm just quoting from your closing remarks on Bill 2. I posed the question to you, and I used the example in debate on second reading of the circumstances, that if I have my arm in a cast and I have that cast changed in the hospital, the physician gets X number of dollars. If he changes that cast in his office, he still gets the same MHSC fee; but in the case of the office, he's splitting up the plaster etc., etc., and the clean up, and there are extra costs to him. Dr. Krahn indicated a similar situation with a bladder examination.

Now, what I'd like to clarify if the Minister can tonight, is whether overhead expenses, if you will, are deemed to be extra billing and whether the charge, for instance, on the cast would be something that they could charge expenses for?

HON. L. DESJARDINS: I think my closing remarks, in second reading, I did say that we were looking at it, but nothing would be changed. This has nothing to do with extra billing at all. At the moment, it is a service that is rendered that is not insured. When you are talking about the cast in the office, it is not insured at this time. But I think my honourable friend knows that the exercise we went through in the Estimates that we are looking at the whole procedure with the MMA also. But at the present time, it is an uninsured service, so it is not affected by this bill at all.

MR. D. ORCHARD: But there is the difference in terms of who pays for the supplies. If it's done in the hospital . . .

HON. L. DESJARDINS: That's what I told that we were looking at. I might say this, as I mentioned to Dr. Krahn before, my information is that the MMA has always resisted the fact of two levels - for care even for somebody who had a much larger capital investment than those who had none and the service was done in the hospital. At this time, there was nothing done, but I did say we were looking at the whole thing. But I hardly see what this has to do with the principle of extra billing.

MR. D. ORCHARD: Mr. Chairman, I think it has a lot to do with the cost of medical services.

HON. L. DESJARDINS: Right, but not extra billing.

MR. D. ORCHARD: But, Mr. Chairman, there has been those who presented briefs here tonight who believe the ban on extra billing is tantamount to having more services go through the hospital where it takes longer to do them, so you do less of them.

HON. L. DESJARDINS: I understand that.

MR. D. ORCHARD: And that has a pretty important repercussion in terms of the quality and the availability of health care services, but more importantly, Mr. Chairman, and to the Minister, that if you have not a provision in the fee reimbursement to a physician for procedures that can be routinely done in the office, which have some additional expenses involved and he can do the same procedure in the hospital and not have any additional cost, you are going to further load your hospital system.

HON. L. DESJARDINS: I recognize that. I recognize that fully and I've said that these discussions are taking place with the MMA and that's actually where it should be, where it's recognized, and there might be some changes. But, I repeat, this has nothing to do with the principle of extra billing. In increasing the cost, yes, but not with the principle of extra billing.

MR. D. ORCHARD: Well then, could the Minister explain why it has nothing to do with extra billing if you're denying now any charge above the fee schedule for services performed in a doctor's office?

HON. L. DESJARDINS: I can't answer it any better than I have. My honourable friend might not like the explanation. But this, I say, has nothing to do with this bill. In the past, there also has been the suggestion that the fees in the hospital would only be 75 percent because the medical profession have talked about the operating costs that they had; that has been accepted; and they don't have that cost in the hospital, so it has been suggested that they would receive 75 percent because of using the hospital. In the states and so on, there is a charge for using the hospital and the facilities and so on, that has been rejected. So it is not as simple or one-sided as it might appear and we are looking at that. I'm not going to repeat it again.

MR. D. ORCHARD: But, Mr. Chairman, the Minister has stated that when Bill No. 2 passes third reading, it is going to be proclaimed and you are going to be into a circumstance right away where you are going to be faced with it. Just as soon as this bill is proclaimed, you are going to be faced with that very circumstance and if you haven't got an answer for it, then you are going to see your hospitals potentially loaded up with routine office cases. That is something I think this Minister should be concerned about.

HON. L. DESJARDINS: I told you that we are discussing this with the MMA and the solution will be arrived at one way or another.

MR. D. ORCHARD: Then since your discussion with the MMA, do we presume that you are not going to proclaim the bill until you have reached a conclusion in your discussions with MMA?

HON. L. DESJARDINS: If you presume that, you are presuming wrong. That is not the case. This will be proclaimed as soon as it is passed.

MR. D. ORCHARD: Mr. Chairman, then the Minister has got the problem I have identified and it is an important feature of this bill then. But if he is not willing to deal with it and he doesn't have an answer for it, then fine, that's the way the record will show.

HON. L. DESJARDINS: I have the answer.

MR. D. ORCHARD: You have the answer?

HON. L. DESJARDINS: I told you the answer.

MR. D. ORCHARD: What is the answer?

HON. L. DESJARDINS: I told you the answer, that there are also two sides to look at. The suggestion has been made that they were not full, but you have not mentioned that at all, that there would be no full payment because the operating costs are included in the payment and there is no operating cost in the hospital. That was rejected. I can't promise a solution, the discussion is taking place with the MMA and that goes on all through the year, the discussion. And year after year there are many problems that we have tried to rectify continually to improve the system.

Excuse me, Mr. Chairman, I would like to make sure that we understand. If the suggestion is that we're going to have a debate, that's one thing; if I'm going to be asked a question for clarification, and then we'll go through the bill clause-by-clause, and anybody is free to bring amendments or reject or vote against any clause. Now I think that is not usually done, but I'm ready to try to answer for clarification at this time. Now if it's a debate, it's something else. I'm not going to evade the debate; there's no way that I could if I wanted to, I think it should be done clause-by-clause though.

MR. CHAIRMAN: Mr. Mercier, a question of clarification.

MR. G. MERCIER: Yes, Mr. Chairman. Does the Minister feel that extra billing is a problem in the Province of Manitoba?

HON. L. DESJARDINS: I feel it is problem. I've said repeatedly, my honourable friend knows that, that it hasn't been the problem that we've had in other provinces. The principle is wrong, as far as the party in the government is concerned, we've made that very clear. But because of many other problems that we've had we felt it wasn't a major problem. We did not initiate it, it was brought in by a Federal Government, was supported by the three parties. There has been a change of government federally; the same support stands from the three parties. We certainly are not going to reject it when we believe in the principle that there should be no extra billing.

Now I said repeatedly in the House, outside the House, that we did not object to anything in the bill brought in by the Federal Government. We objected to many things that were not included in the bill that we felt were higher priority. I haven't changed my opinion, neither has a government since then.

MR. G. MERCIER: Mr. Chairman, what is the principle that the Minister keeps referring to?

HON. L. DESJARDINS: The principle of extra billing.

MR. G. MERCIER: What is the principle?

HON. L. DESJARDINS: Well, if you don't know you'll never know. The principle of extra billing is someone that decides to extra bill, there's a percentage of the - and I'm excluding the chiropractor at this time. It's true that it's not the same situation. There are a number of people that decide to extra bill.

The main component of this plan, and the most important thing, is the question of universality. In fact,

some of the things that were mentioned in this committee before, I don't know if they'll surprise you, but I would agree with. There's nothing I would like better than at least bring in the Quebec model, whereas somebody could opt out completely, but both the patient and the doctor would be out, at least it would give an option to the doctors. But in discussions with the present Federal Minister, and the Cabinet, we felt that the priority was to retain the universality point and that was the only way to do it. So that is something that, if at all possible, we would have liked to have done, but we've lost the universality and we make no excuse for that, nor apology. We feel the most important thing is the universality and this is the situation.

MR. G. MERCIER: Mr. Chairman, and to the Minister, is the principle then that the Minister's referring to the fact that any medical practitioner who provides insured medical or health services in the Province of Manitoba, has to accept what the government decides they should be paid for that medical service?

HON. L. DESJARDINS: That's not the principle, that is what's going to follow. The principle is that we establish in Manitoba one level of care; not two levels of care, for those can afford it and those that can't. That is the reason why, with both the chiropractor and the doctors, we have been ready to discuss the question of binding arbitration.

I just want to make one correction to the statement of Dr. Bohemier and I'm sure that this wasn't done purposely, but the Chiropractic Association, or the officials of the Association, were informed that we would discuss the binding arbitration under certain conditions in a meeting that we had February 2nd, and one before the meeting that we had here, it wasn't after, it was before. Now what has changed is this, we've looked very carefully at the question of the Quebec model of opting out, and when the final decision was made that gave more reason because we recognized at the time the chiropractor is at a point that they had no way at all, they had to accept. And if they couldn't go the Quebec model they had to stay in and they had to charge what they were told.

So we are ready, under certain conditions, we are ready to discuss binding arbitration the same as we did with the medical profession. And that will be the change. I don't think anybody's jumping up and down and turning cartwheels, but the MMA, the medical profession, not all of them, there has been a small group that have resisted that and it will be interesting to find out, maybe if they want to tell us what they extra bill. For instance, I can tell you that the psychiatrists are extra billing to a tune of over 37 percent; I consider that pretty extravagant, those that are extra-billing mind you.

So this is the situation, there is no agreement signed with the MMA, nor with the Association of Chiropractors. But I think it is very close and I don't expect that it should take too long to decide that, but we feel that both of them have a point. It was something that we resisted before with the MMA, as you know, especially when they can opt in and opt out and that has been rectified and we're very close to having an arrangement. The principle is one level that is affordable by all Manitobans.

MR. G. MERCIER: Mr. Chairman, did the Minister give any consideration to a process or procedure whereby Manitobans could complain against what might be alleged to be excessive billings and perhaps a committee of doctors, of government officials and lay persons could rule on whether or not extra billings were excessive, considering the costs of the services provided, keeping in mind what is probably true, and I offered in defence of the Health Services Commission, in many cases they simply don't have the money it would appear to provide an appropriate fee level for the service rendered by the physician?

HON. L. DESJARDINS: That's exactly the point. If it were true that the reason was because the Commission, or the government, or the people of Manitoba did not have the money, that means that only those that can pay a little extra would receive the care; or they certainly would be the first one in line, the first priority, and that's exactly what the Federal Government doesn't want. All the parties agree with that federally and that's what we don't want here; and that's what I thought you didn't want when you voted in favour of it in second reading, when you voted in favour of the principle of the bill.

MR. G. MERCIER: Is the Minister not concerned, in view of the representations that have been made to the committee, that there may very well be a lessening of accessibility to the health care system, or deterioration in the quality of health care, or less encouragement for the development of innovative and health procedures?

HON. L. DESJARDINS: Mr. Chairman, I certainly can't tell the future. This has been prophetized at every step when Medicare was brought in; it was going to be the end of the standards of care. I think the standards have improved greatly. There might be a few that will leave the province; the majority won't. I know the Past President of the MMA was one who left a practice in the States; he couldn't stand it at all, he felt that he wanted to practise medicine. He came back to Manitoba because he felt the standards were much better; that is something that we can't control. I have always said that the doctors and those providing care should be well paid; I never said that they were overpaid.

But there is a limit what the people of Manitoba can pay, especially when the Federal Government, who was one of the creators of this plan, one of the originators in a partnership, now decided that they want a plateau or that they want to cap their contributions, and that is being done.

There is no way, you have heard me say during these last few months that if we keep on just the way we are going now without increasing, without improving the standard of care, that we will lose the whole ball game because my budget only, at the Commission, would be more than triple in 10 years. It's easy for doctors, like some of them said today, that there should be a blank cheque. That just can't be done, it's unfortunate, though.

Some of these people that are making their representations are getting around $300,000 or so before they start to extra bill. Fine, I am not saying they are not worth more than the.., but there are a lot

of problems that we have to try to solve before we can be satisfied.

MR. G. MERCIER: Mr. Chairman, it's 11 o'clock. I move that the committee rise.

HON. L. DESJARDINS: Well, I wonder, Mr. Fox has an amendment that is not going to change anything on Section 1, it is the wrong wording. I wonder if Mr. Fox could move it and I would be satisfied to call it a day. This is not going to involve you in the final bill; it is correcting a wrong reference that is being made in the present bill.

MR. CHAIRMAN: Clause 1 - Mr. Fox.

MR. P. FOX: Mr. Chairman, I would like to move

THAT section I of Bill 2 be amended by striking out the letter, figures and words "H35 of the Revised Statutes" in the 2nd line thereof and substituting therefor the figures, words and letter "81 of the Statutes of Manitoba, 1970 (Chapter H35 of the Continuing Consolidation of the Statutes of Manitoba)."

MR. G. MERCIER: In order that you can deal with that motion, I will withdraw my motion.

HON. L. DESJARDINS: Oh, I didn't realize you had a motion. Sorry. I thought you had made a suggestion.

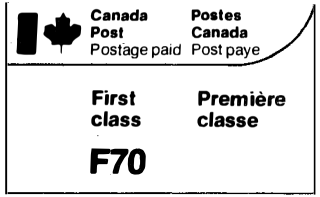
MR. G. MERCIER: No, I will withdraw the motion.

MR. CHAIRMAN: Any discussion of the motion? Is it agreed? Agreed and so ordered.

HON. L. DESJARDINS: Mr. Chairman, I would like to suggest the committee rise.

MR. CHAIRMAN: Committee rise.

COMMITTEE ROSE AT: 10:58 p.m.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