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MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Fifth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

Monday, April 27, 1992

The House met at 8 p.m.

COMMITTEE OF SUPPLY

Madam Chairperson (Louise Dacquay): This section of the Committee of Supply will please come to order.

Hon. Darren Praznik (Deputy Government House Leader): Madam Chairperson, I understand that the Minister of Education (Mrs. Vodrey) due to illness will not be available tonight for Estimates in this section, and we have had an opportunity among other House leaders, and I would think we would ask if the committees could rise into House so we could, with agreement, make arrangements for the section of the committee dealing with Health to reassemble in the Chamber, as we will only be going with one section of the committee tonight.

Does that require a motion? If it does, I so move that–

An Honourable Member: It does not.

Mr. Praznik: It does not. If it does not require a motion, then I would ask that we call leave to bring the committee into the House.

Madam Chairperson: I would like to suggest that the committee temporarily interrupt the proceedings so that Mr. Speaker may resume the Chair so that we can determine whether there is unanimous consent of the House to change the Estimates process for this evening. [Agreed]

Call in the Speaker.

* (2005)

IN SESSION

Hon. Darren Praznik (Deputy Government House Leader): Mr. Speaker, I would ask if you could please canvass the House to see if there would be unanimous agreement to have the Committee of Supply resume, but only one section, that in the House, and that the Department of Health Estimates resume for this evening only in the Chamber.

Mr. Speaker: Is there unanimous consent of the House to allow the Department of Health to resume its Estimates process within the Chamber for this evening? [Agreed]

Mr. Praznik: Mr. Speaker, I would move, seconded by the honourable Minister responsible for Seniors (Mr. Ducharme), that the Committee of Supply now resume to consider the Supply to be granted to Her Majesty.

Mr. Speaker: For the record here, we would just like to advise the House that the Department of Education and Training will not be sitting tonight in Committee of Supply, and there has been leave granted by the House to allow the Department of Health to resume their Estimates in the House for this evening only, within the Chamber.

The honourable deputy government House leader does not need a motion to go back into Supply, because you have simply interrupted the proceedings to allow the Speaker back in to grant unanimous consent.

Madam Deputy Speaker, take the Chair, please.

HEALTH

Madam Chairperson: Order, please. Will the Committee of Supply please come to order. This section of the Committee of Supply will resume consideration of the Estimates of the Department of Health.

When the committee last sat, it had been considering item 2.(d) Healthy Child Development, page 83 of the Estimates book.

Ms. Judy Wasylycia-Leis (St. Johns): I would like to follow up with some of the questions that I was asking before we recessed at five this afternoon pertaining to the children's dental health program. The minister said he would provide us with details pertaining to the actual expenditure for the dental health program now versus prior to the change in age limitations, as well as the precise numbers of children no longer served with that change, and more details pertaining to a reduction in the grant line.

* (2010)

Hon. Donald Orchard (Minister of Health): The numbers served were provided this afternoon under

the current structure of the program, and we are expecting the information on budget shortly.

Ms. Wasylycia-Leis: Let me seek a few clarifications then. Did the minister review his material, and can he confirm that the number of children served by the children's dental health program has been reduced from 50,000 to 40,000?

Mr. Orchard: I have to confirm that. I told you that this afternoon.

Madam Chairperson: Order, please. I just want to draw the attention to the committee members that a new procedure had been outlined for this section. You are not obligated to stand if you do not so desire. You just raise your hand. I thank the honourable member for St. Boniface (Mr. Gaudry) for drawing that to my attention.

Ms. Wasylycia-Leis: I thank the minister for that clarification and I appreciate the fact that he feels he did not have to clarify the numbers, although earlier in our Estimates period, he was not quite certain so I just wanted to make sure that he knew what number we were talking about.

Secondly, Madam Chairperson, the minister indicated that for the 1992-93 fiscal year, the total expenditure for Supplies & Services staff, everything included for the children's dental health program is $3,723,000 and I would just like that confirmed and verified.

Mr. Orchard: My staff indicates that is an appropriate number.

Ms. Wasylycia-Leis: Could the minister tell us the equivalent number, in other words, the total expenditure for the children's dental health program prior to the change in criteria regarding age group of children for this program?

Mr. Orchard: Whose turn is it?

Ms. Wasylycia-Leis: I asked a question.

Mr. Orchard: Oh.

Ms. Wasylycia-Leis: I would be happy to repeat my question. I would like to know the equivalent amount to the $3,723,000 which the minister says represents today's total cost for the children's dental health program, and what I am looking for is the amount for the program prior to the change in eligibility requirements?

Mr. Orchard: That was the number that we hoped to have down to provide to my honourable friend forthwith.

Ms. Wasylycia-Leis: Could the minister indicate if that will be in short order, or when precisely we can expect it. We raised it before five o'clock and I am just wondering when, since we are on this line, we might expect that number?

* (2015)

Mr. Orchard: At the risk of running amuck of the process that we are under, "forthwith" means as soon as my appropriate staffperson arrives with the number. If that is not before we pass this line, I am fully prepared to revert back so that my honourable friend can even ask questions on the new figure versus the old figure.

Ms. Wasylycia-Leis: Could the minister indicate when he will be telling us where the missing $65,000 or so in terms of the Grants line for Adjusted Vote 1991-92 will be presented to us?

Mr. Orchard: Hopefully at the same time.

Ms. Wasylycia-Leis: The minister indicated earlier that part of the change in that grant line had to do with the reduction in grant to the Canadian Council on Smoking. I am wondering if that appears under the Grant line, why is that so, and why does it not appear under the External Agency Line?

Mr. Orchard: If my honourable friend takes a look at External Agencies, staff informed me that that is where the $4,400 and $45,000 to Child Guidance Clinic are, and that accounts for the reduction there. The reduction is twofold. First of all, it is those two grants off, but then it is not $49,400 as it should be because other agencies received an increase.

Ms. Wasylycia-Leis: So with respect to the figure for the line Grants, is the minister saying that he is going to explain everything, they will accept the grant to—is it Swampy Cree and Churchill?

Mr. Orchard: That is correct.

Ms. Wasylycia-Leis: With respect to total expenditures, could the minister give us a breakdown for the expenditure minus the children's dental health program? In other words, that would leave $1,132,900,000. Could he explain or give us the breakdown for that in terms of where it is going for Healthy Child Development programs?

Mr. Orchard: What we do out of the $4.8 million roughly in this program, the major portion goes to children's dental health program; $3,723,000 is what we expect to be expended on the children's dental health component of this total budget.

The balance is used for staffing, which provides consultation on child-health matters interdepartmentally and interdivisionally, provides program planning and support for the regional service structure where it involves Healthy Child matters, provides targeted programs such as child-health clinics, Nobody's Perfect, developmental screening, school health, hearing assessments.

In addition to the dental health promotion and treatment for children, we operate and monitor the public water fluoridation program through provision of grants to communities under this appropriation and produce and distribute child health educational materials and maintain the high-risk registry for infant deafness. This is where the screening programs, the public water fluoridation program and distribution of materials around Healthy Child policy and of course working with other areas of the ministry and within the government of Manitoba in terms of providing advice on Healthy Child policy, our co-ordination area.

* (2020)

Ms. Wasylycia-Leis: Could the minister explain what the capital line is for and the reduction in half from last year's estimate to this year's adjusted?

Mr. Orchard: I cannot give my honourable friends an answer on that, because I do not have last year's voted budget in front of me. My honourable friend is saying it is $120,000 and this year $135,000. We did not spend the money I guess.

Ms. Wasylycia-Leis: Could the minister indicate what it was budgeted for in terms of what this branch covers with respect to Capital Expenditures, and then maybe I can understand the reduction by over half?

Mr. Orchard: Madam Chairperson, when we ascertain what we did not expend the money on, I will provide that information to my honourable friend.

Ms. Wasylycia-Leis: I suspect that will be coming when the appropriate staff comes down with the other figures that we are waiting for.

Mr. Orchard: We might have a little difficulty because that was not the question that we posed before five o'clock. Maybe there is a readily available answer that the staff person has. If not, we will provide it as soon as we can find out what the answer is.

Bear in mind, we are dealing with last year's budget here and I think we might be able to answer questions on what we expect to spend $60,000 on this year, but I cannot explain to my honourable friend what we did not spend $70,000 on last year on the Capital line.

Ms. Wasylycia-Leis: I would hope that the minister could answer the questions that I am posing because, in so many cases, we are dealing with a miraculous change in figure from the number we debated last year in Estimates and agreed to and was voted on, to an Adjusted Vote, very major discrepancies time and time again that make us very suspect and curious about this minister's accounting methods.

I am afraid we will have to keep asking these questions. It has been particularly noticeable when it comes to such issues as the deputy minister's salary. If one did not take the time to check back on the amount we agreed to, or we discussed, in last year's Estimates, we would not have unearthed the dramatic hike in pay for the deputy minister which, as the deputy minister knows, has gone up in two to three years almost $16,000, a fairly dramatic pay hike when the rest of the world has been asked to accept zero percent or tighten their belts, as my colleague the member for Wellington (Ms. Barrett) has said, and I would hope that the minister can answer these questions. I am sure he has the information. He is just being somewhat reluctant to answer the questions, and I will come back to this again later.

Could the minister indicate if he has had any comments and concerns expressed to him from professionals and practitioners in the field of dentistry or public health dentistry regarding the change in the children's dental health program now that we have had an opportunity of feeling the impact of this change for about a year now?

* (2025)

Mr. Orchard: Madam Chairperson, we have not had concerns expressed as to any problems that were created from this change. As I indicated to my honourable friend before breaking at five o'clock at committee, as my honourable friend recalls, we maintained the very strong educational prevention fluoride rinse aspect of the program. It appears as if that very early intervention and work with students from ages six to 12 has met the exact goal that I think health care planners had hoped to achieve, that is, an increased health status amongst our youth in the school system because of education and prevention. Any time you prevent caries you prevent oral health problems. You naturally do not

have to have as much accessing of the treatment side, and of course it was the treatment side that we levelled to age 12.

With the strong and continuing emphasis on education and prevention, it would appear as if the level of oral health, dental health, of our school-age population enrolled in this program is maintaining itself.

Ms. Wasylycia-Leis: Madam Chairperson, I would like to ask a couple of questions on the elimination of the grant for audiology services to the Child Guidance Clinic. Could the minister indicate if he has any kind of information to provide us that would shed some light on this decision in terms of the cost benefit for taxpayers?

Mr. Orchard: Madam Chairperson, the decision was made to, as I have indicated earlier, rather than reduce by some $200,000 across the board on all of our agencies, we attempted to focus our grants by prioritizing support of services.

In this case two things entered into the discussion. First of all, you might recall, the Child Guidance Clinic is part of Winnipeg School Division No. 1, which, under the new funding formula, received, shall we say, a more generous increase in budget than other school divisions and could, as I indicated on Friday when questioned by the member for Kildonan (Mr. Chomiak), I indicated that within government we have had to make prioritization decisions wherein within the ministry of Health we have attempted to eliminate duplication in Admin and Finance and in other areas of the ministry where, under the former structure of the commission as a freestanding entity and the department as a freestanding entity, we are now achieving those functions for the ministry under one ADM. That led to a consolidation of staff, of some reduction in staff numbers and of course a more effective use of the global budget of the ministry of Health.

* (2030)

We are asking organizations, funded agencies outside of government, to likewise do the same kind of prioritization within their budgets. I used the example that, should the Child Guidance Clinic believe that their service, in terms of the initiatives undertaken with support of the $45,000 grant from the ministry of Health, was certainly more important than other services they provide, that they have the opportunity, the flexibility to prioritize, to reprioritize their service provision regime.

Should this be one of their priorities, they would have the ability to rearrange their funding and provide it. However, I also indicated that may be a decision made by the Child Guidance Clinic. At this stage we certainly can not prejudge that or even speculate that it might be.

In the Winnipeg region, which serves the area of Winnipeg School Division No. 1, we currently staff four hearing centres: Victoria Hospital, Deer Lodge, Seven Oaks and Concordia. That is within the Winnipeg region, so those services are accessible by residents of the city of Winnipeg. In addition we also fund within the Hospitals division five audiologists at the Health Sciences Centre and one audiologist at St. Boniface. The point I am making is that directly, in terms of hearing screening, six of the hospitals in Winnipeg have the services available.

Secondly, in terms of hearing screening, there is the opportunity and, no doubt, it happens on a regular basis where physicians giving check-ups to children might do a preliminary screening as well if the parent identifies some problem. I mean, that is not an unusual investigation of a physician during a routine examination of a child.

In addition to that, as happened throughout rural Manitoba, the school divisions themselves have reinforced or filled to a significant degree the hearing screening that was done. As I explained last year, around this similar issue, we did not expect there to be a diminution of service in rural Manitoba, nor do we expect that circumstance to follow this year's curtailment of grant support to the Winnipeg School Division to the Child Guidance Clinic.

Ms. Wasylycia-Leis: Is the minister at all prepared to review this decision pending a thorough presentation by the school division on this matter and a further impact study of this particular decision?

* (2035)

Mr. Orchard: Our staff are meeting with the school division, and certainly we are willing and prepared to assist the Child Guidance Clinic in establishing appropriate linkages with existing resources within the Winnipeg regional system so that children can certainly have access to existing services elsewhere in the city of Winnipeg. We do not anticipate a difficulty, given that this was not the only service provision opportunity for those children of Winnipeg School Division No. 1.

As I indicated, Victoria Hospital, Deer Lodge Centre, Seven Oaks Hospital, Concordia Hospital all have the presence of our Winnipeg region staff and the presence of audiologists; in Health Sciences Centre, we have five audiologists, and one audiologist at St. Boniface, all providing services around early detection and treatment of hearing loss.

Again, our Manitoba Health audiologists, I indicate to my honourable friend, will continue to assist parents and teachers and public health nurses, physicians and other health professionals in the effort to continue with prevention efforts, early identification efforts and, where needed, rehabilitation efforts in terms of any hearing impairment in children.

Ms. Wasylycia-Leis: Thank you. I am sure we will revisit this issue in the future, but I do not want to take up more time right now. I would like to ask one more question on the children's dental health side as it pertains to the reference the minister made to the grants for the Swampy Cree Tribal Council and for Churchill. I am just wondering, if they were listed as expenditures last year but they were not expended, why that was the case. Who made the decision to revisit a decision taken as part of the budget? Was any of this decision communicated? What was the impact?

Mr. Orchard: I am not sure, Madam Chairperson, I follow the essence of the question. This is a very terrible place, you know. We are much more comfortable in the committee room where we are close and do not have to worry about echo in the Chamber and we can hear and we co-operate fully and completely and provide full and informative answers and full and informative questions.

Ms. Wasylycia-Leis: Maybe I will just try to put my questions a little shorter and more concise.

First, we know that there was $75,000 under Grants estimated for the fiscal year '91-92. According to the Adjusted Vote, only $4,000 was spent. That leaves $71,000. The minister has indicated that a good portion of that reflects a grant to Swampy Cree Tribal Council and Churchill. I am having trouble understanding this. If we approved certain grants for expenditure for the 1991-92 fiscal year, on what basis were they not expended and how was this communicated?

* (2040)

Mr. Orchard: Maybe I can help to unconfuse my honourable friend. This year we are budgeting, for instance, under the External Agencies, $159,300. We are anticipating providing funding to the Churchill Health Centre of $63,500 for the provision of children's dental health services out of the Churchill Health Centre. We are providing $13,200 support to St. Amant Centre for provision of children's dental health services there. We anticipate that we will provide $70,700 to Swampy Cree Tribal Council this year for provision of children's dental health services in their catchment area.

We expect to have a constant number of $11,900 for fluoridation grants. When I make reference to a constant number for fluoridation grants, we are budgeting the same amount as we had last year. In the previous three cases, Churchill Health Centre, St. Amant Centre, Swampy Cree Tribal Council, we are budgeting modest increases in their provision of grant money.

The reason for the major difference, which I believe if one goes to the Estimates is $44,500, is two things: the reduction of the Winnipeg School Division No. 1 grant of $45,000, the reduction of the Canadian Council on Smoking and Health grant of $4,400, which totals a reduction of $49,400. But there has been an increase of $4,900 to Churchill Health Centre, St. Amant Centre and Swampy Cree Tribal Council.

So the net difference year over year reflects the elimination of two grants and the increase of three of the remaining four.

Ms. Wasylycia-Leis: I think probably if the minister would give us a piece of paper with this broken down it might help. Is the minister saying that sometimes he puts grants to External Agencies under the Grant line, and sometimes—no, okay. He is not saying that.

Therefore, I still come back to my question about the change from the budgeted $75,000 under the Grant line to the $4,000 Adjusted Vote for the Grant line. The explanation for the discrepancy there, that was my original question, it is still my question.

Mr. Orchard: Madam Chairperson, that is precisely the detail that I am going to provide to my honourable friend, but to give you an idea of what it is, last year we had listed under the $75,000, support funds for Wascana College, for instance, to assist in the training of dental nurses.

That grant has been internalized into the balance of our operating costs as they appear along the line. They have been accommodated in–is it Supplies & Services, that portion of the portion of the budget?

Ms. Wasylycia-Leis: For the same purpose.

Mr. Orchard: For the same purpose.

Ms. Wasylycia-Leis: So the confusion was created by the minister referencing with the Grant line.

Mr. Orchard: I did say that. I was wrong.

Ms. Wasylycia-Leis: Okay. So if I understand, Swampy Cree and Churchill should not have been referenced with respect to the Grant line, and we will get the details later on–fine, I am happy, thank you very much, we are ready to pass the line unless–

Mr. Gulzar Cheema (The Maples): Madam Chairperson, can the minister tell us in the area of Acute and Ambulatory Care, what is the function of this branch and why do they have this separate branch other than the hospitals?

Mr. Orchard: Madam Chairperson, basically the objectives are as laid out on page 38: "To establish a strategic plan for ambulatory and acute care. To monitor and assess the impact of the shift of hospital services from an inpatient to an outpatient basis." Under Activity Identification: "Develop policies, standards and procedures for acute and ambulatory care. Identify the factors influencing acute and ambulatory care service patterns. Develop strategies to minimize the length of stay in acute care facilities while ensuring the quality of patient care. Develop cost effective and efficacious ambulatory care services." Our Expected Results: "A mix of acute and ambulatory care will be provided in the most cost effective, efficient and appropriate manner."

We separated this out as a separate program initiative because really this is an area of focus that is going to be important in terms of the reform and the change in the health care system that we are moving towards, where we are looking at all aspects of the way we provide patient care services and where they are provided. So we have focused acute and ambulatory care as a specific undertaking within Healthy Public Policy because it has significant implications on the very major part of our budget in the hospital side.

Can I just break off, because I have erred? I had the information late at the close, and I will bet you I left that note in the office, but maybe it might be appropriate at this time because some of the statistical identification has been worked up by the Centre for Health Policy and Evaluation. Earlier on in the Estimates, probably about two or three weeks ago, I made the offer to my critics as to whether they would be interested–[interjection] Oh, you got the memo? Good.

I was wanting to give advance notice of that because Wednesday we are scheduling to have the Centre for Health Policy and Evaluation make an overview presentation to members of the Legislative Assembly to give you an idea of some of the information that is emanating from their analysis of how we spend our current health budget, with particular emphasis on the program side of hospitals. I think you would find that some of the analysis becomes part of the discussions and analysis that this area of the ministry would undertake program and policy development around.

Mr. Cheema: I do not think I have difficulty understanding the concept. My reason for questioning is very simple: why we have such a major grant in terms of having the policies for some of the major initiatives in the Department of Health. They are going to come. Why have we buried this branch in the prevention area? I just wanted to know what the reasons are. Why is this branch not a part of the Health Services Commission or where it could fit into the model? Maybe the minister has some other explanation?

Personally to me it does not make any sense to have this branch if that is the purpose of this branch, and that seems to be the expected results out of the whole thing, especially when so many things are going to happen in the area of health care reform. Particularly, those reforms are going to be major in terms of the hospital management and the ambulatory care. That will involve all the hospitals and that will have an impact on the hospital budgets in the long run and the short run. I would say that it should be somewhere else rather than here.

Mr. Orchard: Well, my honourable friend poses a very logical question. I mean, if you want to consider the traditional way that we have approached planning, this is a misfit. This would be more appropriate under the Manitoba Health Services Commission or in the hospital line. You can make the same case in the next appropriation under Capital Planning. Okay?

The reason why we have them under the Healthy Public Policy division and the leadership under the

ADM there is that it puts not solely an institutional planning focus on them. It widens the planning focus and the opportunity for discussion within the ministry, that takes it beyond the tendency. I am trying not to be critical of past performance, but when everything was within the hospital line, the breadth of communication, discussion and seeking of advice was not there that it is now and will get even more broad in terms of its consultative role by having it under Healthy Public Policy.

* (2050)

We know that decisions that are made in the acute care sector of our hospitals have implications on our community service provision, on our community support systems, our regional health systems. This is the logical place within the ministry, where we have a Healthy Public Policy approach, to take not narrowed policy development approaches driven by close attachment to the institutions themselves, but rather to have a widened focus under Healthy Public Policy and bring all of the system players together around issues such as ambulatory care–how we make it happen, how we integrate it more effectively, the acute care bed role. Where it needs to be enhanced and where it needs to be lessened and how you lessen it.

In Capital Planning, very important, to come around Capital Planning across the system and acute long-term care, et cetera, so again, that interface with our community-based programs can be more appropriately achieved under the new division of Healthy Public Policy. I know from first blush, it looks like a misfit but, in fact, it is a very comfortable fit, because it widens the scope of thought and planning around ambulatory care from a narrowed institutional function to a system-wide function.

Mr. Cheema: Madam Chairperson, I think we can make arguments on both sides. It depends on where you are coming from. I would say that we can probably have this branch fit more into the health care reform package in terms of the hospitals and the community care, because if you have this only one–how many staff have we, one, two, three staff who are responsible for developing a policy for the whole of the province and the city of Winnipeg.

What kind of resources and services are they going to have? How are they going to base their decision? They still have to go to the Health Services Commission and the other branches within the health care system. It will be best for them to be under the Department of Manitoba Health, under the assurance of the Deputy Minister of Health who is responsible for the department of the hospitals, because ultimately what ambulatory care, as the minister knows, there has to be maybe a focus of attention, and that had been in the past. Specifically, when you are going to transfer some of the services from the hospital to the community there have to be alternate ways of providing care. The alternate ways of providing care, one of them is to have the outpatient services or day surgery are not for admission surgery, but then eventually you have to expand that to the community clinic concept.

As I said from the beginning, when some of the hospital beds are going to go, that space you want to use for the community clinic concept and ambulatory care. That is still going to be within the hospital settings. There will be better communication when you have a department, when both sides know what they are doing. I am not saying that the ADM of this department will not have a direct say, but I think it is more important for the Health Services Commission to have a say than the hospital administrators, and the hospital boards to have a direct say in all those decisions. Otherwise, it will create more confusion and more committees and probably more consultation. So it depends on how you can fit this, and from the minister's point of view, he will have all the arguments.

I think if you talk to somebody who is not within the Department of Health, they will probably say–and the health economist will say–it fits more into the reform package. The reform package is going to have a major impact on the hospitals, and right now I think there should be more co-ordination from that point of view. I would still make an effort to make sure that this branch should be more in line with the Health Services Commission rather than the Department of Community Care at this time. It can be reviewed in the future to see how it will fit. I mean, there are only three positions, but I am still going to ask who these individuals are and what they are doing and what their qualifications are. I would like to know that.

There are a lot of questions out there, and I certainly would first want to hear what the minister has to say in terms of whether he is going to change his mind and about this branch–where it really belongs.

Mr. Orchard: Madam Chairperson, in many ways my honourable friend reinforced my argument, and

the value of having this not attached directly to the hospital side will become more and more evident. Let me give you an example. My honourable friend mentioned that, you know, we in the reform package were moving as quickly as possible in terms of hospital-based services, where appropriate for the patient, move those to the community, but the observation–and everybody I talk to says, well, that is not new, everybody has tried to do that. They are right, because I will tell my honourable friend that we have invested in recent years, like since we have come into government, quite significantly in terms of ambulatory care. But you know what has happened? There has not been a correlation of where it fit in the system and the change in the system. It ended up being an add-on to the institutional budget. We did not achieve throughout the ambulatory care investment a reduction in operating costs at the institution. That is where I go back to the Centre for Health Policy and Evaluation's first report, where they talked about outpatient services.

In the past, with a lack of overall planning and a focus on the institution, which has been the tradition in terms of provincial planning in this province and in many other provinces, where you end up with ambulatory care being an institutionally driven program and an add-on to the hospital program. Under the reformed system, ambulatory care, outpatient services, we will be guided by the recommendation of the Centre for Health Policy and Evaluation that they must fit into the system, and if you move patient services out of a hospital, you must close the bed that they occupied or else it will be used for another purpose and you have both budgets going up in concert.

That is why, without criticism of the former process of planning, any time ambulatory programs were considered under the former planning ability of the commission alone, they were planned as a hospital initiative, not a health care system initiative and had the focus and the result, as I have said, they have tended to be add-on. The outpatient service side went up in cost, and the inpatient side grew as well. We cannot do that. That is the reform process that will allow us to, when the budget moves outpatient with the patient, it stays outside the institution, and is not merely duplicated and added on to the institutional budget.

We think the planning process that is envisioned here through this Acute and Ambulatory Care division will allow us that–how would I put it nicely?–the honest-broker approach, because there is no vested interest, there is no tie to any part of the system, be it community, or be it institutional, but they have the ability to bring those diverse forces together into reasoned policy development and utilization of resource. You change from what has been an approach in the past, where the budget drove the kind of program where you turn and have policy and program can drive the budget, and the latter is where we have to be.

Mr. Cheema: I am still going to try again.

The process is going to be like this, for example, just a hypothetical example, that in a given hospital that you shut down, but if they are going to be restructuring the system, there are 20 beds, for example, that have to go out of the chronic care or the acute care or wherever you want to take them out, and if you are going to take the money with a patient, then you are going to set up the ambulatory care. Ambulatory care in terms of whether it is going to be a community clinic concept or you are going to have an outpatient surgery procedure or not-for-admission procedures, or a short stay at the hospital, they are all going to be part of the ambulatory care. That is what it is.

So we would rather see the system in terms of the space and the sources being used within the hospital too. Because that myth that the community hospital or anything within the hospital building is the hospital, I think that is not true any more. Hospitals in a given community are a part of a community and they are a community hospital. Whether they will function as the acute care beds only, that decision has to be made. But, certainly, it will be much better to have ambulatory care along with the acute care hospital, so that you have the emergency care there, you have the ambulatory care, you have the outpatient surgical procedure, and the hospital is going to be the mix of services that you outlined in your speech of the first day.

* (2100)

I think that fits into your government's own major initiative on health care reform. I think that is the way probably it will be best suited because then it is not only–then interested groups can not make a noise because you are transferring the money with the patient and you are still providing the same care within the same geographical location, plus in the physical space also.

I think it will be really sad to see if beds are closed, then you have to still spend capital money to build something somewhere else. That will not make any sense. I think that is why I am saying it will probably make more sense for this branch to be within the department with Manitoba Health, with MIC right now and once the reform has taken place then the adjustment can be made. This three-member staff, a major, major program is going to get lost in the shuffle if it is just going to be a part of the Department of Community Services, and that is the argument I would like to make right now and see how it will function because things are going to change. I am not sure whether within three or four years we may even see a major change in terms of the whole reorganization of the department.

It is going to come eventually. We have seen major changes. At least, we know there are five branches and each and every branch know what they are doing. You want them to even streamline their own branch so there is no duplication of services so somebody would know what they are doing and they are responsible at the same time to make decisions. That is the argument I would make for change for this specific branch.

Mr. Orchard: Madam Chairperson, I accept my honourable friend's argument and I will even go so far as to say that if this does not work out, then I am open to that kind of discussion, but I think that the approach of having this as part of Healthy Public Policy with a much wider focus than the traditional institutional thinking, community thinking and never the twain shall meet. The opportunity to interrelate and to plan conjointly is enhanced by having this separated from either community or the institutional side to the MHSC provision of services. We think it will work. If it does not work, my honourable friend's suggestions will be acted upon naturally, but I have confidence that it will work.

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

My honourable friend asked who the people were. At this stage of the game we have not recruited to fill this part of the ministry, so in talking concept, that is all we are talking about. We have not had any people there to carry out the envisioned changes and planning as I have articulated them. I guess to put it bluntly, to date I cannot be proven right or wrong and neither can my honourable friend. That is why I appreciate his comments because I will give those careful consideration as this process matures.

Mr. Cheema: Mr. Deputy Chairperson, I just want to reinforce again that if the decision about the individual who is going to be hired has not been made yet–I think that is probably the right one because, when you are going to focus on a reform and then you want to have a major policy and make sure that somebody has a background in those areas, I think that will be very positive. Specifically we could have a look for a person who has a background as a health economist. I think that is the person who will fit, not a vested-interest group, whether a physician or somebody else, or a health care professional.

If we are going to put a health care professional specifically, I do not think we are going to go ahead much–I think somebody else from the outside, who will have an interest for the public and the taxpayers and who will have a vision for the future that this kind of system can work, because if you have a short-sighted approach, it will fall apart.

I think, especially when you are going to have three persons, probably somebody from the Department of Health who has already worked on these issues, I am sure the Deputy Minister of Health can pick somebody who is very smart, who can have all this ambulatory care to bring into the real picture. I think it is going to be very important. I think we have a vested interest because we want this thing to be successful.

It is very important that the ambulatory care and the outpatient services become an efficient part of our health care system because, when we go outside, if we tell those things, we want to make sure those things are delivered. Whether they are delivered in six months or one year, ultimately they have to be. That is why it is very essential that we have advocated as of '88, and I will reinforce that, that in the '90 campaign, from our party, we said that is a major step and we should follow that direction.

I would say to the minister, we have a vested interest that the minister has to be successful; otherwise we are all going to look very bad on these issues because taxpayers want to have the changes. If we are going to keep on adding services, we have made many arguments, you cannot have two services for the same thing. Ultimately you have to close something else. That is why I think it is very essential that we should have this branch and have a serious look where it would probably best fit with the hospital care system right now and with the ambulatory care. Eventually you

may have to have an ambulatory care facility, a major initiative in terms of health care reform.

Mr. Orchard: Again my honourable friend expresses concerns. I think that they will be answered as this function and ability matures. Some of the suggestions my honourable friend has made parallels thinking in terms of the individual and their training requirements that the ministry has right now in terms of recruiting to this position.

The other important thing that my honourable friend said that essentially needs reinforcing is that if you have ambulatory care or outpatient services–how do I word it? My honourable friend did it pretty nicely, but basically the institution, to have an outpatient service, you had to move away right from the institution. There was always the opinion, I think, fair or unfair, right or wrong, that if an outpatient or community services was attached to a hospital, it really was not real community services and vice versa, although there were not many examples of vice versa. I am sensitive to that, and I will tell you what our thinking is around assuring that you can have that continuity emanating from the hospital as the starting institution; that is, if any institution wishes to propose to government the creation of outpatient services as part and parcel of the reformed process, the movement away from institution to community, and they wish to be the proponent of that service, we will listen very diligently. But the criteria for delivery have to be based on staffing patterns, expertise, costing and policy guidelines that we would utilize with pure and free-standing community-based services.

In other words, the hospital can participate in community-based services, providing they do not simply transfer hospital costs to community-based services but rather base their service provision on known cost parameters that we have experience with already in the community-based system. I mean that is talking about breaking down some of the brick-and-mortar barriers, and that is appropriate, and it will be part of the discussions that we undertake.

Mr. Cheema: I just wanted to add a few more lines before I give the floor to the member for St. Johns (Ms. Wasylycia-Leis). I think it is going to be an important point as the minister has raised. In the past, there was the myth that anything in the hospital is acute care, and eventually for the last 10 or 15 years that has been changing because you started to have chronic care beds and then you started to have day hospitals, then the ambulatory care in some hospitals. So that concept is changing.

There are going to be problems because you go into somebody else's territory, the hospital boards and the hospital administrations. The Department of Health will have a rough time, but I think the Department of Health has a responsibility. If you are going to make major decisions, then the Department of Health must have a say. When you are going to have ambulatory care within the hospital, I think that is the way to go. That will have some control also because it is very essential that the Department of Health should have the control, not individual communities, because that creates money problems in the long run. Then the protection of turf comes in.

* (2110)

I think that is the problem. It has been in the past; it will continue to be so in the future unless you have specific directions given to the given institution that every institution has to function within guidelines, whether it is with deficit financing or the guidelines of closing beds or providing ambulatory care or providing not-for-admission care or providing wellness centres, or going to provide fitness centres or going to provide the community care clinic concept.

I think those things have to come into effect. I do not think that we as health care reformers in this country have any other choice, because if you do not do that you are just delaying it for another administration or for another headache. That thing is never, never going to go away unless the Department of Health as a central body has some say how the tax dollars are being spent and what will be the best way to have a good, not only communication, but somebody who is communicating on a day-to-day basis within the hospital. They have to co-operate with each other so that you do not shut down a few beds and say, well, the money is gone somewhere else. Then money will be spent adequately in that given community. I think that will fit the needs. Then people will be happy. Then you are not taking away funds from that community; they are being spent there but in a more efficient manner.

Mr. Orchard: Mr. Deputy Chairperson, a fair comment and really fits along the direction that we envision we can go and then, more importantly, the

path that we have to take. I mean, there are not options which say we can do otherwise today.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, could the minister indicate where these staff years have been taken from and the operating budget has been taken from in terms of the previous budget?

Mr. Orchard: Mr. Deputy Chairperson, from the MHSC staff and budget complement.

Ms. Wasylycia-Leis: Could the minister indicate precisely where from the MHSC budget these staff and budget years come?

Mr. Orchard: Mr. Deputy Chairperson, under the Health Services Insurance Fund. In previous years my honourable friend might have noted an administration line, and that has been devolved throughout the reorganization of the ministry. Part of that devolution has three SYs from varying areas of that administration line, so not only the staff years, but also the supporting budget has come from there.

Ms. Wasylycia-Leis: Perhaps at some point–I do not expect the minister to have this at his fingertips, but before we have completed this Estimates process–could he provide us with a breakdown of the devolution from the administration line under the previous Manitoba Health Services Insurance line in terms of administration and operating?

Mr. Orchard: Yes, that information can be made available.

Ms. Wasylycia-Leis: Just before we move on to the next line, or even pass this line and the previous line, is the minister prepared at this time to provide us with the information on the children's dental health program?

Mr. Orchard: Mr. Deputy Chairperson, because I have an addition to my staff, I want to make sure that–is this the $71,000 that you want to get into?

Ms. Wasylycia-Leis: There are several issues, Mr. Deputy Chairperson. One is the expenditure for the children's dental health program prior to the change in the age eligibility, also the change in the grant line, and I believe that takes care of it.

Mr. Orchard: The Deputy Chairperson, I think we have what my honourable friend wants to hear; $4,299,600 was the children's dental health including Grants to External Agencies last year. This year that figure will be–I have to do a quick calculation here for you–$3,882,700 including Grants to External Agencies.

* (2120)

Ms. Wasylycia-Leis: The final piece of information is the breakdown of the $71,000 that was planned to be spent but was not expended for '91-92.

Mr. Orchard: In last year's print, we had $75,000 in grants, and an approximate figure of $71,000 was included as our estimated cost of accessing Wascana dental nursing training and the denturists training at NAIT. What we have done is not accounted for those costs under Grants this year, but they will be found to be included in Supplies & Services on a fee-for-service purchase arrangement that we have. It is a transfer of line location of roughly the same amount of budget.

Ms. Wasylycia-Leis: There already is a reduction of $92,000 from the estimated amount for Supplies & Services for the fiscal year '91-92, to the actual Adjusted Vote for '91-92. I am wondering if the minister can give us an explanation for the $92,000 reduction and the additional $71,000 that is now reflected in that amount.

Mr. Orchard: Mr. Deputy Chairperson, that is exactly the area in which we have accounted for the reductions under the children's dental health program that I have just given you the global figures on; that was the reason for the reduction. It is operating in salaries because there were some layoffs. There were reductions in operating costs as well.

I realize it gets slightly confusing, but the Supplies & Services cost year over year goes down by the reduced amount of the children's dental health program but is raised by the move of $71,000 approximately from Grants last year for purchase of training services to Supplies & Services as an item in which we are accounting for it as fee-for-service purchase arrangements at Wascana and NAIT for our training needs in the children's dental health program. It is an amalgam of reduction caused by program decisions last year and then increased slightly by a transfer from Grants in the purchase of training services outside the province.

Ms. Wasylycia-Leis: I think we are in the habit now of doing a few lines at a time, so I just have a couple of questions under Capital Planning, and then I will pass it back to the member for Maples (Mr. Cheema). When he is done, I think we can pass several lines.

Could the minister indicate who is in the managerial position under Capital Planning?

Mr. Orchard: Mr. Deputy Chairperson, Linda Bakkem is the management position.

Ms. Wasylycia-Leis: In terms of trying to understand how this section relates to and fits in with the Capital Expenditure portion of the Department of Health, what mechanism is there for co-ordination and who has final responsibility, or where does the buck stop in terms of capital?

Mr. Orchard: On my desk.

Ms. Wasylycia-Leis: I think the minister knew I was not referring to the final decision with respect to his stamp of whatever on it. He knows very well I was trying to figure out the dynamics within the department and where it all fits. Could he indicate who reports to whom in terms of capital when one looks at both capital in this area and capital in the lines we have yet to come to?

Mr. Orchard: Mr. Deputy Chairperson, the planning aspect, which is this function, reports to my ADM, Ms. Hicks, but the actual undertaking of the construction, once the planning process has gone through and the approval process has been acceded to, of course, reports to the associate deputy minister's line of responsibility. But in terms of the planning aspect prior to approval and prior to the reporting of the actual construction process, it reports to the ADM, DM, then to myself.

I guess, again, I will not repeat myself, but much of the same logic is focused here in having Capital Planning as part of Healthy Public Policy rather than attached directly to the commission, where the drive was on the institutional side. Having that under Healthy Public Policy provides a system-like balance in terms of our approach to Capital Planning so that Capital Planning is not done institution by institution in isolation from other institutions and the system at large.

Ms. Wasylycia-Leis: We have been talking about the minister's timetable for releasing his capital estimates, and he has given us no firm commitment on when that might be. That document is, as far as I understand it, basically a five-year capital plan. The expected results for this branch is a five-year capital plan. I am wondering if the minister is now prepared to table the five-year capital plan for his department.

Mr. Orchard: Mr. Deputy Chairperson, the same answer as this afternoon.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, if this branch is intended to play a major role in terms of capital and planning, and one of the only two expected results from this branch is a five-year capital plan, why are we not able to see that plan at this point? What kind of a game is the minister playing?

Mr. Orchard: It is only 9:30.

Ms. Wasylycia-Leis: It is not a laughing matter.

Mr. Orchard: I do not detect any laughter.

Mr. Deputy Chairperson, you know, my honourable friend keeps wanting the capital plan and hospital budgets, et cetera, and what we are trying to do is to–[interjection] ayeeel Now they are throwing things at me. I mean, here I thought this was going to be a pleasant evening of discussion around policy.

The capital plan, yes, in the past has been a five-year projection. Often a number of the projects have taken much longer than five years to reach fruition, but in general terms, you try to lay out over a process what some of the objectives are within the Capital Planning and capital intentions of government.

What we are trying to do under the Capital Planning process this year is to try to establish stronger linkages to program and to reform and to change in care delivery across the system. The Capital Planning process is a significantly more detailed undertaking and a more comprehensive undertaking, I think it is fair to say, than it has been in the past.

I am not trying to be glib or evasive with my honourable friend; I could not table the capital estimates tonight because they are not ready, and they are not going to ready for tomorrow either. I am, quite frankly, on a tightrope on planning a number of initiatives, and I simply am giving my honourable friend the assurance that the capital program will be tabled as quickly as I can make it available.

Now, I will have a better briefing on it because I simply have not had time today to ascertain details around status. I hope to be able to discuss this with my honourable friends tomorrow because I know we are starting to move this Estimates process along. I mean, I just simply tell you, I do not have it to table tonight. I am not playing a game to try to push the system along to the hospital line; I am not being perverse like that. I simply do not have the plan or the capital program tonight, and I will not have it for tomorrow either.

* (2130)

Ms. Wasylycia-Leis: I thank the minister for that answer. I appreciate the frankness; that kind of response helps move things along. I would ask, though, since we are moving along in Estimates and the time is running out for this department, if the minister says it will not be ready for today or for tomorrow, could he give us any kind of assurances that it will be ready for Thursday's set of Estimates?

Mr. Orchard: I would like to leave that discussion open and how be we deal with that first thing tomorrow afternoon?

Mr. Cheema: Mr. Deputy Chairperson, I have two or three more questions in this area. First of all, can the minister tell us if the Manitoba Head Injury Association has received any grants to the External Agencies funded through the community complement of health care? Am I on the wrong topic?

Mr. Orchard: Under Healthy Child Development, the four grants that we maintain is Churchill Health Centre, St. Amant Centre, Swampy Cree Tribal Council and then our fluoridation grants that go to a number of communities.

Under Women's Health, we provide monies to Planned Parenthood, Serena Manitoba, Youville Clinic, the Committee on Unplanned Pregnancy, Klinic Incorporated, and that is it.

Mr. Cheema: Mr. Deputy Chairperson, my question was not under the heading of Healthy Child Development. Simply the question is: Did the Manitoba Head Injury Association get some grants last year and have they received funding through the External Agencies this year or not?

Mr. Orchard: Mr. Deputy Chairperson, we did not provide any grant support funding for the organization the Head Injury Association last year, at least to the recollection of my staff. We may have provided a hospitality grant for hosting an event. I think that is the only support that we provided last year to the Head Injury Association.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us if they have received the application grant for funding by the Head Injury Association this year and what are the reasons for refusal for such a grant?

Mr. Orchard: We have had ongoing discussions for at least two years now with the Head Injury Association in terms of providing grant support from the ministry to assist them with the undertaking of their general activities, and no particular reason other than it is one of many additional applications the ministry receives annually for support of a number of support organizations and external groups.

You know with the decisions we have had to make this year, like my total External Agencies funding is down by approximately $200,000 this year. We simply could not find a way of prioritizing within our existing grant structure to reallocate monies towards head injury, no underpinning reason, other than budget constraints, which is the same, or sort of the consistent constraint we have had when we have had application from a number of other organizations seeking basic support funding to maintain their self-help organizations.

Mr. Cheema: Mr. Deputy Chairperson, can the minister tell us how many Manitobans are receiving the assistance under the Life Saving Drug Program?

Mr. Orchard: Mr. Deputy Chairperson, we are just going to go back and find that figure for my honourable–I have it. We maintain almost 2,000 Manitobans on the Life Saving Drug Program.

Mr. Cheema: Mr. Deputy Chairperson, that answer is already in the book. What I am asking simply is: How many actually receive the assistance under this Life Saving Drug Program? Do we have an exact number of Manitobans who are receiving–those are expected results, but that may or may not be true.

Mr. Orchard: Mr. Deputy Chairperson, I wonder if we might have actual numbers from last year. If we do not have those readily available tonight, we will try to have them available for tomorrow afternoon.

Mr. Cheema: Mr. Deputy Chairperson, that is fine, but I will ask another question. Can the minister tell us, for any person who is on social assistance, when their medication or their other expenses are paid, who is paying those bills? Is the provincial government paying or the City of Winnipeg paying those bills?

Mr. Orchard: You know, Mr. Deputy Chairperson, I am kind out of my league when I get into social assistance because there is the split jurisdiction where the municipal government, our municipal level of government, provides assistance for the first number of months, and then the Social Assistance program in my colleague's department, the Minister

of Family Services (Mr. Gilleshammer), is accessed by those recipients. Now, within the City of Winnipeg, that same process applies, I believe.

Mr. Cheema: Mr. Deputy Chairperson, I am not sure about the answer. What I want to know is how much money the provincial government is paying from the taxpayers' funds, from the taxpayers' money. How much money is he paying to the social assistance recipients who are receiving medical treatment? I just want to know how much money the Department of Health is paying.

Mr. Orchard: In other words, if I can follow my honourable friend, let us say that the figure of 2,000 Manitobans on Life Saving Drug Program is an accurate figure, do I take it from my honourable friend's question you want to have a breakdown as to how many of those 2,000 are on social assistance and receiving the Life Saving Drug Program and how much the budget involves?

Mr. Cheema: Mr. Deputy Chairperson, I will try again because I think with my communication problems with my language skills, I sometimes have difficulty. My question here is that under the Life Saving Drug Program, there are supposed to be 2,000 Manitobans who receive treatment. That is not my question though. My question is how many and how much money are we spending on behalf of taxpayers on social assistance, recipients who are also receiving medical treatment because when they go to a doctor or they go to a pharmacy their bills are paid? We want to know how much money the taxpayers are spending.

* (2140)

Mr. Orchard: Mr. Deputy Chairperson, providing I understand the nature of my honourable friend's question, a number of Manitobans are receiving social assistance and my honourable friend wants to know if we can quantify their cost of accessing the health care system.

Mr. Cheema: Mr. Deputy Chairperson, I will try again. What I am asking is how much money are the taxpayers paying for the recipients who are receiving social assistance plus they are receiving medicare, like the Pharmacare? Their bills are all paid by either the provincial government or the City of Winnipeg. We want to know how much money we are spending in that area.

Mr. Orchard: I am going to have to ask my colleague the Minister of Family Services (Mr. Gilleshammer), because in discussion generally around the issue, it is my understanding that the pharmaceutical cost of a person on social allowance is part of the Family Services Social Allowances budget. We do not get billed for that as a ministry of Health. That is part of the Social Allowances budget, and I would have to get that kind of cost if they maintain that kind of detail from another ministry.

Mr. Cheema: I think it will be worthwhile to know how much money is being spent on those things because it can be very well calculated. Once the person goes to Pharmacare or they are billing to a specific number they know how much money is being paid by the taxpayers for specific services. We would like to know, because there were some changes last year which are having some impact on some of the social recipients who are unable to get access to some of the medical necessities they have. I think it will make some sense, at least for me, to know how much money we have been spending for the last few years, how much money has gone up, and why there has been possibly some cuts.

Mr. Orchard: I think that we can provide, or I will seek that answer from the Minister of Family Services (Mr. Gilleshammer). I think that their support of–it is not the Pharmacare program. I do not want to use the Pharmacare program because we do not provide that prescription service to social assistance. That is directly out of the social allowances budget, and so I am pretty sure they ought to be able to give a figure as to how much that is within their global budget of social assistance.

In terms of additional costs to the health care system, for instance, such as physician office visits, we do not have the ability to identify that, but because the Pharmacare program or the prescription drugs are paid for as part of social allowances, I think that is an identifiable separate budget with the social allowances budget.

I will make the inquiry, or have staff make the inquiry, of Family Services and see if we can provide that tomorrow.

Mr. Cheema: Mr. Deputy Chairperson, I think that will be fine because you know that is exactly what I wanted to know, how much money we are spending on Pharmacare and some of the other medical necessities, other than the physician's fee. That is not the issue. The issue is the Pharmacare and how much money is being spent on behalf of taxpayers, because there have been some changes for the last

few months, and some of the recipients have complained about the issue.

I would like to know because that is not under the ministry of Health, as the minister is saying that it is not under $58 million, but still it would be a good idea to know whether we are spending five, eight, 10 more millions of dollars on behalf of taxpayers, and then probably it would be worthwhile to look into the whole issue of why the department of social assistance is involved. Why not the Department of Health where there can be more accountability or some other things can be taken into account? I am sure the minister would like to get into this issue, but I think eventually those things are going to come and ask for some explanation from the Department of Health.

Mr. Orchard: Mr. Deputy Chairperson, naturally in the absence of my colleague the Minister of Family Services (Mr. Gilleshammer) I accept the overwhelming endorsation that we manage better. Now that my honourable friend's Estimates are over, he cannot be brought into account for that. I thank my honourable friend for that endorsing and my staff appreciate that kind of endorsation as well.

Mr. Cheema: Mr. Deputy Chairperson, I think we are endorsing the Minister of Health (Mr. Orchard) a lot. I think I will restrict to the Minister of Health. I think the Minister of Health was probably pointing towards the member for Wellington (Ms. Barrett) and the member for Wellington being a minister of Family Services, and we are endorsing her and that is fine. I have no difficulty with that.

Mr. Deputy Chairperson, my final question on the issue is: Can the minister tell us if they have done any study in terms of the community program which is also funded by the City of Winnipeg and the federal government? Is there any possibility of duplication of some of the services, because we did discuss that issue the other day? I would like to know why there are three components of the services for the same person, and why we cannot have one area or one person in charge, or one agency in charge, rather than three agencies doing the same thing.

Mr. Orchard: Mr. Deputy Chairperson, we dealt with this issue briefly the other day, and I concur with my honourable friend's observation. We are attempting to put some identification of programs funded by the government of Manitoba, by the province, by the city, by the federal government, and indeed some outside agencies, in an attempt to see whether there would be a more effective use of the global resource to deliver services rather than maintaining service delivery infrastructure which can consume the budget and not make it available to recipients needing the service—very much an issue that we want to try to put some identification around.

If I can basically put words in the Social Planning Council's mouth, I think that is what they have told us, that we need to get our minds around as government in terms of services to children, in their most recent report. We think a number of dynamics are currently in place that will allow a pretty co-operative approach to the issue.

I mean, quite frankly, a lot of these agencies probably developed over the last number of years and have been reluctant to get around the same table in talking about the issue of overall service delivery because of some of the issues we have talked in the past: turf protection, individual identity, et cetera. I think it is incumbent upon government today to have that kind of analysis and understanding, and if there is a potential for amalgamation of service delivery, to bring together service delivery agencies of common purpose and attempt to save in the administration and delivery costs and focus more on programs to people in need, I think we would all be well served—taxpayer and the individuals who may well access those services.

Hopefully—and I say hopefully, and that is a qualifier I will put on—this analysis around that issue over the next number of months will allow us maybe to put some policy direction in place.

Mr. Deputy Chairperson: Item 2.(d) Healthy Child Development: (1) Salaries $2,485,200—pass; (2) Other Expenditures $2,211,400—pass; (3) External Agencies $159,300—pass.

2.(e) Acute and Ambulatory Care: (1) Salaries $134,000—pass; (2) Other Expenditures $22,400—pass.

2.(f) Capital Planning: (1) Salaries $113,800—pass; (2) Other Expenditures $85,800—pass.

* (2150)

Mr. Orchard: Mr. Deputy Chairperson, before you read the resolution I have a bulletin and I only have the one, so I will have to get copies, on Lyme disease, because that came up in the discussion this afternoon. I would provide copies to both my

honourable friends and that should provide the information that was requested.

While I am on the topic, while we are passing this resolution I wonder if I might temporarily leave the Chamber.

Mr. Deputy Chairperson: Resolution 66: RESOLVED that there be granted to Her Majesty a sum not exceeding $16,355,100 for Health for the fiscal year ending the 31st day of March, 1993–pass.

(Madam Chairperson in the Chair)

Madam Chairperson: Will the Committee of Supply please come to order.

Mr. Orchard: Madam Chairperson, in commencing the next appropriation I would like to introduce my Assistant Deputy Minister Betty Havens for the Continuing Care Programs.

Madam Chairperson: Item 3.(a) Administration.

Ms. Wasylycia-Leis: Is Lynne Fineman still occupying the position of head of Continuing Care, Administration?

Mr. Orchard: Yes, Madam Chairperson.

Ms. Wasylycia-Leis: The minister has on many occasions talked about the increase of this government with respect to home care. Could the minister indicate where in these Estimates that increase shows up precisely and what it covers?

* (2200)

Mr. Orchard: Madam Chairperson, I guess on page 84 of the Estimates book under Home Care, the global budget has increased to almost $68 million. In terms of Home Care Assistance, that is a $62-million projected budget this year versus just under $55 million last year. The other increases in that line basically are for salary increases and some modest increase in Other Expenditures and a slight decrease in terms of funding to External Agencies.

Ms. Wasylycia-Leis: The amount expended for Administration for this area of Continuing Care appears to have more than doubled from last year's voted amount. Could the minister indicate on what basis this branch has increased to that extent?

Mr. Orchard: Maybe my honourable friend could give me a little more specificity around the question. What lines are my honourable friend referring to? Is that under Administration, Salaries?

Ms. Wasylycia-Leis: Well, one could look under Salaries or total expenditures for Administration comparing the approved amount for the year ending March 31, 1992, and comparing that to the Adjusted Vote for '91-92. There has been more than a doubling in total expenditures.

Mr. Orchard: Well, I guess I am a little–we have not–our SY complement for the ministry has remained consistent and any significant increase over print last year, Adjusted Vote, in this year's book and projected expenditures primarily involves only a modest estimate for increased salary, but would potentially reflect SY transfers under the reorganization.

But I reiterate that year over year, as my honourable friend saw from the original staffing chart that I provided at the commencement of the Estimates, you will find that in, I guess, the ministry's total staff complement is down given the amalgamation exercise last year, so that changes in this line reflect transfers of existing SYs from potentially other areas that were involved with Continuing Care and do not represent, as my honourable friend may well be concluding, a significant increase in Administration by the retention or hiring of new and additional staff.

Ms. Wasylycia-Leis: I will seek further clarification since I have not been able to find where the total number of staff has stayed constant for this area. When I compare year over year with the Administration line, there has been an increase of three staff. There has also been an increase of staff under the Long Term Care line so that–and all other lines have remained constant from the previous year.

So, in my estimation it seems that we end up with a considerable increase in staff and operating expenses on the administration side of Continuing Care.

Mr. Orchard: Madam Chairperson, my answer is consistent. In the last line that we just passed here, there was the question as to where, for instance, the Ambulatory and Acute planning SYs came from. They came from administration that was formerly under Health Services Commission appropriation. The same circumstance exists here. Under the reorganization of the ministry, the former division of Community Services programming–have I got that right?–Community Health Services Division of the ministry had staff involved in varying functions supporting the provision of services in the community. Under the reorganization those

identical staff year provisions have been reassigned to various reorganized aspects of the department.

I reiterate again that there has been no increase in the number of SYs. In fact, across the ministry as a result of last year's reorganization, there was a decrease of a number of SYs. In fact, we are operating under a reorganized structure with a reduced SY complement in the ministry realigned to appropriately carry out the functions as outlined in the Estimates process under the reorganization. There is no increase in the staff complement, but a reassignment caused by the reorganization of the department and the commission.

Ms. Wasylycia-Leis: What has changed then with respect to Continuing Care administration along the lines of this realignment that the minister references that justifies going from two staff to five staff in this area?

Mr. Orchard: Madam Chairperson, we brought in a computer programmer, a planning and program analyst, and a medical officer from Healthy Public Policy Programs Administration to this division, because in essence they served the Continuing Care Programs in those functions and now they are reflected as directly part of the Continuing Care Programs. Instead of being in Healthy Public Policy as three SYs, they joined two SYs in Administration of Continuing Care Programs with a total complement of five. There has been an accompanying reduction of three. If you went back and tried to do a direct comparison to last year's breakout of the Estimates, there would be three less SYs in, for instance, Healthy Public Policy Programs Administration.

Ms. Wasylycia-Leis: Madam Chairperson, I am sorting my way through this. It still is rather confusing. We have just been through a line where the minister talked about moving SYs from community and hospital services to Healthy Public Policy because of the restructuring of the department. Now we are seeing the minister justifying the movement of SYs from the Healthy Public Policy area to Continuing Care, Administration, because of this realignment and changes within the department. The rationale for such a move is not readily apparent. I think one way the minister could help clarify this is to tell us what duties have been added, what changes have been made to this branch, Continuing Care, Administration, to reflect the need for three new SYs.

* (2210)

Mr. Orchard: Madam Chairperson, the function that is part of the five SYs here under Continuing Care Programs existed under Healthy Public Policy and were in the areas of computer programming, planning and program analysis and medical officer, all attached in terms of function out of Healthy Public Policy to support the Continuing Care Programs.

Now, under reorganization, those SYs which were part of the prior-to-restructuring reorganization other divisions are now part of Continuing Care where they supported the undertaking of the program from another area of the ministry, or what used to be the Department of Health, but now under the ministry of Health are functioning in a restructured capacity supporting the same program that they supported before only—I suppose that one could be blunt—more accurately assigned to the appropriate program area under the reorganization.

Ms. Wasylycia-Leis: Madam Chairperson, I think I will leave that for now and maybe come back to it at some point. I still frankly do not quite understand the rationale since at no time has the minister suggested that there has been new expanded duties facing the Administration branch that would help explain this shift in SYs. I understand in overall terms there has been considerable shift back and forth and all over the place, but I think there still has to be a bit of a framework, and I have not yet heard the rationale.

It would appear that the increase that the minister talks about quite often, the $7-million increase in Home Care expenditures, is again similar to the increase last year, an adjustment to reflect volume workload increases—and that is quoting from the minister's Estimates book. As the volume in cases has gone up each year, has their been a commensurate increase in field staff? If so, where does that show up, and what kind of additional resources have been put into the field staff and services to provide this or meet these new demands.

Mr. Orchard: Madam Chairperson, when you move the budget—and let us deal specifically with Home Care Assistance, (b)(3)—when you take the budget from approximately $55 million that was in last year's Estimates to $62 million, you do not have SYs in this Estimate process because those are service worker providers who are hired with that additional budget, some new and some existing with

additional hours, but they do not show up in an SY count of the department.

Ms. Wasylycia-Leis: Does that mean they show up only in terms of that overall expenditure line, or is there any breakdown indicating how that $7 million increase is broken down?

Mr. Orchard: There are going to be a couple or several components of that increase. First of all, part of it will–I think there is a general salary increase provision in there, I believe of 3 percent. Is that approximately right? Part of the budget reflects a salary increase. Part of the budget will reflect increased service purchased through VON, and part of it reflects increased services provided by home support workers and other individuals delivering the actual care to clients in the community.

Ms. Wasylycia-Leis: I am trying to get an understanding of, as volume has increased year-over-year, how this government has adjusted staffing and resources accordingly. I am assuming that an increase in volume means increased field workers, increased case co-ordinators, assessors and so on and so forth.

I am raising this because, as the minister knows, we have been getting calls and concerns about the translation of government policy into reduced hours in the field, or cutbacks with respect to staff, or less servicing. I do not want to start off this set of Estimates getting the minister up in arms and turning this into a confrontation again. I am trying to start off in a rational, calm way, and trying to understand why, if there has been this increase, which the minister says does automatically translate into increased field staff and resources, why are we getting all these calls on a continuous basis about cutbacks on the staffing end and cutbacks on the service end?

Mr. Orchard: Because some individuals, as has happened ever since the inception of the program, when reassessed, have had their needs assessment reduced, and the provision of care by a given worker to a given client will be reduced or curtailed. You will get those phone calls, which would lead one to believe, if that was all you listened to that there was a reduction in services, in my honourable friend's terminology of "cutbacks."

But naturally, people who receive increased services because of those reassessments and new individuals on the program and those accessing the program for more hours of care or more hours of complex service delivery per week or per day or whatever the comparable time period is, those people do not tend to phone my honourable friend.

So, when you only hear of people who have had their service reduced because of reassessment of need, you hear from those, but you do not hear of the many Manitobans who are either having increased services or been added to the program for new provision of services. Naturally, one does not hear from those.

In balance, every year, we provide more hours of home care services and maintain, I think it is fair to say, people with increasingly complex and demanding needs on the home care community in the program with significant budgetary increases year over year.

Ms. Wasylycia-Leis: If we were just dealing with the odd, isolated case, I could understand what the minister is saying, but it appears that the volume of complaints is growing rapidly, and I do not think we have heard the end of it yet.

Perhaps it would be productive if the minister could give us some precise numbers with respect to anticipated case loads for the '92-93 fiscal year. In providing that, I assume the minister, by now, will realize that there must have been some printing error on page 46, with the expected results, a repeat of last year's figures and for last year's time frame.

* (2220)

Mr. Orchard: Yes, the 23,000 should read 24,000.

Ms. Wasylycia-Leis: I wonder if the minister could complete the answer and fill in the expected results for all of those categories for the current '92-93 fiscal year.

Mr. Orchard: Madam Chairperson, I can give my honourable friend some statistics. Average monthly home care caseload as of December 31, 1991, had risen to 13,181 from the average monthly caseload for '90-91 of 12,741. As of December 31, 1991, there had been more admissions to the program amounting to 8,354 than there were discharges from it of 7,934.

There have been years where our admissions were lower than our discharges, but last year the experience was that we had some 400 more admissions to the program than discharges.

Total number of people assessed by Continuing Care as of December 31, 1991, was 11,742. Of this, 1,867 were panelled for personal care home placement; 8,354 were admitted to the program and

1,521 were deemed ineligible for the program. I think that probably summarizes some of the information my honourable friend was asking for.

Ms. Wasylycia-Leis: That is very helpful information. I had actually been asking for just the corrected information for Expected Results on page 46 for all the categories at some point. It does not have to be right now.

Mr. Orchard: With the exception of the first line, Expected Results, where it says approximately 23,000 Manitobans, that should read approximately 24,000 Manitobans will receive home care services in the fiscal year '92-93. The balance of the figures are deemed to be an accurate assessment of how many people will be assessed for personal care home placement or receive services under home care equipment, Home Oxygen Concentrator Program, medical supplies, et cetera.

Ms. Wasylycia-Leis: Just one quick question on that. So is the minister saying there has been absolutely no change in all of those categories in terms of clients and numbers of clients from the '91-92 fiscal year?

Mr. Orchard: These Estimates are the best ones that we have at preparation time for the Estimates. I simply indicate to my honourable friend that in the areas of assessment for personal care homes, that has been a relatively constant figure for the last several years as has people under Home Oxygen Program, as has people under the Ostomy Program. These figures are the best estimate that we can make on the expected request for services on those various programs. In addition to that, we expect to have a 4 percent roughly increase in the number of Manitobans who will receive services under the Home Care Program.

Mr. Cheema: Madam Chairperson, I am only repeating some of the questions that the member for St. Johns (Ms. Wasylycia-Leis) asked, but I cannot help saying that the minister said there has been an increase in the volume of the services, and there has been a funding increase in the Estimates book. Yet the numbers are shown here, as the minister is saying, with 24,000 Manitobans as last year. That does not really tell me exactly what is happening. Is there an increase in the volume or not, I mean volume is the number of cases. There is something that needs to be clarified.

Mr. Orchard: There is an increase in the numbers of Manitobans that we expect to receive services from the Home Care Program, an increase of 1,000, which is roughly 4 percent, a little better than 4 percent year over year. As well, we expect the trend to continue: that, of those 24,000 Manitobans, a number of them will require increased services over the previous year, so that there is an increased number of people receiving services as well as a number of individuals who will see their level of service provision increased in actual volume. There are two dynamics at work here.

Mr. Cheema: I think it is good to clarify that point, because the issue was raised during the nurses' forum two weeks ago, as the person was asking questions. That individual was saying that there has been a cut in the services. The minister has quoted in the figures where there is an increase of about $6 million, $6 to $7 million more than the previous year. The numbers are still the same, but the severity of or the time for those clients has gone up so that may be the reason, one of the reasons we still have the same number.

But maybe the volume in terms of the time given to a client has gone up, and I think that will explain so many things. I think that needs to be clarified because in the public mind there are cuts. In an actual sense there may not be any cuts.

That is why I want the minister to tell us if there has been any policy in direction change in terms of home care services as a major policy. Some clients have been told—and there is one person in particular and I have attended a couple of meetings with that person along with the Department of Family Services—that so much money per day will be given to a particular client. Once you reach that level, then they are told that is it. Has there been any provision in the home care services like this?

Mr. Orchard: Madam Chairperson, no. The policy that guides the provision of service in home care has remained consistent since 1974. We have always had an assessment of what I guess is known, for lack of better terminology, as over cost care individuals. In other words, individuals for whom the provision of services through home care, the Continuing Care Program exceeds the institutional cost. There are a number of examples where we are providing that service, but we are providing it deliberately. In some cases it is through a contractual arrangement with the individual where they have arranged their own care provision. In other areas with other individuals we provide and

recruit and staff the provision of care directly through the Continuing Care budget.

I think it is fair to say that the reason why the figures that I gave earlier on in terms of individuals in the Continuing Care Program who were panelled for placement in personal care homes, there are circumstances where a panelled individual prior to placement into an available space or an available bed in a personal care home will access the Continuing Care Program at costs above the institutional cost, but that is temporary in most of those cases.

There are instances of individuals where we know our cost of service provision in the community exceeds comparable institutional cost, and that is a direct decision of government that we have made to undertake those arrangements in specific cases. I hope that answers my honourable friend's question. The policy, the criteria for accessing the service for review and the other underpinning principles that have been with the program since 1974 have been consistently applied.

Mr. Cheema: Madam Chairperson, can the minister tell us if there is any form of communication between the department of Continuing Care and the Urban Hospital Council in terms of health care reform? Where would this department fit into the major changes which are coming into effect very soon, according to the Minister of Health?

* (2230)

Mr. Orchard: Madam Chairperson, on the Urban Hospital Council we have our regional director for Winnipeg there, and part of the overall service provision, Winnipeg region, is Continuing Care. From that standpoint that is the reason for that individual being on the Urban Hospital Council, to provide that kind of interface of the institution with available community supports.

(Mr. Deputy Chairperson in the Chair)

Mr. Cheema: Mr. Deputy Chairperson, that, I think, probably is a very smart political answer, but that does not solve the problem, because we have a major reform coming in, and you have a major department with Continuing Care where your emphasis is going to be more and more, whether this year or next year. When you are going to have more clients in that community, more services are going to be required. Why not have the Assistant Deputy Minister of Health part of that reform? That is what we asked. The health care reform package that the deputy minister is chairing is a very closed one. It is not a very open process, and I think it will be worthwhile to open the process even within their own department and have the ADM to sit on that committee so that she could have input, and so that she could better prepare that department for the major changes which are going to come.

Mr. Orchard: Mr. Deputy Chairperson, my honourable friend's suggestion that—I do not know where he is getting all these good ideas, but this is being considered by the Urban Hospital Council right now. I mean, my assistant deputy minister here needs another series of functions to undertake.

Mr. Cheema: Mr. Deputy Chairperson, you know, after 10:30, it is always—mostly it becomes more friendly because probably we are more delirious and we may not be thinking very rationally.

I think the issue here is a very important one because health care reform, where the deputy minister is chairing the whole thing—and I think even within his own department it is not very open. I think it will be to the minister's advantage to have the ADM be a part of the whole process, because she will be part of the whole thing in the future. They have to adjust to the changing needs of the patients and how their care is going to be provided. So I will reinforce again: the ideas are coming from whatever we are hearing from the community and what the minister is telling us. I think the Urban Hospital Council has to be expanded, and expansion must start from the minister's own department. I think that will be very helpful.

Mr. Orchard: Mr. Deputy Chairperson, let us not conclude that by lack of physical presence there is not the opportunity for input under the current structure. I mean, it is there. The whole effort in terms of reorganization of the ministry has brought the ministry together in a more comprehensive manner under Healthy Public Policy. We went through that debate, and we are using the talents and the knowledge and the advice throughout the ministry as required, and actual membership on a given council—that gets us into this whole debate.

You constantly have heard, for instance, at the debate that we were at about a couple of weeks back, that the issue was no representation on committees of government. I pointed out that that is not exactly accurate because the president of the MNU was on the Health Services Development Fund advisory board, and nurses were part of a number of committees struck by government. The

difficulty is that some people do not accept that a nurse who is not their recommendation can be useful to understanding change in the system, and I do not accept that. That is why I have never accepted the argument that there is not nursing or physician or administrator representation on various committees, because we have had probably the most diverse membership across the spectrum of health care providers and consumers and family members that has ever been put in place.

The criticism sometimes is that, if I could translate it directly, the person who would be suggested by the critic, who says there is no nurse or no physician, is saying there is no nurse or physician that we said could be there as an advisor. That is not where I come from, because I do not consider the corollary to that is the nurse we are asking advice. Her or his advice is invaluable because they were not appointed by, for instance, the MNU. I do not accept that. I mean, that is a pretty narrow approach to who should provide advice to government.

Mr. Cheema: I think the Minister of Health just went in the opposite direction. I think I am raising a very serious matter in terms of the head of the department, an ADM who is in charge of a political department, who has an important role right now. The role will eventually be changed when you are going to have the reform come into place, and when they are going to play a major role. That is why I am asking that the party, especially from the department head, will be more advisable, not from somebody, one or two persons. I think it will make more sense then.

The minister has said that they are making all their decisions within the department and communicating with each other. We would rather see a person who is in charge of the department be a part of that whole process. This whole reformed package, when it comes, should be presented to the people of Manitoba as a package, as a whole, not as an isolated approach by other hospital administrators or one or two persons within the department.

I think it has to come as a package which would meet the needs of all the patients and especially in the area of home care and long-term care, which is a major component. The minister has said many times that he would like to expand the role. He has given examples in terms of using the Continuing Care Program in terms of personal care homes and the long-term facilities, so that the beds can be transferred from the Health Sciences or St. Boniface to some of the less costly areas where the patient can probably go to Deer Lodge or another hospital.

That has been happening, so those changes are going to come. That is why we are asking that it will be very appropriate to have the ADM who is in charge of the department to be part of the process, so that when the package comes to the patients or the public and taxpayer, they will have a full package, not an isolated package. That will not really serve the purpose and that will not be–the minister will not be able to solve it in the long run. If he brings a package within his own department, first we have to clean your own act in terms of the whole department participating in the whole process.

* (2240)

The minister has said today for the first time that there is consultation going on within the departments, and I think that is very, very positive. In the past, it was not maintained that the Urban Hospital Council is having the approach as an independent body, and I always thought that was not probably true. I think now, because they are taking more input from the department, they are talking to the individuals in the Department of Health and the deputy minister being the chair, I think it is advisable to have people specifically who did not ask for the other ADMs, we are asking for this ADM very specifically because they have a special role in terms of health care package because of our senior population, because of our personal care home situation, because of our Deer Lodge Hospital, because of some of the health care delivery techniques for the seniors and other Manitobans who are going to require more home care services when they are released into that community, in terms of the IV drug programs. Some patients are being sent home and they are being told their families are being trained and it is functioning well.

Some patients for cancer treatment are coming in the morning and then going home and they are being taken care of within their own structure. But still some help is going to be required. To have this system functioning in the long run you have to have all the components functioning. That is why we have always maintained you need as much consultation on this process as possible, but that is part of the consultation and within the department it will be advisable. I think it will be good for the Minister of Health, then probably he can blame on the ADMs and have two ministers.

I am just joking, but I think eventually that will be very helpful because there has to be some continuity within the whole department and the continuity must start from the Minister of Health to the deputy minister, the associate deputy minister and the three other ADMs, and I think that was the first step. That is why the minister took that step two years ago, one and a half years ago, when they started reorganizing the whole department. At that time we thought that was the reason he wanted to have leadership in all the areas.

I think we should use the leadership abilities within the department and within the experience of these individuals and with the work done by the health policy analysts. I was going through some of the observations and they are very good. Some of them are saying why are we getting so many surgeries done for seniors and all those things? Eventually, I think those things are going to be beneficial if we have the assistant deputy minister of Continuing Care be actively involved and given adequate time to look into those issues. I do not think I can advocate more than that. I am just asking on behalf of taxpayers to have a reform package really put into place in a very realistic way and very practical way so that when the system is changed eventually, it will not fall apart.

Mr. Orchard: I accept my honourable friend's advice on the issue and I will certainly give it full consideration because I think my honourable friend has pointed in the right kind of direction, approaching changes in the system from a system-wide perspective and that requires the greatest input of components that have to interface and work together to make a change from institution to community work successfully for the patient. I accept that kind of advice from my honourable friend and will give it serious consideration.

Mr. Cheema: The other issue that I wanted to talk about in terms of the bridge money which is going to be required when the changes are going to take place and specifically there has been close to about $4 million in the Health Services Development Fund, but that is given only to the hospitals to see where the efficiency will take place. In terms of when you are moving the patient from the hospital to the community, there will be some expenditure and there will be some savings, but still some money has to move with that patient. So I would ask the minister or his department what kind of bridge money they are looking at, at this time, to make sure the transition is smooth so that the money will move with that patient, not otherwise.

Mr. Orchard: Mr. Deputy Chairperson, part of the answer lies in the increase budget allocation under Health Services Development Fund but also the addition this year of the Manitoba Health Status Improvement Fund is part of the Health Services Insurance Fund wherein institutions can access that fund to implement program changes which are going to contain, reduce and reallocate institutional budget program delivery more effectively within the institution as well as attached externally in program development outside the institution.

So there are really two sources of funding that will be available this fiscal year to accomplish the bridging.

I might indicate to my honourable friend, because this might be the appropriate time to mention, if we get to the mental health division we will talk about the longer term plan and basically a four to five-year time frame in mental health reform and the change from institution to community. We do not expect the same length of time required to undertake some of the changes from institution to community on the acute care side.

Basically, the reason we believe that is that we do not have to create the environment for the support programs outside of the institution because people accessing the acute care program have a home, for instance, apartment, private residence, and so that infrastructure does not have to be created. It is there, and the process that we envision is moving the services to that existing infrastructure with the patient. We can see the opportunity for a much more rapid shift of the system and much more rapid shift of the budget from institution to support the enhanced opportunity.

So the bridge funding issue is critical here, but not as long a term commitment before we have results on the institutional side and budget available for potential reallocation. I think the aspect of the two sources of funding, both in the Health Status Improvement Fund under the health services fund and some pretty significant increase in the Health Services Development Fund provides us with the opportunity to access the bridge funding.

Mr. Cheema: I think the minister is right in that aspect because when the changes are going to be made in terms of the general health care other than Mental Health, it can take that long. I think that is probably a reasonable expectation; specifically,

there is going to be a large saving as compared to the Mental Health Services. When you are moving a patient from an acute care bed, you are releasing them at an earlier time.

When there is an early discharge program, other things are going to fall in place; there is going to be substantial saving. So that is right. When you are moving to them to the community, the infrastructure is already there; the family support is already there. You simply have to provide some of the home care. Other support services which are already in place have to be expanded, but the amount of funds that are going to be required probably are going to be enough, if the policy is going to be followed the way the minister has said. I think that is a fair assessment.

My next question is: Can the minister tell us how much money we actually spent on Home Care in last year's budget? There was money put aside, but did we spend all the money?

Mr. Orchard: Yes, we did, Mr. Deputy Chairperson. We anticipate that, with the final reconciliation of year end, March 31, we are going to be very, very close to our budget amount and within dollars either above or below–very, very close to last year's expected expenditures.

* (2250)

Mr. Cheema: Another question in terms of policy direction. Last year during Estimates, and the year before that, there was a proposal and one project where the families could participate as a care provider. Can the minister tell us if that is the case now, or is there not going to be that kind of environment for the family to participate in and then reimburse instead of getting somebody else to come in and provide the care?

Mr. Orchard: No, I think my honourable friend is referring to the Self-Managed Care Project. One of the constraints on the Self-Managed Care Project is that family members are excluded from compensation for service provision. That is consistent right across the Continuing Care Program.

We have had this discussion in previous years and it is a very difficult policy issue to come around. It seems so absolutely logical that if a family member working outside the home gave up his or her job to provide and replace the services that we are paying for with retained individuals outside of the family, the logical case has been made at least a couple of times a year to myself directly as minister, why would we not simply have the family provide the services.

That gets us into a very, very difficult area in terms of administration and establishing the parameters around which a family might be constrained to provide real needs and not have the program, in essence, become one that is difficult to control. That is always a difficult argument, but I do not think, and correct me if I am wrong, I do not think there is any province that allows payment to family. There might be some examples. [interjection] I am informed there are a couple of smaller pilot projects in other provinces.

Basically, one of the underpinning philosophies that has guided the Continuing Care Program from its inception in 1984 is the reliance on family resources first to provide care, and the ministry, hence the taxpayers, providing services in addition to the capabilities of family to provide them–or where family cannot provide them, to provide those services, I think is a better way to put it.

Mr. Cheema: Mr. Deputy Chairperson, the issue has been raised many times, I would say, many times. There are a large number of family members who have expressed the interest that, when the patient goes home and home care is providing services, some of them are medical necessities, and they have no problem with that.

If there are other services which are provided through the long-term, through the Continuing Care Program, families, if they are fully capable, but they are working at the same time, there comes a question of monetary gain. Somebody who is going to stay home if they are not going to be compensated, it becomes impossible, where at the same time, the government is paying somebody else to come to their home and provide the services. It sometimes creates a lot of problems.

I know it is a tough situation because then how do you keep the control? How do you keep the qualification requirement, how do you judge whether the standard care which is supposed to be provided by society at large is being provided or not and then the issue of senior abuse and all those things. It is a serious problem. It looks very good from the outside, but it is worthwhile exploring it and seeing what the other provinces are doing in terms of looking into this issue and seeing if we can learn from the experience of other people.

My next question is: Do we have any special protocol which would have a special qualification for home care providers, other than the VONs and why has there been so much change in the staff in some circumstances? It may not be directly by the ministry of Health, but people who are providing services. Clients are telling I am getting two hours from this person and somebody else comes in half an hour, two hours, and then somebody else is coming for two hours.

There has been some cases, a lot of turnover for the same person. The services are provided by different individuals. First of all, it may be a waste of time in terms of the travel costs we are paying; second is whether the Continuing Care can be provided by six different individuals for the same person for the same kind of problem. I think there are some practical problems patients face in their homes.

Then the argument is made, can we have one person taking care of one person and then sometimes staff is not available at those things. I think if you have a person whose assessment has already been done and you know the need of a given person, I think attempts should be made to make sure there is one person or two persons providing the care, rather than three or four persons. I think that causes some problems. There are a couple of cases where there has been significant distress to a given person. I simply want the minister to know that is a problem and maybe we should try as much as possible to look into that issue.

Mr. Orchard: Mr. Deputy Chairperson, I think as a rule of thumb, the co-ordinators planning the service delivery for an individual try to build in as much consistency as possible around the individual or possibly individuals providing care, because some of our workers cannot provide orderly services for instance.

From time to time, there is no doubt that given the time of day for service provision and other scheduling difficulties, that there is a change in the individual providing the care. I simply indicate that as much as possible we try to maintain consistency in the individual providing the care to the client, but it is not perfect. I think it is also fair to say that as much as we strive, we will probably never be able to make it perfect. We are always going to have anomalies that come up. Then from time to time, too, some of the issues that come up are staff turnover and also where we have to provide instant replacement, if you will, of a caregiver because of either illness or unforeseen circumstances that disallow them from showing up.

But, as a general rule of thumb, we try to seek as much consistency as possible. We understand that the circumstance my honourable friend is referring to is real in some cases because you are dealing with generally frail elderly who develop a reliance on the individual coming into their homes. We are sensitive to that and try to provide as much consistency and the least amount of disruption in terms of new faces as possible.

Mr. Cheema: Can the minister tell us if they have any protocol in terms of checking the health status of these health care providers when they go into those homes? Have the immunization records been checked? Are they being fully screened for any communicable diseases as somebody who will work in a hospital or in a personal care home has to go through? I think that is a very important issue.

* (2300)

Mr. Orchard: Mr. Deputy Chairperson, we do not have the same ability for complete assessment as the institutional side does in terms of hiring personnel. To the best of our ability and within the confines of accepted practice, human rights and employment contract, et cetera, we attempt as best possible to determine the medical histories of employees through reference, et cetera, and through their provision of information. I think it is fair to say that we do not have the same kind of ability of assurance, if that is the right terminology, that an institutional manager would have in terms of their care providers that they hire.

Mr. Cheema: I think it is probably, if not more important, equally important because you have 24,000 patients or clients or whatever you want to call them in the community. When the health care providers are moving from one house to another, I think it would make the most sense even to have full screening done for individuals who are going to provide those health care services.

I think last year when we discussed it in the Health Estimates process and the year before, that there were supposed to be some changes made. I think we would like to encourage the minister to look into this very seriously because some problems are going to occur if proper precautions are not being taken, if the health status is not being checked, if the immunization status is not being checked.

Just the primary assessment, just having a simple form filled, and that form should be a standard one for each and every health care worker when they are going to be employed by the Continuing Care, whether on a contract basis or directly by the department, I think that should be the policy.

Even somebody going into a health care facility, even if that person is sweeping the floor, that person is supposed to go through a proper check. When you have a person going into somebody's house, going to provide care to a given individual, when going from place to place in a given community, I think it is even riskier not to check their health status.

Mr. Orchard: Mr. Deputy Chairperson, my honourable friend has hit on a traditional difference, if you will, between the employment requirements, institution versus community workers, not only in the Continuing Care Program but, for instance, public health nursing, social work, et cetera. We do not have the opportunity–there is, in some instances, a written protocol into the union contract by which we are guided in terms of the investigation or the request for information that we would make on potential employees.

But I sense from my honourable friend's questioning that–is it fair to conclude that you would think we should do a revisit around the issue and see whether we can strengthen the request for immunization records and make our process of employment selection closer to the institutional parameters?

Mr. Cheema: Exactly, precisely. I think it will make even more sense because we have 24,000 patients, or clients, whether they are in a severe illness or in a minor illness, and specifically when they are not in an environment where other quality assurance controls are going on, when they are in their own homes or when the health care providers are visiting from one home to another.

It is not going to be costly at all simply to have basic guidelines put in place that you have to fulfill a, b, c, d, all those requirements, as a simple health status. We all have to fulfill some of the obligations if we want to work in any given setting. So I think you have to meet those standards. Not only are you going to be providing a good environment for the clients, but you are going to protect yourself also. It is a two-way street.

I think it will be helpful to have those things done because it is simply not going to be workable in the long run. Somebody has not really raised that issue right now, but eventually, when you are going to have more and more clients in the community, specifically with the community care component, there has to be some set standard from the ministry of Health. Simply, somebody who wants to provide health care, they must meet the health care standards.

Mr. Orchard: Mr. Deputy Chairperson, my honourable friend is doing a little forward thinking here, not only with the current level of service provision in the community but in anticipation of that growing as the system reforms and changes.

I accept my honourable friend's advice and we will be pursuing what avenues are currently at our disposal to undertake the kind of suggestion my honourable friend is making. Should it become part of the contract with our care workers, we will certainly investigate the opportunity for inclusion of that kind of basic health information.

My honourable friend is making the suggestion from the standpoint of assuring uncompromising ability to deliver safe care in the home, the same as we do in the institution. I think that is a fair approach that my honourable friend is suggesting to government, and I take that suggestion very seriously, and I thank him for it.

I wonder if I might, before my honourable friend speaks–I have my ADM of Mental Health Services in the gallery. Now we probably are not going to get there this evening, and with the agreement of my critics, I would suggest Mr. Toews maybe enjoy an extra hour of sleep tonight. Would that be reasonable? [interjection] Thank you very much, Mr. Deputy Chairperson, and thank you to my critics.

Ms. Rosann Wowchuk (Swan River): I just wanted to ask the minister a couple of questions on Home Care as well. Over the past couple of weeks, or a few weeks ago, I should say, the member for Dauphin (Mr. Plohman) and myself both raised some serious concerns that we had, and concerns that people in the constituency had, about the reduction to the amount of home care that was being provided. The minister had indicated this was just part of a normal review process that these were being reassessed.

I want to ask the minister: Is this same review happening all over the province, or is it just happening in rural Manitoba? The reason I ask is because a few weeks ago or, I guess, maybe a month ago, we saw the changes in Dauphin, the cutbacks; now we are starting to see them in Swan

River and those areas. Is there a particular area that is being reassessed at this time, or what is the pattern to it?

Mr. Orchard: Each region undertakes reassessment with availability of personnel to do that, because you do not do that without utilizing your staffing resource. The reassessment has occurred with some change in service provision in Dauphin. That is not unusual.

I simply take my honourable friend back to '86 and '87 where reassessment in the Central Region saw a significant number of people removed from the Continuing Care Program and referred to support services for senior service provision. That was right in my own back yard. I understood the dynamics behind that. It did not become an issue, because that is exactly the kind of policy guidance that the Continuing Care Program has always had. It does not make those individuals who, with reassessment, have had their level of service reduced or curtailed entirely, but it is within the long-standing policy of the Continuing Care Program.

* (2310)

One might recall some reassessments that were done about two years ago, I guess, in Winnipeg north region where a number of individuals with the advent of more sophisticated Support Services to Seniors had their Continuing Care services reduced or discontinued and referrals made to Support Services to Seniors service capabilities. That is consistent with the program from its inception and particularly consistent with the 1984 decision to bring in Support Services to Seniors as an additional opportunity for service provision and independent living.

Ms. Wowchuk: I guess where I have my problem with this is in a particular case of elderly people who are 75 years old who have been having services for 45 years and now are having their services removed. They do not have family there to support them, and I would think, if the minister says the budget is increasing and there is more provision for home care that someone who is at that age and has been receiving services for several years, I would expect that their services would be enhanced.

In cases such as these where there are two elderly people, one of them may end up in the hospital without some of these supports that are there. That is a real concern to some senior people.

Mr. Orchard: I think maybe my honourable friend might want to indicate what sort of services were curtailed. I mean, medical services provided through the Continuing Care Program have not been curtailed. What has been curtailed is housekeeping or meal preparation services, for which there are in almost all of the cases involved, alternative services available to the individuals. That is consistent across Manitoba.

That was the genesis behind removal of some of the housecleaning and/or meal provision services, for instance, in central regions circa 1986-87. That was consistent with some of the removal of housecleaning and meal services in Winnipeg north region two years ago because Support Services to Seniors' funded programs provided that service in the community. That was the intention of Support Services to Seniors, to provide that not-for-profit replacement service to relieve the pressure on the Continuing Care Program so we could focus on provision on what I, without properly being appropriate in all cases, but what I call medical provision of services for which there are no reasonable alternatives in the community.

In terms of the housecleaning aspect and the meal preparation aspect, there are mature and growing and viable alternatives in the community and, where available, our reassessment leads clients to access those services rather than the taxpayer-provided service.

Ms. Wowchuk: In the case of the individual that I just raised, the services are housekeeping services and meal preparation, but I feel quite strongly that these people are going to end up in the hospital without the supports that are there.

If we are taking away housekeeping services and meal preparation. I feel quite strongly that these people are going to end up in the hospital without the supports that are there.

If we are taking away housekeeping services, I want to ask the minister: What is the anticipated amount that he expects to save in this department by removing these services from clients in the province? Is there a targeted amount in the budget that he intends to reach by reducing these services?

Mr. Orchard: No. There is no targeted amount. Of course, this is almost a deja vu debate we are having that goes back to '88, goes back to '89, et cetera. This is part of reassessment when alternate services are available in the community. In all of these cases, there are alternate services available

in the community and/or provided by family and relatives. In cases like that, the expectation has never been that government taxpayers will continue to provide house cleaning and/or meal services where alternates are available in the community.

Where we continue to provide the service and where we continue to see our budget demands grow, hence the reason why we move from roughly $55 million this year to a projection of $62 million next year, is in the provision of what I call–for lack of a better generic identification–the medical-type services as provided by a nurse, as provided by a home care worker with more intensive care provisions required.

For house cleaning and for meal preparation, where there are alternatives in the community and reassessment occurs, the clients are referred to that service. It is not that they will be denied that service. It is that it will be accessed in an alternative way. It may be that in those cases, the individual will end up paying for a meal versus having them buy their food and having someone come in and prepare it for them.

It is consistent with what the program has done over a period of years from 1974 and particularly is consistent with the policy thrust put in place with the approval and the funding of Support Services to Seniors program in 1984, exactly designed around providing financial support of the taxpayers to the retention in a community service provision environment of a volunteer co-ordinator who would co-ordinate not-for-profit services either by volunteers or by paid staff to provide the housekeeping, the meal preparation services in the community and the volunteer co-ordinators to then provide, if that is the basis for service provision in some Support Services to Seniors organizations, to add to that with a number of other activities appropriately identified by the community such as visiting or availability of volunteers to drive seniors to shopping or social events or medical appointments, to even establish volunteer visiting programs.

I know my special assistant in my office on a regular basis in the evening hours or on days off would provide a reading service as part of the volunteer support commitment to seniors in the community. Those were enhanced services that the community, through volunteer and other methods, provided to enhance the independent living skills of Manitobans. At the same time, the Continuing Care Program would provide the needed–and, again, I am using the terminology–medical services that could not be appropriately provided by volunteer or not-for-profit services, such as house cleaning and meal preparation.

Ms. Wowchuk: Mr. Deputy Chairperson, having recently gone through an experience where a family member used the services of housekeeping and meal preparation, I realize that these are very valuable services and are very much appreciated.

When a client is reassessed and has services taken from them, are they provided with lists, names of people who are available to do the services, or are they left on their own to find the services?

* (2320)

Mr. Orchard: That information is generally provided by Continuing Care either directly as a list of service providers that are available or a resource co-ordinator's name, where appropriate, so that the individual can contact the resource co-ordinator and be referred to a service provider.

Ms. Wowchuk: Would this just be individuals who put their names in that they are willing to do service, or does it have to be a registered company? I am just asking for clarification, because I am thinking to my own community and I do not know of any organization. How would you get the names of the people who are available?

(Mr. Jack Penner, Acting Chairperson, in the Chair)

Mr. Orchard: Generally, the maintenance of the list of individuals who will provide the housekeeping, the meal preparation services, are maintained by the resource council supported by Support Services to Seniors in the community. That is often the volunteer or not-for-profit service provider who will recover a modest hourly wage, if you will, for provision of services.

Where there is an attempt to provide greater neutrality as if, for instance, it is a roof repair that may be required on the client's house, again the resource council will attempt to provide a number of opportunities of individuals. I think the rule of thumb is pretty consistently applied that the resource councils try to have referrals made to the community. I mean, the community relies on the volunteers, relies on businesses and other entrepreneurial firms often to support the additional activities of the Support Services to Seniors

programs or the resource council programs and often come to those businesses to ask them for financial support for other initiatives. Hence, it is only appropriate that the resource councils, as much as possible, try to steer major repair needs and other needs to those same local businesses.

Ms. Wowchuk: With the change in services, there are many home care workers who have had their hours of work drastically reduced. Are there any guidelines or is there any stipulation put in place that people who are delivering some home care but have had their hours reduced, is there anything that prevents them from then working for a client who has had their services taken away?

Mr. Orchard: No, I do not think there are any constraints, but let me tell you what my honourable friend–out of the work force of 79 home support workers in the south part of the Parkland region, seven workers have been phased out or will be very shortly through natural reductions in their working hours as a result of the reassessments I think it is fair to say. In addition to this, one worker has resigned and one has moved, so there are a total of nine of 79 in terms of reduction.

Now, I do not think there is any constraint that the individual could be retained by the client to provide those services. We do not prevent that.

Ms. Wowchuk: The reason I raise that question, Mr. Acting Chairperson, it was my understanding that there were some people in Dauphin who were asked to sign a conflict-of-interest form saying that they would not do work with clients if they were having some hours with other clients.

Mr. Orchard: This has kind of mystified everybody here. Maybe if my honourable friend had more detail, I might be able to respond or have staff give me a more appropriate response. Right now there seems to be some consternation.

Ms. Wowchuk: That was what we were told by some workers in Dauphin who said that they had to sign a conflict-of-interest form. I believe we even saw the form, I may have it downstairs, saying that they could not do work for a client if they were working for other clients. I just ask for clarification whether there is any restriction for people who have had their hours reduced, and it would seem only fair since they are not able to work at the job they had that they be able to pick up additional hours elsewhere if that is the direction this department is going.

Mr. Orchard: I do not know if we are going to answer this. I think the issue becomes–our home support workers, working and putting hours in for the department, and then holding a second line of work, I think that might be a problem, but I cannot even clearly answer that for my honourable friend.

Ms. Wowchuk: Okay, that is fair. I would like to, at some point, get a copy of that and just get more clarification on it. I may have it downstairs and I will bring it back tomorrow.

Mr. Orchard: That would be helpful in terms of finishing off the discussion.

Ms. Wowchuk: The final question that I have is, when people have their services reduced–and understandably many of them are very frustrated, elderly people who do not know what they can do about this–is there an appeals process? When I say the appeal process, I do not mean calling your MLA and asking her to call the minister and deal with it in that way. What is the channel of appeal that they can have their services reinstated if necessary, or if they feel that they just cannot manage without these services?

Mr. Orchard: I want to get this right. The appeal process commences with a case co-ordinator. If it can be advanced to the regional Continuing Care co-ordinator, to the regional director, to the director of Continuing Care, to the ADM, to the DM, and then to myself.

There are a number of appeals to the process, and that is where I have always been very consistent. As a matter of fact, that appeal process is now part of the information package that is given to each Continuing Care client at the time they access the services so that there is a phone number and a contact person that they can appeal to. I have always said that in these circumstances–I am sensitive to the concerns that they have been improperly assessed, and wherever we have had complaints, we have always investigated. On some occasions, we have found that the reassessment process was not appropriate and we had to do a reinstatement in part of the services.

But I do have to say that in most cases the assessment has been fairly and consistently carried out. There has not been–I know the allegation in the past has been that there has been some driving force that has caused this to happen in an unfair and inappropriate fashion. That has not proven to be

the case in almost all of the reassessment service decisions.

* (2330)

I have to tell my honourable friend that when I was in opposition I found that same case to be the fact, because, as I mentioned to my honourable friend earlier on this evening, there was a fairly significant reduction in the house cleaning, meal provision services in central region–I am going by memory, but circa 1987 or '86–and that was because of a growing maturity in that area of Support Services to Seniors programs and alternate services that the program through its policy structure under reassessment would have a referral to alternate services made in a curtailment of the services under the taxpayers' support in Continuing Care Programs. I would think, with a few exceptions, most of the ones that I had investigated back in that time as an opposition critic were consistent decisions, some of them at that time, where a second look was taken and some level of service was reinstated, but most of the time the assessment and the decision was appropriate.

Ms. Wowchuk: Well, I am pleased to hear that there is an appeal process of that. That in certain cases, services are reinstated because sometimes people who are doing the assessment can make a mistake and can come across a little harshly and cause some severe concerns for elderly people.

I had said that was my last question, but I have one other one and that is on, as well, the role of a politician. What I have found is that when I call into an office to get some information about a particular case, I am told by case co-ordinators that they cannot talk to us. They will say, no, I cannot talk to you about this.

Is there any particular reason why a case worker cannot–I am not sure if I am using the right term, case co-ordinator is not supposed to talk to a representative of the Legislature?

Mr. Orchard: We got into this debate and this issue back in '88, '89, where staff were really put in a difficult position because members of one of the opposition parties, that is all I will put it on, being quite exuberant were going directly to staff and asking for information and for direction directly from staff that has elected people, is appropriately channelled through other elected people, namely, myself.

Appreciate that it puts professional staff in quite a little dilemma. Well, what the heck, might just as well. It was the official opposition back in '88, '89, and they had come in with quite a group of numbers. I think it is fair to say by a lot of perception, we are government in waiting. By going directly to professional staff to ask information directly that is appropriately provided through myself as the elected minister and other departments as the elected minister, they were in some ways potentially compromising the neutrality of the Civil Service.

I mean, if they give the information, what could it be used for? Sometimes, the message does not get transmitted perfectly and so therefore the person, the professional within the ministry providing the information, would then be as subject to the question, why that particular information went out, if it did not end up getting relayed in the House or wherever, accurately. The individual was on the spot, who provided the information. So that we have established a consistent protocol for information. It is not that we want to deny you the information. We will provide the information, but we do not want the potential compromise of staff professionalism to be there by having them responding directly to individual patient concerns. There is the other issue, when you inquire on behalf of a person, I am always very careful in responding to that because there have been instances where individual circumstances have been raised without the permission of the individual.

Staff simply cannot provide information unless they have some assurance the formal process of asking through my office is quickly responded to. I mean, we put a priority on these; I am sure my staff will vouch for that. When we have some of the concerns about service delivery in programs of the ministry, we very quickly ask for a response from the people who are directly involved.

That is a priority request out of my office, to try and provide quickly the information my honourable friend might request, so that it is a matter of trying to consistently apply a policy of how the ministry can provide information to members of the Legislature.

Ms. Wowchuk: I just want to close with a comment. I feel very strongly that the home care service that we have had over the years built up in Manitoba is a very good service. It has enabled many of our seniors to stay in their homes and live independently and live with dignity for a longer period of time.

As I said, within our own family we have just experienced this, and I would hope that we would retain this service, that it would give other individuals and seniors that ability to stay in their home rather than be institutionalized.

Because it is my fear that by taking away these services, we are going to have many more people ending up in hospitals, taking up beds that are much more expensive and living with much less dignity than they can now and going into an institution where they eventually just become a number.

So I would hope that the minister would take that into consideration and try to keep up the services that we have developed. In particular, in rural Manitoba, because I know that there are many of those cases that have been brought to my attention where family members have been asked to look after their parents, family members who maybe live 20 miles away. This is just impossible for them to carry out, and in those cases there are elderly people who are left without services. So I would very much like to see the service maintained then as it is and allow these people to live in their home with dignity.

Mr. Orchard: Mr. Acting Chairperson, well, I accept my honourable friend's advice and have acted upon it and indeed have exceeded it, because that is why we are budgeting a $7 million addition to the Continuing Care Programs this year.

That is probably, well, I think it is the largest single increase in any program line. My honourable friend whispers from her seat, what about the service? That provides more service, not less. My honourable friend is hung up on housekeeping and meal provision, and I appreciate that my honourable friend is hung up on that. But Continuing Care Program is much more complex than that and was not designed to do that when there are alternatives in the community. That is consistent. That is the way the program has been managed for years and years and years.

If my honourable friend is saying that is inappropriate and we should reverse it, then my honourable friend is saying that we should take budget away from needed medical needs and divert it to housekeeping, meal preparation, when those alternatives are available outside of government in the community. I do not think that is an appropriate use of taxpayers' dollars to accomplish what my honourable friend says is a goal that she has and she hopes the government will see to and will have.

I cannot accept my honourable friend's criticism. I do accept my honourable friend's urging to continue with the program, and I want to indicate to my honourable friend that is why the program has moved from, prior to our being in government, expending $35.5 million to a projected expenditure of $62 million in this fiscal year. Now, $35 million to $62 million is a significant increase; that is almost a $27 million increase while I have been Minister of Health in the Province of Manitoba. That is not a cutback; that is a significant increase in the provision of service which has enabled many Manitobans to maintain their independent life style.

One of the things that happens when individuals get on this case about cutbacks is you create a fear that the program is no longer available or is available in reduced services when, in fact, the exact opposite is true. That does not help seniors who want to maintain an independent life style if they are sitting there in fear that the needed medical services that Home Care provides will be reduced, because they have heard this talk about cutbacks from people in the Legislature, cutbacks which are a part of the program in terms of reassessment. So that is why we have spent a full $7 million more this year, and the budget has grown from $35.5 million when we came into government to a projection of $62 million this year.

Ms. Wasylycia-Leis: Mr. Acting Chairperson, we perhaps might not be quite so critical and always ending up in this same confrontational approach around these issues if the minister would be a little more forthcoming with some of the information that he has sitting on his desk and which would help certainly clarify the situation.

* (2340)

Let me start by asking when the minister will table the three reports pertaining to elderly, one specifically dealing with the home care situation, completed by the advisory network many, many months ago, which have been sitting in final form on the minister's desk for almost a year now.

Mr. Orchard: Mr. Acting Chairperson, as we have discussed at earlier hours in the Estimates process, it is my intention to have those reports a part of the public discussion in the near future. It will not happen this week though.

Ms. Wasylycia-Leis: I know the minister feels he has been asked this so often he treats it as a bit of a joke, but in fact one of those reports, the Advisory

Network report on Home Care is very critical of home care arrangements and directions of this government.

It would certainly help this debate if the minister would provide that report, so these concerns could not always be dismissed as fiction on the part of opposition members and attempts on the part of the New Democrats to stir up the masses and instill fear in the hearts of Manitobans, because we are in fact reflecting concerns from constituents, and they are not out of line with reports the minister has received.

With respect to that report the minister has had on his desk for over a year now, there is a clear reference in that report to the explosive situation vis-a-vis staffing and the inadequate resources to keep pace with increasing caseload and numbers of clients with greater needs and more acuity of care requirements.

Could the minister indicate how he is addressing that situation with respect to staffing and specifically provide us with an increase, if any, in case co-ordinators and case assessors?

Mr. Orchard: That staffing complement has remained consistent for a number of years now.

Ms. Wasylycia-Leis: Well, if that is the case then, the point we have been making all along has been made very well by the minister. He has indicated that in the years he has been around, since 1988, the increased investment in terms of home care is in the neighbourhood of $27 million and that relates directly to increased volume.

(Mr. Deputy Chairperson in the Chair)

However, the minister has said tonight that the number of case co-ordinators and case assessors has not increased whatsoever. I would like to ask how it is possible for the same number of people to handle such a major increase in volume and do the job as was originally intended and outlined in the Continuing Care guidelines?

Mr. Orchard: Well, Mr. Deputy Chairperson, certainly, if we did not have the financial constraints around hiring, we may well have added several individuals to assist in that caseload management, but that has not been the flexibility that we have been able to put towards the program. We have been very, very well served by our case co-ordination staff and our assessors in the Home Care Program. They have done Trojan work in terms of administering the program.

We are attempting to make the administrative side, the paperwork side, if you will, of the system more effective through some changes so that staff have a more effective opportunity in terms of delivering their workloads. Clearly this is not an example of what one would have as maybe a classic perception of civil servants who read pocketbooks in the afternoon. That is not the case. We get full service value from this staff complement which has remained constant over a number of years.

Ms. Wasylycia-Leis: A complement of staff that I think is at the breaking point because of the increased volume that they must deal with without any additional resources. I think we are now getting at a very serious critical issue in the Department of Health, and I am glad we are getting it straight to the point.

I think it is interesting to note that there has not been a single additional case co-ordinator or case assessor hired even though the volume of clients has gone up dramatically over the last little while. Yet, at the same time, and in this budget year alone, there has been a significant increase in this context of senior management staff to three in the area of administration and several more in the area of professional resources under Home Care. Yet, there is nothing that has been changed in terms of the description of those branches in the department, and the minister, after being questioned, has indicated no change in duties or anything to reflect that kind of warranted increase in staff. So I think the minister needs to access priorities here and deal with a very critical situation, one that is perhaps becoming a crisis. I will leave that point for now.

The other way in which one can judge the effectiveness of a program, as well as in terms of increasing staff to meet increasing clients, are increases with respect to programs like Adult Day Program and respite care and other supports in relief for families. I have not been able to find any increase in those areas as well, unless the minister would like to clarify that for me.

Why has this increase in budget not been used to provide the supports and relief programs that families need in order to keep people in the home longer and ensure that we can keep people in less costly care arrangements?

* (2350)

Mr. Orchard: That is certainly a process that is of consideration with the reform in the health care

system. I mean, those are exactly the areas and the initiatives that we think will make successful reform of the system not only possible but very appropriate.

Ms. Wasylycia-Leis: Is that why there has been a significant drop in participants in the Adult Day Program and numbers of programs funded by this government?

Mr. Orchard: I cannot presume my honourable friend's information is accurate, so I cannot comment.

Ms. Wasylycia-Leis: I do not have any secret, hidden information. I am simply comparing statistics provided in this year's Estimates book to last year's Estimates book showing quite a drop in participants in the Adult Day Program and the number of programs funded by the department. With respect to respite care, there is a very slight increase, hardly commensurate with the stress that families are facing as we deal with an aging population.

I am wondering how long do we have to hear this line about health care reform while the funding and policy directions of this department go in the opposite direction, and how much more difficult will it be to make up for lost time and resources whenever this so-called magical health care reform agenda does take off?

Mr. Orchard: Those initiatives are not static and unchanging, but there are two issues that come to play. Our resources, we are committing significant amounts. Last year's budget totally expended on home care service provision. I guess if my honourable friend wanted to give us permission we could maybe reduce the services in home care and reallocate them to other services that she is identifying as being needed and possibly more appropriate.

My honourable friend knows that is not exactly an acceptable solution, and that is why the acceptable solution emanates from a reallocation of institutional budget to the community. Our traditional response over any number of years in the past has been to accede to increase in community demands. That budget has grown and at the same time we have not, where we have replaced institutional services, removed the budget from the institution and transferred it to the community. That process will be very much a part of the planning and change in the system in the 1990s that will commence with this budget year and will carry on for a two-year change period of time.

Ms. Wasylycia-Leis: Mr. Deputy Chairperson, only this minister could argue that a cutback in a community-based program like the Adult Day Care Program is consistent with a health care reform agenda. Only this minister as well could argue that it makes sense in these times to take money out of the homemaking, the housekeeping part of home care, and try to, whenever we raise these questions, turn it back on the opposition and suggest that what else would one do if one had limited resources.

I think one begins by saying, is this asking the question: Is home care in the eyes of this minister and this government truly a prevention program to keep people out of expensive institutional care, or is it but a hospital replacement program? Now, with the minister's emphasis on anything but community-based programs that offer relief to families, and with his emphasis on anything but homemaking programs which clearly keep people in a healthy state of mind and body without having to turn to more expensive care arrangements, we are only left with the conclusion that, under this minister and this government, Home Care has moved dramatically from a prevention program to a hospital replacement program.

I would like to ask the minister how he justifies that shift, given the continued reliance of his department upon the Continuing Care guidelines which clearly spell out homemaking services as an essential part of the Home Care Program; and how we can avoid coming to the conclusion that this is a cutback when, on the one hand, all the program information suggests that homemaking services are essential, but, on the other hand, the minister by his words and his actions is suggesting that that is the last resort, the last area for funding, the lowest priority.

Mr. Orchard: Mr. Deputy Chairperson, with all of the gentleness that I can muster at four minutes to midnight, my honourable friend has just doused the committee with a liberal amount of balderdash, and that is as direct as I can put it. My honourable friend says that the housecleaning services are an essential part of the Continuing Care Program and always have been, and that is the whole argument the NDP have always made. What my honourable friend wants to do is forget the policy adopted in 1984, Support Services to Seniors, and what the intent of that policy was to do was to replace in the community alternate services in housekeeping and

meal provision. Why? To provide that as an alternative source of that service to home care clients living independently in the community.

I have even gone so far–and this has caused me untold angst in my security of my political future by giving the previous government credit for having their mind around the issue, appropriately, in developing Support Services to Seniors to provide house cleaning in an alternative way other than the taxpayers providing it. To provide meal services in a service provision other than directly paid for by the taxpayers. It has showed a great deal of understanding of the system back in 1984 when the Howard Pawley government accepted that policy recommendation from professionals who were planning changes appropriate to the Continuing Care system.

In 1986 and '87 and those years when my region of the province and my honourable colleague's region of the province, the Minister of Northern Affairs (Mr. Downey), when his region of the province was very proactively establishing Support Services to Seniors, providing those not-for-profit cleaning services, those meal preparation services, and Continuing Care was reassessing and referring those clients in our respective constituencies to Support Services to Seniors programs, did we make it an issue every day in the House? No. Because that happened to be a reasonable direction of the policy of government of the day. It made sense. We are carrying on with it. But again, we have been through this probably five times in the last four years. My honourable friend now in opposition is saying, well, you know, there is a change in government policy. You are not doing what we did when we were government. That is why I say my honourable friend just at four minutes to twelve imbued us with a liberal dose of balderdash. Because that is exactly what happened in 1986 and '87 in my constituency as a result of your policy.

Mr. Deputy Chairperson: Order, please. The hour being twelve o'clock, what is the will of the committee? Committee rise? What is the will of the committee? We will carry on.

* (0000)

Mr. Orchard: I am going to be very brief in my discussion with my honourable friend. She says that we are moving this system towards a hospital replacement system only. Well, that is not accurate. This program is the most sophisticated program for supporting independent living of seniors in their homes, in their communities that is available in Canada. It was an initiative that has gone through four government changes now, and each successive government has built upon successes in the past. I want to tell my honourable friend that now we are at a crossroads in terms of health care system reform, and we will see an increasing role of community-base services from within the Home Care Program with budget reallocations from the institutions that support it–budget going with the patient.

That is what I have consistently said now for about two months around the philosophy of change and reform in the health care system, and we will build upon the strengths in the system, and we will find our budget to build upon those strengths, not by going either to the taxpayers and demanding tax increases or the money lenders and borrow more money, but by using resources within the system of Health, the $1.8 billion, and do a reallocation from within to more appropriately provide services to those in need.

That is going to mean a more effective system in terms of its delivery and a more effective service in terms of enhancing the ability for Manitobans to live independently as they so desire to do.

You know, when my honourable friend gets into this argument, my honourable friend is exercising revisionist history at its greatest degree, because my honourable friend wants to forget the policy, the direction, the intention behind Support Services to Seniors as approved as a new program by the Howard Pawley administration. Now, I understand why my honourable friend wants to do this because that is the role of an opposition politician, but it is not helpful in establishing credibility around the issue to, all of a sudden from opposition, deny one's roots, but my honourable friend makes that choice.

Ms. Wasylycia-Leis: I just want to take a couple of minutes to indicate that there has been no rewriting of history on our part and no misuse or abuse of our role in opposition versus government. There has been clearly a shift in policy, and I say that for a couple of reasons.

I say that on the basis of what the minister has told us tonight and his accounting for the budgetary issues before us. I say that on the basis of my review of past developments around this area and this issue and knowing that at no time was the development of any nonprofit organizations doing

homemaking in any of our communities anywhere intended as a replacement for Home Care.

At no time were those services replacements for Home Care services, and I say that on the basis of simply the recommendations of the Price Waterhouse review which the minister tabled in October 1988, which, clearly, in terms of the area we are dealing with now, made two recommendations that indicate what had been the case in the past, or leading up to 1988, and what is clearly now the new policies under this government. I refer specifically to the recommendation that suggested, in fact, the government start looking at a hospital replacement program, in terms of Continuing Care.

Number two, that the department adopt the development of independent, and I am quoting now: the development of independent, not for profit cleaning services in all communities across the province. This effectively should take the program out of the business of providing housecleaning services.

Mr. Deputy Chairperson, I think that accounts for the fact that prior to that point there had been no such policy, and that, in fact, this government is clearly acting on the recommendations of the Price Waterhouse report.

I look forward to pursuing this further tomorrow. I am sure though that the minister–knowing the minister–will want to have a last word on this.

Mr. Orchard: Mr. Deputy Chairperson, the Price Waterhouse report, my honourable friend is accurate in the quotation of the recommendation: that as soon as possible government ought to make the support services program available across the province for the provision of housecleaning and meal preparation services.

Because where it was introduced into the province since 1984, it had done just that and successfully done it. Guess who was in government? Not us, we did not come in until 1988. The Price Waterhouse report was done in '87-88 and built on the success of that service development through Support Services to Seniors.

They recommended that we move as quickly as possible in advancing that across the province. Yes, that is what they recommended based on the success of that program which I have said to my honourable friend already once tonight, every time I compliment the Howard Pawley government for their foresight in introducing it, I jeopardize my future political career.

Mr. Deputy Chairperson: The hour being after twelve o'clock, what is the will of the committee? Committee rise.

Call in the Speaker.

IN SESSION

* (0010)

The Acting Speaker (Mr. Laurendeau): The hour being after 10 p.m., this House is adjourned and stands adjourned until 1:30 p.m. (Tuesday)

Legislative Assembly of Manitoba

Monday, April 27, 1992

CONTENTS