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Thirty-Fifth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

Monday, May 4, 1992

The House met at 8 p.m.

COMMITTEE OF SUPPLY
(Concurrent Sections)

HEALTH

The Acting Deputy Chairperson (Mr. Jack Reimer): Will the Committee of Supply please come to order.

This evening this section of the Committee of Supply, meeting in Room 255, will resume consideration of the Estimates of Health. When the committee sat last, it had been considering item 5.(a) Administration: (1) Salaries, on page 87 of the Estimates book. Shall the item pass?

Mr. Gulzar Cheema (The Maples): Mr. Acting Deputy Chairperson, the other day I made it very clear to the minister that–[interjection] the deputy minister says, perfectly clear, so I will try to make it an in-between clear.

The many issues we have in this section probably will be mostly addressed when the reform package will come, and it will give us some idea which way the government is going, because the numbers are all going to change very dramatically. If they are not going to change, then we are not talking about health care reform; we are talking about a patchwork.

* (2005)

I sincerely hope the government will move forward, because I think they have an opportunity. People are willing to listen and they are willing to accept, and as long as they can explain to us and to the public, I think we will go a long way. I will just go on, on a basic few other questions with which I have concern.

The other day we asked the minister to provide us a copy of the deinsuring of services from the various other provinces. Can the minister tell us if they have done work on that area?

Hon. Donald Orchard (Minister of Health): Mr. Acting Deputy Chairperson, staff attempted to contact the other provincial jurisdictions. I guess it is fair to say, they are all a little sensitive about sharing information on what has been changed in terms of their insured services planned. Everybody is a little, I guess, gun-shy on the use of the deinsurance word. We apparently got a lot of reports back which say nil, like nothing has been changed, and we know that probably is an incorrect reflection.

In the meantime, for what it is worth–and I have just received this from staff right now, and maybe my honourable friend has it–Health and Welfare Canada puts out a Canada Health Act annual report, 1990-91, and their relevant sections in here indicate–I will just give you an example, starting with Newfoundland and going across Canada.

They deal with public administration, comprehensiveness, universality, portability with each province, and under insured services they go through a list of what is insured. The difficulty that I can see from this–and I have a copy that I will give my honourable friend. The difficulty I see with this, just on first blush, is that it does not get into the specifics like tattoo removal or reversal of sterilization as we did last year. We do not have an accurate tally that we can share with my honourable friend which indicates what is happening in other provinces.

So, Mr. Acting Deputy Chairperson, I will leave that for the member for The Maples. Maybe he can offer suggestions or maybe we can discuss this further to see what suggested next steps we might take. I can think of a couple of steps which are not through the formal administrative inquiry that we have made. I guess we could attempt, through the various equivalents to the Manitoba Health Organizations, to try and come to grips with it that way to get a sense of what is happening, because they are generally in tune with changes.

The other thing I suppose we could do in part or in whole, but we might have to collaborate, we could ask opposition caucuses to give us a tally of what government is doing. That would mean we would have to go to Liberal and Conservative and Social Credit oppositions in the NDP provinces and Conservative oppositions in the Liberal provinces and Liberal oppositions in the Conservative provinces, yes, Liberal and New Democratic

oppositions. I do not know whether we would end up with as accurate an analysis of what is really happening. Failing that, I am open to suggestions.

* (2010)

I think what my honourable friend is asking is a valuable piece of information, because it deals with where we have come at the issue as Ministers of Health in terms of trying to assure some comparability of services across Canada. All of us are dealing with providing medically necessary services. Where we find that we are not under the fee schedules, we make adjustments. We have done it in Manitoba, and we know other provinces have done the same thing, but we have a difficulty in coming up with a reconciliation of that across Canada.

Mr. Cheema: Mr. Acting Deputy Chairperson, the minister is right, because all the provincial governments are in a major confusion and in a panic to come up with all the cost-cutting measures and probably do not know which direction to go. So they are watching the person next door to see what the other provinces are going to do and then may go off to some of what is their own services.

One thing is sure that we do not have, as I said from the beginning, a universal system all across this nation. We have 12 or 13 medical systems put into place, and that is why the Canada Health Act, as it stands today, basically depends upon the provinces and their ability to pay, and that is what is going to happen in the long run. Whether it happens this year or next year, eventually those decisions have to be made.

Certainly, I would like the minister to give us some idea whether in our province where most people now realize that the health care issue is not a political issue, and I personally believe it is a nonpolitical issue. They want to look at everything. They want to see what services we are delivering. Can we deliver some of those services in a more meaningful way? Can we have more efficiency in the delivery of some of the services? Can we probably go back and decide what is a medical necessity and what is the first level, second level, third level or fourth level of services?

I certainly want to ask the minister if they are considering in having a good look at the whole system. Certainly, I do not want to pre-empt the whole health care reform, but I would like to have some direction, the minister's own views and his government's views on whether they have had a good look at the whole range of services which are presently covered. Has there been a reasonable doubt or other reasons where some of the services which are presently covered are not medically a necessity, as last year some of the services were taken out?

Initially, there was a lot of cry that we are going to lose so much and everything is going to crumble. But now it has been more than a year, and some of those things have not happened. Certainly, whenever change in the services is being made by this administration it has so far simply been able to define them under the regulation. Whenever the services are required for medical reasons, they have to be insured.

If not, then I think we should have a good look at the system, and I just want to know in this reform package, will we see any drastic or major changes?

Mr. Orchard: Mr. Acting Deputy Chairperson, let me take issue with my honourable friend in terms of the 10 or 12 systems across Canada. In essence, I want to make a separation with my honourable friend.

My honourable friend is right when he indicates that the ministries of Health operate 10 or 12 somewhat differing services across Canada. But basically, as far as compliance with the Canada Health Act goes, on the mandated, if you will, services that are being provided there is probably a great deal of consistency across Canada.

* (2015)

For instance, hospital admissions and a number of medical procedures that have a great deal of commonality are covered in every health plan across the province. If I could put an analogy out that as far as Canada Health Act services go, and you could go on a scale of one to 100 in terms of procedures, I think you would find commonality in procedures being included as an insured service in, probably, 85 out of 100 cases.

It is only in the last 15 percent, if my honourable friend follows what I am getting at, that you might find any kind of variation between provinces. I think it is within those procedures that there is the gray area that needs to be discussed as to whether they are medically necessary services or whether, indeed, they have simply been put there because of pressure from negotiations or pressure from

providers or varying pressures that have allowed these procedures to be included.

Let me give you the example that comes most quickly to mind, that being in vitro fertilization. The in vitro fertilization program was funded independently at the Health Sciences Centre a couple or three years back. When they decided they could no longer carry it on–and they did not even, as I recall, ask government for financial support, because they did not meet their projected budget in terms of revenues, et cetera–they dropped the provision of service.

Now that becomes a confused issue in that it was an insured service by some allegations, and it was being dropped as an insured service. The point was it was never an insured service in Manitoba and probably will not be under current circumstances. But, for instance, Ontario does provide it as an insured service, and that is a difference that is in that top 15 percent of the plan. So that is sort of the analogy that I use for my honourable friend.

When my honourable friend makes the case that there are 10 or 12 different differing health systems, he is right, because for instance in Manitoba under Pharmacare we provide coverage for everybody. Everyone under 65 has a codeductible of approximately $190, and then 80 percent copayment thereafter. We are unique, with the exception of Saskatchewan so far, I believe, in having that complete a coverage. Most other provinces provide extreme financial hardship support and provide seniors support in varying ways.

Some provinces are more generous in their senior support in that Ontario, I believe, has, until very recently at least, provided a 100 percent coverage. We do not. I mean, we still insist on seniors paying an upfront deductible on a copayment.

A number of other services–some services insure to one degree or another chiropractic services or optometric services. There is that variation because the Canada Health Act does not mandate that chiropractic, optometric, et cetera, is part of the Canada Health Act.

Similarly, there is a great degree of variation in the way ambulance services are funded province by province, because the ambulance service is not part of the Canada Health Act and a mandated funded service, so that we have a system that provides per capita support and some other funding formula enhancements and enrichments, but it is not certainly consistent across Canada.

From the standpoint of services provided beyond the mandate of the Canada Health Act, yes, we do have significant variation. I think my honourable friend might agree that, on the Canada Health Act insured services side, we may have as much as 80 percent uniformity in service provision across Canada with the balance of 20 percent showing some degree of variation province to province. That is where I think, as time moves along and as budget constraints force changes, we will even get more consistency in that last 20 percent.

Mr. Cheema: The second aspect of the Canada Health Act, which each and every province deals with in a different fashion, is the so-called tray fee or facility fee. The provinces have not been able to restrict those tray fees, because the Canada Health will only punish if you have extra billing or you are charging user fees, as long as those two criteria are not met. That is why in some provinces the tray fees are being asked by the professional to be paid by the patients. I think that is unfair, because if somebody goes to a doctor's office and they have to pay $15 to $18, but if the same person were to go to a hospital where he still does not have to pay from his pocket, it just creates a problem.

* (2020)

Anyway, in the hospital it is more expensive and the minister's staff will tell them it is quite expensive as compared to the offices. That issue has been raised by professionals as well as by the patients, and I think there has to be some clear definition. I want to make one thing very clear. That did not start in 1988 or '89, that has been there as of '85, '86, and '87. That is not a new phenomenon as far as this province is concerned.

In B.C. I know for sure that the tray fee is not allowed, because I think they have made it very clear that the tray fee is a form of extra billing and it should not be charged to a patient. I would like to ask the minister, rather than the patient paying a tray fee in the doctors' offices where they perform the same services they would perform in a hospital–so I would like to have some clarification from the minister.

Mr. Orchard: Apparently in terms of the issue of tray fees, I cannot confirm whether the circumstance in B.C. is as my honourable friend described, but pretty well every other province has a system similar

to ours which is really no system, if I can be that direct.

Only Alberta has included in their schedule of medical benefits with the AMA a tray fee. I think major tray service is $15 and a minor tray service is $5. They are the only province that has allowed that or has included that in their manual or schedule of benefits. We have not, and my honourable friend is quite correct. This is something that is not a new phenomena and it has been a practice that has carried on since our passage of the parallel act in Manitoba to the Canada Health Act federally. Ever since the '84 passage of that act, tray fees have from time to time been charged to the individual; and, to put it bluntly, because it has not been objected to in a strenuous way, we have not moved to intervene on that process between the physician and the patient.

Mr. Cheema: Mr. Acting Deputy Chairperson, I think that is unfair, because somebody has to pay in a doctor's office a fee, and the same person, if he would go to a hospital, does not have to pay anything. In a way, it is costing more to the government and no cost to the professionals or to the patient. I think it should be looked at from a point of view to make sure that the patients are treated fairly both in the hospital as well as in doctors' offices, and that issue I think needs some clarification on whether the government is going to make sure that this fault which has existed for some time will be corrected.

Mr. Orchard: Mr. Acting Deputy Chairperson, I accept my honourable friend's concern and will undertake some discussions within the ministry, but I cannot give my honourable friend tonight or even in the near future a commitment of any action that we might undertake, but I recognize what my honourable friend is saying in terms of the potential of this issue.

* (2025)

Mr. Cheema: Mr. Acting Deputy Chairperson, can the minister tell us, have they received a large number of complaints from the patients over this issue?

Mr. Orchard: No, we have not received a large number of complaints. I have maybe received a couple, three letters in the last couple of years.

Mr. Cheema: Mr. Acting Deputy Chairperson, can the minister tell us through his staff, have they received any complaints in terms of extra billing in our province that any patient or any physician has been charging, for example, a standby fee?

Mr. Orchard: Mr. Acting Deputy Chairperson, this issue came up a couple, three years ago, or maybe two years ago, and I thought it was resolved, and I guess it is.

I am informed that the standby charge that some psychiatrists have asked does not contravene the Canada Health Act because there is no charge for standby as a schedule of reimbursed fees, and it does not contravene the act because it is telephone advice that is being, in essence, charged for a low–I mean, it is a standby fee for telephone advice, basically. So it was left as a patient provider issue, because it did not contravene the Canada Health Act, apparently.

Mr. Cheema: Mr. Acting Deputy Chairperson, I just want to clarify. I think there was an issue that was about two and a half years ago. After that, if there have not been any complaints, then it has not been a major issue and that seems to be okay with me.

Can the minister tell us about the other issue in terms of the facility fee now? We have five clinics, and I must say five of them–I think four started back in 1985, '86 and '87 and now the fifth, the Western Surgery Centre, which has also started some of the procedures. For example, they are doing some outpatient orthoscopic or some knee surgery, even though they are getting patients from the Workers Compensation Board or a third-party liability. The question remains that those facilities are still charging a so-called facility fee, and that even does not legally contravene the Canada Health Act. Those facilities are all approved by the College of Physicians and Surgeons for the purpose of serving a specific kind of procedures. I have no difficulty with that point of view, but we still have a problem in terms of some of the patients who can pay a facility fee, for example, $800 or $900 for cataract surgery, and somebody who has to wait for 18 months because they do not have $800 to $900.

I wanted to know what the minister is doing and/or the department is doing setting up remote outpatient surgical procedures where the patients can go and have those surgical procedures done, so that they do not have to pay or wait or at least not feel that we have a two-tier system. I think it is unfair for someone to wait for 18 months and the other person next door can go within six weeks or three weeks and get his surgical procedure done.

Mr. Orchard: I agree with my honourable friend in terms of the apparent fairness issue because that is a serious issue. That is why this whole waiting list and numbers on the waiting list issue is being investigated very diligently right now with Dr. David Naylor out of Toronto chairing a committee composed of the vice-presidents of medicine at St. B., Health Sciences Centre and Victoria Hospital, Dennis Roch and Ken Clarke out of the ministry staff.

* (2030)

Here is the issue. If I can be so blunt, the issue of waiting lists and waiting times is often a lever used in the system to garner more money to do more things, and it gets all into this whole issue of: Are we doing the right things? Just because we have established a demand that we should be doing more procedures as judged by the professionals doing the procedures, the question is, do we need to do more procedures? The variation in surgical rates as you go region by region of the province and/or the country are demonstrating that the waiting list or the demand for the procedure may not always be outcome-driven for the patient's improvement of health.

I will tell you how we have been handling the system to a degree within our office. When we have received phone calls–because from time to time some physicians who put a patient on a waiting list which may have a slated time for elective surgery six months, 12 months, or even 18 months down the road, in some cases such as hip replacements, the physician, the provider says, to the patient when they ask why so long, phone the Minister of Health, the government is not giving us enough money. When we have had those phone calls, we have made the very direct suggestion: Have you considered referral to another specialist? There is a great diversity in the number of procedures performed by given specialists throughout the system. Some of the busiest ones will have the longest waiting lists, and maybe other practitioners can provide a little quicker service.

That does not take away the overall constraints on the system of surgical time in other hospitals and other areas of the same hospital, but if we fall victim to the pressure of the waiting list and the length of the waiting list as the only indicator that our service is deteriorating, that has not analyzed a number of things, including the appropriateness of choice of individuals for a procedure which we have left up to the discretion, we have never asked for a second opinion of practitioners.

Secondly, the waiting list itself when it is developed by 10, 15 or 20 different specialists for a similar procedure or the same procedure, we have found that we are at a real quandary and that we have not had an ability to analyze the waiting list globally to assure that the right patient is being prioritized for the first service. Example, someone who has a waiting list of 30 people versus someone who has a waiting list of 60 people, the person with the shorter waiting list might have someone with less urgent requirements advance simply because he has fewer patients to put through his allocation of surgical time. That is one of the areas that Dr. Naylor and the vice-presidents of medicine are attempting to develop criteria around.

I do not understand the necessity or the timing of, for instance, cataract surgery because that one often comes up. I have had some discussions with professionals which indicate that there is a less than optimum time to perform the surgery and a more optimum time. Sometimes, patients will not accept a waiting period of time for the disease maturity. I do not know whether that is right or wrong, but I have to trust the information that I have received unless I misunderstood what was being said. Again, sometimes the pressure for the cataract surgery is pushed by the patient without necessarily having all of the information on when and how the procedure ought to be undertaken. So there is a whole dynamic in this argument.

In the majority, though, the private surgical clinics–Western, for instance, I think it had its start up in terms of a free-standing surgical clinic for plastic surgery, because back seven or eight years ago a number of plastic surgery procedures were removed from the insured services list. They were deinsured, and that led to that clinic, for instance, being established to provide the noninsured service where it was entirely paid for either by the individual or private insurance.

The same is not exactly true for the cataract surgical centre that was, for instance, in Brandon where we pay the physician fee, the surgeon fee, but we do not pay for lens or facility fee which leads to that approximate cost of $1,000 per eye.

Mr. Cheema: Mr. Acting Deputy Chairperson, the minister has touched on many issues within his answer. The first issue that he has raised deals with

the waiting list and with various procedures. One report was the Fraser Institute report from Vancouver, and that report was not very scientific, but those things come from time to time. The professionals do have a waiting list, and it depends upon where they are practising, or whether they have enough OR room available, or whether they are more in demand than the others.

There are so many aspects of a waiting list, but something has to be done, because the government is paying those bills. There should be some co-ordination, probably a central registry place where the waiting list can be rechanneled to make sure that people do not have to wait extra when the others are available or the other hospitals can do those procedures, especially when the patients are coming out of the Winnipeg area. Certainly that can be improved.

The other issue, the minister has said, well, the waiting list is not the true indicator for health care services, and that may or may not be true, but the issue here comes, as I have asked the minister many times, when you do not have protocols, when the patient has to be referred, at least there should be some guidelines. There are special circumstances when the rules can be changed, but most of all there have to be protocols. That patient has to be seen; the patient has to be referred; the patient has to undergo surgical procedures. I think that would eliminate a lot of problems, because, as I said the other day, it does not matter how many medical review committees you have, there are always answers to those questions, as long as the health care providers can justify, and most of the time they can. So I think there has to be a mechanism where the protocols are being followed because the taxpayers are paying the bills. Each and every government is talking about the issue.

I sincerely hope the government will come up with some kind of policy in the reform package to deal with this very, very serious problem, and not only for the patients but also for the health care providers. They also have to feel comfortable that they are protected, because when they have a protocol, then they do not have to do something that a patient will demand, or the treatment is guided by the very high technology, or some of the results that may or may not have a high outcome value.

I think one example is the CT scanner issue. The second is the mammography issue. I think those are the two very prime examples then of how things can be changed. So certainly we hope that the minister will come up with some policy or some statement in terms of dealing with this very major issue.

* (2040)

If you look at the books, how much–$297,941,000–is paid for the medical insured services, that is a lot of money–no question about it, 2,000 practising physicians. Certainly they are also a major employer. They employ a lot of people, and that issue has to be taken into account.

The way that things are happening now, either we will have a system or we will not have a system within a few years, unless you have some kinds of checks and balances put in place. The fee system, which was set up in 1966 and later on affirmed in 1984, was never meant to be the way it is right now. It was meant to serve in a way, with the ability of taxpayers to pay the system.

But, at that time, they did not take into account the various other factors, such as the technology, the population, the high patient demands, and this view or this phenomenon that the medicare system is free, and that is certainly not the case. I think so many things have contributed over a 26-year period to much of the proliferation of the health care services. In a system which was supposed to serve the patient, I think it has lost touch to some extent; from the patient, it has gone in the other direction. That is why we are having such a serious difficulty.

So I would like the minister to tell us if we are going to see some major changes in his health care reform as regards the fee for services and also the setting of protocols and having some say from the taxpayers' point of view.

Mr. Orchard: Mr. Acting Deputy Chairperson, the issue of fee schedule reform has been on the agenda for some time. That very much starts to get at some of the challenges in the way we dispense a very significant portion of that $297 million in the medical line.

I had the opportunity to be–I do not know; what did they call it?–the guest lecturer on Friday at the–it was good, it was a good session.

Basically, the issue is around bioethics and the ethics of health care expenditure because there is a lot of discussion across Canada right now as to how we develop our funding and our policies to preserve medicare, and the issue of rationing comes up and deciding who receives treatment.

I used a fair bit of information and some overheads at the discussion, and I have to say to my honourable friend I was maybe a little more provocative in some of the information that I laid out than what has been possible in the past.

Generally, Ministers of Health have had to soft-pedal around these kinds of issues and probably would have carefully been busy elsewhere rather than going to present a one-hour lecture on the ethics of health care expenditures, but I think the opportunity is there to have the kind of discussion my honourable friend has been urging on me and on government in terms of how the system has to change and serve a blueprint for that change and a goal and vision for that change.

An interesting thing came out of it. I made the point in fee-for-service billings of physicians. Let me background the issue. The issue came to me as one that because the availability of finances is constraining our ability to carry on many things in the health care system, allegedly, if we cannot find more money, then we have got to consider rationing. Therefore, how do we get around the issue of rationing? How do we curtail certain services to certain people, if that is a bottom-line definition of rationing?

I presented some other challenging thoughts in terms of how we currently spend. One of the things that I pointed out was that right now we have physician billings on fee-for-service, and we do not keep track of anyone who bills less than $40,000 a year. The range in that billing goes from the $40,000 at the bottom end of the range–there are some that bill less, but we do not keep as close a tab on that–and it ranged up in the last full year to $998,000 of fee-for-service billing by one physician. The billings for the one physician leads to two analyses which I shared with the group on Friday.

First of all, that ability to generate $998,000 annually of billings has been enabled through a vastly changed technology in the procedure offered by that specialist. The fee schedule was set at a time when there was very, very difficult-to-use technology, the skill requirement was considerable, and the time commitment was quite considerable. The fee schedule reflected that commitment of knowledge and time and expertise.

With changing technology, fibre optics being, I guess, the main driving factor, that procedure is turned into a very, in relative terms, quick one, but the fee schedules remains the same so that the individual can do significantly more of these procedures on an annual basis at the same rate as reflected by old technology.

I put the challenge out. I said, before we even talk about rationing, should we not be coming around that? Let us even say that the income was reduced to a half-million dollars per year, I mean, the Canadian industrial wage for the same year was $26,000 across Canada, Manitoba slightly below that. To say that we are going to bring in a mechanism which may restrict this physician's opportunity to bill to a half-million dollars annually makes a lot of people out there, slugging very hard to make a living, shake their heads and say, what the hell is going on basically?

I do not want to get into an alarmists' debate on this, but before we are driven by the system to consider curtailment of service or rationing of service or whatever, I suggest that is an issue that Manitobans would insist we come around.

The other corollary of the system is that in one procedure that is a fairly common procedure now in medicine, the Manitoba fee schedule pays something over $2,300 for that procedure, whereas in Ontario, the same procedure, the specialist bills for slightly over $1,200. That does not make sense in relative terms, and at the same time I am told that a similar skill-required procedure as one surgical specialist can bill $2,300 in Manitoba for, a similar skill time requirement procedure of another internal specialist in surgery would only bill something in the neighborhood of $800. There are disparities in the fee schedule, and we have been trying to get fee schedule reform, which is a difficult process to come around, because the MMA over the last number of years has been solely responsible for the allocation of their portion of that $297 million, and in doing so, without question, have created disparities within the fee schedule.

The normal reaction in the past has been, let us solve it by putting more money in. Well, we cannot solve it by putting more money in today. We want to solve it by using the existing budget in a more appropriate fashion through a reformed fee schedule. After bringing that issue up, I am pleased to say that the new president of the MMA indicated to the meeting that he wished to pursue a fast-tracking of our fee schedule reform now that we have a consultant on board. I simply say that we intend to pursue that and see how quickly we can

come around fee schedule reform, because it has a significant impact on what we do.

Waiting lists, yes, the process in place that is structured and has not begun to operate in terms of trying to come to grips with the waiting lists in a number of key areas of service delivery.

* (2050)

The report from the Fraser forum in February told an interesting story. If you read that thing, or if you read the media coverage of it you would think Manitoba was a basket case. That is not so. First of all, only five provinces reported, and this report was developed by surveying physicians. Physicians in five provinces and two territories obviously did not respond. Within the provinces that there was some response it was by no means all of the physicians. In Manitoba a total number of 69 physicians responded in 10 areas. We probably have 700 physicians in there so there might have been a 10 percent response rate at best.

Then, on some very key services like coronary artery bypass, when you analyze the waiting list time, British Columbia reported 12.3 weeks, Manitoba 11 weeks, New Brunswick 10 weeks, Newfoundland 52 weeks, and Nova Scotia 26 weeks. We are within one week of the lowest in Canada but yet that was not the impression we got in terms of the presentation of that. In terms of other open-heart surgery, B.C. was 16.5 weeks on average, we were 8, New Brunswick was 10, Newfoundland 33, and Nova Scotia 26 again. We were the lowest, but that did not get reflected.

What did get reflected was primarily, if I can find it, the waiting list on hip surgery–because arthroplasty is hip surgery, is it not?–and there we were behind all of the other provinces in that we had a 41.9 week waiting time whereas B.C. identified 27.3, New Brunswick 16.5, Newfoundland 19.3 and Nova Scotia 20. Yes, we are significantly different from the other ones, but that is a worst case scenario. Others certainly do not indicate that kind of difficulty.

In terms of trying to come to grips with changing the way the system spends $1.8 billion, yes, we are going to look at fee schedule reform; yes, we are going to try to establish provincially, where we can, protocols for access of service. Where we can deal with the protocols for access of service, we are going to try to engage national standards so there is some consistency across Canada.

I presented this protocol argument on Friday, and protocols, I think, I have to tell you that my sense right off the top right now is that a number–or quite often physicians will consider the protocol initiative as being an infringement on their right to practise. I think that is a fairly general analysis of why protocols have not necessarily been generally developed.

I presented the counterargument on Friday and the counterargument is this: the American system has incredible fee schedules and those incredible fee schedules, they far outstrip our fee schedules for surgical procedures. They will be double, triple, quadruple, sometimes five and six times what we pay in anywhere in Canada. That has left the United States being quite a magnet for some of our very best practitioners and I do not suspect we will ever be able to stand up to prevent that from happening.

What is not told is the fact that the malpractice insurance is so incredibly high down there, their fee schedule has to be a multiple of ours. Some obstetricians delivering babies in the States have minimum $100,000 annual malpractice. Ours is in the neighbourhood of $10,000, which is amongst the highest in Canada.

I have said that I do not want to get into the U.S.-driven system whereby practitioners practise defensive medicine. They go through every known and available test that they can, so that they cannot then be, if something is not found or the patient unfortunately dies, that someone cannot sue that practitioner for not having done every last possible, conceivable, identifiable test to cover not necessarily disease identification or patient concerns but to cover themselves from malpractice.

I can see the protocols if we can get our minds around them provincially and then nationally as being–how do I put it so that it is understandable?–a method of preventing litigation. Like, if you have followed the protocol that is set provincially or nationally, saying that these are the appropriate investigations one ought to undertake and you have done that, then you do not have to practise defensive medicine which means the CAT scan, the MRI and blood tests and I mean on and on, and you will not have some underemployed and overzealous lawyer suing you.

You know, the development of protocol, as my honourable friend has mentioned this time and on a number of occasions–and I agree with him and we are trying to move in that direction–I think if we can

get beyond sort of the preconception that protocols are meant to curtail one's opportunity to practise, but rather to put some sense around what is an appropriate level of care to avoid litigation, I think that puts a different light on protocols.

We are moving in that direction in terms of the reform, and I cannot overestimate and I know my honourable friend knows this, but the analysis done on a number of processes and procedures and policies in government, and their outcomes, as analyzed by the Centre for Health Policy and Evaluation guides us in providing protocols, if you will. Protocols is not the right word to use for some of their analysis outcome. It is in some cases but not always. But it provides us with better guidelines to formulate policy around because it is a knowledgeable analysis of what we do and what the outcomes are.

The reform of the system is envisioned to be very wide-ranging, not narrowed to merely the issue of how many beds do we have, but rather what we do to provide maintenance of health, and in the case where health is unable to be maintained, what sort of appropriate interventions can we focus the system to deliver to hopefully bring an outcome of increased health or life or mobility or any number of quality of life issues that can be identified in the analysis of providing medical services to cure illness or treat disease.

We are not going to take and deal narrowly with the system as a physician issue, as a nursing issue, as an institutional issue, as a community issue. We are going to bring the system under one umbrella for an understanding of how it interrelates and how you can make shifts within the system without compromising the patient care and, at the same time, develop several other tracts in terms of analyzing where there can be crossover of professional disciplines, for instance, where fee schedule reform fits, where distribution of physicians fits. I mean, there is a whole complexity of issues there that are all part of ongoing process and discussion centred around the general theme of reform of the health care system.

Mr. Cheema: The minister has described his protocol and guidelines, I think, in the most suitable fashion. I think that is the message the professionals have to get is that the protocols and guidelines are not only to protect taxpayers but to also protect them.

I think that will help the province and also the Manitoba Medical Association to come to grips with the problem. The problem is the system is guided by a fear of malpractice suits, and we are seeing within five to eight years time the health insurance for the practitioner has gone up by more than 180 percent in some cases, and that is just a tip of the iceberg as compared to the United States. Still, if we do not make sure that we are protecting our system in terms of the–when I talk about the system, the health care providers are a part of the system, and the patient, then I think we can achieve a goal because that is the kind of view they have that the protocol is to tell me what to do.

When I have gone through so much education, I know what to do. I think that issue has to be taken. It is not a question of what they know. It is the question of what are the normal guidelines and what is possible based on the scientific analysis on a major population base and on our geographical basis and our location and everything else has to be considered.

* (2100)

That is why if we have guidelines, and if those guidelines can be changed accordingly, I think the process is going to evolve that way, that something which is going to be put in place now, it will require some changes on a year-to-year basis or just some of the changing needs of the society. I think naming guidelines and protocol is the same, so that it seems probably so intrusive, if I may say that. I think it is their ability to practise medicine or somebody who is, for example, the Associate Deputy Minister of Health is being told, these are your protocols, we are going to make sure that we are going to monitor every week. That cannot function. I think there have to be some guidelines which will be very, very helpful to safeguard the patients, health care providers and, above all, the taxpayers who are paying the bills. I think that is very positive.

The other statement the minister has made, I have said for four years now that the system cannot function in a piecemeal approach. Each and every part of the system has to function in a way so that other parts of the body know what the first half is doing, the head knows what the toes are doing. It has to function in a very, very co-ordinated fashion.

That had been missing for a long, long time, and the Ministers of Health have taken four years as a period of getting it good publicity, raising their

profiles, but not really meeting the needs of the patients and the taxpayers. I think that had been lacking in the past, and I think that was very unfortunate because if the decision was made in 1985, '86, we would not be having problems now. The decision we are sure going to make it now as a team probably–not probably, I should say they will help, no question–in 1993 or '94, whoever comes to take care of the ministry. I think that kind of approach has been lacking for a long time.

(Mr. Marcel Laurendeau, Deputy Chairperson, in the Chair)

I think those three issues from our point of view are very essential to discuss in a very open fashion to see how it could be done in a different fashion. The government should put to the organization, how would you do it in a different fashion if you had to make a decision? How are you going to spend this $1.8 billion? If you are sitting around the same table in a very active role and you still have the same patient and the same amount of money, how would you divide it? I think that kind of issue has to be discussed very openly, and we are going to challenge each and every health care professional group to tell us how they will do it in a different way and whether they will consider the ability of taxpayers to pay. If they are not going to consider that, then I think we are missing the point here.

I think it is so essential that those issues are discussed, and we are going to judge the health care reform from that point of view. The minister knows that anything which is going to be done has to be based on five or six of those major principles which we stated when I had my opening statement. Those were the basic principles: the ability of taxpayers to pay, what is a necessity, what is not a necessity, the changing needs of technology and, above all, making sure the patient is the focus of attention, not a specific interest group as had been the case in the past.

One other issue I want to ask the minister was the health fee schedule form, one issue the general practitioners have been raising with me personally. They have been asking why in the major part of their practice–and the staff is here, they are very knowledgeable in that area. The general practitioners do provide more than 80 percent of the care. They have been lagging behind all of the specialties across this nation and in this province specifically.

If a patient goes to their office, whether they can see the patient for a partial exam or they can see them for complete physicals, in between the more than one area if they are examining, they cannot bill more than $85.09; that is partial exam billing. If they bill $85.40, which is a complete physical, then the Medical Review Committee will come and ask them why they are overbilling. It is not overbilling, because they do not know which way to go. Either they can bill partial examination, which is original examination, or they can bill the complete physical.

I think that has caused a lot of confusion and they know, with the publicity which we have had recently with the medical group, more and more physicians have called me and asked me to ask the minister. They feel that they have lacked the input in the fee negotiation for the last few years, in some cases, and they have not been able to present their case very well.

I would ask the minister through his staff to make sure that when the system is being reformed, they should also look at some of the major technical problems which do exist, and when the Medical Review Committee looks at the whole billing practices of a given physician, that is causing a major problem in terms of general practitioners. I am sure Mr. Harvey is well aware of that issue.

Mr. Orchard: I do not understand that Issue, but I take my honourable friend's suggestion seriously and I will take that up with staff.

Let me deal with the issue of the system-wide reform, Mr. Deputy Chairperson, because, as I have said to my honourable friend, I look forward to listening to the response, listening to the criticism, but I have also offered some caution to some of the groups that I have met with that if there is criticism and there is significant disagreement with the process that they publicly state, my first question is going to be: You do not like this, how do you suggest we improve the process?

I have been very, very blunt and very direct, that I am not going to stand idly by and listen to complaints which are driven by other than patient concerns. If this is turf protection, if this is job protection, if this is prestige protection, or any number of the dynamics that can be part of the system, and that is what is driving criticism of the reform process; I put people on notice that they are going to be asked to come up with an alternative that will work better and, bearing in mind one of my

honourable friend's considerations in terms of reforming the system, that being the taxpayer's ability to pay. If the criticism comes up as to how we approach reform and the alternate suggestion on how we proceed means pouring more money at it, that is a nonstarter. That is just a nonstarter, and I have said that very clearly.

I do not say it to intimidate or to quash debate. That is impossible to do in a major system-wide change, but I do itto make sure thatthere is the open opportunity for an honest second opinion and difference of opinion. We have done that before as my honourable friend well knows when I have had proposals that I have put before the Legislature and he has found fault with some of them. Where that fault is legitimate and remediable, we have done it, and I intend to approach this reform of the system in the same fashion.

We do not have all of the answers, but I do not expect–like, it is a delicate balance. If groups want to be genuinely involved in the reform process, then they have to genuinely be committed to change which may impact them negatively but benefits the patient, because we all have to a common denominator in this and that is the individual needing care in the province of Manitoba.

* (2110)

I want to close though by broaching a couple of things. In terms of the medical liability insurance, we are sort of at a nonstarter stage with the Pritchard report, and I think Sherry Wiebe in your caucus was a member of the committee that developed the Pritchard report. I do not understand all of the stumbling blocks to that report, and we are implementing some of its recommendations, but it seemed to me that it had a pursuable goal–I will put it to you that way–that maybe offers some of this check and balance against going the American way of litigation and enormous malpractice suits.

Not tonight, because I do not want that to take up the time tonight on that, but if my honourable friend had advice on that and where we should go, I would be interested in hearing that at a later date.

Two other points that I want to make. My honourable friend commented that any changes we make to the situation around the reform process are going to be beneficial two, four and five years from now. My honourable friend is right, and I often harken back to discussions I would have with Mr. Desjardins. When he was Minister of Health, he said, some of the things we are doing or wanting to do will make your job easier in government. I have to say, in retrospect, I now fully appreciate that, because when the no-deficit policy, for instance, came in and there were a number of bed closures in '86 or '87, Mr. Desjardins pointed out to me that we would probably benefit from those–and he is right–from both of those policies.

I simply say that my honourable friend's open approach on the debate of health care and where the system is going has made my job considerably easier, because I want to tell my honourable friend I would not have been able to go to the Faculty of Medicine and be the guest lecturer at noon on Friday on the ethics of health care expenditure and throw the kind of challenges out if I would have been facing an opposition critic who was going to take every one of those all or completely out of context and come to the House and talk about, well, the government is going to do this, that and the other thing.

I think from the feedback we have got in terms of the presentation I made on Friday, I think there have been an interesting challenge of thought process that has emanated from that. I think that is nothing but healthy for the change in the system where I have the ability to stand and, without fear of extreme political retribution, lay some honest questions on the line as to what has to be considered by people in the health care system.

So the reform process we hope is comprehensive; we hope it identifies a lot of the challenges and a lot of the goals and a lot of the methods of achieving solutions; and that it enjoys a pretty wide and complete opportunity for debate by Manitobans as well as care providers.

Mr. Cheema: We have talked about professionals, their accountability. How about patient's accountability? Are we going to monitor patients, also see whether patients should be seeing four doctors, five doctors, three doctors, two doctors, one doctor? I think we have to have some kind of policy, from the government's point of view, whether the patient has to be notified in terms of how they are going to use some of the services.

Mr. Orchard: My honourable friend might recall a little bit of a kafluffle we got into with the MMA back about a year and a half ago, because apparently going back maybe even four years ago or five years ago, there were discussions to try and establish a PURC committee, they called it, Patient Utilization

Review Committee. I know during the last negotiation, there was some correspondence that emanated from my predecessor, I think, on the patient review committee, a suggestion back and forth to undertake establishment of this committee.

I am informed that current discussions with the MMA and with the ministry are leading to the formation of that committee and a commencement of its review of multiple doctoring by individual patients. I think my honourable friend recognizes the necessity and so does the MMA, and so we are moving towards the establishment of that Patient Utilization Review Committee. Hopefully we will have maybe some suggested methods of dealing with the issue after discussion with the MMA.

Mr. Cheema: Mr. Deputy Chairperson, one very sensitive question, to which certainly the minister can say yes or no or maybe: Are we considering in terms of capping some of the insured services, for example, how much a health care provider in a given speciality can charge to the taxpayers?

I mean, that is a question which has come up in other provinces and which is under consideration in many areas, and I think that issue needs some clarification and some discussion. I think the issue is a very important one. I mean, the issue is, what is the value of your profession and how much in a fee-for system your value can be paid by taxpayers? I think that is the issue, and I would like some comments from the minister.

Mr. Orchard: Mr. Deputy Chairperson, let me deal with one other piece of information on the Patient Utilization Review Committee. We are also going to have representation on that committee from the Manitoba Pharmaceutical Association.

I have to indicate to you that the pharmacists, the professional association, in meeting with me for several years now, have pointed out some pretty interesting cases of multiple doctoring in terms of acquisition of prescriptions. They are very concerned about trying to bring methods of check and balance in place because they consider it to be a very abusive practice which is completely outside of providing needed medical services.

In terms of capping, Ontario proposed to put an upper-limit cap on specialist incomes–well, all incomes, the general practitioners at one level and specialists at another. I think a number of other provinces have proposed similar undertakings.

Today, like right now, we are not giving that consideration. I am going to be quick to say that who knows but what two and three years down the road we may not have to consider it. We are not considering it right now because I think there is far more value to working co-operatively with the MMA in trying to come to grips with some of these issues.

One of the ways that I think there may well be an opportunity–well, I definitely think there will be an opportunity–is in terms of free schedule reform, the example I gave earlier, where technology had changed the procedure to such an extent that quite significant billings were now possible.

The MMA is not, I do not think, happy about that circumstance either. I mean, that can be used in a very negative way, reflecting on their association and the way that the fee schedule is developed over the years. I sense genuine concern to try and resolve the issue with the MMA, and certainly we have our consultants set to do fee schedule reform. I think that we will end up with some reasoned approach other than simply an outright cap on total income by a given specialist or general practitioner.

One of the things that you may incur, and again, I only share this because it was part of the rumour mill around Ontario's establishment of caps. Now this is only rumour, so I do not know whether it actually happened, but apparently some of the specialists closed their offices and went on holidays for a month or a month and a half. That is what we were told. Whether that actually happened or not, or whether that was merely posturing publicly to try and make government recant on their decision, I do not know, but it does present a bit of a dilemma.

If you have a fee schedule which allows a pretty significant generation of income, is the method of dealing with the growth of that income in capping it so that you cap the number of procedures, or is it in fee schedule reform where maybe, if it is too generous a fee schedule, you do not deny patients services by putting a cap on, but you readjust the fee schedule to make a more reasonable income possible? I prefer the latter. I think it will work without the opportunity to have government accused of denying practice capability which would deny patients service.

* (2120)

Mr. John Plohman (Dauphin): Mr. Deputy Chairperson, I wanted to ask the minister if he could tell me exactly what month of the year in 1990, I

believe it is according to the report, that the CT Scanning Committee was established.

Mr. Orchard: What is the question again?

Mr. Plohman: What month in what year did the minister establish the CT Scanning Committee?

Mr. Orchard: Mr. Deputy Chairperson, I would only presume that there were some preliminary discussions with Dr. MacEwan, our radiology consultant, but given the issue of requests for installation of CT scanners had come in in a fairly regular basis, we asked in February of '91, Dr. MacEwan to visit each facility to review requirements, et cetera, and receive input regarding a policy approach government should consider. So that looks–February '91.

Mr. Plohman: Mr. Deputy Chairperson, the Dauphin Hospital had, as the minister knows, established a fund for the purchasing of a CT scanner, and they have committed about $600,000. I imagine the minister is familiar with that, or should be.

Can you tell us when the first approach was made for a CT scanner, with funds raised by the Dauphin Hospital and at the foundation, to the minister?

Mr. Orchard: Mr. Deputy Chairperson, we do not have Dauphin's circumstance here, but it could be any time after, oh–when did we approve Victoria? Was that late '88 or early '89?

Let me take my honourable friend back prior to May 1988. When I came into office in May of 1988, Victoria General Hospital had a CT scanner sitting in the basement. The administration of the day, that my honourable friend was part of, had indicated that they would not allow the operation of that scanner under any circumstances, and had refused operating costs, et cetera.

I landed in the middle of that issue as the new Minister of Health, and we took some seven or eight or nine months to come around the issue with many, many meetings with Victoria Hospital and with our radiology consultants, et cetera, et cetera. I have to tell my honourable friend that there was a lot of advice on both sides of the issue. The advice that the department was using was indicating that our current capacity at Brandon General Hospital, St. Boniface and Health Sciences Centre was sufficient to deal with the patient load. That was back in mid-1988.

Victoria Hospital made the case, as Dauphin is making, as Thompson is making, as Concordia, Seven Oaks, Misericordia and Grace are making, that they have patient demands which require CT scanning, and therefore, they need them within the facility. One of the areas that Victoria indicated to us is that they would operate a scanner on the basis of simply replacement of current costs of accessing scanners outside the building, and also, they forwent a new RF unit, I believe, in order to establish the CT scanner.

So we set up a number of criteria that we believed might be appropriate back in '89, and they were criteria by which we could guide the installation and operation of the scanner at Victoria Hospital. We agreed to a monitoring process of upwards of what?–two years we were going to analyze the operation at Victoria General Hospital, to find out if in fact the scanner, as installed, had operated according to their expectations in terms of budget costs as well as patient access, et cetera, et cetera. We then indicated to all of the facilities that we would not be making any further decisions on installation of CAT scans until we had a review from the Victoria Hospital, first part of '89.

So do you go into the first part of '91, which is about when we put Dr. MacEwan to survey all of the hospitals in terms of their need? We indicated that the only conditions under which we would approve facilities, I think that is a fair way to put it, would be under similar criteria to Victoria Hospital, but that was not just simply the fundraising and the ability to buy the capital tool would not guarantee anybody's operation of a CT scanner.

Subsequent to that we have eight organizations fundraising for CT scanners. As recently identified in the CT Scanning Report, we do not need eight additional CT scanners in the province of Manitoba. Current indications are that current capacity is sufficient if we reconfigured operating costs.

That has not met with universal approval or like, but the simple question that has to be answered by each of the facilities is: Where do they believe they will get the additional operating costs from within their global budget to operate a CT scanner? Because with few exceptions, and I say few exceptions because I know of none that have been demonstrated today, can they operate that scanner on the basis of access costs of patient transfer to other facilities where scanning is to be done. If they believe they have additional dollars within their

global budget that they can reallocate to the operation of a CT scanner, then obviously they cannot very well make an argument that their deficits are simply because of short funding of government. Do you see the argument I am coming to?

You cannot have it both ways, that you have surplus money within your budget to operate a scanner above what you currently have for patients going out, and then say but this deficit is because you did not give us enough money. It cannot be both ways.

Our discussions with the facilities are going to be very, very direct and very, very firm. We will see how they react in terms of their proposals to government, should they make any. We have a very definitive plan of action that we intend to undertake to assure the integrity of our imaging capability in Manitoba so that it does not get completely out of control.

My honourable friend is familiar with the figure that I have often used that over a period of 15 years, from '73 to '88 I believe are the numbers, we went from $16 million or, pardon me, $13 million?–$16 million to–well, it does not matter, it is a 450 percent increase any which way.

Experts like Dr. MacEwan and the Centre for Health Policy and Evaluation are concerned that this is an inappropriate use of a very scarce resource, and it has not contributed to health status improvement. It is a status symbol, yes, but whether it contributes with additional capacity to health status improvement is definitely not provable.

* (2130)

Mr. Plohman: The minister is saying really if there can be system savings overall that there could perhaps be additional scanners approved, but only if it saved dollars as opposed to cost additional dollars. Does he feel that reconfiguring the existing scanners is one possibility as well in terms of servicing adequately and efficiently existing patient loads?

Mr. Orchard: I am not sure I understand my honourable friend's suggestion about reconfiguring current scanners, but I will give him an opportunity to explain that later on. I am saying to my honourable friend that the case made by hospitals is that their patient load and their cost of scanning, all they have to do is bring those home and they can operate a scanner. That is not accurate. The cost of operating that scanner are significantly higher than the costs of replacement services outside the facility.

The next proposal that appears to be going to be made is that we can find the additional operating dollars from within our budget, and then the next breath is, but we have a deficit because you did not give us enough money.

What we are saying is that anyone who comes to us with a proposal that they can operate a scanner is going to receive quite rigorous examination of their proposal to assure the integrity of their budget. If they cannot prove that integrity of the budget, we will not be approving the installation of a CAT scanner.

Mr. Plohman: The chairman of the hospital board in Dauphin is saying that when the Dauphin Hospital first looked into buying a scanner, the government said that if the facility had the money to buy it, the government would pay to operate it. Was that said when this minister was minister, or was that something they are basing on previous commitment that was made by the previous government?

Mr. Orchard: I would think neither, because I would find it pretty strange that the previous government, even though the member for Dauphin (Mr. Plohman) was around the cabinet table, would have said to Dauphin, you buy a scanner, we will operate it, when Victoria General Hospital, when my honourable friend was in cabinet, said to Victoria Hospital when they had a scanner plugged in, we will not provide you with any money, and you cannot operate it. Certainly, I know of no communication with the Dauphin chairman of the board which would lead them to believe that if they bought the scanner, we would pay the operating costs.

Mr. Plohman: That is what they are saying. The Liberal critic is talking about pretty strong statements. It is his own supporter in Dauphin, as the chairman of the board, Mr. Sarin, who has said this in fact, has made the statement that the government did say that they would operate it. I just wanted to ask the minister whether in fact that is an accurate statement. The current chairman of the board was not the chairman of the board at the time the minister would have been discussing this, obviously. It may have been Bob Forbes who is no longer with the board, as the minister knows, I think a couple of years now, but was a long-time member of the board and chairman of the board.

So the funding was undertaken, nevertheless, with the idea that a scanner could be purchased and operated. I am wanting to determine from the minister what kind of a commitment he or his staff had given to the Dauphin board prior to their undertaking a major fundraising effort. We know that any funding that came from the foundation was committed after this government was in power because the foundation was established since 1988. It was a private members' bill by myself, so I realize, of course, that there was no funding undertaken through the foundation for a scanner prior to April 1988. So I wanted to see whether the minister had made any commitment with regard to operating that, given them any encouragement, anything at all in that regard.

Mr. Orchard: No, Mr. Deputy Chairperson, the only thing that my honourable friend might be able to refer back to his chairman is the Victoria installation, which then becomes an open invitation without any discussion or approval, to go out and fundraise, expecting that, well, we can get the government to approve the operation. But no commitment was made to any facility, including Dauphin, by this government to go out and fundraise with an expectation, as my honourable friend has quoted the chairman of the board as saying that–I believe his words, the member for Dauphin (Mr. Plohman) said that government told the chairman of the board that if you buy a scanner, we will provide the operating costs.

I do not know who would have said that to the new chairman. You might want to check and find out who indicated that to him because I would be interested in finding out. It was not myself, and I do not believe it would have been any member of the staff. If my honourable friend made that commitment to the Dauphin Hospital board prior to 1988, then he would have been in great conflict with his Minister of Health who was refusing that similar circumstance to Victoria General Hospital.

Mr. Plohman: Well, certainly the minister knows that commitment was not made prior to '88 because, at that time, the board was not in a position of actually pursuing this issue. They had pursued a number of other issues with the government on a number of building projects and changes to the existing building that were in the plans at that time, and the minister knows full well about those.

I do not think they would have also been encouraged by what happened at the Victoria Hospital either, because at the Victoria Hospital, they saw a CAT scanner that was not operational. So that would not have given them encouragement, as the minister says. It would have been the opposite. If anything, it would have stifled any enthusiasm they had for going ahead and purchasing a CAT scanner without knowing that they would be able to operate it subsequently. So I do not see any encouragement there.

I want to ask the minister, if he did not give any such undertaking, we will have to find out where this came from, but the chairman of the board is attributed to saying that in the latest edition of the Dauphin Herald, just last week's.

The minister could perhaps shed some light on the waiting period for residents now in facilities for CT scans. It has referenced Dr. Keith McIver of the Dauphin General, the chief of staff, as saying that there is a large waiting list in all facilities in excess of six weeks. I ask the minister if that is an accurate statement attributed to the Dauphin chief of staff, Dr. Keith McIver.

Mr. Orchard: I presume that–now I do not have specific information as I thought on Brandon, but Brandon has been very, very–in relative terms, has a much shorter waiting time than, say, HSC or St. Boniface. I think Dauphin uses the Brandon General Hospital for their referrals.

Emergency and urgent are immediate scheduling; there is no waiting for those. It is elective that do have some period of time for waiting. Now, with the McEwan report, currently there is a waiting list analysis and it is in progress.

* (2140)

I will give you what was found just as to, say, a couple of months prior to my announcement. Initially it was believed that there were 6,000 patients on the waiting list and many of them with serious illnesses. That was the allegation, and maybe this has something to do with the quote that my honourable friend is using. So, initially, they believed there were 6,000 patients on the waiting list.

On analysis, there were only 2,500 patients awaiting examinations so that the list immediately dropped from 6,000 to 2,500, and the delays were from three to eight weeks. On analysis, two-thirds of the patients had appointments requested by their physicians or at the patient's convenience. In other words, they set the date in which they would get their

scan. Only one-third of the patients were experiencing delay, and almost all of them on study would not benefit medically by an earlier examination. That is the finding of Dr. McEwan, the provincial radiology consultant on the issue. One-third of the 2,500, so roughly 800 of the patients were experiencing delay, and almost all of them on study would not benefit medically by an earlier examination.

Subsequent to this report and analysis, we have struck–the chairman is Dr. McClarty–a committee to go through and analyze on what basis the last statement was made. Bear in mind two-thirds, or 1,600 of the 2,500 roughly, were within that three- to eight-week waiting period because they had booked that time, so I think my honourable friend would understand the delay. The one-third who were experiencing delay–none of these would be urgent or emergent because those are access scanning very quickly, immediately for that matter–almost all of them on the study would not benefit medically by an earlier examination.

That issue is one of the issues that will be undertaken for a review by the new committee because it says almost all of them, not all of them, but almost all of them.

What we want to try and establish through Dr. McClarty's committee is how we determine who those excluded by the "almost all" can be identified and how their case can be advanced as opposed to others who would not be compromised by a three-, four- or five-week wait.

Mr. Plohman: The committee that the minister refers to has, I take it, not yet been established, the ongoing committee. If it has, that is another request or concern. Of course, they are asking to meet with the minister–that the Dauphin General Hospital has, and they would like to have representation on that committee.

Is the minister going to have rural representation that has not yet been established? If it has, who are his rural representatives? Will he be inviting the Dauphin community to put forward a name, or will he be choosing someone from the community on this committee, especially in light of the fact that this goes back to some time around the Victoria Hospital situation that the minister outlined and that fundraising has all but been completed for the purposes of purchasing a scanner.

Mr. Orchard: Mr. Deputy Chairperson, is my honourable friend saying that simply because a community raises funds for a purpose, government should fund that purpose in health care, because that seems to be the implication?

Mr. Plohman: It is a factor. I asked you another question as well.

Mr. Orchard: No, but I mean let us get–it is a factor. So in other words, that should influence how government spends and establishes new programs.

Mr. Plohman: I wish the minister–in the interest of dealing with these issues, if he wants to talk around circles, we can all do that. I asked him a very direct question of whether he has established the committee, whether he has rural representation and whether he is going to be inviting representative from the Dauphin community. That was the direct question.

I also gave some rationale in light of the fact that the community had begun this process when there were obviously very unclear guidelines established by this minister for expanding the use of CT scanners in the province. They had some understanding, whether the minister wants to admit it or not, that he may be considering funding the operation if they were able to raise the funding for purchase of the scanner. They may put forward a very good case that there could be net savings, as the minister outlined earlier, in terms of the transfer of these patients to other facilities to access the same services.

In terms of what the minister is saying, no, that is not a criteria for spending government money. What I asked the minister was whether it was his consideration that they would have a representative on the committee as they are requesting.

Mr. Orchard: Mr. Deputy Chairperson, I cannot answer whether Dauphin will, because we are asking MHO to provide for us a rural community hospital official to be on that committee. It may well be Dauphin; it may well be Morden-Winkler; it may well be Steinbach; it may well be Thompson. I cannot presuppose whom MHO might suggest.

The reason why I am quite interested in my honourable friend's position on whether simple fundraising in a community and the existence of funds raised in a community should be the reason why government then provides the operating costs, what his position is on that now that he is in opposition and representing a hospital which has

allegedly raised the money, is that I simply point out to my honourable friend that, when in government, my honourable friend did not believe that was an appropriate process. As a matter of fact, he was a member of a government that in a circumstance very similar to that–mind you it was not in his own home constituency, but in a constituency of another MLA or another part of the province–when they raised the funds, the government he was part of said: we will not provide, under any circumstances, the operating costs.

My honourable friend now seems to be saying, well, maybe it should be considered. I find this quite interesting because this is yet another change in New Democratic approach and policy from government where they say one thing, and then when they get in opposition, they say another thing, particularly if it happens to be in their backyard.

Mr. Plohman: The minister knows better than that. He should realize that there was a rather–well, could be that he wants to take the position that the opposition can have it both ways, but in reality there was a major expansion in the number of CT scanners over the latter part of the '80s. So because of that, it was time to take a look at what criteria was being used, and where this should all stop because it is expensive. That is perhaps one of the criteria that the minister at that time was looking at, to establish some guidelines before moving forward with Victoria just as the minister had to do once he assumed that office as he outlined to us a few moments ago.

I want to ask the minister if he has information as to the precise annual operating costs of a CT scanner, which is really what we are talking about here?

Mr. Orchard: The investigation by Dr. MacEwan would indicate annualized operating costs of $800,000 to $1 million a year.

Mr. Plohman: Yes, the report, executive summary, seems to indicate an operating cost of $1 million each. I wonder why they use that term if the minister says there is a range there. It is a significant difference.

The cost that was referred to in the Dauphin area was $300,000. Is that by no means accurate or even close to accurate? Can it be significantly less that $800,000?

* (2150)

Mr. Orchard: Mr. Deputy Chairperson, my honourable friend just chastised me because I gave a range of $800,000 to $1 million when the report says $1 million. I do not believe that $300,000 is an achievable operating cost for a CAT scan. I believe that because that is what those expert in analyzing the costs of CT scanning operation have indicated is an impossible operating cost on the annualized basis to achieve.

Mr. Plohman: Yes, Mr. Deputy Chairperson, the minister's report from the CT Scanning Committee also talks about six scanners per million population as the Canadian average. Does he feel that there is anything unique about Manitoba that would indicate that perhaps the Canadian average is not necessarily the relevant figure in Manitoba at this particular time, or is not necessarily pertinent information for us to be using? It sounds good, but of course, is the minister considering in that, that that is the limit? Is he looking at geographics, demographics and population density and so on and those kinds of criteria in determining limitations for this kind of service?

Mr. Orchard: Mr. Deputy Chairperson, as my honourable friend knows from the chart that is in the consultant's report, six puts us roughly at a Canadian average, seven would put us slightly above, and certainly, acceding to all the other requests would put us at approximately double the Canadian capacity.

That would be inappropriate by anyone's analysis, even in their wildest dreams of demand would not think it reasonable to dedicate the resource that 14 CT scanners would put upon the system serving a population of one million.

The distribution of those scanners: you must recall that from opposition we urged and the government of the day acceded to the placement of one of those scanners in Brandon to serve the Westman region inclusive of Dauphin. Indications are that that scanner has the capability of undertaking that service of the community.

You have to appreciate that requests out of northern Manitoba are made on the basis of inconvenience; however, there is a rather sophisticated medical transportation opportunity to access scanners in the city of Winnipeg from northern Manitoba locations that was not available to the Westman region.

When my honourable friend made reference earlier on to the distribution of the scanners, I was wondering what he meant by that. I would be interested in getting his thoughts and his suggestions on that because we are always guided by good advice from opposition members.

The current distribution is two in each of the teaching hospitals and one at Victoria and one at Brandon General Hospital. It would be an inappropriate and wasteful use of resource if we were to accede to all of the requests that are now before us for CT scanners, all of them persuasively presented to government that they have raised the capital costs, all of them making persuasive arguments in terms of convenience of patient care, et cetera.

When we discussed this issue with another one of my honourable friend's colleagues about three weeks ago, he made the argument that it was quite traumatic that patients be transferred from Concordia Hospital to St. Boniface Hospital. I made the case that it could be equally traumatic for those residents of my constituency, for instance, to be transported from a Swan Lake, a Carman or a Morden or Winkler Hospital to Winnipeg for that same scanning procedure. So, therefore, ought we to put a CT scanner in those four hospitals as well? Well, he was quick to indicate, no, that would not be appropriate.

So it is always a decision as to where it is appropriate to have them, but there are minimum requirements of service and protocols for access to that service which guide both the numbers and the location. Right now, the group who studied the MacEwan report presented a report to us with the recommendation, and if my honourable friend has it in front of him, that the available funds contemplated for an additional CT scanner and space should be used for patient needs at the present sites and that no money be allocated for acquisition or operation of additional scanners at this time, and that an ongoing committee be established to deal with the issue of CT scanning and MRI.

Mr. Plohman: I recognize that those are the recommendations, and of course, the minister is not–and I am not even asking him to outline where that committee might say would be the best location and distribution of these services in the future.

I would take it from that establishment of that committee, though, the minister is not ruling out going slightly above the Canadian average insofar as the number of CT scanners available to Manitobans.

Mr. Orchard: Mr. Deputy Chairperson, the original deliberation of the CT Scanning Committee was to give a recommendation as to whether we ought to consider the installation of one additional scanner. They gave us the best possible guidance that they could as to where that scanner could be located. Their recommendations were as I just read.

Mr. Plohman: So that is precisely what Dauphin was waiting for in terms of the scanner. They were hoping that the recommendation would be, obviously, that would be located in Dauphin and they could proceed. They were told not to proceed, and there would be no funds to operate with in the meantime. They waited a good year or more for that report and, of course, now it says continue to wait.

I am asking the minister whether the establishment of that additional committee, that ongoing committee, will serve as a decision-making body, a recommendation body, for the minister for additional scanners in the future?

Mr. Orchard: That committee may well, in terms of establishing a protocol, reinforce the decision that our current scanning capacity is sufficient for a population of one million.

Mr. Plohman: The minister has mentioned that there was a scanner established in Brandon by the previous government, and certainly for serving the western region, that was a good start. It was not determined at that time that that would be the be-all and end-all of CT scanners in the western rural area of the province, it was simply the most needy at that time in terms of population. So, when the minister mentions Brandon and the decision of the previous government with regard to that, that did not mean that was the be-all and end-all of CT scanners for rural Manitoba or for western Manitoba. It was only the first.

Insofar as ruling out Dauphin or talking about criteria, does the minister feel that the Residency Program in Dauphin has any impact on this kind of a decision? Also keeping in mind that the Dauphin Hospital is a regional centre that at least services a much larger area than the declining community of Dauphin, at least in terms of numbers as we saw in the last sentences, I do not think the minister should take any pride in the fact that our numbers are dwindling.

Certainly, we need to have greater economic development in our rural areas if we are going to maintain our communities and indeed they are going to grow.

At the present time, not only serving the community of Dauphin, the hospital serves a much broader area, and it is from that respect a regional hospital and with a residency program, I would ask the minister whether in fact–he talked about the teaching hospitals–he feels that this is a significant factor in that kind of a decision?

* (2200)

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

An Honourable Member: Proceed.

Mr. Deputy Chairperson: Proceed.

Mr. Orchard: Mr. Deputy Chairperson, that is not a deciding factor as to whether Dauphin Hospital needs and can utilize a CT scanner, no more than it is a deciding factor that Thompson or Steinbach or Morden-Winkler needs a CT scanner. There are utilization factors; there are patient profiles; there is protocol for access which determine need much more than size and/or patient load of a hospital, and in that case many hospitals will never have a CT scanner in them.

Mr. Plohman: It is quite evident that many hospitals will never have a CT scanner; it is just not possible to afford to have a CT scanner in every hospital.

Of course, the minister has established this committee. I understood from his earlier comments that various hospitals will be making presentations or proposals, and they will be scrutinized with very tough guidelines as the minister said. Are they going to be making this to the committee, proposals for a CT scanner in their facility, or are they going to be making these to the minister?

Mr. Orchard: The committee is designed to provide guidance to government as to where the needs can be met, to analyze the current waiting list and methods of management on that waiting list which will reduce some of the accusations my honourable friend has shared with us tonight about length of waiting time, et cetera. It will also hopefully establish some protocol which will guide the utilization and the patient access to CT scanning, and any application for any technology, whether it be CT scanning or any other technology that is made to the ministry for installation and any of the many hospitals we have goes through a process of analysis to identify need. Should the analysis identify that the need is legitimate, and if funds are available, decisions are made to proceed to allow the facility to proceed with the acquisition of that technology.

So there is a general committee process to deal with the global issue of installation of CT scanning technology, and there is the specific facility-by-facility request as stimulated by the availability of purchase funds through fundraising which is a separate approval process and which will have very stringent scrutiny.

Mr. Plohman: One last question on this issue, Mr. Deputy Chairperson. I just want to ask the minister if he determines as a result of these recommendations that there should be no more scanners purchased this fiscal year, and does he go further than that, or does this mean for this fiscal year when they say, at this time? What is the interpretation of that recommendation?

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

Mr. Orchard: At this time, means until there is a justifiable case for an additional scanner and where it should be located. Then, at this time, becomes a decision at some time in the future potentially to install and fund another one, but at this time can last until that justification is identified to the ministry.

Mr. Plohman: Yes, Mr. Acting Deputy Chairperson, and the minister then expects that this new committee will be up and operating to deal with these issues when?

Mr. Orchard: Very shortly, Mr. Acting Deputy Chairperson.

Mr. Plohman: Has the committee been established and named?

Mr. Orchard: The committee has been named. It is called the Manitoba Imaging Advisory Committee and the chair has been determined to be Dr. McClarty. We are seeking representation from a number of other disciplines and organizations including MHO.

Mr. Plohman: Mr. Acting Deputy Chairperson, we will watch with interest on that issue.

I wanted to ask the minister a couple of brief questions regarding the current operating budget and status of the Dauphin Hospital. What is the

current situation with the deficit that was there, and what co-operative efforts have been made by MHSC in dealing with that issue?

Mr. Orchard: Mr. Acting Deputy Chairperson, the deficit at the hospital is approaching $400,000 and in quite recent meetings with the board a deficit retirement plan has been created and approved, which will take a commitment by the Dauphin General Hospital to remove that operating deficit over an approximate two-and-a-half-year period of time.

Mr. Plohman: Mr. Acting Deputy Chairperson, has it been determined that deficit was the fault of the administration of the Dauphin Hospital or the way it was operated? In other words, they were operating above and beyond which was the norm for a facility of that size, or was there some other problem that was identified as a result of any reviews that MHSC might have undertaken?

I refer to possibly the fact that the hospital is basically a new facility operating without an established budget for a number of years, and therefore, because of the uncertainty in establishing that for a new facility, a period of years was required to establish what would be a relatively appropriate level of funding to ensure that all beds were operating and fully staffed.

Could the minister indicate whether, within this commitment or deficit reduction exercise, the province is sharing in that reduction directly? Is it only by way of perhaps closing some beds or understaffing that is being accomplished, or how is it being accomplished?

Mr. Orchard: Mr. Acting Deputy Chairperson, the $400,000 was an accumulated deficit. I am informed that this past year they have operated in fact with a surplus budget, and it is my understanding that they accumulated the deficit because they were operating above the staffing guidelines that were provided to them within their budget. They had done that for at least two to three years which led to an accumulated deficit. They are now operating within their staffing guidelines as provided for in the budget, and hence believe they are able to achieve retirement of the deficit in that two and a half year period of time

Mr. Plohman: Are they operating now autonomously as most major facilities, of course having to justify their budget when they go in, but in terms of not operating line by line through MHSC?

Mr. Orchard: Mr. Acting Deputy Chairperson, they are operating on a global budget, and it is within the global budget that they are retiring the $400,000 deficit over the next two and a half years.

Mr. Plohman: Has it been determined that the operation that was above and beyond the guidelines at the time they were established has changed? In other words, are they allowed additional dollars for operating based on a review that might have been made or a case that might have been made, or is it still on the basis of the same guidelines that were in place during that period of time?

Mr. Orchard: Some minor adjustments on nonglobal items, but basically operating within the global budget.

Mr. Plohman: Could the minister just indicate perhaps some reasons why there might be 25 beds closed at any one time at the hospital there at the present time?

* (2210)

Mr. Orchard: Tied in with the shift of patients over to the personal care home the new 25 beds that we built, and I am informed there is no waiting list for PCH placement now and no–[interjection] Oh, for surgeries? Oh, sorry. No waiting lists for the surgeries right now and they are utilizing their bed capacity for appropriate medical needs. They are not admitting people who do not need to be at a hospital, in other words.

Mr. Plohman: So the minister is saying that all of the panelled patients are now in the personal care home and there is no waiting list that has to use acute care beds for the purposes of personal care patients?

Mr. Orchard: Essentially, that is correct. There is not "no" panelled patients in the hospital, but a significantly lowered number of panelled patients in the hospital with the opening of the 25 beds.

Mr. Plohman: Just on that, Mr. Acting Deputy Chairperson, is the Dauphin addition to the personal care home now operating fully normal and fully staffed and with all beds being utilized?

Mr. Orchard: Without having exact numbers, it is pretty close to being fully operational now, if not fully operational.

Mr. Plohman: Can the minister indicate why there were no LPNs hired in that operation?

Mr. Orchard: I do not even know whether that is accurate, so I cannot indicate why.

Mr. Plohman: The minister has no information or any speculation he could make as to why the administration, in consultation with MHSC, would not have approved the staffing with LPNs in any way? Is this the normal procedure for all personal care homes in the province now, or is this procedure for all new personal care homes?

Mr. Orchard: Mr. Acting Deputy Chairperson, first of all, as I indicated to my honourable friend, we do not have knowledge as to whether my honourable friend's statement is correct. If it is correct, I have no explanation because I have received none. If my honourable friend's statement is correct and he wishes an explanation, we will ask that of the administration.

Mr. Plohman: My understanding is that the staffing complement is arrived at as a result of MHSC working closely with the administration to determine the needs and the type of staff that would be included in that kind of operation. If I am wrong, I would be pleased to be corrected.

Mr. Orchard: We will see what we can do in that regard.

Mr. Plohman: I thank the minister for that undertaking. I think it is something that the nurses in the facility are extremely concerned about. I would have assumed that would have found its way back to the minister at some point. If it has not, then I am pleased that he has taken note of it today.

There are a couple of other questions I wanted to ask the minister. He may recall that I did send a letter to him suggesting that he might want to look at publicly elected boards as opposed to the situation in Dauphin where the shareholders or members could vote for the board members. There was quite a controversy there last year over the abortion issues, the minister may recall, and there was a lot of polarization of the community. This issue came up in terms of how the board represents the public at large, and there was some discussion about whether there should be a change in the way they were elected or appointed.

Can the minister indicate whether he has looked into that any further, into the issue of having publicly elected hospital board members?

Mr. Orchard: Mr. Acting Deputy Chairperson, this issue has come up. It came up most recently at the debate of the MNU. The nursing as a profession suggested a way that they might achieve greater representation on the board as to public elections.

We have given some thought to that but at the present are not convinced that necessarily will resolve the kind of problem that my honourable friend identifies in terms of polarization of the community.

I will give my honourable friend two points to ponder, and he might give me some guidance as to whether he wishes me to pursue that with the Dauphin Hospital on his behalf for the community of Dauphin. First of all, if we had an elected board capability for the area served, then I do not see how that would avoid the polarization around a single issue. In fact, it would make it a focal point of the single issue. Secondly, as I understand the structure of the legislation, if we were to confer my honourable friend's wish on behalf of the citizens of Dauphin to have an elected board, the responsibility for the deficit would then be transferred to the property tax owners and would be able to be levied against the property in Dauphin.

I would be interested in making sure that my honourable friend in advancing that is not advancing it on behalf of the property owners of Dauphin.

Mr. Plohman: Mr. Acting Deputy Chairperson, it is a nice argument on the part of the minister that there really is no relationship to the question asked. In this particular case, my reference to the polarization was a characterization of the problem that resulted, not necessarily that this was the solution, but it was a problem that caused a searching of souls really to look at the way the operation did take place, and maybe some changes that could be made, and whether it might help in the future with accountability–let us put it that way–at least a perceived and perhaps real accountability in the eyes of the public.

So that was why that idea was put forward and one that certainly would deal with at least the perception of accountability, I think, in terms of the vote if all people could vote for those elected officials in real accountability. But it did draw attention to the operation of the hospital which had not been something that was foremost in the minds of the majority of the public for perhaps many years. There was just a board there that went about their business and did their job. It was not something that was forefront in the minds of the majority of people.

I think in terms of the deficit, that is something that the minister is responsible for and MHSC as well as the administration of the hospital. Together they

have to work that out. It may be that the guidelines were not sufficient to allow for proper operation. The minister has admitted that there have been some adjustments that have taken place. I hope that it is realistic and that we cannot lay the blame for closure of beds on the feet of this minister because he is underfunding. I hope that is not the case, and I have prevented myself from making that kind of direct allegation until I know that that is a fact. I think it is something that he should consider when something like this happens, when you are dealing with a new facility as well as how it was administered at that time. All of these things have to be considered.

So I just ask the minister whether he has, in fact, looked at some changes to how boards were appointed, and even incorporated as was brought forward. It was not a fact of knowledge for the majority of the public that that was a privately incorporated facility using public funds. There was some concern about that as well, that there should be a change under The Health Act.

Maybe the minister could indicate how many facilities are incorporated in a similar way to the Dauphin Hospital in the province—the majority of the major facilities, or is it relatively few?

Mr. Orchard: We can get specifics, but most of our major facilities are incorporated under private act.

But, you know, I am intrigued with my honourable friend's statement that he says, deficits in hospitals are now government responsibility. My honourable friend now wants to be a little more narrow in his statement by saying, that deficit meaning the Dauphin Hospital in his home town—

Mr. Plohman: Possibly. You heard it all, put it in context.

* (2220)

Mr. Orchard: Now he is saying possibly. I mean, my honourable friend is a typical New Democrat.

When in government my honourable friend sat around a cabinet table with Howard Pawley and the Minister of Health, I believe it was Wilson Parasiuk at the time, and when they ordered the mandate of the closure of 130-some hospital beds in Brandon and Winnipeg, they also said, there shall be no deficits in the hospital system.

Now my honourable friend, from the comfort of opposition, is saying, deficits are the government responsibility. He has flip-flopped on a policy put in place while he sat around a cabinet table and agreed to a policy of the Howard Pawley government. I mean, that is the kind of moral bankruptcy we run into with New Democrats consistently across this country.

That is why the government of Ontario is in difficulty, because they promised all sorts of wonderful things from opposition and flip-flopped on almost every single one of them when they got into government. Now we see the converse from people like the member for Dauphin (Mr. Plohman) who in government make policy and then in opposition want to flip-flop from it. That kind of consistency does not add credibility.

Mr. Plohman: Mr. Acting Deputy Chairperson, I have a number of other questions. I do not know that that response deserves to be dignified. It is clear that the minister has found a way to misrepresent the position I have made. I will, for the record, indicate clearly that in the case of the Dauphin Hospital I think it was quite clear that there was a case that was being made for additional funding based on disputes over staffing criteria and things like that, and the minister obviously would have to sort all of this out.

As I indicated, it was quite possible that there was an obligation on behalf of the minister, and he has admitted to that to a certain extent earlier on. I think we can leave it at that, and I will not dignify his comments with regard to flip-flopping. He obviously chooses to hear certain things and not hear other things.

(Mr. Deputy Chairperson in the Chair)

Two questions that I have wanted to ask: Has the minister looked at the issue of psychiatric services and beds for the Dauphin Hospital? Has the minister had any representation made recently about those services in Dauphin?

Mr. Orchard: Mr. Deputy Chairperson, as discussed earlier when we were dealing with the Mental Health review line, in the interest of brevity and not wanting to repeat answers, my honourable friend might want to consider some of the discussion around the Parkland, Westman, West Central Mental Health Council co-operation around developing an action plan for service provision in those respective regions which has input from Dauphin, et cetera. They will be presenting to government what they view as a reasonable plan of action to implement over the next little while.

Elements such as my honourable friend has suggested may well be part of the recommendations for action that the Regional Mental Health Councils of Parkland, Westman and West Central come up with.

Mr. Plohman: Certainly it is a serious issue of concern to the community in terms of the general psychiatric services in rural areas, and particularly in Parkland, and one that the minister should consider addressing. It is a difficult one, and he mentions it was there prior to 1988–certainly a growing concern, one that was relevant for a number of years previous that I can recall as well.

I point out to the minister, as he knows, that you cannot necessarily accomplish everything at once, but you certainly can work towards it, and I think the minister should be doing that. I make that plea on behalf of the community of Dauphin because it is a serious issue.

I want to raise one other question before I turn this back–and the patience of my colleague the critic is certainly acknowledged here–the issue of naturopaths being covered under medicare. I was looking through the information that the minister just tabled–and I will turn this over to my colleague as well–for the outline of the various programs in the various provinces. Naturopathy has been something that several constituents have brought to my attention that the province of Manitoba does not cover those services, and some provinces do.

I was looking through the information the minister presented here. It is not mentioned in most provinces as to whether it is excluded or not, but P.E.I. does not allow naturopathy and neither does Manitoba; B.C. does. Alberta, Ontario, Quebec, New Brunswick, Nova Scotia do not mention specifically excluding it, but it is possible that it is included as well there since it is not excluded.

Has the minister had representation from people in the province of Manitoba and from the medical profession to have these kinds of services included under medicare?

Mr. Orchard: Mr. Deputy Chairperson, I just want to indicate to my honourable friend in terms of Mental Health Services provision, yes, I fully agree with my honourable friend that you do not make changes overnight. It has taken us four years to get to where we think we are going to make some changes. I know that my honourable friend will be dismayed to know that a lot of plans have been before previous administrations starting in about 1971 and not acted upon.

The advantage that I have today in terms of being Minister of Health is I have at least one of my critics urging reform of the mental health system and I intend to harness that good will amongst the opposition party. Unfortunately, my honourable friend was a member of government when they had the luxury as myself as opposition critic, even using Dauphin as a specific example, to develop more community-based mental health systems. My honourable friend, as a minister of that government, could not even persuade the minister of the day to make some modest changes to Dauphin when the critic in the opposition Conservatives was suggesting Dauphin be chosen.

So I appreciate my honourable friend understanding how difficult it is to move things in government because he certainly must have been totally frustrated at his lack of achievement in Dauphin. I understand my honourable friend's frustration, not getting anything done.

Naturopaths are not covered in any province except British Columbia, and it is my understanding that 12 treatments per benefit year for patients less than 65 are covered and for patients over 65, 15 treatments per benefit year. Fee schedule for initial visit is $20 and $14.70 for subsequent visits. We are unable to provide any naturopath coverage in the province of Manitoba, and do not have any plans to include it as a fee schedule or an insured service item.

Mr. Plohman: Well, the minister obviously was not very familiar with this service, and perhaps, he would want to look into it to see whether in fact it might be a cost-effective way and certainly fit into the preventative health model that would certainly avoid the high costs of hospital care and drugs and so on that cost a way more, much more. So it can be a cost-avoidance by ensuring that this treatment is something that is broadened in Manitoba, perhaps it would save money. I think the minister should at least look at it from that perspective.

* (2230)

Mr. Orchard: I appreciate that piece of policy advice from the official opposition as to where they think government should be moving in health care.

Ms. Judy Wasylycia-Leis (St. Johns): Mr. Deputy Chairperson, let me first of all apologize if I repeat any questions that have been asked in my absence

for the last couple of hours, and if I do ask a repeat question, please indicate and I will withdraw the question and check Hansard.

I would like to begin by asking for the information that the minister said he would make an effort to bring forward this evening, the first being the unachieved target for this past fiscal year for urban hospitals, the second is the target–and I am going to use the word "restructuring" target because that is how it has been put to me–for the present fiscal year for urban hospitals, and how both the unachieved of last year and the target for this year are being allocated in terms of on a hospital-by-hospital basis. Those are two questions.

The third is the operating grant for the psych services building, Health Sciences Centre. The fourth is the details on the capital construction of the psych services building, specifically the information on a stage basis for the construction of that building with information pertaining to tendering and the lowest bidder.

There are some other things I will come to that the minister made a commitment to get, but it will come back to that.

Mr. Orchard: Deficits are $4 million from across the Urban Hospital Council group, and unachieved targets from last year, $12 million. They are going to be prorated amongst the facilities on the basis of, we anticipate, their allocation of the global budget.

Pardon me, that allocation is only on the $12 million. The $4 million, of course, is facility by facility as incurred.

Ms. Wasylycia-Leis: Just to get clarification, the minister is saying the total deficits for urban hospitals for this past fiscal year or this present one is $4 million. I am not sure what–

Mr. Orchard: As close an estimate as we can achieve without consolidation of the books at fiscal year-end, March 31, 1992.

Ms. Wasylycia-Leis: The minister has indicated that the unachieved restructuring target for this past fiscal year is $12 million, and that is being prorated across the board?

Mr. Orchard: Prorated to the eight urban hospitals on the basis of their percentage of budget.

Ms. Wasylycia-Leis: I am still having some difficulty with this, and I will try to be as succinct as possible. Could the minister indicate, first of all, why it is that if certain hospitals did not meet this restructuring target last year, that the unachieved target is being prorated across the urban hospitals?

Mr. Orchard: The $12 million was a target issue put before the Urban Hospital Council, and when unachieved, is distributed according to their budget.

Ms. Wasylycia-Leis: Could the minister indicate who directed the restructuring target to begin with?

Mr. Orchard: Mr. Deputy Chairperson, last year when the hospitals struck their budget, they asked for X number of dollars, and government said, no, we can give you this number of dollars. Within that, a target reduction of $18 million was between the total request and what we could accede to. That had to be found and was not found.

That has caused deficits to be brought forward into this year which are the first call on the increase of $53 million in the hospitals. This year we are asking the hospitals to meet their commitments with new budget money. We have provided dollars for certain salary categories that have already been agreed to. We have given a funding mandate for contracts which are to be negotiated, and we have given some increase on the supply side. We are asking the hospitals to manage within the budget of $949 million or $948 million, an increase of $53 million to our hospital system this year over last year.

Some of the budget goals that were set last year, in terms of the negotiations of demands placed by the hospitals on the system and our ability to provide the money, were not met and must be met from this year's budget.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, this is very confusing, and I do not think it is because it is late or that I am not able to analyze the numbers given to us.

I think there is a great deal of confusion created by the minister and this whole process of budgeting. I do not know if it is deliberately designed to confuse us or not, but it certainly is having that effect.

How can the minister say that whenever we have raised the question of these budget reduction exercises that urban hospitals tell us they are going through, whenever we have asked about these restructuring targets, the minister has consistently said that the numbers we are talking about are the difference between what the hospitals have requested and what the government has allocated? He has consistently turned it back to us and said, do we believe in a deficit policy or not for hospitals?

Yet now as we piece our way through this it becomes clear that there really are two separate issues. There is an issue of deficits, and unless I have mixed this up, the minister has said that the first call on the $53 million this year will be $4 million in deficits held over from last year.

So if there are $4 million worth of deficits from our urban hospitals, how can there be $12 million unachieved, so-called restructuring target, when in fact that number is supposed to be all a result of deficits which are a result of the facts that hospitals asked for more than this government was prepared to give.

* (2240)

Mr. Orchard: No matter how confusing the issue is, there was $898 million, I believe, available for the hospitals last year. Their demands were maybe $950 million? I do not know what the total number was. The budget number was $898 million. From that the Urban Hospital Council was mandated with a $12-million agenda across the board to reach their portion of the $898 million of hospital spending. That was not achieved.

That has to be achieved out of this year's global increase of $53 million, and that is going to be the first call before the hospitals can consider new program or whatever because there is no deficit. They did not meet their budgetary goals and targets last year.

Now, the easy answer, of course, is to simply go to the taxpayers or the money markets, borrow more money and put it into the system. But that is not what we are doing. That is not what has been done ever since the no-deficit policy was put in place.

Now, this year there is $53 million more for the hospital system than we budgeted last year. That is to meet all the requirements of the hospital system, salary increases, a negotiating mandate, a supply increase and retirement of unmet budget goals from last year.

I cannot make it any plainer than that, and the only thing, I suppose, that makes it plainer is if we said, okay, we will give you the money in addition to the $53 million that you ran in deficit last year and in the targets you did not meet. But we are not doing that because we are asking the system to come around and manage better, bluntly put, and that is going to mean making management decisions.

I will give you an example. Brandon General Hospital recently made some changes in the way they operate their hospital. That, I think, had about a three-quarter-million-dollar impact. Yet, you know, they are planning to operate on the same level of patient care, because with support from community services, et cetera, they are able now to reduce their institutional budget because a number of services are being replaced either by day surgery or community-based services.

We are making the similar proposal to all of the hospitals. I make no bones about it, they all want more money. But we are not in a position to provide more money. We have budgeted $53 million more expenditure this year than last. I will put that, and the only exception I will make because I simply do not know whether Alberta and B.C. have provided their hospitals with a greater increase in available money year over year.

I know that we are significantly higher than Saskatchewan at 6.1 percent in our Hospital line year over year. Saskatchewan's preliminary indication is 2.8 percent less, so there is a 9 percent difference between our funding in Manitoba and Saskatchewan's funding. Ontario, I do not know whether it is 1 percent or 2 percent, but that is four points different at 2 percent than what we are doing.

I know Nova Scotia just brought down a budget wherein they have frozen their hospital budget. Newfoundland, I believe, has carried forward–well, significant reductions last year. At any rate, I know my honourable friend is wanting to make the case that hospitals need more money. I would love to be able to accede to the case that hospitals need more money and provide it through some magic fund which did not involve the taxpayers or going to the money markets and borrowing against our future. I do not have the luxury of doing either.

In the process of providing an opportunity to make management decisions in our hospitals, we are providing $53 million more this year than what we budgeted for last year to cover hospital activities. It is not enough, but it is significantly more generous than other provinces are making available to their hospitals. We are asking our managers of the system to undertake management initiatives to operate within budget and to not compromise patient care. We hope they are able to accede to that.

As we talk, shall I say, they are developing management and action plans to present to government as to how they will be able to carry out

their operations with the budgets that are being contained in a $950-million approximate hospital budget, $53 million higher than last year.

Ms. Wasylycia-Leis: I am not trying to make any case any which way. I am not trying to argue more money for hospitals or less money for hospitals; I am simply trying to get information so that we can then make judgments. I still have not got all that information, so I will have to ask a few more questions.

At the start of that last long answer, the minister said, both the $4-million deficit money and the $12-million unachieved target would be the first draw on the $53 million this year. Now is it both, is it one or the other, or is it $12 million plus $4 million?

Mr. Orchard: Both.

Ms. Wasylycia-Leis: We now have for the $53 million: $14.5 million for anticipated salary negotiations; $17.5 million for pay equity–although I know there is some adjustment based on personal care homes that we have to subtract from those numbers, settlements pertaining to personal care homes, so there is some reduction there–$12 million for the unachieved target hospital budget reductions of last year; $4 million in hospital deficits–and I fail to still see the difference between the unachieved budget reduction target of last year and the $4-million deficit, which the minister had said before was the same thing–and we have a new restructuring target or hospital reduction target for this year of, I understand, $10 million.

I understand that there is $15-million divided over the next two years, $10 million for this year and $5 million for next year. That is where this number that has been in the press of $27 million appears to come from, the $12 million unachieved of last year and the $15 million for this year and next year. So we are now looking at more than $53 million.

Could the minister give us some clarification on that, and is that $10-million restructuring target also part of this $53 million?

Mr. Orchard: The $53 million is an increase in money year over year out of which the operations of the hospitals can be achieved. Included in that, they have to retire their deficits, meet unmet targets, provide monies for the increased negotiated salary agreements. There is a figure in there of–what was it?–$14.7 million for all of the contracts that are coming up, but that is personal care home and hospital.

Ms. Wasylycia-Leis: The minister can describe this in any way he wants, but as far as I understand it, and I may be wrong, in fact there has been quite a shift in terms of hospital financing in the last couple of years and I am just trying to get a clarification of that. I am not saying one way or the other if it is bad, good or indifferent, I am simply trying to get an understanding of that shift.

Now the minister is pointing to other provinces where there has been that dramatic shift and change in the way hospitals are funded and considerably less money on the table to deal with hospital needs. That may be something we have to look at, but I am trying to figure out what happened last year and this year that is quite a change.

By all accounts, these are people in the system saying this, that last year was really the first time since–I think the year given is 1970, that hospitals have actually seen a cutback and that in fact funding to hospitals has been far less than inflation. While there may be an increase on the supply side there has been a serious decrease or even zero percent on the salary side so that hospitals end up in effect with budgets insufficient to meet even the most basic of services as happens with the cost of living and inflation. They end up with less money and that in effect is a cutback.

* (2250)

Now, maybe that is the only way we can deal with hospital budgets right now. I do not know, but I am trying to get a sense of that and what it means, and when we get all the details at some point from the minister about the present fiscal year and the budgeting for hospitals what it is going to mean in terms of services. Can the minister indicate that there was a shift in policy starting last year with financing of hospitals and that there were in fact directives to hospitals to cut–I know the minister does not like the word "base," but that is what it amounted to, cuts to the base, because the increases did not at all keep up with cost of living and wage settlements and therefore there were reductions to the base and that is a cut to the base.

Mr. Orchard: If we went back to last year now, I think the hospital line increased by–we can get that kind of number, but it was probably in the neighbourhood of $48 million or whatever. I realize that gets to be kind of confusing when my honourable friend is hearing tales of woe from somewhere in the system.

How in the world can you possibly come around an issue where your analogy is you have cut back when you have provided $50 million more funding in last year's budget over what was in there for what would be '89-90? I guess the answer simply put is just: Give them everything they ask for and then they will not bother you.

That is not the real world. Each year we have provided more money not less to hospitals; not as much as they have wanted, not as much as they would like to have spent, but certainly the biggest single increase in program line expenditure in my department has gone to the hospital side.

Yes, it is not as much as they have asked for and in restructuring their operations we are asking them to use less dollars than what they are asking for, yes. They are developing the management plans to tell us how they can structure their service delivery with the least impact upon the patient to deliver care within an increasing budget, but not increasing as fast as they want it to be.

Now, my honourable friend makes the case about "less than the inflation rate." Well, I do not know whether I buy into that or not, because what is the inflation rate? The inflation rate is something like 4 percent last year. But yet nurses' salaries, which are a significant component of the hospital, went up by–how much last year?–by the time you have had added the two increases, about 10 percent.

So, you know, if my honourable friend says we should be providing funding at the rate of inflation, I would be glad to, because this year the rate of inflation is projected to be something under 2 percent, and we are providing 6.1 percent more money.

But you know what drives the hospital budget is the salaried negotiations of employees, and pay equity, and other legislative initiatives that put money in caregivers, not to provide more care, but more money to provide the same hour of care they did last year, the year before, the year before, the year before. As long as we have wage settlements approaching double digit per year, and you provide even 6 percent increase in funding, you are going to run into squeezes somewhere in the institution. That is why this year all the demands are there for the support workers to demand more.

They have gone through a salary freeze, and we dealt with this issue before supper. Love to give them a hefty raise, but you know what? The real world out there in the rest of the economy of Manitoba were without government support, probably has had wage freezes, wage rollbacks, layoffs, closures, all the things my honourable friend's colleagues daily get up and with glee point out to the people of Manitoba that the private sector is rolling back, is doing this and making tough decisions.

At the same time, we seem to be of the thought pattern emerging here that, by golly, we can operate hospitals in isolation to that reality in the rest of the economy. Well, not so.

Certainly they want more money than what we are giving them, but more money is not available. So they are going to have to manage, and they are going to have to manage in a way that does make a best effort at protecting patient services and remaining within budgets, without deficits. They are developing action plans, hopefully, to be able to do that.

I am not saying it is easy decisions for the hospitals. I do not have easy decisions in the ministry of Health. The Minister of Finance (Mr. Manness) does not have easy decisions in allocating $101 million more to the ministry of Health. It is not going to be enough, but it is a heck of a lot more than other areas of government have received, certainly a lot better than other provinces are doing.

Now, to fill out my argument with my honourable friend: For the fiscal year '91-92 that we have just nicely ended, we had a $47-million increase in hospital funding that year, not a decrease, but a $47-million increase. That was 5.6 percent compared to 6.1 percent this year. Not enough, but it is a total of 11.7 percent over two years when inflation would total 6 percent over those two years.

You know, how much more do we pour into the hospital system before we ask the hospital system to operate within budget and to do more with less money? In almost every place you go in the Manitoba economy, the Canadian economy, the North American economy, everybody is doing more with less. Health care is going to be part of that.

Ms. Wasylycia-Leis: Again, I am just trying to get all of these different statistics straight, and the overall policy of this government clear, because it is still not clear. Until it is clear, we cannot really be that helpful in terms of the minister's overall strategy, and we cannot make a decision one way or the other

if what the government is doing is good, bad or indifferent.

Again, the minister refers to a $47-million increase to hospitals last fiscal year, the one we have just ended, but it appears that this government is very good at giving with one hand and taking with the other, because in fact he gave $47 million to hospitals. We do not know exactly how that broke down. Then it also took away $18 million as part of this hospital budget reduction.

If the minister would like to clarify that, that would be fine. I will pose that as a question then. Let me ask a related question to that since I can get it all out and we can get the definitive answer.

I think I was quite wrong when I suggested that of the $53 million this year that included the roughly $14 million or so for contract settlements, the $17 million or so for pay equity adjustments and the $4 million for deficits. Then I also suggested the minister was rolling in near the $12 million unachieved from last year and the $10-million restructuring target for this year, but in fact that cannot be the case. The unachieved target and the new target for this year is what the minister is taking off of the $53 million.

So as far as I can tell, and I would be glad for the minister to clarify this, we are looking at roughly the $14.5 million for contracts, $17.5 million for pay equity–although we have got to take off the personal care homes out of that–$4 million for deficits, and that leaves about $18 million which must be for supplies. Therefore, that is about a 2 percent increase on supplies which is less than the cost of living. Then on top of that the minister is saying, take off $27 million, or, for this year I guess it is $12 million and $10 million, so that is $22 million. Is that not the case?

* (2300)

Mr. Orchard: While my honourable friend is saying that government gives with one hand and takes away with another hand, I want my honourable friend to give a slight amount of consideration to how and for all intents and purposes these budget numbers, which have been approved, have been at least expended, maybe a million or two more, okay? For fiscal year '90-91, the budget was $845 million for hospitals–Urban Hospital Council members, a rough figure, 60 percent of that budget.

For '91-92, that figure grew to $892 million, and for '92-93, that figure I am asking concurrence around, is $947 million, and we expect them to spend it all.

Now, how can my honourable friend make the statement without some questioning as to what is happening when you go from 845 to 892 to 947. You say we are giving with one hand and taking away with the other when 60 percent of that is being expended each year by the hospitals that she says, we give on one hand and take away with another.

They spent the money, increased money. They did not spend as much as they asked for because we would not give it to them. That is where we get into $12 million, $18 million, $4 million, all of the numbers that bounce and float.

But my honourable friend has to acknowledge that we go up every single year in funding, and if we threw the floodgates wide open, this year's budget would have been a billion dollars, not $947 million, and that would have meant $53 million that we–well, I suppose an easy solution would be to have flattened the home care budget and pulled $7 million of increase out of home care and put it into the hospitals, because they would have spent it. But I do not think my honourable friend would have been happy with that somehow.

How is it that hospitals should be treated any differently than any other part of government? They are given a budget and they are asked to operate within it, and they are going to have all sorts of opportunities to create pressure on government to make them recant and give them more money, aided and abetted by anybody who wants to argue for them. We have given more money each and every year including this year.

It is not as much as they want because they have incurred deficits and have not met targets, but does that mean we recant on the process of trying to bring some management discipline to the hospitals? I say no. But you cannot make the argument that, as you just did five minutes ago, we give with one hand and take with another, because otherwise that means somebody is living pretty fat and sassy with a Swiss bank account with $47 million more spent last year and are going to sit in a bigger bank account in Switzerland with $53 million more this year, if we have given and then taken away. That is balderdash! We have given, given, given.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, the question is, if this minister and this government have given, given, given, and hospitals have received

dollars to the tune each year at least equal to the cost of living, then they would not now be in deficit situations or having unachieved targets or cutting back services. So that does beg the question since the hospitals are not getting that money in terms of the operating budgets, where does the money then go? [interjection] The minister says they are. The fact of the matter is, if all these hospitals were getting these kinds of increases, we certainly would not be looking at the kind of cutback scenarios we are today.

Now, there is another whole element here at play which I am not necessarily objecting to, I am just trying to sort out. We are dealing with two different processes, two different elements to this minister's strategy with hospitals. One is the annual budgeting process and how they figure out the cost of living and what they are going to give for supplies and what they expect salary negotiations and how much money is on the table for all of that. There is a separate process for so-called reform purposes where this government and this minister is asking, urban hospitals at least, to come up with reductions to their hospital budgets for the goals of downsizing hospitals presumably.

That is being translated in terms of these dollar figures that are bandied about all over the system so they are not fantasy on my part. The numbers of $18 million and $12 million and $27 million and $15 million are widespread in the system. The hospitals have been trying to come to grips with these targets for the last number of months. As well they have been handed bed-target-reduction figures.

So there are two separate processes going on here. I do not necessarily object. I am trying to understand what hospitals have been asked to do because, in fact if it was a simple, straightforward matter of hospitals getting the money that the minister is talking about, we would not be sitting here today talking about why are some hospitals looking at major bed downsizing, why are some hospitals talking about closing operating rooms, why are some hospitals saying they cannot meet the waiting list for surgery, and so on and so forth.

There is clearly some other dynamic here from the department and the minister, and I am just trying to get that clarified.

Mr. Orchard: Let me help my honourable friend. In the last two years the combined increase on the Hospital line has been 11.7 percent, significantly greater, almost double the inflation rate. My honourable friend asked the very legitimate question, what in the world is going on? They are getting more than double the inflation, or they are getting approximately double inflation rate. Why is it they are talking about all of these dire consequences because of underfunding at double the inflation rate?

Exactly the question because we asked them for fiscal year '90-91 to spend $845 million. We asked them in '91-92 to spend $892 million. We are asking them this year to spend $947 million. The difficulty is that last year they spent more than $892 million, if you want to be blunt, without authority to do so, and under the no-deficit policy that is in place they have to make that up first call on this year's budget. But that begs the question, why was it not achieved last year? Good question. It is not because the funding increase was not there because the money is gone, it has been spent by the hospital and more.

Now, if my honourable friend believes that there should be some other method by which we attempt to get hospitals to develop operating plans to stay within budget, I am listening. I am listening, because we have given increased financial commitments every single year that we have been in government. It has not been enough in some years, and that is leading hospitals to tell my honourable friend, oh, this dire agenda, or whatever they may or may not be telling my honourable friend. The problem is I do not have any more money to give them, because the taxpayers do not have any more money to give them, and furthermore other departments in government do not have any more money to give hospitals.

That leaves the challenge to operate with the budget that is increased by 5.7 percent last year, 6.1 percent this year on the Hospital line and attempt to maintain services through better management and more effective use of the resource.

There are management decisions that can be made within hospitals to allow that. You know what will not happen?--is if they believe they do not have to undertake those management decisions, because somebody is going to make a political issue out of their lack of funds because they are over deficit. That is the first and foremost thing that has happened and allowed the hospital system to command over 50 percent of the operating budget of the ministry of Health. It can go on forever, but we cannot afford that.

Now, if we had provided less money in the last three years, I would be standing here defenseless, but when we have provided more money and my honourable friend is making the case that the more was not enough more, well, that is fine, I accept that. I mean, that is a different argument.

To try to make the argument that we did not provide them more money is not legitimate. We asked them to spend $845 million in '90-91; $892 million in '91-92, and we are asking them to spend $947 million this year. Last year, we know they spent more than that. That is the problem.

* (2310)

Ms. Wasylycia-Leis: Maybe if we break this down again, and if I pose a few more specific questions, maybe we will be a little further ahead.

Perhaps, the minister then could explain, if the reason for the deficits and unachieved targets, which is the first draw on the $53 million of this year, is a result of hospitals spending more than the $892 for 1991-92 fiscal year, then what is the right number? Is it $4 million? Did hospitals overspend that amount by $4 million or by $12 million?

Mr. Orchard: Overspent by $4 million and did not achieve a $12-million target.

Ms. Wasylycia-Leis: See, we are right back where we started, because the minister is not clearly setting out what he is up to. I mean, I am going to have to come back to this. Maybe he should get a flip chart out or a blackboard.

He keeps coming back to the fact that this whole situation that we are in is because hospitals spent–let us just use the 80, comparing the last two years–more than this government was prepared to fund, and that being $892 million. That is what he keeps coming back to.

If that is the case, and that is the case, which the minister says amounts to $4 million, then would the minister please explain once more where the $18-million budget-reduction target came from, what it applies to? If it is not to do with the difference between expectations or desires or wishes versus what the government is prepared to accommodate, then what is it a target against, where did it come from, why do we have a $12-million unachieved target for this coming year?

Mr. Orchard: Because it was not achieved in the fiscal year in which it was proposed to be achieved. You know, I do not know how to help my honourable friend here, but we have ourselves a situation where every year the budget has increased. I can run through the numbers again in terms of overall increase to the hospital system.

It is not enough. I agree it is not enough, but I also do not agree that the simple solution is putting the money in as my honourable friend would seem to suggest, and I am even putting words in her mouth there. Basically I get that sense, that that would solve all the problems if we simply give them more money. That is what the member for Dauphin (Mr. Plohman) said earlier on this evening and certainly the member for Brandon East (Mr. Leonard Evans) has said that, but there are other issues that need to be addressed in terms of the management of our hospital system. Well, I am going to suggest that after a couple of minutes here we just take a couple of minutes break and then come back.

You know, within the hospital systems hospitals are major organizations and they are spending significant amounts of money, and the easy answer every time there is a challenge on the budget is, well, we are going to have to reduce service. My honourable friend mentioned closing an operating theatre, closing beds, laying off nursing, et cetera. Well, you know what? We have some other suggestions to make as the operating plans come in, i.e., management and compensation levels in management.

Every organization in the private sector is operating with a flattened management structure now. Every private sector company with few exceptions that are surviving today have a flattened management structure. Is that not a reasonable request for hospitals to take a look at the management structure? It means tough decisions. You might have to actually eliminate a layer of management possibly. But is that a more appropriate management adjustment to budget to contain budget growth than the immediate consideration, which is very highly politically charged and will gain public support against government, of closing an operating room or laying off nurses or closing beds or reducing service level?

Is there not an opportunity to take a look at areas of comparable service delivery within our hospitals like personnel, like purchasing, like training programs and a number of other issues that we have before the Urban Hospital Council where not every hospital develops everything they want within their

four walls and their jurisdiction, but they develop a shared service concept?

I mean, that is what has happened two years ago or a year ago I guess in Toronto. They combined organizations within hospitals, I think, with a pretty significant collapse of common administrative functions. We are not suggesting an amalgamation of hospitals in Winnipeg into one super operating body. But I will tell you, before we are going to accept that there are no other areas to look at other than closing a surgical theatre or laying off nurses or closing beds or curtailing patient services, we have some pretty hard questions on internal management of the hospital.

I have broached a little topic recently, and I would love to have this analysis. I am going to describe it to you briefly because I think it would help us all understand. I would like to see a scale developed of one to 100 of our hospitals, regardless of size, and you analyze for the budget and you develop an effectiveness rating based on how many patient days of given medical and surgical services you do on the basis of the beds and the hospital count. A real DRG, if you will, across all hospitals, because I want to tell you that I think we would find some pretty dramatic and successful smaller hospitals that do one heck of a job on a very modest budget.

Some of our larger hospitals have got involved in any number of ancillary activities with layer upon layer of activity, and when you find how many dollars actually come out the end of a tube in terms of patient care you might find it to be significantly less than some of our smaller and more effective hospitals. That is not a precise science, and we do not know whether we can achieve that kind of analysis, but I would like to have it because otherwise government keeps getting buffeted around by institutions that are major and significant saying that unless we have more money we are going to have to close operating theatres, as my honourable friend has already mentioned, obviously from some prediction from someone in the system, or that we are going to have to close beds or reduce patient services.

Well, I want to tell you, before we accept those kinds of plans we are going to ask the other very pertinent questions: Have you considered, for instance, your personnel departments, your purchasing departments and other departments which are nonpatient care and have an opportunity for shared services beyond the confines of individual hospital institutions? Until we get an answer, we are going to have some very tough negotiations, and that is what this whole exercise is about. Each year as we have given more money it has not been enough. It has not been as much as requested. It never will be. We are into some tough decision making at all levels of government, and health care is no exception. This budget round is no exception, where we are asking hospitals to develop management plans to present to government as to how they are going to deal with the expenditure of $947 million this fiscal year.

* (2320)

Mr. Deputy Chairperson: Would it be the will of the committee to take a two-minute break? [Agreed]

* * *

The committee took recess at 11:20 p.m.

After Recess

The committee resumed at 11:28 p.m.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us, have they done any study in terms of the patients who live, for example, six months in Manitoba and six months somewhere in Los Angeles or Florida and enjoy the sunshine and the weather, and how much money we are paying on their behalf to the private insurance companies out of the province?

Mr. Orchard: Mr. Deputy Chairperson, let me get my honourable friend's question correct. Do you want to know how much we are paying for Manitobans who are out of province up to six months in terms of medical services they access, how much we pay to the providers out of province? Let me ask for further clarification. People may be down only a month, but they access medical services. If we can give you a number that would show what we have paid for out-of-province services regardless of whether the person is gone one month or up to the six months, that would be sufficient?

Now bear in mind that there is another side to that coin that we do not have, and that is the amount–okay, we pay equivalent Manitoba physician rates, equivalent Manitoba hospital costs based on a hospital of the same size that a person is in, on an average per diem basis, and anything in addition to that is picked up by the individual's private insurance coverage. It is that latter thing that we do not have. We will have that figure tomorrow.

* (2330)

Mr. Cheema: Mr. Deputy Chairperson, we are only concerned about the money we are paying at par with what we are paying in Manitoba and not the private insurance companies. Can the minister also get us information in terms of the total amount we have paid during the past year for the testing and some of the referrals which were done out of the province, specifically to the States, how much money we have paid through the Health Services Commission?

I will try to explain it again. For example, if somebody is going to the Mayo Clinic, which is referred by the physician for services we do not have in Manitoba, how much have we paid for the last years on a year-to-year basis, '88, '89, '90, '91, '92?

Mr. Orchard: There are two separate issues. The first one is those who leave the province, maybe spend some time in Texas or wherever, and the other is out-of-province referrals for services that are not available in Manitoba. That is all services, so would that be just to other provinces as well, or do you want just to the U.S.?

Mr. Cheema: Just to the U.S.

Mr. Orchard: We can pull that.

Mr. Cheema: Mr. Deputy Chairperson, can the minister also find the amount of money we have paid to other provinces for some of the services which are not available? Not the amount if somebody is visiting and gets sick, I am not talking about that, but just for referral for special cases?

Mr. Orchard: Yes, we will attempt to provide that for out-of-province Canadian referrals. [interjection] We may not be able to get the out-of-province Canadian referrals for tomorrow, but the other two we have. So we will, for sure, have the first two and we will make our best effort at the third one.

Mr. Cheema: Mr. Deputy Chairperson, as long as we can get them within a week or two weeks, that is fine. Just for our own information, we want to know how much the province is paying for these services.

Can the minister tell us what the policy is in terms of what the minimum residency level is for somebody who would like to go to a personal care home, because there have been some incidents that people have asked us, if they were here for two years or three years and if they leave the province for more than six months, whether they can get into the personal care home and still qualify for the benefits?

Mr. Orchard: Two years immediate prior residency, minimum requirement, or–how does the 30-year rule work? [interjection] Okay–a combination of previous residency in the province of 30 years or more. Either scenario will qualify you, but for people newly moving to Manitoba, there is the two-year residency stumbling block. I have had requests to my office in terms of whether we can make exceptions to the rule.

Mr. Cheema: Mr. Deputy Chairperson, the reason I am asking that question is because some individuals who are, for example, newcomers and are coming into Manitoba, if their parents are also coming with them and within six months or one year they get into a situation where they have to be panelled for a personal care home, in those circumstances, it has become very difficult in terms of some of the individuals as far as their financial status is concerned. Also, I think, if they are continuing to occupy a hospital bed, they cannot go home. So somebody else is paying their bills.

I would like the minister to review that policy in view of the changing demographics and changing needs of Manitobans.

Mr. Orchard: I am informed that we have a residency program–no, let me explain this better. After three months, an individual can become eligible for hospitalization, if you will. [interjection] Only from other provinces, that is right. It seemed they were as–after our two-year residency rule would trigger here, yes.

Mr. Cheema: Mr. Deputy Chairperson, if somebody is coming to Manitoba, first time, from another country, and if they have landed status, they become eligible the same day for medical services but they do not become eligible for personal care home placement and some of the other services. I think that is where the disparity is and that situation needs to be reviewed.

Because that would have been okay, probably, 10 or 20 years ago, but with the changing needs of Manitobans, the newcomers and their families are coming, there have been situations where patients and their families are in a very difficult situation. I think that needs to be reviewed from a practical point of view.

Mr. Orchard: Yes, just in talking with senior staff here now, apparently when these rules were all developed, some provinces did not provide any assistance on the Personal Care Home Program.

So this was put in place to prevent–well, like with the medical program, I mean, the national, because it is an insured service and every province has it. There was an instant eligibility or, well, not instant, there is a three-month waiting time, but your former province-of-residence's program would cover you for that first three months in Manitoba, so you are always covered, but on the long-term care side, yes. But now that most provinces have, that is an interesting issue maybe to advance to see whether we can narrow the reciprocal arrangement and maybe work in concert with other ministers.

Mr. Cheema: Mr. Deputy Chairperson, the second part of the question is that somebody is coming, for example, new to Manitoba, and they have applied for their parents or their relatives who arrived in Manitoba. For example, within two months or one month they get into a situation where they will require a panelling for a personal care home, and if they are in a given hospital, they will not qualify under the present regulations. They cannot, according to the present rules, and they are having a lot of difficulty.

That situation is going to become more and more of a problem in the future because of the make-up of Winnipeg in terms of the new Canadians who are coming, and they are experiencing some of the difficulties. I would certainly ask the minister to look into this situation.

I am not talking about from province to province; that can be taken care of with consultation with other provinces. Where somebody is coming for the first time to this country and ended up in Winnipeg and has a family here and had a landed immigrant status, I think that issue has to be reviewed, because otherwise it could be challenged. Somebody could challenge the ruling very well, and it probably would not hold in a court of law. It will not, because you are covering them for medical necessities under the Canada Health, and personal care home situation is not in any way different from the insured services for some other things.

Mr. Orchard: Not that I want to get into the success or nonsuccess of a challenge, but bear in mind that the Personal Care Home line is not an insured service under The Canada Health Act, and it is at each provincial government's program implementation that it is available.

But there is the pragmatic problem of, if you have got the person hospitalized, which they qualify for immediately–and I hear what my honourable friend is saying and will try and see whether there is any–I want to get a handle on what the potential costs are, too. I hate to be that crass, but I just was under pressure earlier on tonight to help our hospitals along. We are under those kinds of demands constantly.

Given the anomaly and immediate versus two years, yes, that deserves a revisit to see whether there is an opportunity for a refinement of the policy.

* (2340)

Mr. Cheema: Mr. Deputy Chairperson, I will try again. For example, a patient ended up in hospital, and they landed only a few months ago, and they have a condition which requires hospitalization and after that two months, if you revise their status, and they are supposed to be panelled for a personal care home.

The family cannot afford the normal rate if they are not qualified. In that circumstance it becomes very, very tough for them to continue to afford the medical necessity. They are asking, why are we not being covered? So if you tell them that is the policy, and they are raising a lot of questions, is the minister right or will that uphold in a court of law.

It is just a matter of time till a certain group gets together and lobbies the government; probably they will have no choice than to change the regulation.

Mr. Orchard: My honourable friend is making a legitimate case or a reasonable argument, and we will have a discussion on this a little later on if that would suit my honourable friend.

Ms. Wasylycia-Leis: Just before I go back to hospital budgets, one question on this whole area of insurance, and this has to do with Order-in-Council No. 334. I am wondering if the minister could explain what the reason–unless this has already been asked [interjection]

I am wondering what the reason for this change was, and what the implications of the–I am referencing the change as listed in Order-in-Council No. 334 which changes–I do not know what it means, but it has to do with wording around medical services in respect to benefits payable rendered to persons outside of Manitoba; specifically, I see the biggest change pertaining to sections with respect to more elaborate wording, whenever the following phrase is referenced in the opinion of the commission could not be adequately provided in Manitoba. I am wondering if the minister could give

us an explanation for that Order-in-Council change and why it was necessary.

Mr. Orchard: I think all that regulation does is clarify the procedure of when Manitobans can access and have paid for referral services out of province. It did not provide any change in approach. It only clarified or committed to regulation the rules under which referrals for out-of-province services unavailable in Manitoba would be considered and would be covered under our medical plan.

Ms. Wasylycia-Leis: So is the minister saying that the change by this Order-in-Council does not have any impact in terms of who can access services outside of Manitoba, who can have those services paid for? Will it mean any change in terms of who is covered or not covered and how they get covered and so on?

Mr. Orchard: Mr. Deputy Chairperson, it does not change the eligibility under the Manitoba plan for individuals who are referred out of province, particularly to the U.S. because in the Canadian system we just have reciprocal billing arrangements but for accessing services, for instance, at Mayo Clinic as an example.

It clarifies the rules of eligibility and the circumstances under which we would cover those costs for a Manitoba resident. It does not introduce a new concept or new principle but merely clarifies by regulation what has been going on as a matter of practice. That just legitimizes essentially a practice that has grown up over several years and I guess was not guided by formal regulation in the past.

Ms. Wasylycia-Leis: With respect to hospital budgets, perhaps I will start asking some more specific questions. I will try to be more specific.

First of all, could the minister tell us for this past budget year and the one we are in what is the total budget for just the urban hospitals?

Mr. Orchard: For my honourable friend the member for The Maples under regulation under the Health Services Insurance, entitlement to personal care, there is a clause in here which does allow for flexibility in decision making. I will read the Clause 37(2), The commission–this will all be changed to the minister I guess, basically–may waive the waiting period requirement for a person who meets the criteria set out in Clause 36(b), if it is satisfied that a waiver is desirable to avoid an inappropriate use of health care resources, i.e., hospital placement for a panelled person.

Mr. Cheema: That does not solve the problem for the family members. I think the decision then is left up to only the Department of Health and the hospital. Then the family still has to apply and go through all the procedures. I think it should be uniform, acceptable like somebody else. I mean, if someone's family is here and established their roots already, and they ended up coming within three months or six months, they should be allowed to have access to the services the way the others would have.

Mr. Orchard: Getting back to the question–I have forgotten the question, I am sorry.

Ms. Wasylycia-Leis: Let us start all over again trying to figure out this question of targets and budget reductions and so on by asking the minister for what the total is for this past fiscal year and the one we are in for just urban hospitals or members of the Urban Hospital Council.

Mr. Orchard: I will tell you what we will do. We will try to give the figures for the Urban Hospital Council members basis preliminary reconciliation on '91-92. That was the question, was it not?

Ms. Wasylycia-Leis: My request was for, based on the figures the minister has given for overall expenditure for hospitals, $892 million for the past fiscal year, $947 million for the one we are in; of that, how much is for urban hospitals?

Mr. Orchard: In '91-92, of the $892 million we have been talking, $680 million was for our urban hospitals and that would include Brandon.

Ms. Wasylycia-Leis: And for this fiscal year, the one we are in?

Mr. Orchard: Now we are asking tricky questions. An increase of $43 million, 6.4 percent actually.

Ms. Wasylycia-Leis: Does that make it $723 million?

Mr. Orchard: Uh-huh.

Ms. Wasylycia-Leis: One other clarification before I figure out this issue of targets, the $4 million figure that the minister gave us for deficits I presume was for all hospitals in the province of Manitoba.

Mr. Orchard: No.

* (2350)

Ms. Wasylycia-Leis: Was it for Urban Hospital Council members?

Mr. Orchard: I have already indicated that about 14 times, yes. It is included in the number that my honourable friend arrived at.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, if the minister would give us full information and not in such a disjointed way, then maybe I would not be asking the same questions over and over again, but it is still hard to figure this all out and put it all together.

Of the $680 million, was the $18-million target off of that number or off of something else?

Mr. Orchard: That was an included number.

Ms. Wasylycia-Leis: So is the minister saying that–could the minister explain for us the difference between the $4 million incurred in terms of deficits, and the $12-million unachieved target?

Mr. Orchard: Both were included in the $680 million for last year and the $723 million this year.

Ms. Wasylycia-Leis: Is the minister saying there was a $4-million deficit for urban hospitals going into the '91-92 fiscal year?

Mr. Orchard: No. Look, let me try to help my honourable friend. Six hundred and eighty million dollars was what we had projected the Urban Hospital Council members would expend last year. They spent more than that, and out of the $723 million that we expect they may well spend this year, they have to retire deficits and unachieved targets from last year which were included in arriving at the $680-million global budget. That seems rather straightforward–$680 million was the achieved spending targets for the eight urban hospitals by the Urban Hospital Council members. When they did not achieve that, they carried forward those unachieved goals, whether it be achieving the budget goals through no deficits or achieving targets for expenditures, they did not achieve them. They carry forward any unachievements in their budget. In other words any overexpenditure from last year, above the 680, they carry forward the 723 this year. That is the first call. That is the way it has always been.

Ms. Wasylycia-Leis: If they did not achieve it, is that not a deficit? Why is the minister using two different figures, 4 million and 12 million?

Mr. Orchard: Because the Urban Hospital Council agreed to work towards $12 million and did not achieve it.

Ms. Wasylycia-Leis: Where does the $4 million come from then?

Mr. Orchard: Overexpenditures. Deficits.

Ms. Wasylycia-Leis: The minister has been very good at using a lot of bafflegab this evening, and maybe he is taking advantage of the lateness of the hour. He has clearly not answered the questions I have posed to try to get an understanding of where these numbers come from.

Mr. Deputy Chairperson: Order, please. Could I ask the honourable members to go through the Chair so that Hansard does not run into a problem.

Mr. Orchard: Six hundred and eighty million dollars was the budgeted expenditure of the hospitals. The Urban Hospital Council to live with the $680-million budget had to achieve $12 million of identified program savings or operational savings in the hospital. It did not achieve that. So that is first call on the $723 million. In addition to that, they overexpended by some $4 million, roughly. That is not finalized because the year-end reconciliation is simply not calculated out to the last dollar, and that is a deficit position that comes out of, with the no-deficit policy, this year's budget. I mean, they more than spent the $680 million last year, and now with those kinds of overexpenditures and targets not being met that is first call on the 723 we are putting up this year.

Ms. Wasylycia-Leis: Did they overspend the $680 million by $4 million or $12 million or is it a combination of both?

Mr. Orchard: Probably two hours ago, eight hours ago, a combination of the both.

Ms. Wasylycia-Leis: Is the minister then saying that urban hospitals are running deficits for this fiscal year that we are now in to the tune of $16 million? Is that now what the minister is calling this unachieved target?

Mr. Orchard: In the Urban Hospital Council they agreed they would attempt to find $12 million of program and other reduction expenditures–just straight global expenditure reduction. They did not achieve that last year to stay within a $680-million budget. So they have to achieve that this year out of the $723-million budget. In addition to that, they overexpended by some $4 million by last calculation in terms of deficits, and depending on which hospital incurred the deficit, it is first call for whatever dollars it is of the $4 million. I do not know the distribution rate now, but roughly 50 percent of our urban

hospitals will probably have that $4-million deficit. Some will not have deficits.

Ms. Wasylycia-Leis: So is the $18 million which was the target for '91-92 not then a target against the base of urban hospitals?

Mr. Orchard: It is the first call on the $723 million this year.

Ms. Wasylycia-Leis: Let me try another angle. Could the minister indicate what this so-called target set by his department or the Urban Hospital Council is for, to be deducted from the base of the '92-93 budget?

Mr. Orchard: Let us take my honourable friend back to April 1, 1991. Demands were made in terms of how much money the hospitals wanted to expend. We said no, here is what we want you to spend. That figure happened to be $680 million. That was the baseline budget that was established for the Urban Hospital Council membership last year. This year it is $723 million, and the first call is unachieved targets on budget last year. In other words, any dollars they expended above the $680 million is first call on the $723 million this year, because that is what "no deficit" means. That is what it means by meeting your budgetary targets.

Ms. Wasylycia-Leis: Unless the minister is prepared now to say finally that the $12-million unachieved target is actually a deficit, then I think we are dealing with something quite separate and apart from this whole issue of hospitals running deficits or not, because in fact the minister has not ever said the $12-million unachieved target is a deficit in clear terms or, as he put it, an overexpenditure. Therefore the requirement of meeting that unachieved target is not tied to a no-deficit policy. It is a separate issue.

* (0000)

Mr. Deputy Chairperson: The hour now being 12 midnight, what is the will of the committee? Carry on?

Mr. Orchard: Yes. I do not know how many times we can dance on the head of a pin, but $680 million was the budget for the Urban Hospital Council members last year. I just asked whether we had '90-91's numbers so that my honourable friend could see that in the progression that I shared with her earlier on, where we went from $845 million to $892 million, the members of the Urban Hospital Council shared in a significant portion of the $47-million increase. It was not as much as they asked for, and when they did not achieve their budgets within $680 million and the global adjustments and the targeted adjustments, out of the $53 million this year, they have to find the deficits as first call.

That has not changed since–my honourable friend sat around the table and should have asked these questions of the Minister of Health in her administration. What we are in the process of receiving from the members of the Urban Hospital Council now are plans of action, one and two years in duration depending on the facilities, telling us how they are going to meet the budget target of $947 million globally for the hospitals, $723 million of that to be dedicated to the Urban Hospital Council members. Those action plans will detail the operational initiatives of the hospitals to expend $723 million this year.

If my honourable friend wants to know, did they ask for more? Yes. If my honourable friend wants to ask, did they want their deficits covered? Yes. If my honourable friend asks, did they want targets to be eliminated? Yes, but what we have done is set a global hospital budget $53 million more this year than last year, of which the Urban Hospital Council members are being asked to expend $723 million. In acceding to that request, they are developing action plans to show how they will structure their operations to achieve that targeted expenditure rate of $723 million for the Urban Hospital Council.

Ms. Wasylycia-Leis: Could the minister give us that figure for 1990-91 for Urban Hospital Council members?

Mr. Orchard: $645 million.

Ms. Wasylycia-Leis: Could the minister tell us, what is the total value on the request made to government for each of those three years from the Urban Hospital Council?

Mr. Orchard: We do not have that, but it was significantly above $645 million in '90-91, significantly above $680 million in '91-92, and significantly above $723 million in '92-93. I do not know whether it was $50 million more or $75 million more in each particular year. I do not know, but it was more.

Ms. Wasylycia-Leis: I would ask the minister to provide us with that information, since it is the minister who has, whenever we have asked the questions about these budget target reductions and restructuring targets and so on, said, the numbers

we are dealing with are the difference between what urban hospitals have demanded and what government was prepared to fund.

So I would like to know in the case of going from '90-91 to '91-92, what the figure is, because the minister says one day it is $18 million and now he is saying it is a significantly high number, it might even be $50 million. So there is clearly a difference here, and I am wondering if he could provide us with those figures, so I can understand then what these targets mean.

Mr. Orchard: I would suspect that the budget goes through a first blush, a second blush, a third blush and then you get down to negotiating. That is why I cannot tell you what the original request was from the hospitals.

I think if my honourable friend remembers her brief tenure as a minister, probably the first time you looked at your Estimates from your department there was a request—and I will just pick a figure. Let us say your department had a budget in the previous year of $30 million, I would venture to say the first time you looked at Estimates the request was probably for $40 million. Then you came back because you had Treasury Board targets that said, no, you cannot spend $40 million, you can only spend XYZ. They would come back at somewhere, maybe $35 million, and then finally you would end up at a figure of maybe $31 million or $32 million.

There is a whole process of discussion and negotiation, where you go from the optimal request of all program expansions, new expansions, et cetera, could come down to where the real budget discussions are going to be, around the maintenance of service within the hospitals. That has always been the $18-million difference, but what the hospital started out requesting before we got down to the $18 million, I cannot answer that. It could have been $50 million more, $60 million, $100 million more. I do not know.

That is rather irrelevant and pointless, because institutions and people in health care make incredible demands. One might recall in October of 1989, the Manitoba Nurses' Union was asking for a 30-percent raise in one year. Well, I mean, that is part of the posturing of negotiations in dealing with the funding agency.

The real difference is in the $18 million that they said was bare-bones operation, and we said, no, here is bare-bones operation from government's standpoint. That is the difference between what they indicated would be, if I can use such nondescript language, bottom line on each case. We asked, is the funder to manage within $645 million in '90-91, $680 million within '91-92, and $723 million within '92-93?

What those original requests were, I suggest they were a fair bit less this year than two years ago and three years ago, because there is some sense of reality coming even within the health care system that they cannot make unlimited demands on the public treasury. What the original total, all up request was is a meaningless figure because it has never been acceded to. The $18 million was a bottom-line absolute difference that hospitals said they needed. We said, we could not provide, manage your way across the system to make it happen, and that is where the $18 million came in.

It was not that the hospitals started out saying, we need $698 million last year. That was not their first request. I do not know what their first request was, but it was higher than that. Negotiation took it down, where they said this was their absolute bottom line; our analysis said, you can manage on $680 million and that is what we made available. That is what we asked them to manage around. They did not achieve that. That is why it is carried forward this year. That is why we are developing one- and two-year management plans to deal with it.

You might recall some discussion—well, you were not here, but the member for Dauphin (Mr. Plohman) was talking about the deficit at the Dauphin Hospital, which had reached $400,000, because they had staff beyond the funding guidelines within the budget. The board and management have agreed that they will not do that and have presented us with an action plan, that they reduce that $400,000 deficit within global budget over two-and-a-half-year period of time.

We accept that management plan from the Dauphin General Hospital board and administration. Currently, our Urban Hospital Council's members are developing their management plans. Some hospitals have to deal with their unmet targets only, some have to deal with unmet targets plus the deficits they incurred in their operations.

But all of them are developing one and two management plans to indicate to us how they will deal with it in this fiscal year, with an increased

budget of $723 million to deal with, over the $680-million budget they dealt with last year.

I know my honourable friend is wanting to use the language of cutbacks and it-is-not-enough. That accedes to the argument that you give them what they ask for; we are not there. I hope that has been a reasonable explanation which takes one from step A to step B.

* (0010)

Ms. Wasylycia-Leis: Hardly a reasonable explanation, because, in fact, it is the minister who has confused this dialogue by referring, one minute to $4 million in deficit that is the first call on the $53 million; then he says there is the $12 million, which is the unmet target. One minute it is okay to lump it all together and say that is deficit, and that is all on the first call against $53 million. The next minute it is they are two different things. Why would he have come out with these two different figures if they did not mean two different things?

Is he saying that if the $12 million unachieved this year and the $10 million, or whatever, for the fiscal year we are in, target is not met, that is going to be considered not in compliance with the no-deficit policy?

Mr. Orchard: Any time a hospital operates beyond the budget, that is deficit, and it naturally comes to the first call on their next year's budget. They presented government with management plans, as Dauphin did, to operate or to reduce their deficit within a management plan over a two-and-a-half-year period of time. One- to two-year operational plans are being developed now around the budget target of $723 million for urban hospitals.

They must take into account deficits if they incurred them, or unmet targets from last year's $680-million budget. Yes, they have to consider those. Those are not magically paid dollars. We are asking them, within $723 million, to manage care delivery, et cetera, and to give us management plans to show us how they are going to do it.

Ms. Wasylycia-Leis: At the risk of sounding like a broken record, I will ask this again. The $4 million in accumulated deficits for the Urban Hospital Council members, are, the minister says, a result of overexpenditure. The $12 million from the Urban Hospital Council members is unmet target.

I do not know the difference between overexpenditure and unmet target. It seems to me the outcome is still the same. There is a difference between what was required in the minds of the hospitals and what the government was willing to pay, and that money has to be found from somewhere, dealt with in some way, either by way of government changing its targets or forgiving deficits or for hospitals to reduce parts of their operation.

So there has been no explanation to date, the whole evening that we have gone around and around this issue, for the difference between this $4-million deficit and the $12-million target. I think, in fact, what is the case is that we are dealing with, as I said before, two separate processes, two separate parts of a government agenda, and rather than the minister just simply being straightforward and saying what it is so we can get on with it, he continues to provide us with a lot of bafflegab to bamboozle us with different figures and keep changing the line around them and moving the target and playing a shell game so that we really cannot get at the heart of the matter.

I simply wanted to understand where these targets came from, why they exist and on what basis they were established, and yet I cannot get that answer. The minister has not clarified.

He has even made me more suspect of the government's agenda by throwing out different figures tonight, by saying on the one hand there is a $4-million deficit. That is the first draw on this $53 million, and then changing it and saying there is another $12 million which is the first–whatever word he uses–draw on this $53 million.

He has indicated that there is more this year in terms of a target and may be spread over two years, but that is a lot of money that adds up to be drawn against the $53 million, to the point where there is not a lot left for salaries, for supplies, for basic inflation in hospital budgets, never mind everything else he said was part of the $53 million which was any new projects, any new programs in hospital, any new capital projects in the operations of those renovations or additions or new facilities.

I am still left with the conclusion, after all of this, that we may be dealing with what we suspected all along, which was a zero percent budget to hospitals, because if you subtract everything the minister says must come against the $53 million, what is the funding policy? What does it amount to for

hospitals? What percentage are we actually talking about when all is said and done?

Mr. Orchard: I guess I do not know how I can argue against my honourable friend's logic or lack thereof, and I do not want to be offensive, but how in the world can one get into this circumstance where there are cutbacks, where there are reductions in funding, where there are allegations of dire consequences, when for the Urban Hospital Council membership you go from $645 million in fiscal year '90-91 to $680 million in fiscal year '91-92, to a projection of spending of $723 million in fiscal year '92-93? Each year, an increase. Each year, a pretty significant increase. Each year, not as much as requested. Each year, operating under a no-deficit policy. Each year, more money. And my honourable friend is saying, I do not understand what is happening here.

What is happening here is hospitals are spending $645 million, $680 million and projecting to spend $723 million. In addition to that, they have run incurred deficits which they must take as first call against their current budgets.

I do not know what else to tell my honourable friend except to indicate to her that if she reckons this is a fairly tough policy in Manitoba for hospitals to deal with, it might be kind of interesting to pick up Hansard on the debates in Ontario and Saskatchewan, for example, or Nova Scotia or New Brunswick or Prince Edward Island or Newfoundland where hospitals are significantly constrained. My honourable friend from the luxury opposition as a New Democrat is saying, give them the money.

Point of Order

Ms. Wasylycia-Leis: On a point of order, I have never once suggested give money, give more money, give less money. I have simply tried to get a handle on this government's funding policy vis-a-vis hospitals, and if asking questions suggests to this minister that I am on one side of the issue or the other then I do not see why we have Estimates, what we are doing here, why he keeps questioning the integrity of opposition members and suggesting that there has always got to be some hidden agenda behind everything. All I am trying to do is understand what the minister's policy is. Now, let me ask it this way–

Mr. Deputy Chairperson: Order, please. Let us start with the fact that the honourable member did not have a point of order. It was a dispute over the text.

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* (0020)

Ms. Wasylycia-Leis: If the budget for urban hospitals for '92-93 is $723 million, but, if as the minister says, we must subtract from that amount $12-million unmet target–and I am just repeating what the minister has said to me. When you subtract against that $12-million unmet target $4-million deficit level, $10 million as I understand it to be the new target for '92-93, we get a total of $26 million which must come against 723 which brings it down to 697, which means an increase of $17 million from '91-92.

If that is what the minister is saying, fine. I just want to hear what is left? What is left to handle normal negotiations and inflation in terms of supplies. Never mind new programs and everything else, let us just deal with some of the basics and what hospitals are up against.

I am not for one minute suggesting we do not have to look at finding ways to trim hospital budgets. I have said before, I have talked about the top-heavy administration, I have talked about unnecessary procedures and places to find savings in hospitals. I would be happy to have that kind of more in-depth dialogue, but I cannot even get to square one in terms of understanding what level the minister is prepared to fund hospitals to, once we have taken into account all of these different scenarios which clearly must be put against the so-called new, increased levels for hospitals.

Mr. Orchard: Mr. Deputy Chairperson, you do not deduct from $723 million the numbers that my honourable friend has just talked about and end up with a net figure of $696 million to spend. They will spend $723 million. They will spend $723 million, not $696 million. If I could get away with that, I would.

I would love to have that imposed on them that you only spend $696 million. That is the first suggestion I have got from my honourable friend that I have some sense of agreeing with, but do you know what? Can you imagine the screams and hollers that you would hear when your alleged people you are talking to hear that you only want to give them $696 million now, that you are deducting all of these things?

I am saying to you that last year's budget was $680 million. This year's budget is $723 million. If they have over-expended last year and they spent a million dollars more on their budget last year, that million dollars is part of the increase that they will get this year. It means they will still spend $723 million this year, not less–$723 million more than last year by $53 million in the whole Hospital line.

My honourable friend surely must understand that when she was around the cabinet table, passed the no-deficit policy, and hospitals incurred deficits, their increase the next year had to pay for the deficit of the previous year first. That is nothing new. I mean, what is baffling about that?

They are going to spend the $723 million this year. I hope they do not. That would be delightful to have some lapsed funding in hospitals, but I suspect they will spend it all. They are not having it reduced down to $696 million, as my honourable friend has done her mathematics to arrive at. No. They are going to spend $723 million this year.

They want more. Not unusual. I do not know how I can get my honourable friend into the thinking that nothing has changed in terms of the way hospitals cannot incur deficits; where they exceed their budget allocation, they must retire it in ensuing years' budgets.

Dauphin, $400-million deficit accumulated over three years of operation prior to last fiscal year. Action plan, operational plan to retire that within the global budget over the next two and a half years. An action plan to reduce the deficit, not to have government give them more money, not to have government give them less money, but to give them their global increases and within that they will manage the elimination of a $400,000 deficit.

They are going to have a bigger budget in Dauphin this year than last year. All of the Urban Hospital Councils are going to have a bigger budget than last year, but where they have incurred deficits from last year, they must retire those from the budget increase this year, from the global budget this year.

That is what has happened every single year. My honourable friend finds that baffling, difficult to understand, confusing, and on and on and on. Tt is a very simple concept: if you have over-expended from the previous year, your increase in the current year will have to recoup that deficit either in one year or a two-year period of time, action plans for the expediting of that being developed right now.

Nothing terribly baffling about that, except that they are not getting less money, they are getting more money. I can go through the numbers again if it gives my friend any comfort, but they will be the same numbers I give her for the hospital budget globally, or for the Urban Hospital Council membership for three fiscal years.

More money every year, not less. Not as much more money as they would like, but more money as to manage within the no-deficit policy passed by Howard Pawley and the NDP in 1986-87. Continued in May, 1988 on by the Progressive Conservative administration of Gary Filmon. Can I help my honourable friend with any more information?

Ms. Wasylycia-Leis: Just a couple of short, brief questions here. Is the minister saying that there is a $4-million deficit for urban hospitals for 1992-93 that must be retired first and its first call against any increase which happens to be $53 million for hospitals? That is the first question.

Mr. Orchard: The $4-million deficit they have to achieve where they incurred in this year's budget. Not every facility has incurred a deficit, in other words.

Ms. Wasylycia-Leis: Is the minister saying that as far as his Estimates reveal, he believes there will be–there is for 1992-93 a $4-million deficit from among urban hospitals, from members of the Urban Hospital Council, that it must be retired by the definition of the no-deficit policy, and therefore that is the first call on the $53 million.

Mr. Orchard: That is the first call on the Urban Hospital Council portion of the $53 million.

Ms. Wasylycia-Leis: I would like clarification on the other part of this equation, and that is the $12-million unmet or unachieved target set by the Urban Hospital Council last year for the 1991-92 fiscal year. That unmet target, unachieved target of $12 million, must also be part of the first call or next in line in terms of the portion of the $53 million set aside for the Urban Hospital Council.

Mr. Orchard: The $680-million budget for last year '91-92 was predicated on achievements of no deficit and had the built-in $12-million target adjustment achievement to be at 680. This year, 723 is the global budget for the Urban Hospital Council membership with that budget unachieved having to

be achieved. Yes, exactly as I have said ever since about 3:00, no, about 4:00 this afternoon. I cannot make it any clearer to my honourable friend.

I do not know what is so confusing. I mean, I have said that–this must be about the 25th time I have said that. What is so confusing about that? What is it that you cannot quite understand when I say, yes, it has to be achieved, it has to be achieved. It has to be achieved within the budget that went from $680 million last year to $723 million this year, not a decrease as my honourable friend is wont to believe, but an increase.

* (0030)

Because I know my honourable friend has a great fondness in her heart for two other provinces, Ontario and Saskatchewan, I want to deal with Ontario. Ontario this year would have gone from $680 million–if we used the Ontario funding formula, we would have put in–is it 1 percent or is it 2 percent? There is a little confusion here. If you are a New Democrat you say 2 percent, if you are a deputy minister from Ontario you say 1 percent, but let us split and let us go 1.5 percent. That means that there would be $692 million in Ontario to deal with their budgetary requirements if we funded à la Ontario.

If we funded à la Saskatchewan, we would have 2.8 percent less which would be–they would have $662 million to deal with same care delivery that they dealt with with $680 million the previous year. Taking last year's budget, $680 million in Manitoba, Ontario formula for funding would give them $692 million to operate on. Saskatchewan formula for funding would give them $662 million of funding to operate on. What does Manitoba's funding give them? According to my NDP friend, a cutback of $723 milllon.

I do not know how much more plainly I can make it. They are in raw terms $30 million better off in the province of Manitoba than they would be if they were being funded as in the province of Ontario. They are $51 million better off in Manitoba than if they were in the neighbouring province of Saskatchewan.

I fully recognize and acknowledge, as I have acknowledged now for the last five hours today, for approximately 30 hours before that when we talked hospital funding, they asked for more, yes. They did not get more; they did not get as much more as they requested, I should say, but they got more. If they were in two other jurisdictions they would have got significantly less more than what they are getting in Manitoba.

That does not make for very good English, but it is a very accurate fact. The difference is $30 million between an Ontario funding formula and a Manitoba funding formula, $30 million less if we followed the Ontario model and–I just have to make sure I have it right because this seems–61 not 51–$61 million less in dear old Saskatchewan, under a Saskatchewan funding formula.

I wonder where they would rather be, Ontario, Saskatchewan, or Manitoba, because if you think for one minute the hospitals in Ontario and Saskatchewan are not going in with deficits, because there are no-deficit policies in place in those provinces, too, and they are being asked to deal with pay equity for which they have had no funding over the years, salary increases which there has been no funding provided in the baseline funding, and an increase in funding even giving my honourable friend the generosity of 2 percent in Ontario and 2.8 percent less in Saskatchewan. Let us put it into perspective. Where would you rather be?

I know my honourable friend says, just give them the money. Let them spend it. That is not what New Democratic Parties in two neighbouring province, east and west, are saying when they are in government. You know, I bet you the frustrating part of it is, I bet you the Minister of Health, my honourable colleague Frances Lankin, in Ontario is having to deal with this issue with probably a Conservative critic who is saying, give them more money. I do not know what is going to go on in Saskatchewan.

Does my honourable friend see any sort of anomaly in here that is building up? We are talking about less money and being unable to operate and all these dire consequences when there is a 6.1 percent increase in the budgetary allocation year over year. It is not as much as they asked for, but it is a significant increase in monies which we are asking them to manage, and I will go through it again.

They develop one or two management plans to deal with their budget allocations, as Dauphin has done, not with a $400-million deficit, but only a $400,000 deficit. I had a little slip there in case the good folks in Dauphin are reading Hansard. We

can go on and talk about this for another 20 hours, I do not care. The answer I am going to give my honourable friend is going to be the same one I have given now for approximately 25 hours of discussion. It is not an answer that satisfies my honourable friend. I do not know what would satisfy my honourable friend, because on the one hand she is saying that she does not want them to have more money, but then when they are getting more money, she seems to be saying to me, well, it is not enough, it is not real. Well, it is real.

There is going to be $723 million spent by those hospitals this year. That is real money, real tax dollars, real deficit, because if you want to get blunt about it, every dollar we are spending here is a borrowed dollar. I do not know what else I can provide to my honourable friend in terms of information, but I will try. I will try to answer my honourable friend's questions.

Ms. Wasylycia-Leis: That was an awfully long, defensive answer for a straightforward question about what constitutes basically the $53-million increase, since my question had to do with the fact that the minister has indicated already that the $12 million unmet target and the $4-million deficit resulting from overexpenditure, and the new target for this fiscal year of roughly $10 million are put against the $53 million. So I am simply trying to get an understanding of what is the real increase, because, in fact, I am not any more satisfied after several hours of going around and around this issue that we are dealing with a real increase and not anything more than creative accounting and some pretty interesting budgeting processes put in place by a minister who is no stranger to creative bamboozlement and bafflegab.

So let me ask once more. Let me try it a different way. Of the $53-million increase for hospitals, what is the share for urban hospitals of that?

Mr. Orchard: For about the 20th time, $43 million.

Ms. Wasylycia-Leis: Could the minister give us now the breakdown for urban hospitals of the $43 million?

Mr. Orchard: By hospital? No, I cannot give it to you by hospital.

Ms. Wasylycia-Leis: Not by hospital, but by category as we discussed earlier with respect to the overall $53 million.

Mr. Orchard: The major components are: just about $11 million out of the MNU agreement, and then we have annualization of pay equity on top of that, which is just under $3 million. So that would be, I suppose, salary adjustments. Then we have economic increases, including a provision for the contract settlements that are to be negotiated that we have given them the funding mandate for, which would total about $14.5 million for those economic increases, supplies and other parts of the budget, included in that being the allocation for salary bargaining under the unions that are coming to the bargaining table this fiscal year. Then we have a little over $3 million in other funding.

So that should come up pretty close to the $43 million when you add in new construction.

* (0040)

Ms. Wasylycia-Leis: Just a clarification there, $3 million, what was that for again?

Mr. Orchard: Just about $3.5 million on dialysis and other programs.

Ms. Wasylycia-Leis: So does that mean about $10 million for capital?

Mr. Orchard: A couple of million more.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, of that, how much, and this relates to an earlier request, has been set aside for operations of the new psych services building, Health Sciences Centre?

Mr. Orchard: A fair bit of the new construction costs are there, and we do not have that broken out.

Ms. Wasylycia-Leis: My question had to do with operating dollars for the psych services building. Why would that be under new construction?

Mr. Orchard: Because there are interest costs associated with the investment in new construction and they are pretty significant, and in terms of the operating cost, I cannot provide what the final figure is going to be in this budget, because we still have not completed our negotiations with the Health Sciences Centre.

I will be very direct. How do I put this genteelly? The requests to operate the new facility are significant, and we are being very pointed in our negotiations to achieve a lowered operating budget than what is being asked for, i.e., my honourable friend has probably heard some of the speculation around increased operating costs, et cetera. Not that I want to reinvent the issue around budget again, but again there is a difference between what is asked for and what is finally negotiated and

achieved, and we are still working on that budget finalization.

We do not have a finalization nor is it an urgent issue, because we are looking at roughly a September gearing up. But the one thing that we do know is that we have an investment, and we have the capital construction costs, new construction additional costs that, with interest, are adding a fair significant chunk of that approximate $11 million that is part of this budget increase.

Ms. Wasylycia-Leis: Is the minister now prepared to give us the information we had requested with respect to details pertaining to the construction of the psych services building, the tendering process on a stage basis and the actual expenditure and the lowest bid for each stage?

Mr. Orchard: The psych health building was undertaken by project management. A request for proposal was sent out and five respondents were interviewed. The successful proponent was UMA Spantec and offered one of the lowest, total cost proposals and was prepared to work within a fixed-fee amount. In other words, for their project management fees they were willing to, on their proposal, operate with a fixed-fee amount.

Construction tendering was by sequential tendering of multiple bid packages, the staging. There were approximately 32 bid packages to subtrades as the work progressed. UMA Spantec acted as the general contractor for their fixed fees.

All tenders were by prequalified bidders selected by Spantec and the Health Sciences Centre from those subcontractors who answered the public call for consideration of their qualifications. In the course of the construction there was only one subcontractor that disputed the qualification criteria, and I believe that was resolved, but I do not think that particular subcontractor received any of the work.

We had allocated $51,700,000 for the project all up, and we believe that upon completion that it will be achieved for $50,705,000. So as it stands right now, it looks as if it will come in slightly under what we had projected in the '92-93 capital budget.

Ms. Wasylycia-Leis: Could the minister give us the details with respect to the 32-bed packages? Could he break it down in terms of the tendering process and the lowest bid?

Mr. Orchard: Well, not tonight. I would have to provide that information. It might take us a day or two to get it.

Ms. Wasylycia-Leis: That had been the intent of my earlier question to have that level of detail pertaining to the staged construction and tendering process of the psych services building, so if the minister could provide that as soon as possible I would appreciate that.

Mr. Orchard: I will make every effort. Yes, indeed.

* (0050)

Ms. Wasylycia-Leis: Let me just try one more question or a couple more before we call it an evening. Back on the–I would not want to not end on the question of hospital budgets. I just want to ask the minister, now that he has given us sort of a breakdown of the $43-million increase for urban hospitals, and it is covered in terms of MNU, pay equity, economic increases, new programs, capital and bargaining.

He has also said that the $4-million deficit must come against the $43 million and the unmet target of $12 million, and presumably the new target for this year, does that mean hospitals for that have those deficits and those targets to meet that they will have that much less in terms of dealing with contract settlements, increase on supplies, pay equity, MNU, new capital and so on?

Mr. Orchard: They will have their budget increased from last year to qualify for their portion of the $723 million. It is a roughly similar increase with the exception of where new construction may have a greater impact on facility A versus facility B. Some facilities probably do not have any–oh yes, there would be a number of our Urban Hospital Council members who have no commitment from the capital construction costs, so they would not access any of that. The Urban Hospital Council members must develop their budgets around the reconciliation of their share of the $723 million which is being provided, and that is $43 million additional. If they have incurred a deficit, they must retire or offer to government an action plan by which they will retire unmet commitments from the previous year's budget, just as we recently concluded with Dauphin General Hospital.

Ms. Wasylycia-Leis: To just follow that up with a hypothetical example, if a facility has, say, a $2-million deficit, in other words, overexpended the previous year and has been assigned, say,

$8-million target, that is a combination of unachieved target of the past year and new target for this year, then that $10 million must first be met and addressed before. Then whatever is left, if there is anything left, goes toward meeting the requirements in terms of salary negotiations, increase in supplies, pay equity, capital–no, never mind capital–everything else but.

Mr. Orchard: Mr. Deputy Chairperson, I cannot deal with a hypothetical facility which may have XYZ. Every facility is going to have an increase in their budgetary commitment this year over last year. It will vary, and the reason it will vary is whether there is new capital construction that is coming on. Otherwise, there is roughly–and I think I am accurate in saying roughly–the same commitment to their budget in terms of past agreements such as the Manitoba Nurses' Union. There is a differential commitment by facilities in terms of pay equity because some were more complete in the pay equity process than others.

The bargaining mandate and supplies and the other general economic increases, they are consistently applied across the global budgets that the respective facilities have. The variation which will come in is dependent on how well the respective facilities were able to achieve management of last year's budget, which in total was $680 million and this year is $723 million. So they are going to have to manage and meet new and past obligations out of the $43 million, and that will vary facility by facility. Some facilities did not have deficits and in fact had a modest surplus. Their problems in managing their share of the $723-million budget will be less than those who have incurred deficits.

The $723 million will be expended by those facilities, and in order to indicate to government how they will expend those dollars, they are developing action plans, action plans which will outline how they maintain their program with the level of funding commitment, the renewed and increased level of funding commitment, that we have made this year over last.

Within these respective management plans that varying facilities will offer to us from the Urban Hospital Council will no doubt be a variation of plans according to whether they have deficits from last year, et cetera, and that will vary each plan.

Some will be relatively less difficult to achieve than some of the ones where deficits have been incurred, but they are to develop their plans around an increased budget of $43 million at their disposal, not a decreased budget, but an increased budget. It is not a big enough increase, as I have said before, but it is an Increase over what they had budgeted last year. Each one of them will be developing their plans and presenting them to government for approval.

Ms. Wasylycia-Leis: Could I just get a–I was going to say get a quick answer, but I should not be so presumptuous–raise the issue briefly of these bed reduction target numbers that we have discussed before that, I believe the minister has indicated are part and parcel of the Urban Hospital Council decision-making process and related to the budget reduction targets. Are these bed reduction targets part of these budget reduction targets or in addition to the budget reduction targets?

Mr. Orchard: Mr. Deputy Chairperson, I do not want at one o'clock in the evening to get into my honourable friend's desire to speculate around bed closures, the advent of any and all, that the system is going to reduce the size of the acute care hospitals, and in doing so will mean a reduction in size of the teaching hospitals according to their bed complements.

In the process of doing that it is not a narrowed isolated exercise of dealing with the hospitals only. It is putting the patient at the centre and using much of the information that my honourable friend had the privilege of seeing Wednesday last, and managing around appropriate admissions, length of stay and other issues of management wherein we believe that the patient's opportunity to access needed care in a reformed health care system will be uncompromised.

That means shifting resources to community and to lesser cost institutions where appropriate for the patient and where achievable within the context of system-wide reform. That process is a process for discussion and action over the next ensuing months. I am not getting into my honourable friend's speculation around that issue right now.

But I do indicate to my honourable friend that with all of this speculation that she may be hearing that the reform of the health care system on the acute side is accompanied by a $53-million increase in our hospital funding, not a decrease, but a $53-million increase in our hospital funding, and a $7-million increase in terms of our Continuing Care Program.

In addition to that, funds specifically targeted in the health services line, the $3 million for reform projects. In addition to that Health services development funding increased by $4 million to provide bridge funding where appropriate in terms of the reform of the acute as well as the mental health system. In addition to that, the Support Services for Seniors programs will be undertaking the funding of some additional projects this year.

All in a deliberate effort to shift our resources with the patient to the most appropriate cost-effective level of care. That is a reform of the system that is said by many to be long overdue and will be a subject of significant discussion in the near future.

* (0100)

Ms. Wasylycia-Leis: Again, Mr. Deputy Chairperson, I raised a question that was not passing judgment or making comment, I was simply questioning where these targets are being set, what they mean, what they are based on. I will not pursue it at this late hour, but I will come back to it again, since it is a question that needs to be asked if we are going to be able to understand what the minister's plans are with respect to change in our health care system.

I would like to ask just a couple of brief questions before the evening is over. Could the minister just tell us, what is the overall increase being set aside for community health clinics?

Mr. Orchard: Just about three-quarters-of-a-million dollars.

Ms. Wasylycia-Leis: Could the minister give us some idea of how he is breaking that down as he is doing with hospitals?

Mr. Orchard: It is in terms of their program delivery, and it is to meet their salary obligations, their supply obligation, same as what they have to do in the hospitals.

Ms. Wasylycia-Leis: Perhaps it is too late to ask for this now, but I will ask the minister now for–perhaps, he could provide it tomorrow–how he breaks down the three-quarters of a million in terms of, as we have gone over this evening, with respect to hospitals, in terms of salary negotiations, supply increases, programs and so on?

Let me just conclude this evening by asking one other small area of this whole section and that has to do with the–and it ties into the hospital issue and the Urban Hospital Council, and that is the hospitals innovations fun. This new fund of $3 million as described in the Estimates book, this fund is to be administered by the Urban Hospital Council, yet is to apply to all facilities or all hospitals in the province of Manitoba.

Is that the case, and if so, what is the rationale for that?

Mr. Orchard: It is an administrative procedure to launch a new hospital innovations fund.

Ms. Wasylycia-Leis: We are referring now to the Manitoba Health Status Improvement Fund. I am assuming we are all talking about the same thing. Could the minister indicate why this fund is to be administered by the Urban Hospital Council, when it is the Urban Hospital Council that is in fact trying to come to grips with the size on the institutional side and working among themselves for reducing budgets and achieving bed reduction targets?

Mr. Orchard: I guess we could have created a new committee and established another committee, and then my honourable friend could have said all we do is establish new committees.

The concept is in terms of hospitals innovation fund. Our CEOs are members of the Urban Hospital Council and probably have as much collective and combined experience in management of hospitals to recognize a good innovation plan as any group that I am aware of in the province, and their assistance is, we think, probably valuable as we launch this fund in helping hospitals to achieve program changes and operational changes which will make them more effective care deliverers in the new realities of constrained budgets of the 1990s.

If my honourable friend is unsatisfied with the answer as to why the Urban Hospital Council, then, I give up. Tell me who should be doing it, if not them.

Ms. Wasylycia-Leis: Could the minister indicate if he has consulted with rural hospitals and how they feel about their chances of accessing this fund that will be administered by the Urban Hospital Council?

Mr. Orchard: Well, my honourable friend might be aware that we are meeting with our Rural Hospital Council which is newly established. At the time of production of Estimates, we did not have a Rural Hospital Council. There will be an opportunity, as the council in rural Manitoba matures in its deliberations over issues, they may well have a portion of that fund to decide for themselves. That

decision has not been made, but it is a distinct possibility to give that input.

If my honourable friend is concerned that there may be some inability for rural facilities to access it, because the old boys' club in the Urban Hospital Council might trample them, I accept that concern, and that is why we are open to the consideration of our rural health council having the ability to make decisions around a portion of that fund.

Ms. Wasylycia-Leis: As a last question, what mechanism will be in place, if any, to involve the Centre for Health Policy and Evaluation, which by all of their reports in the seminar of last week, is dealing very much with quality improvement issues? Will there be a role for, or some connection there between Urban Hospital Council and this centre that is dealing with quality assurance?

Mr. Orchard: I would expect that should there be an analytical role that would be most appropriately accomplished by the Centre for Health Policy and Evaluation around applications to this health services improvement fund, we would certainly not hesitate in seeking their input and analysis.

Ms. Wasylycia-Leis: I certainly look forward to continuing this dialogue tomorrow.

Mr. Deputy Chairperson: The hour being approximately 1:10 a.m., what is the will of the committee?

Committee rise.

EDUCATION AND TRAINING

Madam Chairperson (Louise Dacquay): Order, please. Will the Committee of Supply please come to order. This section of the Committee of Supply will continue to consider the Estimates for the Department of Education and Training. We are on page 39, Item 2, Financial Support - Schools (a) School Grants and Other Assistance.

Would the minister's staff please enter the Chamber.

Mrs. Sharon Carstairs (Leader of the Second Opposition): Madam Chairperson, just before we adjourned at five o'clock I had asked some questions which the minister had answered by saying that she had not in fact entered into any negotiations because they had some concerns that the independent schools might want to open other concerns.

I just want to make the comment that if you have never raised the issue with the association, then you have no way of knowing whether they would be inamenable to seeing some financial changes made, provided that the spirit of the agreement was not in any way going to be violated and that you would meet your target of 80 percent by 1998, a position that I support. If you do not at least raise the issue with them, you are never going to know whether they are amenable to being part of accepting some responsibility for the implications of the recession. I think everybody else has been asked to accept those implications, and I do not quite understand why the independent schools have not been at least asked to consider playing a participatory role as well.

Hon. Rosemary Vodrey (Minister of Education and Training): Madam Chairperson, I appreciate the support to the end point of the agreement that the member has raised, and I have to just take that a little bit further at this point, to say that we have viewed the agreement as an agreement at this point. That we are aware, as I said before, that there were some issues which I am sure the MFIS would like to have had included, and at this point, to open up the agreement would offer the opportunity to then bring forward some other issues. There are some issues which, again, we are perhaps not able to incorporate at this time.

So I appreciate her support to the end point of the agreement and, at this point, to say that we see the agreement as one which is an agreement, and it was believed to have been that. There were concerns raised, I am led to believe, at the time of the agreement around any kind of potential changes. I am led to understand that they were told that that should not happen, and so at this point, we are viewing it as a settled agreement.

Mrs. Carstairs: The critic for the NDP raised the issue that at Ravenscourt, in particular, there are no special needs children. The last time I looked at the tuition fees at Ravenscourt, they were running about $7,500 a year. So unless a special needs child was going to benefit from that kind of educational program, I find it difficult to believe a parent would invest that kind of money in that program.

But I would like the minister to put on the record, if she can, the fact that there are similar programs in the public schools for which there are no special needs students. I would, for example, identify the International Baccalaureate Program that is taught

at at least five schools that I know of in this city, and to my knowledge, there is not a single special needs child in any one of those programs. There are also gifted courses; again, to my knowledge, there are no special needs children in any of those programs.

Can the minister verify that information?

Mrs. Vodrey: First of all, I would like to acknowledge the comments of the honourable member in terms of the high quality of programming offered in the public school system, particularly in relation to some of the programs offered, and the International Baccalaureate Program was one program that was referenced. In addition, there are other programs for gifted and talented young people, and so on. I think that at this point it is reasonable to assume that there may not be children with significant learning difficulties; however, at this point, we cannot confirm it. We do not have the numbers specifically in terms of the young people who make up those programs. I suppose we also have to acknowledge that academic giftedness does not necessarily preclude some kinds of learning difficulties or needs for assistance in the area of speech and hearing and so on.

However, I certainly acknowledge the points that the honourable member has made, particularly in relation to some of the very high quality programming offered at this time within the public school systems across the province.

Mrs. Carstairs: The requirement that was referred to at Ravenscourt, and again I think it was Ravenscourt that was referenced, although it certainly could have been St. Mary's or St. Paul's or Mennonite Brethren, is that there are entrance examinations for those schools. Can the minister verify that there are similar entrance tests for other programs within the public system as well, and acceptance is based on success in those entrance examinations?

Mrs. Vodrey: Madam Chairperson, there are programs within the public school system that are, some of them, very academically oriented programs, such as the ones referenced by the honourable member, the International Baccalaureate–there is also the advanced placement program, the A's program. All of these programs do have a component of testing or assessment as a mechanism to get in and also recommendations as a mechanism for admission.

Mrs. Carstairs: Madam Chairperson, I would like to move in to the area of small schools. The small schools concept which is primarily a rural concept, although not exclusively but primarily a rural concept, has been one that we have had in the province for some time. I think its fundamental purpose is wherever possible to keep elementary children in their local community, although not exclusively elementary children, but I think that has been primarily the focus of small schools program.

The province is continuing to fund small schools, and I do not see any change, if any, in the way in which that funding is going on, but they seem to be removing some of the supports, for example, the small schools conferences, the support available from Regional Services. Can the minister explain why they are continuing to fund, a commitment which I support, and, at the same time, weakening the effectiveness of the program by reducing some of the supports?

Mrs. Vodrey: The issue of small schools may be more fully addressed under the PDSS section, appropriation 16-3. Just to answer some points which I think may be helpful, first of all, we still provide funding to small schools through the funding formula with the lower divisor, and also we do have a small schools consultant whose role it is to assist in terms of issues specifically relating to those smaller schools. Through the student support program, which is the new program for students at risk across the province.

* (2010)

There is also a component there, and there has been a great effort to have that program also be responsive to the issues that would come up in the smaller communities and the small schools. In terms of the small schools, they are recognized in the base support in that a smaller divisor, as I said, is used in the calculation of the recognized expenditures through the new funding formula. In addition, categorical support for small schools has been retained.

Mr. Dave Chomiak (Kildonan): Reference was made to some of the previous questions with respect to entrance requirements for the International Baccalaureate Program and others. Can the minister indicate what the fee is for individuals to enter the International Baccalaureate Program?

Mrs. Vodrey: At this point, the International Baccalaureate and the AP, there is not a fee charged to the parent. However, where the program is not offered in a division, there can be a residual cost to the division. The answer to the question was, I believe, in the area of programming and programming available within the public school system, and as I mentioned when I answered the question on those programs earlier, I appreciated attention being drawn to those very high quality programs presently operating within the public school system.

Mr. Chomiak: My only point for raising the question was to point out the fact that access to those programs is not necessarily–it may be restricted by some academic level, but is not restricted by the financial impediment of having to pay thousands and thousands of dollars as one must pay in a school like Ravenscourt to enter that particular program.

That was the problem with the Liberal apologetics in trying to somehow compare the program of the I.B. Program with the program at St. John's-Ravenscourt or some other. The comparison cannot be made and the fact that an inner city kid or some other child does not have access to Ravenscourt as opposed to the I.B. Program, I have great difficulty dealing with that Liberal-type argument.

Mrs. Vodrey: I would just like to extend the honourable member's view of the independent school system beyond the one school which he continually references, and remind him that the independent school system is composed of 53 schools and that within those schools there are schools of the Catholic system. There is also other religious programming as well and there are many, many schools, schools who have visited this Legislature located within the constituency of the members opposite. Simply a reminder that the independent school system is more than simply one individual school.

Mr. Chomiak: I would like to remind the minister that her reason for supporting, for putting in the millions and millions of dollars in increase to the system was because of the Catholic school system. It had nothing to do with the nonparochial schools, which is what the government gave gratis, without any consultation with the public, to all of those other schools that the minister and her colleagues and the Liberal Party strongly support. That is our objection with respect to access and the accessibility of all to the programs.

Mrs. Vodrey: The honourable member seems to be taking a single issue on a very comprehensive agreement. I think that it is important to remind him that this is a very comprehensive kind of agreement, it is on a very complex issue, and the schools represented are all members of the MFIS or the Manitoba Federation of Independent Schools. In striking this agreement it was an agreement to fund all of those member schools as a unit in exchange for not providing the immediate 100 percent funding to a specific group of schools and capital for those schools.

Mr. Chomiak: I am wondering if the minister has any kind of tally or toll about the total in terms of the number of Level I students that are presently in the system?

Mrs. Vodrey: Could I ask for a clarification? Is the member asking for the numbers within the province or within the independent system? It was not clear to us.

Mr. Chomiak: Within the province as a whole and division by division, if that is at all possible.

Mrs. Vodrey: This is a new funding formula and so, for the honourable member's information, we do not fund Level I according to an individual or person by person. The funding for Level I is done by formula, and we do not label Level I individuals case by case or separately.

Mr. Chomiak: Can the minister indicate for me why the figure of 180 was chosen for the divisor to deal with the Level I children?

Mrs. Vodrey: I am advised that this number was chosen to reflect the distribution of students in schools throughout the province and that the department had a series of negotiations by their own experience with individual school divisions. By experience and discussion this number was arrived at, again appearing to accurately reflect the distribution across the province.

* (2020)

Mr. Chomiak: I am very interested in how and why this number was chosen because it is obviously of great significance to school divisions, and I would appreciate it if the minister has any more detail as to how that figure was arrived at. I would appreciate that.

Mrs. Vodrey: I am advised at this point that previously–and again in short my answer remains the same, but I am advised that previously the department met with each division within the province and they talked about the number of requests for Level I funding. After three or four years of this process, there was a sense of having looked at the statistics and having been through the process that, No. 1, that mechanism was extremely expensive and that the divisor of 180 appeared to be a reasonable distribution based on occurrence. I will also remind the member that the Level I special needs funding has increased significantly this year. In 1991-92, the amount was $31.1 million, and in '92-93, $45.3 million.

Mr. Chomiak: Is the minister saying that the school divisions felt that this divisor figure of 180 was inadequate or a reasonable figure to utilize?

Mrs. Vodrey: Madam Chairperson, I am advised that the change occurred in 1988, which does take us back several years, and that at that time when the change was made there was no questionnaire sent out in terms of polling the divisions specifically. However, I am advised that there was at that time a satisfaction that we had ended the process of continual negotiation year by year, and that there had not been any complaints from the divisions. Again, I remind him as well that in this year we also increased the funds available for Level I special needs.

Mr. Chomiak: Yes, I have been reminded of that. The reason I posed that question was because of the opportunity I had to attend a public function with officials from the Department of Education and the Leader of the Liberal Party (Mrs. Carstairs) and the number was proposed that the official from Education was queried as to what the percentage of special needs students are in the public school system, and the figure given by the public official was rather low, something like 4 percent.

I think the literature I have read puts it up somewhere around 15 percent, and that is why I posed the question. I am wondering if the minister has any comment or viewpoint on that, because all the individuals who attended the learning disability conference were, I would say, surprised by how low a figure was placed on that percentage of students by the officials from the Department of Education.

Mrs. Vodrey: Madam Chairperson, I am informed that at this point we stand by that percentage. The difficulty appears to be that it has been very difficult for all parties–and it is not just in terms of government, but education and parents and other interested clinicians and support–to agree on a definition of Level I, on a definition of learning disabilities, and that the percentage may vary from a low to a high. So it appeared to be a very important change to de-emphasize the incidence and instead to focus on the interventions provided, and those interventions are provided on a case-by-case basis.

Again, I will be very happy to discuss the interventions made on behalf of Level I special needs young people when we get to the appropriation for PDSS, 16-3.

* (2030)

Mr. Chomiak: Madam Chairperson, I asked several questions about the Child Guidance Clinic last year at PDSS, and the minister at that time indicated I should have asked those questions at this particular appropriation. So I am wondering if the minister can advise me where she would request that we make specific questions about the Child Guidance Clinic?

Mrs. Vodrey: Madam Chairperson, my suggestion is that issues which relate to programming through the Child Guidance Clinic would be best covered under 16-3(e). If the member has a specific question regarding funding relating to the Child Guidance Clinic, then now is the appropriate time for those questions.

Mr. Chomiak: Can the minister indicate what funds specifically proceed directly from the department to the Child Guidance Clinic?

Mrs. Vodrey: The funding for the Child Guidance Clinic is provided in two ways. First of all, there is funding by way of a clinician grant, and if the honourable member likes I will just read in the formula.

The ratio of students per clinician this year has been lowered from 900 to one to 700 to one in terms of the ratio. In the city of Winnipeg, this means that a larger proportion of the employed clinicians will be on the grant and the Child Guidance Clinic has many more clinicians on staff than there are in fact grants available. Secondly, the amount of the grant from the department for each eligible clinician has been increased from 34.1, which is 31.0 plus 3.1 to 45,000 for '92-93. There is no longer any distinction

between support for clinicians' salaries and support for administrative costs.

The school divisions receive a net increase of $10,900 per eligible clinician and any part of this may be used for administrative costs. So the net total increase in '92-93 for the Winnipeg School Division No. 1, who then funds the Child Guidance Clinic and the suburban school divisions who are part of the CGC, is $2.1 million. This is an increase of 64 percent over the current school year.

So the funding comes in two ways. One, funding to the Winnipeg school division based on the formula which I have just explained, and then the Child Guidance Clinic is funded by the Winnipeg School Division. Secondly, that same formula is applied to suburban divisions and those suburban divisions may wish then to buy the service also from the Child Guidance Clinic.

Mr. Chomiak: I am wondering if the minister would be willing to table that formula with us, so that we could examine it in a little bit more detail.

Mrs. Vodrey: I am informed that formula is in the funding booklet, which I tabled for the member a little earlier today.

Mr. Chomiak: I thank the minister for those comments. Can the minister indicate whether or not she has an opinion or whether the department has an opinion on the potential effect of several suburban school divisions no longer participating at the Child Guidance Clinic and setting up their own independent units?

Mrs. Vodrey: Madam Chairperson, this really is a matter of local decision making. Divisions have had the option of directly operating their own clinical services since grants for clinicians have been provided by the Department of Education and Training.

The department's primary role is to provide funding support for clinician services, and this level of support, again, has been increased significantly for the school year of 1992-93. The department, though, would expect that an acceptable standard of clinician support for students with special needs will be maintained regardless of the administrative structure chosen by those divisions.

* (2040)

Mr. Chomiak: Could the minister indicate what that acceptable standard might be?

Mrs. Vodrey: Madam Chairperson, my answer is that really that there is no reason to believe that the acceptable standard of service would be any less or would be reduced should the school divisions decide to enter into their own clinical services agreement.

For Winnipeg School Division No. 1, should divisions decide to do that, then they would have fewer young people within their division and fewer young people to service.

Mr. Chomiak: Madam Chairperson, in 1990-91 early identification education support from the provincial government amounts to about $200,000. This no longer is available, and as I understand has been folded into the students-at-risk program, the $10-million program of which $7 million is already allocated.

I am wondering whether there is any component in the students-at-risk program for early identification which by all literature and by all counts is, perhaps, the most significant factor in terms of ensuring that dropouts, ensuring an adequate education for children.

Mrs. Vodrey: Madam Chairperson, the honourable member is correct that this funding has been rolled in, but for the criterion for access that would be better discussed when we actually discuss the student support branch which is 16-3(j).

I just would like to add that the Education Finance Advisory Committee had suggested rolling that in together.

Mr. Chomiak: I am also seeking direction from the minister with respect to determining whether or not there are any funds allocated in this budget–well, essentially I want to talk a little bit about French governance and the money spent on French governance, and I am wondering if this is the appropriate area.

Mrs. Vodrey: The information and discussion regarding both the funding and the programming around the Francophone governance would probably best be discussed under the appropriation 16-4, Bureau de l'éducation française.

Mr. Chomiak: Then I assume discussion of early identifications, support compensatory, inner-city support also goes with students at risk. That will cover questions under this appropriation at this point.

Mrs. Carstairs: Madam Chairperson, the minister put something on the record, which I do not think is accurate, a few minutes ago with respect to the International Baccalaureate Program, but it also applies to other programs. It is my understanding that, if a school division is prepared to fund the program, then indeed it will, but there are incidences where divisions will not fund students from their division going into a program in another school division, and in that case the parent does have to pick up the cost if they wish the child to go to that program.

For many years the students from Transcona-Springfield School Division who wanted to go to the River East International Baccalaureate Program were forced to pay those fees. Not only were they paying nonresidence fees, but they were paying supplemental fees because of the cost of the I.B. Program. Then the government finally recognized it as an accredited program and no longer pilot status, Transcona-Springfield funded their students. They have now made their decision not to fund the students, even though some of those students are partway through the program. That funding is now entirely the responsibility of the parent, and my understanding is that those fees this year will be $2,000.

Mrs. Vodrey: I am sorry if I did not make that clear in my first answer to that question. In some school divisions there are some reciprocal agreements, and some school divisions do pay residual fees on behalf of their students.

However, in some cases it is true that they do not, and there is not that kind of an agreement in place. If students do wish to attend that kind of a program, then they will be responsible for what is the residual fee. The province does pay the grant to the receiving school divisions, but the residual amount would be what would have come through local taxation.

Mrs. Carstairs: Can the minister tell us if all private schools now in the province of Manitoba have an elected board or are some of them still appointing their boards?

Mrs. Vodrey: Madam Chairperson, I am informed that we are in the process of monitoring that. We have begun to monitor that and to the best of our knowledge that is the case. Just to make sure that the differentiation is also noted, the requirements are that the independent school have a legally incorporated board of directors, and that they have an elected advisory board.

* (2050)

Mrs. Carstairs: Some of the independent schools charge no tuition; some of them charge very high tuitions. Does the department have any knowledge as to what scholarship aid is available in these schools which charge tuitions?

Mrs. Vodrey: I am informed that at the moment we do not have a list of the scholarship aid available at those independent schools which do charge tuition. However, it is certainly some information which I would be interested in and prepared to undertake.

Mrs. Carstairs: I think both the minister and the critic might be pleasantly surprised. My understanding at Balmoral Hall, for example, fully one-third of all students receive financial aid, either partial or full. I would assume that similar monies are available at St. Mary's and St. Paul's, certainly they were some years ago at St. Mary's.

Can the minister tell me what is the status right now of Cartwright independent school? Is it anticipated that in the near future they will receive anything above and beyond the $1,000 flat grant?

Mrs. Vodrey: At this point, Cartwright School is an unfunded private school or independent school, a nonfunded independent school. There are some schools operating in that category within the province. The future of Cartwright School is not clear as of this evening, because the people of Cartwright are considering a number of options at this point. They have not all been fully explored or fully brought to their end point yet.

Mrs. Carstairs: Well, Cartwright community school does receive a $1,000 curricular materials grant, so it does receive some funding. Has the three-year period or length of time when a school must be functioning before it is entitled to receive funding, has that become part and parcel of the rules of the Department of Education now?

Mrs. Vodrey: At this point, that three-year time frame is the operating rule of the department, and staff are working on an amendment to 16-5(f) to look at that further.

Madam Chairperson: Item 2.(a) School Grants and Other Assistance $573,918,300–pass.

Item 2.(b) Phase-In Support $5,600,000.

Mr. Chomiak: I have a few questions on the Phase-In Support which in the Estimates book is

noted at $5.6 million, which on the November 19 announcement of the minister was set at a two-year phase-in period of $12 million, which at the subsequent announcement on March 5 is an additional figure of $1.3 million, which when the minister's initial announcement was established with respect to the funding formula was set at $6.2 million. I am just wondering if we can come to grips somehow with these figures and the differences between them?

Mrs. Vodrey: I would like to clarify that because there is a difference between the school year and the fiscal year. On the school year the number is $8 million; on the fiscal year it is 70 percent of that or $5.6 million.

Mr. Chomiak: Does it still hold that the two-year phase-in will be $12 million therefore, which would be $8 million, I presume, this year and $4 million next year; unless you use the different differentiation it would be $5.6 million in this year's Estimates and $6.4 million in next year's Estimates?

Mrs. Vodrey: Yes, I am informed that the two-year school year support will be the $12 million estimated.

Mr. Chomiak: Can the minister outline what she anticipates school divisions will be required to do following the end of this two-year phase-in period, because some school divisions will be quite significantly affected by the lack of a phase-in, by the lack of this particular program, particularly St. James, Assiniboia, Fort Garry, St. Vital, Norwood, Seven Oaks to a certain extent, River East, Whitehorse and Antler River, as well as Leaf Rapids.

Mrs. Vodrey: This two-year time frame was given to assist divisions to look at their operating and their revenue side, and it was always seen as an adjustment period. If it had not been supplied it would have required school divisions to immediately make adjustments both in their operating and their revenue, so this has been an opportunity to allow divisions and to encourage divisions to look at their patterns on both sides, and at the end of the two years to then operate on the formula.

* (2100)

I add to that that we have met with divisions and the department continues to meet and have contact with divisions. We have some task forces operating on some areas which are of particular concern to some divisions, and we are hoping to look at some of the problems, some of the issues that they have raised in applying the formula to assist them before the end of the two-year phasing.

Mr. Chomiak: Does the minister allude to the fact that it would result in either cutting programs or raising taxes? Does the minister have any advice for those school divisions facing that prospect?

Mrs. Vodrey: I believe what I said was that the divisions would be able to have the opportunity to make the adjustments that were necessary. Those adjustments may come as they examine both the operating and the revenue side. I have met with those divisions and I have met with a number of the divisions that the member has named, among many others, and at this point I have the belief that those elected officials, and they are elected officials, will also work very hard in terms of managing within their school divisions and that they will look at both their operating and their revenue side. Again, I will continue to keep the communication open between the department and those school divisions, and those other elected officials, and also the superintendents and the educators in the field, to have an opportunity to discuss with them some of the decisions that they will be making.

Madam Chairperson: Item 2.(b) Phase-In Support, $5,600,000–pass; 2.(c) General Support Grants, $18,500,000–pass.

Item 2.(d) Teachers' Retirement Allowances Fund–

Mr. Chomiak: I have a few questions in this area. Firstly, I was very surprised to see that this item was moved from its previous stand-alone appropriation into this part of the Supplementary Estimates. I am wondering if the minister can advise me as to why this appropriation was changed to this part of the Estimates because it is a very significant, symbolic, and perhaps more than symbolic, move to move the appropriation.

Mrs. Vodrey: The reclassification, I am informed, is strictly an accounting issue. It does not represent any change in the way retiring teachers' pensions and benefit costs, as specified by statute, are funded. This accounting is considered better in the sense that these significant payments on behalf of teachers are grouped with the programs to which they relate.

Mr. Chomiak: So the reason for the move in the appropriation was to reflect a form of accounting?

Mrs. Vodrey: Yes, I am informed again that it was seen as important to put this into accounting where the function actually exists. So it has now been moved into an area which discusses support of education.

It does retain a separate status by its line in that it was seen simply to have been more beneficial to place it here.

Mr. Chomiak: Madam Chairperson, I raise this issue because, in fact, it is more than just a symbolic issue, and I think it is more than a question of accounting, at least from my perspective. As I understand, in other jurisdictions, most notably B.C., this particular line of appropriation was moved into the public school sector and was placed as a charge against school divisions.

In other words, it was offloaded onto individual school divisions. This strikes me as a first step and a move given the preoccupation of the government for the past several years to offload: offload expenditures; offload taxes; offload programs; offload support, from moving central supports in the Department of Education, offloading them onto school divisions.

This to me–as soon as I opened the Supplementary Estimates book it struck me as such. This strikes me very much as a move in that general direction. I am sure the minister would like to comment on that.

Mrs. Vodrey: Madam Chairperson, first of all I am surprised at the questions that have arisen from an honest answer given from this side of the House. However, I also would add to that that I do not feel any necessity to explain decisions made by other provinces.

I have explained to the honourable member how the decision was made by this government, and that there has not been an attempt for offloading, and he has received from me the honest answer.

* (2110)

Mr. Chomiak: Madam Chairperson, will the minister give her assurance to the House that this particular charge will not be entertained as a charge upon school divisions?

Mrs. Vodrey: This particular area is covered by a separate piece of legislation, The Teachers' Pensions Act, and at this point there is no intention of changing that legislation.

Mr. Chomiak: Has there been any change to the committee that looks after the fund or any other significant change with respect to the fund this year?

Mrs. Vodrey: No, to our knowledge there have been no changes this year.

Mr. Chomiak: Finally, does the minister anticipate any major changes or studies or reviews of The Teachers' Pensions Act or any other aspect of it in this fiscal year?

Mrs. Vodrey: No.

Mrs. Carstairs: Madam Chairperson, I have had two interesting phone calls about teachers' retirement, and I have to say in all the years I have done Estimates these are the first two calls I have ever gotten, both of them involving the same matter. Teachers have retired, gone on pension, and school divisions have then hired them again. Is that acceptable, and how does it work? I mean, would they build up more pension funds to then retire a second time? Is it possible to be collecting both a salary and a pension?

Mrs. Vodrey: Madam Chairperson, I am informed that, yes, this is possible, to retire and collect a pension and to become re-employed in another division. The reason that it is possible is the TRAF plan does not prohibit it, but I am informed that it is not likely that teachers can then contribute again to the pension plan.

Mrs. Carstairs: In this case it was the same division they were rehired in, but I do not think the answer would be any different.

Has there been any discussion with school divisions as to the appropriateness of this action considering the number of newly graduated teachers who are having difficulty finding employment in the province of Manitoba?

Mrs. Vodrey: The Teachers' Pensions Act was one negotiated by teachers, so it is not possible for any kind of a unilateral change. However, government does meet with TRAF and there would be opportunities to raise this as a point of discussion, and I could certainly bring the issue forward.

Madam Chairperson: Item 2.(d) Teachers' Retirement Allowances Fund $41,075,000–pass; 2.(e) Miscellaneous Grants $187,200–pass.

Resolution No. 27: RESOLVED that there be granted to Her Majesty a sum not exceeding $639,280,500 for Education and Training, Financial

Support - Schools for the fiscal year ending the 31st day of March 1993–pass.

Item 3. Program Development and Support Services (a) Division Administration: (1) Salaries $187,000.

Mr. Chomiak: Madam Chairperson, I have never been entirely clear as to what this Division Administration body actually undertakes, the four staff years. I wonder if the minister might just give a brief description. I have read the descriptive notes on page 48 of the Supplementary Estimates and they have not proved to be that enlightening for me.

* (2120)

Mrs. Vodrey: The administration in this branch is charged with the leadership and the direction and the co-ordination of seven branches–I will just draw to the attention of the honourable member the branches–that of Curriculum Services, the Native Education Branch, the Child Care and Development Branch, the Instructional Resources Branch, the student support branch, the Manitoba Textbook Bureau, and the Distance Education Technology Branch and, in addition, that same leadership and direction and co-ordination to the Independent Schools liaison and the Home Schooling officer.

Mr. Chomiak: Yes, I am aware of the various branches, but I am wondering if there is a strategic plan or a priority list or some kind of list that would give me some better understanding. I mean, in short, these four people administer the seven branches that all have administrators as well?

Mrs. Vodrey: The administration that the member refers to in terms of administration for each of the branches, as well as the division–there is an administrative head for the division, and then, following that, there is administrative direction provided to each of the branches. That has really been important, so that there is a local person there to carry out the direction provided from the administration above it.

Also, it has become very important to have that administration in place, not only to send out information accurately as government policy is developed through the department and the branches, but also to receive information as policy is applied in the field and for us to have the opportunity to receive back that information in an orderly form.

Another administrative duty is also to relate to other government departments. Those government departments would be provincial government departments as well as federal government departments; also to access other resources within the community, the province, and the country, and then to apply the strategic plan. There is a strategic plan overall for the department, and then the administration has to look at applying what parts apply to its branch and divisions and has to provide, in addition then, an operational plan and a mid-term plan that apply directly to that particular division.

Administration overall assists in providing an integrated view to avoid a separate series of policies, which could then be developed independently. But with the administration structure such as this, the important point is that there is then an integrated view of policy, not a separation.

Mr. Chomiak: I had intended to cease my questions at that point, but one of the minister's responses prompted me to continue along this line of questioning a little bit. Is this the area of the department where co-ordination, therefore, takes place between other government departments and the Department of Education?

Mrs. Vodrey: Yes, there is an element of co-ordination across government departments here, and one the honourable member might be leading to inquire about is the co-ordination across four government departments in providing service to students. That co-ordination does occur at the working level within this department and this particular ADM.

Mr. Chomiak: The minister is in receipt of a report provided to her by MAST, MASS, MASBO and other educational organizations dealing with the question of a co-ordination of government services. That report requested of the minister a response or reply by December 31, 1991. While I appreciate the minister was not at that time incumbent in the portfolio, I am wondering if the minister can outline for me when she anticipates responding to those initiatives of those organizations, as they relate to an area that is clearly one that I think all of us in this Chamber agree the government must move toward, and that is a better and more efficient utilization of resources and cross-departmental resources to the education system?

* (2130)

Mrs. Vodrey: To bring the member up to date, the deputy minister does chair an interdepartmental

committee and it is at the working level with the assistant deputy minister, whom I referred to just a moment ago. At the moment, I am informed that this particular working group is experiencing some very positive work together and that there is a great deal of co-operation and integration at this point.

It has a very active status. It meets approximately one time monthly. At this moment it is a little too soon to talk about the report, but we have taken the whole issue extremely seriously. We recognize that it is a very multifaceted issue. It is very complex, but I am informed that there has been very good progress with departments working in a very meaningful way.

Again, just to inform him in more detail, the Child Care and Development branch, which we are discussing right now, of the Department of Education and Training is working with the branches of the departments of Family Services and Health to increase service collaboration to respond more effectively to children with extreme behavioural disorders. One example of this collaboration is the interdepartmental Crisis Resource Committee which has representation from the departments of Education and Training, Family Services and Health. This committee collaborates with schools and Family Services agencies in developing a comprehensive 24-hour education treatment plan in cases where children between the ages of five to 12 have extreme behavioural disorders.

The department provides consultation to school divisions and promotes professional development initiatives to address the training needs of division personnel. The department is collaborating with the departments of Family Services, Justice and Health in developing service protocols for those children who require multidisciplinary services.

The brief from the four educational organizations that the member spoke about, the Manitoba Association of School Trustees, the Manitoba Association of School Superintendents, the MTS and the Manitoba Association of School Business Officials, has been reviewed by the human resources committee of cabinet. Senior staff from the departments of Education and Training, Family Services, Health and Justice are meeting, as I said, to identify ways and means of increasing collaboration and co-ordination.

Again, I remind the member that these meetings appear to be quite successful. Very positive efforts are being made to provide this integration and necessary co-operation. The Department of Education and Training also has an ongoing relationship with the four educational organizations and will consult and provide updated information as these complex issues related to interdepartmental service and collaboration are addressed.

Other interdepartmental committees which I think would be important to at least mention are the interdepartmental committee on drug strategy, one on domestic violence, and also one on the issue of apprenticeship.

Mr. Chomiak: Madam Chairperson, my final question in this area at this point. Has the minister had an opportunity to discuss with the Minister of Health (Mr. Orchard) the removal of the $43,000 grant for the audiologist consultant position at the Child Guidance Clinic?

Mrs. Vodrey: I have had the opportunity to discuss this matter with my colleague the Minister of Health. He, in the process of that discussion, explained that he has also had some extremely difficult decisions to make. In this particular area, he has advised me of the alternate places and resources available to children and families where this service may be obtained, and our discussions have been along the nature of making sure that services to children and families are available.

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

The Acting Chairperson (Mr. McAlpine): Item 3. Program Development and Support Services $20,671,900–

An Honourable Member: Just 3.(a) $217,100, and we will pass that.

The Acting Chairperson (Mr. McAlpine): Excuse me. Item 3.(a) Division Administration: (1) Salaries, $187,000–pass; (2) Other Expenditures, $30,100–pass.

* (2140)

Item 3.(b) Curriculum Services: (1) Salaries–

Mrs. Carstairs: Can the minister give me a list of who in this department is actually a curriculum consultant, and can she also give me a list of those areas which they are consulting to? In other words, are they an English consultant, a reading consultant?

Mrs. Vodrey: Yes, I am happy to talk about the curriculum consultants, and I would like to start with

some of the groupings. There is, first of all, in the social studies area, a co-ordinator for curriculum. In addition, that co-ordinator also acts as a home economics and health consultant. There is also a consultant for early years, a consultant for guidance, a consultant for physical education, a consultant for social studies and sustainable development.

In the languages area, there is a co-ordinator for languages. The co-ordinator of the languages area also acts as a consultant in ESL and language contact. There is then a consultant in the gifted area, a consultant for English language arts K to 12, a consultant for multiculturalism, and a consultant in the area of German.

In the technology and science area, there is a co-ordinator for technology and science. That co-ordinator also acts as a consultant in the area of business education contact. There is a consultant in the area of industrial arts, consultant in work education and vocational education, consultant in mathematics, consultant in science.

There is an assessment area, and there is a co-ordinator for assessment. That same individual also acts as a consultant in the area of assessment design or is responsible for assessment design. There is another consultant in the area of assessment design, and a second consultant in the area of assessment design in the bilingual area.

There is a high school strategies area, and there is a co-ordinator for high school strategies. There is a consultant in the area of the High School Review implementation and learning materials. There is also a consultant in the area of career education and guidance.

Mrs. Carstairs: I would like to go through some of the things that are not there. From the list that the minister has provided me with, I can only assume that there is no consultant for art, no consultant for music and no consultant in drama, nor is there one who looks after all three of those areas. In other words, any form of artistic pursuit by any student anywhere from K to 12, there is no consultant in the Department of Education. Is that correct?

Mrs. Vodrey: Mr. Acting Chairperson, yes, I am informed that the assistant director of the curriculum branch, an individual whose name is Alan Janzen, is also the contact person for arts. Arts includes music and dance. In the area of drama, that falls under the English language arts consultant. At this point, we did move into a management model, and the contact person does however maintain contact with schools and also may assist schools in connecting with divisions who currently have a service or a program that might be of interest with another division.

Mrs. Carstairs: Is it appropriate to say that the people who are the contact persons in dance, art, music and drama have no formal academic training in art, dance, music and drama?

Mrs. Vodrey: Mr. Acting Chairperson, the answer to the honourable member's question is no. This individual is in fact very qualified, first of all, by training and then by virtue of experience. He does have specialized experience, particularly in the area of music. I am informed, at this point, I guess today he is in fact adjudicating at a music festival in Gimli.

Mrs. Carstairs: Can I also assume that he has training in dance, training in art and training in drama?

* (2150)

Mrs. Vodrey: First of all, he is not the drama consultant, as I explained. The drama consultant falls under the English language arts area, and I would also like to emphasize this individual's role is as a contact person. It is not necessarily the same as an expert in all areas. The department at this point has chosen to take a leadership function in addition, and this leadership function also assists divisions in putting divisions in touch with very specific experts within the fields of inquiry.

Mrs. Carstairs: Well, thank you, but my answer to that is balderdash.

If you do not have people in the department with knowledge about the particular discipline for which they are the contact person, you have serious problems.

Let us move on to another area. We have someone listed as the social studies co-ordinator who is also the consultant for home economics. Can I assume that this person has a Master's degree in History, Geography, Economics and also a degree in Home Economics?

Mrs. Vodrey: To avoid any confusion, let me clarify again that the co-ordinator is the co-ordinator of social sciences, and that particular co-ordinator, I am informed, does have a Master's degree. She acts as the consultant in the area of home economics and her graduate degree is from the Faculty of Human Ecology. There is, in fact, a

particular social studies consultant, and I am informed that that individual is extremely well qualified in his area to act as a consultant in that particular area.

Mrs. Carstairs: Is the social studies co-ordinator or consultant, whatever the individual is called, expected to work within the curriculum fields of history, geography, economics at the senior high level as well as the Spaceship Earth, world history, Canadian history fields from 7 to 9, as well as the 4, 5 and 6 programs.

Mrs. Vodrey: I just noticed in the member's question that she seemed to be using somewhat interchangeably the role of consultant and co-ordinator. I would just like to define again that there is a co-ordinator of social sciences, but there is a consultant in the area of social studies. That is a specific individual who I am informed is very well qualified.

If the question regarded the role of the consultant, I would just like to inform the member that, in order to meet the changing needs of the evolving management model of the Curriculum Branch, the function of the consultant will become much more that of a curriculum manager. The scope of the responsibility may be interdisciplinary, or it may focus on a specialized area of education within the framework of the early, middle and senior years.

Consultants' positions will vary according to their responsibilities at a given time. Consultants will provide professional consultation to the school system and educated groups and assist in the planning of curriculum implementation and professional development activities. Consultants will provide leadership to contract and short-term personnel to complete curriculum or assessment related projects.

In the area of social studies, the individual spoken of is responsible for the area K to 12 and is responsible for the options and electives which then fall within the scope of social studies, and those might include electives such as economics or law.

Mrs. Carstairs: Presumably the social studies co-ordinator could be responsible for K to 6, which is six program initiatives, responsible for at least three in the senior high level, maybe more, depending on the options available, because a Canadian studies option is often part of the Grade 8 curriculum, and then, could be responsible for how many core courses in the senior high? The ones that I am certainly aware of are history, geography, law, economics and there may be more. How many actual courses would this one consultant be responsible for?

Mrs. Vodrey: Mr. Acting Chairperson, the answer is yes. That individual is responsible to act as the consultant for a number of course areas.

I think it is also very important to understand that the individual does not act completely alone, and that the individual does use support and also provides support to and receives support from a curriculum committee and, in addition to that, a K to 12 steering committee. That particular steering committee has representatives on it from the educational groups, superintendents, trustees, teachers, as well as representatives from the universities.

Again, it is very important to recognize that this is not just resting on a single individual, but instead a partnership. It has been very important that we recognize that there are extremely talented individuals within the educational system operating throughout Manitoba in a great number of functions, and through these partnerships it is really very appropriate that this individual, acting as the consultant in the area of social studies, by way of example, also benefit from these partnerships.

This individual also belongs to the special area grouping, sponsored by the Manitoba Teachers' Society in the social studies area. He is also an active member and draws advice from, as I said, the special area group, and the name of that group is the Manitoba Social Studies Teachers' Association.

Mrs. Carstairs: If one even listens to the description of what this person is responsible for, one would know that this person could not possibly accomplish all of this activity in any given year. That is the sad reflection about what is happening to the consultant and curriculum branch of the Department of Education.

We have watched in the past two years the reduction in six consultants. We have watched curriculum services taking a much reduced role in the function of education. I told the minister that I would do what I could to give her my concerns, and this is my primary concern, is what is happening to curriculum in the province of Manitoba. What is happening in curriculum in Manitoba I think is reflected in the poor test results that our young people are getting.

If we continue to overload people, whether they be social studies consultants, or whether they be science consultants, or whether we have no consultants at all, as we do not have in some of the fine arts areas, then we are not providing for our young people the type of education resource at the department level that we should be providing.

* (2200)

(Madam Chairperson in the Chair)

I do not fault this particular minister for this. This has been going on over a period of years. The result is that this particular services branch is becoming less and less important. I think that if we are going to beef up our educational system this is a branch of her administration which needs a rather major overhaul.

This is not to make any criticism of the people who work in this branch, who if anything, I think, are highly overworked. That will be a surprise to the civil servants listening, but I believe they are. I do not believe that they are getting the kind of job satisfaction that they should be getting by being afforded the challenges because they simply do not have the time to put into the area.

I would like to move on to specifically the science co-ordinator. The science co-ordinator does not have as many individual courses that he or she is responsible for as the social studies co-ordinator, because the science programs are essentially the same from K to 10, but then has to accept responsibility for biology, for physics, for chemistry and whatever else is being offered at the present time. I want to know how the minister's more senior staff believe that we can write curriculum, evaluate curriculum, meet with the interested groups including the specialty areas, co-ordinate with school divisions, provide support for schools, apply support for teachers in the field with the reduction of consultants that has been happening in this department.

Mrs. Vodrey: First of all, I would like to acknowledge that there are areas of our curriculum which of course we would be interested in continually improving, and we do look to that, and we do see curriculum as dynamic and involving, and in need of attention.

The science and technology area has been one that has been identified. In fact, there has been a recognition of the need to provide attention into that area. So I would like to talk to the member and give the member a little bit of information about some of the work that we do already have underway.

Just before I do talk about that, I would like to thank her for her acknowledgement of the hard work of the people working in this area at the moment, but to say that it really is not a simple problem, and that there has been a recognition that in dealing with our curriculum and making sure that our young people are receiving the finest education possible, that that cannot be accomplished simply by adding another consultant or two, that the problem is in fact a wider one and a problem which needs to have a more complex method to address the issue.

One way that the consultants have attempted to do that is by looking at regional talent pools, by reaching out in the partnership that I described, and by identifying within regions of the province, talented teachers and teachers with specific expertise at the local level. Those people are then available to assist in the implementation of curriculum and are available as talented individuals, very close to the areas in which they live.

I would like to talk just a little bit about some of the new programs and courses which are currently underway also, in an effort to make sure that this area of curriculum which the member has identified as being very specifically important and of specific interest to her. In recognizing that, I would just like to tell her that at the moment there are curriculum revisions underway in the K to 8 mathematics area, with an emphasis on skill development.

Plans are underway to produce a province-wide distance education Calculus 305 course, that we are looking at major improvements to the science curriculum, revisions in the K to 9 program, a teacher-resource package for K to 4 and the 5 to 8 package is underway, new textbooks for Grades 7 and 8 and revisions are underway in the Grade 10 or Senior 2 sciences. In the English language arts, K to 12 program, it is a well-recognized curriculum with emphasis on outcomes in both oral and written language skills, and in the technology and vocational education area, we are looking at the provision of co-operative education courses to students in high school, and that co-operative education model is one of particular interest.

We are also looking at more options in this area, a greater choice for students, and expanding partnerships with business and industry, and looking for more opportunities for work experience.

In addition, we are looking at computer-assisted math being developed with Alberta, Saskatchewan, and B.C., for Math 100, 200 and 300. The whole curriculum is on a disk of this size, a CD disk size. It is considered a state of the art program.

We are also looking at participation in intergovernment and private sector initiatives, the Manitoba Technology Initiative, the Science Technology Awareness Network, Industry Science and Technology Canada Innovations program and the Winnipeg Chamber of Commerce Science Technology Strategy.

* (2210)

In addition I would like to talk very briefly about some other of the programs which we are offering. The Skills for Independent Living program which is a unique and compulsory course designed for students at the Senior 2 or the Grade 10 level, and it will be piloted in Manitoba high schools in the coming year. The course was developed as a result of the recommendation from the major educational stake holders and the High School Review advisory committee that all students in the province should experience instruction and activities focusing on critical life skill areas such as the understanding of self and conflict management, planning the future and exploring careers, time and fiscal management, critical decision making and entrepreneurship and personal development through an independent research study.

Now the K to 12 English language arts curriculum, these guides have been recognized across Canada. This is the second area I would like to emphasize. Internationally they have also received recognition as models for the development of language. Recently a delegation of Her Majesty's inspectors from the Department of Education and Science in England visited a number of schools in Manitoba to see the English language arts curricula in action.

The curriculum guides have a solid basis in current research. They allow for flexible programming and provide the differentiation of instruction to students with a wide variety of learning interests and abilities. The guides have broadened the base of English language arts to include all the modes of communication: oral, written, visual and kinesthetic. There is a strong emphasis on the relationship between thinking in language and on the significant place that language plays in learning.

The art curricula–and art was mentioned as an interest for the honourable member–the art curriculum guides have been seen as exemplary documents because of the well-laid-out program that supports classroom teachers in the delivery of the program. The guides integrate the appreciation of art with the practical experience of students in the media of painting, drawing and building.

The family life education is a unit which teaches facts and encourages the development of skills and attitudes which constitute self-understanding and healthy interpersonal relationships and successful family life. It promotes the development of physical, emotional, social and intellectual well-being of young people.

The overall aim of the family life educational optional unit is to improve the quality of individual and family life. The unit has three main goals: promoting the family as an important social unit; encouraging the development of positive lifestyle practices that promote family living; and encouraging responsible lifestyle practices that promote the positive development of an individual's sexual well-being. The unit promotes sexual abstinence as the best health decision for young people and many requests for the curriculum have been received from other provinces. The stress on the importance of values on decision making has been appreciated by students and parents.

I would also like to speak of the AIDS education. Manitoba was the first province to introduce AIDS education at the elementary level. At the Grades 5 and 6 levels, students are provided with five hours of AIDS education instruction and students learn factual information about AIDS and other infectious diseases which attack the body's immune system. They have an opportunity to obtain answers to the questions that they have about AIDS through discussion and through small group activities, and the students develop a better understanding about people with AIDS.

Then, in addition, some other areas I would just like to mention, Manitoba students also have had the opportunity to experience multidisciplinary approaches in the area of, first of all, sustainable development. Manitoba Education and Training has been a leader in the integration of the concepts of sustainable development into the curricula K through 12, and the principles of sustainable development based on the balance and dynamic of environment, economy and the health of society,

those three areas, are blended into the study of science, social studies and Skills for Independent Living. Workshops and resource materials for teachers have been developed to support the integration process.

I would just like to speak again about the high school technology and vocational education. The introduction of the single-unit credits in technology and vocational education is innovative, and it is creating wider opportunities for all high school students to sample a variety of technological and vocational experiences. Through work experience students are able to benefit from the partnership of industry and education, combining practical experience with exposure to modern technology and production methods.

Finally, I would like to talk about multicultural education. Manitoba is the only province that offers three provincially developed bilingual programs in heritage languages, German, Hebrew and Ukrainian, within the school system. Manitoba Education and Training not only funds the programs through grants, but also provides consultant, curriculum and materials development support. Manitoba has the most enabling legislation in the country in support of bilingual instruction. In addition, we offer eight other core language programs, and these include Spanish, Chinese, Portuguese, Filipino, Hebrew, Ukrainian, German and Icelandic, and the commitment to heritage language is an affirmation of the value of language and the multi-ethnic, multicultural diversity of Manitoba. Manitoba is the only province where the Department of Education and Training is the key player in the celebration of multicultural week through the development and distribution of posters and activity packages for schools.

Mrs. Carstairs: Well, if I wanted to tell her what some of the problems were with all of those curriculums, it would take me the next two years, but let me just point out a few. She talked about the AIDS education curriculum, which is a wonderful curriculum. She talked about the family life curriculum, which is also a wonderful curriculum, except it is not compulsory. The two, which should be worked together, cannot be worked together because not all divisions use it.

So certain things which you could be teaching in AIDS education, you cannot be teaching because the kids have not had family life education, because it is not compulsory in that particular school division. In Skills for Independent Living, which would be a wonderful opportunity to teach about wife abuse, child abuse, it is not in the curriculum, tragically enough. The minister talks about computer-assisted math, but it is only a valid program and will only be a valid program if every student has an opportunity to have a computer in a hands-on mode, and that is not available in every school in the province of Manitoba.

I could go on and on and on with what sounded like some wonderful ideas and concepts, but all of which have a great number of flaws.

I want to ask about a specific resolution which was passed at the recent MAST convention which was attended by the minister and it said: Be it resolved, that to replace the curriculum policy review council the Minister of Education and Training establish a consultative process to provide advice on issues of curriculum development and implementation.

It went on to say in their comments: The elimination of a curriculum consultative process has removed a valuable vehicle for input by school boards on curriculum development and implementation at the provincial level. School boards are responsible for the implementation of provincial curriculum and must retain the right to have input in the curriculum content and implementation process.

Yet, a few minutes ago, the minister indicated that one of the functions of all of these co-ordinators and consultants was of course to keep this communication line going. Well there obviously is a breakdown. Is the minister prepared to accept the resolution of MAST and to replace the curriculum policy review council?

* (2220)

Mrs. Vodrey: Madam Chairperson, I certainly have been aware of the issue raised by the honourable member, and in fact through that awareness had directed my staff in the Department of Education to begin to work on this particular process.

So the motion or the resolution that the honourable member raises certainly was not the starting point for us in Education, and, in fact, we had already been working on a model before that resolution. The resolution simply served to underscore the concern that MAST put on this, but we had already been working in the department on this particular issue, and staff again has been

collaborating with the organizations before the convention, and staff then initiated discussion on the structure and on a draft terms of reference.

The committee has been called the interorganizational curriculum advisory committee. It has had several meetings. It will have a final meeting, I am advised, on May 12. On May 12 the committee will have a look again at its draft terms of reference, and when they are finalized it will then submit them to the minister.

I am informed again that the organizations have been extremely positive in how they have worked together on this committee. They are also looking at the issues, and I believe that they will be well accepted.

Mrs. Carstairs: The minister talked about the language arts curriculum. In the elementary grades, is the focal point of language arts curriculum still whole language?

Mrs. Vodrey: Madam Chairperson, I am informed that the term "whole language" is not the term that is used within the curriculum, because it has been so open to misinterpretation.

However, I am informed that we do, in fact, the Department of Education does support the principles related to whole language. However, there is also a recognition that a strict adherence to that particular philosophy can sometimes lead to difficulties in the area of spelling and punctuation and grammar, and that there is an effort through the English language arts program to provide an intervention and to work with those particular difficulties.

Mrs. Carstairs: Can the minister tell us if there has been an analysis done within the curriculum branch of Marilyn Jager Adams' book, "Beginning to Read: Thinking and Learning about Print"?

Mrs. Vodrey: Madam Chairperson, at this point I am informed, we would have to check directly with the consultants. There had not been a directive from the department to examine that book in particular, but we can, in fact, check with the consultants.

Mrs. Carstairs: Well, thank you. I do recommend that the department look at it. This is not just another book on reading, this was in fact commissioned by the U.S. Congress as a result of a great number of concerns about what was happening to reading in the United States, and reviews 600 studies on the field of reading. Even if you do not accept all of what she has to say, it is certainly worthy of further analysis by anybody in the language arts field.

As to a question I asked earlier and was referred to this particular section, I would like to know the pedagogical reasoning for the elimination of history and geography as separate courses for 100 and 101 in the Grade 10 level?

Mrs. Vodrey: I am informed that the Grade 10 social studies curriculum has very similar objectives for all students, and that as a result of that cluster of similar objectives for students, the differentiation occurs then within the classroom, and the differentiation is, at that point, based on the instructional skill and programming of the teacher, but that the single course is because of the similar objectives for all students in that particular course.

* (2230)

Mrs. Carstairs: But one would assume that there would be similar objectives in mathematics and similar objectives in science, and yet they have made the decision that they should offer separate programs in science and mathematics because the skill level that will be acquired by students in Math 100 will be quite different from the skill level of students in a Math 101 curriculum.

Does the minister and her department not believe that there are also differentiations in skill levels to be acquired in Geography 101 and Geography 100, History 101 and History 100? As a teacher who has taught both of those subjects, I can tell you that the skill level acquired is dramatically different.

Mrs. Vodrey: First of all, I would just like to take the member back to the fact that this was created by this differentiation and the discrete bodies in math and science. The similar objectives in the geography was a recommendation by the High School Review steering committee which did spend a great deal of time on this particular issue.

That steering committee is made up of members from the educational organizations and the educational groups. It was an agreement reached by, and a recommendation by, that particular group that math and science were in fact more discrete bodies of information with different methodology –one a more abstract and another a very much applied methodology.

In the area of geography, by way of example, in the social studies, this was seen by that group at Senior 2 or the Grade 10 level as a more

homogeneous course, and that the differentiation would occur as a result of the classroom teacher's practice.

In the area of the math and science, the differentiation also was partly an intent to assist in having young people not drop out of math and science so early by strictly focusing on the abstract versus the applied area.

I hope that answers the member's questions.

Mrs. Carstairs: No, it does not because I still do not think that the curriculums should be merged together. I would refer the minister to the comments by Judith Maxwell and the Economic Council of Canada in which she said that what we are doing is teaching to the middle and we are not separating for purposes of the academically talented, and that is why more of the academically talented are looking at AP programs, are looking at baccalaureate programs.

Others, quite frankly, find that middle program too challenging and they get discouraged and drop out of the mix. That was one of their most fundamental recommendations, that we should not be teaching core curriculums, that we should be judging our students and providing the appropriate curriculum for the individual student. I think that what we have chosen to do here is to go backward.

Mrs. Vodrey: Well, it seems that there is within the educational field certainly a point of discussion on this, but I will remind the member that we have also sought the opinion of other teachers who have also taught in the field, who also have experience and who also have raised and given us their opinions and have come to a consensus, come to an agreement through the advisory board or come to agreement for the recommendation. I would like to point out a few things.

First of all, Judith Maxwell also pointed out that in the K to 6 levels we in Canada are doing very well and that there is little or no separation of ability levels there. Now in the Senior 1 level, yes, there is not any differentiation. At the Senior 2 level we have not moved backward, but we have in fact provided differentiation in the area of science and math, and I have explained to the honourable member how it is that those two particular areas have been chosen as a result of differentiating between the very abstract and the applied.

* (2240)

Then in Senior 3 we move to–and I believe the member has continually forgotten or missed this–full differentiated programming, and at Senior 4 we have full differentiated programming. Judith Maxwell also said that the orientation need not be fully differentiated, that it is the differentiation at the senior levels which is the most important. We, in this province, are providing that and moving towards that in our curriculum.

Mrs. Carstairs: Let me tell the Minister of Education that I have had a number of phone calls from teachers in the field who are very critical of this decision. This is not my criticism. This is criticism coming from those presently teaching in the senior highs in the province of Manitoba who are dismayed at what is being done with this particular decision of the government.

Can the minister tell me what provincial program assessments in reading are being done at the present time, and which tests they are using to assess that reading?

Mrs. Vodrey: There will be a reading assessment done this year in May of 1992, and the assessment will focus on Grades 4, 8 and 11.

Mrs. Carstairs: Can the minister tell me what testing they will be using?

Mrs. Vodrey: Yes, I am informed that this is a provincial assessment tool, that it has been developed by the technical advisory committee in consultation with our staff, our curriculum consultants.

I think it is very important to note that it is based on our curriculum, and that again there will be a random sample of students selected. It is to focus on our own programs, to assess our curriculum and the implementation of programming within the province.

Mrs. Carstairs: Can the minister say whether the test results will be made public? What comparative tests will be used to measure the success of the curriculum? Will they be compared against test results done a previous year, or will they be standing alone?

Mrs. Vodrey: Madam Chairperson, I am informed that after each provincial assessment the results are compiled into a provincial report. They are not published school by school. They are not put into report school by school, but instead for a provincial picture.

In addition, there is also a student survey and a teacher survey to examine attitudes towards a particular curriculum or subject area being assessed. Then the results are distributed to school divisions and have always been distributed to school divisions.

Schools, themselves, with their individual results may then look at their individual results and compare them to the provincial results, but the tests were not designed to have schools in particular compete one against another, but instead to assess and to have schools then look at how they compare to a provincial survey or a provincial result, at this point.

As well, though the students are selected by random sample, I am informed that some school divisions often have full participation of their student body in this particular assessment.

* (2250)

Mrs. Carstairs: The minister has indicated the school divisions get the results, but what she has not indicated is does the public get the results?

Mrs. Vodrey: Yes, I am informed that these provincial results are, in fact, public. They are published and people may have access to them.

Mrs. Carstairs: Last year pilot testing was done of Grade 12 mathematics both in January and in June. Can the minister now give us the results, not on a school-by-school basis, I do not want it on a school-by-school basis, but on a global basis for the province of Manitoba?

Mrs. Vodrey: I would just like to clarify for the honourable member. It is two different sets of exams now that we are talking about. We were talking about the assessment of curriculum exams, and that is the reading that we are doing this year. She has also referenced the provincial Grade 12 exams, which are a different set of exams. Last year, they were a pilot of the process and last year, I will just remind her, there was an option of counting that exam for zero or for 30 percent. As a result of it being a pilot of the process last year, the statistics were not released.

However, this year, last year being a pilot of the process, it was decided to again test the area of mathematics. When those June results are available, we will then make public both the January and the June results. I would let her know that we have already sent to the schools the January results, and they know what their results were and also what the mean for the province is.

Mr. Chomiak: I am wondering, given the hour, whether the committee might agree to a five-minute break.

Madam Chairperson: Is it the will of the committee to take a five-minute recess? [Agreed]

Committee will reconvene at eleven o'clock.

* * *

The committee took recess at 10:54 p.m.

After Recess

The committee resumed at 11:05 p.m.

Madam Chairperson: Order, please. Will the Committee of Supply please come to order.

Mr. Chomiak: Madam Chairperson, I have a few questions in this area, some related to some of the topics that have been covered already. I will try not to be repetitious as well with respect to these questions.

I, too, had discussions with teaching professionals and others in the education field with respect to the changing curriculum for history and geography. The points that have been made to me with respect to that–and I guess I want to preface my comments by saying this is not necessarily an adversarial system all the time in this Chamber.

I am not an educator by profession or training. The arguments have been presented to me on both sides, and I just think that some of the arguments for/against the move are valid. Some of the arguments that I have heard in favour of the decision are valid to me, and I suppose at some time the department and the branch have to take some leadership and make a decision. That is what government and leadership is all about.

At the same time, when people in the field continue to question and show–people for nonpolitical reasons but totally legitimate educational reasons express their concern. I think perhaps taking a step back and reviewing the rationale and the reasons behind these decisions has some merit.

I probably will not do justice to the individuals who talked to me in terms of the arguments, but I will put them in my own words, at least some of them.

The first thing that comes to mind is the fact that the No. 1 reason cited in the learners study, that I

mentioned in the House several weeks ago, to the dropout study, the school leavers study. Boredom was cited as the No. 1 reason for dropouts. I guess my question is, will this not move towards a core curriculum? At least on the surface, it appears to me, work towards increasing boredom in classrooms insofar as those who would be challenged by a more specific course will be bored and otherwise? I am wondering if there is any comment by the minister on that particular point?

Mrs. Vodrey: The issue of boredom which the honourable member raises is a serious consideration, and one has to ask what the reasons for boredom might be. Sometimes it is a lack of motivation, and sometimes the lack of motivation comes about because material is simply too abstract or too complex for some students to actually become engaged in the process of learning.

In the introduction to high school, the recommendations that we received were to go in these areas which we have been discussing with a single curriculum, a core curriculum, and through that core curriculum attempt to have students, through a dynamic teaching methodology, through a dynamic and a stimulating learning environment, to have students, whatever their ability, experience both a high achievement and experience success. It is the experience of success based on what will be required of teachers, again through their methodology and through the learning environment that they create, that success that will then provide the engagement of young people in the curriculum, then hopefully their success and their willingness and desire to remain in the school program.

Mr. Chomiak: At least to me, that sounded somewhat contradictory because I am advised that a lot of the dropouts, and again we do not have the data empirically to base this on, that at least a third of the dropouts at the University of Winnipeg are so-called A and B students which leads me to the point that perhaps this group of students will not feel challenged enough by that program. If it is going to be differentiated in the classroom anyway, does it not amount to the same thing?

Mrs. Vodrey: I take the honourable member back to the point that there is differentiation at the Senior 3 and Senior 4 level. Senior 3 and Senior 4 would be those grade levels that he has just discussed being Grade 11 and Grade 12, those opportunities in programs such as the University of Winnipeg in which there is differentiation. The differentiation also occurs at Senior 2 in science and math, and the core curriculum is available in Senior 1 for all subject areas. In Senior 2, the differentiation again is in science and math with the core curriculum in areas such as social studies, and again in that area there has been a focus on teacher differentiation. I remind him again that there is differentiation at the Senior 3 and the Senior 4 levels.

* (2310)

Mr. Chomiak: For the sake of time, I am not going to pursue this in any more detail other than to ask one more question. I have also been advised that the ideological basis upon which this is based is studies done by Robert Slavin at Johns Hopkins University and others. I am told these studies deal, not with senior students, but with middle year students, and that the data upon which this decision was based is flawed.

Mrs. Vodrey: I am informed that the Slavin study, which the honourable member referred to, in his particular work he studied both streamed and nonstreamed students in programming, and he found that the nonstreamed were more successful. The important point, I am advised, is that in looking at this particular issue, Slavin was only one researcher whose work was examined, and that there did not appear to be any research which supported streaming, but it was the decision of the advisory committee that the content level at particularly Senior 3 and Senior 4 was so complex and difficult that it would make it extremely difficult for the teacher to attempt to integrate at that level, and so the streaming decision was made at the upper levels of Senior 3 and Senior 4.

Mr. Chomiak: Madam Chairperson, I am quite interested in how the implementation for Answering the Challenge is proceeding. There are a number of strategies that I would appreciate updates on. I am wondering if perhaps the best way for me to do this–well, let me ask the minister: Does she have any kind of briefing notes that outline the status of the various 80-odd strategies in Answering the Challenge?

Mrs. Vodrey: Madam Chairperson, I will just give the honourable member some update on the implementation of Answering the Challenge.

First of all, the new course Skills for Independent Living has had its first half piloted in about 200 classrooms throughout Manitoba. Secondly, a number of divisions have already piloted the credit

system in Senior 1 or Grade 9 and have provided some feedback. Thirdly, the new funding formula allows for nonvocational students to take individual vocational courses on a credit-by-credit basis. Fourthly, the Education Finance review has provided new support for the guidance services, special needs students, library services and professional development. In addition, a native education advisory committee has been appointed made up of native people from across the province who represent various stakeholders in education. The Distance Education and Technology branch has linked 67 rural and northern schools into the Manitoba Satellite Network, which provides two-way audio and one-way video delivery of Distance Education programs to rural and to remote schools.

A gifted education advisory committee has been appointed to provide directions on advanced courses, delivery modes, curriculum extensions, appropriate teaching strategies and teacher training courses. A school library policy statement has been developed which states, in part, that students in Manitoba schools should have access to a school library program that is integrated with the school's Instructional program. This integration of classroom and school library is fundamental to the resource-based learning model which is essential to student achievement of the goals of learning for Manitoba.

Finally, a province-wide examination procedure has now been put into place, and Senior 4 mathematics was examined in 1990-91 and will be examined again in 1991-92. Biology 300 and Physics 300 will be examined in 1992-93. Also, in several weeks we will have a complete implementation grid ready to send to the divisions for their information.

If Itwouldbe helpful to my colleagues, I could offer a copy of the grid be sent to both of you also.

Mr. Chomlak: Madam Chairperson, as I understand it, the Department of Education policy for subject course accreditation at the high school level is 110 hours minimum and 120 hours maximum for one credit. Is that in fact the case?

Mrs. Vodrey: Yes, approximately 110 to 120 hours is a guideline expectation, and I stress that it is a guideline because it would vary between semester and nonsemester programs, and also in terms of local decision making based on how many classes will be offered in a day.

* (2320)

Mr. Chomlak: Can the minister indicate how this matter is monitored by the department with respect to the hours?

Mrs. Vodrey: I am informed that again these are guidelines, and because they are guidelines there are not statistics maintained regarding this.

Mr. Chomlak: I just want to take the minister through one example of potential situations in a semester system. We assume 197 school days for '92-93, which I believe is the minister's announcement, and we take off 10 days for administration and professional development. We are leftwith 187 days.

If, in a semester system, these are divided into 93 and 94 per semester and the school uses a 65-minute period, this could mean 100 to 101 hours which would result in a four-year high school program of a student not having those, perhaps up to as many as 40 hours, in certain subjects.

Mrs. Vodrey: I think it is important to note that curricula is not necessarily driven by the clock or by a number of guideline hours, and that is important to note that, in fact, learning outcomes are what have been defined.

Sometimes these learning outcomes are accomplished through a shorter number of hours and sometimes they would require more than the guideline number of hours. Also, and I know the honourable member would know this, that all students do not learn at the same pace. So I think it is really very important for us also to focus on the outcomes expected within these curricula.

Madam Chairperson: Item (b) Curriculum Services: (1) Salaries $2,244,700–pass; (b)(2) Other Expenditures $1,411,200–pass.

Item (c) Native Education: (1) Salaries $621,500–

Mrs. Carstairs: I am sure the minister has had an approach from a group of aboriginal peoples interested in producing an Anishinabe history textbook. Has the minister in fact met with this group and have there been any discussions as to whether such a curriculum or textbook would be developed for our aboriginal students in the province of Manitoba?

Mrs. Vodrey: Madam Chairperson, yes, we were approached by a group from Roseau River to assist and fund in the development of a textbook, and at this point the department does not fund the developmental costs of the textbook, of preparing that textbook, but certainly offered to review the material developed, and on that review and on its passing through the process set out by the department, to list it as a curriculum support. So in summary, we very seldom provide the money to develop textbooks.

However, we do provide support to native students within the public school system through our Native Education Branch, and the Native Education Branch is developing curriculum information for the public school system and has a number of initiatives going on at this time.

Mrs. Carstairs: Can the minister tell me what involvement this particular branch has had with the Children of the Earth school?

Mrs. Vodrey: As the member knows, the Children of the Earth school is operated by the Winnipeg School Division No. 1. However, I am informed that our Native Education Branch has been involved very extensively in assisting them in the area of curriculum development.

Mrs. Carstairs: Thank you. Can the minister tell me where they are obtaining those curriculum materials from?

* (2330)

Mrs. Vodrey: Madam Chairperson, the school program at the Children of the Earth aboriginal high school, that school program does follow the provincial curriculum and it offers general and university entrance courses for Senior 1 through Senior 4, and core courses such as mathematics, language arts, science, social studies and physical education are modified to a certain degree to reflect the aboriginal culture. Those programs, those modifications are being developed locally. They are being developed to fit this school's particular needs, and our Native Education Branch is providing guidance in this particular area.

Mrs. Carstairs: The minister indicated that they did not usually provide developmental funding, but this is quite a new area that we are moving into here, when we are now beginning to not only have aboriginal schools, but where they are looking to modify their curriculum and to provide appropriate materials. One area, obviously, which is important to them in the development of curriculum materials is in the whole social studies field, and particularly history, because they reject much of what has been in European-oriented textbooks of the past.

One only has to look this year at the celebration, by some, of the 500th year of Columbus's so-called discovery of the New World. They do not believe it is a discovery at all because they believe they were here and he did not find them, and the importance of developing that kind of curriculum material. I understand they have looked to some materials available in Saskatchewan because there have been some schools there for some time functioning.

Has there been any discussion with Saskatchewan or with Alberta, where the majority of aboriginal young people are located, about a kind of joint liaison with developing curriculum materials, be it this textbook or other texts, which could be used in these kinds of school settings?

Mrs. Vodrey: Just to clarify some of the responsibilities, Winnipeg No. 1 has the responsibility for the school, the Children of the Earth school and the staff, and their staff has been a very talented staff and has also been quite capable of doing a great deal of research themselves.

Our role in the department has been to be consultative to the Winnipeg No 1. School Division, along with all the other divisions in the whole area of aboriginal education. Aboriginal education has included native studies and education, also English language development, literacy and academic success in the core subjects. I would just like to underline that the whole staff has been involved in this area of aboriginal education, as well as our Native Education Branch.

In addition to that, in answer very specifically to the member's question, the branch has been very active in assessing and auditing curriculum development from across Canada, and I am informed that Saskatchewan has been very active in this area, and that we have certainly been in contact with Saskatchewan to look at what information they have.

In addition, the Native Education Branch cost-shared the development and the production of the native people of Manitoba poster series with Indian and Northern Affairs Canada. These posters were distributed to all schools and native organizations in Manitoba and are designed to highlight the past and the present aboriginal cultures

in this province. They provide curriculum support material for social studies, language arts, music and art programs. The branch is continuing to develop other resources which present a positive and accurate portrayal of the native peoples' contribution to Canadian society.

Mrs. Carstairs: I think everyone is concerned about the dropout rates, but nowhere should we be more concerned about it than among our aboriginal young people who drop out of schools. Is this branch of the department doing any particular evaluations of why aboriginal students are dropping out of schools and coming up with specific techniques to try and keep them in school longer?

Mrs. Vodrey: We certainly are concerned about the number of aboriginal young people who are at risk for failure and for dropout rates. When I chaired the provincial task force on literacy, this became an issue which was very much highlighted to our task force. Following the results of that task force, the Literacy Office was formed and the Literacy branch does provide specific support and literacy support to native organizations.

The Native Education Branch, in addition, focuses on many strategies which are effective in promoting the retention and the academic success of native students. I would just like to give some examples of support for school based planning to help teachers adapt their curricula, their classroom resources, and their teaching styles to build on the strengths of native students, the implementation of an integrated in-service model which aims at involving schools, parents and other government departments such as Family Services, Corrections, Health and native organizations such as local friendship centres in a collaborative planning and delivery of in-services.

* (2340)

I think that one is particularly important because it again really speaks to the partnership issue and the necessity of whole parts of the community to become involved, not simply segmenting a single in-service and targeting it to a single group of participants. They also provide program support for divisions and districts funded under the English language enrichment for native students support program, and its goal is to promote academic success by enhancing the English language schools of students who speak a native language and the nonstandard dialect of English; also participation on an immigration and employment Canada-Manitoba education and training Stay in School program designed to strengthen the linkages between education and employment.

That was certainly an issue which I remember very well was raised also in the Literacy Task Force. In addition of the promotion of the stay-in-school initiative through the aboriginal career awareness days which feature native role models; and early intervention programming which stresses the importance of home-school partnerships, and the role of native parents as their children's first teachers; and cultural awareness workshops with native and non-native students to build positive relationships and interpersonal communications and to develop self-esteem.

Mr. Chomiak: Just following up on those comments, I think we have made the point, certainly on many occasions in this Chamber, that one of the keys to dealing with dropouts or the retention rate issue is, of course, identification. Are there any specific initiatives that are addressed to the whole question of what was termed, certainly in Saskatchewan, a dropout rate amongst aboriginal people of 50 to 75 percent, as I understand it from the Royal Commission report?

Are there any specific initiatives being undertaken to deal with that major problem?

Mrs. Vodrey: Madam Chairperson, I think a starting place is to say that it is important to recognize that the school system by itself cannot satisfactorily address the complex issues that affect the education of native students, and, to that point, that it is very important to look at the issue of partnership. I will just remind the honourable member of the answers that I have just given in the question just preceding which looked at a whole list of mechanisms that we have in place and programs that we have in place to address the issue of the high failure and the dropout rate.

I would also like to talk a little bit more about some of the other issues in native education which we are looking at. First of all, Answering the Challenge looked at a number of initiatives relating to native education, and just to give the member an update, Strategy 7, the career counselling one, was to ensure the availability of career information through the career symposium and regional information centres, and during the fiscal year '91-92 the education branch, career counselling consultant

conducted teacher-student workshops involving 18 schools from 11 divisions as well as organizing information displays at the two provincial career symposia.

The Native Education Branch has developed career awareness posters and video tapes to promote positive role models for native students. Strategy 10 speaks to community involvement in education to encourage the development of school-community partnerships. The Native Education Branch has really had some success in bringing together a variety of education stakeholders in the Parkland region for parent participation workshops, and consultants from each of the Native Education Branch's program areas focus on parental community participation as an integral component of their in-service presentation, and they encourage schools to include native community representatives in the planning and the delivery of professional development in in-service sessions related to native education.

Strategy 22 speaks to multicultural education and that is in-service support to assist schools in dealing with issues such as racism, stereotyping and discrimination. The Manitoba Education and Training interdivisional multicultural education committee is developing a teacher handbook called Beyond Bias, which will be used in in-servicing to promote a balanced selection of learning resources and the implementation of antiracist classroom strategies. Strategy 23, 24 speaks directly to native education, and a native advisory committee and the identification of goals and objectives for the department.

Now, a 10-member advisory committee was struck in 1991, and it was made up of native people from across the province who represent the various stakeholders in education, and the committee has focused its initial efforts on reviewing current programs and will draft recommendations for Seniors 1 through 4 and K through 12 native education policy by the date that they are aiming for is the spring of 1993.

Strategy 25, again, speaks to native education, the integration of native content in core curricula and the availability of native studies resource materials. Currently the native representatives sit on curriculum services committees for language arts, skills for independent living, and in addition, I would also like to say that the student support branch will have a number of projects which again speak directly to answering the challenges of native education.

Again, I could just go over very briefly what I had said previously regarding addressing the high failure and the dropout rates among native students in that we are really looking for support for school base planning to help teachers adapt their curriculum. We are looking at the implementation of an integrated in-service model, and I spoke of that previously, talking about making sure that schools, parents, other government departments, native organizations, are involved in the collabarative planning and the delivery of these in-services, and that program support for divisions funded under the English language enrichment for native students support program.

That goal is to promote academic success by enhancing the English language skills of students who speak a native language or a nonstandard dialect of English, and again we participate with Immigration and Employment and Canada-Manitoba education and training Stay in School program, strengthening the linkages between education and employment and the promotion of stay-in-school initiatives through aboriginal career awareness days which feature native role models, early intervention programs stressing the importance of home-school partnership and cultural awareness workshops with native and non-native students, again to build that positive relationship and the interpersonal communications and to help develop self-esteem.

In addition to that, continuing with the Answering the Challenge, native studies senior years' source book which supports the social studies curriculum will assist with the content integration in terms of native content and core curriculum, which I spoke about earlier, and the Native Education Branch is developing resource materials for native studies including native writers, a Jordon Wheeler video, a Metis history kit, teacher notes to accompany native people of Manitoba poster series, and native language teaching video.

The Native People of Manitoba poster series was distributed to all Manitoba schools in 1992. The Native Education branch resource centre assists teachers in identifying classroom and professional development materials. The annual updating of the native education listing in the Manitoba Textbook Bureau catalogue and the publication of the

resource bibliography, "Native Peoples" provides sources for classroom teachers.

The ongoing development and revision of the native language instruction materials for Cree, Ojibway, Dakota, Dene and Island Lake dialect promote maintenance of native languages.

Strategies 26, 27, Native Education, speaks to the involvement of native people in the curriculum development at the department or the school division level. The Native Education Branch has assisted Curriculum Services in identifying native resource people to sit on the curriculum committees. The Native Education Branch promotes the involvement of the parents and community members in all aspects of education at the school and division and district level.

* (2350)

Strategy 64-65, which speaks to students at risk and dropouts, the identification of necessary programs and services, the co-ordination with the federal government and school divisions to maximize the effectiveness, while the Native Education Branch consultants focus on effective approaches such as mentorships, peer counselling, co-operative learning and conflict management to build native students' self-esteem and school success.

Native Education and student support branch representatives sit on a steering committee with Employment and Immigration members to co-ordinate the Stay in School program. The branch focuses on developing school and community linkages to provide programs for at-risk students, many of whom are native youth.

Ms. Jean Friesen (Wolseley): I wanted to ask about the connections between the programs of this branch and the proposed urban aboriginal strategy of the government.

Mrs. Vodrey: This particular branch, the Native Education Branch, is primarily a K-12 curriculum branch, which assists in the design and the implementation of curriculum and also promoting native awareness. The Urban Native Strategy does not fall directly under this department, but it would be important to note that the director of the Native Education Branch sits on the technical advisory group for that Urban Native Strategy.

Ms. Friesen: Could you tell me how many times that group has met?

Mrs. Vodrey: Madam Chairperson, again I will remind the honourable member that this is not part of the Department of Education and Training. However, we will find out how often that committee has met.

Ms. Friesen: I am asking that because the minister said that this branch does, in fact, have liaisons with other government departments. This is obviously one that is relative to the Urban Native Strategy. For four years we have been waiting for that Urban Native Strategy. I am very curious as to how many times this committee has met in the last four years, so that when the minister does table that information, I hope she will be able to provide us with the timing of those meetings too, because it seems to us that that strategy has been buried for the last two years. So I am interested not just in the meetings of this year, but in the timing of the meetings over the last four years.

Mrs. Vodrey: Madam Chairperson, again I remind the honourable member that this does not fall within the Department of Education and Training. Though she is right that we have our director of Native Education sitting on the technical advisory group, we do not provide for this particular group any in-kind support or any co-ordination, and that the details of the co-ordination of this Urban Native Strategy should be addressed to the Estimates of the Minister of Northern Affairs (Mr. Downey).

Ms. Friesen: I accept the explanation that it does not fall under this department, but in past years I have asked in Native Affairs, I have asked in Urban Affairs, now I am asking in Education about the Urban Native Strategy. It seems to me that over the past three years we have seen in the province of Manitoba a tremendous change in the population, a great change in the political agenda for aboriginal people.

I see here a department, a particular section of a department, where the budget has declined and then stabilized over the last two years in an area where it seems to me there are some very significant problems facing all of Manitobans.

I wonder how the minister looks at her overall budget in this sense, and how in view of the issues that are facing Manitobans in the area of aboriginal relations, why the budget of this particular section has been kept at this level, a reduction from past levels?

Mrs. Vodrey: Madam Chairperson, again, I would invite the honourable member to pass on her comments directly to the Minister of Northern and Native Affairs (Mr. Downey). I will tell her that I will also pass on the comments that she has raised this evening.

* (0000)

Then, I would just like her to know that with the resource base that we have in this particular department, in this particular area, we have made progress with students in K to 12. That is the mandate of the Department of Education and Training, to provide assistance, to work with students and teachers and families and community members and with the curriculum in the K to 12 area. Progress has been made, and this branch has been very effective in their assistance.

Ms. Friesen: Madam Chairperson, that does raise another issue that I wanted to talk about, and that is the effectiveness of these programs.

Certainly there has been an expansion in the number of in-services and the number of teachers who have been affected or whose consciousness perhaps has been raised by the workshops and conferences that have been presented over the past number of years by this section.

But what evidence does the minister have that this material is reaching the classrooms?

Mrs. Vodrey: Madam Chairperson, I am informed at this point that there are no formal or specifically quantifiable statistics, but I would like to provide the honourable member with at least some of the statistics which speak to the action that has been presently undertaken.

In the '91-92 school year the in-service activities, in the area of native awareness there have been 111 sessions, 23 school divisions, 50 schools affecting 250 personnel, and 4,100 students, 200 community members and 15 other organizations.

In the area of native studies: 97 sessions, 22 school divisions, 45 schools, 778 personnel, 1,600 students thereby affected, 1,500 parent and community members and 10 other organizations.

In the area of native languages: 72 sessions, 24 school divisions, 21 schools, 540 personnel, affecting 300 students, 125 parent or community individuals, and the other organization in the area of native language has been the University of Manitoba. In the area of English language development: 26 sessions, 16 school divisions, 16 schools, 1,350 personnel, 40 students, 50 parent or community members and 5 other organizations. In the area of career counselling: 48 sessions, 18 divisions, 11 schools, 480 personnel, 1,800 students, 225 parent or community members and 6 other organizations. In the area of early childhood: 9 sessions, 10 school divisions, 4 schools, 30 personnel, 100 students, 175 parent or community individuals and no other organizations in that category. In the area of community liaison: 25 sessions, 8 school divisions, 18 schools, 300 personnel, 200 students, 45 parent or community members and 3 other organizations.

In addition, the Native Education Branch provides for teachers to increase their effectiveness In native education. The native student rate of academic success continues to challenge educators. We certainly recognize that there is a concern in the area of both the retention and the success of native students and that teachers require assistance in the area of curriculum design and implementation and teaching strategies and also cross-cultural understandings to meet the needs of native students.

As schools increase their request for assistance and resources–resources do remain limited–the Native Education Branch is moving in the direction of prioritizing its support for professional development and in-servicing for schools committed to long-range planning and implementation and follow-up to address the issue of systemic change. Although the branch plays a leadership role in school planning, it encourages the schools to take ownership for their decision making and to establish a school-community network which is integral to native education initiatives.

In addition to school-based in-service delivery, the Native Education Branch has collaborated with the University of Manitoba's Continuing Education division and teacher training. The branch also co-sponsored the Thompson-based native language instruction certificate program which graduated 22 instructors in June 1991, and it is participating in the delivery of the second course which runs until 1993 in Winnipeg.

The Native Education Branch co-operated with Winnipeg Education Centre to deliver the first Native education summer institute in July 1991. It provided the opportunity for 60 early- and middle-years teachers who enrolled in the six-credit course to

interact on a daily basis with native academic and elders, and their final evaluation rated the course as the most meaningful professional development that they had ever experienced. The Native Education Branch is providing the leadership for the second institute, which is scheduled for July, 1992.

Ms. Friesen: Madam Chairperson, that was a long catalogue, but it did not answer the question.

The question I asked arose from the minister's statement. In spite of the fact that this department department had remained stable in budget over the last year and in fact had a decline from earlier years in an area which has significant social consequences for all the population of Manitoba, she did claim that there was success and progress.

I was asking for evidence of this success and progress. I accepted and I started from the premise that the department has had many in-services, it has reached many teachers, and it does have many conferences, and the minister essentially enumerated those. My question is: Do you know that this is reaching the classroom? How are you measuring success in the classroom?

Mrs. Vodrey: First of all, in terms of looking at what may be a quantifiable result, in terms of assessing students, in the data we do not distinguish specifically aboriginal students. To do so would really be prejudicial, so we do not receive specific data in provincial assessments which identify aboriginal students.

The information of the effect is somewhat more informal than the actual assessment, and the informal data have come through the department's continued contact with superintendents, with principals and with teachers, and those people have informed us of three, by way of example, ways to measure development. First of all, in student achievement that they would report at the local level; secondly, in their reporting of students' self-esteem that they have been able to measure behaviourally and interactively; and, thirdly, in the role of parents within the system and the role of parents in terms of being involved as partners and being involved in their child's education.

* (0010)

Then I would just like to say to the member that in recognition that this is, in fact, a very serious problem, and it is not one which is amenable to a quick fix, that there would be an extremely notable or significant method to quantify immediately that we have recognized that this is a process, and that certainly we are hearing through our reporting system that there has been an observable change and effect.

An Honourable Member: Committee rise.

Madam Chairperson: Is that the will of the committee? Committee rise.

Call in the Speaker.

IN SESSION

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

Legislative Assembly of Manitoba

Monday, May 4, 1992

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