



Third Session – Forty-Third Legislature
of the
Legislative Assembly of Manitoba
Standing Committee
on
Social and Economic Development

Chairperson
Jelynn Dela Cruz
Constituency of Radisson



Vol. LXXX No. 3 - 6 p.m., Tuesday, May 5, 2026

MANITOBA LEGISLATIVE ASSEMBLY
Forty-Third Legislature

Member	Constituency	Political Affiliation
ASAGWARA, Uzoma, Hon.	Union Station	NDP
BALCAEN, Wayne	Brandon West	PC
BEREZA, Jeff	Portage la Prairie	PC
BLASHKO, Tyler	Lagimodière	NDP
BRAR, Diljeet	Burrows	NDP
BUSHIE, Ian, Hon.	Keewatinook	NDP
BYRAM, Jodie	Agassiz	PC
CABLE, Renée, Hon.	Southdale	NDP
CHEN, Jennifer	Fort Richmond	NDP
COMPTON, Carla	Tuxedo	NDP
COOK, Kathleen	Roblin	PC
CORBETT, Shannon	Transcona	NDP
CROSS, Billie	Seine River	NDP
DELA CRUZ, Jelynn	Radisson	NDP
DEVGAN, JD	McPhillips	NDP
EWASKO, Wayne	Lac du Bonnet	PC
FONTAINE, Nahanni, Hon.	St. Johns	NDP
GOERTZEN, Kelvin	Steinbach	PC
GUENTER, Josh	Borderland	PC
HIEBERT, Carrie	Morden-Winkler	PC
JOHNSON, Derek	Interlake-Gimli	PC
KENNEDY, Nellie, Hon.	Assiniboia	NDP
KHAN, Obby	Fort Whyte	PC
KINEW, Wab, Hon.	Fort Rouge	NDP
KING, Trevor	Lakeside	PC
KOSTYSHYN, Ron, Hon.	Dauphin	NDP
LAGASSÉ, Bob	Dawson Trail	Ind.
LAMOUREUX, Cindy	Tyndall Park	Lib.
LINDSEY, Tom, Hon.	Flin Flon	NDP
LOISELLE, Robert	St. Boniface	NDP
MALOWAY, Jim	Elmwood	NDP
MARCELINO, Malaya, Hon.	Notre Dame	NDP
MOROZ, Mike, Hon.	River Heights	NDP
MOSES, Jamie, Hon.	St. Vital	NDP
MOYES, Mike, Hon.	Riel	NDP
NARTH, Konrad	La Vérendrye	PC
NAYLOR, Lisa, Hon.	Wolseley	NDP
NESBITT, Greg	Riding Mountain	PC
OXENHAM, Logan	Kirkfield Park	NDP
PANKRATZ, David	Waverley	NDP
PERCHOTTE, Richard	Selkirk	PC
PIWNIUK, Doyle	Turtle Mountain	PC
REDHEAD, Eric	Thompson	NDP
ROBBINS, Colleen	Spruce Woods	PC
SALA, Adrien, Hon.	St. James	NDP
SANDHU, Mintu, Hon.	The Maples	NDP
SCHMIDT, Tracy, Hon.	Rossmere	NDP
SCHOTT, Rachelle	Kildonan-River East	NDP
SCHULER, Ron	Springfield-Ritchot	PC
SIMARD, Glen, Hon.	Brandon East	NDP
SMITH, Bernadette, Hon.	Point Douglas	NDP
STONE, Lauren	Midland	PC
WASYLIW, Mark	Fort Garry	Ind.
WHARTON, Jeff	Red River North	PC
WIEBE, Matt, Hon.	Concordia	NDP
WOWCHUK, Rick	Swan River	PC
<i>Vacant</i>	The Pas-Kameesak	

LEGISLATIVE ASSEMBLY OF MANITOBA
THE STANDING COMMITTEE ON SOCIAL AND ECONOMIC DEVELOPMENT

Tuesday, May 5, 2026

TIME – 6 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – MLA Jelynn Dela Cruz (Radisson)

VICE-CHAIRPERSON – MLA JD Devgan (McPhillips)

ATTENDANCE – 6 QUORUM – 4

Members of the committee present:

Hon. Min. Asagwara, Hon. Min. Simard

Mrs. Cook, MLAs Dela Cruz, Devgan, Mr. Piwniuk

APPEARING:

Jeff Wharton, MLA for Red River North

PUBLIC PRESENTERS:

Bill 26 – The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses)

Joyce Kristjansson, Association of Regulated Nurses of Manitoba

Fernanda Vallejo, Latinas Manitoba Inc.

David Grant, private citizen

Bill 27 – The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act

Fernanda Vallejo, Latinas Manitoba Inc.

Nichelle Desilets, Doctors Manitoba

George Fraser, private citizen

Joyce Kristjansson, Association of Regulated Nurses of Manitoba

David Grant, private citizen

Bill 28 – The Health System Governance and Accountability Amendment Act (Nurse-to-Patient Ratios)

David Grant, private citizen

Fernanda Vallejo, Latinas Manitoba Inc.

Joyce Kristjansson, Association of Regulated Nurses of Manitoba

Bill 32 – The Improving Access to Breast Cancer Screening Act

Jennie Dale, Dense Breasts Canada

Fernanda Vallejo, Latinas Manitoba Inc.

Jennifer Borgfjord, Breast Screening Advocates Manitoba

David Grant, private citizen

Bill 50 – The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act

David Grant, private citizen

Nichelle Desilets, Doctors Manitoba

George Fraser, private citizen

WRITTEN SUBMISSIONS:

Bill 26 – The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses)

Jennifer Breton, College of Licensed Practical Nurses of Manitoba

Bill 27 – The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act

Jennifer Breton, College of Licensed Practical Nurses of Manitoba

Bill 28 – The Health System Governance and Accountability Amendment Act (Nurse-to-Patient Ratios)

Sue Vovchuk, Long Term and Continuing Care Association of Manitoba

Jennifer Breton, College of Licensed Practical Nurses of Manitoba

Bill 50 – The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act

Deb Elias, College of Registered Nurses of Manitoba

Laura Panteluk, College of Registered Psychiatric Nurses of Manitoba

Sophia Ali, Manitoba Alliance of Health Regulatory Colleges

Jennifer Breton, College of Licensed Practical Nurses of Manitoba

Jeff Onyskiw, AbbVie Corporation

MATTERS UNDER CONSIDERATION:

Bill 26 – The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses)

Bill 27 – The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act

Bill 28 – The Health System Governance and Accountability Amendment Act (Nurse-to-Patient Ratios)

Bill 32 – The Improving Access to Breast Cancer Screening Act

Bill 50 – The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act

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Clerk Assistant (Ms. Melanie Ching): Good evening. Will the Standing Committee on Social and Economic Development please come to order.

Before the committee can proceed with the business before it, it must elect a Chairperson.

Are there any nominations?

Hon. Glen Simard (Minister of Municipal and Northern Relations): I nominate MLA Dela Cruz.

Clerk Assistant: MLA Dela Cruz has been nominated.

Are there any other nominations?

Hearing no other nominations, MLA Dela Cruz, will you please take the Chair.

The Chairperson: Our next item of business is the election of a Vice-Chairperson.

Are there any nominations?

Mr. Simard: I nominate MLA Devgan.

The Chairperson: MLA Devgan has been nominated.

Are there any other nominations?

Hearing no other nominations, MLA Devgan is elected Vice-Chairperson.

This meeting has been called to consider the following bills: Bill 26, The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses); Bill 27, The Declaration of Principles for Patient Health Care Act and Amendments to the Health System Governance and Accountability Act; Bill 28, The Health System

Governance and Accountability Amendment Act (Nurse-to-Patient Ratios); Bill 32, The Improving Access to Breast Cancer Screening Act; and Bill 50, The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act.

I would like to inform all in attendance of the provisions in our rules regarding the hour of adjournment. A standing committee meeting is considered to consider a bill must not sit past midnight to hear public presentations or to consider clause by clause of a bill, except by unanimous consent of the committee.

I would also like to inform all members of the public in the gallery—and the public in the gallery of the rules of decorum for standing committees. Please note that any participation from the gallery is not allowed. Examples of specific actions that are not allowed include clapping, cheering or interrupting presentations. Taking photos or video of the meeting is also not allowed. And please set your phones to mute. I thank everyone in advance for their co-operation.

Next, we have public presentation guidelines. Prior to proceeding with public presentations, I'd like to advise members of the public regarding the process for speaking in a committee. In accordance with our rules, a time limit of 10 minutes has been allotted for presentations with another five minutes for questions from committee members.

Questions shall not exceed 45 seconds in length, with no time limit for answers. Questions may be addressed to presenters in the following rotation: first, the minister sponsoring the bill or another member of their caucus; second, a member of the official opposition; and third, an independent member.

If a presenter is not in attendance when their name is called, they will be dropped to the bottom of the list. If the presenter is not in attendance when their name is called a second time, they will be removed from the presenters' list.

The proceedings of our meetings are recorded in order to provide a verbatim transcript. Each time someone wishes to speak, whether it be an MLA or presenter, I first have to say the person's name. This is the signal to Hansard—to the Hansard recorder to turn the mics on and off.

Written submissions from the following persons have been received and distributed to committee members: Jennifer Breton, College of Licensed Practical Nurses of Manitoba, on Bill 26; Jennifer

Breton, College of Licensed Practical Nurses of Manitoba, on Bill 27; Sue Vovchuk, Long Term and Continuing Care Association of Manitoba, on Bill 28; Jennifer Breton, College of Licensed Practical Nurses of Manitoba, on Bill 28; Deb Elias, College of Registered Nurses of Manitoba, on Bill 50; Laura Panteluk, College of Registered Psychiatric Nurses of Manitoba, on Bill 50; Sophia Ali, Manitoba Alliance of Health Regulatory Colleges, on Bill 50; Jennifer Breton, College of Licensed Practical Nurses of Manitoba, on Bill 50; and Jeff Onyskiw, AbbVie Corporation, on Bill 50. Thank you.

Does the committee agree to have these documents appear in the Hansard transcript of this meeting? *[Agreed]*

Now, on the topic of determining the order of public presentations, I will note that we do have out-of-town presenters registered, marked with an asterisk on the list in front of all of us.

With this consideration in mind, in what order does the committee wish to hear the presentations?

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Just in numerical order.

The Chairperson: It's been suggested by Minister Asagwara to receive the presentations in numerical order.

Is that agreed by the committee? *[Agreed]*

Thank you for your patience. We will now proceed to public presentations.

* (18:10)

Bill 26—The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses)

The Chairperson: So beginning with public presentations on Bill 26, The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses).

The first on our list here is David Grant, private citizen. David Grant?

We'll drop your name down to the bottom of the list.

Next, we have Joyce Kristjansson of the Association of Regulated Nurses of Manitoba. Joyce joins us on Zoom. We'll have them connected momentarily.

Joyce, if you can proceed to unmute your microphone and turn your video on, you may proceed when you're ready.

Joyce Kristjansson (Association of Regulated Nurses of Manitoba): Okay. Thank you very much.

Good evening. My name is Joyce Kristjansson. I'm a registered nurse and currently the executive director of the Association of Regulated Nurses of Manitoba. We're the professional voice of nurses in Manitoba. We represent registered nurses, nurse practitioners, registered psychiatric nurses, licensed practical nurses, student nurses, retired nurses and internationally educated nurses working to get licensed in Manitoba.

Our members work in both unionized and non-unionized positions across the province, in organizations funded by the Department of Health as well as other government departments, for-profit and not-for-profit corporations, and many have their own businesses. Nurses work in multiple areas, including clinical practice, education, research, leadership and policy in both paid and volunteer roles.

Bill 26 sets a provincial objective and a priority that health services are to be provided in a manner that does not require nurses to work mandatory overtime. We support that objective and want to work with government and service-delivery organizations to make that a reality.

We continue to talk about beds in reference to health-care services. But we need to recognize that appropriate staffing of those beds, especially of nurses, is a key component of health-service delivery. As our models of care shift, care is provided in more places than 20 years ago, and it involves more people. As each discipline becomes more specialized, including nursing, we need to find a balance that ensures that care is provided. To me, care is a mixture of subject-matter knowledge, the application of ethical principles and the physical delivery of care. It's an integrative activity, which I've often heard referred to as both an art and a science.

Over my career, I've worked many extended shifts. I know that I'm not at my best when I've been working 16 or 18 hours. In an emergency, adrenaline will help me get through. But there is a downside later for me and, often, when I'm working overtime, for my clients.

As a society, we've found ways to mandate rest breaks in industries like transportation, and we need to do the same in health care. Staffing of health-delivery organizations is complex and requires

specialized knowledge and skills. The rules are often both written and unwritten, and the knowledge is not well articulated.

In order to eliminate mandatory overtime as a solution for nursing staffing, we need to work to ensure that the rules for staffing are understood and followed. This requires collaboration between union and management, as well as the staff responsible for staffing.

The elimination of overtime is a laudable goal, as is the minimization of the use of agency nurses and the introduction of nurse-patient ratios. Each of these impacts the other and is complicated by historical practices, unclear interpretation of collective agreement language and system funding. As with many bills, the success of this initiative will depend on the details of its implementation.

ARNM is here tonight to support this bill and to encourage the prompt establishment of the oversight committee referenced in 3(1.4). We believe it's important that this committee include representation from nurses in many roles and positions as it develops the benchmarks and reporting required.

We note that section 10 of the proposed bill recognizes the need for different benchmarks in different areas of a health facility and of the province. This is important, and it needs to be considered as Bill 28 is implemented. ARNM is willing—ready and willing to work with government, service delivery organizations, unions and colleges to help ensure that mandatory overtime for nurses is truly only used in emergency situations, not used as a daily staffing solution.

Thank you very much.

The Chairperson: Thank you, Joyce, for your presentation.

We will now proceed with some questions from the committee.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Joyce, it's great to see you, always.

First, I want to start off by saying thank you so much for making the time to present this evening at committee, and thank you so much for your work and your leadership at ARNM. You've led that organization now for years and have done a phenomenal job. And you've been a great partner for our government to work with in taking really important steps to strengthen the nursing profession and to make sure

that we are listening to the voices of nurses across the province.

Really appreciate you sharing your own personal experience in terms of having worked mandated overtime on the front lines of our health-care system. I, too, can relate to that. I know what it's like to go home at the start of—to go to work at the start of a shift, think you're going home at a certain time and find out some way through that you're going to be staying for a double and how disruptive that can be and how it can really exhaust you. So I just want to reassure you that our government is on the same page as ARNM. We want to make sure that mandated overtime is not being—

The Chairperson: The minister's time has expired.

Joyce, would you like to reply?

J. Kristjansson: No, I don't think so. I'll leave it at that.

Mrs. Kathleen Cook (Roblin): Hi, Joyce, it's nice to see you. Oh, which camera am I—I'm looking at that one.

Hi. Thanks for joining us tonight. I don't have a question per se. I think your presentation was very self-explanatory, but thank you for the work that you do and thanks for your presentation tonight.

The Chairperson: Thank you, Mrs. Cook.

Joyce, would you like to respond?

J. Kristjansson: Thank you.

The Chairperson: All right, thank you very much again for your presentation, Joyce.

We'll proceed down the list here. Next up, we've got Mrs. Fernanda Vallejo from Latinas Manitoba Inc.

Thank you, Mrs. Vallejo. You may begin your presentation.

Fernanda Vallejo (Latinas Manitoba Inc.): Hello, everyone. Nice to see you all again.

Is this about Bill 28, right?

The Chairperson: Bill 26.

F. Vallejo: Twenty-six, okay.

The Chairperson: Sorry, Mrs. Vallejo, you may begin.

F. Vallejo: So hello, everyone. My name is Fernanda Vallejo. I am the founder of Latinas Manitoba Inc. This is a non-profit that supports a Spanish-speaking community, especially women.

I'm here in support of Bill 26. As a community builder and leader, I often hear from people who feel they are not receiving attention or care they deserve. At the same time, I also speak with nurses and health-care professionals directly. Health care is not easy work. The responsibility is to care for patients properly and safely.

* (18:20)

So this conversation is not only about overtime, it's about making sure health-care workers have enough support and enough staff around them to continue providing good care. Through our partnership with the Minister of Health, Latinas Manitoba is helping identifying and refer internationally trained health-care professionals, and we have many of them already here in Manitoba. We also have people willing to relocate—so people from other provinces and countries are interested in this great opportunity. They are qualified; they are ready to work; and they want to contribute.

But many are still not fully integrated into the system. Since we share this initiative—well, as I mentioned before, a lot of people—health-care professionals around Canada and overseas are interested. So while we support Bill 26, we also believe long-term solutions must include better workforce integration and more collaboration and using the talent that already is here.

So, that's how we can reduce the overtime. That's one of the solutions that we were thinking about. And yes, sometimes our nurses are overwhelmed, burnt out—they have families, they have lives, right? But if we can get more people that are ready to work, we'll have a better health system for sure.

And, of course, I spoke to a couple of nurses; they said, our priority are our patients. So they are willing to be there, but we need to think about their mental health and personal situations as well.

Okay. Thank you.

The Chairperson: Thank you, Mrs. Vallejo.

We'll now proceed with questions from the committee.

MLA Asagwara: Thank you so much. It's great to see you again. And thank you for your leadership and advocacy in community. And thank you for your partnership. Your organization does great work in our province, and it's been a real privilege and pleasure to work alongside you to make sure that more health-care workers know about the opportunities in Manitoba.

I think you spoke really, really well to what this bill is working to address. And I think you also spoke to the fact that we need to do this in a way that really prioritizes the well-being—the whole well-being—of nurses and health-care providers. So really appreciate that you made time to speak to this tonight in support, really appreciate your partnership in working with our government to support more nurses. And looking forward to the ongoing work we do together moving forward.

Thanks for being here.

The Chairperson: Mrs. Vallejo, would you like to respond?

F. Vallejo: So, thank you so much.

I know that all the cases that I've been referring to the ministry are not being followed up with me or with our organization, but I've been receiving really nice feedback already about job opportunities, on how to pursue with their profession here. So we won't have to see them work in a Tim Hortons, for example, right?

As well, I would like to mention that—no; that goes in the next bill. So that's good enough for now.

Mr. Jeff Wharton (Red River North): Thank you very much for your presentation. Really nice. And thank you for the work you do. I did have a question that—

The Chairperson: Sorry—Mr. Wharton.

Mr. Wharton: Oh, sorry, right there?

The Chairperson: Yes. Mic just wasn't on.

Mr. Wharton: Trying to address—can you hear me now? Hello?

The Chairperson: There you go.

Mr. Wharton: Hi. So just quickly, you touched on your ability to recruit other health-care providers into Manitoba, per se. Could you elaborate for the committee a bit on that? Because I know there's a shared feeling for that to happen. We want that to happen so that we can continue to grow the amount of health-care providers we have in the province.

So if you could elaborate on that, I'm sure the committee would appreciate that. Thank you.

F. Vallejo: I actually—the non-profit, they need more support because this is extra job for a mom of four kids that is in charge of a non-profit that supports, like, 2,000 Spanish-speaking women, right?

So what I can say is, we've been posting, we've been mentioning. We posted the video about the agreement, the partnership. And people are coming to us. But maybe we need that extra stamp so we can get that credibility and more people can be referred to the minister.

The Chairperson: Thank you, Mrs. Vallejo.

Any further questions from the committee?

Seeing none, thank you again for your presentation.

Bill 27—The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act

The Chairperson: Moving along, we'll be calling—moving along, we'll now be accepting presentations on Bill 27, The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act.

We will now be hearing from David Grant. We'll be dropping David Grant down to the bottom of the list.

Next up, we have Mrs. Fernanda Vallejo. Back to the microphone. This one is Bill 27.

Mrs. Vallejo, whenever you're ready.

Fernanda Vallejo (Latinas Manitoba Inc.): Once again, my name is Fernanda Vallejo. I represent Latinas Manitoba, a non-for-profit organization that supports the Spanish-speaking community, women, families here in the province of Manitoba.

We agree with the principles of this bill, especially equity, accessibility and patient-centred care. But I want to be honest. There is a gap between these principles and the real experience people are having. Many people are struggling with long wait times to see a specialist, delays across the system, overcrowded emergency rooms and, in some cases, late diagnoses—some cases. We have also seen stories in the news and hear concerns from community about people waiting many hours in emergency rooms before receiving care.

I also want to mention something we hear from patients dealing with cancer. Some people feel there should be more designated or quieter waiting areas for patients who are going through cancer treatment or serious medical conditions.

Okay, at the time, through our work with Latinas Manitoba, we are supporting a growing number of pregnant women without the Manitoba health card.

Because when access is unclear or delayed in those situations, the risk is higher.

We are also working to involve more international-trained health cares—okay, before I start with that part, we also have a partnership with the Minister of Health. We've been referring all those cases of the Spanish-speaking community that are coming to me that are pregnant, without Manitoba health cards, for different reasons. This is Canada. Here we respect the human rights. And I think we all should have access to the Manitoba health-care system. Okay, so that's what I want to add before.

And we, as I mentioned before, we have a lot of international-trained health professionals who are already here in Manitoba. Some of them are currently working in entry-level jobs instead in being in their medical path. So we are serious about patient-centred care. We need to make sure that access is not only 'definated' but actually filled by people, if that makes sense.

Thank you.

The Chairperson: Thank you, Mrs. Vallejo.

We'll now proceed with questions.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Thank you again for being here to present on this tonight and for, as always, speaking up on behalf of people who have very real lived experiences and who were affected by the challenges that we're dealing with in health care.

I just want to reassure you that, whenever you refer a case to us, we take it very seriously; you know, we know that every experience is a person, a family, a community that's affected. And so we're going to keep working as hard as we can to make those improvements in health care and repair a system that was damaged for a long time. But we do that in partnership.

* (18:30)

So, again, I can't emphasize enough, this partnership with your organization and other organizations is the way that we can continue to make the necessary improvements to health care as we move forward.

So thank you so much for making time to be here to speak on this.

F. Vallejo: Thank you.

So there was a case of a lady; because she came to Canada with, I think, the overseas insurance

approved for 362 days, she couldn't access the Manitoba health card because those three days of difference. We submitted the request, but I don't—I know you—that the Minister of Health or the department are not follow up with me, but I hope this person deserves the help that she needs.

And I would like to ask all the MLAs around here and—on the table if I can get your contact number so we can send a letter of support every time that I have these different situations. I can have someone outside from Winnipeg—let's say, Gimli—or I can have someone from different parts of the city, and, yes.

The Chairperson: Thank you, Mrs. Vallejo.

Mrs. Kathleen Cook (Roblin): Thank you for your presentation.

And so I am—in my role, I'm the Health critic for the official opposition, and you're welcome to reach out to me any time. And I might have my card on me now; if not, I'm easy to find. I'm Kathleen Cook; I'm the MLA for Roblin.

Thank you for coming tonight, and thank you for your presentation. *[interjection]*

The Chairperson: Mrs. Vallejo.

F. Vallejo: You brought this to the table because sometimes I'm sending emails to an MLA and also cc Minister of Health assistant or other person, like an MP, and I don't hear back from them, so that's why, okay?

MLA Asagwara: Yes, thank you so much for that.

That's a really important comment, and the—just for awareness, the—some of those correspondence, they go—as I think you know—to some degree, for some of that, go directly to those folks.

And so some of it is privacy, so we—our departments or organizations—like the RRO is an example—will follow up directly with people and not share the same information with the organization to respect privacy and those details.

But I've already—based on what you said, I want you to know I've already given feedback that there's a way we can make sure that, at the very least, you know that folks have been followed up with, even if we can't share the details. So, I'm making sure that, moving forward, we put a bit of a process in place that can reassure you of that.

F. Vallejo: Thank you.

The Chairperson: Seeing no further questions, next on our list of presenters we have Dr. Nichelle Desilets, who joins us virtually.

Dr. Desilets, you may begin your presentation.

Nichelle Desilets (Doctors Manitoba): Good evening, everyone. My name is Dr. Nichelle Desilets. I am board chair and past president of Doctors Manitoba.

Thank you for the opportunity to speak to Bill 27. As the association representing the medical profession, including over 3,600 physicians and over 1,000 medical learners, we have consulted with physicians in preparing our official response to the proposed legislation.

The expectations outlined in this legislation will sound very familiar to physicians. That's because many of them already—are already embedded in the profession's ethical foundation, the Code of Ethics and Professionalism of the Canadian Medical Association. That code requires physicians to treat every patient with dignity and respect. It requires us to support informed decision making. It requires us to provide safe, competent, high-quality care. It requires us to protect privacy and confidentiality, and it calls on us to advance equity and improve access to care.

In other words, much of what Bill 27 describes as patient expectations are not new expectations for physicians but rather part of a code that we have been expected to meet for years as a regulated—as regulated medical professionals.

But what Bill 27 does is important. It takes principles that have historically applied to individual physicians and begins to apply them to the health system as a whole. Patients should expect to be treated with dignity not only by their doctor but by the system through which they move. They should expect clear communication not only in a clinical encounter but across their health-care journey. They should expect safe, co-ordinated, patient-centred care, whether they're in a clinic, in a hospital or navigating between environments. That shift from a professional obligation to a system expectation couldn't be more important. And for that reason, Doctors Manitoba supports Bill 27.

We support the idea that these expectations should be clearly articulated. We support making them visible to patients. We support reinforcing them in the places where care is delivered. These are the right principles.

But there's one major question that remains, and that question is about timely access to care. Of course, physicians support timely care. It is core to good medicine. Delayed care can mean delayed diagnosis, delayed treatment or worse outcomes. But the expectation of timely care is also the most complex and the most dependent on the system capacity.

Bill 27 requires that principles, including the expectation of timely care, be posted in physicians' offices. The challenge is that, in many cases, physicians do not control the factors that determine whether or not care is timely. I can provide a few examples.

Access to a family doctor has improved in Manitoba significantly. Our province posted the biggest ever increase in physicians last year in our history, and it was also the biggest in Canada, according to the Canadian Institute for Health Information. The most recent report from the OurCare national study found that Manitoba leads the nation with 89 per cent of Manitobans connected to a family doctor or primary-care provider. Another survey by Angus Reid found that 73 per cent of patients report that they can access non-urgent care easily. Both of these are above national benchmarks.

That is real progress, but it's not the full picture. More than 150,000 Manitobans still do not have a family doctor, and 27 per cent of patients still report difficulty accessing non-urgent care. There are opportunities to improve access.

For example, Medinav is a promising tool that helps patients find same- and next-day appointments across different clinics, but today it only lists appointments from a small number of regional health authority clinics. There are dozens of independent community medical clinics across Manitoba that offer same-day or next-day access. Many would be very open to posting these appointments on Medinav, but they are not currently included. This sounds to me like an easy fix.

Emergency care is another example. Manitoba continues to have among the longest emergency department wait times in Canada. The most recent data from WRHA shows that the 90th percentile wait time is over 11 hours, double the national average of 5.5 hours reported by CIHI. In many cases, patients are staying in emergency departments longer than clinical benchmarks recommend, as outlined by the Canadian Association of Emergency Physicians.

In rural Manitoba, where I practise, the situation is even more challenging. A recent investigation by The Globe and Mail found that roughly 70 per cent of rural hospitals in Manitoba experience full or partial emergency department closures compared to 38 per cent nationally. It's no surprise, then, that only about 25 per cent of Manitobans say that they are confident that they can access emergency care in a timely way, according to polling by Angus Reid.

Diagnostic imaging is another pressure point. Wait times for CT scans are now approximately 12 weeks in Manitoba, up from eight weeks in 2024. This is six times the national average of about two weeks. MRI wait times are approximately 23 weeks, up from 15 weeks. That is nearly three times the national average of about eight weeks.

The clock on these reported wait times only starts after the request is processed by central intake. Right now, however, there's a significant backlog at central intake, resulting in lengthy delays. This means several more weeks are added to the wait times reported by Manitoba Health. The biggest challenge with this is that physicians have zero line of insight into where that requisition is at, even to confirm if the fax was received by diagnostic central intake. Not only can we not guarantee timely access, we can't even confirm for our patients that their testing request is being processed.

* (18:40)

Surgical wait times have improved significantly in several areas, which is encouraging, although some remain longer than national averages. Notably, Manitoba still does not report surgical wait times in a way that allows for comparison to clinically recommended benchmarks, such as the percentage of patients that are treated within target time frames.

Across all of these examples, one thing is clear: Timely access is not a new challenge. It's a long-standing system issue. And while physicians are committed to improving access for our patients, we do not control many of the key drivers: workforce capacity, infrastructure, co-ordination of systems, resource allocation, not to mention finally axing the fax.

Within physician practices, patients can sometimes face longer waits for appointments or consultations. We've been looking into this and there's certainly some room for internal improvements, something we are working on with physicians.

But often, when this occurs, it is a direct reflection of system constraints, particularly the physician shortage and a lack of team-based care. Manitoba needs approximately 246 additional physicians just to reach the Canadian average, and far more—over 2,400—to approach the average of high-income countries according to the Organisation for Economic Co-operation and Development.

So back to the legislation in question. We support the expectations in Bill 27. We support making them visible. We support reinforcing them through signage and communication. But if we are going to tell patients that they should expect timely care, we must also ensure that the system has the capacity to deliver it.

Thank you.

The Chairperson: Thank you, Dr. Desilets.

We will move on to questions.

MLA Asagwara: Dr. Desilets, thank you so much.

It appears as though perhaps you are here with us today virtually, in a clinic, it looks like if I'm not mistaken. So I—you never stop working. You are so dedicated. I can't thank you enough for your leadership at Doctors Manitoba and for being a strong voice for health care, for primary care, for doctors in this province in your capacity.

And I want to thank you for your willingness to sit down and work with our government to move things in the right direction. I want to thank you for taking the time to provide such a comprehensive and thoughtful presentation tonight.

And I want to reassure you that your concerns are going to be addressed in collaboration with Doctors Manitoba and physicians in this province to make sure that we, you know, do this legislation, enact this in a way that serves everybody in the best ways possible.

So thank you for presenting, and looking forward to continued partnership as we move forward.

The Chairperson: Dr. Desilets, would you like to respond?

N. Desilets: Thank you, Minister Asagwara.

I would just like to reiterate that physicians are happy to be at the table, providing feedback and collaboration when finding solutions to these challenges.

Thank you.

The Chairperson: Further questions?

Mrs. Cook: Hi, Dr. Desilets. Thank you for your presentation; it's nice to see you. And congratulations on the completion of your term as president of Doctors Manitoba. I think you've had a very good year, and I think you've made a couple of important points in your presentation.

I just wondered, for clarity, if you and if Doctors Manitoba is hoping to see the legislation slightly amended so that these expectations aren't going to be posted in doctors' offices specifically, given some of the concerns you've raised about physicians' inability to guarantee that timely access.

N. Desilets: Thank you very much for the question, MLA Cook. So we support posting these expectations, including the principle of timely care. But what—well, what we would like to see acknowledged is that all players have a responsibility in access to care.

So, physicians may or may not be able to exert some control in their own practices, but system-wide access, such as ER wait times, wait times for diagnostics, wait times for surgical procedures and overall supply within the health-care system is driven by factors that are outside of a physician's control.

So what we are looking for is a shared-system responsibility, not an implication that an individual provider has to fulfill that expectation.

The Chairperson: Thank you, Dr. Desilets.

Any other questions from the committee?

Seeing none, thank you again for your presentation.

We'll move on to Mr. George Fraser, who joins us here today.

George Fraser (Private Citizen): It's a pleasure to be here this evening. Just a little background on myself just to set some context: I am a retired association manager and—

The Chairperson: Apologies, Mr. Fraser. I'll just need to recognize you again.

G. Fraser: Yes. I just wanted to set some context: I'm here as a citizen of the province, of course. I'm a retired association manager. I've had an eclectic career in amateur sport, working for the Manitoba Sports Federation as their executive director as it—before it evolved into Sport Manitoba. I've been in the construction side of association management with the Winnipeg Construction Association, and with the Manitoba Home Builders, Canadian Agri-Marketing Association. And an interesting opportunity I was presented about 20 years ago, and that was to work

with—excuse me—massage therapists who were looking for self-regulation.

And so I've been in this room many times, beginning with the original Health minister of that day, Dave Chomiak, who said he had an idea. And I'm still here on behalf of the massage therapists as a volunteer; I want to make that clear. They have the frustration have—of being approved for regulation—self-regulation—2015, and they await in an off-ramp with their lights on, flashing, for a transitional council. Now, we're—there's two things going on here, and I'll try to talk more about this in, say, bill—the Bill 50 that I also have appeared before.

What I handed out was an op-ed by Paul Thomas, professor emeritus of political studies at the University of Manitoba. I thought it should be here. And perhaps you've seen it, and if you haven't, maybe you have a chance to read it. He asks some very good basic questions, I think, that should—that need answering and will come along.

I would like to say—and just in a brief summary—I agree with Dr. Desilets that the words are not window dressing, as perhaps the Free Press editorial page headline seeker put in. I think they are timely. It's always good wherever you are and whatever you're doing to review these—the statements of some principles, and in this case, very important principles. And I'm trying to read through things here; I'm on the last week of a double-cataract operation, and everything's going well—reasonably well.

So there are some things that Paul raised too. One of the issues is the 5.1, which was the basis for legal action in court and for other body or persons having decision-making authority. I'm not so convinced, and maybe the minister can make comment, and I would like to know if we have opinion from the Law Society.

I think health patients do not want to lose that privilege. In fact, it may play out in the RHPA process—very specific type of process that the Province of Manitoba has been engaged in for many years—as the College of Physicians and Surgeons, which I'll use as an example, goes through. And you may find that the patient at the end of the day still wants to seek legal position, whatever it is, for whatever the reason. And I think that's a caution, a caution at this point from that standpoint. So I think that's—that would be important.

* (18:50)

And to legislators who are here setting legislation in place, it's a great thing to pay attention to. The Regulated Health Professions Act in this province, modelled after Ontario, is a fairly lengthy, detailed document and so it needs respect, whether it's in transition or not, and particularly it needs attention for—if you're a very sophisticated health profession like doctors are and health and nurses are and some of those and others that do not have so many reserved responsibilities that the act requires.

So I think that that was a cautionary thing for me, for it to be looked at. The signage and the repetition of that message also has to be, for example, in the case of massage therapists who are working in multi-faceted clinics these days with physiotherapists, with chiropractors, and so there has to be co-operation in that respect from their standpoint too.

The attention to the relationship between the patient advocate and the system and the complaints process, again, outlined in the RHPA—that raises a question of the training and the background that these people are going to play, because they may be called ultimately—and, again, gets back to the point of law, which I'm not a lawyer so I can't speak to that clearly, but I would have hoped that perhaps there would be some comment perhaps from staff who are lawyers. Obviously, they must be in support of it, but I would say that others might not be. And I hate to dwell on that, but it's a reality.

We have members of the legal profession who are involved in—across this country in the complaints and discipline process and hearings, and these are quasi-judicial hearings, that you'll find three sets of lawyers in a hearing at the same time on behalf of the patient, on behalf of the of the health professional and on behalf of the regulatory college. So it's—it can be a very tense situation for anyone who's sat through those. So, caution, I would say. Not that it should stop it, but it should be very clear you wouldn't want to take that privilege away.

So I'm not—I'm sorry; I'm watching my time down here. Perhaps I'll stop at that point. I'll have a little more to say at the time of Bill 50.

The Chairperson: Thank you, Mr. Fraser.

We'll proceed to questions from the committee.

MLA Asagwara: Yes, thank you so much, Mr. Fraser, for taking the time to be here and for your service to Manitobans. You've obviously served in a number of roles, some of them volunteering, including a continued role, voluntary role in health care and in other areas that really make a difference in Manitoba.

So I want to thank you for that and thank you for taking the time to present in such a thoughtful and very intentional way. You've raised some points that are for us—we're taking very seriously. We are consulting with our legal experts and partners and looking at other jurisdictions, as well, in terms of best practices and opportunities here to do this right in Manitoba.

So thank you for taking the time. I would be more than happy to offer some correspondence to you to answer some of those questions in a more fulsome way beyond this committee.

The Chairperson: Mr. Fraser, would you like to respond?

G. Fraser: Yes, well, in an eclectic career I've got empathy for the elected officials around the table. I had the privilege of being a City councillor at the City of Winnipeg and the deputy mayor for Susan Thompson, so I've been through the war too.

Thank you.

The Chairperson: Further questions?

Mrs. Cook: Hi, Mr. Fraser. Thank you so much for coming tonight and for your presentation. I think you've raised some really good points. I still have some questions about this bill, some of which I raised at second reading, but I think you've highlighted some of those concerns in your presentation, as well, and just thank you for being here and putting in the time.

The Chairperson: Mr. Fraser, would you like to respond on the record?

G. Fraser: Just thank you.

The Chairperson: Thank you, Mr. Fraser. We'll hear from you shortly as well.

Next on Bill 27, we have Joyce Kristjansson from the Association of Regulated Nurses of Manitoba joining us on Zoom.

When you're ready, please turn on your camera and microphone and begin your presentation. All right, Joyce, you may begin.

Joyce Kristjansson (Association of Regulated Nurses of Manitoba): As I said earlier, my name is Joyce Kristjansson. I am a registered nurse and currently the executive director of ARNM.

My review of this bill came from a more personal perspective, but I think it's one shared by many nurses and other health providers. As a health-care provider, I am often the designated family member involved in

working with my loved ones in their interactions with the health system. Like most families, we've had both positive and negative experiences.

I agree that the guiding principles that are laid out are principles that we all adhere to. They are part of the nursing code of ethics as well as the medical code of ethics and other disciplines. Unfortunately, they aren't always followed, and it's not always clear where people should go.

I want to focus on three specific areas tonight. Respect and dignity is one. It is really important to us as a nursing association—and, I believe, to the people of Manitoba—that respect and dignity include the fact that racist and discriminatory practices will not be tolerated. These exist and occur in the health system with individual practitioners and sometimes systemically.

I will draw to the attention of the members of the committee a comment that was made to the minister and MLA Compton last month when they were talking with nurses across the province and we were discussing issues of respect and dignity. One of our members commented that the lack of respect and dignity shown by members of the Legislature sets a very bad example for all Manitobans in terms of what respect and dignity look like.

Secondly, privacy and confidentiality is important, but so is communication among members of the health team. This has been clarified multiple times through PHIA legislation, PHIA education, PHIA interpretation. But unfortunately, I've been in two recent family cases where important information wasn't shared between different parts of the health system. As a result, my brother's referral for necessary surgery sat for eight months until it was activated by an emergency room visit. My daughter's home care was not co-ordinated with other care until I managed to personally link home-care specialist and family physician.

Thirdly, and most importantly, I want to reference the opportunity to raise concerns. A part of nursing's role is to advocate, and on a daily basis, nurses are advocating for patients in health settings. Unfortunately, their advocacy is often seen as a problem and not as an opportunity to address systemic issues. There is a need to collect these multiple small, daily examples of advocacy and use them to improve the system.

* (19:00)

An office of patient advocacy, experience and quality, as referenced in this legislation, is only useful if it is independent and if it is able to deal with issues. Many issues cross the boundaries that we have currently set up in the health system and require support and navigation.

In my brother's case, there were three different service delivery organizations and two private clinics involved. Each was much more interested in passing the problem to another than getting the health services delivered. Last week, after 18 months and eight emergency urgent-care visits in five facilities, in two health regions, he finally got the surgery he needed.

In my daughter's case, I as an individual who had worked in the system for over 50 years needed encouragement and support from front-line providers and months of wrong starts to find the right person to help me resolve the issues.

I talked with many individuals and families who have issues and concerns. They're afraid to bring those forward because they fear retribution for speaking up. The current practice of naming executives as advocates in smaller organizations and the culture of blaming people for system problems contributes to this.

If, as a health system, we want to meet the expectations set out in this bill, we need to clarify the roles and responsibilities of patient advocates, set in place benchmark for investigations and the resolution of issues. After listening to our last presenter, I'm also struck by the need to clarify which issues need to be referred to professional colleges and which will be dealt with by these advocates.

I have a very strong belief that progress in making things safer and better in our health care system requires that we share our learnings and not repeat the same mistakes. In Schedule B, there is a recognition about sharing some learnings, but I would like to see this expanded from service delivery organizations to also include health organizations and corporations so that the knowledge that we gain as a system can be shared as a system.

Thank you very much.

The Chairperson: Thank you, Joyce.

Questions from the committee?

MLA Asagwara: Joyce, thank you so much again for taking the time to be here and present this evening. I also want to acknowledge and thank you for sharing

your own personal experiences with challenges in the health-care system. You know, I'm very sorry for the experiences that your family members have had. I know you know that we're working very hard to make the system better, but we know that the current state of the system does affect families in ways that we have to do better than.

So I want to thank you so much for your contributions and your presentation tonight. Thank you for being such a strong advocate for all Manitobans, not just your loved ones, and we will ensure that we continue to work with you as we move forward.

The Chairperson: Joyce, if you would like to respond.

J. Kristjansson: Thank you, Minister.

Mrs. Cook: Hi again, Joyce. Thank you for your presentation. I made a ton of notes because you made a— I think a lot of really good points, and your comment about respect and dignity and the comment you relayed about the example we set or don't set in the Legislature I think was important, and we take that to heart and I hear you loud and clear.

I also am particularly interested in the idea that the patient advocates as laid out in this bill should be made independent. I think that's important. I have a number of questions about how this role will differ from patient relations staff or client relations staff that currently exist in the health-care system, and I think that the government—

The Chairperson: Member's time has expired.

So, there's still time within the question section.

Joyce, would you like to respond?

J. Kristjansson: No, I don't think I have any response to that.

The Chairperson: Further questions?

Mrs. Cook: Only that I was just going to add that I think you've made a really important suggestion and a really good idea, and I hope it's something the government takes into consideration and possibly considers amending the bill accordingly. So thank you for that.

The Chairperson: Joyce, final opportunity to respond?

J. Kristjansson: I agree that there needs to be some clarification about client relations versus advocates as defended—identified in this bill and a need to ensure that we make it as easy as possible for people to come forward with a concern.

The no-wrong-door option for sharing a concern, i.e. that the person who receives the concern will get it to the right person if they're not the right person, I think would be helpful, but it then requires that we educate all the people in the health system about where to go with concerns and that's not something that we've done well to date. So, opportunities for improvement.

The Chairperson: Thank you again, Joyce.

Bill 28—The Health System Governance and Accountability Amendment Act (Nurse-to-Patient Ratios)

The Chairperson: Moving on to the next bill for presenters here, we have Bill 28, The Health System Governance and Accountability Amendment Act (Nurse-to-Patient Ratios), and our first presenter on the list is David Grant, who joins us in the room today.

David, you may begin your presentation.

David Grant (Private Citizen): Sure. My apologies for not being here; I was down the other end. Last time we had multiple bills, I did many running back and forths. This time, I just went down there and stayed.

Anyway, on Bill 28, nursing ratios, this is an election issue, and—or the—related to this is the 1999 election campaign. And, ironically, the day that that was announced in '99, I was talking with the president of the Nurses Union on what we could do to bring in more nurses. That's 26-plus years ago.

And we—between us, you know, she knew what she was doing and I had some ideas, and neither of us could come up with a really good solution long-term to fix that, the not-enough-nurses problem. There were very few ways that we could think of to improve care, and all the best ways would take many years. The prospective premier at that point said he'd fix stuff in six weeks, and we both knew that that wouldn't happen. But it is something that is an ongoing problem.

The ratios—patient ratios, I believe that's sort of a traditional long-standing tradition. The minister would know, having worked in the field, that when the media talks about we have a problem with not enough beds, well, there may be empty physical furniture there and rooms, but if you don't have the staff, you can't let a patient be in that room.

And so really the—I perceive this—it's like saying that there's 5 per cent unemployed people when, you know, 60 per cent of us have work or—have work of any kind. We know the 5 per cent unemployment's not

true, and we know the no beds available is not true. It's not enough people.

And on the other hand, one could think about it—that's a hard rule, and maybe changing the ratio is a prudent thing to do because somebody who's going in for routine surgery would rather have that surgery and have one third of a person looking after him afterwards rather than be sent home because he can't have one half of a person looking after him. So you look at—I mean, I've spent my life as an engineer. We look at compromise and best ways of solving things.

And the idea of hard and fast ratios is something that the health system has had for generations. And not necessarily that that's what this bill is doing, but certainly, if we look at the—from the hospital administrator's point of view, if it was a privately owned hospital, they would never let a patient come in that couldn't have the standard of care. They'd rather send them down the street.

* (19:10)

In our case, we don't have that option. And I would suggest that, you know, that person—I had a friend going in for some surgery, and he's all prepped, doc's all prepped, and somebody calls in sick and he's sent away. Luckily, he didn't have to wait another year; he got served within three weeks. But it does call into question that problem, and it provides old people like me with an incentive to not get sick.

But, anyway, that's beside the point. So, anyway, that was—my comment on the ratios is that perhaps the hard and fast ratios that are tradition are something that we should revisit, and look at the balance of benefit, you know, cost and benefit of doing that.

And there's another thing that the media—not only do they lie saying not enough beds but also about the nursing shortages, that when the minister took over, we were down a whole lot of nurses. And we know they didn't all die of COVID, but we—and very few of them got sick; if you look at the sick days in 2020 and '21, they're no worse than 2019. So we have a very healthy stock of nurses, and I think that's something media were misleading us about. They should have told us that.

We had two big problems the media have been silent on. One is the number of nurses who were sent home because they didn't care to get the vax or retired—and that happened to some of our physicians—and then the fact that our mayor, a few years ago, boasted about us being a million strong. Well, wait a minute: if we don't have enough nurses, and some of

these people are going to need health care, we've got an extra burden. So not making excuses for the minister, but those are two burdens that she's had to face, and they certainly don't help. And that's something it's unfortunate the media have been silent about. And even the—her department, you know, before she took over, was silent on how many people did we really lose to retiring early—and, you know, making our—her problem far worse.

So, anyway, yes. So without getting into the relative merit of the mRNA mandates, but the effects of that and the increasing population are things that are out of your control, you know, that was done before you got here, and it was done—it's still being done to you by Ottawa by increasing our population. So those are my comments on that, is that when you're stuck with this, some of us would rather have care and not have the full complement of theoretical nurses. And I'm not sure if that's even legal, but if you're in charge, maybe. But that was—the solution is change the ratios and—since you can't bring back the ones who retired in '21 and you can't make the flow of TFWs slow down or anything. So those are just my comments on it.

It's a serious problem, and it's too bad the media aren't being honest about empty—about beds, bed numbers and the reasons why we're down so far in nurses. And it's unfortunate that, you know, we're down so many. And if the department now was to say, we're down—two years ago we were down this many nurses versus 2019. Because the previous government was very tight-lipped about that, about how much of a mess they made with their mandates of the nursing supply. So if that number is available, I think waving those numbers around would take some of the heat off the minister. And I'm not sure number affecting ratios is really going to be good for us in general, but I would suggest that it would be better than not having treatment.

So thank—that was my comments. Thank you.

The Chairperson: Thank you, David.

Before proceeding to questions from the committee, I would like to remind the committee and public presenters of the importance of accurately using pronouns when referring to different members of the committee. I let something slip earlier when a member of the committee asked if the proper way to address me was Madam Chair. Actually, it's honourable Chair. Similarly, I had advised folks to use the correct pronouns for other folks as well here today.

Moving on to questions from the committee, Minister Asagwara.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Thank you, honourable Chair. I apologize; I think I referred to you as Chair before, so I will correct course. Thank you, Mr. Grant, and just for everyone's awareness, I do use gender neutral pronouns.

It's good to see you here. I really appreciate that you make time to present at these committees. You've made a number of very, very important observations in terms of how we got to where we are in terms of nursing and nursing care and ratios in Manitoba.

I really appreciate your comments on the importance of likely having a bit of flexibility and being nimble in terms of ratios so that we're not preventing people from getting care in scenarios where we know they've been waiting for this really important care. So I just want to reassure you that we are going to work with the implementation committee to implement this in a way that prioritizes people getting care first and foremost. But thank you so much for your presentation.

The Chairperson: Thank you, Minister.

D. Grant: Sure. And as we discussed on the—with the bill, on gendering, I always try to refer to you as minister. I think I did in everything I said. I kept using minister all the time because I think that's the appropriate thing, is a first name or a title. And I would refer to the Chair versus honourable Chair, but that's partly because I don't know your name, but Chair works nicely, anyway. But that was—I appreciate that, and thank you for recognizing that.

The Chairperson: Thank you, David.

Any further questions from the committee?

Mrs. Kathleen Cook (Roblin): Not a question, but thank you for making time to come out tonight and present. Thank you.

The Chairperson: David? Okay. Perfect. Thank you so much again.

Moving along the list of presenters for Bill 28, next we have Mrs. Fernanda Vallejo of Latinas Manitoba.

Mrs. Vallejo, you may begin.

Fernanda Vallejo (Latinas Manitoba Inc.): Good evening, honourable Chair, Honourable Minister and their committee or—okay.

So my name is Fernanda Vallejo. I'm the founder of Latinas Manitoba Inc. I'm here in support of Bill 28, and I also believe this bill is directly connected to Bill 26.

After speaking directly with nurses, I understand something important. Ratios cannot always be the same in every area of a hospital. For example, in ICU, nurses may only be able to safely care for a small number of patients because those patients need much more attention and monitoring, correct? In other hospital areas, a higher number might be manageable. I was said—a nurse told me, we'll be okay with six to eight, okay, depending in which area of the hospital they are.

But what should never happen is a nurse being responsible of an unsafe number of patients, like 20. Those are the numbers that were mentioned to me, okay? Because this is not about making the worker easier—the work easier, I mean; it's about making the care safer.

Okay, and one of the solutions that I've been thinking of and I mentioned during the last past two bills is the partnership that we have, that we're referring new professionals, and I hope to see them in hospitals working as nurses in all the health-care areas. That will be really helpful for the province.

And we are also solving another problem. People are saying there are not enough jobs, so, okay, that's how Latinas Manitoba is contributing here.

So many of these people—the international professionals—health-care workers, sorry—are still working outside health care, even—okay, even if they are trained professionals. So while we're discussing 'saffing' shortages, we also need to recognize that talent already exists inside our province.

Thank you. I'm sorry about my accent.

The Chairperson: Well, thank you, Mrs. Vallejo. I think that your accent's incredible.

Moving on to questions from the committee.

MLA Asagwara: Yes, thank you again for taking the time to present. You are—you're very, very clear in your communication and very consistent in terms of your advocacy, and I really appreciate that.

You touched on a few things that are really important, and I really appreciate that you have reflected here on what nurses are bringing forward to you and understanding that there needs to be, again, a bit of flexibility and nimbleness in terms of

how we approach nurse-to-patient ratios across different sites and across the system. So certainly that is the approach we intend to take with guidance from the implementation committee.

Thank you for being here tonight.

* (19:20)

The Chairperson: Mrs. Vallejo, if you'd like to respond.

F. Vallejo: No, I don't have nothing to say here. I just would like to have a meeting after this. One thing at a time.

Mrs. Cook: Thank you for your presentation on this bill. We appreciate it, and you never need to apologize for having an accent.

F. Vallejo: Thank you so much for that compliment and it's pretty nice to be here, always, okay.

The Chairperson: Thank you again.

Moving along, next we would like to hear the presentation of Joyce Kristjansson from ARNM. Once more, again Joyce joins us online.

When you're ready, Joyce, you may begin.

Joyce Kristjansson (Association of Regulated Nurses of Manitoba): As I've said, I am Joyce Kristjansson, a registered nurse and currently the executive director of the Association of Regulated Nurses of Manitoba.

I've watched the discussion about the implementation of nursing ratios for over 30 years in the health system. I've seen them implemented in a few places in the world. The idea is one that I can support but, as with so many bills, the details are where the issues really lie. We need to think about the fact that the work of nurses includes physical, mental, emotional and spiritual care for the patient, and sometimes for their family, depending on the place of work. It's also impacted by who else is there to provide care and support. Might be health-care aides, clerks, housekeepers, other professionals, but often it's left to be just the nurses.

The issue of nurse-patient ratios is one that is pretty hot within the nursing community. There are people who speak for it, people who speak against it. Many of the concerns that have been raised this evening, particularly about the need to understand how that works across the system. It appears that this legislation is a plan to build on the excellent work that was done by the committee struck during the last negotiations with MNU.

However, because that committee report remains confidential, nurses are coming to me with questions about what areas will be prioritized, what tool will be used to determine patient numbers and acuity, and what nursing time will be required to complete the tool? Is there a hierarchy to be followed in meeting the ratios? What work won't be completed if we need to move nurses from areas of lower acuity to higher acuity? How will this be operationalized and integrated, including daily staffing, the creation of master rotations and the allocation of funding.

When I spoke earlier this evening to Bill 26, I mentioned that there's a need for the implementation committee for this bill to work collaboratively with the implementation committee for Bill 26 and to include multiple representatives. I know that large representative committees can be limited in their effectiveness, but at least we need a way to communicate the work on an ongoing basis to the many groups of nurses and health-care managers so we can come to a common understanding of how decisions are being made, implemented and evaluated, not only for the areas directly affected, but for other parts of the system.

Our current governments and communication structures do not provide this level of communication and information sharing. As the minister knows, I've talked about that piece for a very long time and in many ways. Article 60(2)(a)(iv) of this bill references qualification and training requirements for inclusion in a ratio. This is a huge example of disconnects in our system. We have no current way of tracking these numbers. We struggle to even have accurate data on the number of nurses working in the province and the numbers needed.

If anybody wants an example of where this becomes really problematic, I'd be happy to share with them some of the details about the manual workarounds that we set up during COVID to meet the mandates required in long-term care for single-site staffing models. We don't have the tools to know who is in our health-care system, where they're working, what they're doing.

ARNM is ready to work with government, service delivery organizations, unions and professional colleges to help ensure that if the decision is to implement nurse-patient ratios, we do it in a way that improves the delivery of health care in Manitoba, not meets an expectation of a few people that ratios will solve a problem. Ratios are part of a solution, but they're not an entire solution.

Thank you.

The Chairperson: Thank you, Joyce.

Starting with questions from the committee. Apologies, Minister Asagwara.

MLA Asagwara: Thank you so much, Joyce. Not a question. Again, just want to express my gratitude for you taking the time to be here and presenting in such a thoughtful way, and very comprehensive presentation that you've provided in regards to this legislation.

I think that your last statement is a really, really important one and accurate one. So nurse-to-patient ratios are important, but they're not the only lever that we need to pull in order to improve and continue to fix health care in this province.

So thank you so much for your time and your expertise tonight. And, again, I can't emphasize enough your partnership and your organization's work moving forward is going to be really key to us doing this the right way amongst other initiatives.

Thank you.

The Chairperson: Joyce, would you like to respond?

J. Kristjansson: No, thank you.

The Chairperson: Further questions? Mrs. Cook.

Mrs. Cook: Hi, Joyce. Not a question, but thank you for your expertise, both as a nurse and as an advocate and the perspective you've provided tonight.

Thank you.

The Chairperson: Joyce, a response?

J. Kristjansson: Thank you.

The Chairperson: Thank you again, Joyce.

Bill 32—The Improving Access to Breast Cancer Screening Act

The Chairperson: We're now moving on to presenters for Bill 32, The Improving Access to Breast Cancer Screening Act.

Our first presenter will be joining us virtually. We'd like to hear now from Ms. Jennie Dale of Dense Breasts Canada.

Ms. Dale, when you are ready, feel free to begin.

Jennie Dale (Dense Breasts Canada): Bill 32 is an important opportunity to strengthen early detection and improve breast cancer outcomes for Manitobans. I'm Jennie Dale, founder and executive director of

Dense Breasts Canada, DBC. Thank you for the opportunity to speak today.

I'm a breast cancer survivor and patient advocate. For the past 10 years, DBC has advocated, province by province, to improve breast cancer screening and equitable access. Our recommendations are grounded in evidence and aligned with leading clinical organizations in Canada and internationally. To ensure Bill 32 achieves its full impact for Manitobans, it's critical that access to breast cancer screening reflect each woman's level of risk, not just intent—in intent, but in practice.

* (19:30)

Currently, women at increased risk, whether due to age, genetics, personal history or breast density, do not consistently receive the screening needed to detect cancer early. The bill's preamble recognizes the importance of early detection, noting that it increases survival and reduces invasive treatments such as chemotherapy and mastectomy.

Indeed, the evidence is clear. Screening can reduce breast cancer mortality by over 50 per cent. When cancer is found at stage 1, five-year survival is close to a hundred per cent. At stage 4, it's closer to 33 per cent. Early detection also lowers health-care costs and reduces the burden on the health-care system. Canadian data shows the average cost of treating stage 1 breast cancer is approximately \$39,000, compared to over \$370,000 for stage 4.

We support the bill's intent to improve early detection and remove barriers for underserved populations, such as Indigenous groups, where we know that First Nations and Métis women aged 60 to 69 experience higher mortality rates than others. Expert bodies, such as the Canadian Society of Breast Imaging and the Canadian Association of Radiologists and many others, recommend a number of optimal breast screening practices.

Bill 32's screening and access plans can align with best practices in other provinces by beginning screening at age 40, offering annual screening, a high-risk program and supplemental screening for women with dense breasts. Ensuring optimal practices within the plan would strengthen early detection and ensure Manitoba keeps pace with advances in screening across the country.

Bill 32 states that the cancer authority's screening plan must include criteria for determining whether an individual is at increased risk. Clearly defining criteria is essential. Without that clarity, key groups, such as

women in their 40s, individuals at high risk, women with a personal history of breast cancer and women with dense breasts, risk being overlooked as policies are developed.

Clear direction at the legislative level helps ensure these groups are recognized and included in practice. Here's why these groups matter. First, women in their 40s: Breast cancer incidence is rising in younger women, with the largest increases under age 50. One in six breast cancers occur in the 40s, and these cancers are more aggressive. Breast cancer is the second leading cause of death in this age group, yet screening can reduce mortality by up to 44 per cent.

Manitoba has taken an important step by committing to lowering the screening age from 45 to 40 this December. However, strengthening this with annual screening and 3D mammography would further improve early detection in this age group. Four other provinces screen annually from 40 to 49. Women aged 45 to 49 in Manitoba are currently screened every two years and no invitations are sent at age 40.

There's also an equity dimension. Recent Canadian research shows that while white women have a peak incidence of breast cancer in their early-to mid-60s, women of all other racial backgrounds experienced this peak much earlier, often in their 40s. About a third of breast cancer cases were diagnosed before age 50 in Filipina, Arab, Inuit, Korean, West Asian and multi-ethnic women compared to 16 per cent in white women.

Black women also have an earlier peak incidence and are more likely to present with aggressive cancers called triple negative, and at a later stage. They experience mortality rates 40 to 70 per cent higher than white women in mid-life. Annual screening is critical to reduce disparities. Screening every two years does not adequately reflect differences in ethnicity, age of onset and biological risk. Access to screening must match risk.

Lowering the screening age to 40 alone will not increase participation to target levels, however. Across Canada, uptake in the 40s remains low due to a lack of awareness and inconsistent physician recommendations. Screening programs must include invites, remove barriers and support physicians with clear clinical guidance. The bill addresses public awareness, but physician education is also essential. Some providers may still be relying on older guidance. To ensure Bill 32 achieves its goals, there must be a plan to support physician education.

Second, high-risk individuals: There's an opportunity within the bill to include a funded, organized high-risk screening program. High-risk individuals, including those with genetic risks such as BRCA mutations or extensive family history are not always consistently identified, and many do not receive the level of screening required to find cancer early. Other provinces, including Ontario, Nova Scotia, have already demonstrated that organized high-risk screening programs are feasible and life-saving. Alberta's program begins soon.

Manitoba can take this next step by implementing a similar program with access to annual MRI, the standard of care for those at highest risk. Risk should be identified early, beginning at age 25, using validated tools. Physicians must be supported to assess risk and make appropriate referrals. AI-supported risk assessments are emerging and are able to identify those at highest risk in the next five years. As technology continues to evolve, it will be important for Manitoba's screening approach to remain responsive and forward-looking. A structured high-risk screening program supported by modern assessment tools is essential. Without it, high-risk individuals may continue to be identified too late or not at all.

Third, another important opportunity is the inclusion of women with a personal history of breast cancer. These women are at higher risk of recurrence, yet are not included in organized screening programs. Including this group would help ensure more consistent risk-appropriate care for women who remain at elevated risk. Manitoba should include this group in its organized screening program. Ontario is working toward this with implementation planned for 2027.

And last, importantly, women with dense breasts. Women with dense breasts are not explicitly addressed in the bill. They represent approximately 43 per cent of women and are at elevated risk. They face two challenges: increased risk of cancer and increased risk a cancer may not be detected on mammography due to masking by dense tissue. Mammography alone is not sufficient for this group.

Manitoba has taken an important step by notifying women if they have dense breasts. However, notification alone is not enough to improve outcomes. Access to appropriate screening is essential to reduce missed and later stage cancers. Mammography is referenced multiple times in the bill, yet ultrasound and MRI are not mentioned. Women with dense

breasts need access to these tools for equitable and effective care.

Bill 32 proposes that screening and access plans be updated every five years. Breast screening is evolving quickly, and a five-year review cycle may not keep pace with rapidly evolving technology, including artificial intelligence, contrast-enhanced mammography, abbreviated MRI and risk assessment tools. As written, the bill remains focused primarily on access to mammography. Without recognizing these modern technologies and more frequent review cycles, there's a real risk that expanded access will not translate into improved outcomes.

On Sunday, CTV featured researchers at the University of Manitoba. They're developing a new technology to work alongside mammograms and improve cancer detection, highlighting just how quickly this field is advancing.

Bill 32 is an important opportunity, but its impact will depend on how clearly it defines and delivers risk-based screening. Today, in Manitoba, too many women are not getting the screening they need, whether they're in the 40s, at high risk, living after a breast cancer diagnosis or have dense breasts. Manitoba has the opportunity to address the gaps and build a modern, equitable screening program, one that reflects current evidence and incorporates advancing technology. Early detection saves lives but only when women can access the screening they need. This bill is Manitoba's opportunity to make that a reality.

Thank you.

The Chairperson: Thank you, Ms. Dale.

We'll now proceed to questions from the committee.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Thank you so much, Ms. Dale, for your presentation. You managed to fit a whole lot into the time allotted, so thank you so much for being so organized and providing such a comprehensive presentation this evening.

I want to thank you for your advocacy and for being such a strong voice for breast cancer survivors, for breast cancer screening, for breast cancer care across Canada and certainly here in Manitoba. I want to reassure you that the plans that we are—this legislation is ensuring the experts in this province develop are going to cover almost the entirety of the concerns that you've laid out here today.

And there's a lot more work to do in addition to this bill, so thank you for the presentation. Thank you

for your work, and we look forward to keeping you up to speed and working with you as we move forward.

The Chairperson: Thank you, Minister Asagwara.

Ms. Dale, would you like to respond?

J. Dale: Yes, I'd like to thank the honourable minister for the attention that the Province is giving to breast cancer screening. It's wonderful to see, and I'd like to personally thank her for all the social media posts and the awareness that they are raising amongst women in Manitoba. The energy, the passion, the humour, the creativity that goes into those reels, it's so great to see the awareness being raised, so thank you.

The Chairperson: Thank you, Ms. Dale.

Just a gentle reminder before proceeding to the next question. Of course, members of this committee, please—as well as members of the public—please make sure to use the appropriate pronouns when addressing folks here.

* (19:40)

Mrs. Kathleen Cook (Roblin): Hi, Jennie. Thanks so much for your presentation and for your continued advocacy. I just—I hope you are—I hope you know what a difference it's making, not just here in Manitoba, but across the country for women who need to access breast screening. I think it's in large part to your efforts that we've seen the needle move somewhat here in Manitoba. So thank you for that.

I don't have a question, but I really appreciate you making a presentation tonight.

The Chairperson: Ms. Dale, would you like to respond?

J. Dale: Yes, thank you, MLA Cook. I appreciate those words and I want to thank you so much for your voice and how you represent all Manitobans. It's greatly appreciated.

Thank you.

The Chairperson: Thank you again, Ms. Dale.

Is there any other question for the committee? Seeing none, thank you again for your presentation.

Moving down the list, next we have Mrs. Fernanda Vallejo from Latinas Manitoba. Whenever you're ready, you may begin, Mrs. Vallejo.

Fernanda Vallejo (Latinas Manitoba Inc.): Okay. Good evening, honourable Speaker—no, Chair—sorry, Honourable Minister and committee.

My name is Fernanda Vallejo. I am the founder of Latinas Manitoba Inc. I am here in support of Bill 32 because when it comes to breast cancer, early detection can save lives. Many women still face barriers such as language barriers, lack of information, failure to entertain a diagnosis, long wait times to see a specialist.

I also believe conversations around breast cancer screening should start earlier so we can create more public awareness, because many women been noticing discomfort or symptoms before the age range that is usually discussed for screening.

For example, in 2024, we had a Winnipegger that was turning 29 years old, and one week before she—her marriage, she passed away, right? So I'm proposing if we can try to do this for younger ages, not 40, 45, so if a 32-year-old woman is feeling something different, she deserves to be checked, okay?

I also—okay—yes, I also believe conversations around breast cancer screening should start earlier, because many women been noticing discomfort or symptoms before that age range; that is usually the excuse for screening. And when someone feels something is wrong, they should feel encouraged to seek help early, without fear or confusion. I also believe support and access should include immigrant women, regardless of their status of type of visa.

Yes, we all deserve to have access to health care. Because situations can change, some people may lose their status while living in Canada or may be in transition between permits or immigration processes. At Latinas Manitoba, we are already helping bridge some of these gaps by sharing information and helping women better understand the health-care system.

Thank you.

The Chairperson: Thank you, Mrs. Vallejo.

We'll now proceed with questions from the committee.

MLA Asagwara: Thank you so much, Mrs. Vallejo, for this presentation and for your remarks. I want to reassure yourself and everyone for their awareness, that anyone who has symptoms, any woman or person who has symptoms, is absolutely able to access screening and able to access diagnostics to get the care that they need, and it's really important that people know that.

And to your point, a lot of people don't know, which is part of the reason why this bill specifically identifies not only the planning that needs to be done, but the outreach and education that must be done to ensure that all communities, particularly those that are most affected by bad outcomes, have those tools to get the screening and the care that they deserve.

So your organization is a great example of how we get the word out to people who need that information, so thank you so much for presenting tonight and again for your advocacy.

The Chairperson: Mrs. Vallejo, would you like to respond?

F. Vallejo: Yes, so in terms of providing more information, once again, I offer myself or the organization to help the Province, the government, to do interpretations for a Spanish-speaking community. I'm here, okay?

And I want to knowledge to the minister about a lot of work that they are doing, but I also would like to bring to the table the screening of endometriosis. That's another topic that my community brought to me.

The Chairperson: Thank you, Mrs. Vallejo.

Mrs. Cook: Thank you for presenting on this bill.

And I imagine that your organization will be important when it comes time to implement some of the provisions of this bill, particularly around identifying barriers to screening for your community. I imagine you'll be a wealth of information, and I look forward to hearing more from you about what you think needs to happen in Manitoba.

So thanks for coming tonight.

The Chairperson: Mrs. Vallejo, would you like to respond?

F. Vallejo: Thank you everyone. Have a good night.

The Chairperson: Thank you, Mrs. Vallejo.

Moving on, we will proceed with a presentation of Mrs. Jennifer Borgfjord from Breast Screening Advocates Manitoba who joins us virtually today.

When you are ready, Mrs. Borgfjord, you may turn your camera on and unmute yourself and begin your presentation.

Jennifer Borgfjord (Breast Screening Advocates Manitoba): I'm not sure how to turn my camera on

here, sorry. There, I found it. And it's not clicking. Okay.

Good evening. I am Jennifer Borgfjord, co-founder of Breast Screening Advocates Manitoba. Thank you to the committee for the opportunity to speak about Bill 32. I'll briefly share my story and offer recommendations to help make this bill as effective as possible.

I have dense breasts, and without my own advocacy, my story could have been very different. About eight years before my diagnosis in my mid-40s, I asked my family doctor for a mammogram because I was—had concerns about lumpy breasts. I was reassured that I was too young for breast cancer and, without a family history, I could wait until age 50. I was also told that self-exams and clinical breast exams were no longer recommended. I left reassured and trusted that advice.

When I turned 50 in 2020, I had my first screening mammogram. The results were normal. I did not know that dense tissue both increases breast cancer risk by two to five times and also makes cancer harder to detect on a mammogram. Mammogram accuracy declines by 30 to 40 per cent in women with dense breasts. Cancer appears white on a mammogram and so does dense tissue, creating a camouflage effect.

In April 2023, I again received a normal mammogram result. Four weeks later, I felt a lump in my left breast. I was tempted to ignore it because I just had a normal mammogram result. However, recalling my mother's parting wisdom to be my own health-care facilitator, I booked an appointment to have it checked. Even then, I encountered skepticism. Had I not just had a normal mammogram?

When no fluid could be drawn from the lump, I was sent for an ultrasound. At that appointment, the technician suggested it was likely just a formality given my recent normal mammogram results. As the technologist scanned my breast, the atmosphere in the room shifted. She left and returned with a radiologist. The mass was suspicious and biopsied immediately.

Ten long days later, my doctor called and began with the word: unfortunately. I had breast cancer. An MRI was ordered and revealed a second mass not seen on the mammogram. I was told about it the day before lumpectomy surgery and was given 20 minutes to decide whether to proceed with a mastectomy or delay surgery for another biopsy.

Feeling terrified, I chose further investigation. Thankfully, that mass was benign. But the stress of

those moments remain with me. As I recovered, I began educating myself. My social media algorithms led me to dense breasts, a topic I should have known about long before my diagnosis.

* (19:50)

I learned that there are four categories of breast density—A, B, C, D—and C and D are dense breasts. I learned that access to supplemental screening for dense breasts such as ultrasound or MRI can improve the chances of earlier detection. Mammography alone detects about five cancers per 1,000 screens. Supplemental ultrasound can detect an additional two to seven cancers per 1,000 women screened, while MRI can detect approximately 12 to 16 additional cancers per 1,000.

I learned my primary care was influenced by outdated guidance from the Canadian Task Force on Preventive Health Care, which recommended to doctors that screening should start at age 50. And I learned that my well-being depended on my willingness to question, seek clarity and advocate for myself within the health-care system.

Today, even with breast cancer and dense breasts, the only imaging I am offered is an annual 2D mammogram, the very tool that did not detect my cancer in the first place. And my story is not unique. Women with dense breasts are a large underserved group whose needs are not reflected in current policy or access to care. My experience reflects a broader gap in our system and that is what this bill has the opportunity to fill. Bill 32's intent to improve access for at-risk populations is important.

To support this, women with dense breasts should be explicitly recognized as an at-risk group, and the criteria used to define increased risk must reflect current evidence to ensure they are appropriately included and not inadvertently excluded. Three key barriers must be addressed to provide risk-appropriate screening to women with dense breasts: reliance on outdated information, human resource constraints and physician education.

The bill's preamble emphasizes evidence-based care. Strengthening this to emphasize current evidence is critical. At present, the decisions affecting women with dense breasts continue to be influenced by older guidance. Historically, screening guidance in Canada has been shaped by the Canadian Task Force on Preventive Health Care, which recommended against supplemental screening. However, its recent breast screening recommendations were widely

criticized by clinicians, advocates and provinces for its approach to evidence and governance, leading to the task force being disbanded by the federal Health minister in March 2025.

A new advisory body is expected to begin in mid-May, but updated breast cancer screening guidance will take time. Right now, there is an opportunity to ensure that government decisions reflect the full body of current evidence. Based on recent correspondence and publicly available information on breast check platforms, task force guidance continues to influence decisions related to screening for women in Manitoba, which—where there is no access.

When the task force stated that there is insufficient evidence that supplemental screening reduces deaths, that does not mean there is no evidence; it means there are no completed randomized control trials, or RCTs, for ultrasound and MRI. The absence of RCTs is not absence of evidence. A substantial body of observational studies, modelling and emerging trial data demonstrate the benefit of supplemental screening, and six provinces and territories have already acted by providing access to ultrasound or MRI to women with dense breasts.

To ensure equitable care, screening decisions must be based on current, comprehensive evidence, not limited to randomized trials or mortality alone. Provinces like Manitoba have evolved their approach to screening at 40 based on emerging evidence. There is similar opportunity here to ensure that access to supplemental screening reflects current knowledge and improves outcomes for those at higher risk.

However, even when provinces move beyond task force recommendations, physicians may continue to rely on it. Physicians are the single greatest influence on whether a patient participates in screening and they play a key role in facilitating access. When it comes to dense breasts, some primary-care providers may not be fully aware of the associated risks or the potential role of additional screening, and this can affect patient care.

Manitoba should provide clear clinical guidance to family physicians and nurse practitioners on breast density, masking risk, supplemental screening options and referral pathways. Expanding access to supplemental screening requires addressing system capacity, and right now, that capacity is limited. Women in Manitoba with a symptom of breast cancer currently report long wait times for diagnostic breast ultrasound.

A plan to increase access must include a plan to address human resource challenges. This includes increasing ultrasound training opportunities, supporting mammography technologists to expand their skill sets in ultrasound and ensuring sufficient practicum placements. Incentives such as training support and return-of-service agreements can help build and retain this workforce.

Radiologist capacity and access to modern equipment must also be addressed. Expanding access will require co-ordinated planning, but with the right investments, it is achievable and will ensure that women can access the screening they need in a timely and effective way.

We support the bill's intent to increase transparency and accountability. Data collection is essential to this. To be meaningful, it must be—go beyond collecting participation rates. It must include methods of cancer detection, stage at diagnosis, and 'intra-val' cancers. Without 'intra-val' cancer data, Manitoba cannot know how many cancers are being missed after a normal mammogram result. Including ethnicity and recurrence data would further strengthen understanding of disparities and outcomes. Better data will drive better care. What we measure shapes what we improve.

It will also be important to ensure that patient perspectives are included as screening plans are developed, because lived experience helps identify gaps that are not always visible in data alone.

Bill 32 is an important and welcome step, and to meet its intent, it must include women with dense breasts, support access to supplemental screening, educate physicians, build capacity and measure outcomes that matter. The goal is fewer missed cancers, earlier detection, better outcomes. Earlier detection only works when all women can access the right screening at the right time.

Thank you.

The Chairperson: Thank you, Mrs. Borgfjord, for your presentation.

Now we'll move on to questions from the committee.

MLA Asagwara: Mrs. Borgfjord [*phonetic*], thank you so much for your presentation. Thank you so much for sharing your personal journey as part of your presentation and for your tireless advocacy in Manitoba. Your voice is heard loud and clear, and your advocacy has made and is making a real impact

and is going to continue to make a huge impact in the way that care is delivered in this province moving forward.

I want to reassure you that there is a provision in the bill for additional screening for high-risk individuals, including women with dense breasts, to be included in provincial plans going forward. There's also more work that we know is going to need to be done in the system to build more capacity and to strengthen this care moving forward.

So we intend very much to continue to work directly with you and many other advocates in the dense-breast community who've been advocating for a long time for us to take this step and go further and we will.

So thank you so much for presenting today, and looking forward to continuing to work with you and many others moving forward.

The Chairperson: Thank you, Minister Asagwara.

Mrs. Borgfjord, would you like to respond?

J. Borgfjord: I would just like to thank you for having me here today.

Thank you to Minister Asagwara. I would just like to make one suggestion, is that if—or when patient voices are included in the discussion, if it could be a formal committee or some sort of formal process to move our patient voices forward.

Mrs. Cook: Yes, thank you for your presentation and, just touching on the comment you just made, actually, I think that's a really good point.

And without reading the bill back to front once again, I don't know that there's a mechanism for advocates or patients to have input into the access plan that the cancer authority is required to develop under this legislation. Is it safe to say that you would like to see a mechanism by which you and other patient advocates would be able to provide input?

J. Borgfjord: Thank you very much. Yes, I think that would be a welcome addition for those of us with the lived experience.

MLA Asagwara: Thank you again so much. I do want to point out that there is, in fact—CancerCare Manitoba does actually have that mechanism in place, and so we can share information with you in terms of what that looks like. And given the significance of the plans that they are going to be bringing forward, there is work that they are doing to ensure that that patient perspective, which they build into the way that some

of that planning is done, is specifically addressed in this case.

* (20:00)

So we'll be happy to share more information with you as that moves forward, of course.

The Chairperson: Mrs. Borgfjord, would you like to respond?

J. Borgfjord: Yes, please. Thank you very much for that information. As—I was aware there was some patient advocacy, but any emails or letters or correspondence we've sent has gone unanswered, so I appreciate hearing that.

Thank you.

Mrs. Cook: Yes, I just wanted to thank you, Jenny [*phonetic*], for your continued advocacy within Manitoba. It does make a huge difference and thank you for everything that you do.

The Chairperson: Mrs. Borgfjord, I'm assuming—last response here.

J. Borgfjord: Thank you, everybody, for inviting me and for letting me share, and thank you honourable Chair, for doing such a wonderful job. This is my first experience and I appreciate it.

The Chairperson: Well, we hope to have you back at committee sometime. Thank you very much for taking the time to join us on Zoom today.

We'll be moving on to our next presenter, who is in the room here with us today, David Grant.

Oh, David, you may begin.

David Grant (Private Citizen): I wanted to say it was refreshing to hear the previous presenter and how much information she has. The degree of her expertise was very refreshing, and it's good that people like that get to have input here. And Ms. Cook's comment about the inputs from stakeholders and persons with interest in development plans was a very valid question, and I'm glad the minister made reference that it is in place. So that's one of our—one of the concerns is that people be listened to.

The steps in this bill are logical. It does remind me—I think there was a bill a year ago or so on this topic that private members—that didn't get very far, but it's good to see the government responding with this bill. I think there was something in a Toronto headline once of the federal government stealing the ideas of an opposition person, and the opposition person feeling complimented. But it gets the job done if they want to call it their own.

But, anyway, this is a very good idea, a very good bill. It reminds us that cancer screening is not universal. You know, there are improvements and this is certainly a topical one. As I got old, I realized that the cancer screening that I was asking for each time was no longer standard in Manitoba. And I'm not sure that these were—are the correct—politically correct words, but there are people that are not worth saving, or not worth testing, and I find that disappointing.

It was explained to me that if they did find cancer in a 70-year-old or a 75-year-old, they're too feeble to be fixed. And I think that's a myth and that's incorrect, that if the person has a bunch of co-morbidities, as they call them, if they're in their last year anyway, then maybe the colorectal testing and all that stuff might be pointless.

But for people who aren't, I would suggest that that's something that a 75-year-old being checked for prostate or colorectal or whatever is as valid as what we're doing with Bill 32. And it's not quite on topic, but that's my position, strongly in favour of Bill 32.

But it's disappointing that testing is no longer standard for old people, for cancer screening, and the idea that old people can't be fixed. A.J. Foyt, one of my motorsport heroes, is currently recovering from major abdominal surgery, and he's 90. So old people can be fixed. He's been through a lot and I don't think he lived a great life, because for the last half of his life, he's probably had 100 too many pounds and living a bad life, but—I try to avoid. But it just shows that when there's a need, intervention and saving lives is still possible for old people.

And that was my only comment, and congratulations on the bill and thank you.

The Chairperson: Thank you, David.

We'll now proceed to questions from the committee.

MLA Asagwara: Yes, thank you so much, David, for your presentation, and I really—I appreciate you sharing so directly and candidly about ageism in health care. And, you know, it's important for us to recognize that that's a very real experience that people have that is inappropriate and should never happen and we have to do better in making sure that Manitobans of all ages have access to the screening and cancer services that they need.

And your line, old people can be fixed, is going to stick with me. That's a line that's going to be with me as we move forward in doing this work. So thank you so much.

The Chairperson: Thank you, Minister Asagwara.

David, would you like to respond?

D. Grant: Sure. And thank you for your response. And we are reminded that the—not just ageism but there are, as I said earlier, that I have an incentive to live a healthy life because I don't want to be operated on at 80 or whatever, which is not very far away. So among that population of really old people who have been very careful with their lives and do have a chance of making it to 90 or 100, those people are certainly worth fixing. Everybody, if you ask them, is worth fixing.

And so the idea of screening: we are short of doctors; we are short of nurses. We're probably not short of lab techs. Like, I worked in a lab for years and the process for doing that is not a limitation. You know, it saves money to not test them. But I would say that some of these chemical-only diagnostic tests for other cancers, you know, obviously the breast cancer one involves a skilled technician and machinery. The ones where it's test tube stuff, I would hope that that could be reinstated because catching something like that early is, with the chemical to the blood tests and so on, does save money even if it's an old person.

But anyway, thank you very much for being responsive, Minister.

The Chairperson: Thank you, David.

Mrs. Cook: Thank you for your presentation, and on this the minister and I agree. I have nothing further to add to their comments and reflections on your presentation. So thank you for coming tonight.

The Chairperson: Any final comments to the questions? No?

D. Grant: Thank you to both Ms. Cook and the minister. Thank you.

The Chairperson: Thank you, David. I recommend you stay at the podium.

For those joining on YouTube, pigs are flying outside. Both sides are agreeing.

**Bill 50—The Pharmaceutical Amendment,
Regulated Health Professions Amendment and
Public Health Amendment Act**

The Chairperson: All right, so moving on to presentations to Bill 50, The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act, first on the presenter's list is David Grant.

David Grant (Private Citizen): At the outset, the idea of allowing a pharmacist to substitute medicines, last time I got a prescription for a name brand, my pharmacist said, would you like to save \$8? And probably illegal, but that was probably a good thing. So that's sort of reflecting that I approved of it then. I didn't take—I took the name brand because I think it was only two or three, but—so that part of Bill 50 seems like a good idea.

The idea that a doctor could forbid a substitute seems iffy. Like, we have to recognize that doctors are among the most heavily lobbied professionals in the world. That—when I was an engineer, nobody came up to me and said, buy Atlas Copco compressors because we want you to. But there's a lot of pressure on physicians to help out corporate benevolence.

So that's one thing that I would suggest: that if this bill is going to allow that—a doctor to forbid a substitute—I would suggest that that should only be allowed if the doctor can provide a good medical reason. In other words, if it's known that the substitute is less effective then there's a medical reason, but if it's because he got a fancy trip somewhere, I think that provision is probably a bad idea. And as I say, medical reasons given.

Joining medical—joining Manitoba's regulators is a good idea, too. Manitoba's regulators are small. We have all these professions running and we run them independently of Alberta and Ontario and so on. So regulators there tend to have 10 times as many professionals and the costs of running a regulator are much lower in a big place. So that's one thing.

* (20:10)

The cost of regulating, if you bunch a bunch of them together, the cost per member is lower and the organization can do a better job. So that's another aspect.

And then I would suggest that I remember bill 36, the first one of the minister's bills that I spoke in favour of, it was a start of improving regulation, so I think if we're going to merge regulators, there's an opportunity to have them be more effective.

And the idea, I think bill 36 dealt—it's slightly off topic, but bill 36 dealt with the problem of a regulator sweeping bad apples—the stories of bad apples under the rug, and if that isn't allowed, that was a good thing with bill 36. I would say the same is applied.

As I said then to you and Minister Wiebe, that there's a need in Manitoba to improve our regulators.

Too many complaints, too many mistakes, are hidden. They're either not fully investigated or nothing happens, and so I would say that if we're going to be taking in medical regulators and combining them—because we have quite a few—there are ways. And I would invite you to invite the people like me and people who've got other concerns to be involved in that merging because every time there's a complaint, professional complaint, there should be a report of what was done about it.

If somebody had a phone call and it said he's a nice guy, get that rid of that, that—if that was reported, it would never be allowed. And so—but that—right now, our confidentiality rules and our protection of reputation rules allow that kind of thing to happen way too often.

So that was—it's only slightly related to Bill 50, but it does say join regulators and so, as I say, the publication of complaint reports, there shall be a—the bills can say there shall be a report and it shall be published and you can redact the names out, protect the innocent, but at least make a whole lot more transparency.

And, anyway, that's stuff I said to you before, Minister, and I would hope that, as we join these things together, you will invite interested parties to make them way better.

So thank you.

The Chairperson: Thank you again, David.

Moving on to questions from the committee, we'll start with Minister Asagwara.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Thank you, David, again for your presentation and for your very apt observations and for highlighting areas of opportunity where we can, you know, find efficiencies, reduce duplication and just overall improve the way that these bodies function.

You touched on a few different things here, and I've made a couple of notes, so I just—I want to thank you for bringing your points forward, and you've given us some items to reflect on, and I appreciate that.

The Chairperson: Thank you, Minister Asagwara.

David, would you like to respond?

D. Grant: No. Thank you, and look forward to seeing further improvements.

Mrs. Kathleen Cook (Roblin): Hi again. I don't have a question per se, but thank you again for making time to come out here tonight and present. I think it's really important that members of the public have their voice heard. Manitoba's one of the last provinces to make it possible for members of the public to come and present on every bill that comes before the Legislature. So thank you for your input.

The Chairperson: Thank you, Mrs. Cook.

David, any final remarks?

D. Grant: Thank you, Mrs. Cook.

The Chairperson: Thank you, David.

We'll move on to our next presenter, who I believe will be joining us on Zoom.

I'll call upon Dr. Nichelle Desilets of Doctors Manitoba.

Dr. Desilets, you may begin when you're ready.

Nichelle Desilets (Doctors Manitoba): Thank you again to the committee for the opportunity to appear today on Bill 50. My name's Dr. Nichelle Desilets. I'm currently the board chair and past president of Doctors Manitoba.

I will focus my remarks on the proposed amendments to The Pharmaceutical Act, specifically the introduction of therapeutic substitutions by pharmacists.

I'd like to begin clearly: Physicians are supportive of therapeutic substitution, in principle. Pharmacists are highly trained medication experts. They are often the most current on drug supply disruptions, pricing dynamics and formulary alternatives. Enabling them to substitute therapeutically equivalent medications, particularly in the context of drug shortages or cost savings, has the potential to improve patient care, reduce delays and generate meaningful savings for both patients and the health-care system. In practical terms, this matters. When a prescribed medication is not available or when a clinically equivalent alternative is significantly more affordable, the ability for a pharmacist to act promptly without waiting for back-and-forth authorization can prevent treatment interruptions and improve medication adherence for our patients.

We also appreciate that the bill enables substitution of therapeutic equivalents, not just generic drugs, which are identical to the brand name prescribed medication. That reflects the reality of modern pharmacotherapy. Many physicians would welcome support in navigating equivalencies. For example,

knowing the appropriate dosing conversion between medications like Losartan and Telmisartan is not always straightforward in a busy clinical setting. So, to be clear, this is a modernization that makes sense.

However, our support for this bill comes with two important concerns that we believe are essential to address for this policy to succeed. The first is placement of guardrails and assessing motivation for substitution. The bill currently proposes to allow a pharmacist to substitute whenever they determine that two 'trugs' have the same or a similar therapeutic effect. It also appropriately allows patients or prescribers to opt out of this. But beyond that, there is limited clarity on when substitutions are appropriate.

From a clinical and public trust perspective, this is a gap. Therapeutic substitutions should be grounded in clear patient-centred rationale, such as due to a drug shortage, improving affordability for the patient or the payer, and enhancing clinical appropriateness based on patient-specific factors. Those are strong defensible reasons.

But what is not addressed explicitly in the legislation is the risk of substitutions being influenced, either directly or indirectly, by financial incentives within retail pharmacy environments. Our concern comes not only from what we've heard from physicians across the province, but also what we've heard from our patients. Doctors generally understand and support the concept of substitutions, but we were surprised to find during our consultations with the public that they were very suspicious, fearing the drive for pharmacy profits would undermine the treatment decisions that they had made with their physician.

It turns out that these fears are not without some merit. Pharmacists are regulated professionals bound by codes of ethics, just as physicians are. But it is also true that many pharmacists practise in a for-profit retail setting, many of which are operated by large national chains. There have been well-documented concerns in other jurisdictions, including investigations in Ontario, about corporate pressure tied to revenues or sales targets and product selection.

A 2024 report from the Ontario College of Pharmacists into the prevalence and impact of corporate influence on pharmacists found a staggering 85 per cent of surveyed pharmacy professionals reporting experiencing pressure to meet targets, quotas, or to work under constrained time frames, contributing to high levels of distress and duress. Workplace pressures were most commonly reported

in large corporate chains, such as Shoppers Drug Mart, Loblaws, Rexall, Costco, Walmart and Sobeys.

Physicians operate under a strict conflict of interest standard set by the College of Physicians and Surgeons of Manitoba, which explicitly prohibits financial gain influencing prescribing decisions. Pharmacists are similarly guided by the College of Pharmacists of Manitoba, whose code emphasizes patient welfare and the avoidance of conflict of interest.

We do not want to see public trust in our pharmacy colleagues eroded by the scope of practice expansion, nor do we want to see pharmacists put in ethically challenging and morally distressing situations as their colleagues in Ontario have found themselves. So we suggest that the government's legislation enabling substitution should be explicit in prohibiting those driven by profit.

The act or any accompanying regulation or guidance should clearly define acceptable reasons for therapeutic substitution and explicitly prohibit substitutions motivated by financial gain to the pharmacist or pharmacy owner. This is not about questioning pharmacists' professional integrity; it is about protecting it. It is also about protecting public trust and confidence in our health-care system, and that means that treatment decisions are based on patient interests and not corporate profits.

* (20:20)

The next concern I'd like to raise is closing the loop in communication between providers. This concern is operational, but it's just as critical. Today, when a pharmacist wants to make a therapeutic substitution, they must contact the prescriber, often by fax, to obtain authorization. This is inefficient. It contributes to administrative burden. It delays care. Removing that step when appropriate is a sensible improvement.

But the bill goes further. It does not require the pharmacist to notify the prescribing physician when or after a substitution is made. This creates a new risk.

As physicians, we remain responsible for managing the patient's overall care, including medication interactions, side effects and treatment effectiveness. To do that safely, we must have an accurate and current medication record. If substitutions occur without timely notification, we risk medication discrepancies, confusion during follow-up care, increased risk of adverse drug reactions and duplication of therapy or unintended changes. In other words,

what we may reduce in communication on the front end may only recreate it less reliably on the back end. This is particularly concerning in Manitoba's current health-care environment where digital interoperability remains limited.

So the question is not whether communication should occur; it must. The question is how to do it efficiently. We do not want to replace fax requests on the front end with fax notifications on the back end. Instead, we recommend that the minister ensure collaboration between the College of Pharmacists of Manitoba and the College of Physicians and Surgeons of Manitoba to establish a standardized, streamlined notification process. This may require support from Manitoba Health and Shared Health to develop digital solutions that automatically update medication records, provide timely structured notifications, integrate into—and integrate into existing clinical workflows.

If we get this right, therapeutic substitution can reduce burden and improve patient care. If we get it wrong, it could introduce new risks and inefficiencies.

In closing, Bill 50 is a good policy direction. It leverages the expertise of pharmacists. It improves system responsiveness. It has the potential to save money and improve patient outcomes. But for it to succeed, it must be anchored in two things: first, clear patient-centered guardrails, and second, reliable, modern communication between providers. If those elements are addressed, physicians will be strong partners in making therapeutic substitution work for Manitobans.

Thank you.

The Chairperson: Thank you, Dr. Desilets.

We'll now proceed to questions from the committee.

MLA Asagwara: Thank you so much, Dr. Desilets, for your very, very thoughtful presentation, informed—obviously expert—presentation to committee on Bill 50 tonight.

You've raised some really important questions and concerns, and I want to thank you for doing that on behalf of physicians and Doctors Manitoba and we look forward to working with you folks as we move forward to make sure that this bill is as strong as it can possibly be and really in making sure that Manitobans have access to the primary care that they deserve across the province.

Thank you.

The Chairperson: Thank you, Minister.

Dr. Desilets, would you like to respond?

N. Desilets: Thank you, honourable Chair and Minister Asagwara.

I just want to echo that we are prepared to work together to make sure that all health-care delivery, primary care and otherwise is the best it can be for Manitobans.

Thank you.

The Chairperson: Thank you, Dr. Desilets.

Mrs. Cook: Thanks again, Dr. Desilets, for your presentation. I think you've raised a couple of really important points for the government's consideration. And thank you for everything that you do, both as a physician in Manitoba and as an advocate for other physicians in the province.

The Chairperson: Dr. Desilets, would you like to respond?

N. Desilets: Thank you, honourable Chair and MLA Cook. Thanks for those comments.

The Chairperson: Thank you for joining us, Dr. Desilets. Have a great rest of your night.

Moving down the list here we have Mr. George Fraser, who joins us here in person.

Mr. Fraser, when you're ready to go, feel free to start. Mr. Fraser, would you like to begin?

George Fraser (Private Citizen): Yes. Okay, most honourable Chair.

I'm going to shake things up a little bit here. I'm speaking only to part 2, The Regulated Health Professions Act, and the main premise, amalgamation.

I think this is misplaced. I think it should be drawn outside of what Dr. Desilets was speaking about. I don't know. Internally, I would not personally have handled it in this way. It's a very important consideration, no question.

I circulated to you what has happened in British Columbia, and that document I just handed out is dated 2024 June. And there are—the two leading provinces in Canada with respect to regulated health professions are Ontario, which Manitoba copied in its original text for the act, and British Columbia. There are other RHPAs. Alberta's got one. There's one in the Northwest Territories, and there's one in Atlantic Canada. But those two are the main reference points.

So you can see in the document that I've handed out that they've gone to very—if I could use that pharmaceutical word—generic regulatory bodies.

Now, enforced amalgamation in our province—we've had lots of problems in municipalities, in education. And I—Minister, I'm putting you somewhat on the spot. I can't find the consultation behind this. Now, it's needed for—from a discussion perspective, because the cost of running regulatory bodies is advancing rapidly, driven by complaints and discipline, the legal side of this whole process. So it's legitimate.

Now, who pays for the regulatory structure—millions of dollars? It's the health practitioners that do. It's not on your budgets here, although there's some liaison and reference from that perspective. Every practitioner and every body—regulatory body pays. They pay extra fees for the operation. And if there's a heavy call on—as there has been, on complaints and discipline for whatever reasons—and we're into that mode here in Manitoba too—then yes, you should look at amalgamations. Because it should be clear to the legislators here, this document gives another very specific power to the minister, as it should. The rest of the act does that as it moves along.

So a very responsible position. And there—I'm standing here saying I don't know if there's been any requests for amalgamation. Perhaps there has been.

But I know that it'll be difficult for some—as you can see in the BC structure on here, just as a quick reference, it'll be difficult for many patients, clients, to understand where did that massage therapy group go. Well, they're in the College of Complementary Health Professionals of BC. What does that mean? Who are they?

So you would have a tremendous transition that you would have to make at this moment. And I mentioned the word transition. Manitoba has not completed the transition to RHPA status for all of its regulatory health organizations. Minister, I'll put you on the spot again, you probably know where that stands. Halfway, maybe? The major nurses and doctors have been taken care of, but groups like massage therapists, who I've represented before, have not.

* (20:30)

So is this the best time? Don't—I would suggest don't lose the idea and, perhaps, that this—there can be consensus here to move that section out and for reconsideration and not hold up the rest of Bill 50, which is important, as Dr. Desilets spoke to this matter.

And not only is it important to them, but to the pharmacists of the province too.

So it's an example of the complex nature of regulation within health care—the health-care world. So I would—again, I would just—I think that would be a wise thing to do at this point in time and allow some response, and I think you'll get a mature response from the—from all health professions that I've been familiar with dealing with when they—they'll give you the reality of what's on the ground.

And then, of course, there's the difficulty that the minister needs the capacity, if the requirement is there from a financial perspective, to indeed make a decision. Do you—do we go to this model or do we stay where we are? Because we had—we've had opportunities, as long as government has changed, for parties. The last time was—do you continue with the RHPA model or not? Here's a new amalgamated model which was—had controversy attached to it in British Columbia, but now we're beyond two years of use within their environment.

I don't know exactly what's happened. The minister may know more about that than I certainly do, but I think it's in a very preliminary stage and may not be in its final form.

That's all I have to say.

The Chairperson: Thank you, Mr. Fraser.

Before we proceed to questions from the committee, I would just like to provide a kind reminder to direct remarks through the Chair, so avoiding the use of you or things like that.

So moving on to questions. *[interjection]* You're good.

MLA Asagwara: I do apologize. I was actually sort of engaging with Mr. Fraser as he was delivering his presentation, which was a very strong and important presentation. I can say that we have consulted with regulatory bodies, and I can say here that there have been requests made to us from smaller regulate—regulators that would like to amalgamate to have better efficiencies and, quite frankly, more capacity to function to the best of their ability.

And so I don't disagree with you, actually. I, myself—really, I was hopeful that this would be a stand-alone piece of legislation. The decision was made to build it in with a few others for efficiency in terms of bringing forward legislation in this session and, you know, it pairs very well with what we brought it forward with.

But, ultimately, you're correct. There's a lot of work that's going to go into this process moving forward. We have the benefits of learning from jurisdictions like British Columbia.

Much smaller jurisdiction here in Manitoba, and so we should be able to do this in a way that not only learns from, sort of, what they have been able to do and maybe some of their missteps or things they would have done differently, but to do it in a way that people can be pretty pleased with long term.

The Chairperson: Thank you, Minister Asagwara.

I, unfortunately, let you go a little bit longer than anticipated, so I will allow the opposition, as well, to do the same.

Though, Mr. Fraser, would you like to respond?

G. Fraser: Yes. I know there's been some sharing of things like space and probably some administration, but again, the BC model, if that's where the government is going in this respect, it brings on a whole new concept. I mean, you've got neutral administrators and it's a much broader concept of amalgamation than perhaps you're saying to me and I'm imagining, you know. So, again, I think we need to pause and talk it through.

The Chairperson: Thank you, Mr. Fraser.

Mrs. Cook: Thank you, Mr. Fraser, for your presentation. I can't speak to the impetus behind the bill. I did ask some of those same questions during second reading on the bill in the Chamber, and you're correct that not all of the regulated professions have been moved under The Regulated Health Professions Act, and that is a massive undertaking.

I think you've raised a couple of good flags here. Thank you for that, and thank you for your presentation and your advocacy.

The Chairperson: Mr. Fraser, final response?

G. Fraser: Thank you.

The Chairperson: Thank you again, Mr. Fraser. I hope you have a great night. Thank you for joining us.

**Bill 26—The Health System Governance and
Accountability Amendment Act (Eliminating
Mandatory Overtime for Nurses)**
(Continued)

The Chairperson: Now for our last two presentations, they were two presentations that were dropped to the bottom of the list.

So the first is on Bill 26, The Health System Governance and Accountability Amendment Act, and for that, I call upon David Grant to present.

David, you may begin.

David Grant (Private Citizen): First, I want to thank the previous presenter. He raised a couple of good points. And the cost of regulation, I think, is where the minister was considering.

The cost of regulation in Manitoba can be monstrous. A thing not much more than a typo has cost both sides and a regulator I know more than \$1 million, and it's all in lawyer fees. So that's something if a small regulator wants to save money, they could either amalgamate or just cut back on the lawyer time.

Anyway, moving on to this Bill 26. Back in the '90s, my partner was an ICU nurse in Toronto. She liked me and she moved to Toronto, and that helped Manitoba Health a little bit because you had an experienced ICU nurse. But she did notice that the culture here was a bit different—this is in the '90s—than in Toronto. And she was used to her system and not used to quite so much last-minute calling in, unable to work. That seemed to bother her even though it wasn't—it affected her a little bit because she got forced to stay over and stuff.

But—so the idea of eliminating overtime moves in the other direction. If we had some magic thing that had our people try really hard to be in good shape for six in the morning so they didn't have to call in, everybody's lives would be better. But we have this system, and in the '90s she noticed that huge cultural difference because none of the ICU nurses in her hospital ever did that. They would call in the night before if there was a problem. But that certainly messes with things, and current contracts really don't enable the health authorities to make that any better.

So, again, we're back to health—hard ratios and so on. Overtime, I would think, was a solution to that. Overtime ends up harming quality of life, and that affects somebody's decision to retire or not retire. So, theoretically, if you didn't force overtime on people, maybe they'd retire a bit later. But it seems counter-indicated. That's my thought on that one, on the overtime aspect.

Because we have to keep the ratios up, we have to keep more nurses on the job. Having them work overtime versus scheduling is—calls back to when I first became a worker. I noticed that a lot of the people I worked with would call in sick as a way of

getting a day off, and it struck me that the cost to the company of a scheduled day off, a vacation day or a requested day off, is much lower than an overtime day. And yet the people I was working with, City of Windsor, Ontario, routinely did that and contracts are written to support that sort of thing. You have a certain number of days.

And, again, we're not in the business of writing new contracts, but if we had a contract as far as overtime is concerned, that (a) you have this many days off in the year according to the contract, and you can use them up two at a time by calling in sick, as you're supposed to be into work or not showing up, or you can use them one at a time with a scheduled day off, which reflects the cost to the employer.

So that was an idea I had formed 50-something years ago, and I've never seen it done. But if a contract did spell it out like that, we could be generous. And in cases of nurses' contracts, you could be generous in giving in that contract a whole lot more days off in the year by combining sick and vacation, and the people might enjoy it more.

* (20:40)

And certainly be easier on everybody, on the person who wanted to go home and sleep, and now they can't because they're forced into overtime. So I can support it from that point of view, but I think there is another solution and I'm not sure it would ever work, but it—that what's what I would hope for.

So thank you.

The Chairperson: Thank you again, David.

Moving on to questions from the committee.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Yes, no question here. Just thank you, David, for taking the time and for sharing some really interesting personal examples in terms of the differences in culture in health care, you know, in Ontario versus here. I've heard a lot about that. We actually had a meeting earlier today where we heard a little bit about that from a nurse who's worked in Chicago versus Manitoba, in acute settings. So it still resonates to this day, in terms of those differences and highlights for us what we need to do differently.

So thank you for your comments and for being here and speaking on this.

The Chairperson: Thank you, Minister.

David would you like to respond?

D. Grant: No, thank you, Minister.

The Chairperson: Further questions?

Mrs. Kathleen Cook (Roblin): I don't have a question. You were very clear, but thank you for your presentation.

The Chairperson: Thank you, David. You might want to stay up at the podium.

Bill 27—The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act
(Continued)

The Chairperson: Moving on to—with the list of presenters we dropped to the bottom of the list for Bill 27, The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act.

And I call upon David Grant. You may begin.

David Grant (Private Citizen): Again, my apologies for being in the other room, but this tends to happen. I used to run back and forth and miss everything, and this time I decided to say hi here and then run over there and stay there. And they finished up earlier.

So setting standards for care seems like a good idea, and I think as consumers—and certainly we would like to know that there's a standard, I think the media who might be picking on health care in general probably like that idea. Anyway, the—I was reminded of—my dad moved to the States, he still stayed Canadian, and he had a health plan down there that cost him less than my share of federal taxes to support at the time, and he was badly injured. And I remember I was there at his bedside in Washington state. And his doctor looked at—you know—his condition and stuff and said: I think I want an MRI.

And so I went with him in a transport vehicle to the clinic and came back and the guy was still seeing his next patient. And that's a different phenomenon than I was used to decades ago. But that is, if we're setting standards, if we could have the health-care system we'd love, it would involve stuff like that, where the doctor is concerned about something and you don't have to wait months. And that's because there were enough. And that may be a consequence of not everybody is crowding that MRI, because they can't afford it.

But he had paid his \$10,000 or \$15,000 a year for his health plan, and it gave him that benefit. So it's something that—that's more a Canada Health Act,

Ottawa issue, but it did bring in that if we have standards, they're obviously not going to be US health-care system, you know, prepaid system standards. So it does call that into question, that standards and trying to meet them and improve things is obviously our goal, but they're still not likely to be what we would like.

And I won't say anything about wait times or anything because that's been an issue for—since the '90s in elections, but certainly I'd be in support of that. The idea that people would be shielded from consequences of decisions they make or mistakes they make, that's another issue.

And anytime somebody who could prevent harm should be doing it when they don't, whether it's because, oops, or they were busy or whatever, they should at least get a letter of, you could have done this, or that's your second strike, or whatever it is.

But the idea of consequences for harming the health system or helping—harming a patient is a bad idea. And shielding professionals, I think, is immoral. The fact that drug companies are shielded in the US from any kind of side-effect lawsuit is an interesting win for them on that year that they lobbied somebody, but it's bad for us patients.

And so I think the idea that this bill offers shielding for mistakes or incompetence is always a bad idea.

So—just my comments on it, and thank you. That's it.

The Chairperson: All right, thank you again, David.

On to questions from the committee.

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): Thank you, David, for again—for taking the time and staying and managing two different committees and contributing to both. Your comments are, as always, very thoughtful.

And I hear your concern around, you know, accountabilities for health-care workers. You know, our focus is on making sure that the system is accountable to patients, that health-care workers—being a health-care worker myself—that we are accountable to patients. So I want you to know that I hear you on that point, and there's more work for us to do in that space for sure.

The Chairperson: Thank you, Minister.

David, would you like to respond?

D. Grant: No, I—that's—we—the fact that shielding is in there is something I don't like in general, but there may have been a good reason, and the same with the forced overtime. There's a good reason because it covers that—those patients who are already in there.

So thank you, Minister.

The Chairperson: Thank you, David.

Further questions?

No further questions from the committee. Thank you for your time today, David.

And that concludes the list of presenters that I have before me, so to our long list of public presenters, once again, thank you for making your voice heard.

* * *

The Chairperson: In what order does the committee wish to proceed with the clause-by-clause consideration of these bills?

An Honourable Member: Numerical?

The Chairperson: It's been suggested by the committee—*[interjection]*

Minister Asagwara.

MLA Asagwara: Numerical?

The Chairperson: Minister Asagwara has recommended that we proceed in numerical order.

What is the will of the committee? *[Agreed]*

Bill 26—The Health System Governance and Accountability Amendment Act (Eliminating Mandatory Overtime for Nurses)
(Continued)

The Chairperson: All right, we will now proceed with the numerical clause-by-clause of Bill 26.

Does the minister responsible for Bill 26 have an opening statement?

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): No.

The Chairperson: Hearing a no from Minister Asagwara—we thank the minister.

Does the critic for the official opposition have an opening statement?

Mrs. Kathleen Cook (Roblin): I do not.

The Chairperson: Hearing a no, we thank the member.

During the consideration of a bill, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Also, if there is an agreement from the committee, the Chair will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose.

Is that agreed? *[Agreed]*

Clauses 1 through 3—pass; clauses 4 through 7—pass; clauses 8 through 10—pass; clause 11—pass; clauses 12 and 13—pass; clause 14—pass; enacting clause—pass; title—pass. Bill be reported.

Bill 27—The Declaration of Principles for Patient Health Care Act and Amendments to The Health System Governance and Accountability Act

(Continued)

The Chairperson: Does the minister responsible for Bill 27 have an opening statement?

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): No.

The Chairperson: Hearing no, we thank the minister.

And does the critic from the official opposition have an opening statement?

Hearing no, thank you to the member.

During the consideration of a bill, the preamble, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Also, if there is agreement from the committee, the Chair will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose.

Is that agreed? *[Agreed]*

* (20:50)

Clauses 1 through 3—pass; schedule A, clause 1—pass; schedule A, clauses 2 and 3—pass; schedule A, clause 4—pass; schedule A, clauses 5 through 7—pass; preamble to schedule A—pass; schedule B, clauses 1 and 2—pass; schedule B, clause 3—pass; enacting clause—pass; title—pass. Bill be reported.

Bill 28—The Health System Governance and Accountability Amendment Act (Nurse-to-Patient Ratios)

(Continued)

The Chairperson: Does the minister responsible for Bill 28 have an opening statement?

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): No.

The Chairperson: Hearing no, does the critic from the official opposition have an opening statement?

Mrs. Kathleen Cook (Roblin): I do not.

The Chairperson: Hearing no, thank you to both members.

During consideration of a bill, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Also, if there is agreement from the committee, the Chair will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members have comments, questions or amendments to propose.

Is that agreed? *[Agreed]*

Clauses 1 and 2—pass; clauses 3 through 5—pass; clause 6—pass; clause 7—pass; clause 8—pass; clause 9—pass; clause 10—pass; enacting clause—pass; title—pass. Bill be reported.

Bill 32—The Improving Access to Breast Cancer Screening Act

(Continued)

The Chairperson: Does the minister responsible for Bill 32 have an opening statement?

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): No.

The Chairperson: Hearing no, does the critic from the official opposition have an opening statement?

Hearing no, thank you to both members.

During the consideration of a bill, the preamble, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Also, if there is agreement from the committee, the Chair will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members may have concerns—or, comments, questions or amendments to propose.

Is that agreed? [*Agreed*]

All right. Clauses 1 and 2—pass; clauses 3 and 4—pass; clauses 5 through 7—pass; clauses 8 and 9—pass; preamble—pass; enacting clause—pass; title—pass. Bill be reported.

**Bill 50—The Pharmaceutical Amendment,
Regulated Health Professions Amendment and
Public Health Amendment Act**
(*Continued*)

The Chairperson: Does the minister responsible for Bill 50 have an opening statement?

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): No.

The Chairperson: Hearing no, does the critic from the official opposition have an opening statement?

Mrs. Kathleen Cook (Roblin): No.

The Chairperson: Hearing no, thank you to both members.

Again, during the consideration of a bill, the enacting clause and the title are postponed until all other clauses have been considered in their proper order.

Also, if there is agreement from the committee, the Chair will call clauses in blocks that conform to pages, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose.

Is that agreed? [*Agreed*]

Clauses 1 through 3—pass; clause 4—pass; clauses 5 through 9—pass; clause 10—pass; clause 11—pass; clauses 12 and 13—pass; clauses 14 through 19—pass; clauses 20 through 22—pass; clause 23—pass; enacting clause—pass; title—pass. Bill be reported.

The hour being 8:56, what is the will of the committee?

An Honourable Member: Committee rise.

The Chairperson: Committee rise.

COMMITTEE ROSE AT: 8:56 p.m.

WRITTEN SUBMISSIONS

Re: Bill 26

• The provincial objective and priority that health services be provided in a manner that does not require nurses to work mandatory overtime is applauded. Together with the implementation of nurse-to-patient

ratios, these two pieces of proposed legislation present opportunities to positively impact health and well-being of nurses, the recruitment and retention of the nursing workforce in Manitoba and the protection of patient safety.

• While we support the policy goals of the proposed legislation, we have noted some areas that may benefit from clarification. Specifically, we have observed that the language used in section 3(1.3)(a) of Bill 26, regarding when mandatory overtime is still allowed, is quite broad. The clause states that mandatory overtime may be required "in a present or imminent situation or condition that requires prompt action to avoid or limit loss of life or harm to an individual's health." This wording appears to include any situation where prompt action is needed to reduce any negative impact to a person's health, regardless of severity. While we do not oppose this broad exception, a nurse's interpretation that a client was not at risk of harm may differ from that of the client/family, the employer, the regulator, and the government.

• As an example, consider that a nurse could be mandated to work overtime if there is a present (not imminent) condition that requires prompt action to limit (not necessarily avoid) harm to an individual's health (not necessarily loss of life). This scenario could arise in an understaffed unit, due to vacations and sick calls, requiring a certain number of nurses to ensure clients with complex needs are appropriately cared for in order to limit harm caused by delayed medications or treatments. Nurses, employers, and the regulator may all interpret the applicability of 3(1.3)(a) differently.

• Bill 26 will amend both The Regulated Health Professions Act and The Licensed Practical Nurses Act to state that a refusal to work mandatory overtime is not a breach of the duty to provide care, and is not professional misconduct, if the mandatory overtime was not permitted by 3(1.3). This change is understandable; however, the broad terms of 3(1.3) may jeopardize fair and objective processes for both nurses and complainants should complaints to the regulator boil down to contrary interpretations of whether mandatory overtime was permissible. Without more explicit guidance on how 3(1.3) is to be interpreted and applied, informed and fair decision making could be at risk.

Manitoba's three nursing regulators have developed shared guidance for nurses on the duty to provide care, which advises nurses how to meet their professional responsibilities when working with limited human

resources. Should Bill 26 become law, we will update our Duty to Provide Care Guidance Document to clarify for our registrants the circumstances in which the duty to provide care continues to apply. The best way for regulators to amend such documents is to have a clear understanding on how best to interpret section 3(1.3). For this reason, we suggest that Government consider providing increased clarity around the criteria that constitutes permissible mandatory overtime.

Submitted on behalf of:

Deb Elias, CEO/Registrar, College of Registered Nurses of Manitoba

Laura Panteluk, Registrar/CEO, College of Registered Psychiatric Nurses of Manitoba

Jennifer Breton, Executive Director, College of Licensed Practical Nurses of Manitoba

Re: Bill 27

We commend the Government for publicly articulating the principles that will guide health system decision-making in the interests of Manitobans. There is considerable alignment between the expectations set out in subsection 3(1) of Bill 27 and the expectations already established through professional standards of practice and codes of ethics governing regulated health care professionals. Any opportunity to reinforce these shared expectations, and the foundational principles of high-quality care, is welcomed.

- We respectfully recommend that amendments to the Bill be considered to reduce ambiguity and mitigate the potential for confusion, which may otherwise negatively impact health care providers and the clients they serve.

- There appears to be no mention that clients of regulated health care professionals are entitled to receive care that meets the professional standards, codes of ethics and practice directions of the respective professions. This omission may result in a missed opportunity to affirm well-established expectations that already guide safe, ethical, and competent care across Manitoba's regulated health professions. We recommend an addition in 3(1) to advise clients that, when receiving care from a regulated health care professional, they can expect care that meets the professional standards, code of ethics, and practice directions of that profession. The poster could include contact information for the applicable regulatory bodies.

- Some of the expectations, which are to be published or posted by health care professionals, pursuant to 3(4), appear to be expectations that are best addressed at a system level, within the publicly funded/publicly operated system. We are referring specifically to the expectations respecting community access (individuals will receive access to care to the extent reasonably possible in or close to their community) and timely access. While both are important goals for publicly funded health care services, it is unclear whether the Government intends for these expectations to apply to non-insured services and to providers practising wholly outside the publicly funded health care system, including those who provide elective interventions. We note that the Whereas clauses make mention of The Canada Health Act. However, we do not see language in the body of the Bill that limits the application of the principles and expectations to publicly funded and publicly operated health care services.

Government may wish to consider:

- moving the expectations regarding community access and timely care to section 2, guiding principles for making decisions about the health system and/or
- amending the Bill to more explicitly identify that the declared principles are applicable to services provided pursuant to The Canada Health Act.

- The requirement to post the expectations in 3(4) does not appear to recognize that many health care professionals provide care only within clients' homes. Government may wish to consider amending the Bill to clarify how health care professionals or health services delivery organizations are to communicate the expectations in environments where the expectations cannot be posted. As examples, consider:

- home care nurses,

- nurses who deliver nursing foot care services in clients' homes, and

- nurses who deliver private duty nursing services in clients' homes.

- We fully support efforts to provide for respectful and dignified work environments for nurses. We also support the engagement of clients in their care planning. At the same time, there is a potential for unintended consequences if a nurse was to misunderstand the effect of the Bill, and how the patient expectations in 3(2) interact with the nurse's professional standards including their duty to provide care. Our principal concern is that a nurse might misinterpret that the legislation provides them with

authority to disengage from providing assigned care to a client who has not fully met the patient expectations set out in 3(2). Client behaviour may be impacted by the nature of their health condition (e.g., dementia, substance use, or a mental health condition). If the effect of the Bill were misunderstood, there could be adverse outcomes for some of Manitoba's most vulnerable populations. We recommend that Government consider amending the Bill to clarify that 3(2) does not absolve professionals of meeting their professional obligations under legislation, professional standards, codes of ethics, and practice directions.

Thank you for the opportunity to share our comments.

Submitted on behalf of:

Deb Elias, CEO/Registrar, College of Registered Nurses of Manitoba

Laura Panteluk, Registrar/CEO, College of Registered Psychiatric Nurses of Manitoba

Jennifer Breton, Executive Director, College of Licensed Practical Nurses of Manitoba

Re: Bill 28

The Long-Term & Continuing Care Association of Manitoba recognizes the intent of Bill 28, The Health System Governance and Accountability Amendment Act, and the government's commitment to strengthening accountability and staffing across the health system. We support this direction. However, we must be clear: without deliberate inclusion of long-term care in both the development and implementation of this legislation, there is a significant risk that it will not achieve its intended outcomes for one of the most complex and vulnerable sectors.

Bill 28 establishes a framework for nurse-to-patient ratios through regulation. The success of this framework will depend entirely on how it is implemented. As it stands, the legislation does not distinguish between acute care and long-term care environments. This is a critical gap.

Long-term care must have a defined and ongoing role in shaping the regulations and staffing models that will follow. Without this, there is a real risk that hospital-based models will be applied to personal care homes. This approach will not work. The care environment, resident population, and scope of practice in long-term care are fundamentally different and require a distinct approach.

We are also calling for meaningful transparency. Reporting overall staffing averages is not sufficient and does not reflect the realities within homes. Public reporting must include staffing levels by shift and by skill mix. Anything less will fail to provide an accurate picture of care delivery and will limit accountability.

Workforce capacity remains the single greatest pressure facing the sector. Mandating staffing levels without addressing recruitment and retention will create expectations that cannot be met. This is particularly urgent in rural and northern Manitoba, where workforce challenges are most severe. Targeted and sustained investment is required. Without it, this legislation risks setting standards that the system does not currently have the capacity to achieve.

It is also essential to recognize the full scope of nursing practice in long-term care. Nurses in personal care homes provide clinical oversight, coordinate interdisciplinary care, manage medications and infection prevention, and support residents and families. During evenings, nights, and weekends, they are often the most senior person on site, responsible not only for clinical care but for the overall operation of the home, including emergency response and staff support. These responsibilities are not reflected in traditional ratio models.

For these reasons, a one-size-fits-all approach to nurse staffing will not support safe or effective care in long-term care settings. Staffing frameworks must be flexible and grounded in the realities of the sector.

Equally important is the need to maintain a clear focus on person-directed living. Personal care homes are not hospitals. They are the homes of residents. Any staffing or accountability framework must support quality of life, dignity, and individualized care, not undermine it through overly rigid or inappropriate models.

In closing, we support the intent of Bill 28. However, intent alone is not sufficient. The impact of this legislation will be determined through its regulations and implementation. We are requesting the following actions:

- Formal inclusion of long-term care representation in the development of all regulations under this Act.
- A defined consultation process with the sector prior to finalizing any nurse staffing ratios or related requirements.

- Explicit consideration of long-term care in the design of staffing models, distinct from acute care frameworks.
- Implementation of mandatory public reporting that reflects staffing by shift and skill mix.
- A clear workforce strategy, including targeted recruitment and retention investments, aligned with any mandated staffing requirements.

We are asking that these elements be confirmed prior to the finalization of regulations. Without these measures in place, there is a high likelihood that the legislation will not be workable in long-term care settings. We are ready to engage immediately and work in partnership with government to ensure that the implementation of this Act is practical, achievable, and supports safe, high-quality, person-directed care for residents.

Sue Vovchuk
Long Term and Continuing Care Association of
Manitoba

Re: Bill 28

We support the objectives of Bill 28, particularly its intent to establish clear minimum staffing standards and to enhance accountability within the health care delivery system. Establishing nurse to patient ratios through legislation represents a significant policy intervention, and we acknowledge the government's commitment to improving conditions for both patients and nurses. At the same time, we wish to highlight a few regulatory considerations that may merit careful attention as this Bill advances and is implemented.

- We understand from our review of Bill 28 that ratios will first be developed to support service planning and then will be implemented as targets. From the public's perspective, there is a risk that legislated nurse to patient ratios will be interpreted as a guarantee of service levels. If the health system cannot meet the targets (for example, during periods of system strain), nurses may face increased conflict with patients and families and heightened scrutiny, despite having limited influence over staffing decisions. This could undermine the nurse–client therapeutic relationship and negatively affect nurses' morale and job satisfaction. To avoid misunderstandings, we recommend clear public messaging and education to accompany the passage and implementation of Bill 28.

- We also encourage the Government to continue engaging with nursing regulators as implementation proceeds, particularly in relation to public communication, clarity of accountability, and fair processes for both nurses and patients. Alignment between legislative intent, regulatory frameworks, and operational realities will help ensure that the objectives of Bill 28 are met without unintended consequences for the nursing workforce or the public they serve.

Thank you for the opportunity to submit our comments.

Submitted on behalf of:

Deb Elias, CEO/Registrar, College of Registered Nurses of Manitoba
Laura Panteluk, Registrar/CEO, College of Registered Psychiatric Nurses of Manitoba
Jennifer Breton, Executive Director, College of Licensed Practical Nurses of Manitoba

Re: Bill 50

Dear Members of the Standing Committee on Social and Economic Development,

On behalf of the College of Registered Nurses of Manitoba and the College of Registered Psychiatric Nurses of Manitoba, we respectfully submit the following comments on Bill 50 – The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act for the Committee's consideration. Our comments focus on the provisions of the proposed bill that would amend The Regulated Health Professions Act (RHPA).

We recognize that, in certain circumstances, amalgamations may serve the public interest by improving efficiency and addressing regulatory gaps. An amalgamated college may be in the public interest where:

1. The regulators support and request amalgamation; and
2. Analysis demonstrates that amalgamation would improve the efficiency and effectiveness of regulatory operations

In our view, these conditions must be met before concluding that an amalgamation would benefit the public.

Amalgamations are inherently disruptive and require careful advance analysis. When imposed on unwilling parties or pursued without such analysis, amalgamations may instead create dysfunction and inefficiency and may not serve the public interest.

We are concerned that the Bill's amalgamation provisions would allow the Minister to initiate amalgamations where these conditions have not been met. In addition, in its current form, the Bill would permit the Minister to issue an amalgamation order on the Minister's own initiative, without requiring consultation or prior study on colleges which are not seeking amalgamation. This could create tensions and dysfunction and undermine effective regulation, contrary to the public interest.

We are also concerned that the Bill does not set out clear requirements for the selection and composition of the first council of an amalgamated college. It provides no guiding principles (e.g., required competencies) and does not require that the first council include members of the professions to be regulated. As a result, there is no assurance that professional expertise will inform decision-making during the amalgamated college's formative period.

Finally, we have concerns with the provisions relating to the appointment of an amalgamation administrator. The Bill sets out no required qualifications, criteria, or experience for an appointment by the Minister, despite the administrator's broad authority during the transition, including assuming roles and functions currently performed by councils and committees. These provisions also raise accountability concerns: beyond accountability to the Minister, it is unclear how an administrator would be accountable to the public for transition decisions.

Concentrating such authority in a single individual (or a small number of individuals), in the absence of clear criteria and oversight, is not an appropriate governance approach for decisions of this significance.

We respectfully request that the Committee consider amendments that would strengthen procedural safeguards and transparency, including:

- Limiting potential amalgamation orders to only those colleges/associations which are seeking amalgamation.
- Meaningful consultation with affected colleges, the public, and other stakeholders before the Minister issues an amalgamation order.
- Clear criteria to assess whether an amalgamation is in the public interest before the Minister issues an amalgamation order.

- Clear principles for selecting first council members and any administrator, together with transparent accountability measures.

- Requirements for the first council's composition to ensure appropriate representation of the professions to be regulated.

The public interest is best served when consequential decisions – such as the amalgamation of regulatory bodies – are made thoughtfully and on a principled basis. Meaningful consultation with those most affected, rigorous analysis of potential benefits and risks, and clear criteria for selecting the leadership of an amalgamated college are essential.

The Bill does not address these issues and could allow amalgamations to proceed without consultation or meaningful consideration of whether they are likely to succeed and improve regulatory outcomes.

An evidence-based amalgamation process would provide greater confidence that decisions to amalgamate will advance the public interest and improve the efficiency and effectiveness of regulation.

Thank you for your time and consideration.

Deb Elias

College of Registered Nurses of Manitoba

Re: Bill 50

Dear Members of the Standing Committee on Social and Economic Development,

On behalf of the College of Registered Nurses of Manitoba and the College of Registered Psychiatric Nurses of Manitoba, we respectfully submit the following comments on Bill 50 – The Pharmaceutical Amendment, Regulated Health Professions Amendment and Public Health Amendment Act for the Committee's consideration. Our comments focus on the provisions of the proposed bill that would amend The Regulated Health Professions Act (RHPA).

We recognize that, in certain circumstances, amalgamations may serve the public interest by improving efficiency and addressing regulatory gaps. An amalgamated college may be in the public interest where:

1. The regulators support and request amalgamation; and
2. Analysis demonstrates that amalgamation would improve the efficiency and effectiveness of regulatory operations.

In our view, these conditions must be met before concluding that an amalgamation would benefit the public.

Amalgamations are inherently disruptive and require careful advance analysis. When imposed on unwilling parties or pursued without such analysis, amalgamations may instead create dysfunction and inefficiency and may not serve the public interest.

We are concerned that the Bill's amalgamation provisions would allow the Minister to initiate amalgamations where these conditions have not been met. In addition, in its current form, the Bill would permit the Minister to issue an amalgamation order on the Minister's own initiative, without requiring consultation or prior study on colleges which are not seeking amalgamation. This could create tensions and dysfunction and undermine effective regulation, contrary to the public interest.

We are also concerned that the Bill does not set out clear requirements for the selection and composition of the first council of an amalgamated college. It provides no guiding principles (e.g., required competencies) and does not require that the first council include members of the professions to be regulated. As a result, there is no assurance that professional expertise will inform decision-making during the amalgamated college's formative period.

Finally, we have concerns with the provisions relating to the appointment of an amalgamation administrator. The Bill sets out no required qualifications, criteria, or experience for an appointment by the Minister, despite the administrator's broad authority during the transition, including assuming roles and functions currently performed by councils and committees. These provisions also raise accountability concerns: beyond accountability to the Minister, it is unclear how an administrator would be accountable to the public for transition decisions.

Concentrating such authority in a single individual (or a small number of individuals), in the absence of clear criteria and oversight, is not an appropriate governance approach for decisions of this significance.

We respectfully request that the Committee consider amendments that would strengthen procedural safeguards and transparency, including:

- Limiting potential amalgamation orders to only those colleges/associations which are seeking amalgamation.

- Meaningful consultation with affected colleges, the public, and other stakeholders before the Minister issues an amalgamation order.

- Clear criteria to assess whether an amalgamation is in the public interest before the Minister issues an amalgamation order.

- Clear principles for selecting first council members and any administrator, together with transparent accountability measures.

- Requirements for the first council's composition to ensure appropriate representation of the professions to be regulated.

The public interest is best served when consequential decisions – such as the amalgamation of regulatory bodies – are made thoughtfully and on a principled basis. Meaningful consultation with those most affected, rigorous analysis of potential benefits and risks, and clear criteria for selecting the leadership of an amalgamated college are essential.

The Bill does not address these issues and could allow amalgamations to proceed without consultation or meaningful consideration of whether they are likely to succeed and improve regulatory outcomes.

An evidence-based amalgamation process would provide greater confidence that decisions to amalgamate will advance the public interest and improve the efficiency and effectiveness of regulation.

Thank you for your time and consideration.

Laura Panteluk
College of Registered Psychiatric Nurses of Manitoba

Re: Bill 50

Dear Members of the Standing Committee,

I am writing to you from the Manitoba Alliance of Health Regulatory Colleges (MAHRC) to share some reflections on Bill 50, The Regulated Health Professions Amendment Act, currently before the Legislature.

MAHRC is a collaborative forum that brings together Manitoba's health regulatory colleges to support shared learning, dialogue, and system-level improvement in the public interest. It serves as a space for connection and exchange across the regulatory community and supports 21 health regulatory colleges that are either currently under The Regulated Health Professions Act (RHPA) or will be in the future.

In our view, Bill 50 represents an important opportunity to shape the future of health profession regulation in Manitoba, and we appreciate the intention to evolve and strengthen professional regulation in the health care system.

Within our network, we have been reflecting on the introduction of the Bill and noted that MAHRC and its members are concerned that we were not afforded the opportunity for early engagement prior to its development. Given the scope and potential impact of this legislation, we had hoped there might be opportunities for dialogue that would allow for shared learning, questions and exchange of perspectives.

Some of the issues we would like to learn more about relate to the impetus for this legislation and how it might work in practice. For example, is it intended to be responsive to specific colleges/associations which are seeking amalgamation? Does government intend to proceed with amalgamation efforts independent of colleges/associations requesting amalgamation? Further, what consultation process is contemplated prior to the Minister making their own determination that a particular amalgamation is in the public interest? How is that public interest defined?

Health regulatory colleges hold valuable practical insight through their role in public protection and professional oversight. Creating space for that insight to inform legislative decisions and policy conversations can often strengthen both process and outcomes.

We also understand that elements of Bill 50 may be informed by developments in other jurisdictions, including British Columbia. Through collegial relationships with regulatory partners in BC and Nova Scotia, members of our network have been following these changes with interest and are frequently consulted by these jurisdictions during their amalgamation processes. These connections offer perspectives on both the possibilities and the complexities of system transformation, which may be helpful to consider in the Manitoba context.

As self-regulating bodies, colleges contribute to maintaining standards of practice, accountability and public trust. Legislative changes of this nature naturally prompt thoughtful questions about implementation, governance and how best to support a strong and effective regulatory environment.

Looking ahead, we welcome opportunities for dialogue as Bill 50 moves forward. A collaborative and consultative approach, one that includes spaces

for exchange with the regulatory community, will help ensure the framework is both effective and grounded in the shared interest of all the regulatory colleges.

Thank you for your time and for your ongoing work on this important matter. We look forward to engaging and participating in discussions.

Sincerely,

Deborah Handziuk
President
Manitoba Alliance of Health Regulatory Colleges

Sophia Ali
Executive Director
Manitoba Alliance of Health Regulatory Colleges

Re: Bill 50

The CLPNM recognizes that modern health legislation should include mechanisms that allow amalgamation where it demonstrably strengthens public protection and regulatory effectiveness. We understand there may be circumstances in which very small regulatory colleges with few members may benefit from joining together, particularly if supported by the colleges and members of the relevant professions. Our comments focus on governance, accountability, and public-interest safeguards that would become important if amalgamation is contemplated or directed.

Our observations are offered constructively and with the objective of strengthening the Bill so that, if used, it supports stable, credible regulation and maintains public confidence during a transition and beyond.

Re: First Council Composition and Decision-Making

Bill 50 provides that the first council is appointed through an amalgamation order and that standard RHPA council composition requirements do not apply. As drafted, there are no minimum requirements to ensure that the first council includes:

- public representation;
- experience in health-profession regulation; or
- expertise relevant to the professions being regulated.

The first council is empowered to establish regulations, by-laws, standards of practice, codes of ethics, and practice directions that directly affect public safety and professional conduct. In our experience, regulatory quality and defensibility depend on balanced decision-making that incorporates public representative perspectives and profession-specific

expertise. Absent such safeguards, there is a risk of competency gaps at the very stage when foundational regulatory instruments are created.

As the Bill currently does not include any expectation for the first council to have knowledge or experience related to health regulatory colleges, the applicable professions, or the health system, it is unclear what measures will be in place to ensure that critical decisions would be made in a manner that ensures the best interest of the public into the future.

Ramifications of uninformed decision making for any of the topics noted in 166.4(1), would have long-term, far-reaching impacts which may subsequently impact the public, the system, and the professions.

Re: An Amalgamation Administrator

Bill 50 also introduces the option to appoint an amalgamation administrator with broad authority that may overlap with that of the first council. Concentrating quasi-judicial, governance, and operational powers in a single individual – without defined competency criteria or clear limits – creates governance and accountability implications.

The RHPA currently provides a mechanism to appoint an administrator where a college requires support in carrying out its mandate. It is unclear why a separate and more expansive administrator role would be required specifically for amalgamation, particularly when existing regulatory structures possess extensive expertise in managing these complex and dynamic systems. An administrator appointed pursuant to 166 of the RHPA may only be appointed if the college or association requests an administrator, or if "the college or association requires support in carrying out its mandate, powers and duties under this Act." It is unclear why similar criteria has not been included in Bill 50, in the proposed 166.1.

Bill 50's amalgamation administrator provisions appear to concentrate an exceptional amount of authority in the hands of a single individual, who may or may not be familiar with standard industry principles related to professional regulation, procedural fairness, financial controls, and who may or may not have expertise relevant to the practice of the profession.

We have also noted that while there is a requirement in 166.4(2) for the first council to consult the members of the pre-amalgamation colleges; there is no requirement for an amalgamation administrator to consult.

Additionally, the powers and duties of the amalgamation administrator appear to include significant overlap with the duties and powers of a first council (166.2(1)(c)). This overlap may lead to confusion and a potential for dysfunction during an already complex process. The need for an amalgamation administrator is unclear, given the powers that are granted to the first council in 166.4(1).

Manitoba's regulatory colleges, their councils/board, their staff, and their legal counsel, have expertise in operationalizing professional legislation in a manner consistent with fiduciary duty, board governance, procedural fairness and regulatory best practices including the principles of risk-based and right-touch regulation. Empowering a single individual with such extensive authority, particularly when the colleges may not require support, appears unnecessary and contrary to the principles of sound board governance, which provide for accountability through collective decision-making. For these reasons, it is difficult to envision a circumstance, not already addressed in the existing 166 of the RHPA, in which the appointment of an amalgamation administrator would be necessary.

Re: The Role for Professional Expertise

Canada has a long-standing tradition of professional self-regulation, rooted in the historical guild system. This model is based on the principle that members of a profession possess essential subject matter expertise needed to ensure that the practitioners are competent and ethical as they provide care to the public. Professional involvement in regulation helps colleges to develop high-quality practice standards, and to assess and evaluate the conduct and competence of other members.

In recent years, professional self-regulation in Canada has evolved into a more collaborative model that formally incorporates public participation. This is commonly reflected in the equal or near-equal representation of public members and professionals on governing councils, boards, and committees. The CLPNM has adopted this cooperative model of regulation and currently has an equal distribution of public representatives and licensed practical nurses on its governing Board.

This cooperative approach to professional regulation strengthens public accountability and enhances public confidence in regulatory decision-making, while continuing to ensure that professional expertise informs the standards, guidance, and decisions that shape professional practice and conduct.

While we acknowledge that members of a regulated health profession, and their unique expertise, might still be represented in the make-up of an amalgamated college, we see no assurances in Bill 50 that there will be a role for professional expertise in the amalgamation process, or in the ongoing regulation of the professions.

As a first council would have authority to establish regulations, by-laws, standards of practice, codes of ethics, and practice directions that direct the practice of the professions, it is essential that the expertise of the affected professions be represented on the first council.

Recommendations for Consideration

To strengthen Bill 50 from a public-interest and governance perspective, we respectfully recommend consideration of amendments that would:

- establish minimum public representation on the first council,
- establish minimum profession specific representation on the first council,
- exclude members of regulated health professions, who are not members of the pre-amalgamation colleges or the newly amalgamated entity, from participating on the first council or from being appointed as an administrator (consistent with existing provisions of the RHPA),
- clarify eligibility criteria for first council appointments, emphasizing regulatory governance, profession specific expertise, and relevant system expertise,
- limit and clearly define the role of any amalgamation administrator, including circumstances for appointment, scope of authority, and safeguards against overlap with council functions,
- strengthen transparency requirements, including clear consultation, reporting, and rationale-setting for first council and/or an administrator during transition,
- require a defined operational and financial transition plan before the exercise of extraordinary amalgamation powers,
- consider removing reference to an amalgamation administrator and instead rely on section 166 of the RHPA, and
- incorporate language that supports a collegial and collaborative approach to amalgamation that leverages the expertise of the existing colleges, and

which involves them directly in the process for a smoother transition.

In the event that amalgamating colleges are unable to arrive at agreement on one or more matters relevant to the amalgamation, we encourage Government to consider establishing a role for a mediator instead of appointing an amalgamation administrator. This approach would set the colleges up for a more collaborative ongoing relationship once amalgamated. Matters not resolved by a mediator could be escalated to the court, if necessary. It is our view that adopting these amendments will help to strengthen governance structures during and after an amalgamation, avoid overlap in powers between the administrator and the first council, avoid concentrating an exceptional amount of authority in the hands of a single individual, and will leave adjudication of difficult or contentious decisions to those with mediation expertise.

Submitted on behalf of:

Jennifer Breton, LPN RN BN, Executive Director, CLPNM, and
Kristi Cantello LPN, President, Board of Directors, CLPNM

Re: Bill 50

Dear Committee Members,

AbbVie would also like to express our thanks to Minister Asagwara and members of The Standing Committee on Social And Economic Development for the opportunity to provide you with our comments on Bill (No. 50) – The Pharmaceutical Amendment.

AbbVie's mission is to discover and deliver innovative medicines and solutions that solve serious health issues today and address the medical challenges of tomorrow. We strive to have a remarkable impact on people's lives across several key therapeutic areas, including – immunology, oncology, neuroscience, and eye care.

We welcome the efforts of the Government of Manitoba, in collaboration with the professional organizations concerned, to explore ways to broaden the scope of practice of pharmacists in Manitoba, and to improve the accessibility and quality of health services for Manitobans.

The idea that pharmacists can do more in assessing health status, in prevention, and in prescribing and treating diseases by "the appropriate use and management of medications in order to maintain health,

restore health, or provide appropriate symptom relief" is generally welcomed.

AbbVie believes the success of the overall approach depends on interdisciplinarity, healthy communications between health care professionals, and the integration of the pharmacist into the patient care continuum to ensure effective management.

AbbVie also believes that the choice of treatment should be the result of a decision taken jointly by the doctor and the patient. Any decision to change a patient's medication should be made by the prescribing physician in consultation with the patient.

With regard to the Bill 50, The Pharmaceutical Amendment for therapeutic substitution by pharmacists, AbbVie would like to draw attention to the following important considerations:

- Patient care - different classes of medications require specific lab follow-up or monitoring.
- Administrative Burden - Physicians also are required to request coverage for medication funding under Exception Drug Status (EDS). This funding request is specific to the drug prescribed; switching to another therapy would require the submission of a new EDS application. The physician must make the application to the EDS office as pharmacists do not have the authority to submit EDS applications for medications.
- Unforeseen Costs to the health system may arise from:
 - o Tariff 8003 which compensates Manitoba physicians for facsimile communications incidental to applications for drug coverage pursuant to Part 3 of the Prescription Drug Cost Assistance Act, Specified Drugs Regulation (Exception Drug Status Approval).
 - o Tariff 8005 which compensates Manitoba physicians for communications initiated by pharmacists.

Any amendments to Bill 50 should ensure that the patient and their practitioner support any substitution, and that the substituted drug will provide a similar therapeutic outcome for the patient. Moreover, any

amendments should ensure that new patient pathway barriers, such as coverage approvals, do not create delays in access, additional administrative burdens or costs.

With respect to "Exception if instruction not to make substitution": Per 76.1(2) Despite subsection (1), the member must not make the therapeutic substitution if the member is instructed by the practitioner issuing the original prescription or the patient:

- (a) not to make a therapeutic substitution; or
- (b) to dispense the originally prescribed drug.

AND

The "Method of giving instruction" in 76.1(3)(a)

The current draft wording allows the pharmacists to over-ride the prescribers clinical assessment and any discussions about choice of therapy made between the prescriber and the patient. It also may negate the requirement for patient consent. One could also foresee situations wherein the prescriber neglecting to document "no substitution" on the original prescription may lead to confusion and inappropriate treatment.

AbbVie suggests the Committee consider:

- Amending "is instructed by the practitioner" to read the "unless the prescriber provides approval in writing or orally"
- Under 76.1(3)(a)(iii), amend the word "or" to "and" thereby requiring consent from both the prescriber (76.1(3)(a)) and patient (76.1(3)(b)) before a therapeutic substitution can be made by the member.

In closing, AbbVie supports the expansion of pharmacy scope of practice provided that changes remain patient-centric and will improve the patient's outcomes while removing barriers to care or avoiding risk to patient continuity of care.

Thank you for your time and consideration.

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