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DEBATES
and
PROCEEDINGS

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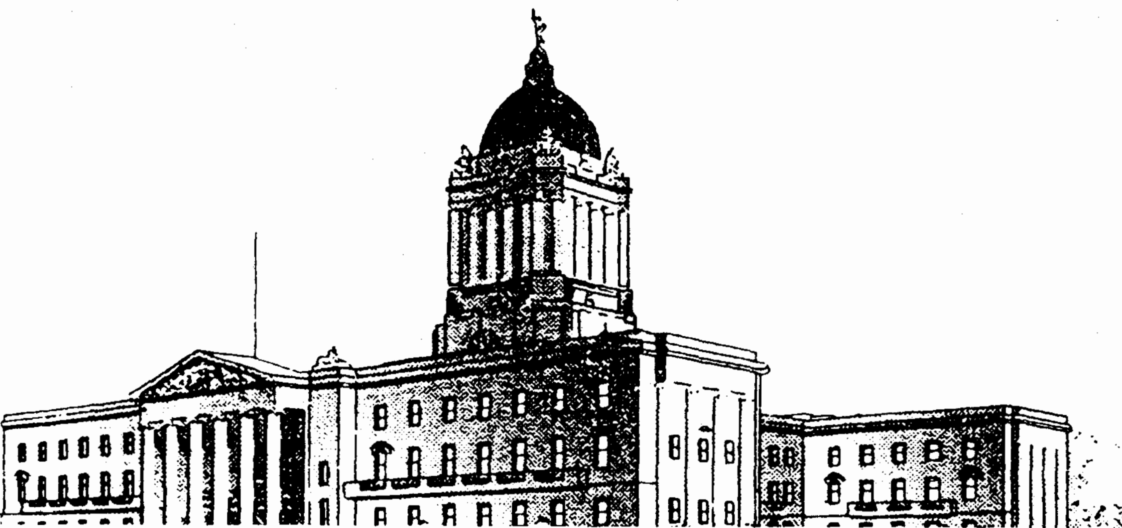

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Thirty-Seventh Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

Tuesday, July 30, 2002

The House met at 10 a.m.

PRAYERS

ORDERS OF THE DAY

GOVERNMENT BUSINESS

Hon. Gord Mackintosh (Government House Leader): I move, seconded by the Minister of Finance (Mr. Selinger), that the House resolve into Committee of Supply.

Motion agreed to.

COMMITTEE OF SUPPLY

HEALTH

Mr. Chairperson (Conrad Santos): Good morning. Will the Committee of Supply please come to order. This section of the Committee of Supply, meeting in the Chamber, will be considering the Estimates of the Department of Health.

When this committee last sat, it was agreed to have a global discussion in all areas and then proceed to a line-by-line consideration, with a proviso that if a line has been passed leave would be granted to members of the Opposition to ask questions in passed areas. Would the minister's staff please enter the Chamber?

Hon. Dave Chomiak (Minister of Health): The staff are just finding their way here, Mr. Chairperson, because of the change of venue, so it might be a moment or two before the staff is actually in attendance. In the interim, I might provide the Member for Charleswood (Mrs. Driedger) with some information that she requested yesterday.

Mr. Chairperson: Is that agreed? *[Agreed]*

Mr. Chomiak: The member asked about the functioning of MRIs in Winnipeg. There are two in St. Boniface and one at HSC. In June 2001 the machine at St. Boniface was down for ten days for software upgrading. All three MRIs are currently operating. I might add, Mr. Chairperson, that there is an additional MRI that we are planning to provide at Health Sciences Centre, as I understand it, and as well in Brandon.

The member also asked about communications. In October a tender was awarded. The contract had an option to renew on a project basis. The option was exercised in 2001.

Mr. Chairperson: While waiting for the staff, we can use the time.

Mrs. Myrna Driedger (Charleswood): Yesterday, when we ended Estimates, I believe that we had some discussion about health care systems from other countries in the world. A question had been posed to the minister, and I think he was only at the beginning of his response in all of that. The question was related to my wondering, I guess, how people are to know what the minister's priorities are for health care or what his goals are for health care, what his vision is for health care, if he is not prepared to share with the public what his plan is for health care. How are people to know what direction he is going in if he does not have this what he calls fiat from on high so that he could then be all over the map with where he is going? People have no ability to judge him then, but maybe that is his intent. I would like to know how he feels people are to understand where this Government is going in health care if he is not prepared to make a commitment to what his goals and visions and priorities are.

Mr. Chomiak: Mr. Chairperson, I answered that question I thought, but obviously I have not made it clear to the member opposite with respect to that. I will review some of the issues that I raised with respect to that.

As I indicated, when we came into office the first priority was the issue of health care personnel. As the member knows, during the 1990s,

there were significant cutbacks, dramatic cutbacks to both programs offered as well as the training of personnel. So, when we came into office, I am not sure if the member was aware, there were dramatic shortages in all health care personnel right across the field. I canvassed the Department of Health staff, as the member indicated, whether or not stats were taken, and the stats were actually not taken very accurately. The staff were, in fact, not supposed to provide specific information. I canvassed that information, Mr. Chairperson.

Now, as we know, the program offered at the College of Medicine was cut unilaterally by the government in terms of the number of students enrolling at the Faculty of Medicine. The member will also know that the nursing programs provided across the province in various other venues were cut and slashed, Mr. Chairperson. That is aside. I am not even dealing with the issue of the layoffs and the firings. I am just talking about the training programs.

* (10:10)

Our first identification was of the need to train personnel. That is why the first priority, and it was indicated both following the election and since the election, was to train health care personnel. What has that resulted in? Actions speak louder than words. There are more than double the number of nurses in training now than there was a decade ago. We increased the number of positions at the Faculty of Medicine by 15 and increased the number of residency positions by 15. Let me contrast that, Mr. Chairperson. During the 1990s, nursing programs were cut. In the first several years of our regime, nursing programs were put back in place, double the number of nursing.

In the years of the nineties, medical programs were cut. Under our regime, nursing programs and the number of people enrolled has doubled. Is there any confusion with the public in terms of what we are doing? I think it is generally acknowledged that this is a government that recognizes that the infrastructure of humans, the training and the personnel is the factor that has to be dealt with, but it just does not stop there, Mr. Chairperson. It just does not stop there. We have announced increased positions for occupational therapists. We have announced increased positions for physiotherapists, also health care professionals. We have taken the X-ray lab program, and we have expanded the X-ray lab program. We have expanded the lab technician program, new enrolments, new students, new areas that we were suffering and continue to suffer shortages in.

We have expanded the sonographers' class. The member stood up about a year and a half ago and complained about the loss of sonographers. I checked the statistics. They had not expanded the class, (a), and (b), most of the class that had been trained under the previous regime had left the province.

We are still having challenges with that program, but we expanded the enrolment in that program. Let me review it again for the member: increase doctors, increase nurses, increase occupational therapists, increase physiotherapists, increase lab techs, increase X-ray technicians, increase sonographers. In addition, radiation therapy programs, Mr. Chairperson, is another area that we have had to put in additional resources.

Theme 1, goal 1, project 1, rebuild the infrastructure that had been allowed to deteriorate and fall into terrible state in the 1990s. *[interjection]*

Well, the Member for Fort Whyte (Mr. Loewen) says this is tiresome. It is basic. Not only basic economics, Mr. Chairperson, it is basic building in a health care system.

Now, every other jurisdiction in the country, Mr. Chairperson, has followed our lead. Every other jurisdiction in the country is now increasing the enrolments in all of their professions. Now, I am doing this from memory. There are other areas with respect to human resource training that we have also expanded, which reminds me of health care aids. Health care aids, we have dramatically expanded the number of health care aids that we are training in Manitoba.

Mr. Chairperson, what does the member or what does the Opposition expect to do when you

did not train personnel and you are in a situation where you have to provide the care? There will be further training initiatives as we continue: job 1, rebuild human infrastructure; goal 1, rebuild human infrastructure.

Now, concurrently with that is also the question of trying to deal with the issue of keeping your human resources here. Job 2, doing what we can to keep people here. Now, the member asks: What can the public expect? Well, let the public look at the statistics for the past two years. For the first time in probably a decade, we have more doctors practising in Manitoba than before. I will repeat that. We have more doctors practising in Manitoba than several years ago. Directive, action, conclusion. Does that mean we are sitting on this success? No, Mr. Chairperson. We have in place a specialist recruitment fund. We have in place a rural and northern doctor strategy. Now, members opposite have stood up and complimented this Government for putting in place that strategy, and I welcome and I appreciate the fact that members opposite have recognized it, but this was a deliberate strategy put in place by this Government to retain and recruit doctors that was not in place for the past decade.

Let us look at it again. No action, losing doctors for decades, action, not only increasing the number of doctors but putting in place a program to retain doctors. Option, goal, working on achievement, and what does the rural and northern plan consist of? It consists of expanded residency positions. It consists of an Office of Rural and Northern Health announced, residency positions announced, bursary program and a repayment program for medical students announced and in place. If memory serves me correctly, over 150 medical students have taken advantage of it. Office announced, director of the office announced, doctor in place. That is rebuilding human infrastructure, job 1, goal 1, highest priority in the health care system where the majority of your resources go towards health care professionals.

Let me turn to nurses briefly. Yes, Nurses Recruitment and Retention Fund. We took two things that the nurses told us: We want the diploma program back. We brought it back despite the objections of many individuals on that side of the House. We brought the nurses diploma program back to graduate more students. Secondly, we took some of the funding from the nurses recruitment and retention and provided it to the regions to pay for nurses for their programs. Need for nurses, program, action, can it be any clearer? Not only that, we have put in place a task force to review nurses' working conditions, of which some significant, the member smiles, but some significant. We can go through it point by point if the member likes. Some significant changes have occurred, not the least of which are issues like extending benefits outside of Winnipeg to make it fair to all nurses across the province. Little things like that may not mean a lot to people in this Chamber but mean a heck of a lot to people out there who are providing the service.

Concurrent with those issues is the fact that we have concluded collective agreements with most of our health care professions that were respectful, that were bargained and were negotiated. Now, when we started negotiating with the nurses, members opposite said settle, settle, settle, pay more, pay more, pay more, and then when we settled they say you are paying too much, you are paying too much, you are paying too much.

Point of Order

Mr. Chairperson: A point of order being raised. The honourable Member for Charleswood, on a point of order.

Mrs. Driedger: Thank you, Mr. Chairperson. I challenge the minister to come up with the evidence to support those last comments because nowhere, anywhere will he find any of those comments made.

Mr. Chairperson: May I remind members, points of order are violations of the rules of the House or practices in this Chamber. Anything substantive is not a point of order. It is a matter of differences of opinion.

* * *

Mr. Chomiak: Thank you, Mr. Chairperson. Yes, to continue, both the Member for Charleswood and the Leader of the Opposition (Mr.

Murray) stand up and say you are spending, overspending, too much spending in health care. That speaks for itself, and members opposite have made it very clear where their positions are. It is very clear that every time there is a program, they say spend on that program, and I could name them off, and every time we spend on those programs, they say you are overspending on health care. They cannot have it both ways, but just to return to my issue: So we settled, and in addition we have tried to deal with the issues of full-time, part-time by having a joint task force between the nurses and the department and the health authorities to deal with the issue of full-time, part-time work.

We are going to do something that I think is innovative and helpful, that is, we are going to work with the nurses to try to solve the problem. Now, we may not be able to do that overnight, but we have in place a joint task force to work with them as part of the collective agreement to try to deal with that issue.

* (10:20)

So, if I return, Mr. Chairperson, back to the question of the member, I do not know how many more times I have to repeat it, but the first priority was dealing with the human personnel, the infrastructure problem, the difficulties surrounding the cuts, the slashes that occurred during the 1990s, and our need to rebuild the workforce, the labour force, the personnel force in health care through expanded training initiatives in every single area. That was job one, that was goal one. We made that very clear from the day we came into office that we would deal with that issue.

The second goal, Mr. Chairperson, was to deal with the hallway medicine problem. Despite members' claims, which I think we have agreed to disagree, the member is going to say whatever the member wishes to state, it has been very clear that independent, third-party bodies have reviewed the hallway situation and said it is an 80% improvement from the previous Conservative regime. That is an 80% improvement from what was done. As I indicated to the member yesterday during the course of these Estimates debates, we continue to work on that issue every single day as we proceed.

The next issue, Mr. Chairperson, was dealing with administrative changes. When we came into office there were two health authorities in one region, two health authorities in the city of Winnipeg doing two functions. We said we think it would be a lot better if we would deal with the administrative issues by eliminating some administration. That is what the public says. That is even what the Opposition has said that they have heard.

We have acted on it. Not only have we eliminated and melded two boards together in the city of Winnipeg, but outside of Winnipeg we have merged two regional health authorities together. So we have decreased the number of health authorities. But that is not all. We have also taken existing bureaucracy and we are molding that into existing bureaucracy to decrease the levels of bureaucracy, also something that people purport that they want us to do, but when we undertake it some individuals–well, I will not discuss that. I just think most Manitobans are very pleased with what we are doing. I think they are very pleased.

We took the VON and we melded the VON into the Winnipeg Regional Health Authority. We have also melded Deer Lodge into the Winnipeg Regional Health Authority, are in the process of doing so. Administration, less levels of administration, Mr. Chairperson.

Point 3. That was point 3, Mr. Chairperson, if the member is keeping track.

Point 4, Mr. Chairperson, was dealing with primary care, preventative care and providing care in the community. Let me just cite some examples, because I suggest that one can say it, but it is best illustrated by what has been done. Let me give some examples. Cervical cancer screening, prevention, probably, I am advised, will save up to six lives a year, if memory serves me correctly. Cervical cancer screening. In place in 1999? No. In place now? Yes. What does that suggest? Childhood injury campaign. In place in 1999? No. In place now? Yes. Water subsidy program. In place in 1999? No. In place now? Yes. In fact, the water subsidy program is so popular that I understand MLAs in Conservative ridings are actually handing out those kits in their constituency offices. Good. We encourage

that. We want that. That is called prevention. That is called dealing with difficulties before they start.

Expansions in the community, Mr. Chairperson, almost too numerous to mention, and I will refer to my notes briefly when I turn to that particular subject, but numerous examples in the community.

Now, let me set another example, emergency measures. When we came to office, the City of Winnipeg had nine ambulances on peak periods, as I understand it, and then there was a tenth partially paid for by the Province. Now it is sixteen. Soon it will be more. Does that suggest something, Mr. Chair? That suggests attention paid to primary preventative health care, as well as emergency services. When we came to office, we doubled the funding that we paid to EMS outside of Winnipeg.

Now, members opposite may say you have not done enough, and I suggest there is much more to be done, but we doubled what members opposite had done. We doubled what members opposite had done in our programs.

Example five of prevention and community: Our asthma program, not only is it very effective both in the city of Winnipeg, but it is being rolled out around the province, Mr. Chairperson. It has reduced the incidence of individuals having to report at ERs significantly. We have taken that program and rolled it out, and we are rolling it out to the regions.

The list goes on and on and on. Let me reiterate for the member. Rebuilding human infrastructure, dealing with administration, expanding community and preventative programs, 80 new ambulances in the province of Manitoba, 70 of which are in rural and northern Manitoba, the biggest renewal of equipment, I suggest, in the history of the province, and by bulk purchasing we save several million dollars that we can put back into the health care system.

What does that suggest to members opposite? Does that suggest lack of commitment to expanding and building an EMS system? I say otherwise. It deals with prevention. It deals with community care. It deals with dealing with the gaps that are in place in the health care system, Mr. Chairperson.

Prevention, community and a variety of other issues that I will turn to if I have sufficient time, Mr. Chairperson.

Item No. 5, rebuilding the infrastructure that was allowed to lag under the last decade. What happened in the last decade, Mr. Chairperson, was that surpluses were used up, contingency funds at all of the institutions and related areas were used up. Basic maintenance and basic equipment was allowed to go on and on and on until we reached a period where our basic health care equipment is in real difficulty, severe difficulty. If memory serves me correctly, in our first two years of office we put $76 million just into renewing basic equipment, some of it with the assistance of the federal government, but $76 million. If memory serves me correctly, that is far in excess of anything ever done over the past decade prior to our coming into office.

Let me reiterate. Human infrastructure, administration, community-based programs, infrastructure, Mr. Chairperson.

Now, infrastructure just does not include the equipment. Members opposite should know that we have renewed significantly capital across the province of Manitoba: new hospitals, yes; rebuilding hospitals, yes; new personal care homes, yes; rebuilding personal care homes, yes. The numbers are too numerous, but I will just go quickly from memory: Boundary Trails, new hospital, done; Gimli, new hospital, on its way; Swan River, new hospital, on its way. Personal care homes: The Pas, Flin Flon; in the central region, in Winnipeg, new personal care homes, new hospitals, new equipment, renewing infrastructure, Mr. Chairperson.

Together with that, Mr. Chairperson, has been the challenge of IT. There is no doubt that IT has been a difficult challenge for all governments over the past decade, made more difficult by the SmartHealth debacle that occurred in the 1990s. I do not know if members opposite remember, but SmartHealth was supposed to be a $100-million investment that saved $200 million.

* (10:30)

Point of Order

Mr. Harry Enns (Lakeside): With the assistance of his capable staff, can he point to a single year of the 11 years of the Filmon administration where the health care budget was cut, a single year where the health care budget was cut, a single year? Let us make this a pleasant morning, David.

Mr. Chairperson: May I remind honourable members again that points of order are not to be used for substantive debates. Points of order are violations of rules of the House or proceedings. *[interjection]* I am just doing my duty. The Chair is just doing his duty.

* * *

Mr. Chomiak: Mr. Chairperson, I am happy to answer that question for the Member for Lakeside (Mr. Enns), but I want to just point out the Member for Charleswood (Mrs. Driedger) asked me to point out what the goals and objectives were of the Department of Health. I am proceeding. I am laying background.

With respect to the SmartHealth, I was not going to go down that road because I know it causes a good deal of angst, but I want to indicate that with respect to IT there are developments that we are working on with respect to redeveloping IT, including lab technology IT and including IT infrastructure across the province that is considerable and will require millions and hundreds of millions of dollars of investment.

I just want to point out to members opposite that there have been new developments in IT that are significant. The Member for Lakeside (Mr. Enns) might be interested to know that we have to build IT into our capital projections now for Treasury Board. It was not the case in the past. Because of the needs and the incredible requirements for IT that are built into all projects, all projects have gone up dramatically in cost because of the infrastructure for IT, which is a new development.

Mr. Enns: I am just a little ranch boy from the Interlake. What is IT?

Mr. Chairperson: Information technology.

Mr. Enns: Oh, okay. Well, that has passed my generation by, too, Mr. Chairman.

Mr. Chomiak: Mr. Chairperson, just for edification for the Member for Lakeside (Mr. Enns), the major projects, for example, the Brandon redevelopment; the CRSP redevelopment, Health Sciences Centre; CancerCare redevelopment; Boundary Trails. All of the new capital developments require significant infrastructure IT built into the capital that was not actually accounted for previously, which has added significantly to the cost of all ventures. It is quite dramatic. It is quite useful, but it is something that was not a subject of actual debate even five or six years ago. We now build in significant IT components into each of the projects.

Boundary Trails, for example, which was a hospital already virtually completed when we opened it, had built in IT that cost several million dollars just to train staff in utilization of the new IT prior to the hospital even opening, which is all a new kind of development and something that had not been accounted for before and which was part of my fifth point to the member opposite with respect to the plan, IT.

The sixth point that I wanted to add was innovation. The sixth point was innovation. I can go back to any of these issues for the Member for Charleswood (Mrs. Driedger), particularly preventative and community health, Mr. Chair, to go through specifics, because I am only going from memory, but the sixth point is innovation and redeveloping the system. That in essence is one of the more fundamental issues that has to be dealt with. While I put it as a separate point, it actually is a factor that we look at with respect to each of our other developments.

Let me give two examples of innovation. One, of course, is providing more day surgeries, and I do not want to prompt additional debate that is unnecessary at this point, but I am happy to deal with it with respect to expanded– *[interjection]* No, the member is correct. Day surgery started decades ago. That is correct. What we are doing is taking it even several steps further by providing day surgeries in other locations and by moving around surgeries in the city of Winnipeg with respect to day surgeries, other locations being Pan Am that the member is well

familiar with, and the fact that we are moving surgeries around the Winnipeg system as we move more intensive surgeries into tertiary care facilities, already announced, already in progress, Mr. Chairperson.

The second innovative point–and I want to make this point because I think it is very crucial–is the fact that several years ago hospitals used to compete for resources, and we have tried through regionalization to lessen the impact of this competition and share resources in a more functional fashion, but now we are trying to do that with the provinces. The two examples that Manitoba has the taken the lead on is the western pediatric heart surgery program whereby Manitoba, Saskatchewan, Alberta and B.C. share the services, generally in Edmonton, of heart surgery on children, where they have the expertise, the Centre of Excellence, and they do the volume that is necessary to keep their acquired skills. That, of course, as I indicated to the member opposite, was a crucial recommendation of the Sinclair, Thomas reports which forms the basis of a lot of our decisions.

The next decision that has taken place is the gamma knife issue and the fact that we are going to be purchasing a gamma knife here in Manitoba, and the other provinces are not going to be purchasing a gamma knife, that they are going to utilize our gamma knife resources rather than invest in the costs of a gamma knife. From our perspective, not only is it an efficient and more effective use of resources, but it serves several other factors for the province of Manitoba.

First of all–*[interjection]* Oh, Mr. Chairperson, I have been on this very exciting topic, but I have been advised that my time is up. I hope the member now is much better aware of the goals and objectives of the department as I have outlined in the seven major steps, and I am quite prepared to elaborate on any one of those issues anytime for the Member for Charleswood.

Thank you, Mr. Chairperson.

Mrs. Driedger: I certainly do appreciate hearing from the Minister of Health (Mr. Chomiak) where he put his priorities in health care. I have to indicate that after the NDP being in government for almost three years, that is the first time, I think, I have heard the outline of the priorities of the Minister of Health. So I truly do appreciate hearing where he is setting his priorities in health care and what his goals are in those areas.

A couple of comments about comments the minister just made where he indicated that I and my Leader when we were looking at the various health care contracts and the minister would say that we said, spend, and then we said he spent too much. I certainly do challenge the minister to provide evidence on any of that. In fact, I have gone back through all the newspaper clippings and I have gone back through all of the questions that have been asked of this minister, and there is not one place where any of us have said either spend more or you spent too much. What we did say is that when salaries are offered, when contracts are negotiated, we definitely need to be competitive.

The other question that came out of all of this is can we afford what the minister is putting forward. I think that is a very legitimate question as one is negotiating contracts. Is there the financial ability within our budgets to provide the kind of funding? I think those are fair comments to be made on this particular issue, that we do have to look at being competitive, but I think it is a very legitimate question that needed to be asked in terms of can we afford what is being offered to people.

Certainly, I had a lot of concern, and I have stated it publicly that at the election time we knew there were 160 health care contracts that were coming up this year alone. I was very surprised that out of the billion dollars of new money that this Government got in their first two years, there was nothing put aside to address any of these contracts. Everybody, including the minister, knew in 1999 these contracts were on the horizon, and yet there was no money put aside in order to deal with significant dollars that are now being added to the health care budget. As we are all worried about whether or not the health care budget is going to hit the wall at some point, these are quite legitimate questions to be asked.

I challenge the minister. If he wants to keep going down the road of the Tories saying spend more, spend more, and then turning around and saying that we said he spent too much, I think for his own credibility on the issue he should

provide documents that can support those particular statements.

* (10:40)

The other question I would have would relate to his comments around the human resource rebuilding that particular infrastructure, and we have seen recently with the Deloitte & Touche report that there is a recommendation for a layoff of 180 nursing staff. There has already been, according to the Deloitte & Touche report, redistribution of nursing numbers throughout the system. What Deloitte & Touche is recommending in their report is that there are too many staff in the system, that we have too many nurses and too many health care aides. His recommendation is not for taking those 180 positions and redistributing them. Their recommendation is to lay off 180 nursing staff. Of that, 100 health care aides are being totally eliminated from med surg.

The minister just made some comments around the area of staffing of health care aides and in fact the report itself indicates a cutting of a hundred health care aides on med surg and basically no replacement of them, which means that nurses are now going to have to pick up those jobs, because the report is saying we have too many health care aides in the system and the report, in some instances, is saying we have too many nurses in the system.

If the minister is talking about rebuilding human infrastructure, is he then intending to ignore the results of the Deloitte & Touche report, a $600,000 report, by the way, that is not talking about redistributing these 180 people in the system, because they have already done that in their numbers? This is a net layoff of 180 staff. So if he is going down the road of talking about rebuilding human infrastructure, how does he intend to handle this recommendation by Deloitte & Touche?

Mr. Chomiak: I thank the member for raising that question, because the member might be unaware. I know the member may have only had copies of six or seven pages that she gave to the media that only talked about staff. Maybe the member only had the six or seven pages that she provided to the media.

As I understand it, if the member reads the whole report, the whole final report, the conclusion that she not only told the media but is suggesting during the course of these Estimates is not accurate. That is not what the report states, Mr. Chairperson.

The member waved a copy of what I think was the draft report at me during Question Period. She did not table anything. She did provide six or seven sheets to the media of a draft report, and perhaps that is why she is having difficulty. I suggest to the member that she wait until the final report is made public before she goes too far down the line about conclusions. If what the member says is accurate, she will have ample opportunity when the report is publicly released, which it will be, to make her points, but, until that happens, the member is dealing with (a) a draft report, (b) as far as I can tell, partial information and (c) I think jumping to conclusions that may not be appropriate if the entire report is reviewed. So I am only making that suggestion to the member. There will be ample opportunity when the report is released to make all of those claims when the report is released. At this point, I do not think that working on that assumption that I have already outlined is, in my view, appropriate.

So I am just suggesting that to the member, that then the member can make all of the claims she wants when the report is released publicly. But I would suggest that the six or seven pages distributed to the media from a draft report and the conclusions the member is drawing from those six or seven pages may not be accurate or may not be an accurate reflection of what the report says.

Mrs. Driedger: Well, the report was clearly their final recommendations to the minister, issued in January of this year. The recommendations are what are being currently discussed in the health care system.

I am not jumping to conclusions. I read directly from the report, and their recommendation is for the layoff of 180 nursing staff. They break it down to all of the hospitals. What I had is the full report, the full interim report. I did not have a partial report. I have the full interim report of recommendations.

I am assuming that for $600,000, though, at the end of it, there is going to be a much more substantive report. These were only recommendations that have been made, a significant number of recommendations. It looks at various hospitals throughout the city. It shows a redistribution of nursing staff throughout the city. It breaks it down to the number of layoffs in each place and the number of nurses or health care aides who are hired in each place.

The bottom end of it all is a recommendation for the layoff of 180 EFT positions within the health care system, a large number of them being at the Health Sciences Centre and St. B because some of the community hospitals will benefit from having more nurses added to the system.

But it also has talked about a new staffing model. It also indicated that there were too many nurses in the system. It definitely indicated that there were too many health care aides in the system. It talked about the misuse of health care aides for constant care. It has actually a number of recommendations.

It also talks about low morale. It also talks about angry nurses. It also talks about negative tone amongst nursing staff, particularly in critical care areas. I can understand where they are feeling angry, where morale is low, where productivity, I am told, also is affected because of all of this low morale. All we were doing in bringing that information forward the other day was asking the minister for a confirmation as to whether or not he is going to accept that recommendation.

He skated around the issue, he avoided answering it here in the House. That leaves it totally open to speculation by the media and anybody else that hears about it as to what the minister is going to do about it. So if he wants to unequivocally say that that is not where he is going, that he is going to reject those recommendations, that he is going to reject this $600,000 report, he has had a number of opportunities to do that. I mean, he is saying that we are jumping to conclusions, there will be a final report. Yes, there will be a final report. I am sure there will be final recommendations, because, perhaps, some of the recommendations they are making will not be followed.

The minister was asked for verification of this, confirmation of it, where he stood on it, whether he was going to accept it or not, and he skated, as my colleague from Lakeside just said. So the minister has an opportunity to put some of the facts on the table.

* (10:50)

The report definitely recommends in a number of areas where those layoffs will occur. I know the minister is on record as saying, well, there will be no layoffs, we have a nursing shortage, is what he told the media. There will be no layoffs, but is he going to take these 180 nurses, then, nursing staff, because they are not all nurses, they are registered nurses, licensed practical nurses, in fact in the report there is a recommendation for increased usage of licensed practical nurses in hospitals and two pilot areas where they are working extremely well, which does not surprise me, because I have always had a high regard for licensed practical nurses. Some of the ones that I worked with in my early days were some of the best nurses I worked with. I have great regard for them.

There are a lot of aspects to this report. The fact of it is the minister has had some opportunity to tell us what he is going to do with this. Is he going to take those 180 nurses, which are basically layoffs? There is no recommendation in the report for moving those nurses anywhere in this system. They are losses of jobs in the system.

I think the minister has found himself in the same position perhaps that we were in in the nineties. He likes to always talk about the Tories firing a thousand nurses. The fact of it is that with restructuring and a movement of nurses out of hospitals into community care, into long-term care, with the opening of beds, with a change in focus in health care, there were nurses that were taken out of acute care hospitals. Those nurses were redistributed in the system, but in order to do that they had to first be laid off, because there is no other mechanism to do that. According to contract clauses there is no mechanism for moving nurses easily in the system. The minister I am sure is fully aware of that, but it is now so ironic that he is now in the same position that we were in in the nineties, where there is a recom-

mendation by people out there in the system where there have to be some changes in order to improve the health care system.

He has now got 180 equivalent full-time positions, which could equate, because we know a lot of positions are part-time in the system, in fact two-thirds of the nurses in the system are part-time. We could look at 180 EFTs actually turning out to be, oh, it could be 400 part-time people. It could be 600 part-time people. So, if we wanted to look at 600 part-time positions being moved throughout the system, those are going to be layoffs. We may not lose those people from the system because they may get hired into the huge number of vacancies, which we know the nursing shortage is certainly double what it was when this Government took over. So those nurses may not lose a job, but they will certainly lose the job they are currently in.

I think the minister has now got himself in a bit of a pickle because he has had so much fun accusing us of firing 1000 nurses, and now he is forced into the same position by this recommendation. That is why he is not comfortable with this recommendation. But is he going to take a recommendation from a $600,000 study and throw it in the garbage and say, no, we cannot do that because then the goal of this study was to find ways to improve the effectiveness of the health care system, to improve the efficiency of the health care system, to put the dollars where needed? For him to back away from this recommendation is also going to put him in a bind. For him to accept the recommendation is going to put him in a bind.

All we asked when we brought those numbers forward is what the intent of the minister is. Is he going to accept the recommendation to lay off 180 EFTs?

Mr. Chomiak: Well, I do not want to sour on the member's statements or anything, but I think, if anyone were to read the preamble and the member's comments, they would note the following: first, the member stated it was an interim report, draft I believe; second, that the member said the minister did not say anything about what he was going to do and skated around, but then, later on her statement, said, oh, the minister said there will be no layoffs because there is a nursing shortage.

I think, if anyone even reviewed the member's comments in her statements, the answers to the questions are very clear. I need not amplify anything.

Mrs. Driedger: I can certainly appreciate the minister's discomfort with all of this. I have said, from the very beginning, this was a draft report. I have never put it forward to be anything more than what it was. Somebody was concerned enough with that report to leak it to us. Certainly, there are other questions that arise from this particular report, but I stand behind the statements I have made on it.

I have actually had nurses come up to me over the last few days in disbelief that this recommendation is out there, considering the mandatory overtime that is being forced on nurses right now. They really do not understand the fact that this recommendation is even appearing at all.

Certainly, the minister has had opportunity to clarify this. Of course, we want to see an improved health care system, and it makes sense to do reviews so that one can take information. I am sure the minister will be held to account. I do not think I have to press this one particularly vociferously at this point in time because, over time, I think the nurses are becoming more and more aware of what is in the report. I am already told there are positions at St. B that have been eliminated. That is even indicated in the Deloitte & Touche report, that changes at St. Boniface Hospital are already underway in 2001-2002. So, obviously, there is already activity going on with this. I am sure the nurses will be paying attention to this issue, as will health care aides. I am sure they will hold the minister to account on this issue as well.

Mr. Stan Struthers, Acting Chairperson, in the Chair

The other issue of the minister indicating that the Tories shut down training in the medical college, that was something that happened across the country. There was the Barer-Stoddart report in the early nineties. The report at that time

recommended that we had too many physicians in the system, and because there were too many physicians in the system costs were rising too quickly. It was a recommendation by that particular group at the time that what needed to happen across the country is medical colleges needed to decrease the number of students in training.

One of the people who was a strong, strong voice, and still is today, saying we have too many physicians in the system, that physicians are not organized in the way that would best meet the system's needs, but is probably one of the strongest voices in Canada for the fact that we have too many doctors in the system and still says that today is Michael Rachlis. I understand when the minister first became the Minister of Health (Mr. Chomiak), he hired Michael Rachlis as a consultant. Michael Rachlis put out a report. He certainly had a number of suggestions for the minister to follow in putting forward a multi-year plan. I was curious at the time, because I know the minister likes to criticize us very soundly for decreasing the number of students in the med school here. I cannot remember if it was 10 seats that might have been eliminated but he has certainly taken advantage of every opportunity over the years to criticize us for that.

I am curious, I would like to ask the minister why he would hire Michael Rachlis and pay him several thousands of dollars to consult with, when here was probably the biggest voice in Canada for saying we had too many doctors in the system and it was causing us problems; then he hires this person to put together a report which, basically, deals with some of these issues. I wonder if the minister might tell us why he would hire Michael Rachlis, considering Michael Rachlis's position on this and the minister's sound criticism that it was not the way to go.

* (11:00)

Mr. Chomiak: A couple of points. First, the fact that we expanded enrolment at the Faculty of Medicine, the fact that we expanded residency positions, the fact that we gave bursaries to students to stay in Manitoba, the fact that we set up a Rural and Northern Health office, the fact that we hired a director for rural health, the fact that we put in place a foreign medical graduates program to allow foreign medical graduates to practice medicine in Manitoba, suggests, I daresay strongly, that we are in favour of having more doctors in Manitoba.

I do not know if the member is aware but every time I have been through Estimates her colleagues from rural Manitoba have asked us to do that, get more doctors in rural and northern Manitoba.

I want the member to know there has been a variety of people that have consulted to the Department of Health on a variety of issues. Linda West worked for the Department of Health and gave significant advice. In fact, as I understand it, negotiated the last collective agreement with the doctors, was on contract to the Department of Health. The member is familiar with Linda West. Linda West has also done work for the Conservative Party and is in fact, I think, soon to be a candidate, if not a candidate for the Conservative Party. That person was hired and was working for the Department of Health.

There is a variety of opinions. There is a variety of information that is sought and reviewed by the Department of Health in order to get an informed view and informed opinion as to what we should do, but we make no apologies for the fact that we knew we had to do more to train doctors in Manitoba and, just as importantly or perhaps more importantly, to retain doctors in Manitoba. There was considerable work done in Manitoba about how we can best do that. The recommendations from a task force, together with recommendations from rural doctors that had done their own program, suggested, if memory serves me correctly, six or seven initiatives. We have done all of them. In fact, we have done additional initiatives to the six or seven initiatives recommended.

They recommended expanding the Faculty of Medicine; we have done that. They recommended expanding residency positions outside of Winnipeg; we have done that. They recommended expanding family residency positions, and we have allocated family residency positions for that program. They recommended an Office of Rural and Northern Health; we have done that, and we are going further. They recommended a director to work with rural and

northern students to go to schools, to go to physicians, to work with them to make it attractive for students to go into medicine, to make it attractive for students to stay in medicine, to find out what conditions we can do in rural and northern Manitoba to keep those students there. That is what the director is hired for, and I daresay one of the member's colleagues stood up and praised the hiring of that physician by this Government to do that.

There was also recommendations, Mr. Chairperson, to put in place bursaries for physicians to go to rural and northern Manitoba. Now, I am not familiar with the decade prior to my coming to this Chamber. I am not sure if we had a practice in the past to do that, but we have a return of service provision to those 150 doctors, not all of them, but some of them, that they will practice in Manitoba as payback for their medical training. Now, that is not a new idea. That idea has been around for decades. We implemented it. We put it in place as a result of recommendations from a task force. So there was a menu and a package of recommendations that were called for that we put in place.

In addition, we put in place a program, at the time, the first of its kind in North America, to take foreign medical graduates who could not achieve residency positions, who could not practise in Manitoba and give them the opportunity to (a) go through a three-day review to see whether or not their credentials were up and then put them into a residency position similar to a conditional registry that is already in place or, if they needed a year upgrading in order to get them into a situation where they can get a conditional registry prior to doing their part 2 of their exams, we put that in place. We have foreign medical graduates taking this program who are or will be practising in rural and northern Manitoba. We put that in place. That was a part of an overall recommendation made to us to deal with doctors, only one component of an overall personnel and health care professional platform but a significant one.

We found out that other jurisdictions, like Saskatchewan, were retaining 50 percent or 60 percent of their medical graduates, whereas, when we came into office, Manitoba was only retaining 30 percent or 35 percent of their medical graduates. We sat down with the students at the medical college and said, what do you need. What do we have to do to keep you here? We met with PARIM and said what can we do for medical students to keep them in Manitoba, and we continue to do that, part of an overall retention strategy.

Mr. Chairperson, it goes beyond determining whether or not Barer-Stoddart, in '92-93, was right or not right. The fact is enrolment was cut, programs were cut. We were deficient here in Manitoba, and we aggressively pursued a campaign to deal with that. If that was the only thing we did in health care, I think that would be significant, considering what I have heard from members, particularly when I leave the city of Winnipeg and when I go to rural northern Manitoba. Doctors are generally priority No. 1. So we put in place the most comprehensive program, I suggest, that has ever taken place in this province, and we make no apologies for that.

Generally, I do not find members opposite criticizing that. In fact, when I talk to members opposite, they generally are very pleased that we have taken the steps we have taken. If members opposite have any more suggestions that we could put in place as part of this program, we are happy to accommodate those suggestions.

Now, as I indicated to the member opposite previously, in the last two years, we have been able retain more physicians than we have lost in this jurisdiction. That is for a variety of factors. We hope to continue that trend line. That is very significant. There might be ups and downs in that curve, but we hope and we believe we are going in the right direction.

Now, most of our programs will not have an impact until long after I am out of this chair, Mr. Chairperson, but the fact is some of them will have immediate impact or short-term impact, but the long-term prognosis for practitioners in Manitoba is generally good for two reasons: (a) we are training a lot more; (b) we have put in place a whole series of initiatives to keep them here. That has been our plan and our policy. It is a long-term strategy.

I daresay a decade from now probably the full impact of what we have done the last two years will have its effect in the province of

Manitoba. Well, between now and then, there will be significant political debate, but I suggest that we put in place a significant, effective, long-term and medium-term plan, which is the best we can do, and anything we can do in the short term, we have done, to keep and maintain doctors in the province of Manitoba.

I will not apologize for doing that. I think that most members of this Chamber are supportive of that initiative. In fact, I would suggest that all members of this Chamber are supportive of that initiative and welcome that initiative. I know that because I have had discussions with members from all political stripes in this Chamber about these issues. There is a general consensus, in my view, that these initiatives are welcome, appropriate and are in the best interest of all Manitobans.

Mrs. Driedger: I certainly do acknowledge the rural and northern recruitment and retention efforts that have been put in place by this Government. It certainly builds on the efforts that we had been putting in place in the nineties, with the hiring of Dr. Garry Beazley, to look at many of these challenges and to find some resolution. Certainly, this Government has taken it forward, as they should have, and built on it. We certainly do support the initiatives for recruitment and retention.

I think there were some Winnipeg physicians, and I have not heard from Brandon, but certainly there are urban physicians that have some concern that this concentration of trying to just recruit for rural and northern Manitoba is not necessarily helping them, because it is not focussing much on them. I know, in Charleswood alone, we have some real human resource challenges because there are some positions that cannot be filled there. In fact, it is not just in Charleswood; it is in other parts of the city.

Mr. Chairperson in the Chair

* (11:10)

Certainly, the doctors in Charleswood that have been in touch with me were somewhat offended by the fact that some of the announcements did not include any efforts to try to bring physicians into the city. In fact, the member from Dauphin has even been on record as–*[interjection]* Dauphin-Roblin–saying that–has indicated that that was not as much of a concern for Charleswood because doctors there did not necessarily have to look after that many patients. He put out a letter to the editor on it.

In fact, I have a physician in Charleswood, he alone has a caseload of over 4000 patients. So it is not just in rural Manitoba that physicians are struggling to deal with large caseloads. It is also here in the city. This doctor phoned me and was quite offended by the member's comments from Dauphin-Roblin when–*[interjection]* actually, the comments of the member from Dauphin-Roblin were in the paper. I have the clippings of that. The physician–in fact, there was more than one physician–was actually hoping that some of these initiatives could certainly be put into place, as well, and they are hoping for some spin-off for themselves to try to deal with the physician shortage in the city, too.

So certainly, I am not criticizing the efforts of the Government. I think they have certainly built on the past efforts. They have taken things further, as they should have, and hopefully, as the minister said, it may take some years to see some changes, and I hope there will be some changes. Unfortunately, we know that adding a few more seats to the medical college is not going to quickly turn anything around. It may take seven years for those few extra seats to pay off.

I am curious if the minister had any conversations with Doctor Rachlis, because Doctor Rachlis, certainly, felt that–and you know he makes some interesting arguments and he is highly acknowledged for his work, but he makes some arguments that we have too many physicians here, and we should be looking at reorganizing how they actually function and to look at that in more detail because then you may find, according to him, that you have enough physicians. It is just you have redistributed the workload accordingly, and we might not have such big concerns then down the road related to a physician shortage if his advice was taken.

I am wondering if the minister and him had any discussions around this issue and if there were any possible innovations in any of that that the minister might be contemplating.

Mr. Chomiak: Mr. Chairperson, as I indicated, we do consult widely. In fact, I have had many conversations with Linda West when she worked for the department, on contract to the department, in terms of her recommendations as to how we deal with these issues. We certainly had some discussions with Doctor Rachlis.

But I am glad the member mentioned the city of Winnipeg, because I think it is very important that the member understand that a lot of these initiatives impact on the city of Winnipeg and she I think might have misinterpreted perhaps the initiatives. For example, the College of Medicine graduates, the majority usually practice in the city of Winnipeg, not in rural and northern Manitoba. The expanded seats will impact on that. The expanded residency positions, particularly in family medicine were aimed towards more practitioners in family medicine, which seems to be the issue that we are dealing with in the city of Winnipeg.

In addition, the specialist recruitment fund that has brought back, if memory serves me correctly, 60 or 70 or 80 specialists, I am just going by memory, almost exclusively are in the city of Winnipeg. Those are all initiatives that impact on the overall physician supply.

The member seems to be suggesting, in the first part of her statement, that there were not enough doctors. She cited Charleswood, in Winnipeg, and then in the latter part suggested that there are too many doctors. I know that the stats are quite dramatic–

Point of Order

Mr. Chairperson: Point of order being raised. Member for Charleswood.

Mrs. Driedger: I think it would be important for the minister not to misinterpret what I am saying. I am not saying that there were possibly too many physicians in the system. I am indicating that Doctor Rachlis has said that. I was just asking the minister if they had any conversations around that. I would ask him to please not misinterpret and put misinformation on the record.

Mr. Chairperson: These are not points of order. Points of order are not to be used for substantive debates.

* * *

Mr. Chomiak: I thank the member for that clarification. I do not know when the member talked with Doctor Rachlis. Maybe she could table in the House her discussions or her notes when Doctor Rachlis said there was too many doctors in the city of Winnipeg.

I do know that I had discussions with Linda West when she worked for the department, when she did considerable work in this area. I know that Linda West did work in this area. I know that we have had a variety of people doing work in this area and there has been a variety of opinions, but I want the member to point out that our extensive physician program is based on the work of the task forces, doctors and a variety of individuals and groups that provide information to us.

The member has indicated a doctor or doctors from Charleswood have contacted her with respect to difficulties. I know some doctors have extraordinary workloads. I know that we have taken initiatives to try to redistribute those workloads. Again, not in place in '99. Now in place in 2002. We have taken initiatives to deal with that situation.

In addition, there is an entire change. I do not know if the member is aware, but there is an entire change in the way that doctors practice. There is significant different approaches to practice. Doctors are taught differently than in the past. There is a different type of doctor that has come out, has graduated. We effectively have more doctors, but some doctors are working less hours. We have some doctors carrying incredible workloads. We have issues of doctors no longer covering practices in acute care institutions. We have instances of being forced to hire hospitalists to deal with the doctor situation. And I am aware, I do not know if the member opposite is, but as part of dealing with those initiatives, when the member was assistant to the Minister of Health, Mr. Stefanson, when he was Minister of Health, they put in place a project to deal with doctors and put them on salary at a clinic, at Assiniboine Clinic, I believe is the name of the clinic, dealing with Grace Hospital. They reviewed that kind of an approach.

We have looked at varying approaches. I know in point of fact when we negotiated a new

collective agreement with the Manitoba Medical Association, we put in place a clause and funding to deal with doctor recruitment and retention. Again, not a new concept but one perhaps new in the Manitoba context is that we are working with the doctors to retain physicians. We actually have clauses, we actually have it as part of our new collective agreement, the ability to work with the MMA to retain doctors. That is an innovation. That goes to the goals and objectives of the Department of Health I illustrated earlier when I talked about innovations. That is another example of the many innovations that we have undertaken to change and to deal with health care.

I am not sure if the member is aware, but we have one of the highest percentages of doctors in this jurisdiction on salary than any other jurisdiction in the country. We have also recognized that as part of the new collective agreement. Again, as part of an innovative approach, let us compare the last collective agreement with this collective agreement. This collective agreement has a specific clause and funding aimed at retention of doctors.

I would suggest that is part of the overall plan that I cited at the very beginning of my comments dealing with human infrastructure as part of it. Quite significant. Part of the new collective agreement. I do not know what the member's position is on the new collective agreement. I would be curious as to the member's position with respect to the new agreement that we have entered into with the MMA, but I think that the provision for retention and recruitment of doctors and that particular clause is a significant factor.

* (11:20)

Just to sum up, we by no means have confined our activities to rural and northern Manitoba. However, in rural Manitoba, if memory serves me correctly, in northern Manitoba it is one doctor for 6000 patients. In rural Manitoba, it is one for every 2000. In Winnipeg, it is something like one for every 500 to 600, roughly. I am going from memory.

I think there is a recognition by members in this Chamber that we have to do better outside of Winnipeg. That does not mean we forget the city of Winnipeg. That is why we have increased the seats. That is why we have initiatives in terms of family doctors. That is why we have initiatives in terms of foreign graduates. That is why we have initiatives in terms of specialists. That is why we have more doctors here now in the last two years. I hope I have been able to help the member understand that we are not just confined to that issue and that we have tried to look at the well-being of the entire province. Dealing with rural and northern Manitoba with some severe difficulties and dealing with the difficulties in Winnipeg is part of an overall package that I have already illustrated and pointed out to the Member for Charleswood.

Mrs. Driedger: I appreciate hearing the comments from the minister on that topic. I would like to ask for some clarification. I do it with some hesitation, because I know in the past every time I am asking for clarification the minister tends to want to twist my question and then runs around saying, well, she said this or she said that. Again, I am asking for clarification because we are dealing with different numbers that are put out there. I am not saying one is right and one is wrong.

All I am asking for from the minister is that he treat this with the respect I would hope he would and clarify for me some of these numbers that are out there. It is related to specialist vacancies. According to the College of Physicians and Surgeons, they have indicated that 68 physician specialists were recruited to Manitoba, giving Manitoba more specialists per capita than B.C., Alberta and Saskatchewan. Yet the Premier in his franking piece said there were 95 specialists recruited to Manitoba. What is missing in all of those numbers is the fact that in the last FOI that I have, there were 59.5 specialist vacancies in the WRHA alone.

I would like to ask the minister, while it is easy to talk about what we are recruiting in terms of specialists coming in, it is easy for the Premier to put in his franking piece that while he has recruited 95 specialists to Manitoba, he does not indicate that perhaps even more have left. He does not indicate that we have almost 60 vacancies in the WRHA and we have lost some very talented people like Dr. Todd Sekundiak. Certainly, there are a number of specialists who are feeling a great deal of frustration, perhaps

with the small "p" politics, the medical politics within the system. So we have lost some really, really good specialists from this province, some rising stars, and we have not been able to keep them here.

When I am hearing that we have recruited 68 specialists but the Premier (Mr. Doer) is saying 95. We have 59.5 vacancies at the WRHA and perhaps there is more or a bit less; this was a few months old. Then nobody is mentioning how many are leaving, so we cannot even do any really good comparison.

Can the Minister of Health set the record straight with all of the conflicting numbers coming from his caucus on how many specialists have been recruited to Manitoba and how many are leaving? Are we at a net loss or a net gain? Where are we?

Mr. Chomiak: With all due respect to the Member for Charleswood, I will attempt to answer her question. You can have vacancies and still recruit specialists. The numbers from the College of Physicians and Surgeons are for a specific time period and the numbers we put out with respect to attracting specialists, if it was put out by the Premier–I am only going from memory at this point–if the Premier said 90 or 95, that probably is the accurate number. I will confirm that particular number.

There will always be specialist vacancies in Manitoba. We will never have all of the specialties or subspecialties that, in an opportune or perfect situation, would be available. There are specialist vacancies in Edmonton. There are specialist vacancies in Vancouver. There are specialist vacancies, I daresay, in Toronto. There are specialist vacancies in Manitoba. There are and there will be.

We have attracted specialists to Manitoba as a result of the specialists fund. There are vacancies. The college numbers with respect to the numbers are for a specific time period.

Mrs. Driedger: Can the minister indicate whether or not we are short for cardiac surgeons? We read in the paper that we had nine, four have left. Is nine the number we should have for a safe program? Are we only now operating with five out of nine?

Mr. Chomiak: I am advised that we are operating a safe program with the number of cardiac surgeons we have now.

Mrs. Driedger: Can the minister confirm that we only have five cardiac surgeons in Manitoba, and are we supposed to have nine?

Mr. Chomiak: I wonder if the member might, because I want to give the member the correct answer, clarify what she means by supposed to.

Mrs. Driedger: If we have been operating in the last number of years with nine surgeons, is that the number predetermined by, for instance, the WRHA, as the number of cardiac surgeons that should be in Manitoba in order to carry out the size of the program here? Who, in fact, determines how many surgeons in any specialty we should have, but particularly the cardiac program? If we have been dealing with nine over the last number of years, is that predetermined by the WRHA to be the ideal number that we should have?

Mr. Chomiak: I take it from the member's question that, if there were nine in the program, that is the supposed to that the member is making reference for?

Mrs. Driedger: I am just asking the minister for clarification. Certainly, I would think that, with the challenges we are seeing in cardiac surgery right now with the patients being bumped all the time, this is a serious issue. I would think that he must have asked these questions of the WRHA and would want to ensure that all of the information on this program is transparent so that we could get on with solving this issue.

I am just asking him for information on this program, and I think it is very basic information. We know we have a certain number of neurosurgeons in the city. We have a certain number of any other number of specialists, and those numbers seem to be fairly stable over many, many years. Neurosurgery, where I worked, we had so many neurosurgeons. In fact, the Department of Neurosurgery, probably in concert with the WRHA, and then obviously maybe in concert with the Government, determines how many surgeons you need, how many specialists you need to operate a program.

* (11:30)

Mr. Chairperson, has the minister had discussions with the WRHA on how many cardiac surgeons we should have in Manitoba?

Mr. Chomiak: I take it from the member's question that she is reframing the supposed to to how many we should have. Do I understand that correctly?

An Honourable Member: He is playing word games with you, Myrna.

Mrs. Driedger: Mr. Chairperson, I do believe, as the member of Lakeside said, he is playing word games with me. It is not the first time. The last two sets of Estimates we have encountered this numerous times. I am just asking for some transparency in here. The minister could try to answer this any way he likes. My question is: Do we have the set number of cardiac surgeons we should have in Manitoba, and are we currently short?

Mr. Chomiak: As I understand it, the advice in terms of the number and the recruitment is undertaken by the appropriate Regional Health Authority. The Regional Health Authority feels, at this point, the number of cardiac surgeons we have in place and the number of cardiac surgeons that they are in process of recruiting, if they are recruiting, is sufficient.

Mrs. Driedger: Well, Mr. Chairperson, I do not buy the answer because, being a nurse in the system for 23 years, I have a better understanding of the health care system than that, and, within each program, there are numbers that you strive to have. That is how the WRHA is able to tell me that we are short 59.5 specialists in Manitoba, because they are basing it on the number of specialists that operate in each program, the number of surgeons, the number of internal medicine people. So that is how they can actually turn around and tell us how many vacancies there are, because there are set numbers of doctors working in each program.

I think the minister is trying to dodge this issue. I know it is a sensitive issue. I appreciate that. But it also has some bearing in terms of patient safety. I read in the paper that the mortality rates in cardiac surgery are up, which could be for, you know, a number of reasons. We see bumping of cardiac surgery. Again, yesterday, there were two out of three surgeries bumped at St. B. Only one emergency surgery was able to be done.

Well, it makes me wonder why they were only able to do one emergency case. Why were they not able to do any regular cases? Were there not any regular cases scheduled? Well, there must have been if two got bumped, but two got bumped and they could only do one emergency case. It almost seems like St. Boniface Hospital is perhaps only able to do one cardiac surgery a day if it is a long one, maybe if it is a complicated one.

I understand that that has impact on the length of time of surgery, but we have had, according to the media reports out there, nine cardiac surgeons. I am told that in this last year alone we have lost four. It begs some very, very serious questions. I am just asking the minister for some transparency in this, some accountability of his position as the Minister of Health instead of trying to dodge it to come clean and tell us what those numbers should be in Manitoba and what kind of efforts are being made to recruit cardiac surgeons.

Mr. Chomiak: The member's question was a wide-ranging question that touched on a whole variety of issues that I will attempt to deal with in order to help assist the member in acquiring the information that she seeks.

The recommendations with respect to the number of cardiac surgeons, the decisions with respect to cardiac surgeons are made by the appropriate health authority. As I said in many instances, I am not in a position to tell the WRHA who they should hire. The member has enough experience working in the health care environment to know that I am not the appropriate person to tell who should be hired and who should be fired.

With respect to the mortality rates, I suggest to the member that the raw figures that were provided both in the paper and publicly by, I believe it was, Ms. West and the Member for River Heights (Mr. Gerrard), I think should wait

until the fall until we can do comparative figures with other jurisdictions, because the information provided showed some varying degrees. Also I suggest that it be better debated when we have comparative statistics with other jurisdictions.

With respect to the issue of the procedures that have taken place and the bumping that has taken place, that is not something that we obviously are in favour of or advocate. Steps have been, will be taken in order to deal with that particular issue.

With respect to the number of surgeries, from the data that I saw with respect to cardiac surgeries we are on course this year to exceed the number of cardiac surgeries done both last year and, I believe, the year before. In fact, in May of this year, there were more cardiac surgeries than in any comparable period for some time. They are some significant acceleration of cardiac surgeries, and, as I indicated both in Question Period and publicly, the waiting list for cardiac surgery has gone down significantly.

* (11:40)

Now, there have been difficulties as part of the acceleration process at St. Boniface Hospital, and we are looking at that. It is a variety of factors of which I could get into, but I do not want to use up all the time on that particular issue.

The Winnipeg Regional Health Authority has confidence in the cardiac surgeons that are presently in place. The member might also know that we are expanding significantly our cardiac program, not just surgical, but otherwise. For example, the echocardiograph, we are expanding in the number of suites available. That has caused some dislocation, because we are putting in, I believe, a new biplane over at the Health Sciences Centre, and we are forced to just do the two at the St. Boniface Hospital.

There are other issues as we redevelop our cardiac program, but it is an $18-million investment over several years to reconfigure and redevelop and enhance and expand the cardiac program in Manitoba. That is an ongoing process. It is a multiyear process. We started it, not this year, but the year before. The member is aware of and we have discussed this frequently, so I am not going to get into the Bell-Wade issue unless the member wishes to, in which case, I am happy to do it, but we have discussed frequently the issue of sites, and we resolved that we would be developing cardiac surgery at two sites, one program, two sites. In addition, we are significantly expanding catheterization capability, other ability with respect to technical programs and enhancing the ability to do other kinds of an improved, hopefully, quality of cardiac surgery here.

It is a multiyear program. The surgeons in place now, the cardiac surgeons, the WRHA has confidence in them. The mortality rate issue, I think, again, we can have this debate now, but I suggest–and I am not trying to hide from it because we will be back in session, I am certain, in the fall. The member can raise it then when the stats are out, the specific stats on a comparative basis, and we will take a look at it at that point. I do not know if the member has any additional questions, but I will leave it at that.

Mrs. Driedger: Mr. Chairperson, the minister has been very evasive about dealing with the number of cardiac surgeons in Manitoba, and certainly we have heard that we have nine. We now only have five. We appear to be short. That is verging on almost half of the surgeons that we would normally have. I would ask the minister if he has had any discussions with the WRHA about this particular shortage of cardiac surgeons and whether or not nine is the number that has been established for the cardiac surgery program in this province that we are now short for and whether or not he has had further discussions with them as to how they are going to address this shortage.

Mr. Chomiak: The member is concluding, as I take it from her question, that there should be nine surgeons here, and I asked her to explain it, and then has said we only have five, therefore we have a shortage and what are we dealing with with respect to the shortage. That is what the member asked.

I have previously, in good faith I have tried to find out from the member what she meant by the optimum supposed variance. The member has now said we must have nine, we only have

five, therefore we are short, what are we dealing with in order to deal with the shortage.

I advised the member, the WRHA advises me that they have confidence in the five surgeons who are doing cardiac surgery in Winnipeg at present. I will just clarify one thing for the member. Just one second.

The issue of cardiac surgery and the mortality rates is one that I think we will deal with more specifically when we can have actual comparisons. The member will be aware that we have just been through a very, very sensitive and difficult process with respect to a cardiac surgeon in Winnipeg whereby there was a very lengthy, drawn-out process with all kinds of legal ramifications from it that was undertaken, just as recently as last week a report by retired Judge Krindle that the WRHA had appropriately dealt with the surgeon in question and that there was appropriate justification on the part of the WRHA to undertake action against that surgeon. The member will know that the statistics cited–well, I will hold off on that. I will leave it at the point that I have already indicated.

Mrs. Driedger: I was not asking the minister about Doctor Del Rizzo. In fact, I am quite prepared to wait for the mortality rates to be reported so that we can address them as they become available.

I certainly understand that mortality rates I believe were not kept for a year within the program, because Verna Tribula, the nurse that was compiling those mortality rates, retired, which begs its own questions as to why nobody maintained the mortality rates for a whole year. Then they brought her back from retirement and had to go back through all that data in order to pull those mortality rates together, somewhat disturbing that that happened in the place, but I am not talking about mortality rates at this point in time. I am not talking about Doctor Del Rizzo.

The minister is certainly ducking the question that I have. He is obviously worried that I am trying to trap him into something, so he is skating all over the place on this particular issue, but programs have a certain number of physicians in them as determined, you know, perhaps some of it even by history. As programs expand or decrease, you have to have so many physicians in order to carry out those particular programs. Obviously, if the WRHA can turn around and tell you how many vacancies there are, there has to be available the number of physicians that there should be in each program.

Perhaps the minister would like to have a discussion with his staff right now. If he does not have the answer, perhaps he could have a discussion with his staff right now and find the answer.

Mr. Chomiak: Mr. Chairperson, I thank the member for that question, and I thank the member for that suggestion, but I am perfectly able and willing to answer the member's question, should she pose it.

Mrs. Driedger: Mr. Chairperson, I would like to ask the Minister of Health: How many cardiac surgeons should there be in Manitoba's cardiac surgery program?

Mr. Chomiak: If my memory serves me correctly, Mr. Chairperson, I do not think there is a set number that one could say there should be or is supposed to be or must be with respect to the program. I think with respect to cardiac surgeries, it is based on the volume, the complexity and the type of surgeries.

At present, as I understand it, there are five cardiac surgeons operating. At present, I am advised that they can adequately deal with the workload that they are facing at present.

Mrs. Driedger: Well, then, according to what the minister has said, he is limiting the number of cardiac surgeries that can be done in Manitoba because if you only have five surgeons, they can only handle so many surgeries. So, in fact, in the mid-nineties, we were doing hundreds more of cardiac surgeries than have been done last year. In fact, Dr. Brock Wright has now said 1173 were what were done last year; 1173 would be what is done this year.

By the minister's answers then and by avoiding this question, if we only have five surgeons, we can only do a certain number of surgeries, so, in fact, he is limiting the number of cardiac surgeries that can be done in Manitoba.

Perhaps this is then accounting for the bumping that is happening right now, because if we had nine surgeons, obviously by his answer, we could do more cardiac surgeries.

* (11:50)

If a year ago we had nine surgeons and if now we have five, obviously hundreds of surgeries are not going to be done this past year or hundreds of surgeries will not be done in the future because we cannot possibly do it with only five surgeons. We are going to see waiting lists increase, and all of this is certainly coming from the minister's answer and his ducking of the question.

I mean, he is right. If you only have five surgeons, he is right to say, well, they can handle the caseload. Yeah, they can handle the caseload of what five surgeons can do. If you had nine surgeons, you would certainly be able to do more cardiac surgeries. So actually what he has done in Manitoba, then, is limit the number of patients who can have cardiac surgeries, and I think that could be leading to some of this bumping.

Mr. Chomiak: That is the problem, Mr. Chairperson, with a little bit of information. The member has reached the wrong conclusion,W-R-O-N-G, wrong, wrong, wrong. The member has taken information and extrapolated it inaccurately. That is one of the reasons the member has had trouble with credibility. I do not want to go down that road, but that is a problem. To take a response and to turn in into what the member did is not, in my view, appropriate or accurate, even remotely.

The member said: Well, you are doing X number of surgeries. You have X number of surgeons. Therefore, you cannot do more surgeries. Therefore, you are limiting the number of surgeries. There is nothing more patently wrong. Besides, we are doing more surgeries now than we did in the mid-nineties. *[interjection]*

If the member would allow me to finish my answer. I allowed the member the opportunity to finish her extrapolation, which was totally inaccurate. I just indicated to the member opposite that we are on track this year to do more surgeries. Does that mean? What does that mean? Does the member not realize, in the question–*[interjection]*

The answer preceding, I said more surgeries. Let me point this out to the member opposite. We are doing other procedures, not just open-heart surgery. We are doing a series of other procedures.

That is part of the problem with giving specific answers to specific questions. Let me just point this out to the member opposite. Maybe this will help. In December '99, there were more people waiting for heart surgery, just after we assumed office, than there are in our most recent statistics. What does that suggest? Does that suggest that members opposite were rationing because they had eight or nine or ten or fifteen or twenty surgeons? It depends upon the slates, and it depends on the number of the type of procedure that is provided. I think the member opposite knows that, but, from the information that has been provided to me, we are on target to do more surgeries this year than we did last year.

I understand that we have hired some surgeons over the past several years. Some surgeons have left. I understand, in May of 2002, more cardiac surgeries were done in May than any other past year. I know the wait for elective cardiac surgery is down. For the member to suggest that we are capping or rationing heart surgeries, and to suggest that it is a reason for bumping heart surgeries, is wrong and does a disservice to the public of Manitoba. If the member wants to have a discussion about that particular issue, I am prepared to discuss that issue and discuss that issue in detail, but, for the member to take the number of surgeons and to suggest that is a reason for a difficulty or any kind of difficulty, then I think that is not accurate. I note that on FIPPA information, '96-97, the number of cardiac surgeries was 1040. In '98-99, it was 1147. I do not understand what the member is talking about in terms of inaccurate information, because the information that was FIPPA'd, I think, to the member showed there were more surgeries in '98-99 than there were in '96-97.

Now, with respect to '95-96, '94-95, et cetera, I am not sure if they compiled central

statistics, because we were not government. You know what? I could not get the information. Do you know that? They would not give me the information. I asked for it. It is true. I was not entitled to get that information. I asked for it consistently. What has happened is that we have changed The Freedom of Information Act to extend it to the regional health authorities and the institutions. Therefore that information is now available.

So the member opposite says I should look at '94-95, '95-96. You know what? '96-97 has been FIPPA'd and compiled, 1040; '98-99, 1147. That seems to me to be up, not down. But I do not think it is useful for the member to extrapolate this information and to leap to these conclusions that the member leaps to. What I think is important is, are we rebuilding our cardiac program? Yes. Are we expanding the number of cardiac surgeries we are doing this year? I am advised yes. Are we trying to do more? Yes. Are we trying to make cardiac surgery and enhanced cardiac surgery and cardiac programs in general an overall continuum? Yes. Have the waiting lists gone down since we came to office? Well, I have already indicated from December '99, the numbers are higher than they are now.

What can I conclude from that? If I were to extrapolate the information that the member did with regard to surgeons, I would say, well, gee, the surgeons were doing less than they are now. The fact is this year we are on track to do more surgeries than last year. We are continuing to rebuild the cardiac program. That is why we have put a significant multiyear plan in place for $18 million. It is a multiyear plan to redevelop the cardiac program and expand the cardiac program. There have been significant developments that have taken place since that time. The data shows that we are on track to do more surgeries, as I understand it, this year than last year. The program is continuing. I look forward to continuing this discussion when we meet. I presume we will be meeting after Question Period this afternoon until the House should adjourn.

I would like to point out to the member that with respect to specialists there have been significant recruitment and retention initiatives undertaken. That data has resulted, I think, in some of the better statistics from CIHI. The member cited her own statistics which showed, in terms of specialists, we are better than other jurisdictions, for the most part, in western Canada. In terms of GPs, we are significantly better than most of our counterparts in–

Mr. Chairperson: The hour being 12 noon, pursuant to the rules, I am interrupting the proceedings of the Committee of Supply with the understanding that the Speaker will resume the Chair at 1:30 p.m. today and that after Routine Proceedings the Committee of Supply will resume consideration of Estimates.

LEGISLATIVE ASSEMBLY OF MANITOBA

Tuesday, July 30, 2002

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GOVERNMENT BUSINESS

Committee of Supply

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