



Legislative Assembly of Alberta

The 30th Legislature
First Session

Standing Committee
on
Private Bills and Private Members' Public Bills

Bill 203, An Act to Protect Public Health Care

Wednesday, June 19, 2019
10 a.m.

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First Session**

Standing Committee on Private Bills and Private Members' Public Bills

Ellis, Mike, Calgary-West (UCP), Chair
Schow, Joseph R., Cardston-Siksika (UCP), Deputy Chair

Gotfried, Richard, Calgary-Fish Creek (UCP)
Horner, Nate S., Drumheller-Stettler (UCP)
Irwin, Janis, Edmonton-Highlands-Norwood (NDP)
Issik, Whitney, Calgary-Glenmore (UCP)*
Neudorf, Nathan T., Lethbridge-East (UCP)
Nielsen, Christian E., Edmonton-Decore (NDP)
Nixon, Jeremy P., Calgary-Klein (UCP)
Pancholi, Rakhi, Edmonton-Whitemud (NDP)
Sigurdson, Lori, Edmonton-Riverview (NDP)
Sigurdson, R.J., Highwood (UCP)

* substitution for Nate Horner

Also in Attendance

Feehan, Richard, Edmonton-Rutherford (NDP)

Bill 203 Sponsor

Feehan, Richard, Edmonton-Rutherford (NDP)

Support Staff

Trafton Koenig
Philip Massolin
Sarah Amato
Michael Kulicki
Janet Schwegel

Parliamentary Counsel
Manager of Research and Committee Services
Research Officer
Committee Clerk
Managing Editor of *Alberta Hansard*

Standing Committee on Private Bills and Private Members' Public Bills

Participant

Ministry of Health

David Skene, Director, Barrister and Solicitor, Health Law

10 a.m.

Wednesday, June 19, 2019

[Mr. Ellis in the chair]

The Chair: Good morning. It's 10 a.m. I'd like to call this meeting of the Standing Committee on Private Bills and Private Members' Public Bills to order and welcome everyone in attendance.

My name is Mike Ellis. I'm the MLA for Calgary-West and chair of the committee. I would ask members, staff, and guests at the table to introduce themselves for the record, starting to my right with the deputy chair.

Mr. Schow: Joseph Schow, MLA for Cardston-Siksika.

Mr. Neudorf: Nathan Neudorf for Lethbridge-East.

Mr. Sigurdson: R.J. Sigurdson, MLA for Highwood.

Mr. Jeremy Nixon: Jeremy Nixon, MLA for Calgary-Klein.

Mr. Gotfried: Richard Gotfried, MLA for Calgary-Fish Creek.

Mr. Feehan: Hi. Richard Feehan, MLA for Edmonton-Rutherford.

Member Irwin: Janis Irwin, Edmonton-Highlands-Norwood.

Ms Pancholi: Rakhi Pancholi, Edmonton-Whitemud.

Mr. Nielsen: Good morning, everyone. Chris Nielsen, MLA for Edmonton-Decore.

Dr. Amato: Good morning. Sarah Amato, research officer.

Dr. Massolin: Good morning. Philip Massolin, manager of research and committee services.

Mr. Kulicki: Good morning. Michael Kulicki, committee clerk.

The Chair: Wonderful. Thank you. We do have a substitution today: Ms Issik for Mr. Horner. My understanding is that Ms Issik is going to be teleconferencing in although I do not believe she is on the phone just yet. When she is, I am sure that folks in *Hansard* will let us know, and then we will proceed with an introduction for her.

I do have a few housekeeping items to address. Please note that the microphones are operated by *Hansard*. Please set cellphones and other devices to silent for the duration of the meeting. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV, and the audio- and video stream and transcripts of the meeting can be accessed via the Legislative Assembly website.

Next we'll go to approval of the agenda. Are there any changes or additions to the agenda? Yes, Ms Pancholi.

Ms Pancholi: Thank you, Chair. I would like to suggest that we add something to the agenda, which we could perhaps do after the approval of the minutes for the last meeting. I'd just like to add committee procedures, just some questions about some of the committee procedures.

The Chair: Yeah. We can add that to the other business at the end. We can put committee procedures there with other business. Sure.

Ms Pancholi: Okay.

The Chair: Fantastic. Anyone else? Okay.

Ms Pancholi: Sorry. Just that one of the items that I want to discuss about procedure, I'm just thinking about the timing of it because it might influence how we do number 4 on the current agenda, which is the review of the bill. It's just procedural, but I'd like to address the concern that I have before we get into the meat of reviewing Bill 203, just in terms of process.

The Chair: Well, I mean, you have the floor at the moment, so let's hear what you have to say.

Ms Pancholi: Sure. I'm happy to discuss it now. One of the questions I was going to ask with respect to committee procedures is that we make sure that all the motions that we're voting on go up on the screen or are provided in writing. I know we discussed that with respect to teleconferencing, but I think that because the precision of the wording is very important, I would appreciate that whenever we're voting on a motion, it go up on the screen before we vote.

The Chair: That is an excellent point.

Ms Pancholi: Okay. Thank you very much.

The Chair: Great. Thank you so much. I think that's an excellent point. Do we need to do an agreement on this? It's just a procedural thing.

Dr. Massolin: Yeah. I would say that those are just the motions for deliberations, not these pro forma motions, right?

The Chair: I understand. Yeah. Fantastic. Thank you. Oh, Ms Issik.

Ms Issik: Hello.

The Chair: Hi. How are you doing? Would you just mind introducing yourself to the committee at this time?

Ms Issik: Good morning. I'm Whitney Issik. I'm the Member for Calgary-Glenmore.

The Chair: Thank you very much, Ms Issik. Okay.

Ms Pancholi: Sorry. There was one other item as well. I think my colleague . . .

The Chair: Sure. Okay. Sorry.

Mr. Nielsen: It's at your discretion, Chair, where you want to place this. Just around the technical briefings, a bit of a discussion around that would be helpful. I'm happy to do it now, but if you would prefer to move that to other business, I'm fine with that as well.

The Chair: Will this in any way affect Mr. Feehan's presentation?

Mr. Nielsen: Not at this time, no.

The Chair: Okay. Well, then, why don't we wait until the other business portion if you don't mind?

Mr. Nielsen: Okay.

The Chair: Okay. Thank you, sir.

Anything else? No. Okay. Fantastic. All right.

I'd like to get a member to move that the agenda for June 19, 2019, meeting of the Standing Committee on Private Bills and Private Members' Public Bills be approved as distributed.

Mr. Neudorf: So moved.

The Chair: Okay. Thank you very much. Any discussion on that motion? No. Okay. All in favour say aye. Any opposed? Ms Issik on the phone? Thank you. Okay. The motion is carried.

Now we will go to approval of the minutes. We have the draft minutes from our June 11, 2019, meeting. Are there any errors or omissions to note? Seeing none, could we get a member to move that the minutes for the June 11, 2019, meeting of the Standing Committee on Private Bills and Private Members' Public Bills be approved as distributed?

Mr. Nielsen: So moved.

The Chair: Thank you very much. I heard Mr. Nielsen, but I saw Member Irwin, so I'll go with Mr. Nielsen. Thank you so much. Any discussion on that motion? Okay. All in favour, say aye. Any opposed? Ms Issik? I understand you're on mute. I appreciate your patience. Thank you. That motion is carried.

Okay. Now we will go to the review of Bill 203. We have a presentation by Mr. Richard Feehan, MLA for Edmonton-Rutherford. Hon. members, Bill 203, An Act to Protect Public Health Care, was referred to the committee on Thursday, June 13, in accordance with Standing Order 74.11. Therefore, the committee must report to the Assembly on Bill 203 on or before Thursday, June 27. After the bill received first reading, an invitation was sent to the bill sponsor, Mr. Richard Feehan, to present to the committee. Additionally, an invitation was sent to the Ministry of Health to provide a technical briefing as well.

At this time I'd like to invite Mr. Feehan to provide a five-minute presentation. Then I will open the floor to up to 20 minutes of questions for Mr. Feehan, following which we will hear from Mr. David Skene, who is representing the Ministry of Health.

Mr. Clerk, if you are ready.

Mr. Feehan, thank you very much. The floor is yours.

Mr. Feehan: Thank you very much, Mr. Chair. I appreciate the invitation from this committee to be able to speak to my private member's bill, Bill 203, An Act to Protect Public Health Care.

Public health care is a defining characteristic of Canada. It is frequently cited when citizens are asked to list what makes them proud to be Canadian. The NDP are proud to be the party that initiated public health care, beginning in Saskatchewan under the leadership of the greatest Canadian, Tommy Douglas. Our government was also proud to stand up for the protection of public health care in Canada. We believe that access to health should not be dependent on the size of your wallet or the balance on your credit card. We were proud during our tenure to hire 4,000 nurses and build 2,000 long-term care and dementia care spaces. We committed to the Calgary cancer centre, the south Edmonton hospital, and ended parking-lot medicine in rural Alberta.

This bill continues the work of enhancing the medical well-being of Albertans by protecting both the letter and the spirit of the Canada Health Act. The Canada Health Act lists the conditions that provincial and territorial governments and their health insurance plans must respect in order to receive the federal cash and contributions. The five conditions, of course, are well known, and they are: public administration, accessibility, comprehensiveness, universality, and portability. These are the values which we intend to protect with Bill 203. The NDP believes that these conditions are essential to a healthy health care system in the province of Alberta.

This bill provides amendments to the Alberta Health Care Insurance Act which would prohibit extra billing for insured services by any person and prohibit fee-based private clinics from

billing individuals to whom they provide insured services. This legislation would add a prohibition on extra billing for insured services, which applies to any person. The legislation would prohibit fee-based private clinics from block billing individuals to whom they provide insured services. There would be an exemption, of course, to ensure that clinics could provide insured services in an emergency. A section of this act which suggests that practitioners can charge extra fees by prior agreement would be deleted.

Alberta Health has identified a few issues related to fee-based private clinics, particularly a lack of accountability to Alberta Health. First, the minister cannot request information directly from clinics, and there are limited record-keeping requirements for uninsured services. Secondly, they also create an opportunity for preferential access and queue-jumping, which I will address later in my presentation.

10:10

Let me address a particular argument that often arises in support of private health care clinics, the argument that the addition of private clinics will help to decrease wait times. Simply put, the evidence does not support this argument. For example, a study done by Koehoorn studied the cost of care and return-to-work time for approximately 1,300 WCB patients in the province of British Columbia who received privately funded and public services for knee surgery. They found that expedited privately funded care was more expensive and did not improve the return-to-work times. In fact, patients receiving care in the public system did marginally better, and they did so at a lesser cost.

Another example from Australia, who expanded private insurance, found that it did not, over the duration of the study, decrease wait times. Rather, they found the opposite. In regions where private insurance was most often used, the wait times in the public sector rose. I can address why a little bit later.

An article written by Mr. Duckett specifically finds that while privately funded health care services slowed the pace of growth of demand in the public sector, public services demand still continued to grow but with diminishing access to resources to address the increased need. So demand goes up, but because the resources have left town, left the system, there is an imbalance between demand and access to resources.

Tuohy, in a study of all of the OECD nations with parallel private insurance for health care, found that privately funded care produces longer wait times and draws resources out of the public system. They also noted that shortening wait times in the public system is usually most successfully achieved by increasing the amount of public investment, not private investment.

Finally, Besley study... [A timer sounded] Is that my five minutes?

The Chair: Yeah. Thank you, Mr. Feehan. I think you'll probably have an opportunity when the question and answer portion goes.

I recognize Ms Pancholi. Just one moment, though.

Ms Pancholi: Sure.

The Chair: Before we start the clock, I think we'll probably have a lot of questions for our guests here today. So if I could ask that we have the question, maybe one supplemental, and we'll give other people a chance. We'll just get in the rotation. Please signal me or my vice-chair, and we'll have a list going regarding speakers and stuff like that.

We'll set the clock for 20 minutes, and we will begin with Ms Pancholi.

Thank you very much.

Ms Pancholi: Thank you, Chair. I believe we might have run out of a little bit of time there. I'm wondering if Mr. Feehan has some additional points that he thinks he would like to add to his presentation.

Mr. Feehan: Well, I won't continue with the studies. I can provide more of them. Thank you for the question.

There are a couple of things that I think are important. You know, this has been tested in Canada as well, particularly, for example, in the province of Manitoba. They created a situation where people could pay an additional fee, which they refer to as a "tray fee," if they chose to have cataract surgery in private facilities. At the time that that fee was in place, the Manitoba researchers found that patients whose surgeons worked in the public facilities could expect a median wait time of about 10 weeks, but when the surgeons were both in the public and in the private system, they tended to push off the public patients so that they could focus on the private patients. As a result, the median wait time for those on the public list was 26 weeks, actually increasing the wait times for people who were part of the public system.

One of the other issues that I really want to put on the table here is the fact that in the private parallel system there is a serious problem with cherry-picking the cases that they work with. What happens is that in the private system doctors and companies, of course, supported by insurance companies, try to find the easiest, quickest dollar. I mean, it makes sense. They're in business. So they take the cases with the fewest complications, where people are younger and will naturally tend to have quicker recovery, and they tend to push off patients who are older, patients whose health needs are more complex. As a result, what we see is that wait times for people in the public system go up because they're in a pool of people who have more complex needs. It also means that private businesses make a lot of money off the health care system while the health care system itself, the public system, has to deal with an increasingly complex level of care all the time and frequently with fewer resources as the individuals who were providing health care in the public system are now shifting their time, their energy, and their work efforts into the private health care system.

What we're doing is we're setting up a system that bleeds off good, quality care to the public in the province of Alberta, and the only way to achieve any kind of better care is to have the dollars to do it. So immediately you create what's essentially an American, two-tiered health care system. We all know from listening to what happens in America that there are a very large number of people who simply have no health care available to them at all.

Now, we wouldn't have quite that same system here in Canada because we would still have a public system, but what it does mean is that people with dollars would experience a very different health care system than people without dollars. That's extremely problematic because, first of all, it undermines our provincial commitment to the Alberta health care act and the five conditions that I read out earlier. Secondly, it creates an inequality in society, which has further consequences, which I can go into further, but I won't belabour that point until I get more questions.

Thank you.

The Chair: Thank you, Mr. Feehan. I think you had some very good words that you said there.

Ms Pancholi, if you don't mind, I think we have a question here from . . .

Ms Pancholi: I still get a supplementary question though. Is that correct?

The Chair: Sure. Okay. Go ahead.

Ms Pancholi: Thank you, Mr. Chair.

I think we've seen from previous conservative governments that they do believe that there are certain basic health care items that should be luxuries that people should pay for such as health care premiums, diagnostic lab services. I'm wondering, Mr. Feehan, if you can talk to me about what kind of extra fees Albertans could be expected to pay if this bill is not passed.

Mr. Feehan: There are a couple of different sets of fees that have been proposed in the past. Some of them are specific to particular surgeries. You pay a particular fee to arrive in a clinic and have the services done quicker than you would receive in public health care for one particular surgery. This can range from as little as an extra \$15 for a visit into a doctor's office to hundreds or even thousands of dollars, of course, for a complicated operation procedure.

We know from research that even the \$15 actually tends to prevent people of low income from accessing health care services. They simply decide: I don't have \$15 today, so I'll try to wait until I have \$15 to do this. As a result, their health worsens, and the cost to the health care system in the long run increases.

The other type of fee that is very common, of course, is a fee such as, you know, some of the clinics that were being established in Calgary over the last number of years before they were prohibited, a fee where people pay a global fee for access to services across the board over a course of a year. That global fee allows them quicker access to medical professionals and also, perhaps, sometimes – you know, it's a business, and you're selling something, so you try to find ways to raise the value of what you're getting. So you add little bits, suggesting, for example, that your doctor will spend a few more minutes with you than they would in the public health care system because they're seeing fewer people. Perhaps they will involve other professionals in your care, which is actually available in the public health care system.

What we'll find is that, increasingly, the resources shift to those kinds of clinics away from the public health care clinics, increasing the backlog in the public health care clinic and providing services to only a select few who can say: I have \$10,000 to spend on hip surgery, or more, \$30,000 to spend on hip surgery. When we get into the place of saying that your health care is dependent on your ability to produce a credit card, then we are in a dangerous place in terms of everyone having access.

At first it seems like it's good, you know, because a few extra people get a few extra services. But it isn't long before that layering of the health care system results in some people receiving what is actually substandard health care, waiting in waiting rooms for their turn to be seen by a doctor who's over in a private clinic and is coming over only after he's tended the people who paid him a lot of money.

10:20

The Chair: Thank you, Mr. Feehan.

Mr. Neudorf.

Mr. Neudorf: Thank you. Mr. Feehan, I wonder if you've done any consultation with stakeholders in the radiology field. Particularly, I know that in Lethbridge we had one public access radiology MRI in the hospital that had wait times of months and years for simple things, knees and hips, that kind of thing. A private radiology clinic opened in co-operation with the university, and people that were willing to pay a few hundred dollars were able to have access. Maybe they were in extreme pain, but their priority wasn't as high. In Lethbridge we saw the exact opposite to what you are describing. Those with the ability, instead of going to the United States or Mexico, experiencing a second tier, so to speak, outside of the

country, we were able to keep them within Canada. We see numerous people from Calgary and Edmonton as well travelling to Lethbridge because it's in Canada. We actually have seen a halt on the brain drain from rural and southern Alberta, where these doctors, instead of setting up shops outside of Canada, now set up within Canada. So we've seen the exact opposite. I wonder if you have done any consultation with that group of people.

Mr. Feehan: Thank you. I think that's an excellent question. It helps us to address two issues, I think, in what you're talking about here. Now, I mentioned earlier that when these things first begin, sometimes there seems to be some real benefit. You have \$300 in your pocket, and you can go and get your MRI. Of course, you would view that as a positive. What happens, though, is that over a period of time those costs begin to separate out people who can afford them and who cannot. Of course, those costs can rise to any level, and people who could afford \$300 maybe couldn't afford \$3,000. So it doesn't really solve a problem in the long term. We know from the research studies that over time what happens is that we lose services in the public health care system and that, therefore, the vast majority of people who can't simply pay out of pocket end up by having longer wait times.

Sorry; I should have written down some of your questions. You're suggesting that this helps in terms of a brain drain, those kinds of things. In my consultations with members of the community, when I speak with people in the community about the services they provide and why they provide them privately, they essentially tell me it's because they simply cannot do the work publicly because the resources aren't there. Many of them would be happy to go in and provide radiology services, for example, in the public health care system, but they're limited at the number of sessions that they're allowed to provide within a clinic in the public health care system. That's really the issue. If they were able to stay within the public system and provide a greater number of services, MRIs, for example, within the system, they'd be happy to do so. It's when we take money away from the public system that we are unable to provide those kinds of services to professionals to engage in.

I think the issue here is that we're missing the point of what the problem is. The problem is that we should be making sure that MRIs are highly available. I mean, a good health care system would make sure there are MRIs in small communities, not only in major centres. A good health care system would make sure that they can be done 24 hours a day so that more people can access them. That's the resolution that we need. If we start to go to the private clinic, then we simply bring all the negatives of the American health care system into the Canadian health care system. I know you're saying that it helps prevent a brain drain, but so would actually providing these same doctors and nurses and technicians the resources to do it within the public health care system. They want to work, they're highly trained, they're extremely ethical, and they just need an opportunity. That's what we need to protect.

The Chair: Mr. Neudorf, do you have a follow-up?

Mr. Neudorf: I do.

Thank you very much for that. I wonder if you've done any cost calculations on this because what you're really talking about is diverting public funds, increasing that.

This MRI was set up within the last four years. Dollars for health care were increased during that time, and we still saw a limit to what we were able to provide publicly in Lethbridge. That's why the private industry stepped up, provided their own funding, to increase accessibility, increase the access there. What you're talking about

is again directing funds from somewhere publicly to increase that, which we just don't have. We don't have that. Have you done any calculations of what the cost to the public system would be on an annual basis across the province to try to institute additional resources like buildings, MRIs? I know the private equipment was in excess of \$2 million without the renovation costs for that private clinic. What kind of costs are you suggesting here across the province?

Mr. Feehan: Yeah. Sorry. I didn't bring in a particular analysis of the costs, of increasing MRIs, for example. You know, that takes a complex analysis across a large system. The research I brought in to read to you was the research that looked globally at the costs overall for the health care system. As I indicate, we tend to get worse service in the public system over time by systems that allow these kinds of extended private clinics.

The Chair: Mr. Gotfried, you're next on the list.

Mr. Gotfried: Thank you, Mr. Chair, and thank you, Mr. Feehan, for presenting to us today. One of the best things we can do is to consult with our constituents. I was very intrigued running into a number of doctors during the recent campaign. One of the doctors, a very passionate doctor, a young doctor who had a practice, shared with me that he felt that if there was some latitude for him to put even a small percentage of his business into a private option opportunity, he would then be able to hire more staff, to possibly invest in more equipment and thereby expand the capacity of his practice such that even if he were using some of that capacity for some additional services, he would bring more capacity to the public system. That intrigued me. That thought intrigued me.

The fact was that the idea we all want is to bring more capacity to the public system. I think we would all agree that more capacity in the public system is what we are focusing on so that we can reduce wait-lists and we can reduce wait times for specialists and people to get in to see people so that they can address their health issues.

I wonder if you've addressed that, whether you've talked to doctors, specifically, maybe who have experience in this or would like to invest more in themselves, their businesses, and in the community and in delivery of health care. Again, what I find when I talk to doctors is that they're universally very passionate about what they do. They don't get into that profession because they're not passionate about helping people. When we listen to them and their good ideas, there's an opportunity for us, again, to bring that additional capacity to the public system. So I'd be curious if you've done some research on that, spoken to doctors about that, and done any calculations on what the net gain to the public system could be under such circumstances as suggested by this particular doctor.

Thank you.

Mr. Feehan: Thank you. Thank you for the question. I have had opportunity to speak to a number of doctors. Of course, doctors have a wide range of opinions on this. It's not like they are a singular block as, you know, any of the rest of us are in terms of what they would like to see.

The issue that you're addressing is that somehow if we create a private system, that brings resources into the public system, and it's not true. You can build up a private practice, and indeed a doctor may be able to hire more people, put an MRI machine together and hire some people to run that, but that doesn't become available to the public system. That stays as a private reality. They don't invest in those things and people or the machinery and then somehow bring that over to their public work. That has to be kept in a private system. So they, indeed, do build up a system, but in doing so,

they're draining all of those resources from the public system. All those people they hire to run that machine or to visit patients are people who are no longer available to be hired in the public system.

It has been demonstrated across countries – this is what I was trying to indicate to you earlier – that over time that tends to bleed people out of the public system and makes it so that the public system lists get worse and worse and worse so that there truly is a very distinct difference between receiving private care and public care over time. That's what we have to avoid. It's not what happens on that day that you go in and get your one service. It's what happens over a period of 10 years. These private systems do build up. Of course, the doctor would like to.

10:30

It also puts the doctors in a compromised position at a certain point. Are they businessmen, or are they doctors? That's always something that people have to juggle. I don't think it's an either/or, so let me be clear about that. I understand that they're both. But at some point decisions need to be made. Are we seeking to increase profits, or are we seeking to increase the public's access to good, universal public health care? It really is incumbent upon the government to ensure that while people, of course, should benefit privately – you know, we all get salaries – from the work that they do, the personal need of increasing profit should not interfere with the public need of good health, which has huge benefits all across the system. One of the things that they talk about in the States all the time is that the cost of health care to businesses is extremely high.

Mr. Gotfried: Mr. Feehan, in the interest of time, could I ask you a supplemental question?

Mr. Feehan: Yes.

Mr. Gotfried: Thank you for your thoughtful answers. Maybe I'm missing something. Number one: actually, every doctor in this province is a businessperson, and I want them to be good businesspeople. I want them to be efficient businesspeople. I want them to be passionate businesspeople as well as passionate physicians because that's how we will deliver a high quality of care, if they are not only good at what they do, but they are good at managing what they do.

I'm a little bit off on the numbers that you said, because in speaking with this particular doctor, he said that even if they restricted the percentage that I could put in – so let's just say that he doubles his capacity in terms of hiring staff and equipment and things like that and says: I'm okay with giving only 20 per cent of that to my private practice. Well, the math on that is pretty simple, that we're going to get a net gain in the capacity that we bring to the public system. Here's a doctor, I knocked on his door, and he's telling me this story. By his math, as a passionate doctor – and he was, because I talked to him for longer than probably I should have at the door – his proposition was: if I could do that, I would be comfortable with it being restricted, and I would then bring a net gain of maybe 30 per cent capacity into the public system.

What you're telling us here: do you have any statistics to back up the net loss that you've said that you've seen and that has been proven in other situations?

The Chair: Thank you very much, Mr. Gotfried.

You know what? I think time has expired, Mr. Feehan. Thank you so much for your presentation. I can tell that all the members here were certainly engaged and listening intently.

We noted that Ms Issik had exited the phone, and we welcome her to the table. Welcome, Ms Issik, to the table.

If we could get Mr. Skene to the table. Thank you so much. We do have a technical briefing by the Ministry of Health. Of course, Mr. Feehan, you are welcome to stay if you would like, sir.

Hon. members, as mentioned, an invitation was sent out to the Ministry of Health to provide a technical briefing on Bill 203. At this time I would like to invite Mr. David Skene, the director of the ministry's health law unit, to provide a five-minute presentation, following which we will have up to 20 minutes of questions from members. I have already started a list that would have continued with Member Irwin and then Member Neudorf. I don't know if we want to continue with that, but we can assess that after the five-minute presentation.

Thank you very much, Mr. Skene. The floor is yours.

Mr. Skene: Thank you very much, Mr. Chairman, members. I'm here to provide an overview of Bill 203. I noticed that most of the conversation about it and the questions that were being asked dealt with the issue of private health care and the privatization of health care. I think it's important to recognize what Bill 203 does as it has been presented.

First, Bill 203, An Act to Protect Public Health Care, adds a preamble to the Health Care Insurance Act and incorporates basic principles from the Canada Health Act into that preamble. It expands the prohibition against extra billing to any person from where it is now, which is only with respect to physicians and dentists. It creates a deemed contravention of the act in the following situations: if you have a fee-based private health organization, which is a person who has entered into an agreement or arrangement with a physician to deliver insured services and/or noninsured services, that fee-based health organization charges a block billing fee, which is a fee charged or collected in advance in respect of two or more noninsured medical services, and that physician, while under the agreement or arrangement and while opted in to an Alberta health care insurance plan, provides an insured service with respect to the period to which the block billing fee applies.

If all of these requirements are met, the block billing fee is deemed to be a fee that is charged as a condition of receiving an insured service. This contravenes section 11(1) of the Alberta Health Care Insurance Act, and under section 14 the fee-based private health organization would be liable for a fine of \$10,000 for a first offence, \$20,000 for second or subsequent offences.

The important thing about Bill 203 is that, at the end of the day, with respect specifically to the fee-based private health organization, it regulates a fee. Say we have two facilities operating side by side. Facility 1 provides a range of insured and noninsured medical services, it's under an arrangement or an agreement with the physician to provide those services, and facility 1 charges a membership fee for people to come and access that service. Facility 2, next door, provides the same services under the same type of arrangement with the physician but charges a fee for noninsured services after those services are delivered. It provides an invoice, for example, to that individual patient. The first facility is liable for the fine; the second facility is not. The only difference between the two is the timing of that particular fee. Because the fee was charged after the noninsured services were delivered, the provisions of the act, the deemed contravention would not have occurred.

The second point that I'd like to raise concerns the current environment and the current regulatory environment with respect to block billing. The committee members have been provided with a copy of the standard of practice issued by the College of Physicians & Surgeons of Alberta. That standard of practice is entitled Charging for Uninsured Professional Services. For the purposes of

the record I would refer the committee to section 8, which reads as follows:

If a regulated member offers a block fee option, the regulated member must not:

- (a) refuse to provide an insured professional service because a patient has not paid a block fee for uninsured services;
- (b) include in a block fee any service for which the regulated member is compensated through any other means, including any charge for a professional service which is included as part of an insured professional service; and
- (c) promise or provide preferential services to a patient who paid a block fee.

In other words, the College of Physicians & Surgeons does regulate in the area of block fees for uninsured medical services. It's important to note – and it is noted in the standard which has been provided – that standards of practice are enforceable under the Health Professions Act and will be referenced in the management of complaints and in discipline hearings. There is some teeth to the standards that have been cited.

The third point I'd like to raise concerns enforceability. Bill 203 does not in and of itself create any additional enforcement tools. In other words, we do not have any provisions in Bill 203 with respect to a fee-based private health organization that requires retention of records, that compels the disclosure of records, and that deals with the collection, use, and disclosure of personally identifying health information. As noted, in order to establish this deemed contravention under Bill 203, it is necessary to get some certain information in hand. You would need to review the specific information as between the physician and the facility. You would need to see that arrangement or agreement to establish whether it exists. You would need to see the fees that have been collected, when those fees have been charged, and you would need to understand which services those fees apply to. All of that requires the collection of information. I am not saying that Bill 203 is unenforceable. Of course it's enforceable, but parts would be more difficult.

The Chair: Thank you, Mr. Skene. Time has expired here.

As I did have a list going, I would certainly open the floor to Member Irwin. If you did want to start this, you certainly are welcome to, followed by Mr. Neudorf, and then we'll take Ms Pancholi. We'll take further comments.

Member Irwin, when you are ready.

10:40

Member Irwin: Thank you. Thank you for your presentation. You know, we've seen a number of queue-jumping scandals in the past under Conservative governments. We know that testimony from medical professionals in 2010 and 2011 showed that some private patients had been bumped up for cancer screening, and they were treated within months while other Albertans, everyday Albertans, were waiting for years. During that testimony one health professional noted that she was asked to sort of help VIP patients, including some from former Premier Ralph Klein's inner circle. We're just wondering, thinking about queue-jumping. Can you talk about how queue-jumping relates to privatization of health care services? Without protections in this proposed bill, do you think that queue-jumping could continue?

Mr. Skene: Queue-jumping is not addressed in Bill 203.

Member Irwin: So there are no provisions whatsoever that . . .

Mr. Skene: Not in the specifics of Bill 203. The idea with respect to Bill 203 is to ban this block billing fee from being charged, which is this fee charged in advance. I would also refer you back to the

standards of the College of Physicians & Surgeons, which specifically states that a block fee for an uninsured service must not be used to gain preferential access. In that type of a situation I would submit that the standards of the College of Physicians & Surgeons would apply to that physician's conduct.

The Chair: Supplemental, Member Irwin?

Member Irwin: No. That's okay. I'll look it up.

Mr. Skene: Of course.

The Chair: Thank you very much.

Mr. Neudorf.

Mr. Neudorf: Thank you very much. If you don't mind, your first point about the prebilling and postbilling, in terms of the fee: how does this bill address that fee regulation? Does it in fact enshrine in law that all access to a medical procedure would be feed in the same way? Is that the intent?

Mr. Skene: What this bill does is that it specifically says that if you are block billing for noninsured medical services, you can't bill for those fees in advance of the service being provided. If you do so, then that fee is deemed to be a fee that's charged as a condition for receiving an insured service.

If we are talking about fees for insured medical services, this bill does not address that directly.

The Chair: Supplemental, sir?

Mr. Neudorf: I would like to. I'm just trying to get the wording.

How do you see that this bill would impact accessibility for people, for instance, who would live in a rural site where their local physician or whatever may not have the expertise, the equipment, the location, the facilities to do that? This is actually a question of access as opposed to a question of queue-jumping. Does this allow independent competition so that physicians who have that expertise, equipment, accessibility points can charge a fee that is related to that increased cost to their business? Does this still allow for that quote, unquote, competition and fair reimbursement for the cost associated with providing that service?

Mr. Skene: Thank you. I believe that if Bill 203 is passed, what you are looking at is a regulation of this particular type of organization, a fee-based private health organization. As such, if that facility is operating in a rural setting and is precluded from operating by operation of this bill, then the ability of an individual to go to that particular facility would of course be impacted.

Mr. Neudorf: Thank you.

The Chair: Thank you.

Ms Pancholi.

Ms Pancholi: Thank you, Chair, and thank you, Mr. Skene, for your presentation. You referred to the standards in the College of Physicians & Surgeons. I understand, of course, it's slightly different than what's being proposed by Bill 203. It's not prohibiting the block fees; it's, as you said, sort of regulating it. I guess my question is: are you aware – and you may not be – of whether or not the College of Physicians & Surgeons has been enforcing this provision and to what extent? I mean, I appreciate that it's set out in the standards. I don't know if you'd be privy to that information, as to whether or not they are enforcing this

provision and how many infractions they deal with or complaints they deal with under this provision.

Mr. Skene: I'm afraid I don't have that information, Member. I would suggest that it is possible we could ask the college for some of its enforcement data.

Ms Pancholi: Thank you. I think that would bring some value to having the College of Physicians & Surgeons contribute to this discussion as well.

I guess just a related question. I think you mentioned in your presentation that what's suggested in the bill would require gathering of information that maybe currently is not available to look into whether or not these kinds of fees are being provided. So, in your mind, would that lend itself to an amendment, perhaps, to this bill to allow for that kind of information gathering, or would that also require an amendment to the Health Information Act? How would that information gathering be empowered?

Mr. Skene: I believe that the best way that it would be empowered would be through changes to Bill 203 to address those specific elements then, and there could be more. I sort of hit the highlights.

With respect to the interaction with the Health Information Act, that's often accomplished through that particular bill that you're amending.

Ms Pancholi: Great. Thank you very much.

The Chair: Thank you very much, Ms Pancholi.
Mr. Nixon.

Mr. Jeremy Nixon: Yeah. I was wondering if you can tell us a little bit more about how this bill would address or wouldn't address wait times.

Mr. Skene: Well, again, as to the previous member, Mr. Neudorf's, question the issue is that through this bill and through regulating this particular type of health care delivery, if you have a number of people who are accessing a fee-based private health organization, which through its business model would not be able to change its billing practices, they would no longer be able to operate. I believe that could have an impact on those individuals who are accessing that particular facility.

The Chair: Mr. Nixon, do you have a follow-up?

Mr. Jeremy Nixon: No. Thank you. Good now.

The Chair: Okay. Is there somebody else on this list? Are there any further questions at this time?

Seeing none, okay.

All right. Well, Mr. Skene, thank you so much for being here. I certainly appreciate that. I'd like to thank Mr. Skene for attending today. Thank you for your time, sir.

Okay. We shall move on. Decisions on the review of Bill 203. Hon. members, in accordance with the process accepted by the committee at its last meeting, the committee will now need to decide on how to proceed with its review of Bill 203. At this time I'll open the floor to discussion on whether the committee would like to hear from stakeholders on Bill 203 or whether it would prefer to conduct an expedited review of Bill 203. I saw Mr. Sigurdson first and in the corner of my eye Mr. Nielsen. We'll start with that.

Mr. Sigurdson: Well, I think we've identified through, you know, just a little bit of the conversation that we've had that there are some

issues with the bill. I think we have to continue to look into this and possibly get some more stakeholders in to get some information to make sure that this isn't going to have any, I guess, for lack of a better term, unintended consequences to it. I'd like to see a little bit more stakeholder involvement on this.

The Chair: Okay. Mr. Nielsen.

Mr. Nielsen: Thank you, Mr. Chair. I couldn't agree more. I think we need to be hearing from people about why I think this bill is important to be considering in terms of our public health care system. I mean, one of the great things that I had the opportunity to do was to go down to the U.S. during the 29th Legislature to talk to U.S. legislators. I kept hearing over and over again about how they envied not only our political system but our health care system as well and some of the wishes that, you know, they had what we had up here. So I think it's very, very important that we look deeply into this, and I would agree that we bring forward some stakeholders.

The Chair: Thank you for your comments, sir.

I had Mr. Nixon next. No. Sorry. I must have seen Mr. Gotfried. My apologies, sir.

Mr. Gotfried: Thank you, Mr. Chair, and thank you to our presenters and to the committee for some great questions. With some of the information we received here, the direction I'm getting from my constituents is that we need to reduce wait times, we need to reduce the queue times for health care services, and we need to find ways to bring greater capacity, as was highlighted to me by the doctor I spoke to. Whether his way is the right way or not is not the question. It's: how can we bring more capacity?

We've heard here that we actually are taking a risk with Bill 203 of taking capacity out of the system and that there are some challenges with the breadth of this bill, but also from the College of Physicians & Surgeons we're seeing that there are some protections for Albertans with respect to block billing, with respect to wait times, with respect to access to services, which is what we are all here for, to ensure that the public system not only guarantees that access to services but, even more so, that we direct resources and capacity to the public system.

I see some shortcomings in this private member's bill, and I'm concerned that it will have the unintended consequences of actually driving capacity out of the system. I'm feeling rather uncomfortable with us proceeding with this particular bill because of those shortcomings at this point in time, Mr. Chair, so I would have a hard time supporting this at this point in time.

Thank you.

10:50

The Chair: Mr. Gotfried, just to understand you correctly, you've mentioned, for example, the College of Physicians & Surgeons. Are you suggesting that you would like to possibly hear from them? Is that a suggestion?

Mr. Gotfried: We've heard from our experts from the ministry here already, Mr. Chair, so not necessarily. In doing so, I think that we have – you know, we're charged here with making some decisions on ensuring the Legislature can address legislation which is appropriately drafted to achieve the desired objectives.

The Chair: Thank you, sir.

Member Irwin, I saw you next.

Member Irwin: Yeah. I think David's comments show that we should in fact invite the College of Physicians & Surgeons, so I would just echo my colleague's comments that this is a great

opportunity to invite them as a stakeholder. Obviously, he's got a very informed opinion, but hearing directly from the college would be quite valuable for this conversation.

The Chair: Thank you very much, Member.

Mr. Neudorf, you are next.

Mr. Neudorf: Thank you. I think we've heard from the ministry and their expertise. I think it was very clear that this bill has some very far-reaching implications in cost that we can't even begin to contemplate as well as what it does within the system that we currently have. It limits physicians and their ability to charge fees for their expertise, their location, their equipment, their skills, and, in fact, limits accessibility. I think we'll see costs increase and wait times increase. I'm very concerned that this bill will have, actually, the opposite effect from that that is intended, and I think that there are some problems with that bill.

The Chair: Thank you.

Mr. Schow, you were next on the list.

Mr. Schow: Thank you. Having listened to both sides and listened to Mr. Feehan and also Mr. Skene, the primary concern that comes to my mind, being an MLA from a rural area – this may sound a bit self-serving, but I'm concerned about access. Frankly, I'm very concerned about access. We have limited access to health care as it is. [An electronic device sounded] Is that an Amber Alert? It's probably a wildfire Amber Alert. Forgive me, Chair.

I do have a concern about access, and that concern was made very clear by Mr. Skene in the sense where this bill will limit the ability for patients in rural parts of the province, specifically, to seek the medical assistance they need. In referencing the college of physicians here as well, I appreciate the input in this. I would personally recommend that I don't think we need to hear from further stakeholders. I do believe that Mr. Skene made a pretty clear point that this restricts access, and I would recommend to expedite it and not bring stakeholders in.

The Chair: Ms Pancholi.

Ms Pancholi: Thank you, Mr. Chair. Perhaps this is a result of my experience having worked as a lawyer within public service, but I thought Mr. Skene did a very good job of being clear about what the parameters of his knowledge and contribution to the discussion were and what they weren't. I thought he did a very fair job of outlining the bill, but he was also very clear about the extent of his expertise. He did not present that he was here to speak on behalf of the College of Physicians & Surgeons. I also hesitate to characterize the two presenters that we had today as both sides of the story because, again, having worked in the public service, I know that their duty is to provide neutral, solid, good advice, which I believe Mr. Skene has done here today.

I think what it speaks to is that there are still stakeholders and individuals with contributions to this discussion. It is a big discussion. It's a complicated one. You know, we have public health, private health that in and of themselves are big issues that cover things like queue-jumping and access and cost and fees and all that, but we need to be clear about what the bill is and what it isn't. I think, as clearly presented from what we heard today, we don't know some of the information from the College of Physicians & Surgeons. I think it would benefit us all to hear that information. I think, when dealing with private members' bills, we should take the opportunity to get the information to make informed decisions, and I think that involves listening to stakeholders. I believe that we should be considering the input of stakeholders.

The Chair: Are there any other comments at this moment?

You know, I've heard some very compelling arguments, really, on both sides. I've heard some compelling arguments to hear from the stakeholders. I've also heard some concerns. I think that from there, since we don't have consensus one way or the other, I'm afraid that we're going to have to vote. We're going to be voting – I want to make sure that I get my wording right on this. I'm certainly by no means the Speaker here.

Unless you have any other comments, we will just go from there. No. Okay. Really, what we're asking for is a ye vote to have stakeholders attend or a nay, which would be to then have what is called the expedited version, which eventually puts it to further debate, and then another step would lead us back eventually into the House.

Can I get a member to move – Mr. Gotfried, I saw your hand go up first – that

all members who are in favour of having further stakeholder consultation, say aye.

Okay. All those opposed, say no. Okay. All right. Excellent. So we have some consensus to talk further on further consultation.

Let us go now to the invitation of stakeholders. All right. The committee has decided to receive additional feedback from stakeholders on Bill 203. We will now proceed to a discussion about which stakeholders the committee would like to invite in accordance with the review process that the committee agreed to. Each caucus may invite up to three stakeholders to present to the committee at an upcoming meeting. The committee may also choose to receive written submissions from stakeholders. I'll now open the floor to a discussion on the stakeholders that the caucuses would like to invite.

Mr. Neudorf: I had talked to a number of constituents within my riding that have expertise in the implications of this bill. They are both radiology associates and pharmacists. They both have private enterprises within the public system, and both have fee-based business models. Whenever we talk about adjusting the accessibility to fees and payments, whether insured or uninsured, one of the questions I had hoped to ask earlier and would like to hear more about, one of the challenges that pharmacists in particular face with the public system, is accessibility to insured drugs.

What they found is that these drugs that are covered by insurance are often out of supply, backlogged, unavailable, and as if they were controlled by large drug conglomerates, their costs are exceedingly high. Then when you cap the fees, they are caught in the middle. I think that this impact is very, very far reaching to that group, so I would like to make sure that those two professional groups are invited.

The Chair: Is this an organization that you're talking about?

Mr. Neudorf: There is a college of pharmacists of Alberta and then a radiology association. I'm not sure what the professional group would be for Alberta, but I'm sure there is one.

11:00

The Chair: Okay. Well, I'm sure you can get back to the clerk, I'm assuming, if there is a specific group that you can provide us the name for.

Mr. Nielsen.

Mr. Nielsen: Thank you, Mr. Chair. Obviously, I think one of the stakeholder groups that was mentioned here was the College of Physicians & Surgeons, so I would suggest we invite them.

The Chair: I've heard that come up a few times in the conversation throughout the course of the morning.

Is there anybody else anybody can think of?

Mr. Jeremy Nixon: Do we have an opportunity to consult and get back to the committee on our recommendations?

The Chair: Yeah. Mr. Nixon, we're on a very tight time schedule. We have to report back to the Assembly by Thursday. Sorry; Thursday next week. My apologies.

An Hon. Member: Jeez.

The Chair: Yeah. Yeah. So, really, we have stakeholders. I ask you to, for lack of a better term, let us know now, and then we will send the invitation out to those stakeholders for likely a meeting at the beginning of next week.

What was just noted, too, Mr. Nixon, is that you can certainly send your list to the clerk by the end of the day as well. You do have a little bit of time.

Mr. Jeremy Nixon: Can we ask the ministry for recommendations?

The Chair: I mean, how you get those recommendations would certainly be up to you.

Member Irwin.

Member Irwin: Yeah. I'd like to add a couple of recommendations for stakeholders, Friends of Medicare and Public Interest Alberta.

The Chair: Thank you, ma'am.

I guess from the opposition side that's three. Yeah. Okay.

Is there anybody else from the government members' side?

Mr. Neudorf: If this isn't covered in the college of physicians, then if there is a professional body provincially for dentists, I would like to make sure that that is added to the list.

The Chair: Okay. Is there a dentists' association? Well, we'll find out if there is a dentists' association of some kind. Now, we don't have to have this but . . .

Mr. Gotfried: Mr. Chair, you know, I think that my concern here is that we're sort of rushing to try and pick out who we'd like to have present here. Is there a way that we could have 48 hours to submit to the chair and deputy chair a list of recommended stakeholders? No?

Mr. Kulicki: It's a tight timeline. Today at 4:30.

The Chair: Well, yeah. I agree with the clerk. I mean, we're under a very tight timeline here, sir. Certainly, you can make a submission by the end of the day.

Mr. Gotfried: Okay.

The Chair: That being said, you know, the opposition certainly have their three. You, Mr. Neudorf, had mentioned the college of pharmacists, and then we kind of have a dentists' association that has been named. There's no obligation to make a decision at this moment. If you would like to provide the chair and the deputy chair a name or even two by the end of the day, then you will have your three stakeholders, which meets the requirements of what was agreed upon by the committee.

Mr. Gotfried: You're saying end of the day?

The Chair: End of the day today.

Mr. Gotfried: 11:59?

The Chair: Well.

Mr. Gotfried: That's our workday. Our workday today actually will be probably until 11:59.

The Chair: Sir, go ahead.

Dr. Massolin: Mr. Chair, I think we've got the name of the Alberta dental association here.

Go ahead, Dr. Amato.

Dr. Amato: It's called the Alberta Dental Association and College.

Dr. Massolin: I think the government caucus therefore has two stakeholders.

The Chair: Yup, two.

Ms Issik: I believe Mr. Neudorf raised the radiologists. I think that would be an important one.

Dr. Massolin: Oh, the radiologists. Okay. That would make it three, then.

Mr. Gotfried: And surgeons, I think, are important.

Ms Issik: Surgeon and a radiologist organization.

The Chair: I guess the question I have for staff is: the opposition as well as the government members, are they locked into these stakeholders right now, or do they have until the end of the day, at which point if even the opposition wanted to change their mind, hypothetically, on a stakeholder, they could certainly do that by the end of the day and vice versa?

Dr. Massolin: Yes, Mr. Chair. I think there's some flexibility here. I would suggest, certainly, by the end of the day – and, you know, around this business it's hard to determine what the end of the day is, but I would say the regular business day – so that we could give direction to the committee clerk to get this going.

The Chair: Thank you, sir.

Mr. Nielsen, I saw you raise your hand.

Mr. Nielsen: Thanks, Mr. Chair. I think I'm pretty safe with our stakeholder list.

The Chair: I just wanted to leave it open.

Mr. Nielsen: No need to check back with us.

The Chair: Okay. All right. Thank you very much.

Then more so for the government members if you'd like to give it a little bit of thought, you certainly have till, well, the end of the day – okay? – in order to provide us the list, and we'll make sure that the clerk, through the chair's office, sends out the invitation to all of the stakeholders.

Okay. I guess we'll do a motion. Can I ask the clerk, who might have some thoughts on the wording of a motion that we could use at this time.

Mr. Kulicki: Sure. It'll just be a moment for me to come up with the wording.

The Chair: Okay. Thank you.

Clerk, of course, when you're completed, if you can make sure it's on the screen for Ms Pancholi and the rest of the team here. Okay. All right. It looks like we have something up there. Let me just read it first. How are we with that, right? That the Standing Committee on Private Bills and Private Members' Public Bills invite the College of Physicians & Surgeons, Public Interest Alberta, and Friends of Medicare to present on Bill 203, An Act to Protect Public Health Care, at an upcoming meeting of the committee and request that the government caucus members submit their list of three stakeholders by the end of the business day on June 19, 2019.

Any further discussion on that?

Ms Pancholi: You have to clarify what end of business day means. Is it our business day, or is it most people's business day?

The Chair: I think ours is – what? – 2 in the morning.

Ms Pancholi: Who knows when ours is?

The Chair: I agree with you. I think everybody had the same thoughts.

Clerk, you're going to work on a little bit of better wording on that?

11:10

I think the consensus from both sides is that they were kind of looking for, you know, a business day. Maybe they're looking for something a little more specific, maybe a time or something like that. I think 4:30. Does anybody disagree with 4:30? Okay. That's fair. I think that's fair, right? Let's just put a time in there of 4:30 p.m.

Mr. Nielsen: Just so that there's maybe some confidence on the other side there, if they happen to turn in their list at 4:31, I'm probably not going to hold it against them.

The Chair: Okay. That's good to hear. Thank you so much.

Mr. Sigurdson: Can we hold you to that?

Ms Pancholi: We draw the line at 4:32.

The Chair: Mr. Schow, did you have a question?

Mr. Schow: No. We've got the motion.

The Chair: Okay. Can I get somebody to move the motion? Mr. Neudorf shall move that

the Standing Committee on Private Bills and Private Members' Public Bills invite the College of Physicians & Surgeons, Public Interest Alberta, and Friends of Medicare to present on Bill 203, An Act to Protect Public Health Care, at an upcoming meeting of the committee and request that the government caucus members submit their list of three stakeholders by 4:30 p.m. on June 19, 2019.

Okay. Any further discussion? All in favour say aye. Any opposed? Carried.

All right. Thank you. It's been a long morning. We had a long night last night. Let's go on to other business. Ms Pancholi, I believe we addressed your committee procedures concerns. Did you have any other comments in regard to that?

Ms Pancholi: I think there was just one that my colleague Mr. Nielsen submitted.

The Chair: Yes. We're going to get to his. Okay.

Ms Pancholi: Yes, but mine is addressed. Thank you very much.

The Chair: Thank you so much.

Mr. Nielsen, the topic of technical briefing.

Mr. Nielsen: Yes. Thank you, Mr. Chair. I guess it's a little bit procedural because, as we know, we did have that subcommittee to come up with the different avenues that we can go, be it expedited or – I can't remember what the technical word was – full briefing, whatever it was. With our meeting today we had a technical briefing already prescheduled with the ministry, which I do very, very much appreciate, but I guess what I'm a little bit concerned about was that for our first two bills that we had, there wasn't a technical briefing automatically scheduled for those. I'm just kind of wondering why there seems to be a little bit of an inconsistency. Is this: going forward, we're going to pick and choose, or should we be expecting a ministry briefing going forward?

The Chair: I think the clerk had an answer for it.

Dr. Massolin: I mean, the really quick answer to that, Mr. Chair, is that the committee had not approved the subcommittee to report on process by that point whereas in the previous meeting the committee had passed a motion to invite the bill's sponsors to talk to the bill, but it was at that same meeting that they approved the process.

Mr. Nielsen: So going forward, then, are we to expect a technical briefing?

The Chair: I think that would be the expectation going forward, yes.

Mr. Nielsen: Thank you, Mr. Chair.

Ms Pancholi: I just have to respond a little bit to that. You know, while it is true that the process hadn't been approved, we did have a discussion around this table about a ministry briefing on the previous two bills, and it seemed to be dismissed and just not even considered. If that's what we're doing, then we should have halted the process to allow for the ministry briefing on the previous two bills. What's done is done now, but it has to be stated that it's not coincidental that the first two bills were brought forward by private government caucus members. Then this is brought forward by an opposition caucus member, and it was automatically scheduled.

Just in the interest of fairness, if we are on tight timelines, obviously, according to the standing orders, if that's going to allow for different processes when we're considering private members' bills, I think that's an issue of fairness that we should be concerned about. What happened on Bill 201 and Bill 202 is what happened. It's done now, and we've moved on. But I think we have to agree that if bills are coming forward, even if they're going to be through the expedited process, which is a decision we make at the time, then, actually, according to how we've now responded to Bill 203, a ministry briefing should be a part of every bill that comes.

The Chair: Thank you for your point.

Mr. Schow: Well, if I could just echo the comments of Dr. Massolin, I think that is indeed the process, so I'm not quite sure what the need for the comment was other than to simply put that on record. We are anticipating bringing in the ministry to have a

technical briefing moving forward, so the idea that it was deliberate might be a bit of a stretch.

The Chair: I think Ms Pancholi's point is taken. I don't think that we need to belabour this any further. All I'll say is this. Whether it be the clerk's office, whether it be the government, this is a new process. You know, I think that everybody can admit that – I mean, a lot of things are subjective in life; I get that – this is indeed certainly a more complex bill than the other two. I'm not saying that that is any factor in the decision that was made. I agree with the clerk that there was no process. I think that in the future you will see consistency and fairness, and certainly I don't believe that there was any . . .

Mr. Schow: Malice.

The Chair: . . . yeah, malice or ill intention to have a perception of that.

Thank you for your comments.
Anything else? Mr. Neudorf.

Mr. Neudorf: Thank you. I will keep this very brief. I believe the intent with the subcommittee was that if it impacted the ministry significantly enough, that was the indication where we would invite the ministry, which I felt this bill did. I would be willing to concede that Bill 201 may have impacted that to that degree, but Bill 202 would not have. I think that we still need to use some discretion in the application of that, in all fairness to the members opposite, to make sure that that is heard.

The Chair: That is an excellent point. You're right. I mean, when we look at the grand scheme of things, Bill 201 does actually have a large impact, so I certainly apologize if I thought otherwise.

Ms Pancholi: Sorry. I do have to respond because now we've had two references to some suggestion that a decision was made about whether or not a ministry briefing should be provided for Bill 203. Again, this is the committee that makes that decision. If it was because it was complex or because, you know, it was a bill that did require the ministry, the point is that this committee makes those decisions. It shouldn't be made by whoever is scheduling the meetings, right? Either a ministry briefing is part of the process for all bills, or there is a decision point where we as a committee make a decision about ministry briefings.

I'm not necessarily suggesting that there was any malice, but I'm saying that there was a procedural problem with how the previous two bills were considered. Perhaps we should have halted then to address that. It is what it is going forward. But if there is a decision point about whether or not a ministry briefing is required, it should be the committee that makes it, not scheduling. Perhaps there's a lack of clarity in our process about whether ministry briefings are standard or not, and I think we have to clarify that because if we are making a commitment going forward that every bill will have a ministry technical briefing, that should be reflected in our process and we should make sure that we all have that clear understanding.

The Chair: Okay. Thank you.

Any further comments? Okay.

Mr. Nielsen, was there anything else in regard to the technical briefing?

Mr. Nielsen: No, that was it. Thanks, Mr. Chair.

The Chair: Thank you.

An excellent discussion. Okay. Thank you so much.

I guess we will move on to number 6, the date of our next meeting. Obviously, we're going to put out the invitation to the stakeholders, right? Is anybody opposed to Tuesday morning?

11:20

The complexity on this one here is that we're under tight timelines to report back to the Legislature on Thursday. We have six stakeholders. It's 20 minutes each plus Q and A. We're limited to our, let's say, hour, hour and a half. We may have to look at meeting Tuesday. I'm sorry, Clerk, you mentioned Monday? Monday, Tuesday, and Wednesday. I guess we might as well discuss since we're all here. Is anybody opposed or having further discussion? Mr. Nielsen, I'll get to you in a second. This is where I'm kind of going with possibly, obviously if it works with the stakeholders and if they all approve – there are some moving parts here – a Monday dinner, followed by Tuesday at some point, Wednesday, and of course to report back on Thursday.

Mr. Nielsen, go ahead, sir.

Mr. Nielsen: Thanks, Mr. Chair. We do have one member that's absent right now, and it would be difficult, I think, for any of us to speak for that member.

The Chair: Okay. I appreciate that. I think we're challenged by putting out a poll, we'll call it, just because, you know, if we're going to see six stakeholders and then report on Thursday and we can't meet while the House is sitting, we're really limited to the times. How about we do a couple of things? Let's invite the stakeholders. Let's see if they all agree to show up. I mean, there are some that may decline. I don't know – right? – but that certainly is a possibility. These are things that the clerk's office can work on today. Then based upon the information that we get back from the stakeholders, that will determine how much time is needed. Maybe then we can poll our members at that point to see what works for everybody.

Go ahead, Mr. Nielsen.

Mr. Nielsen: Yeah. Well, it sounded like you had potentially multiple times anyway. I think it's safe enough to just go ahead and poll members with all those times that are potentially available, and we'll see what falls out. I'm sure we could attach a little bit of a timeline to respond by, given the tight timelines.

The Chair: Sure. Sure. Thank you.

Go ahead, Mr. Gottfried.

Mr. Gottfried: Thank you, Mr. Chair. I sit on the Public Accounts Committee, which of course is on Tuesday mornings. If I could just ask that we try not to conflict with that. I know that we may have to, just in the interests of time, but if that's a possibility so that those of us who sit on other standing committees are able to attend, it would be gratefully appreciated.

The Chair: Thank you, Mr. Gottfried. I think, given our tight timelines, though, if there is something where we have to go on Tuesday, you may have to find a substitute.

Mr. Gottfried: Okay. Thank you.

The Chair: Thank you so much.

Okay. Any further discussion on that?

Okay. In regard to the time of our next meeting, I guess the clerk's office will get back to us, but we can probably expect that

we will be looking at a possible Monday, Tuesday, Wednesday in order to make sure that all stakeholders are heard. We don't have specific times at this moment. Of course, pay attention to the e-mails because the clerk's office will be sending us updates as to what is transpiring here. Okay. Is that fair?

All right. Adjournment. Would a member like to move that the meeting be adjourned? Mr. Nixon would. All in favour? All right. Thank you so much. It's unanimous.

[The committee adjourned at 11:24 a.m.]

