The Assembly met at 13:30.

Prayers

ROUTINE PROCEEDINGS

PRESENTING PETITIONS

Ms. Julé: — Thank you, Mr. Speaker. Mr. Speaker, I stand today to present a petition from people within the Bruno area who petition for the Bruno telephone exchange to become part of the Humboldt telephone exchange. And the prayer reads as follows, Mr. Speaker:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to allow Bruno to be part of the Humboldt telephone exchange.

And the signatures on this petition, Mr. Speaker, are from Humboldt, from Bruno, from St. Gregor, Lake Lenore.

I so present.

Mr. Hermanson: — Thank you, Mr. Speaker. I'm able to present a petition regarding the two government Crown corporations, SaskPower and SaskEnergy, who both recently announced significant rate increases for residential and business customers. And the prayer reads:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to use a portion of its windfall oil and gas revenues to provide a more substantial energy rate rebate to Saskatchewan consumers.
>
> And as in duty bound, your petitioners will ever pray.

And, Mr. Speaker, these petitioners come from the communities of Demaine, Craik, Lucky Lake, Birsay, Outlook, and Beechy. Most of these are centres in my riding of Rosetown-Biggar, and I'm happy to make this presentation on their behalf.

Ms. Draude: — Mr. Speaker, I also have a petition to present today from citizens in Rose Valley area who are concerned with the EMS report:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to not implement the consolidation and centralization of ambulance services as recommended in the EMS report and affirm its intent to work to improve community-based ambulance services.

I'm pleased to present this petition.

Mr. Stewart: — Thank you, Mr. Speaker. I rise to present a petition signed by citizens concerned with proposed weight restrictions to Highway No. 43. And the prayer reads:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to recognize the economic harm its plan to close Highway 43 to heavy traffic will do to south-central Saskatchewan and instead to vote necessary funds to upgrade Highway 43 in order to preserve jobs and economic development in the area.

And this petition is signed by individuals from the communities of Swift Current, Pambrun, and Vanguard.

I so present.

Mr. Wall: — Thank you, Mr. Speaker. I rise again on behalf of people in southwest Saskatchewan concerned with the state of our hospital there. And the prayer reads as follows:

> Wherefore your petitioners will humbly pray that your Hon. Assembly may be pleased to cause the provincial government to carefully consider Swift Current's request for a new hospital.
>
> And as in duty bound, your petitioners will ever pray.

And, Mr. Speaker, this petition is signed by people from Humboldt, Saskatchewan, from Swift Current, from Hazenmore, and once again the good folks at the Rush Lake Hutterite Colony.

I so present.

Mr. Brkich: — Thank you, Mr. Speaker. I have a petition here from citizens from all over the province very concerned about rising energy costs. The prayer reads as follows:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to use a portion of its windfall oil and gas revenues to provide a more substantial energy rate rebate to Saskatchewan consumers.

The signatures are from Prince Albert, Estevan, Hanley, Davidson, Glaslyn, Allan, Craik, Weyburn.

I so present.

Mr. Hart: — Thank you, Mr. Speaker. I too rise to present a petition on behalf of constituents of mine. The prayer reads as follows:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to not implement the consolidation and centralization of ambulance services as recommended in the EMS report and to affirm its intent to improve community-based ambulance services.
>
> As in duty bound, your petitioners will ever pray.

Signatures to this petition come from the communities of Wynyard, Wishart and Bankend.

I so present.

Mr. Peters: — Mr. Speaker, I have a petition in regards from

the residents of the Assiniboia area concerned with Pioneer Lodge. And the petition reads as follows:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to take at least the necessary action to ensure that at least the very current levels of service and care be maintained at the Pioneer Lodge in Assiniboia.

Mr. Speaker, the petition is signed from people from Regina, Saskatoon, Moose Jaw and Gravelbourg.

I so present.

Mr. Huyghebaert: — Thank you, Mr. Speaker. Mr. Speaker, I again rise on behalf of concerned citizens reference the cuts at the Assiniboia Pioneer Lodge. And the prayer reads as follows:

> Wherefore your petitioners humbly pray that your Hon. Assembly may be pleased to cause the government to take the necessary action to ensure that, at the very least, current levels of services and care are maintained at Pioneer Lodge in Assiniboia.
>
> And as is duty bound, your petitioners will ever pray.

And, Mr. Speaker, these petitioners come from Lisieux and Assiniboia.

READING AND RECEIVING PETITIONS

Clerk: — According to order the following petitions have been reviewed and pursuant to rule 12(7) they are hereby read and received.

Of citizens of the province petitioning the Assembly on the following matters:

> The centralization of ambulance services;
>
> Swift Current's request for a new hospital;
>
> The level of care at Pioneer Lodge in Assiniboia;
>
> Funding to upgrade Highway No. 43;
>
> Legislation to protect children from tobacco use;
>
> An energy rebate to consumers; and
>
> Ensuring the Hafford hospital remains open.

NOTICES OF MOTIONS AND QUESTIONS

Mr. Elhard: — Thank you, Mr. Speaker. Mr. Speaker, I give notice that I shall on day no. 25 ask the government the following question:

> To the Minister of Highways and Transportation: could you please provide the department's spring tendering schedule for the upcoming year that includes which highways and roads specifically will be repaired?

Ms. Julé: — Thank you, Mr. Speaker. Mr. Speaker, I give notice that I shall on day no. 25 ask the government the following question:

> To the Minister of Health: what is the name of the individual that the Regina Health District has recently hired in order to recruit plastic surgeons and what is the salary that this individual is receiving?

Mr. Krawetz: — Thank you, Mr. Speaker. Mr. Speaker, I give notice that I shall on day no. 25 ask the government the following question:

> To the Minister of Finance: what is the total budgeted cost for the provincial government's public relations and communications campaign promoting the 2001-2002 provincial budget in terms of planning, production, distribution, advertising purchases, and all other associated costs?

I so present.

Ms. Eagles: — Thank you, Mr. Speaker. Mr. Speaker, I give notice that I shall on day no. 25 ask the government the following question:

> To the Minister of Social Services: what are the names of the individuals on the Saskatchewan Council of Children; how many times has the council met to date; and what has the cost of the council been to date?

Thank you.

Mr. Wall: — Thank you, Mr. Speaker. I give notice that I shall on day no. 25 ask the government the following question:

> To the Minister of CIC: how much did SaskEnergy spend on the advertising insert that appeared in the provincial newspapers on April 14, 2001, including planning costs, production costs, advertising costs, and all other associated costs?

And also, while I'm on my feet:

> How much has SaskEnergy budgeted in total for this particular communications campaign?

Mr. Hart: — Mr. Speaker, I give notice that I shall on day no. 25 ask the government the following question:

> To the Minister of Post-Secondary Education: how much has your department budgeted for the current communications campaign promoting the post-secondary student tax credit in terms of planning, production, distribution, advertising, purchases, and all other associated costs?

Mr. Hillson: — Thank you, Mr. Speaker. I give notice that on day no. 25 I will ask the government the following question:

> How much was spent on travel outside of Saskatchewan but inside of Canada, by officials of Crown Investments Corporation and its subsidiaries to investigate investments

made or under consideration during the year 2000; I have similar questions for the years 1999 and 2001.

And also a question — I intend to give notice that on day no. 25 I will ask the government the following question:

> How much was spent on travel outside of Canada by officials of Crown Investments Corporation and its subsidiaries to investigate investments made or under consideration during the year 1999; with similar questions for the years 2000 and 2001.

INTRODUCTION OF GUESTS

The Speaker: — Members of the Legislative Assembly, it's my pleasure today to introduce to the House here, a distinguished visitor, the Hon. Kevin O'Brien, the MLA (Member of the Legislative Assembly) for Arviet in Nunavut, and Speaker of Legislative Assembly at Nunavut. Mr. O'Brien has served as a member of the Legislative Assembly of the Northwest Territories from '95 to '99, and he was elected Speaker of the Legislative Assembly of Nunavut, Canada's newest Territory, on March 29, 2000.

Mr. O'Brien has 15 years of experience at various levels of government — began working in New Brunswick with the municipalities in 1980; he's been a negotiator for both union employees and management. He was senior administrative officer at Tuktoyaktuk. Prior to his election to the Legislative Assembly, he was director of the Northwest Territory Housing Corporation for the Keewatin district.

He lives in Arviet. Mr. Speaker O'Brien is the father of two children — Jaren and his daughter Kelsey, who is here today.

Kelsey attends school at Moose Jaw Sunningdale School, where in addition to going to school, she's also very interested in dance music and soccer. And with her today also, is her mother, Michelle O'Brien, who is a science and math teacher at Riverview Collegiate.

I would ask all members to extend a warm welcome to Speaker O'Brien.

Hon. Members: Hear, hear!

Hon. Mr. Osika: — I beg your indulgence, Mr. Speaker, thank you, and the indulgence of my hon. colleagues to allow me to welcome my good friend, the Hon. Kevin O'Brien, and his family to this Legislative Assembly. I look forward for a long, continuing friendship. Thank you.

Hon. Members: Hear, hear!

Mr. D'Autremont: — Thank you, Mr. Speaker. On behalf of the official opposition, it's my honour to be able to welcome Speaker O'Brien to the Assembly and to his daughter, Kelsey, and to Mrs. O'Brien. And again I'd ask the Assembly to welcome them.

Hon. Members: Hear, hear!

Hon. Mr. Nilson: — Mr. Speaker, it's my pleasure to introduce to you and through you to all members of the legislature, three guests who are here for this afternoon including Rosalee Longmoore, who is the president of the Saskatchewan Union of Nurses; Bev Crossman, who is the executive director of SUN; and Donna Brunskill, who is the executive director of the Saskatchewan Registered Nurses' Association.

Let's give them a warm welcome.

Hon. Members: Hear, hear!

Mr. Gantefoer: — Thank you, Mr. Speaker. I would like to join with the minister in welcoming the representatives from SUN and the SRNA (Saskatchewan Registered Nurses' Association) to, I'm sure, view the proceedings this afternoon. Their input and concern and commitment to the health care field in our province is very much appreciated and I would ask members to join in giving them a warm welcome.

Hon. Members: Hear, hear!

Hon. Mr. Calvert: — Mr. Speaker, I'm very pleased to introduce two other very distinguished visitors in the House today, both of them seated behind the bar and both of them former members of this House.

I would like members to welcome back to this House, Mr. Walter Smishek, who served as minister of Labour and minister of Health in a previous time. And of course our good friend, Mr. Dale Flavel, who represented well the constituency of Last Mountain-Touchwood and served as our Deputy Speaker.

So, Mr. Speaker, I'd like to invite all members to welcome these members.

Hon. Members: Hear, hear!

Mr. Hart: — Thank you, Mr. Speaker. I'd like to join with the Premier in welcoming Mr. Flavel to the Assembly. Mr. Flavel is a constituent of mine and it's always good to see him in the Assembly.

Hon. Members: Hear, hear!

(13:45)

Hon. Mr. Goulet: — Mr. Speaker, in your gallery we have two special visitors. We have my niece, Sasha Goulet, as well as her friend, Krista Berg. They're here visiting Regina from Saskatoon. They've done a little bit of rock climbing. They've been to the Royal Saskatchewan Museum and are poised to listen to what's happening here in the legislature this afternoon.

Please welcome them all.

Hon. Members: Hear, hear!

STATEMENTS BY MEMBERS

911 Service in Southern Saskatchewan

Ms. Higgins: — Thank you, Mr. Speaker. There is good news this week for southern Saskatchewan. I want to highlight major

progress that has been made on the schedule of enhanced 911 service — service that will soon be available all across our province. As of Tuesday, April 17, 911 service is now available for the communities and surrounding areas of Oxbow, Redvers, Weyburn, Carlyle, Kipling, Carnduff, Radville, Grenfell, Moosomin, Wolseley, Broadview, and Whitewood.

In all, Mr. Speaker, this expansion covers 117 municipalities. As of now, 309 municipalities province-wide have access to enhanced 911 coverage, including practically all of southern Saskatchewan. By the fall of 2002 there will be complete coverage of all Saskatchewan, including the North.

It needs to be emphasized, Mr. Speaker, that this coverage is laid for land lines . . . land line telephones. Cell phone messages go to the nearest tower, not to the nearest 911. Their location does not register on the 911 operator's screen — 911 is designed for land line phones, Mr. Speaker.

This is good news for all of us who recognize the need for a quick response emergency system across the province — a system being provided with the co-operation of local communities and SaskTel.

Some Hon. Members: Hear, hear!

Glentworth Residents to Represent Saskatchewan at National Bowling Championship

Mr. Huyghebaert: — Thank you, Mr. Speaker. Mr. Speaker, at a time when rural Saskatchewan is seeing stuff close and people moving out, I'm happy to say that the town of Glentworth has a bowling alley that's functioning extremely well.

I'm a little loath to bring that up in the House because members opposite might find out it's running well and they'll find a way to study it and then close it.

But, Mr. Speaker, Mr. Speaker, the bowling alley is doing very well. And in the 55-plus triples, I would like to comment on three of the individuals from Glentworth. Mr. Gaston St. Jacques, Elvin Mitchell, and Roy Burns participated in this event. And they won through the district, through Moose Jaw, and they won in Regina, and are now going to represent Saskatchewan at the national bowling championship to be held in Brampton, Ontario on June 22, 25.

Mr. Speaker, what makes this a very outstanding achievement is one of the members, my good friend Mr. St. Jacques, is clinically blind and he still participates in the normal bowling league. And I'd also like to report that this is his second trip to the national championships, even though he has this sight impairment.

So, Mr. Speaker, I would like to congratulate these three individuals and wish them well on their trip to Brampton for the national finals.

Some Hon. Members: Hear, hear!

Soil Conservation Week

Mr. Prebble: — Thank you very much, Mr. Speaker. Mr. Speaker, the Minister of Agriculture and Food has declared April 15 through 21 Saskatchewan Soil Conservation Week.

Over the last 10 years, Mr. Speaker, many Saskatchewan farmers have made significant progress in preserving our precious soil resource, and our government is very anxious to support this work.

This year, Saskatchewan Agriculture and Food is providing $200,000 to the Saskatchewan Soil Conservation Association to help that organization continue its educational programs throughout the province. Through this important educational work, our province will see benefits not only in soil conservation, but also in water resource protection and reduction of greenhouse gas emissions and in the enhancement of biodiversity.

Our government has also announced a $26 million conservation cover program to advance soil conservation. This program will provide financial and technical support to Saskatchewan farmers who wish to convert areas of annual cropland to perennial cover as a way of encouraging soil conservation.

Mr. Speaker, as we mark Soil Conservation Week, I would like to thank the Saskatchewan Soil Conservation Association for their hard work and for their commitment to promoting soil conservation in our province. Thank you very much, Mr. Speaker.

Some Hon. Members: Hear, hear!

Battlefords Music Festival

Mr. Peters: — Thank you, Mr. Speaker. Gives me great pleasure today to talk to you about the Battlefords Music Festival which recently delighted the people of the Battlefords with song, choral speech, and instrumental playing.

The Battlefords Music Festival has been in existence continually for 70 years. The first festival had about 30 entries. This year, the festival had close to 850 entrants in many categories. The overall quality of the entrants was very good and a number of students were recommended to go on to compete at the provincial level.

This year, for the first time anywhere; the Battlefords Music Festival had a special afternoon which featured specific First Nations competitions in drumming, story telling, and singing. This reflects the special cultural makeup of the Battlefords.

No mention of the significance of the music festival to the Battlefords would be complete without a warm word of praise and appreciation to the many volunteers who have made it possible for so many years. The festival network is a team of dedicated people working under the umbrella of trust, open communications, enthusiasm and dedication, committed to making each year's festival better.

So I ask you to join with me in offering appreciations to the Battleford Music Festival, the competitors, the teachers, the adjudicators, and volunteers. Thank you, Mr. Speaker.

Some Hon. Members: Hear, hear!

Rawlinson Gift to University of Saskatchewan

Mr. Addley: — Thank you, Mr. Speaker. Those of us fortunate enough to receive a university education, I'm sure would like to be able to help our school assist future students receive the same benefit. Some graduates happily find themselves in the position to do just that.

One such graduate of the University of Saskatchewan, my alma mater, is Gordon Rawlinson, president of Rawlco Radio, who's a product of the College of Commerce. Quite obviously, Mr. Speaker, the good professors at the College of Commerce did their job well, because Mr. Rawlinson has recently donated $1 million to the University of Saskatchewan.

This generous gift is to be used to help First Nations and Metis students obtain the same kind of business education that launched Mr. Rawlinson on his career. The funds will be used to establish a Rawlco Resource Centre jointly run by the College of Commerce and the Saskatchewan Indian Federated College School of Business.

The Centre will recruit Aboriginal students to enter university programs in business administration. The money will also be used to fund a First Nations Business Library and support a counsellor for these commerce students.

Mr. Speaker, it is truism that the future of our province is uniquely tied to the development of the skills of First Nations young people and to the contribution they will continue to make to the province.

I congratulate Mr. Rawlinson for his leadership and for generously returning a portion of what he's gained to the province and to the institution which gave him his foundation.

Thank you, Mr. Rawlinson, and thank you, Mr. Speaker.

Some Hon. Members: Hear, hear!

Tisdale Man Receives Medal of Bravery

Mr. Gantefoer: — Thank you, Mr. Speaker. Mr. Speaker, and members, I would like to bring to your attention about a young man's heroism in our constituency, who was recently presented the Royal Canadian Humane Association's Medal of Bravery by the Commissioner of the Royal Canadian Mounted Police.

Tyler Howes, a 19-year-old Tisdale man and three travelling companions were trapped in a car that was upside and submerged in the Capeau River. He and his friend in the back seat were able to open their door and get our. Unfortunately before the two girls who were in the front seat were able to follow them out, the pressure of the water slammed the door shut and sealed the car.

Mr. Howes persistently made several attempts to free his companions, and through his quick thinking was finally able to break the window and to pull the girls out just as they had lost the last of their air supply.

Tyler does not think of himself as a hero. He said: "It's just something a person does." Tyler's selfless reactions averted what has too often ended in tragic results in similar circumstances.

It is with pride that I ask the Assembly to join me in recognizing Mr. Howes' act of bravery.

Some Hon. Members: Hear, hear!

Johnson Collegiate Wrestling Teams Win Provincial Championship

Mr. Yates: — Thank you, Mr. Speaker. More good news for Saskatchewan and for Regina, Mr. Speaker. In fact there's good news for my constituency of Regina Dewdney. There is good news from F.W. Johnson Collegiate whose men's and women's wrestling teams have just made provincial history, Mr. Speaker.

First, Mr. Speaker, both teams won the city championships. Mr. Speaker, collegiate wrestling is a team sport and winner is chosen by a team's total points based on the performance of individual team members in various weight categories.

Having won the city championship, Johnson Collegiate then hosted the provincial championships. And, Mr. Speaker, both the men's and women's teams won again. This is the first time ever in Saskatchewan high school athletic history that the same school has won both championships.

The women racked up 77 points to their nearest rival's 37. A decisive win. The men had it a bit tougher, also amassing 77 points to Saskatoon Mount Royal's 75.

Mr. Speaker, I want to congratulate all participants on both teams, and by name I want to congratulate coaches Lloyd Church and Kelly Dumont for their outstanding accomplishment in amateur athletics.

Thank you, Mr. Speaker.

Some Hon. Members: Hear, hear!

ORAL QUESTIONS

Dividends from Crown Investment Corporation

Mr. Wall: — Thank you, Mr. Speaker. Mr. Speaker, my question is for the minister responsible for the Crown Investments Corporation. Mr. Speaker, last year the government budgeted a $150 million dividend from the Crowns. But when the government released its 2001 budget last month, that dividend had suddenly disappeared. Why is that? Did the Crowns make less money last year so they couldn't afford to pay a dividend?

Mr. Speaker, to the minister. Will the minister please explain why the Crowns paid no dividend to the government last year?

Hon. Mr. Cline: — First of all I want to say to the House, Mr. Speaker, that this is a question that was addressed on budget day. This is not something that has been hidden until that member gets up in the House.

The reason that dividend was not taken in the last fiscal year,

last year, Mr. Speaker, is because we did not need the dividend last year. We now have that money available for this year and next year and the year after. If we had listened to the members opposite we would have spent all that money last year.

That money has not been spent, Mr. Speaker. That money will be taken. And it is not a question, Mr. Speaker, of if the people will receive that $150 million dividend it is a question of when.

Mr. Speaker, the dividend from the CIC (Crown Investments Corporation of Saskatchewan) to the General Revenue Fund this year will rise by $50 million. I anticipate that the dividend in the next fiscal year will rise by a significant amount of money, so that we will use that money, Mr. Speaker, when it is needed, to provide health, education, and highways in this province, which those members voted against, Mr. Speaker.

Some Hon. Members: Hear, hear!

Mr. Wall: — Mr. Speaker, Mr. Speaker, on behalf of Saskatchewan people I can tell the minister through you, that the people of this province are concerned that the when, in terms of when this money will be used, is when this government believes it's to its political advantage to buy favour with the public and try to improve its flagging election fortunes, Mr. Speaker. That's the when.

Some Hon. Members: Hear, hear!

Mr. Wall: — Mr. Speaker, it's strange that the government decided not to take a dividend from CIC last year, especially with all of the huge rate hikes we've endured and the ones on the way.

If CIC had paid a dividend last year, the government could have used at least some of that money to provide or consider providing a much larger energy rebate instead of the $25 pizza rebate we got a couple of weeks ago. That rebate's worth only $10 million, Mr. Speaker. That government blew more than that in the potato industry last year.

Some Hon. Members: Hear, hear!

Mr. Wall: — Mr. Speaker, to the minister, to the minister: why do Crown corporations make a profit if that money isn't used to the benefit of Saskatchewan people?

Some Hon. Members: Hear, hear!

Hon. Mr. Cline: — Mr. Speaker, this is how incredible and ridiculous the opposition's line of reasoning is. What they are saying is, why didn't you spend all the money last year? That's what they're saying. Why didn't you take the $150 million and spend it last year? That's what they're saying.

And we're saying, Mr. Speaker, because we're going to spend it this year and next year. And we're going to spend it on, Mr. Speaker, health care, which got a big increase in the budget; highways, because we're going to fix the roads; education, because we're going to educate our children; and sustainable tax cuts. Those are things we're going to do because we didn't spend all the money last year, Mr. Speaker.

Those are things the members opposite oppose, but that is what we're going to do, Mr. Speaker, because we're not going to mortgage our children's future by spending all of our money last year, Mr. Speaker.

Some Hon. Members: Hear, hear!

(14:00)

Mr. Wall: — Mr. Speaker, what we oppose, what we oppose is the government hoarding the money and putting it in their bank account while Saskatchewan families deal with increasing utility rates and taxes in this province. That's what we oppose, Mr. Speaker.

Some Hon. Members: Hear, hear!

Mr. Wall: — The minister says that Crown corporations are used to the benefit of Saskatchewan people, but the fact is that whatever profits the Crowns did make last year not one dime of it went to the General Revenue Fund. Not one dime of it for tax relief. Not one dime of it for relief from high utility rate increases, Mr. Speaker. It's kind of hard to understand.

Mr. Speaker, how did the Crown profits benefit Saskatchewan people this year — that's the simple question — when not one dime of this money was returned to the General Revenue Fund?

Some Hon. Members: Hear, hear!

Hon. Mr. Cline: — Well how, Mr. Speaker, you would benefit the people of the province this year by spending the money last year, I don't know. And this is how ridiculous their reasoning is, Mr. Speaker.

They say — the member from Humboldt in the Humboldt *Journal*, the member from Lloydminster in this House, other members, check the record — say that we're spending too much money and that our path of spending is not sustainable. They say, Mr. Speaker, we're spending too much money on health care, education, and highways. That's what they say.

Now they get up and say we should spend more. And not only should we spend more, we should have spent it all last year, Mr. Speaker. Well it doesn't make any sense, Mr. Speaker, because the members opposite are not very good with numbers, Mr. Speaker, and that's why they're members opposite, Mr. Speaker.

Some Hon. Members: Hear, hear!

Health Care Facility in Melville

Ms. Bakken: — Mr. Speaker, yesterday the member from Melville said in this House and I quote:

> The Fyke report will have no bearing on the construction of a hospital in Melville.

Yet in speaking to the media following question period, the same member could not guarantee that the facility now under construction would keep its hospital designation if the Fyke report is implemented. He said to the media and I quote:

> How can I promise that until we've heard and listened to Mr. Fyke at our committee and completed our entire review of the recommendations?

So one minute the member scolds the opposition for asking tough questions about the effects of the Fyke report in Saskatchewan health facilities, and the next he raises his own alarm bells about what kind of health facility will open in Melville.

Mr. Speaker, to the Minister of Municipal Affairs: can you stand in this House and guarantee the people of Melville and area . . .

The Speaker: — Would the member restate the question through the Chair please, 10 seconds.

Ms. Bakken: — Mr. Speaker, to the Minister of Municipal Affairs, through the Speaker: can you stand in this House and guarantee the people of Melville and area that the new facility now being built will be opened and remain as an acute care facility?

Some Hon. Members: Hear, hear!

Hon. Mr. Nilson: — Mr. Speaker, as we work together in this province to build a better health care system, we are going to look and listen and hear all of the different things that people are saying about what we should do.

As it relates to the building in Melville, the people in that community have worked for many years to develop a plan, together with the Department of Health, that builds an integrated facility where they will have the services that they need as the size of community that they are in this province. And that plan will include acute care. It will also include long-term care. It will include emergency response.

What we are doing, Mr. Speaker, is building for the future of this province; building for our children and our grandchildren. We ask the members opposite, what's your plan? What are you going to do? You have a zero . . .

Some Hon. Members: Hear, hear!

The Speaker: — I would ask the ministers in their response also to address all remarks through the Chair and please, the questioner, questions through the Chair.

Ms. Bakken: — We have presented a plan in this House and we ask, where is the NDP's (New Democratic Party) plan.

Mr. Speaker, perhaps now the member from Melville will realize the concern that Mr. Fyke's recommendation to close 50 rural hospitals has caused throughout the entire province, because now he will hear it in his own community. People and health care professionals from across Saskatchewan are very concerned with the Fyke Commission report and the suggestion that acute care services will be regionalized. And they have questions they want answered.

The people of Melville are asking what will happen to the new facility they have worked so hard for. It's fine for the minister to say the building is going ahead, but what if it turns out to be just a building with no acute care beds? What if it is designated just a community care centre?

Mr. Speaker, to the Minister of Municipal Affairs: will it be good enough if the new Melville hospital is deemed a community care centre under Fyke's Health Care Commission?

Some Hon. Members: Hear, hear!

Hon. Mr. Nilson: — Mr. Speaker, we have an opportunity today to listen to Mr. Fyke, ask him questions. And we understand that the members opposite are going to participate in that. We don't know whether they're going to participate in a legislative committee and deal with some of the questions that are raised here.

It's very interesting that Mr. Randy Burton in *The StarPhoenix* this morning talks about what the opposition are doing. It says:

> If the Opposition — which claims it's ready to form government — has better ideas than (Mr.) Fyke has proposed, then let's hear them.

Mr. Speaker, all of the people in the province want to work together to build a better health system. We want to hear the ideas from the member's opposite — and the sooner, the better. Please join the committee.

Some Hon. Members: Hear, hear!

Ms. Bakken: — Mr. Speaker, it's interesting that the government continues to ask us to do the work for them instead of them coming up with their own ideas . . .

Some Hon. Members: Hear, hear!

Ms. Bakken: — . . . the people of Saskatchewan. Mr. Speaker, it's interesting also that the Minister of Municipal Affairs has chosen to sit with the NDP. And the minister has chosen to support the party that closed 52 rural hospitals and the Plains hospital . . .

The Speaker: — Order. Order. Order. The member will continue.

Ms. Bakken: — The minister is choosing to sit with the NDP, who so far has expressed no opinion on the Fyke report. He is supporting their proposal to study the study. Yet in the next breath, Mr. Speaker, the member from Melville admits that the hospital now under construction may not actually be designated a hospital.

Mr. Speaker, the member from Melville must come clean with his constituents.

To the Minister of Municipal Affairs. Will he continue to sit with the NDP and support their record of hospital closures? Or will he fight for the people of Melville to ensure that a full and functional acute care hospital will occupy the new facility now under construction?

Some Hon. Members: Hear, hear!

Hon. Mr. Nilson: — Mr. Speaker, I have a simple question that I would ask through you to the members opposite. Will you participate in the legislative . . . or will members opposite participate in the legislative committee? We need to know the answer to that.

The people of Saskatchewan are interested in knowing what they're going to do about this because this is an issue that surpasses all of the partisan politics in this place. It relates to all of us individuals. It relates to our families. It relates to our children and our grandchildren.

We need to get this right. We need to make sure that we have a publicly funded, accessible, health care system that provides services for everybody.

We on this side of the House are going to work toward that goal with all of our vigour and with all of our might. Thank you.

Some Hon. Members: Hear, hear!

Grants in Lieu of Taxes

Mr. Bjornerud: — Thank you, Mr. Speaker. Mr. Speaker, my question's for the Minister of Municipal Affairs. Mr. Speaker, yesterday the minister asked me how slow do I have to speak? Well, Mr. Speaker, the problem is he was wrong. That's w-r-o-n-g, wrong.

Mr. Speaker, the minister said grants in lieu of taxes have nothing to do with assessment. The fact is, Mr. Speaker, they have everything to do with assessment. And the NDP has decided to apply a double standard when it comes to calculating this year's grants in lieu. Everyone else in Saskatchewan will pay based on this year's assessment.

Mr. Speaker, why the double standard? Why does everyone else have to pay higher taxes based on this year's assessment, while the government can pay on last year's assessment?

Some Hon. Members: Hear, hear!

Hon. Mr. Osika: — Mr. Speaker, thank you. I just want to reiterate, with all due respect, Mr. Speaker, four years ago, all throughout the '80s, there was nothing paid for properties owned by governments. Nothing, nothing — during the '80s there was nothing.

Four years ago, four years ago, Mr. Speaker, listening to community leaders, there was an agreement by the government to pay grants, grants in lieu of taxes on properties that SPMC (Saskatchewan Property Management Corporation) owned, simple as that.

Today, this year, Mr. Speaker — four years ago there was zero — this year, $13.1 million.

Besides that, Mr. Speaker, the government did listen to community leaders —SUMA (Saskatchewan Urban Municipalities Association), SARM (Saskatchewan Association of Rural Municipalities), SSTA (Saskatchewan School Trustees Association) — for more funding for education. This budget — an increased amount for education.

The government's been listening to the leaders of communities to help them, and they have. I don't know what they're voting against.

Some Hon. Members: Hear, hear!

Mr. Bjornerud: — Thank you, Mr. Speaker. Mr. Speaker, before the minister got around to closing the Melville hospital yesterday, you know what he told the media? He said the government couldn't possibly pay grants based on the new assessment because the order in council was already being written. In other words, the government couldn't handle the paperwork.

Mr. Speaker, everyone else has to deal with the paperwork. Every municipality, every school board is forced to use the new assessment, but the government can't handle the paperwork.

In fact, the government told SUMA that it simply would not be able to budget for variations that will occur each year on such short notice.

Mr. Speaker, what does he think every business in this province has to deal with? Higher taxes due to reassessment.

Mr. Speaker, will the minister answer — do grants in lieu have anything to do with assessment?

Some Hon. Members: Hear, hear!

Hon. Mr. Osika: — Mr. Speaker, in January, in January the presidents of three local government associations met with the Finance minister and they reminded the government for the need for education tax relief for property taxpayers in the upcoming provincial budget. They also asked for some assistance to small businesses. Well, guess what? In this budget, there was an increase in education funding. Guess what? There was a 25 per cent reduction for small businesses.

I can't believe that those members opposite voted against that kind of a budget. And now they're saying that this government should not be giving communities $13.1 million in grants in lieu of. Four years ago there was zero, Mr. Speaker; today there's $13.1 million.

Some Hon. Members: Hear, hear!

Mr. Bjornerud: — Thank you, Mr. Speaker. Well, Mr. Speaker, we're now starting to see the effects of the NDP's decision to hire more government employees instead of holding the line on property taxes.

The city of Melfort, Mr. Speaker, has announced a 2 per cent increase in property taxes. That's $2.3 million tax hit for the people of Melfort. And why are they raising taxes? Well, council says it had little choice because there was no increase in revenue sharing. That's $2.3 million tax hike for the city of Melfort alone, thanks to this NDP budget.

Mr. Speaker, how did that minister let this happen? How can he support a budget that will raise property taxes in almost every municipality in this province?

Some Hon. Members: Hear, hear!

Hon. Mr. Osika: — Well the member opposite, Mr. Speaker, did say almost, but I want to once again remind the House and all hon. members and the people of this province that we are not dodging reassessment or shortchanging local governments.

As a matter of fact, the projected amounts that were going to be paid were $12.3 million this year. It's turned into $13.1 million, Mr. Speaker. It's gone up. And as an example, I just want to . . . As an example, let's use the city of Regina. For their grants in lieu of taxes which are estimated, including the city and school boards, is $7.48 million; Canada infrastructure money is 3.28; transit for disabled, .82; urban parks, $2.82 million. And, Mr. Speaker, besides that, the relief on the monies and the additional monies that the city will be getting, an estimated $460,000 as a result of the street light savings and increased municipal surcharges.

I don't know what they're voting against or why they don't want the municipalities to have that money.

Some Hon. Members: Hear, hear!

(14:15)

Support for Agriculture

Mr. Boyd: — Thank you, Mr. Speaker. My question is for the Premier. Last week I asked the Minister of Agriculture if he and your government had received a reply from the Prime Minister to your strongly worded letter that you sent to the Prime Minister following the emergency debate on agriculture we held a few weeks ago. We didn't get a specific answer to that question, so I'd like to ask you again, Mr. Premier.

Mr. Speaker, Mr. Premier, have you received a response . . .

The Speaker: — I would ask the member to continue but to direct his remarks through the Chair, please. Thank you.

Mr. Boyd: — Mr. Speaker, has the Premier received a response from the Prime Minister to his letter that he sent a few weeks ago?

Some Hon. Members: Hear, hear!

Hon. Mr. Serby: — Mr. Speaker, I want to say to the member opposite and to this Assembly that we now, in Saskatchewan, have received a letter from the Prime Minister's office. That letter has also now been circulated to all of the premiers across Canada. And we have now in our possession a letter from the Prime Minister of Canada.

Mr. Boyd: — Thank you, Mr. Speaker. Mr. Minister, I'm sure the farm families of this province would be interested in what that response was and I'd appreciate it, on behalf of the farm families, if you would table that letter here in the Assembly this afternoon.

On another issue concerning farm families, Mr. Speaker, we have learned that the farmland property tax rebate is now way, way over budget and they've only processed about 40 per cent of the applications so far. This is exactly why rural municipalities and farmland owners were saying, months ago, that the program would cost taxpayers hundreds of thousands of dollars in bureaucracy.

Mr. Speaker, the RM (rural municipality) suggested they could handle this program themselves. They felt they could apply the rebates directly to property taxes at the local level, saving administration costs. The government could have put those administration budget costs back into the program.

Mr. Speaker, Mr. Premier, can the Minister of Agriculture explain why the government didn't use the money municipalities could have administered into the program and why the administration is now some $200,000 over budget?

Some Hon. Members: Hear, hear!

Hon. Mr. Serby: — Thank you very much, Mr. Speaker. And I can say to the member opposite that the administration of this program, we had a great deal of discussion with SARM about who should administer this program. And the province, the province said that if the municipalities were interested in administering this program, we would be more than pleased to allow that to happen.

However, Mr. Speaker, why this didn't happen is because in our policy we said that the home quarter in our policy would have to be exempt. And what SARM has said to us, all along, is that they don't have the capability to address the issue of exempting the home quarter for all municipalities that would be involved in this process across the province.

I met with the SARM executive this winter and I said to the SARM executive, Mr. Speaker, that if in fact they arrive at a process in which they can do that, we would be happy to allow the SARM organization to administer the program in this province.

Some Hon. Members: Hear, hear!

Medicare Commission

Mr. Hillson: — Yes, Mr. Speaker, later today we'll have the privilege of having Mr. Fyke come before us. We know that health spending in the province is increasing by 11 to 12 per cent a year. The economy is growing at 2 to 3 per cent, the lowest in Canada according to *Globe and Mail*. Yet I would suggest that the NDP has already decided that Fyke is to be quietly put on the shelf and forgotten.

My question to the government today: has the decision already been taken that Fyke is too hot to handle? Has the decision already been taken that we will go through the sham of consulting and consulting? We will have groups that have already appeared before Fyke come before the MLAs to repeat what they have already said, and we will go through this long enough until the whole thing is quietly forgotten and never dealt with. Have they ceased governing?

Some Hon. Members: Hear, hear!

Hon. Mr. Calvert: — Mr. Speaker, the member from

Battleford or any member over there who for a fleeting moment thinks that we have ceased governing is dead wrong.

Some Hon. Members: Hear, hear!

Hon. Mr. Calvert: — Mr. Speaker, we are giving to this opposition and to the people of Saskatchewan and to providers of health care in our province and to the citizens of our province, the recipients of health care, an opportunity, a groundbreaking opportunity to participate in the formation of public policy, Mr. Speaker, through a process that begins in this House this afternoon with the appearance of Mr. Fyke, a process that will continue with a committee of this legislature being available to the people of our province to give their observations and impressions of Mr. Fyke's recommendations.

Mr. Speaker, based on that work which I hope will involve all members of this House, based on that work, we will develop a plan for the future of medicare in this province and perhaps in the country.

Some Hon. Members: Hear, hear!

Mr. Hillson: — Mr. Speaker, if the government would give at least a preliminary reaction to Fyke, there would be something for groups such as SAHO (Saskatchewan Association of Health Organizations), SUN, the province's doctors to respond to. But with no indication of the government's thinking, all these groups can do is to come before the MLAs and repeat what they've already said — a commission into the commission, an inquiry into their inquiry, a report on the report.

After we go through this process, after we as MLAs hear the same groups who've already come before Fyke, will the government, Mr. Speaker, then say, oh we've now got to wait for the national commission. We've got to wait for the Romanow commission. So we have more excuse for delay. We have more excuse for inaction. Have they decided they are not prepared to deal with the Fyke report?

Hon. Mr. Calvert: — Mr. Speaker, I understand it's very easy to join the ranks of the opposition and become a critic. That's a very simple thing to do. What is a little more difficult, Mr. Speaker, what is a little more difficult is to rise just a fraction perhaps, just a fraction above partisan politics for once on an issue of public importance — the nature of health care in our province.

Mr. Speaker, I don't always agree with my friend Randy Burton in his writings in *The StarPhoenix* but today, Mr. Speaker, I do when he observes at the conclusion of his article today, Mr. Burton writes:

> By the same token if those in the legislature (we) could lay down their partisan cudgels for a minute or two, maybe they could actually make Saskatchewan a different, even a better place to live.

Mr. Speaker, I invite members of the opposition to do just that, including the member from North Battleford.

Some Hon. Members: Hear, hear!

TABLING OF REPORTS

The Speaker: — Members of the Assembly, before orders of the day, I have received a report from the Office of the Provincial Auditor. Order, order. I received a report from the Office of the Provincial Auditor and I hereby table the report to the Legislative Assembly of Saskatchewan on financial statements of Crown agencies for the years ending in the year, in the 2000 calendar year, dated April 2001.

ORDERS OF THE DAY

WRITTEN QUESTIONS

Mr. Yates: — Thank you, Mr. Speaker. On behalf of the government I am pleased to table the answers to questions nos. 70 through 76.

The Speaker: — Items 70 through 76 are hereby tabled.

GOVERNMENT ORDERS

The Speaker: — Members, pursuant to an order of the Assembly, the House will now proceed to the Committee of the Whole.

(14:30)

COMMITTEE OF THE WHOLE

Final Report of the Commission on Medicare

The Chair: — Order, please. The business before the Committee of the Whole today is the examination of Mr. Ken Fyke, Commissioner, with respect to the final report of the Commission on Medicare.

As members are aware, this Committee of the Whole was established by an order of the Legislative Assembly dated April 11, 2001, which reads in part as follows, and I quote:

> Ordered that a Committee of the Whole be authorized to question Mr. Ken Fyke, Commissioner, with respect to the final report of the Commission on Medicare dated April 11, 2001;

On behalf of the committee I would like to thank Mr. Fyke, along with Mr. Patrick Fafard, Ms. Kathryn Dotson, for making themselves available today to answer questions from the members.

Members, for the clarification of the witnesses, and all members of the committee, I want to outline the procedures of this hearing today, which were agreed upon by the respective House leaders.

If there are any objections to the procedures, then I will ask for a motion so that the committee can formally decide its procedures.

Firstly, Mr. Fyke will be asked to make an opening statement of a maximum of 20 minutes.

Questioning will then follow based on 20-minute intervals in the following order: government side, opposition, government again, and then opposition again.

There will then be a 20-minute recess, followed by questioning in 20-minute intervals as follows: independent member, government, and opposition.

The time intervals will be displayed on the countdown clocks in the corners of the Legislative Assembly, here in the Chamber.

Finally, no member may debate with the witness. Mr. Fyke has been invited to answer questions from members. I thank all hon. members for their co-operation.

I now invite the witnesses to introduce themselves to the committee.

Mr. Fyke: — I want to begin by thanking the legislature for this opportunity to discuss my report today. During the past nine months, I have had the great privilege of meeting with hundreds of individuals, groups, and organizations to talk about the future of medicare in this province. I am pleased to be able to discuss my recommendation with all elected members today.

My report is focused around three key priorities: a health system that puts quality first with clear accountability for achieving results; a health system based on teamwork fully utilizing the skills of all health care providers; and a health system that offers security especially to rural citizens through a clear plan for local, regional, and provincial services.

This province has some unique challenges in health care. One of these is to give rural citizens access to services close to home while ensuring quality. There is a significant challenge . . . this is a significant challenge but it can be done.

Rural citizens do not have to fear for the future of health care. By redirecting resources now going into small hospitals, secure, high quality services can be provided close to home. And these services can be sustained into the future.

My recommendations have been characterized as cuts to rural hospitals. What I have actually called for is reinvestment in rural health care and investment in change.

Here is what I recommend. Primary health teams including doctors, nurses, and other skilled professionals to promote and maintain the health of our citizens as well as provide everyday health services; a strengthening of our home care and community services; telephone advice available 24-hours a day; and improved emergency medical services.

This package of everyday services will lead to better health care, not only for rural Saskatchewan, but for all the citizens of this great province.

My report does call for change. Change away from reliance on very small hospitals. Change to a new model with enriched emergency and primary health services.

Primary health services deserve much more emphasis in the health system than they receive today. Family physicians, nurses, public health workers, social workers, addiction counsellors, speech therapists — these skills are the ones that support individuals to sustain their health and well-being day in and day out.

Primary health services are the key to better health and the key to containing health care cost. Every health problem that can be prevented or detected and managed at an early stage is a health problem that will not need expensive treatment down the road. Putting people's health front and centre requires a new organization of services based on teamwork.

In today's environment, with many skills in short supply, it is essential to make full use of all our health care providers. The current system separates doctors from other parts of the system, creating unnecessary barriers. Instead, I recommend bringing physicians into the primary health team as part of the health district operations.

Some people have suggested that my report does not recognize the contribution of rural doctors. The fact is I have the greatest respect for the contribution of family physicians. I know that family doctors have unique skills and abilities that must be used to their fullest. And by working as part of a team, physicians will be able to extend the value of what they do and put their skills to the greatest use. As one doctor said to me, quote: "Let us be part of the system."

Across the country and here in Saskatchewan, many pilot projects and demonstration sites have been set up to offer primary health services through teams. Clients may see a nurse, a pharmacist, a physiotherapist, or a physician, depending on their needs. For rural and urban residents alike, primary health teams will improve the quality of health services.

The role of small hospitals will change accordingly to primary health centres offering a different and wider range of services.

What will happen to the services now provided in small hospitals? They will continue through out-patient care, home care, and community care centres. In some cases where in-patient care is needed, some people will have to travel further. But on balance, on balance, communities will have more services rather than less.

Hospitals are an important symbol for rural communities. The hospital care that is acute in-patient care is a service people need infrequently. The location of a hospital is not nearly as important as the quality of service it provides. And when it comes to hospital quality, size does matter.

I believe that Saskatchewan will be better served by having fewer, stronger hospitals. Complex diagnosis, treatments, and surgery take a full complement of specialist physicians and nurses, technicians, equipment, and facilities. And in a province of one million people it simply makes sense to concentrate these services into fewer centres.

The plan that I have outlined will see specialized services for everyone in the province delivered in three cities: Regina, Saskatoon, and to a lesser degree, Prince Albert. Basic acute and emergency care would be provided in 10 to 14 regional hospitals. Regional hospitals would focus on services that are

more commonly required such as general medicine, maternity care, or care that must be repeated, such as dialysis or cancer therapy.

Each regional hospital would offer a selection of services based on their capabilities and a coordinated plan. Planning for hospital care cannot be done by each facility in isolation. Government must take the lead in developing an overall plan to meet needs and achieve standards of quality.

I have also called on government to provide leadership in other areas. Human resource planning to train, recruit, and retain health providers for the future. In capital planning to ensure the needed facilities and equipment are in place. And hospital bed management to ensure beds are available when the patient needs it. Above all, government must take the lead in setting goals and measuring results — in short, achieving quality.

Through the years, the success of our health care system has too often been measured by quantity — the number of hospitals, the size of budgets, the volumes of surgery. Issues of quality and value have been swept under the rug. And this cannot continue.

Health services are too important and too expensive to go unmanaged. For all that is spent on health care we know surprisingly little about the results. Some of what we do know though is disturbing.

Ten to 25 per cent of antibiotics are neither necessary nor effective. Up to 20 per cent of hospital admissions of the elderly are due to adverse drug reactions. Hospital admissions in Saskatchewan are 41 per cent higher than the national average. To change these things require a focus on quality.

Quality concerns are not in any way unique to Saskatchewan. Questions about quality health care are now being asked across North America and around the world. Let me be clear, achieving quality does not depend on spending more money. In fact, quality improvement generally saves money. Problems of quality include underuse, misuse, and overuse of health services.

More drugs, more tests, and more admissions to hospital may not lead to better results. In fact, too much service can be as bad as too little.

One nurse I talked to put it his way, quote:

> We do because we can, not because we should.

Another nurse who has worked for years in critical care said to me, quote:

> We seem to have lost a lot of our common sense and along with it our compassion.

According to her, quote:

> Quality care means doing what is right for each person instead of doing everything for everybody.

The purpose of the health system must be to achieve better health. Yet we have few tools to measure results. What is not measured cannot be managed, and it cannot be improved.

(14:45)

I recommend an arm's-length quality council be set up to recommend standards of care and report to the public on health system quality and effectiveness. In addition to these changes, my report recommends a number of supporting elements, a smaller number of health districts, the renewal of health science education programs in our province, increased funding for health research, and continued investment in communications and information technology.

Taken as a package, these recommendations will lead to a more secure, sustainable, and high quality health system. Implementing these changes will require an initial investment, but in the long run they will help to keep costs down.

My advice to you is this. Invest in change; resist the temptation to simply spend more on a system as it is. A healthy society takes more than health care. It takes education, it takes opportunities for employment, it takes strong communities, and it takes hope for the future.

All of these can be jeopardized if you simply give in to the demand to spend more and more on health care.

In closing I want to emphasize the need for vision and commitment. Change will require everyone to set aside their long held positions and commit themselves to work together for a greater cause.

I understand that some may fear a loss in what I have proposed. But individually and collectively, there is much more to gain.

Thank you. I'd be pleased to answer questions.

The Chair: — Thank you, Mr. Fyke. As agreed upon by the committee, I'll first turn to a member on the government side for the first 20-minute question period.

Ms. Higgins: — Thank you, Mr. Chair. Mr. Fyke, I would first like to thank you for providing us this opportunity to be able to ask questions on behalf of the people we represent in Saskatchewan, to better understand the commission's report.

Mr. Fyke, as you're well aware, in 1993 the government made some very major changes in our health system as we knew it. We converted some hospitals into wellness centres. But people felt that hospitals were closed. Some were.

For many people, change to health care was disruptive to the system, hard on very many communities, and put major stress on health care providers.

The major question that I'm getting in my constituency, and others I've spoke to since your report was released is, why do we have to go through this again?

Mr. Fyke: — I appreciate that there's been a lot of change in the last 10 years. Ten years in the health system is a long time. My report will build on the developments of the last 10 years and the good things that have occurred in this province. This

province led the way in regionalization.

But we've reached a point in health care, not just in this province but across Canada, where I believe we've got to refocus, refocus our system towards quality and not volume. We have focused on volume for the last 10, 20 years, and while it may be difficult to look at more change, I believe it is the only way that we can have and sustain a publicly funded health care system.

Ms. Higgins: — Could you be more specific in why you feel . . . I mean can we not stay within the same system but still focus on quality?

Mr. Fyke: — The difficulty with the current system, it is not focused on quality. It is focused on volume. We need to change the culture, we need to change the organization as to how it's organized, and we need to change our incentives.

Our system . . . our health care programs today are not a system. We are facing in the next few years in Saskatchewan and in other provinces a real challenge in having enough health care providers to provide the services. We're also facing the challenges of the financial matter as well.

But if we continue to pour money into the current system, we will continue to not . . . we will not get the value for money that we should. The costs will continue to escalate and we will be faced with either alternatives of taking money away from other programs or cutting some of the insured benefits that we have today.

So we have to reorganize the system to focus it on quality, and we have to change the incentives in the system so that our health care providers are fully utilized to the maximum of their skills, and we must focus on quality.

I don't believe that we can do that and still maintain the same organizational structure in the system.

Ms. Higgins: — In your report, Mr. Fyke, you recommend turning many existing small hospitals into primary health centres or community care centres. And I know from people that I've talked to in rural Saskatchewan, their concern is that living in a small community and even having a small hospital, that I have some sense of comfort that when I need medical care it is close at hand.

Now if the reforms that you recommend were to be implemented, and say I did become ill or something serious, had a heart attack, what kind of service could I expect from primary health services or community centres?

Mr. Fyke: — I very much appreciate the concern of rural Saskatchewan about their local hospital. And what I am recommending is taking those resources in 20 small rural hospital and utilizing those resources in that community so that we can have enhanced services for the people of those communities.

I'll speak about community care centres in a moment. I'll just talk now about my recommendation of converting 20 of the smaller hospitals from a 24-hour, 7-day-a-week service to a 10-hour.

The difficulty that those communities have is sustaining a physician and sustaining health personnel. Many people I talked to were worried that in six months they wouldn't have a doctor, so the continuity of care was compromised.

And what I see in a primary health services network is to be able to bring more services to that community, more skills of other providers — for example possibly a nutritionist that would serve several communities to assist with patients with diabetes — and the physician and the nurse working as a team, so that the people in that community would have good, quality, everyday services 24 hours a day, 7 days a week.

I'm also recommending that there be enhanced emergency medical ambulance service in those communities. So that when people have a need for an emergency or urgent care, that that service is available readily. Many of our small hospitals today cannot provide quality emergency services. They have not got the skills nor the equipment; nor do they have enough cases to keep their training up in many cases.

So in a community that currently has a small hospital that would be converted to primary health services, their everyday services would be provided by a team of professionals. What is important in health services are the services from the skilled providers. It is not the bricks and mortar.

Now let me move to the recommendation for the community care centres. I'm recommending that 25 to 30 hospitals — currently hospitals, currently named hospitals — be converted to community care centres. I am not recommending the closure of those facilities.

In many of those facilities now, what is being offered is convalescent care, respite care, and palliative care, and some long-term care. Many of those facilities are called integrated facilities today. I would see very little change in what a community care centre does compared to an integrated health care centre.

But I would see, again, an enhanced service in that community for emergency medicine, emergency ambulance. So that when a person has an accident on the farm or on the highway, that there is a highly qualified emergency ambulance technician who can take that person to the proper facility for the appropriate care. I would see that being going to one of the regional hospitals, the 10 to 14 throughout the province, if that person, for example, has multiple fractures or multiple systems or head injuries or whatever.

What happens today, they come into the smaller hospital, they may wait in the smaller hospital for a short period of time and then they're transferred to a larger facility, and that can compromise their care.

So in each of those communities, they will have access to better emergency services and a broader range of everyday services compared to what they have today.

Ms. Higgins: — Mr. Fyke, I guess I'm one of those citizens who, when I was ill, I went to the hospital or to the doctor and

was availed of services. But I have never considered how they work or why they work or if it's the best quality that the people of Saskatchewan deserve. They have been satisfactory for my family, so I'm trying to understand this.

And I guess when you're saying that community care centres, the things that they provide, I'm struggling to see the difference between what the small hospitals provide and what the community care centres in your plan would provide. I mean taking that hospital sign off the highway or the H off the building itself, what difference does that make? And I'm trying to put this into some kind of order and what the rationale is behind it, and how it would improve the quality of care that residents are receiving.

Mr. Fyke: — The community care centres compared to what an integrated health care centre delivers today, there would be very little change.

What is important with the H sign on the highway? Why is the H sign on the highway? The H sign is on the highway for people to . . . who need urgent or emergent care. That urgent and emergent care, I am arguing, cannot be provided in the smaller centres, smaller hospitals, as well as through a good province-wide ambulance service. You look at an ambulance as possibly a small acute hospital on wheels.

I'm recommending that the ambulance report that was done prior to my work, that there be three . . . I'm endorsing that report and I'm recommending three things in it. One, that there be an upgrading of the training for ambulance driving, ambulance attendants, so that they can deal with critical care at the site of the accident or the site of the injury. I'm also recommending that there be a province-wide . . . a provincial central dispatch system so that throughout the province there's a dispatch system that they can get the ambulance to the site of the accident as quickly as possible.

(15:00)

With an ambulance program, a well-organized ambulance program, the attendant can come to that site and deal with whether it's a, possibly a heart attack — which actually is only 1 per cent of ambulance calls but it's something that rural people raise with me — or a farm accident or whatever, and deal right there with the accident.

What I am told, the research indicates, that it is more important what happens at the site of the accident, that the individual driving the ambulance knows what to do — that is more important than the time it takes from there to the hospital.

The H sign on the highway I think in many ways is an illusion because it signifies that there is acute and emergent care at that facility just down the road. Now this might be difficult for some people, but in fact that is not the best quality care.

And I want to add one more thing to quality. When I speak about quality, I'm not speaking of individuals. I'm speaking of the system is not able to deliver quality because of the training of the individuals in the hospital or the lack of equipment in that hospital.

Ms. Higgins: — So in your estimation, in your qualified judgment, how exactly would your model change the kinds of services that are available in rural Saskatchewan and to the smaller centres throughout the province?

Mr. Fyke: — My recommendations would be, would . . . Let's start at the everyday health services level. We would . . . Under a primary health services model, you would be able to offer a broader range of services to the people in that rural communities.

You would offer a higher level of emergency services to the people in those communities. You would offer a telephone call line 24 hours a day so that people on a farm can have access to a call line 24 hours a day which is proven in many other parts of Canada and the United States as very effective in screening and providing comfort to the individual, whether it's a child with an earache or whether it's a gentleman with a chest pain. And there would be enhanced services in home care and community services.

So if you take a community . . . Let's take a couple of communities. Let's take a community where a primary . . . where a small hospital has been converted to a primary health, health centre. What I've just indicated would occur, there would not be a decrease in the services. Every service that is in there today would be provided to the people but it might be provided in a different fashion.

It may be provided at home rather than in their local hospital. It may be . . . The emergency service would provide a higher quality by an ambulance or there would be a 1-800 number that they could call at any time during the day or night.

Now let's move to a larger community where there's currently an integrated health facility. That integrated health facility I'm saying is a community care centre, should be a community care centre, which would be focusing on respite, convalescence, palliative, people in the last stages of their life, and long-term care. That is what an integrated facility does today. Again that wouldn't change that much.

The physicians in that community would be part of the primary health services team. The physicians in that community would see the following differences. They would have someone to share call with so that they wouldn't be on call 7 days a week — 7 days a week, 24 hours a day. They would have colleagues to share their workload. They would be able to utilize their skills to the maximum of their training.

So that there is a team that would be working to keep the people in that community healthy, providing everyday health services, and also dealing with promoting health and preventing illness and dealing . . . In many of our small communities in Saskatchewan, many of the people living there have chronic diseases, chronic disease of diabetes or from heart or from cancer. A primary health services team would then be able to focus on Mrs. Smith's diabetes, and handling that diabetes in a way that allows her to live an independent life and deal with her diabetes.

I've had physicians say to me that they . . . many of our practising physicians can't provide the kind of follow-up and

backup to a lot of our diabetic patients that they would like to. So in those communities where the services would not be focused on a hospital and a doctor, they would be focused on all the health care providers and be provided in the community and in the home.

I won't go into what is a regional hospital on this question, but that might come up in a few minutes.

Ms. Higgins: — Mr. Fyke, one thing I have, I think there isn't one of us that hasn't had a frustrating experience when trying to get through — whether to ask a question or order something or — on a phone line. With this electronic voice messaging and all the rest of it, it can be a frustrating process.

So I would like you to expand on what you see as the phone line or the help line or emergency line that would be set up province-wide.

Mr. Fyke: — The advice line that has worked and is working, as my report indicates, is working in a number of areas in North America, is really an extension of the primary health services.

There would be a person on the line that would be probably a nurse, who would be able to deal with your problems when you call. It would not be a line that would diagnose what your problem is. It is essentially a computer program with a decision tree on asking certain questions to then determine whether your child's earache is a problem that you have to deal with tonight or you can wait until tomorrow and see your primary health team tomorrow; or if it is chest pain, whether you should call the ambulance and get to a hospital.

So the telephone advice line provides counsel and advice. For example, is it an urgent situation? It does result, the research indicates that it does result in better care and more reliable service and does actually result in fewer calls, fewer calls to the . . . fewer visits to an emergency department because it is a scientific, medically structured call line, call system, that allows the right questions to be asked of the client or of the patient, so that then they can direct the person on the line whether that is an urgent matter you have to deal with tonight or not.

The Chair: — Order. The first session for the government side has expired. I'll now recognize members from the opposition side for the next 20 minutes.

Mr. Gantefoer: — Thank you, Mr. Chair. And first of all, welcome Mr. Fyke and staff.

I would first of all like to express my appreciation, as the Health critic for the official opposition, for the dialogue and communication that you extended to us throughout this process. We very much appreciated it.

On your last meeting with us you indicated, I think, and I would probably be fair in paraphrasing you rather than quoting you, when you said, there are some things you're going to like and many things you're going to agree with; some things your paper would agree almost completely but some things you're going to have concerns with. And I think your prediction was fair and probably very accurate.

In the time since your report has been tabled, there have been a number of issues raised in terms of concerns. And I certainly think that this appearance before the legislature is an opportunity for you to expand on points that were in your report and may have left some issues unclear, although I think as well your report's tone and the way it was written was also very good.

You indicated earlier in questioning that while 10 years is a significant period of time in health care and the pace of change in health care, it's a very significant period of time. Fortunately or unfortunately it's not enough time to have people forget about their past experiences of changes in the health care system.

In 1993 there was a process of change in this province that resulted in many communities having their hospitals — 53 of them I believe — either closed or converted. And at the time there were many commitments and promises made that they were going to be an improvement of services for the citizens that were served by those institutions.

And while I recognize that institutions do not automatically mean health care or quality health care, they are the symbols of a commitment in many ways to communities that health care is there for them when they need it.

In your report you again take this a pretty dramatic step forward. You speak of currently something in the magnitude of 70, I guess, H-designated hospitals at the current time. And looking at the report and your comments this afternoon, as I understand it, you're talking about, of those number, that 20 would be converted to primary facilities, another 25 or 30 would join the integrated health facilities network as I understand it — and I expect that's in addition to the current number that are already in the converted list — and some further closures.

On what basis does this conversion . . . Have you got evidential, studied work or is this a perception? Or on what basis do you make the judgment that further closures and conversions are indeed going to result in a pragmatic sense of improved health care for the citizens that view these facilities as critical elements in the health care system they now enjoy?

Mr. Fyke: — Thank you. I want to comment on . . . I'm not here to criticize or defend the past. I'm here to look at what the system for the future should look like in this province.

I would just make one observation though, that with the conversions that occurred in the last decade in this province, the research indicates that the conversions had absolutely no negative effect on the health of the population of this province.

I would like to now speak to the other issue that I detect in your question as well. I think one of your underlying — and correct me if I'm wrong here — I think one of your questions that you may not have stated entirely or stated, sorry, was whether there is a capacity in the number of . . . are there a number of hospitals left? I don't know if that was going to be part of your . . . That's what I interpreted. That was the next question. Okay. Can I answer that now?

Let me say that the 10 to 14 regional hospitals that I'm recommending, plus the specialized hospitals in Regina, Saskatoon, and Prince Albert will provide about 3,000 beds. The system is currently using about 3,000 beds — 2,900.

But I've also indicated the research clearly indicates that there is lots of room for improved utilization. Even with the conversion of 50 beds over the last decade, we still exceed the national average by 41 per cent on our admissions. We still admit patients to hospitals that other alternative forms of care would be more appropriate. We still have one of the lowest levels of day surgery in Western Canada.

And there are other areas where improvements in the organization and delivery of services can be made so I'm very confident — very confident — that between the 10 and 14 regional hospitals, and the hospitals in Regina, Saskatoon, and Prince Albert will be adequate, sufficient — more than sufficient — to deal with the acute care needs of this province.

(15:15)

Now when you look at why . . . coming back to your question on the evidence, I guess, of the conversions, what people told me when I went around the province . . . there's a number of things that were clear from all . . . many, many people said, we need a plan. We need a plan for health services in this province. People told me they know that the system is not working as effectively as it should and that there needs to be change.

And they also . . . people in rural Saskatchewan told me about the break in the continuity of care and the concerns that they had about losing their physician. They have a physician today and he's here for a few months. Now some areas have been fairly stable but there's some areas that are not. And that they really need stability in the system.

One lady was telling me about what happened to one of her family going into Saskatoon for surgery, coming back and there was no . . . the doctor had left. So I looked at the overall system and first of all looked at the capacity. What do we need in this province for acute care beds? And then, how do we best organize for everyday services? Because it is everyday services that are so important. Probably 80 per cent of the people of this province use the everyday services on an annual basis. Your more specialized services are ones, which is fortunate, we use infrequently.

So with the improved ambulance services in rural Saskatchewan, which again everyone said was a critical factor, and the primary health services team which in North America and around the world is proving that you can provide services in a better organized way that will promote health and use everyone's skills to their full benefit, I arrived at this plan based on a local, regional, and provincial plan which I believe will meet the needs of Saskatchewan very well.

Mr. Gantefoer: — Thank you. In your plan of the organizational structure you talk about the tertiary centres and about the regional centres — I think 10 to 14. And again in your discussion today you've indicated those numbers and the conversions to community care centres of a number of the current existing smaller H-designated hospitals and some that would only serve, I guess, as an 8- to 10-hour primary health care centre.

And you also make I think on page 31 of your report, the comment that 88 . . . after this plan is implemented, that approximately 88 per cent of the population would be within 60 minutes of an acute care or regional hospital, and 98 per cent would be within 80 minutes. Yes; 60 and 80 minutes.

In order to make that and to make that assumption, you must have looked at existing facilities and, for lack of a more descriptive phrase, put some pins in the map. And if you did, would you share that information as to how you see the structural organization looking in order to meet those commitments of time and distance from acute care facilities?

Mr. Fyke: — We used a number of computer models with various options as to which hospitals . . . how many hospitals would provide a one hour, roughly one hour, distance from various parts of the province. So that that is a computer model. It's I guess the best technology that I could come up with to answer the question that how many sites, to distribute those 2,900 beds, how many sites would we require around the province. And looked at a multiple of options.

The reason that I did not put pins in the map for my report is I believe that I was asked to provide an overall plan for the province. I believe that it is important now for the government to sit down with the districts and with those communities to decide where the pins go, because they have to be much more intimately . . . much more knowledgeable about their communities and the various factors that may influence the location than I could be in my travels around the province. So I specifically did not put pins in the map.

I determined a range of 10 to 14, as I did with the community care centres in 25 to 30 and indeed as I have done with the number of districts. I think that that is part of leaving some flexibility to the implementation and I think that is a prudent way to approach this.

In reality it is hard to be absolutely precise on the number. I've given the little range and I believe that that allows the communities and the health districts and government some flexibility to determine what makes sense. So that's the reason.

Mr. Gantefoer: — Thank you, Mr. Fyke. I'm no computer expert, but if the model was based on Health, Department of Health statistics and number of services delivered in certain sites over a period of time, or some statistical analysis of that nature that would be based on actual frequency of incidence, if you like, for lack of a better word, and would relate to where those facilities were provided, or where those services are provided, it strikes me that a computer model could do one of two things.

It could take the rectangular shape of the province and, on the basis of theoretical population distributions, attempt to redefine the province and say, in theory 12 to 14 regional health districts are the appropriate number, based on the number of citizens and health population statistics.

The reality is, is that there are communities that were not for . . .

or thoughtful enough to locate themselves in the best place for a computer model. They've grown and evolved and developed facilities and expertise and personnel, and the population distribution as well was inconsiderate in terms of distributing itself exactly evenly.

And so there is a practical reality as certain communities do exist, certain health facilities do exist, certain physician support services do exist, certain speciality services do exist, and to simply come up with a computer model that is based on theoretical figures is one thing, but to come up with a number that says that services will be provided in a practical way, within the specifications that you laid down in report, I submit requires putting pins in the map.

And I can see why you're reluctant to undertake that exercise, but surely there must have been a model that said, to make these commitments, here's where the sites need to be.

Mr. Fyke: — The options that I looked at were also influenced by the number of physicians in many of the communities. And one could just take the largest communities outside of Regina and Saskatoon and look at the number of physicians and the population size of that community and look at various options. Now there is, again, I guess, repeating my answer before, the model was based on certain assumptions and based on certain travel times. Again there is . . . for me to put the exact pin in the map, as you suggest, I think would be taking away what I believe is better left to the implementation of my report because I was looking at a province-wide plan. It wouldn't take too much to . . . for any of you, and I'm sure you may have looked at the 14 largest communities or the largest hospitals outside Regina and Saskatoon, but I still believe that it's, that my role was to provide a province-wide plan, and that's what I've done.

Mr. Gantefoer: — Well I think that I appreciate your reluctance to pin the tail, but I also think that the general recommendations in your report about these service distances and service times also create some obvious concerns. For example, is it reasonable to suggest that with the major regional hospital in Yorkton that we need a regional hospital 25 miles away in Melville? In my constituency, and there's a significant regional hospital in Melfort but a very significant hospital 30 miles away in Tisdale. You can look at the situation in Estevan and Weyburn that are in close proximity to each other and have major communities.

So those sorts of issues are issues of concern. And in terms of direction that people are looking for and some clarity, coming from your recommendations, those are issues of grave concern and potentially are going to result in a further round of people being very worried and protective about the community's future.

We have a situation in Humboldt that is in the process of planning to build a facility, and less than an hour away from Saskatoon. So I think why you're reluctant to specifically name locations, there is some expectation that in your report's commitments of distance and time and numbers, that some recommendations would come forward in terms of specific locations.

Mr. Fyke: — In regard to the regional hospitals, say 10 to 14 regional hospitals that I recommend is sufficient to serve the people of Saskatchewan with about 3,000 hospital beds, I want to emphasize that each of those regional hospitals would not provide exactly the same services. So when you look at a hospital A that is 30 miles from hospital B, it may be a decision of the district or an implementation that that facility could stay there but it would offer . . . it would not duplicate services that were offered 25 miles down the road.

Now one has to examine also the stability and the expertise of the physicians in that community; and the workloads, etc., to support the programs. But I will still maintain that I believe that it should be left to the implementation as to where those 10 to 14 sites are located. I may have put . . . picked 12 sites that upon implementation a couple of them would make more sense that they be somewhere else.

And I think that is important that I look at the overall provincial plan and leave the implementation to people who know those communities much better than I do, and also look at what the needs are overall of the province to determine, for example in orthopaedics, how many of those regional centres would actually do orthopaedics? I would not see all of them doing orthopaedic, providing orthopaedic services, but some of them would. So I believe this: my conclusion, right or wrong, was to leave this up to implementation and for me to give an overall road map of 10 to 14 regional centres.

The Chair: — Order. The present round of discussion has now expired. I now go to the government side for their next turn.

Mr. Thomson: — Thank you, Mr. Chairman. Mr. Fyke, welcome to the Committee of the Whole. I want to thank you and your advisors for joining us here today.

I have a couple of different issues that I want to get clarified. The first set of issues I'm particularly interested in, in the report, deal with specialized care. In the report you state that consolidation of some tertiary services in a single, provincial location or joint planning with other provinces for delivery of services would be necessary. Obviously this would mean that people are going to need to travel further for these services. And I'm particularly interested in how this consolidation will lead to a better quality of services for Saskatchewan people. I'm looking at page 91 of your report.

(15:30)

Mr. Fyke: — Thank you. In regard to specialty services, what is one of the very important keys to the highly specialized services that we see delivered in health care today is that for quality we need a critical mass of skills, equipment, and indeed patients. And for a population of this province, of one million, that in some cases may require several sites, depending on the frequency of the situation. For example, replacing hips may require obviously more sites than cardiac or pediatric open-heart surgery.

So I focused on the quality issues around the critical mass. That will mean that the highly specialized would be in Regina, Saskatoon, and to a lesser degree in Prince Albert. In some cases, I can see that there should only be one centre for the province. I'm not suggesting what that would be but when the

quality council is up, I'm sure that they would look at the current programs or any future programs and say where does it make sense; can we provide that in two centres?

We also have a situation on the skill training . . . the skills of our highly trained physicians. If you have a program in city A with three doctors, and you have a program in city B with three doctors and one leaves, you've got a problem. If you have one program with six doctors and one leaves, you don't have near the difficulty as far as the coverage is concerned.

I believe you referred to out of province as well. And it makes sense, in my opinion, for a population of one million that there would be highly, highly specialized services that we should be working with our other provinces in Western Canada to have a one-centre share and provide that service. This is no disgrace for a highly specialized service; it is no disgrace to go out of the province for that service.

What is a greater risk I believe, and it was exemplified in the tragedy in Winnipeg, of trying to sustain a very highly skilled program where there were not the volumes or the critical mass to keep the individual skills up.

So I think that it makes sense, as we move down the road in the more sophisticated health care programs, that we look at relationships between Saskatchewan and Manitoba, and between Saskatchewan and Alberta. Indeed, there may even be a need for a highly specialized service serving all of Western Canada.

Again I'll just make one brief comment and let you get on with your next question; need not always be the program is outside of Saskatchewan. Indeed Saskatchewan could be the site of one of those highly specialized programs.

But it just makes sense from a quality point of view, and that's what my report focuses on, quality must be first. But some of those critical skills . . . highly skilled programs need a critical mass.

Mr. Thomson: — Thank you, Mr. Chair. Mr. Fyke, I'm interested then in, as we move to this consolidation under your plan and we improve the quality, what is the impact on waiting lists and waiting times? Is there a reduction? Do we expect the list to stay relatively stable? How would you be dealing with this issue, or is this something that you took a look at?

Mr. Fyke: — Yes, thank you for the question. And I, first of all, I want to say that wait-lists are on everyone's mind in the Canadian health care system. Not just in Saskatchewan but indeed across Canada.

But there is more to wait-lists than just more money. We must ensure that the wait-lists are managed better. We must ensure that those who need the services get them first. And we must ensure that there are protocols and standards and shared workloads amongst physicians. So there's really two aspects to a wait-list, how do you get on that wait-list, and then how do you move up the wait-list?

And I've had many discussions with physicians and others on wait-lists, but the bottom line is that money alone will not solve wait-lists, that we need to manage wait-lists.

There is also a good project going on in western Canada between the four western provinces on the wait-list issue. But if my report is implemented, I can see the wait-list being . . . the wait-list dilemma, or problem, being resolved as a result of a number of initiatives. The way we organize, manage the wait-list, the criteria for people going on the wait-list, when they get on the wait-list, how do they get their surgery or whatever. And having our physicians as being part of the system so that our individual physicians are not keeping their own wait-lists that we systemically cannot manage.

Mr. Thomson: — Thank you. So am I correct to assume then that you're saying through the consolidation you'd be better able to manage the wait-lists because you'd have a team of specialists who would be able to share the workload? I see you're nodding, so I'll accept that that's really the answer to this question.

I'm unclear as to how the decisions would be made as to where these specialized services would be located. Who will be making the decision as to what is offered here in Regina at our tertiary, our main tertiary centre and what would be offered in Saskatoon and what would be offered in all three of the potential tertiary centres? Who will be making these decisions and what would be the criteria?

Mr. Fyke: — The Minister of Health would be making those decisions. And I would hope that the Minister of Health would take into — and I'm sure the Minister of Health would — take into consideration the advice from the districts and the advice from the quality council.

The advice from the quality council would focus on: does it make sense to have one, two or three of these programs; where is the critical mass as patients; which hospital or which community have the current skills now or can maintain those current skills.

And this is a role that I see for an arm's-length body that focuses on quality, that will then focus on evidence and not focus on lobbying on behalf of certain interests. That the decision as to where a certain program, a new program or a consolidation of a program would occur would be based on quality standards in evidence.

Those recommendations, by the quality council . . . The quality council is not a decision-making body. It's a body that will recommend.

I'm sure the Minister of Health then would take those into consideration.

Mr. Thomson: — Thank you. So are there certain services that should be offered in every tertiary centre or is this a case that all the services are basically going to be looked at and evaluated as to what would be hived off to one centre or another?

Mr. Fyke: — No. I would see a lot of services that would be common to all three centres; Regina, Saskatoon, and Prince Albert. There'd be your special surgical medicine.

But when you start getting into your subspecialities, you could certainly look at things like — I'm not suggesting this one; I want to make it very clear I'm just using it as an example — like cardiac surgery. And some of the subspecialists where you would want to look at how you can maximize the skills of the individuals with the volume of patients and the support.

So I would see there would be a core of specialist programs that would be offered in Regina and Saskatoon, and then there could be some others that we would only have one in the province.

Mr. Thomson: — I have one final question on this area before I move into another set of questions. And that relates to questions around how we would involve the College of Medicine at the University of Saskatchewan, and how that relationship would work under your report?

Mr. Fyke: — My recommendation is that the College of Medicine . . . Let me just back up and answer a broader question first, if I may. And that is the direction of all the health science programs in our province and with emphasis at the university, I'm recommending that the six health science colleges focus on a training program that will develop teamwork; focus on training students that will meet the needs of our primary health, our rural health, and our northern health. So that our universities, I believe, our programs need to be . . . take into consideration the needs of Saskatchewan after they graduate. And they need to focus on what I've suggested — primary, northern, and rural.

With specific regard to the College of Medicine, I'm recommending that the Saskatoon Health District become an academic health district so that they place as one of their priorities, education. On the other hand, I'm suggesting to the College of Medicine that one of their responsibilities is indeed service. It is not just education and research, it is also service. The people of Saskatchewan depend on many of the specialists in the College of Medicine to provide a service.

So I'm suggesting that . . . recommending that the College of Medicine in the Saskatoon Health District form a closer relationship with focus on the three: education, research, and service to the people.

Mr. Thomson: — Thank you, Mr. Fyke. When we discuss health care particularly in rural areas, I think one of the groups that we often forget to include in the process, and I'm very interested to know within your report and your vision of how health care should be reformed, what is the strategy for dealing with First Nations people? What is our strategy for involving them, particularly looking at some of their specific health care needs?

I know that a great deal of work and attention is being spent at this point on services around diabetes. And I'm very interested as we move to a regionalized model and to your system or your proposals, how we would deal with this either at the tribal council level or at the band level, both on- and off-reserve, I guess.

Mr. Fyke: — I had a number of excellent meetings with our Aboriginal and First Nations peoples. Many of their needs can and should be dealt with through a better primary health services network. As you indicated, one of their great concerns is diabetes. And I was shocked at the number of amputations that result from complications from diabetes for, indeed for all Saskatchewan residents but certainly for our Aboriginal and First Nations.

When I met with the inter-tribal chiefs and many people in the North, First Nations and the North, they have done and are focused . . . they've done good work on the broader determinants of health, and we need to encourage them to continue a lot of that good work, to be frank about it. Their requests to me were all focused on the primary health services. They were not focused on sort of the high tech programs that we sometimes tend in the health system to focus on.

What I am recommending is that organizationally the Government of Canada, the Government of Saskatchewan, the Aboriginal First Nations organizations, and the districts look at . . . have a structured dialogue I guess on how best to offer the services for our Aboriginal First Nations people.

But I do believe that the direction that we're going in primary health certainly will go a long ways to solving many of their problems.

Mr. Thomson: — Thank you, Mr. Fyke. The other area, that I didn't see a great deal on in the report but I am interested in hearing more about, pertains to the role of . . . the relationship of home care, the idea of how we would make greater use of respite services, how these would fit into the primary health system, and I'd be very interested in how this relationship would work.

(15:45)

Mr. Fyke: — Thank you. The issue around home care and palliative care over the last decade has changed the way we deliver services across this country. Today home care is able to provide much of the acute services that were provided and indeed in some cases are still being provided in many hospitals.

Home care is an integral part of primary health service teams. It's an integral part of our communities, rural and urban, in assisting our elderly people to maintain their independence and maintain their self-esteem by staying in their homes as long as they possibly can before they . . . and indeed many of them can stay in their homes all their lives before they and others may need to consider long-term care facilities.

But home care, respite services, palliative services, are a very integral part, a very integral part of our primary health services teams and are very important to the people in rural Saskatchewan.

Mr. Thomson: — Thank you, Mr. Chairman. I want to return, just to clarify some of the earlier questions that were raised particularly about the changeover from having emergency rooms in rural communities that are currently operating, to greater emphasis on ambulance services and other emergency services that would be provided.

Could you just provide for us again an outline of how this system would work, and in particular, the type of services that

would be offered to rural residents?

Mr. Fyke: — Can I just have a moment to get my facts organized here.

First of all, in relation to what is the loss of the emergency room as you have indicated, in many of our rural hospitals there would still be out-patient care provided in the primary health centres or in the community care centres.

We would have the primary health services team in that community providing the local services. We would have the telephone advice and counsel 24 hours a day. And we'd have trauma and emergency services provided by the improved ambulance, which would then take the individual to the centre that would be able to provide the high quality acute services.

I'm assuming that if the person is critically ill from either a heart attack or a trauma from a accident, that person would be . . . the ambulance would go to the site, do what they had to do there — whether it might be start an intravenous or get an airway open or stop bleeding — and then take the person to the hospital, regional hospital or specialized services.

For example, if you were at southeastern Saskatchewan and you had a heart attack, you may be brought right into Regina where they can do an angioplasty procedure, which is opening up the artery, and treat you.

Right now it is handled in various ways. It can happen that way, but it also can happen that you will go to a local hospital.

And I was just last week told about a case in the southwest, where this person was brought to a hospital and was kept there for a number of hours before being transferred into Regina. And it indeed could have — and it may have, I won't say it did — but it certainly had the makings of compromising the quality of care because of that delay in that smaller hospital.

So what my report is recommending overall, that it, the system work for the benefit of the patient at all times depending on their needs. If their needs, if their need is a serious heart attack, then they get the services they require — everyone in the province gets the service they require. If it's an everyday service, like an earache or a problem with their diabetes and they may need a nutritionist or some other . . . physiotherapist or some other service, that they get that closer to home. That's where they should get it and that's where I'm recommending they do get it.

The Chair: — Order. The allotment for questions by government members has expired. The Chair will now recognize questions by opposition members for the next 20 minutes.

Mr. Gantefoer: — Thank you very much, Mr. Chair, and Mr. Fyke. I appreciate the time and I understand that we'll have a short recess after this set.

I would just like to pick up where we left off a bit and to get it clarified in terms of these regional centres. As I understood you to say — and I'll try to put this into one question so perhaps you can touch on the points that way — that you indicated, when I used some examples like Yorkton and Melfort . . . or Yorkton and Melville, Estevan and Weyburn, Melfort and Tisdale, that in your concept of these regional hospitals you said that they wouldn't necessarily be duplications or mirror images of each other, that there might be complimentary and non-duplicative services that would be offered in those centres.

Using just those six communities' examples, they in essence serve, I would think in your definition, three regional districts, if you like. And if I go just to the straight math, I mean here on three districts, if you like, you would have six hospitals.

Does that potentially change the definition of the 10 to 14 hospital specifics? Or are you thinking in terms of 10 or 12 service delivery areas that in some instances might actually mean that there would be two hospitals serving that district, which would then change the number of the 10 to 14 actual hospitals?

And if that's not the case, in that you're talking in absolute terms of 10 to 14 regional hospitals, then how do you justify or rationalize these parallel services that I thought you indicated in your last response before we left off? And finally, if you don't mean that there would both be paired services, if you like, with a duplication, would, for example, you have acute care beds in Yorkton and acute care beds in Melville? How does that work specifically?

Mr. Fyke: — When I referred to the . . . if there were, and again I'm not going to comment on the names of those centres that you raised; I will leave the 10 to 14 to others to decide where those locations are.

But let's take a certain . . . an area where there may be, it may be deemed that there be two, two regional . . . of the 10 to 14 that two may be closer together than some of the others. Some of their services that they would offer, like basic medical, some basic surgical, and maybe maternity, may be — may be — offered in both.

But again something like orthopedic surgery may not be offered in both because of the, again, coming back to the volumes of the patients, the number of patients requiring the service, and the critical mass of the skills of the doctors. For example, I would find it difficult to believe that we would find orthopedic surgeons for 14 regional centres. Just a reality. I'm just not sure of the exact number we have right now. I think it's four or five centres outside Regina and Saskatoon.

So there would be some common services that would be offered in each of the 10 to 14, but there will also be some of the more, slightly more specialized that wouldn't necessarily jump up to the complex specialized services in Regina and Saskatoon, that would only be offered in some of them.

Again it would come back to what the quality council would say, that to have a safe, high-quality program of X it requires Y. And it seems to us that that should be provided in five of the regional hospitals in the province, that that would meet the need of the outside Regina and Saskatoon. So that's how I see it, that's how I see it operating.

I don't know if I've answered your question fully, or I hope I

have.

Mr. Gantefoer: — Well I think what I — and please correct me because I want to outline how I interpreted your response — that there would be an absolute number of the 10 to 14, in terms of regional, recognized, acute care hospital centres. And without mentioning names, where you would have two communities in close proximity to each other, it is highly unlikely that they would both be regional centres by definition of what a region is.

Otherwise you're going to distort the map so badly that if you have in essence two regional centres within a half an hour of each other in three or four locations, how in the world are you going to then distribute the remaining centres to adequately service the province?

Mr. Fyke: — . . . recognize that there will be some of those centres that would be closer together than others. The constraint that I have, the constraint that we have I guess, is where those hospitals and where those centres are currently located.

You could take an example like Regina and . . . I'm sorry. You could take an example of Moose Jaw and Regina. They're very close and yet there's a lot of services that are in Moose Jaw, that are currently in Regina . . . that are also in Regina.

When you . . . There is not a way of laying out the exact . . . the distances between the various regional hospitals would all be identical unless you built new hospital facilities. And I'm not recommending that, because of cost and other things. I think we have to build on what we've got in the province. And while the 10 to 14 is adequate to serve the province, there will be situations where between or among those 14 there could be a couple of situations where they could be relatively close together.

Again I would then come back and say if that is the case, are there ways that those two can complement each other so that they don't have to duplicate a lot of services based on the volume of services, the skills of the physicians, and the equipment that they currently have.

Mr. Gantefoer: — Thank you, Mr. Fyke. I would like to move on to another few areas in the time I have because my colleagues are anxious to ask some questions as well.

As you're aware, we have a very different environment in the last couple of years in the health care professional delivery system than we had in the past. During a time of budget restraint across this country and perhaps across North America, there were no jurisdictions where there was much reinvestment into health care if you like. And in fact over the decade of the '90s, there was a great deal of curtailing or minimizing new expenditures in the health care field.

And as a result of that, there was for a period of time relative stability in the labour force in that there weren't massive opportunities for people to move and to transfer so you saw less mobility, if you like, among the professionals.

In the last few years there's been commitments of increased investment. And I look to our neighbour to the west where there's been a very significant investment into the health care field and, from what we hear, fairly lucrative contracts being offered in the nursing profession. The fee for service schedule of medical doctors is significantly higher than what is current in place in our province. There is a major commitment to the expansion of the colleges of Medicine and Nursing and the consequent demand for qualified professionals and instructors and that sort of thing.

So there is a very competitive environment and almost on a daily or weekly basis, you know, we see the pressures of that in terms of the information coming forward that specialists are leaving, general practitioners are leaving, nurses are leaving to take advantage of those opportunities, and health districts are finding an increasing challenge in maintaining the professional component that they need to deliver services.

In light of that reality, is it responsible or reasonable for us to leave a high level of uncertainty into the Saskatchewan health care system by taking further time to study your recommendations or is it incumbent that an action plan be presented so that people who are sitting there mulling over their futures and what directions they're going to go will be able to quickly realize that there is a plan in Saskatchewan and they could see a part for themselves in it?

We are of course very concerned about further delays of making a plan, and I think in your preamble this afternoon you indicated that you're calling on government to make a plan, that we need to understand where we're going and professionals in this province need to understand what their role is going to be in or, quite frankly, they may find the alternatives very attractive.

(16:00)

Mr. Fyke: — I would like to comment on physician supply. Overall the medical manpower has been . . . medical person power has been stable. However I recognize that there will be increasing challenges in the future. It is not limited to Saskatchewan. These challenges are going to face the health system right across North America because there are many, many more opportunities for young people now compared with years ago. So it's competing with the health system.

I recommend that there be a province-wide strategy to deal with medical human resources. And I believe, in talking to a lot of physicians and a lot of nurses, that one of the things that will keep Saskatchewan graduates in Saskatchewan and retain graduates, is a system where they feel that they've done a good, quality job when they come home from work.

Right now our health providers — our nurses and our doctors and all the staff — are feeling overworked. They feel frustrated; they've got low morale. And that is again not unique to Saskatchewan.

The one way that I believe that we can be different in Saskatchewan to many other provinces and get the lead right now is to develop a system based on quality rather than volume — focus on quality rather than volumes — where everybody under primary health services fully utilize their skills. There's nothing more frustrating that to have a person train three, four,

five, six or seven years and then be underutilized.

And I believe that again, in the primary health services people will be working as teams so the quality of life will be better for a lot of our physicians. That, taken as a package, I think will help to attract young people and professionals to Saskatchewan and keep them here.

Mr. Gantefoer: — Thank you. In your study leading up to your report, I wonder if you looked at — and I believe you did — in terms of saying that we must invest into the educational future of our health care professionals and that you made comment that there should be an investment in the educational component.

And I'm thinking in particular of the University of Saskatchewan and the College of Medicine, the College of Nursing, kinesiology and those areas — the health sciences — at the University of Saskatchewan.

I think you're probably aware as well that the University of Saskatchewan has made a proposal for an integrated health sciences facility that would bring all of these medical disciplines together and provide some badly needed facilities so that: first of all they would have the experience of being trained and educated in a collaborative environment, which is what I hear you talking about in terms of primary and secondary health care services to some extent; that they would be able to be provided with the facilities they need to attract quality professionals that need not only instructional space but research space; that it would provide a much needed incentive and a methodology of levering the light beam project at the University of Saskatchewan to draw needed research projects to Saskatchewan.

There have been articles published in the *On Campus* magazine by Dr. Roger Pierson, for example, an issue or so ago, that really flag the concern that if nothing is done in terms of a major commitment to the university and the College of Medicine, that indeed we're in dire danger of losing it through attrition and through a bleeding of quality specialists, or for in fact a lack of accreditation because of the erosion of manpower. Certainly Dr. Pierson raises a pretty significant concern, and I've seen in the subsequent issues of *On Campus* that that opinion is shared by many of his colleagues.

Would you be specific about saying pretty directly what your feeling is in terms of the need, first of all, of the value of the integrated health sciences project as proposed in general by the University of Saskatchewan, firstly; and second of all, that there has to be in a very timely way a critical recommitment to the College of Medicine, College of Nursing, and other health sciences colleges at the University of Saskatchewan.

Mr. Fyke: — Well as my report indicates, I recommend that the College of Medicine . . . or the University of Saskatchewan, I should say, through the College of Medicine and the Saskatoon Health District establish a new relationship focused on service, research, and education.

I've also indicated that the universities should be focusing on graduating training students in the six health science faculties that will be collaborative as you — a word I think you use — or interdisciplinary so that they can meet the needs of Saskatchewan which I believe are going to be significantly . . . the significant amount of the need will be based on primary health, rural health, and northern health.

I don't wish to comment on the . . . I'm not knowledgeable enough about the specific requests on the building, so I will not comment on that.

I would only say, as far as your general premise around investments, I do recommend investments in research for the health system. I believe that research will do a lot to sustain our educational programs, and also to attract dollars into the province. I believe, after about three years, you start getting back something like $5 for every dollar you invest; something like that. I stand to be corrected on the exact amount. But I know that research does attract money from outside the province and I believe that is critical to keep this health system on the — cutting edge may not be the right term to use — but on the forefront.

But again I would go back to we have to make sure that we have a system that is quality focused and sustainable, and not let . . . not have a system that continues to grow and grow and take resources away, that should indeed be going to our educational system and our universities. Because it is probably through our universities that we in this province will be able to meet the challenges of globalization in the future, and educate our young people, so that we are able to sustain a good quality of life in this province, and as well a good quality health system that promotes health.

Mr. Gantefoer: — Thank you. And I see in the time allocated this will be my last question, and in posing it I would thank you for your answers.

Your report recommends a significant change or evolution of the way health services are provided on a primary level, in terms of your primary care teams. On the second area, regional level, in terms of the idea of a regional support system that sort of is supportive of the community care facilities and the primary care facilities.

I'm wondering if you could point to examples in your research where this model has been indeed implemented, first of all, so that there is some comfort on a practical level that this is more than an abstract theory, and indeed a pragmatic, practical way to approach things, first of all. And even if there has been some of these examples in your research on a national or international basis, would there be a role for the initiation at the earliest opportunity for a major, significant, pilot project that identifies an area or a district of the province that is particularly ready for this kind of project to really make sure that we find a way of identifying how this could be done in specific, what the pitfalls of the changing practice relationships might be between health care professionals, and sort of a practical opportunity to address how this is done before we roll it out right across the province and find that we've created huge problems that we don't clearly have the answer to.

Mr. Fyke: — Thank you. When one is making a . . . facing a significant change like this, one has to look at what are the best ways to move towards implementation. I believe that the time

has come that it's time to move beyond the pilot projects in regard to primary health services. We've had some . . . is it 12 or 14 sites . . . projects in this province already. We have had . . . there is examples in our . . . Sorry, 18 sites in Saskatchewan.

We have on page 98 a summary of the primary health care developments across Canada. The Prime Minister and the premiers agreed on September 11 last year that primary health reform be a priority. So I would suggest that we look at it as moving now into implementation.

I would just say that in any kind of change, there is risk. There is risk. And that's why it's important to involve the providers and the public in taking this plan — the overall plan that I've given to the Premier and the government and the people of this province — as to how best we get on with implementing it now and move forward.

In the past, a lot of the major reforms in health came about because people believed that they . . . they were convinced that it was going to lead to improvement, and I believe that many of those milestones certainly proved that. And I think it's time now to look at how we . . . what kind of a health system we have and how we can improve it and move on to the implementation phase.

The Chair: — Order. Hon. members, as agreed to at the start, this committee will now take a short recess. I'm asking the Sergeant of Arms to summon members, to signal members to return 15 minutes from now. However, the committee will now stand recessed for 20 minutes.

The committee recessed for a period of time.

The Chair: — Order. The committee now come back to order, please. Order.

Hon. members, I was talking to Mr. Fyke and at times he's having a little difficulty picking up the last parts of people's questions. So I just ask that when questions are being directed, try and keep the same volume up. The difficulty seems to come at the end of questions, so speak more clearly into the mike or just raise the volume ever so slightly when you're asking questions.

Mr. Hillson: — Thank you, Mr. Chairman, and my thanks to members of the Fyke Commission for their attendance here today, and also my thanks to the hon. member for Kelvington-Wadena for surrendering her desk so we'd avoid me having to speak behind you and you getting a crick in your neck as you're questioned from the nosebleed section. So I appreciate that.

It's just been a week since your report came out, but I'm concerned that much of the media has been negative, and I think there are indications that the government is reluctant to act on it because of the perception of it being politically difficult to sell. I realize that it's not your business to be politically selling anything. It is your business to say what you think is a sustainable quality health care system for our province.

But if there have been problems in the way your report has been received, I think it is found in one small statement on page 17 where you say, "The realities of modern health care . . . have simply made the small hospital obsolete." And that clearly has made many people in the province nervous.

And I realize that you have made your proposal about primary health care centres, but nonetheless that statement that small hospitals are now obsolete has unquestionably raised concern and danger flags throughout the province and I'd like you to discuss that for a minute, if you would, please, sir.

Mr. Fyke: — Thank you very much. And I do appreciate the question, I appreciate the observation, and I appreciate the . . . that people in the smaller communities with rural hospitals are concerned about the, I guess I could say, the security and the sustainability of their health services.

I wrote this report in a way that I wanted to lay out the issues very clearly and succinctly. I do believe that we need to move from the system that we have today to a system that is focused on quality.

I am certainly not blaming any person or individual within the current system as to some of our difficulties. It is the reality of health care delivery in the year 2000-2001, that is focused on . . . a lot of it is focused on high-tech, highly qualified people, providers, and equipment. And the reality is a lot of our smaller hospitals, no fault of theirs; they are not able to provide the kind of services that are necessary today. And in reality a lot of people are going by them and moving . . . going to the larger centres.

I have certainly had people from our smaller communities express to me the economic benefit of the small hospital, and the security issue, and I appreciate that. I was born in a small town in Saskatchewan and I have relatives that live in a small town in rural Saskatchewan. I very much appreciate that.

But I also am convinced that Saskatchewan can lead the way in moving to a sustainable health system that provides the services. And I want to emphasize this again. What my report does is provide a plan for the provision of secure sustainable services. It does say very clearly that services . . . what we talk about focus on services, quality services, rather than bricks and mortar.

And I stand by the . . . I stand by my report. It was written to focus on the services. That's what's important. That's what's important to people in rural and urban Saskatchewan. We need to organize differently to provide those services. We need to recognize what the needs are of rural Saskatchewan and urban Saskatchewan, particularly rural — that is everyday services.

And we need to focus on quality. If we do not, we will be faced down the road with some decisions that I think will certainly compromise a publicly funded system.

Mr. Hillson: — Yes, I think that leads into my next question, sir. You've clearly said that the present system, where we have health expenditures increasing at four to six times the growth in our economy, that that system is not sustainable.

So I'd like you to tell us: what in your view is the price of us allowing your report to gather dust while we muddle through

and avoid the hard issues and the hard questions that are raised in your report? What do you think is the price of doing that?

Mr. Fyke: — Well first of all I want to say that I think it is important that the government and the providers and the public have an opportunity to express their views. If there is anyone or any groups that can take my report and improve upon it, I say great. If there's suggested changes that can make it better, I say wonderful. Because I've done my best but that isn't to say that this report can't be improved upon.

So I think it's important that the providers in our health . . . the providers, our public, and our rural communities have an opportunity to make their views known.

If this report is not implemented, I guess a couple of comments I would make. One, I think it's a wonderful opportunity for this province to change the way it's delivering services. It's an opportunity for this province quite frankly to lead the nation again because every province is struggling with how do we have a sustainable public system.

If we place ourselves in a position of just putting more money into the status quo and we go down the road, I can really only see six policy options that the government of the day will be faced with.

One is to establish an alternate insurance system, insurance options, for the publicly funded system. Two, to decrease the current insurance services and de-insure some services; probably de-insure those that are not protected under the Canada Health Act. Introduce user charges in order to bring more revenue in, increase taxes, or increase the share of the budget for Health, take it away from other programs like Education and Highways and others, or to make better use of existing resources. And that's my option that I'm recommending to you, that I don't know of any other options.

I certainly carefully considered user fees and premiums, but those in the final analysis, the final conclusion, are really forms of taxes. They compromise equity. And I've met with a number of people who are very poor in this province who told me the difficulties they are having with some of the . . . they would have if we implemented a surcharge or user fees.

So I think the province will be faced with six, what I can think of, six policy options at some point, and some decisions I guess will have to be made within those six policy options.

Mr. Hillson: — Six policy options, all of them unattractive. In that regard you said this is Saskatchewan's chance to lead the way, but you also said that we're unique. Now I suppose every province is unique, but it does seem to me though that the basic Canadian issue is of course that we're the world's second largest nation with a comparatively small population, half the population of Great Britain or a tenth the population of the US. So the issue of how you service this huge land mass with a small population is true of Saskatchewan, but it's more or less true of all of Canada.

So I'd like you to discuss that. But also what you would say to those who might argue that one reason for delaying action on your report is now to await the national review that was announced by the federal government recently? Is that in your view a valid submission? To what extent have you addressed Saskatchewan? To what extent are you addressing issues which you say are true of the whole of Canada? And would you accept it as a valid position to take that we can delay action on your report now until the national review has been completed?

(16:45)

Mr. Fyke: — I don't think I want to comment on the national study. I think the national study will be focused on national issues. I focused on the provincial issues, so I don't think I want to pass comment on whether we, whether the province, should wait for the national study. I think I have to leave that up to the wisdom of others.

Mr. Hillson: — Then I think I've already indicated that my concern is that while in a democracy it's obviously always good to consult, nonetheless consultation can and at times has been used as an excuse for inaction.

Now specifically you say you have consulted with hundreds of people, yet I'm hearing that maybe some groups have not been allowed the input they should have had. So I'm going to ask you if you feel that citizens in general, but especially those groups with a particular interest and insight, a particular stake — such as SAHO, SUN, SMA (Saskatchewan Medical Association), groups like that who have a particular perspective — have they had full opportunity to come before your commission? And in your view, would they have anything further to offer to the MLAs at this time beyond the perspectives which they have already supplied to yourself?

Mr. Fyke: — Health care is a very, very important public policy issue. I consulted with many people about their suggestions for improvements but I think it is very reasonable for those groups now to be able to formally respond to the proposals that I've laid before the people of this province.

I think it's important that everyone have an opportunity to debate and comment and as I say, offer suggestions that may improve my report. That seems to me to be a reasonable way of proceeding. I've had a lot of meetings with a lot of people, but on the other hand when I was meeting with them it was pursuing solutions that . . . I wasn't meeting with them to discuss specifically my final recommendations. Because my final recommendations were really finalized just in the last few weeks before the report was tabled.

So I think it's reasonable to, very reasonable, to give people the opportunity to comment and indicate whether from their perspective the report makes sense, whether it can be improved upon. I have publicly called for all parties including our professions and our health unions that it is time to look at the greater good and the greater issue that's before us, facing this province, and to come together and make their suggestions. So that's really all I have to say, I think.

Mr. Hillson: — The response to your report has, frankly, largely focused on what is perceived to be cutbacks and I know you strongly object to that. You say this is not a take-away from smaller communities but an enhancement. But nonetheless the media response and the political response has mostly focused

on the perception of cutbacks.

But I notice that under ambulance service you have taken a strong position that ambulance charges should not be distance spaced, and that distance-spaced ambulance charges obviously discriminate against the rural resident, and it is an example of two-tier medicine. Obviously that is going to be very popular, certainly something I like and strongly support.

But my question to you is: how do you see that working so that that is financially feasible? How can that be done? And clearly the present system is totally unfair to those residents who don't happen to live in a tertiary centre. And then in my own case, I know in order to get to a tertiary centre where residents in my community routinely pay 900 and $1,000 ambulance bills, and I'm sure it's higher in other communities.

But so obviously I like it. But how do we do this so this doesn't become a huge financial drain on the health budget?

Mr. Fyke: — The ambulance report, again I would reiterate that this is a report that was done by a group of experts that had done this prior to my . . . or in the early part of my work. The proposal that the patient fee would be not based on distance was based on the fact that it would be cost neutral. So those that would be paying, the people that would be paying more, would be those who travel less distances. In other words it would be a system based on fairness of the use of the ambulance and not based on the actual distance.

So the report that recommended this, the ambulance report, is cost neutral to the province.

Mr. Hillson: — The province of Alberta has moved in part to helicopter service for emergency transportation. That seems very attractive. Do you see that as feasible for our province?

Mr. Fyke: — Again I must outline my qualifications in the whole issue of ambulances. That is not one of my . . . I would not hold myself up as an expert in the ambulance business.

But in my meetings with the team that carried out the ambulance survey and prepared the report, it is my understanding that helicopters are excellent for short distances, high-population areas. That in Saskatchewan where we are travelling in bad weather, great distances to bring somebody in to Saskatoon or Regina, that the fixed-wing aircraft is still the best. It can be used more days of the year, and is quicker, faster, than the helicopter or the rotary wing.

That is the . . . just maybe, if I may, read part of page 34 of the report.

> It is appropriate to address the issue of initiating a helicopter program in the province in this recommendation. Frankly, a helicopter-based, air medical program cannot be supported within the province. The high cost of operation and the limited range of helicopters do not provide an appropriate cost benefit for provincial residents. Helicopter programs have an effective range of approximately 120 to 150 kilometres. This limited range and the susceptibility of helicopters to not being able to fly because of poor weather support the concentration of the province on its fixed-wing air medical program and ground ambulance services rather than investing in a helicopter air medical transport.

So I would have to rely on the author of this report in regards to it.

Mr. Hillson: — And a final question. I'm sure that you've not been happy to see that the initial response has been that again something is going to be taken away in terms of health care — especially from rural areas.

And is there anything in the week since the release of your report that you have thought of that you can say that suggests that your report offers hope and something for the future as opposed to offering cutbacks and take-aways in terms of service?

Mr. Fyke: — I understand the concern that is being raised in certain quarters. I have done my best to clarify my message and I'm attempting to do that today as effectively as I can.

I am absolutely — absolutely — convinced that if we move to a system based on quality with all the investments that I have indicated, that the citizens of rural Saskatchewan would have a better service than they have today. I recognize that it's going to require a lot of change but Saskatchewan has faced change before, they've faced challenges before and if anybody can do it, the people in this province can do it.

I would also comment that in many ways I have been very pleased with the positive response to my report. There have been many groups come out — the professions and the health unions and others — that have been extremely positive. And I believe that even some of the response that I expected from the critics were not as severely critical as I may have thought would happen the day I released the report.

I think it's important that we have a debate in this province, as I guess, part of what we're doing here today and what both sides of the House will do in the weeks ahead and with the people of the province; I think that's a good thing. But there is no doubt in my mind, and I make it very clear and I reiterate this, that this report is good for rural Saskatchewan. It is about more services, better services, higher quality services, and faster services than what they have today.

The Chair: — Order. The present round of questioning time allotment has expired. The Chair will now recognize members from the government side for the next 30 minutes . . . 20 minutes, I'm sorry.

Ms. Junor: — Thank you, Mr. Chair. And welcome Mr. Fyke and your staff. The last question was a good lead into, actually what my questions are going to be at the beginning.

This magnitude of change that your plan proposes will have a huge impact on providers. And I was a provider during the '93 changes and I know that it worries providers both where they work and where they live, what will happen to them.

And I think some of the comments you made about recruitment and retention will also lead to what you see the roles of people in this system, especially in rural Saskatchewan. How would

you see a nurse practising in a primary health care site and a community care centre? And how would you see a doctor practising there and how will you see an emergency medical technician practising?

I want to talk about the roles of people and how you were saying that the services will be better in rural Saskatchewan. And I also want to allay some of the fears of the providers that their work will be there, and what work they will have.

Mr. Fyke: — I see this report as enhancing a lot of the work that our providers do right now. I see a change in many cases. I see doctors being utilized fully, to the extent of their skills, in diagnosing and treating illness. That's what they're trained for. We need physicians. We need them as part of the team. I see nurse . . . but on the other hand, doctors have told me that a lot of what they do, they don't need a medical degree.

What nurses do today, a lot of that work could be done by other professionals, like LPNs (licensed practical nurse). And I would see the nurses having an expanded role in primary health services, through the advanced clinical nurse role, or involved in home care or community services. I see, again, utilizing our nurses to the full extent that they're trained.

And so on down the line. I see pharmacists being much more involved in dealing with drug reactions, in dealing with what is the most appropriate medication to take in this particular case, and is the most expensive drug the one that's necessary. In many cases it isn't.

I see the emergency medical technician as someone who is highly skilled in . . . Now there are various levels of training for the emergency medical technician, your basic and your paramedic, and the other two levels, I just can't . . . four levels anyway. They're highly trained to deal with emergent, an urgent situation, so that when they arrive at an accident on the farm, or they arrive at a motor vehicle accident on the highway, they can very effectively deal with the situation with the patient or the client, be it getting an intravenous line going, being . . . maybe it might be defibrillating someone's heart, it might be getting an airway in, or it might be stop the bleeding so that they can get the person to a centre to deal with their situation.

This is not to say that I am implying that we . . . that I'm considering certain providers as more important than others. It's a team. It's a team of professionals working together to utilize their skills for the benefit of the patient or the client. And that is the wave of the future and that is very much part of the primary health model.

Ms. Junor: — Thank you. I know you're talking about an expanded role for some providers, but some of the providers in the system now don't really want to change their role. Like they're not —I'm going to say nurses since I'm most familiar with that — they don't want to be nurse practitioners or advanced clinical nurses. So a role for a nurse in a rural area in a community care centre, what would the role there be?

Mr. Fyke: — I don't see the role of a nurse in a community care centre significantly different than what it is right now. If you look at respite, convalescent, palliative care — probably not.

I realize that, as we make changes like this, there will be professionals — nurses, doctors, pharmacists, physiotherapists — may not want to embrace this change and may take maybe a little longer to embrace it, but I think that once we have programs working effectively, I think you'll see a lot more job satisfaction with our professionals than we're seeing today.

Ms. Junor: — One more question about the emergency medical services. The technicians that we envision from your report being trained up to a certain level of skill, what will they be doing in the times that they're not in an ambulance, sort of in the mobile acute centre, what would they be doing and how do you see them fitting in this system?

Mr. Fyke: — I believe that the emergency medical technicians and the ambulances in our smaller centres could be health professionals the rest of the day when they're not on a call.

In many of our urban centres, they'll be busy all the time with the ambulance. But in our smaller centres, it could be an LPN, it possibly could be a nurse, it could conceivably be another type of professional working in a long-term care facility or a community care centre who would be able to go out on the ambulance call when they're called and then be able to be part of the . . . either the primary health services team or the community care centre the rest of the time.

I don't think that we can afford to have a system where we have trained ambulance people sitting around waiting for one or two calls a day. I think we've got to make sure we fully utilize those individuals in the system. That's why the report, the ambulance report talks about making sure that the emergency medical transport system is part of the health system.

So I see these professionals having, in many cases, a dual role in some of our smaller centres.

Ms. Junor: — Now when you're changing roles and you're changing responsibilities — who does what and where — I think many people in the providers will be asking, do you see this as a net loss to the system? Are there going to be jobs lost?

Mr. Fyke: — I think over the next five years in the health system that one of our greatest challenges will be to maintain the number of health professionals we're going to need. I believe that there will be changes in scopes of jobs. I do not believe there will be net job losses.

If we could throw a switch and have this plan in place tomorrow, I would see changes in some job responsibilities and roles. And that would mean maybe some of our professionals will have to look at what their scope of practice is and indeed it could require other changes and possibly negotiated within contracts, etc. But I don't see a net job loss.

I certainly see actually a net increase in rural Saskatchewan employment through the ambulance . . . Some of the ambulance programs I say will use some of the driver . . . the people on the ambulance will be integrated into the other, under other programs but there will also be additional people added to the system.

Overall I don't see a net job loss.

Ms. Junor: — Thank you. I'm also interested in . . . you're talking about everybody has to be ready for the change. Everybody has to participate in the change. Do you find that readiness with the providers? Are they ready for a change? Are they going to . . . There's changes that will have to be made in collective agreements perhaps and stuff like that, that I think people may . . . I'm wondering if they are ready for that. Do you think that is . . .

Mr. Fyke: — Well I don't want to . . . I don't think it would be appropriate for me to speak for the unions and the professions. On the other hand, did I witness a willingness to look at new ways of doing things and change? Absolutely. Obviously there are those people who don't want change and you know I speak to that in my report. But there's a lot of professionals who say to me that they know that changes are required and they want a system that will be satisfying to work in.

And I think there's a change out there. I think there's a willingness to change. I think there's also a willingness in the public — and you people are the, are clearly much more expert on this than I am — but I detected a lot of willingness to look at some changes in the health system. Because people fundamentally know it's not working. Now they may not like the change, specific change that I'm recommending, but I think in their heart they know that we need to change.

And I had a number of people give me comments privately that the health system has to change and let's get on with it.

Ms. Junor: — Thank you. I also want to talk about . . . we talked about recruitment and retention for a bit, and there's been a theme actually through several questions, that it'll change the way doctors practice in rural Saskatchewan.

Do you see that it'll be difficult for communities to attract doctors to practice in community care centres or primary health care settings?

Mr. Fyke: — Many communities are having difficulty currently recruiting physicians. I think that if we focus on the job satisfaction and the workloads, it will actually make it easier.

And I think I answered before the break that, when you look at the last 10 years, the number of physicians has been very stable. There's been specific situations where there's a difficulty whether . . . in the specialist's area.

But I think that physicians are willing to look at new ways of working, especially a lot of our younger physicians clearly want to look at ways of . . . many said to me and, you know, obviously may not represent the, obviously, not the total profession but many physicians said to me that they would like to look at alternate forms of payment. They'd like to look at ways that would let them focus on quality rather than where they're having to focus on volume to make a decent income. So I think there's a willingness.

Ms. Junor: — The comment that leads me to ask that question was, that if we don't have a hospital, we can't have a doctor. And I think that you said doctors will come to practice in different ways and they seem to be open to that.

So now my next question, again along the same line, is your proposal to pay doctors differently. And how do you see that helping with recruiting or how do you see it actually happening?

Mr. Fyke: — What's important in changing to primary health services networks is mainly how physicians are organized. That's probably the most critical. There's probably no individual way of paying physicians that is ideal.

I would want to see us reimbursing physicians though in a way that will encourage quality and not volume. But I'm not saying that the fee-for-service would have to go in every situation. The payment method, I believe, should be open to discussion with the physicians and the districts when we implement . . . if the province implements a primary health service.

So I'm being open on that because I think there's alternate ways of paying physicians that will be appropriate and still focus on quality and not on volume.

Ms. Junor: — Thank you. I now want to ask some questions about information. I have a keen interest in SHIN (Saskatchewan Health Information Network), of course, and I think when you're talking about quality, you need to have information. And I think you mentioned that in your report. I'd like you to expand on how you see . . . what importance you see of information technology and gathering of information.

Mr. Fyke: — Well there's an old saying that if you don't measure it, you don't manage it. And we don't measure very well in the health system because we lack the information. This is not unique to Saskatchewan. Indeed Saskatchewan has done some . . . has initiated a number of innovative programs like the one you referred to.

I am recommending that there be investments put into, one of the things is information and communications technology — the electronic client record. I think that a lot of the quality issues that we face today is the inability . . . a lot of the quality issues and a lot of the waste is the fact that we don't have good information systems.

Tests are done here and you're referred to another physician and all those tests are done again. And with the technology today, it would be so much easier to have that information available to all the providers who are providing services to that client.

The other aspect of information that is part of the electronic age is Telehealth. And I refer to the use of Telehealth. And there are some pilot projects in the province where some of our rural communities could be connected to physicians in regional centres or Regina and Saskatoon, where Telehealth could be used to treat and deal with patients so they do not have to travel those distances.

So information technology is one of the investments that I'm recommending that the province consider.

Ms. Junor: — It leads me then to the quality council itself. And some people will think of the quality council as perhaps just another bureaucratic arm of government. Could you explain how you see the quality council operating and its benefits to the

system?

Mr. Fyke: — I consider the recommendation of the quality council one of the, one of the most important recommendations in my report. It will emphasize and assist in changing the culture to one based on evidence and quality rather than volumes and anecdotes.

I see the quality council as being arm's-length from government, and arm's-length from the professions; independent arm's-length, but not a decision-making body. I think it would be more effective . . . I think it will be more effective if it's a body that contemplates some of these very important, very critical issues around quality, around where is the best place for a certain program to be located given the volume of patients and the skills and training of the professions.

It may . . . I see it maybe commenting on where new technology might be introduced and how it might be introduced. It may even, indeed, take over the wonderful work that this province has been known for across this country in the drug formulary committee, in the . . . so that it will be a body that will look at the quality assessment, the performance of the health system, and report to the public.

So it will be a body that will be speaking to the public about accountability and performance of the health system from a quality perspective.

Ms. Junor: — We have somewhat of that role right now being played by HSURC, Health Services Utilization and Research Commission. How do you see those two interacting?

Mr. Fyke: — I see the quality council expanding its mandate, and eventually those responsibilities that HSURC are carrying on that would . . . could be combined into a quality council. In other words, the quality council could take the responsibilities of HSURC. It could indeed take the responsibilities of the formulary committee and if . . . to fulfill their mandate.

There's a lot of good work has been done in this province under . . . with HSURC. It's work that's recognized across this country. So I see the good things of that being built in the quality council. I see the people on the quality council as individuals who are knowledgeable about quality, are people who are . . . represents the professions, the general public, and possibly the university, as people we could draw from.

(17:15)

But people who are not representing . . . wearing certain hats around that table to represent the interests of a certain group. I see them coming there and representing the interests of the people of Saskatchewan on . . . focused on quality, and how do we ensure we have quality, and how do we measure that quality, and how to report to the public. The public have a right to know, and I think it's time that we put a mechanism in place that will provide the public with that feedback on the performance of their system.

Ms. Junor: — Now we talk a lot about quality in the system and switching to quality rather than quantity in your report. Can you define for us, quality?

Mr. Fyke: — Quality is many dimensions. Quality is indeed doing the right thing for the right reason and doing it well. My report defines quality from the Institute of Medicine in the United States:

> Quality of care is the degree to which health services for individuals and populations increases the likelihood of the desired health outcome, and are consistent with current provincial knowledge.

Essentially it boils down to doing the best possible job with the resources available. It also has an aspect of what I call underuse, overuse, and misuse of the health services. In other words, quality can minimize misuse, overuse, and underuse.

And some of the underuse I could refer to is insufficient management of diabetes leading to complications and amputations, insufficient attention to mental health concerns.

In misuse I could use the example of inappropriate prescribing of antibiotics, unnecessary duplicate testing, use of emergency rooms when other options . . . due to the lack of other options, and allocating a lot of resources to treatment when we should be putting more resources into prevention.

And overuse could be the use of hospital beds for non-acute patients, unnecessary routine use of ultrasounds and other tests, and it could even be abdominal surgery for gallbladder removal when laparoscopic procedures would be more appropriate.

So it's using the latest . . . what is the quality standard, and of course that quality standard changes year after year. But that's how I, in a very broad way, how I would define quality.

The Chair: — Order. The current time allotment has expired. And just before I recognize the opposition, hon. members, it's come to my attention that some conversations, especially at, down at this end of the Assembly, can be a little bit — given our acoustics and set up — can interfere a little bit with our guest. So I just ask that, especially at this end of the Chamber, members if they do have conversations amongst each other to go back behind the bar if they could.

Mr. Hermanson: — Thank you, Mr. Chair, and I too would like to express my thanks to you, Mr. Fyke and your officials, for being here. I would also ask you to take my remarks as not being disrespectful but certainly being very frank and forthright.

I believe that many of us expected a better case to be made and a better defence for the recommendations in your report than we've received. I think they've been a little lacklustre.

I think also, Mr. Fyke, you have avoided taking stands on some of the more difficult issues and that does not help in our discussion here today. It seems that what you're saying is, just adopt my report; Saskatchewan will have better health care because I say so. And that's a real concern.

You talk about the primary health care teams and that's a fundamental block in your plan. And there was a wise person — I think it was perhaps King Solomon — who in a proverb said nothing is new under the sun.

And you were asked if you could give illustrations of where this plan has worked somewhere else. And I don't think you actually did give us an example of where this has worked somewhere else, but you said there would be some risk involved. And given the fact that your commission was actually demanded because there are concerns about our health care system, obviously there are lacks now because we took some risks and the risks didn't pay off in the past.

And it rings a little hollow to say just because I say this will work, you know trust me; let's go ahead; let's jump in with both feet and assume that these health care teams are going to suddenly, with the waving of a magic wand, appear. I mean health care professionals are very difficult now to recruit. There is a shortage of health care professionals in Saskatchewan at the current time. And I'm not just talking about doctors, nurses. We're talking about anaesthetists. We're talking about paramedics. We're talking about a whole host of health care providers.

You know in reading your report, I see no reason to believe that suddenly there's going to be a flocking of people into the profession; that people are going to rush into Saskatchewan to fill a void that is already here. And so that leads one to conclude that actually health care may, may deteriorate rather than improve.

The result being that, for instance in my part of the world, there will not be an acute care facility not only within the boundaries of the riding I represent but within many miles of the boundary. And notwithstanding there will be additional pressure on the tertiary centres of Saskatoon and Regina, and certainly many people then from within the urban areas will feel a strain in their health care system.

So my question is, why didn't you provide us a stronger defence for the recommendations you've made? Why did you not give us concrete examples of where these initiatives have worked in other provinces, or if need be, in other parts of the world? Why am I just to believe that suddenly, magically these gaps in our system will be filled simply because your report says they will?

Mr. Fyke: — Thank you for your comment and question. I appreciate that. I would only direct you to 27 pages of bibliography in my report — 27 pages. There is one thing that I made every effort to do and that is reference every suggestion that I could possibly find in the literature and reference either through research in Saskatchewan, research in Canada, or research in the United States.

And the other comment I would make is that there are some very important professions, very important professions in this province that have come out and said that this report is sound — the Saskatchewan Registered Nurses' Association, the College of Physicians and Surgeons.

So I have made every effort that I can to justify my . . . to back up my arguments and my case.

On page 98 I list what's going on across Canada in primary health care development.

I will stand by the comment I did make a little while ago that change is risky. I appreciate that. But this province has taken many risks in the past and not only in the health industry, other industries have taken risks and need to take risks sometimes to move ahead.

So I do appreciate your comments and I very much respect those comments, but I would suggest that I have put a lot of references and bibliography in this report to back up my arguments.

In regard to your constituency that . . . as far as getting care, all the people in your constituency, in your riding will have access to needed services. They will be delivered differently, but I will maintain again that if you have an effective primary health services, effective emergency services, that those services will be of a higher quality than what is being delivered there today.

Mr. Hermanson: — Well thank you for those comments but that's still not reassuring because that was the exact same commitment that was made to me as a resident of Saskatchewan about 10 years ago. And the result was that health care deteriorated to the point that your commission had to be struck and we have to review how we can provide better health care to the people of Saskatchewan — not because it's good now but because it's not good, because it needs to be improved.

I'm not questioning that you have searched and researched well and you have resources, which you identify in your report. But they tend to more or less ratify your contentions there are shortcomings and failures in the system.

In other words we have a problem with diabetes in Saskatchewan rather than again showing that some of the recommendations that you have suggested, particularly the one I mentioned about these primary health care teams, actually working. And again I gave you an opportunity to defend and to tell us how these teams would be recruited and how they would work, but you've just said that health care will be better without saying how that would be achieved.

In the Canada Health Act there are the five tenets to which we all hold. And one of them is accessibility. And when the Canada Health Act was written, I think the greater concern was that health care would not be denied people because of lack of funds. And of course we all agree that that shouldn't happen.

But what has happened is accessibility is not provided simply because of a rationing of health care. In other words, waiting lists have gotten longer and it's becoming a more urgent issue all the time. It's certainly becoming very, very much a concern in Saskatchewan because we have the longest waiting lists in the entire country.

Now the Canada Health Act says something to the effect that reasonable access to ensure health care services should not be impeded. And quite frankly they seem to be impeded simply because there are not enough professionals in the, you know, in some of the key areas. There are long waiting lists and they're getting longer and longer for more and more emergent health care needs.

There's a clause in the Canada Health Act that uses the "where

and as available" rule. And I would have hoped that in your report you would have attempted to clog that loophole because as long as there is an as "where and as available" rule, we can have no health care in this province and we are not in contravention of the Canada Health Act.

In other words we can continue to ration health care to the point that waiting lists become even longer than they are now, and no one thought that there would be as many people on the waiting lists in Saskatoon and Regina as we currently experience. This is frightening in two respects. It's frightening because there will be vast regions of the province with unsatisfactory service and they will have to go to a regional health care centre or to a tertiary centre for more and more of their health care service.

But it's also frightening because that means that our major centres, and particularly Saskatoon and Regina, will become more clogged than they are right now with people in a system that's not meant to handle that many people.

For instance, in your report you could basically argue that Moose Jaw should be just serviced with a health care centre and that the specialists serving the city of Moose Jaw would be better off in Regina where they're part of a larger team, and everybody from Moose Jaw should come to Regina for most of their health care needs. You could make that argument because it's only about 35 miles down the road.

And yet I don't think you would. I don't think anyone in Saskatchewan would suggest that recommendation should be made, but there are other huge areas of the province which have 20 or 30,000 people in which you were saying that they should not expect that same kind of reasonable health care service and that they should clog the systems in the larger centres.

I don't see anything in your report that adequately addresses, other than you talk about some procedural things like day surgeries and that sort of thing. But I don't see anything beyond some of those recommendations which we're already aware of that could be implemented to alleviate these frightening concerns about a rationing of health care in Saskatchewan to the point that the human pain and suffering is even more unbearable than it is at the current time.

Mr. Fyke: — Thank you. I'd like to read page 11, the quote by the College of Physicians . . . Family Physicians of Canada; College of Family Physicians of Canada. Quote:

> The success of health care reform in Canada will rest with the establishment of family medicine group practice networks, and with closer collaboration of family physicians with other health care providers as part of effective multi-disciplinary health teams. The success of heath care reform will be realized with a strengthened rather than diminished role for Canada's family physicians.

That is one of the quotes and one of the many references and many pieces of material that I read in preparing my report.

In regard to wait-lists, I would comment that there are indeed people that are waiting unduly for procedures that shouldn't. But why? It isn't for the lack of surgery in this province. It isn't for the lack of capacity in this province.

(17:30)

We have an admission rate, as I indicated earlier, 41 per cent higher than the national average. In 11, 11 out of 16 surgical procedures across Canada, 11 out of 16, Saskatchewan leads in a standardized rate, number one, 11 out of 16.

What I've indicated about wait-lists, I'll . . . I'd like to just say it again that what is needed in the wait-list issue is better management, not more money. And I would again suggest that just pouring more money into the same system is exactly what we have been doing for the last 20 years, and it hasn't worked. Wait-lists have got longer. The more money you put in, wait-lists get longer.

So I believe that that supports the premise that we have to focus on something different. We have to start focusing on quality. We have to focus on outcomes. We have to focus on performance and accountability, and only then will we have a sustainable system. Just throwing more money at the system today will not sustain it.

Mr. Krawetz: — Thank you very much, Mr. Chair, and welcome to Mr. Fyke. Mr. Fyke, I want to pose a couple of questions only, and I know time is of the essence. I have had a number of concerns raised by people in the Canora-Pelly constituency, specifically from the communities of Kamsack, Preeceville, and Canora. And Dr. Cornelius VanZyl who heads a team of physicians, general physicians, in that area, a very strong team that are currently delivering health care through acute care beds, both in the communities of Kamsack, Canora, and Preeceville, are delivering a very adequate acute care.

And they take great exception to your comments that the small hospital is obsolete. And I guess the question is what is the definition of small, first of all? And in your definition of closing at least 50 hospitals, they believe that you have not listened to them. And their proposal was put forward that there is a need for tertiary care centres, that there is a need for regional quote "secondary" acute care centres, but there is also a need for primary acute care deliverers.

And that proposal was put forward, and they're wondering where that disappeared because you have not looked at that at all. And as a result, the pediatric needs in those communities that I have identified, the seniors' needs for geriatric care, the acute asthmatic concerns, in fact, Mr. Fyke, the cardiac concerns of people like myself, who have been addressed at those very hospitals that I just mentioned, will not be met. They will not be met because now you're suggesting that we have to move on to the next level, which is a regional centre, and I'm assuming that that probably is Yorkton.

So those facilities that I just mentioned lose their acute care status. The concern that Dr. VanZyl expresses, and all of the physicians and health care providers in that area, is that without acute care, there is no reason for them to stay. They are providing a great level of care, acuity in many respects, and as a result of closure of that type of facility, they must leave because their practices will not be sustainable. So that is a concern that they have.

So the question, I guess the general question, Mr. Fyke, is what

happened to the proposals by people like Dr. VanZyl and a number of people who said we need to have primary acute care facilities, as well as the two recommendations that you've made? And how do you expect health care providers and physicians to stay in those centres once you've eliminated the acute care?

Mr. Fyke: — Well first of all, that care will still be provided there. There is acute care that can be given in home care. Home care can be acute care . . . (inaudible interjection) . . . Well it can. You can give acute care in homes and it has been given across this country right today.

As far as the pediatric, the child that you referred to, that will still be handled through the primary health services team and I expect those physicians to be integral parts of that team . . . an integral part of that primary health services team.

The elderly and dealing with chronic disease — I think you referred to the elderly — the everyday services can still be provided in that community by those physicians or by advanced clinical nurses or whatever the appropriate professional may be.

As far as the physicians leaving, there may be some that will say they will leave. But I believe that those physicians will find their workloads, their quality of life, and working within a team to be very satisfying, and I suspect and I believe that the majority of them will stay.

Mr. Krawetz: — Thank you, Mr. Fyke. You know, Mr. Fyke, Dr. VanZyl says that the team approach in the Assiniboine Valley District is something that he supports and is part of right now. And they work very, very co-operatively with home care and with all of the other providers to ensure that the needs of the people are met. That's number one for physicians in the area.

And I want to tell you a little bit about Dr. VanZyl. Dr. VanZyl is a South African doctor and we're very fortunate in this province to have many very competent doctors from South Africa. He was part of a management team in the early '90s that went through this very process, I think, that you're suggesting.

And in the early part of the '90s, South Africa moved in exactly the same way. They closed many, many small hospitals, moved towards regional hospitals, and then tertiary care centres.

And I'm wondering if you, if you've studied that approach because Dr. VanZyl tells me in his two years in the management centre of a strong, of a very large tertiary centre in South Africa, that the problems that developed where everybody flocked to the tertiary care centre because there was no acute care delivery at the small local levels resulted in the fact that the government of South Africa had to close the tertiary care centres for a while and actually move everything back out to those primary, acute care hospitals that they now have. It was a failure. It was a system that failed.

And I'm wondering, Mr. Fyke, if you've had a chance to look at the South African model of the 1990s or any other country for that matter that is looking at health reform and is trying to meet the needs of the people?

Because if you want, Dr. VanZyl's available to discuss this with you, and many other doctors in Saskatchewan are available to discuss this with you, to show you that the combination that needs to be developed is probably somewhere in between where we are today and what you've recommended.

But that their concerns are that the availability of care for people in the cities, in those tertiary care and regional centres that you talked about, that you propose — those 20 locations — that we may end up in the same situation as South Africa. That we will experience high cost of delivery of care at those levels and we'll have to close those facilities and back up to what we have maybe today or at some other level.

Mr. Fyke: — I thank you. No, I want to make it very clear that my report will not force everyone into Regina and Saskatoon. Regina . . . indeed some of the services that are offered in Regina and Saskatoon could go back to the 10 to 14 regional centres. I am in no way suggesting that all acute care come into Regina and Saskatoon. I'm talking about highly specialized care where there are highly trained specialists or sub-specialists that are not in the regional centres. So I'm looking at regional centres giving your basic medical, surgical, maternity, and the wide range of acute services.

The everyday services that people require which is, as I've stated before, those will be available in that community, in your community. They will be there for the citizens of that community. When they require, when they require a serious acute care, specialist's care — heart attack, broken leg, other very acute services — they would go to the regional centre, one of the 14 regional centres. Or in case of a heart attack, would probably come into Regina or Saskatoon.

That is the way that I'm recommending. That is indeed very close to the way that it's being delivered today.

The Chair: — Order. The time allotted for the current time of questioning has expired. The Chair has been asked if we could take a recess for one-half hour before coming back again. I'd ask, are committee members agreed to recess for half an hour? We will stand recessed for one-half hour at which time we will be returning for questions.

And I'd ask the Sergeant-at-Arms if he could signal members five minutes before that time.

The committee recessed for a period of time.

The Chair: — Order. Committee will come to order please. Order please. I'd like to call the committee to order, and up to the next 20 minutes I'll recognize questions from government members.

Mr. Prebble: — Thank you very much, Mr. Chairman. Mr. Fyke, I want to add my welcome to the welcome that others have extended to you in the Assembly. And thank you for the work you've done in putting together a very comprehensive report.

I want to ask a number of questions with respect to the proposed structure of health districts and the restructuring in effect that you're recommending in this report. You

recommended a significant decrease in the size of the . . . or a significant decrease in the number of health districts in the province. And I want to get at why you think it's necessary for a substantial reduction in the number of districts.

As you know, there are difficulties associated with further reducing the number of health districts in the province. Amalgamation is a tricky business. It's often difficult for staff and creates some uncertainty. It involves a merging of various health unions, because you may have CUPE (Canadian Union of Public Employees) representing one health district and SGEU (Saskatchewan Government and General Employees' Union) representing another in terms of a lot of the health care staff.

(18:15)

So given some of the difficulties that are involved in reducing the number of districts, and given the fact that, as you point out in your report there aren't a lot of administrative savings involved in reducing the number of districts, could you explain for us why you think that it's critical to significantly reduce the number of health districts in the province?

Mr. Fyke: — Thank you. You're quite correct. The rationale for recommending a reduction in the districts is not the administrative saving, even though it may be a small administrative cost saving, but that is not the reason.

The reason is, when the health districts were formed nine or 10 years ago, there has been quite a shift in the population and we've seen a number of districts grow smaller. Secondly, I'm asking the districts to take on a lot of additional responsibilities in the area of emergency service, in the area of primary care reform. So you need the capacity within the districts to carry out those extra and very important responsibilities.

The exact number of districts, there's probably no correct answer of exactly one number. When you look at the research again, you're looking at other areas of Canada. In Alberta the average size of a district is about 20,000. The Institute for Research on Public Policy at Queen's University recommends that we should have a size district, for proper infrastructure of everything, of about 100,000 people.

So I looked across the country and looked at British Columbia with 11 regional health boards and Alberta 17, looked at what I was asking them to do. I also learned that there is some difficulty in recruiting really qualified administrative staff for 32 districts. There's certainly a difficulty in coordinating the work of the districts. There is examples where the are districts competing with each other for recruitment of staff, and difficulty in sort of having a unified policy across the province in a number of areas.

So I felt that there had to be a significant reduction so that the size of them would be larger and be able to sustain the responsibilities that I was recommending for them. I concluded that 12 to . . . sorry, 9 to 11 would be a reasonable number. I left again some flexibility there when we proposed one model of 9 with the borders on the amalgamation of the districts, and another one was 11. I thought that it would be prudent to leave the final decision again to when the government and the districts sit down and talk about whether the boundaries should go within this district or on the other side of it. So there's some flexibility between 9 and 11.

I will certainly be the first to admit that it's a judgment call, because it's hard to find evidence as to what is the optimum size. I'm convinced though that some of our districts are too small and, you know, if the final decision, instead of 9 to 11, it was between 10 and 12 or somewhere around that, that wouldn't bother me, not that it need bother me. But that would certainly work for the province.

The important thing is that we have a number of districts that can carry out the responsibilities that will be assigned to them, are able to look at what is best for the total province so that we can have a provincial response to many things so there isn't sometimes a decision made by one district that has implications in the other districts and there's poor communication.

And, sorry, there was one other point that it's just escaped me.

But that was the rationale for a significant decrease to 9 to 11.

Sorry, there was one more point I would like to make. It's important that the districts, no matter what size they are, put mechanisms in place to make sure they receive the input of the public in the communities they serve. And I see this input coming from the various communities into the primary health services networks and also into the district boards and management. And it's important that those priorities of the smaller communities are recognized in the boards.

I know that there's some concern that these districts are maybe too large. I don't believe they are. When you look at Saskatchewan, we've got a large land mass but we only have a million people. And some groups said to me, how much infrastructure can we have for a million people.

So I think the balance that I came down with, looking at all the factors, was in a range of 9 to 11 or 12 — 9 to 11.

Mr. Prebble: — Just as a follow-up on that, one of the things that I noted in the report is that you envision a fairly significant change in the relationship between the district boards and the province. And I know that one of the things that I find as a member of the legislature in my own riding is that a lot of my constituents have the expectation that ultimately the province is responsible for the big decisions around health care. And I have a lot of people phoning me to address questions that perhaps their health board representative might address, but they look to their member of the legislature to address these.

So I'm wondering if you can explain for us . . . I certainly have a lot of my constituents who are looking for the province, I think, to play a somewhat more significant role than we have in the last few years. And I'm wondering if you can explain for us what role you see the province playing in terms of health care delivery decisions? And what roles you see the district health boards playing?

Mr. Fyke: — This is an issue raised with me by a number of the health districts, and particularly by SAHO. There appears to have been misunderstandings in the past on what is the

respective roles and responsibilities of the districts versus the provincial government. I established a broad guideline that said that the provincial government of course sets the policy framework and sets the standards, and the districts manage and evaluate those services.

There are some who are looking for a partnership, and I say in my report that it is not a partnership. There's clearly delineated lines of accountability up through to the Minister of Health, and the Minister of Health is responsible through the government to this . . . to the ultimate authority of this Legislative Assembly, and that that accountability must be very clear.

On the other hand the districts, I believe, once the policy direction is set, they should be left to manage within their . . . within those parameters, as long as they must always recognize that if they make a decision that has province-wide implications, then obviously the Minister of Health and the Department of Health and the government are going to have to deal with that issue so that there is a proper policy decision and proper implementation of that policy from a provincial perspective.

In a province the size of Saskatchewan, with one million people, I think it's always going to be the reality that the average person on the street will go directly to the Minister of Health for a lot of these issues. I think the Minister of Health has got to be careful at times that they do not get pulled into some of these issues, that they refer them back to the district to deal with. But I accept your point that a lot of the members of the public see the Minister of Health as the one that's responsible. And that was probably some of the rationale for some people suggesting to me that we really only need one district for the province.

And if you look at a community district like Calgary, Calgary serves 1.3 million people with one district. But I felt with the, coming back to your previous question, I felt that one district for Saskatchewan was not workable and therefore I recommended the 10.

But I outline in my report, on page 59, the roles and responsibilities for the provincial government and the district as one suggestion for both the delivery of specialized services province-wide and the delivery of primary health services.

It is clear — this is my last comment — it is clear that the province must develop, in my opinion, one health plan for the province and that there be a provincial perspective. You need community input, but on the other hand what's critical for a province with a million people is that there's one provincial plan for specialized services and the delivery of primary health services.

Mr. Prebble: — Just one other question on structure. And this builds on a comment that you already made with respect to small communities.

And if your plan was to become provincial policy, in the event that it did become provincial policy, obviously we'd have much bigger health districts. And I think in rural Saskatchewan there'd be some smaller communities who feel that they've got a real voice right now in their health district but might feel with a much larger district that their voice may not be adequately heard.

So I'm wondering if you've got . . . if you can elaborate on suggestions you might have about how the voices of smaller communities could be genuinely heard in the context of much larger health districts, particularly in rural Saskatchewan.

Mr. Fyke: — Again I would refer the hon. member to page 57 when I talk about public participation and public engagement. And it is important that all communities have input into the priorities and the needs of their community.

But I say there, many have talked about a number of . . . how you provide input, and I say a small population size is one way of encouraging public participation but it is by no means a guarantee. There is considerable evidence to suggest that larger districts can find ways to engage the public about how health services can and should be delivered.

So just size alone does not guarantee community involvement and public input. I think the mechanisms have to be put in place so that there is a meaningful dialogue and a meaningful way of providing that input from the small community into a larger body.

I heard a mixed message in some ways around the province on districts. There are some people who will say that we should leave the number of districts the way they are. They certainly were lots of others who said that we could have larger districts, and there were others who quite frankly wondered why we needed districts.

So there's a whole range of a kind of opinion out there, but at the end of the day I thought that in the area of 10 was appropriate.

Mr. Prebble: — I'd like to change the area of questioning and look at a section of your report that deals with determinants on the quality of health that are not directly related to the delivery of health care services by the Department of Health.

And I think you make a point in your report that I agree with, that we need to pay attention to the real determinants of health care, and that issues like addressing poverty and ensuring we have adequate housing, adequate nutrition in our . . . for all people of the province, is just as important as having good quality health care delivery services.

So I'm wondering if you can elaborate on a recommendation that you make on page 42, where you say that we need to pay attention to strategies to address the broader determinants of health. Do you have any specific recommendations for the legislature about determinants that we should pay particular attention to; and that both with respect to policy development and also with respect to funding, and funding that wouldn't necessarily be through the Department of Health but that would impact significantly on people's health in the province?

(18:30)

Mr. Fyke: — I'm not sure if I have any unique suggestions to make other than I guess my whole report is almost focused on

this, that if we don't change the way we deliver health care, that we will indeed reach the point where we're compromising the health of the population. Because health is more than health care — health is a good job, it's an education. It's other social support networks. It's our physical environment.

And I know that when I talked to people in the North, northern part of the province, their concern was focused on clean water and immunization. And the way that — well my report specifies some of these things in chapter 3 — the way that we will really change the system to one that deals with what I call upstream issues versus the downstream treatment models, is putting the . . . is organizing our primary health delivery system so that we can indeed focus on preventing illness.

For example, coming back again to the large diabetic population we have in this province and ways of handling the diabetics from their onset of diabetes through understanding the disease, understanding how to live with the disease, understanding how you change your lifestyle to cope with the disease — all of those things — if there was more emphasis put on it, it would prevent a lot of the problems downstream which is not only poor quality, poor health care, poor health, it's also expensive.

So there's the broad determinants. I don't think I have anything unique to suggest other than we always have to keep in mind that health care has a contribution to the population health but it is somewhere in the . . . I don't want to use numbers but the research would indicate that it's somewhere in the 15 to 25 per cent impact on the health, whereas other issues in our lifestyle, jobs, etc., could contribute up to 75 per cent.

Mr. Prebble: — Thank you very much for those comments. Just dealing with that same chapter, chapter 3 of your report, you also talk about the importance of a strategy for injury reduction and accident reduction, and this is a particular interest of mine. And I wonder if, during the course of your discussions, was there input from the Institute on Prevention of Handicaps? And could you elaborate on your advice with respect to new initiatives that we might take to reduce accidents and reduce injuries, in effect injury prevention and reduction in the province?

I note with some interest that you see the primary health care teams as playing a very critical role in this regard. But I'm wondering if you have any specific suggestions about particularly province-wide policies that we might initiate that would make a significant difference in terms of injury reduction, accident reduction.

Mr. Fyke: — Thank you. There's a lot of good work in the intersectoral . . . intersectorally. The child action plan is one that's . . . I believe there's another example, but escapes me right now — it must be getting late in the day — that I should refer to.

Again as I indicated on page 40 "Meeting the Health Needs of Northern Communities," the deaths in the North are more likely the result of injury, violence, and lung disease, of heart, than others. So injury and violent deaths is very high. It's not quite as high as heart disease, but it certainly is one of the highest ones.

And that's something that we'll . . . as part of the northern health strategy that the northern communities are working on, which I support very much, in taking a broader approach to their health issues in the North. And they are very focused on again what I would consider as primary health services, not on the high tech end of it. The ones that for a very little cost has a great payback for the health of the people of the North.

The Chair: — The Chair will now recognize questions from the opposition for up to the next 20 minutes.

Mr. Krawetz: — Thank you very much, Mr. Chair. And, Mr. Fyke, I was asking a number of questions when my time expired, and your answer was at the end of that time period. But your comments provoked a couple of comments now that have been generated from other people in the area that I represent.

Mr. Fyke, the last wave of health reform produced 53 hospital closures of which Theodore and Norquay and Invermay were in the area of the east-central side of the province. And there is a very firm belief by the people in that area that health care services have not improved as a result of the closure of those three facilities.

What has become accepted though of course is that the people who require acute care in those communities have to travel further, and the result is of course that the cost is now borne by the individuals who need to seek acute care in the communities of Preeceville or Kamsack and Canora.

Your proposal of course suggests that the acute care in those facilities will also now be removed. And there is a firm belief that the people in those areas see this as a step backwards. They see this as the removal of a need, a service that it needs to be provided in that area. And as I mentioned before, the physicians that I've talked to you about who provide a team approach to delivery of the needs of the public in that area believe that acute care beds are necessary at those community levels.

The question, Mr. Fyke, is that history has shown in the examples in South Africa and in other places that as you move up from the smaller acute care facility to the regional hospital to the tertiary care centre, that indeed the delivery of cost seems to be more expensive.

In your research, did you find that to be true?

Mr. Fyke: — The costs in a tertiary hospital are clearly more expensive than in a regional hospital because you are paying for high-cost infrastructure, and the cost of a regional hospital would be more expensive than providing primary care services which indeed are primarily what's been provided in a small hospital. That's why my report focuses on primary health services as a priority of the health care system because you get the biggest bang for the buck.

And then coming back to what I believe your question was earlier, sir, I want to reiterate it that I am not suggesting that all of the acute care funnel into Regina or Saskatoon — not at all. Indeed some of the care that's coming into Regina, Saskatoon could go back to the regional centres.

I am proposing though that the acute care — that is truly acute

care that requires the skills and the qualifications of people around the regional hospitals that can assure quality care — be delivered at the regional centre. And again at the local level, the everyday health services would be delivered through the primary health services network.

Mr. Krawetz: — Mr. Fyke, one of the concerns that has been raised by people in those four communities that I just identified, that have hospitals by the way including Foam Lake, is that hospitals like the Regina General here in Regina or the Royal University who provide a specialized care and will do cardiac surgeries and will do all kinds of other surgeries that cannot be done in the smaller centres, that there is a need for those people who receive that care to be able to transfer back. They're not yet in the stage of convalescent care; they're still requiring acute care.

Yet the people that administer these hospitals tell me right now that in many instances when receiving calls from the Regina General, they are full. Their acute care space that they have currently is being fully utilized.

Under your proposal, if we are going to now close those facilities and only have acute care available at somewhere between 15 and 20 regional centres, where do you see the people of this province being able to receive acute care if indeed now we have longer waiting lists? We have examples of people who are waiting a year and a half to two years now for specific types of surgeries because those beds are occupied.

We need to develop a system that works in the team approach. And again I'm referring to comments made by Dr. VanZyl who says we need to be involved at that local level as well. If there is a person from Canora who requires an additional three days of acute care and they're currently in a bed in Yorkton Regional Hospital or in Regina General, they could be transferred back to that very facility in Canora or Preeceville or Kamsack as acute care patients. If you remove the acute care in those hospitals, they no longer can do that.

How do you see this functioning in the province as a whole as we move towards reducing the length of time on waiting lists to be able to provide better services for all people in Saskatchewan? Because I hear you talk about equality and the need to ensure that everyone receives services. Well the people in the facilities that I just talked about are now going to have to rely on Yorkton or Regina as the place where they receive acute care after the specific 10 hours that you might have a primary health care centre open.

I'd appreciate your comments.

Mr. Fyke: — Thank you. First of all, I see the . . . well first of all, I want to back up and talk about the capacity. The capacity of beds required in this province to provide all of the acute care is about 3,000 beds. I reiterate again that Saskatchewan residents use hospitals more than any other Canadians — page 27, 41 per cent more than any other Canadians.

I agree with you that when you come into Regina or Saskatoon for specialist services, be it heart surgery or hip surgery or whatever it may be, after that acute phase which may be 9 or 10 days or whatever, they could go back . . . and I would see them going back to a community care centre for their convalescent phase. They could do one of two things — they could go home to Canora on home care with visiting physiotherapists or maybe a visiting nurse, or they could go back to a community care centre for a period of time to convalesce and receive their physiotherapy and then possibly go home.

So there's two routes they would be able to be discharged out of Regina hospital to go back to their local community or home care or the community care centre for convalescing.

The capacity in Regina and Saskatoon — they're having concerns raised about whether there is enough capacity. There is if Regina and Saskatoon will be used for the tertiary services. And that is some of the services that are currently . . . that could currently be . . . or that are currently coming to Regina and Saskatoon could be done in the regional centres.

So A, there is a capacity to provide acute care. What we're probably debating is what is acute care. And that's a difficult . . . that is a very difficult term to define. All again I would reiterate that acute care is being given successfully in home care and can be given . . . would be given in the regional centres and the tertiary centres. I do not classify convalescent as acute care.

Mr. Krawetz: — One final question, Mr. Fyke. Your comments I think may be misunderstood by some urban people. And I'm wondering if you could explain what would happen in Regina, Saskatoon, and Prince Albert if indeed tertiary care provision and those services now provided by a tertiary care centre for those facilities. Are residents then, in the city of Regina for instance, expected now to travel out to the regional hospitals that are now outside of the city to obtain the kind of care that would no longer be available even though it's called acute care? Because now you're expecting that description to change.

Mr. Fyke: — I would see Regina and Saskatoon residents receiving their, what they would normally call services from a regional hospital, they would receive those in Regina and Saskatoon.

On the other hand, I want to reiterate for the people of rural Saskatchewan that when they require a tertiary, highly specialized bed in Regina or Saskatoon, they should have claim on that bed based on their need rather . . . over whether it's a citizen from Regina or a citizen from Yorkton, they should have that claim on that bed based on their need.

Regina and Saskatoon residents would still go to Regina and Saskatoon for services that the Yorkton residents may receive in Yorkton. But what I'm saying that some of the services could go back. I am told by physicians that there are services that come into Regina and Saskatoon now that could be looked after in a regional hospital.

(18:45)

Ms. Bakken: — Mr. Fyke, I guess as I've been listening today your comments and answers to many of our questions have raised many, many more concerns and many more questions which time just does not permit for me to ask.

But I would just like to make a comment about your answer to the member from Canora-Pelly about releasing patients from acute care and how they are going to be looked after when they go back to their home constituency. And I think if you'll look at the case today is that because of being released from hospital too soon there are many cases of repeated hospitalization and added cost to the system and much undue hardship for people that are required to do this. So I would hope that that whole area would be revisited by yourself.

The member from Canora-Pelly also raised some of the issues that I would also like to reiterate but from a different perspective. Some of the concerns he raised have also been raised by a Society of Rural Physicians of Canada and I would just like to quote from a news release that they issued:

> The Society of Rural Physicians of Canada cautions government from centralizing hospital services to the degree recommended by the Fyke Commission. The commission has recommended closing 71 per cent of Saskatchewan hospitals, which will increase travel time to a hospital to over an hour in good weather for 12 per cent of the population.

They further comment:

> Hospitals are not Wal-Marts but more like grocery stores; they deal with perishables. Even if the distant hospital is of excellent quality, the results will not be as good for people who have to travel long distances to receive it.

They further go on to say:

> A further irony is that it may cost more money to centralize. The cost per case in rural hospitals can be lower than that of larger hospitals even before you add in the cost of the ambulance. It is notable that the last series of hospital closures in 1993 did not save any money.

And that is the end of their press release. And we all know in fact that health care costs have escalated in Saskatchewan, and yet the care has not . . . the cost has not been proven by the care received.

I would like to ask you, Mr. Fyke, did you consult with the Society of Rural Physicians of Canada and them and others that are concerned with delivery of health care in rural situations? And secondly, how does your proposal to close 71 per cent of existing hospitals guarantee accessible quality care no matter where you live in Saskatchewan?

The Chair: — Order. Mr. Fyke, just before you continue. Hon. members, just in the last couple of questions I think we've been, or the last two or three questions, we've been leading a little bit more to engage in Mr. Fyke, I think, perhaps in some debate here as opposed to some questions on the report. I think in the last question, certainly there is a question directly there about having consulted on the report, but then I think the second part of the question is definitely, I think, in the opinion of the Chair, leading to engage Mr. Fyke in some debate. And I just would like to remind members to . . . members, we're here to ask questions of Mr. Fyke and his report . . .

Order, order. Order. I'm directing that the questions be asked of Mr. Fyke dealing with his report, and I'm detecting that this is moving to a bit of debate and I'd just like to bring that to the hon. member's attention, please.

Mr. Fyke: — Thank you, I want to reiterate again, my report does not close 71 per cent of the hospitals in this province. My report recommends that 20 hospitals be converted to primary health centres. My report recommends that 25 to 30 hospitals be classified as community care centres, basically recognizing what they're doing now as integrated health facilities.

I would like to also let the hon. member know that I talked to many physicians, including the Saskatchewan Medical Association, the College of Physicians and Surgeons, and many individual doctors about the health care in this province. I do not recall speaking to the organization that you refer to, but I did speak to many other individual physicians.

Ms. Bakken: — Thank you, Mr. Deputy Speaker. Mr. Fyke, you indicated that primary health centres would provide care, and that our estimation of how many hospitals would be closed is incorrect. Are the primary health care centres providing acute care?

Mr. Fyke: — Primary health centres will be the location of the primary health service teams networks. They will be providing the everyday health services that people require. As far as the home care is concerned, they will be providing acute care in the homes. That is acute . . . in not all cases, but in some cases, it is acute care.

Many services that a primary health services team will provide today, on an out-patient basis, a few years ago may have been admitted to hospital. What I define as required in a hospital are those where there is necessary for around the . . . intensive observation on a 24-hour basis, or the bringing together of skills and equipment that is required to provide the necessary care to that patient.

Ms. Bakken: — Thank you, Mr. Fyke. I guess then we can conclude that the primary health centres do not provide acute care.

I spoke to one RN (Registered Nurse) who works in the ICU (intensive care unit) in my constituency, and she has read your report and she has concluded that it does not address the reality of life in rural Saskatchewan which she deals with and works with every day. She notes your report implies we live in a perfect world where everything happens according to Hoyle, and we just don't know that that is just not the way it is.

This RN's concern and many others in my constituency is that timely access to acute care and emergency services will not be available. We've asked you for the names of the hospitals that will be closed and I understand that you're not willing to give those. And so there's grave concern in Weyburn about that, because of our location to Regina and Estevan.

But you have stated that you are endorsing the EMS (emergency medical services) report and their recommendations. Yet this study has been widely denounced in rural Saskatchewan as taking away local control and timely

response to emergency. There have been many questions asked of doctors and citizens across rural Saskatchewan about how this EMS study could provide the services.

There was a great loss of local control in 1993 when hospitals were closed in Saskatchewan and they are very concerned that this is now going to happen with emergency service and ambulance service.

How do you justify endorsing this study, when indeed it does take away local control and it does take away timely access to emergency services?

We have already had cases across the province where, now that the dispatch is in Yorkton, where valuable time has been lost because of the relaying of information back and forth. And yet if that information was directed right to the local ambulance deliverer, they would know where to go and they would provide service much faster.

And I'm wondering how you justify endorsing this report.

Mr. Fyke: — I'm struggling with the last part of your question about the . . . not the timely access to the emergency. I'm sorry, I didn't get the essence of your question.

Ms. Bakken: — Mr. Fyke, I'm wondering how you can . . . You've said you endorse the ambulance report and would implement their recommendations.

Local control is going to be lost in delivery and as well as in, say, of how ambulance services deliver. Presently, we have a lot of volunteers that provide service. The people in the local areas know where locations are if someone phones up and says there's someone had a heart attack at the local church. They know where to go.

There have been cases in my constituency and I'm sure in all other MLAs' constituencies where time, precious time has been lost because of a central dispatch system and having to relay the information. But the more important part I think is that they're losing the actual control at the local level, same as we did in '93 with the hospitals.

Mr. Fyke: — Okay, first of all I want to clarify that the recommendations of the ambulance report that I specifically endorsed is a central dispatch, it is the equalization of the costs — the transportation costs, the patient portion — and it is to improve the services for all of Saskatchewan. It is also the fact that it is going to move to a 24 hour, 7-day-a-week service which a lot of the services, ambulance services in this province do not operate under now. So that the 24-hour service will be available throughout the province, not just in some communities.

As far as the local control is concerned, I see the ambulance program being managed by the districts and how they contract with some of the local . . . I'm just not sure if the concerns that some of the local operators have are legitimate or not until they move towards implementation.

I must conclude my comments though by saying that this report, all the details of it, were not carried out by me and I'm not, I must admit that I'm not that familiar with all the details of the ambulance report. But I do believe in reading the report, that it provides a much better service for rural Saskatchewan moving to 24/7 than the current inconsistency across the province.

The Chair: — Order. The Chair will now recognize an additional 20 minutes of questions from the opposition members.

Mr. D'Autremont: — Thank you, Mr. Chairman. Mr. Fyke, and associates, welcome today.

I've been listening very carefully to the discourse this afternoon and this evening to gain an understanding of exactly what this report is about and why or why not we should accept it. And in listening very carefully to the report that's cost the taxpayers $2 million to prepare by yourself, I have heard a lot of things such as: I believe that this will happen, I suspect that this will be the case, or I recommend that we do this. But in this presentation and in the answers that you have been providing or not providing, Mr. Fyke — and in fact, it's been a lot more of not providing than it has been in providing — in fact, I'd suspect and I feel that you have been relatively uncooperative with our questions. We have been asking some very specific questions related to your report and to the methodology that you used to come forward with your recommendations and you have not provided us with those answers.

How are we to make a determination, Mr. Fyke, on this report, good or bad, when we're being asked by you to accept the I believes, the I suspect, or the I recommends when you provide little to no evidence either today or in your report to support your conjecture?

My colleague asked about the number of hospitals, the number of acute care facilities that would be in this province. You said you used a computer model, the latest technology to make this determination. And when he asked, based on what did you make your recommendations of three cities with tertiary care hospitals, six hospitals, 10 to 14 regional hospitals, your response was well I didn't stick pins in the map.

But what methodology did you use, Mr. Fyke, to make that determination? You're saying 60-miles travel distance around some mythical circle that you expect us to believe is what Saskatchewan needs, and yet you do not provide us with the information to make a judgment on whether there is any validity to your claim.

So, Mr. Fyke, I ask what methodology did you use? What circles did you draw on what map?

(19:00)

Mr. Fyke: — I believe I have been very clear in my report. I have recommended that specialized services be provided in Regina, Saskatoon, and Prince Albert. I have recommended that based on a population of one million and the size of this province and the capacity that the acute care system has to be, that we need 10 to 14 regional hospitals.

And I've also recommended 25 to 30 community care centres and primary health centres. I believe that is very clear. I am

using, I believe, because a part . . . there does in writing a report like this, you look at the information, you look at the research; at the end of the day you have to make a judgment call on some of these issues.

In regard to the capacity of the acute care system, I will reiterate again: Saskatchewan has an admission rate 41 per cent above the national average. We currently use about 2,900 to 3,000 beds. There is adequate capacity in those 10 to 14 plus the Regina, Saskatoon, Prince Albert to provide those services, and therefore there is logic in my recommendation. And as far as the proof, I will only reiterate again that the report is full of references, and there is a full and complete bibliography at the end.

Mr. D'Autremont: — Thank you, Mr. Fyke. Yes, I read your bibliography at the end. And I doubt very many other people will go through and read all those resources that you used, and that's why you were paid $2 million to do this so that the rest of Saskatchewan didn't have to read those.

But when you come forward and make a recommendation and what you call a judgment call, we're being asked to make a judgment call also. And we need some of the information that you used to make your judgment call. Why won't you provide that? What are you hiding?

The Chair: — Order. I've listened to the last few questions here. And the Chair's interpretation of the purpose of inviting Mr. Fyke and his colleagues before the board today is for Mr. Fyke to answer questions of members of this committee of questions to do with his report.

The last few questions I would say that the, by and large, you know the committee has followed this all afternoon. By and large though, in the last few questions, the preambles to the questions that have been posed by many members, the Chair is starting to interpret as being debative, that these are engaging Mr. Fyke in debate. It's up to this committee and the Assembly to debate each other, not with Mr. Fyke, in the opinion of the Chair.

I would ask that all hon. members confine their questions, would minimize their preambles if they could, because I think the Chair's interpretive of these as being debative, and please confine their remarks to questions of the report and of Mr. Fyke.

Mr. D'Autremont: — Point of order, Mr. Chairman.

The Chair: — Point of order.

Mr. D'Autremont: — Mr. Chairman, my point of order is that we have a witness before us today that we are asking specific questions on, who is not answering the questions. I would ask that Mr. Chairman instruct the witness to answer the questions properly.

The Chair: — I think, hon. member, that the Chair has already ruled that the . . . that this is debate and we're not here to debate. We're here to ask questions, so I think that you . . . no I think you're . . . the Chair's interpreting this as being debate and I . . . we're here to ask questions of the member, we're not here to debate.

Mr. D'Autremont: — Thank you, Mr. Chairman. Mr. Fyke, you have stated a number of times this evening that 41 . . . that Saskatchewan utilizes hospital services 41 per cent of the time more than Canadians. Do you have any statistical evidence of that? Do you have any breakdown of that statistical evidence?

Mr. Fyke: — I would refer you to page 27 of my report, hospital visits per thousand residents 1998-1999, adjusted for age and sex — Saskatchewan 133.4; Canadian average 96.7.

Mr. D'Autremont: — Thank you . . .

Mr. Fyke: — I'd like to site the source of that data. It is the Canadian Institute for Health Information, 2001.

Mr. D'Autremont: — Thank you, Mr. Fyke. Mr. Fyke, what are the demographics of Saskatchewan based on seniors, youth, people ages 15 to 55?

Mr. Fyke: — The data that I quoted to you is adjusted for age and sex. Standardized data adjusted for age and sex across the country . . . (inaudible) . . . variation and age.

Mr. D'Autremont: — Thank you, Mr. Fyke. I wonder, though, if you would have the information available on the demographics of Saskatchewan — the percentages of seniors that we have in Saskatchewan compared to the national standard.

Mr. Fyke: — We can provide that information and get back to you; I don't have it with me tonight.

Mr. D'Autremont: — Thank you, Mr. Fyke. Mr. Fyke, we know that there is a serious health issue amongst the Aboriginal community. I have three reserves in my constituency. This creates a great deal of difficulty in some of those areas. Statistics show, I believe, that the Aboriginal community utilizes the health care services at a greater extent than the Saskatchewan average. I wonder if you have any statistics on that, Mr. Fyke.

Mr. Fyke: — I have some data in the *Challenges* document that I tabled in October, but I don't have that data with me now. We'll have to get back to you on it.

Mr. Hart: — Thank you, Mr. Chair. Good evening, Mr. Fyke. I have a few questions that deal with research and education in that section of your report. In your report you make reference in numerous areas about the importance of research to our health care system and the integral role it plays in providing and maintaining quality health care in the province.

In fact on page 65 of your report, you say Saskatchewan has no choice but to make a strong commitment to research. Recently the Canadian Institute of Health Research awarded some 410 research grants. The province of Manitoba received eight of those awards, Newfoundland got a few, and the province of Saskatchewan got none. And this is something that has been going on for quite some time where we score very low in obtaining federal dollars for research and so on.

The College of Medicine is an integral part of our research capacity in this province, and we all know of some of the serious problems that have been facing the College of Medicine in recent months and weeks. We have noted award-winning researcher of the College of Medicine, Dr. Roger Pierson, recently saying that if we don't increase funding to the College of Medicine and fix some of the problems there, that we should perhaps close it. He compares the College of Medicine as a patient in critical condition.

I was wondering, did you look at some short-term solutions to some of the problems at the College of Medicine, and if so, what would those short-term solutions be?

Mr. Fyke: — I met on more than one occasion with President MacKinnon of the university to discuss the issue around training of our health sciences professionals. I do recommend that we invest in health research for all the reasons that I reiterated earlier.

I commented on the role and relationship between the College of Medicine and the Saskatoon Health District. I did not go into the specific issues in the College of Medicine for a couple of reasons. It was beyond my mandate and I knew that the president of the university was dealing with a lot of those issues.

But I do support more dollars going into research. I believe it will bring more money into the province. That will be good for our province, it'll be good for our universities, and it'll be good for the people that are being trained.

It's important though that the College of Medicine and the Saskatoon Health District work out a relationship based on a role for education in the Saskatoon Health District and come to an understanding of their respective roles so that those difficulties that we were seeing and hearing about last fall will be resolved.

Mr. Hart: — Thank you, Mr. Fyke. I read with interest your recommendation of making the Saskatoon District Health region an academic health science centre. And I guess some of the questions that that part of your report raised was how would the university and the College of Medicine and Royal University Hospital and the Saskatoon Health District, what type of mechanism would have to be put in place so that there would be a smooth functioning to prevent turf protection and that sort of thing?

And in your research, did you come across any models in other jurisdictions in Canada and perhaps elsewhere that could be looked at to perhaps we could pattern that sort of a change after?

Mr. Fyke: — I think, or I believe there is, or I know there is several examples in Canada. In Alberta there's the relationship between the Capital Health Authority in Edmonton and the Faculty of Medicine in Edmonton. I know that those have been looked at by the officials in Saskatoon.

And I'm quite confident that the University of Saskatchewan and the Saskatoon Health District will be able to structure an agreement that will recognize the priorities they all have in regard to research, education, and service. I'm quite confident that that can be done, and there's no reason why it can't be done.

Mr. Hart: — I have one more question that deals with the health care professionals in the health care field. You indicate that your primary health services team require highly trained personnel to provide the services that would no longer be available once the hospitals were changed, and you require highly qualified people in the ambulances and that sort of thing.

Did you look at the training capacity of the province to train and educate health care professionals that we have at present, and is it sufficient to provide the people that we'll need in the future? Did you look at that area?

Mr. Fyke: — My report touches on the need for the training programs to focus on interdisciplinary training and to focus on the needs of the health system when people graduate, and what I have outlined as to those important needs in primary health and rural health and the northern health issues. So that's what my report speaks to, and doesn't go beyond that in what my report covers.

Ms. Julé: — Thank you, Mr. Chair, and good evening to Mr. Fyke and associates. Mr. Fyke, I want to continue along the line of questioning that refers to the needs of Aboriginal people in Saskatchewan.

(19:15)

As I'm sure just about every member of this Assembly recognizes, Aboriginal people in Saskatchewan are suffering with a number of illnesses. They're facing an epidemic of diabetes and substance abuse, FAS (fetal alcohol syndrome), teen pregnancies, and many problems related to a high incidence of children, Aboriginal children, exploited in the sex trade.

Aboriginal children and Aboriginal people in general deserve and need mental and physical health services to assist them in their journey towards a wholesome and healthy life.

Mr. Fyke, I am sure that by now you recognize also, as everyone else does, that historically Saskatchewan has had the highest infant mortality rate in Canada. And it has been recognized that a high percentage of those child deaths are deaths of babies and young children from Aboriginal communities.

As the critic for Aboriginal Affairs and as a citizen I am very concerned, and I know that many First Nations people and Metis people are also concerned because they've come to me with these concerns. They are wondering how they fit into this system. We have a very complex problem in that we have many off-reserve Indian people living in urban centres. We also have people that are on reserves that are facing all of these illnesses.

Now although you stated in your report, for instance, Mr. Fyke, that diabetes is a major issue, I don't see any concrete suggestions on your part or recommendations that provide a road map to address that very important issue as well as the rest. I have to ask: how does the consolidation of health services and

expanding the number of health managers address the very serious health issues pertaining to Aboriginal people?

Mr. Fyke: — Thank you. I agree with you that the health of our First Nations and Aboriginal people is not up to the standard that we should have in this province. My report addresses it in two ways.

Primary health services and the primary health service network is one way of dealing with the First Nations and the Aboriginal peoples problems. They are . . . the issues that they raised with me — one of them was what you indicated — is the high incidence of diabetes and that is clearly an area that a primary health services network would improve.

The other recommendation that I make is sorting out the organizational — what's the appropriate word — the jurisdictional issues around our First Nations people who are on-reserve and off-reserve. And I believe that the federal government and provincial government and the First Nations people and the districts need to sit down and work out in a structured way, in a structured dialogue as I've suggested, a way of dealing with these issues. Because there's a lot of . . . there is duplication between what the federal government does and our own provincial health system.

That is as far as I felt I could go in resolving this, and I think I do believe it goes a long ways. I can only say that if there is ever an example that clearly indicates the need for primary health reform it is in that area.

The Chair: — Order. The current allotment is expired for this period of questioning. The Chair will now recognize questions from the government members for up to the next 20 minutes.

Mr. Thomson: — Thank you, Mr. Chairman. Mr. Fyke, I'm wanting to ask about a different set of issues that had maybe not been addressed to a great extent yet today, and that pertains to the contracting of physicians and the contracting of specialist services. Could you explain to me what you mean by this term of contracting. Would this be in place of the current fee-for-service arrangements?

Mr. Fyke: — Currently in our system the physicians practise outside the system. They're not part of the rest of the district structure. Many physicians have indicated to me that they want to be part of the system, as I think I referred to in my opening remarks. It is important if we're going to have a lot of these issues dealt with, that we have one cohesive system that includes physicians and all of our providers.

In order for the districts to operate the primary health services, it is important that the districts contract or employ all the providers on the primary health services teams. And I see that as . . . it could be a contractual arrangement. The way that the physician is paid for his services, I'm leaving open to some negotiation and discussion as long as it focuses . . . as long as the incentive for the physician's payment is focused on quality rather than volumes.

In regard to the specialists, I would like to see over the next number of years our physicians, our specialists, to come into the system as well and be part of the regional hospitals and the tertiary centres.

Specialists are so critical to the health care services in this province. If we had a contractual arrangement with them, and they were being paid and remunerated in a way that would allow them to maybe go out into rural Saskatchewan and provide clinics and maybe in the regional centres, or even indeed be on a consultative basis to our primary health teams, and also working in a way that helps to manage our wait lists in a way that reduces the time line for patients on the waiting list, that the whole . . . that the system would work much better.

We see many physicians in this province on alternate forms of payment and contractual arrangements with some of our districts. And I think there's merit in sitting down with our physicians, the districts sitting down with their physicians and bringing them into the system and having them as part of the system and having their expertise.

Mr. Thomson: — Thank you. So am I correct to understand then that there would be basically parallel systems; that districts would have the option of contracting services with physicians, but some physicians may very well decide to stay on the fee-for-service basis?

Mr. Fyke: — I believe it will take some time to implement some of these recommendations. And I can see a situation where there may be some time before our primary care physicians . . . I would see the primary care physicians being the first to be brought into the primary care teams. I see probably some additional time left for the specialists to be brought into the . . . under the district structure.

Again that's up to the districts and the profession to sit down and discuss how the objectives of this report can be implemented. I think it's important that the doctors and the SMA be involved in those discussions as to how we best do it.

Mr. Thomson: — Thank you. I don't want to move too far along that discussion except I am of the view that this is still one of those critical pieces in order to make this system work, that we would need to look very seriously at contracting, which will mean the physicians will need to . . . I don't know what the appropriate word is. I don't want to say buy in, but they will need to agree to these set of changes.

I'm interested as to what sort of discussions you may have had during the course of your deliberations and your work on the report with the physicians around the province and what their views were. You've mentioned some physicians are interested. Did you meet a fair amount of resistance as well?

Mr. Fyke: — There are people who resist it and there are people who . . . there are people who resist going off fee-for-service. And there are people who would dearly love to go off fee-for-service and move to alternate forms of payment.

I've talked to physicians who are on alternate forms . . . alternate to fee-for-service, and they like it very much. I've talked to physicians who believe a fee-for-service system is the best way to go. I guess there's a range.

I believe there is some research done by the medical association

in this province that indicated up to 50 per cent or a large number of physicians were willing to look at alternate forms of payment. One or two physicians that I talked to — I spoke to more than one or two — but one or two physicians I spoke to indicated that they . . . one was on an alternate form, the other one was on fee-for-service. But they both said that they would . . . the one that was on an alternate form of payment said he liked it very much, was able to manage his time and he didn't have to worry about, I think what he said, the business end of running a physician practice.

Another one, a fee-for-service physician, really lamented to me about not being able to focus on a lot of the chronic diseases that he felt he should be spending more time with his patients, because the fee-for-service system did not reward him for doing that. If you have a target income you have to put the volume . . . see the volume to get the income.

So I think the medical profession is . . . there's mixed feelings across the medical profession as to what is best. I think what we have to do is sit down and listen to the physicians and determine how best to approach.

Mr. Thomson: — Along the same vein, in terms of the consolidation of services and the discussion you had with physicians, and I guess other health care providers, where we have highly specialized services currently in say Saskatoon and Regina, but we may not have a critical mass of them to be able to have an effective practice, or a high quality of service provision, what was the view of these people in terms of combining their practices and their teams and their resources into one centre? Obviously this would mean relocating in many cases if I understand the report correctly. Was there some support for this or is this a contentious issue?

Mr. Fyke: — Oh I guess I would define it as a contentious issue. I didn't sit down with any particular group and discuss about bringing their practice in, but certainly I had discussions with people in the College of Medicine about the need that we look at focusing on programs that can ensure high quality services, and some of those may have to be one site in the province.

At a theoretical level I think they would certainly agree, but I would have to define, if we did move that, we'd have to certainly look at all the implications of it and there would be some hurdles to overcome.

There's ways of doing that and I'll have to just leave it, I believe, for the quality council to start looking at some of these programs and saying what they're suggesting that there isn't probably enough patients to have two programs or for whatever reason.

There may also be other opportunities down the road if certain physicians left the province, or where there's new programs started.

The Chair: — Order. Why is the member on her feet?

Ms. Junor: — So I could ask a question.

The Chair: — Apologies of the Chair.

Ms. Junor: — Thank you. The Japanese have a saying that I think is loosely translated: fix the problem, not the blame. And I know some providers in the system may feel that they have some way contributed or had some part in the inadequacies or the deficiencies that have been pointed out in the report, and may feel that they're to blame.

What do you say to them?

Mr. Fyke: — I say we move on and look at the system as to how it can work better. I think the term I use: there's no villains in the piece, I think is the term I use in the report.

I'm not blame . . . This report is not about blame. This report is certainly not about who's to blame. This report may be about what is to blame and how can we fix it. But I want to emphasize so clear to the members here this evening and to the public that this is a report that looks toward the future as to how we can build and sustain an improved health system, a better health system for this province. It is not about looking for people to blame. That will never move ahead by doing that.

And I had a number of discussions with our health care providers about how I word the report in order that I minimize people feeling that I'm blaming individuals or individual professions.

This is not about blame. This is about recognizing what is, and how do we move forward. The airline industry and other industries have looked at quality and said, and Berwick is quoted in here and Berwick has done a lot of wonderful work in the United States on quality improvement, and I just can't put my fingers on the exact page.

(19:30)

But we have to accept that I suppose we're all to blame — all of us collectively, as a society, and I comment on that in my conclusion. But let's now move on to the future and say how do we all work together to make it a better system.

Ms. Junor: — Thank you. I have another question. The questions I've heard lead me to believe that we still are defining health services as acute care, a bed, or a doctor. Did you find that in your deliberations and in your consultations that people still have that view, or are they of the view that health services cover a broader range?

Mr. Fyke: — I found both views. There are still people who believe that the small hospital and the single doctor is the health care system. And there are other providers who believe that a health care system is broader than that and that the health system is much broader than the health care system.

I believe today there's a lot more recognition of the broader determinants of health and the broader need in the health care system — all the different professionals and technology and the information age that we're going through — I believe there's a lot more acceptance today than there was 10 years ago.

And I'm quite optimistic that in a few years this report will . . . a lot of things in this report will be just very common knowledge in health care systems and be common practices.

Ms. Junor: — I have one more question. When you talk about reporting, the public has a right to know, and decisions should be made on reports of quality and evidence, how will we know when we've made the system better? How will we know when we've got there, when we've made a difference?

Mr. Fyke: — With your permission, can I answer your second-last question, expand on that and then answer that question?

I just wanted . . . I think it's important to your last question. What did the public say? And I just want to quote on our *Challenges* document and our questionnaires:

> Nearly 60% of respondents to *The Challenges Ahead* questionnaire felt that it is the job of the health system to do more than treat disease, illness and injury. They felt the system should promote health through programs that support good parenting, provide nutritional advice, and help people quit smoking. Over 52% of respondents agreed that the health system should make a special effort to reach out to groups that face higher health risks. Others said that it is not the sole responsibility of the health system to address these issues. In the public forums organized by the commission, some participants called for outreach services to seniors, poor families, and other groups. Others advocated support for housing and home care initiatives.

So there was a fairly . . . over, nearly 60 per cent, so it was a pretty broad response to our questionnaire.

Now when . . . your question on when do we know we've made a difference. First of all we've got to set some goals for the health system and decide what it is that we're going . . . how we're going to define success, because today we cannot define success. Today success has been if we're putting more in each year, and we're not defining success.

First of all, before we know where we've gone to, we have to know where we've come from. And we have to define where we are today and where we're moving to. I would like to . . . there's a number of broad indices but certainly an infant mortality, life expectancy, there's a number of indices of . . . broad indices of the health system that can be measured. I'd like to see how we're dealing with a lot of our chronic diseases in preventing the complications of chronic diseases, and how that compares.

And I think that some districts — and many districts are interested in this — they could certainly measure what it is today and five years from now and see how we've progressed on certain health issues that may be unique to their districts.

And the question on the other side of the House here, on the Aboriginal, I think that is an area that we could clearly measure progress over the next five to ten years. And I think that would be wonderful if we did see some real progress in some of those . . . for the underprivileged people of our society.

Mr. Prebble: — Thank you very much, Mr. Chairman. Mr. Fyke, I'd like to ask a question about exactly where you see the provincial government investing additional funds. I think you've made it very clear that we don't necessarily need to be spending more money in order to have a better system, and you want us to move, as I read your report, to a system that has a much greater focus on quality of care.

But in terms of new strategic financial investments, what are you recommending in terms of where the province should invest additional dollars to make a difference in terms of health care quality?

Mr. Fyke: — I'm recommending investments in four or five areas. One in the change that will be required to a primary health services system, which requires transitional funds to move to that system.

I'm recommending investments in emergency services. I'm also recommending investments in measuring quality with the quality council so that we know whether we're getting value for money or not. Recommending health research. Recommending money be put into information and communications technology and a human resource strategy.

I see those investments and I'm estimating that they would in the area of a hundred million dollars over the next four years. And I have to caution that it's very hard to make some of those estimates because of the premises, some of the factors that may change in the next few years.

And I believe if those investments are made, the gap that is referred to, if we take a status quo, maintain the status quo system with health growing at six and a half per cent and revenue of the province growing at two and a half per cent, it's going to have a $300 million gap — that the gap will be less in four years than that. It will not be zero of course, but it will be less than the $300 million. And then the costs would, the increasing costs would decrease.

And I would never . . . I don't think I have any evidence to suggest that the actual costs will go down but it's the rate of increase of the costs that is concerning me from a sustainability point of view looking at the provincial revenues over the next few years.

Mr. Prebble: — Thank you. I just want to ask a brief question to clarify whether there's any proposals in this report that would actually expand the range of publicly funded services right now.

We roughly, in this province, we're putting a little over . . . 72 per cent of our health care costs are covered through the public system and a little under 30 per cent are paid for privately. Are there any service areas where you're recommending that we in effect expand the public system and publicly fund things that are privately funded at the present time in the sense that they're paid for by the individual taxpayer when they're utilizing the service?

Mr. Fyke: — No I am not. Drugs is an area of concern. I believe that we need to address the drug issue between the provinces and the federal government. My conclusion on should public funding cover more services, on page 78 and 79, I comment that:

> Without eliminating unnecessary and inefficient utilization, without reforming the delivery of everyday services and

without realizing the effects of successful prevention and health enhancing social and economic programs, expanding Medicare will be unaffordable, however desirable it may be.

Expanding as you indicated, and my data shows that Saskatchewan is about 73 per cent public, or 72 or 73. The Canadian average is 70 per cent, 70/30.

But we have to make sure that the system is . . . that we're getting value for our money, that we've eliminated unnecessary and inefficient utilization. And then maybe the bonus will be able to expand some of the services that are required.

The Chair: — Order. The Chair will now recognize questions from the hon. members of the opposition up to the next 20 minutes.

Ms. Julé: — Thank you, Mr. Chairman. Mr. Fyke, the people in and around Humboldt have for quite some time now been planning for, in fact they have received funds from the provincial government for the planning of a new integrated health facility in Humboldt.

The Central Plains Health Board concurs that this is a facility that is needed. They have certainly met every bit of the criteria that they believed was necessary in order for that facility to become a reality.

Mr. Fyke, there has been great initiative taken on the part of the rural municipalities surrounding Humboldt, as well as the people of Humboldt. The facility is targeted . . . The targeted cost for this new integrated facility would be about $16 million. And right now the local share, which is about half of that from what I understand, 95 per cent of that local share is in place right now.

So fundraising has taken place. Many, many service agencies and the hospital foundation have been working very hard to make sure that they are meeting their part of the cost. The people of Humboldt believe that that new hospital is in the making. And with the tabling of your report last week, I think there's a little bit of confusion going on in the minds of many people that have worked so very hard for that centre, simply because there's some contradictory in your . . . contradictory sort of statements in your report.

And I'll give you an example of what I mean there. You have stated that a regional hospital, which I believe is what the Humboldt hospital was designated to be, a regional hospital would in fact need three to five doctors, as far as I can understand, in residence or that would serve that hospital.

You also mentioned a population base that that regional hospital would have to cover as I believe 30 to 50,000 population base. So Humboldt serves, or that hospital right now serves about a 25,000, I think, population base. However if there was an expansion of the district boundaries, there may be a change in how many people that hospital may serve.

But nonetheless the other criteria that one would have to meet in order to have a regional hospital is that . . . like I said, there's the doctors, there's — I'm trying to think of all the other criteria you mentioned — but nonetheless it seems like just about everything is in place there. However Humboldt hospital is about not quite a hundred kilometres from Saskatoon. And so that's where the contradiction lies as far as your recommendations for regional hospital.

The part of this that's a little frustrating is the people in that area do not want to delay any longer. They have worked very hard at their plans. This has been on the drawing board for quite some time and, Mr. Fyke, frankly they would like an answer.

They want to know whether or not Humboldt will have an acute care facility, be it an integrated facility where all services will be under one roof you could say, or in one area. And they would like to know, with the tabling of your report, if you can give them a definite answer as to whether or not their dreams of a regional hospital will come to reality soon.

(19:45)

Mr. Fyke: — Thank you for the question. I appreciate that during a major review like this and the tabling of the report will certainly, and has caused uncertainty in the system. And I don't see a way of preventing that because it is a time of where all the issues are reviewed and the recommendations are put together and then those recommendations have been dealt with.

I cannot and will not speculate on whether Humboldt will be a regional hospital or a community care facility. That is going to have to be up to how my report is addressed and implemented between . . . and a decision of the district and the government as to the designation of those 10 to 14 sites throughout the province.

Ms. Julé: — Thank you, Mr. Fyke. Mr. Fyke, in your report under the executive summary portion right at the beginning of your report, I notice that a portion of your mandate was to recommend an action plan for delivery of services across Saskatchewan.

Giving a sort of a vague answer to a question as precise as I have presented to you in my interpretation is not a direct action plan.

The people of the province have been waiting for some very concrete answers. They've been waiting for your recommendations to come across, presenting a clear picture of where the facilities will be, what services will come from those facilities, and what people can expect.

So in respect to the hard work and the dreams of those people that should be able to determine the kind of services they need, and especially when they're working so very hard to put in their own funding, in respect to them and respect for them, I ask that you give us some clearer indication from your recommendations, from your thought process that you've put into this.

Certainly from the information you've gathered there is, or must be, a pretty good indication in your mind as to whether Humboldt will have a regional hospital. Mr. Fyke, could you please give us that answer?

Mr. Fyke: — I would be pleased to comment on my mandate. The mandate that I was given is threefold.

Number two, you refer to the recommendation of an action plan for the delivery of health services across Saskatchewan through a model that is sustainable and embodies the core values of medicare. I have provided that in my report and my report recommends there be 10 to 14 regional centres and I stand by that.

Ms. Julé: — But, Mr. Fyke, in my mind there's a question as to how you could come up with the recommendation of 10 to 14 regional centres without considering what is already here, what people have worked at previously, what is being built now, what the population base surrounding those areas is.

We have hospital plans that are started. There's been a great deal of money projected towards that, not only from the provincial government for planning but certainly in increased mill rates and so on for the people in those areas.

Certainly all of those things should be considerations into whether or not there will be in fact a regional hospital in certain areas. And I would hope that those were taken into consideration when you came up with the number of 10 to 14, otherwise I really have to question how you did come up with that number.

Mr. Fyke: — Again I would reiterate that on the implementation of my report, if it is the government's decision to implement my report, on the implementation phase it is most appropriate to sit down with the districts and with the . . . the government and the districts as to where those 10 to 14 facilities should be located. They may be 10 facilities; there may be 11 and there may be 12 or 13 or 14.

My role was to put a plan before the Premier and the government and this House, the people of Saskatchewan. I am focusing on a provincial-wide plan. And the details of where those sites should be, I again reiterate that I'm . . . I want to and I stand by the decision. My report does not define the actual locations; that that would be left to the implementation across this province with input from the districts and the providers and the public.

Ms. Julé: — Thank you, Mr. Fyke. The recommendations that you have put forward have been after a great deal of consultation with people in this province, with service providers, with service organizations, with the people of the province that are involved in the health system, as well as the people that receive health care.

Those consultations have basically been done. The taxpayers have been willing to pay $2 million for that to be done. The taxpayers now want some very definite answers.

Mr. Fyke, if it's not you that gives those definite answers, surely it seems to me that the recommendations are to be brought before the government of the day and they would look at those recommendations because consultations have already taken place. The people have spoken. And so certainly the government should be acting, just as I believe that an action plan on what is going to be happening as far as delivery of services to Aboriginal people should have been just that, an action plan — that means to act. So I don't see any direction that you have given as far as concrete action taking place.

So would you agree that the consultations were very thorough? Because I would hope they would have been for $2 million. And if you in fact agree with that, would you agree with me that the government should act in one way or the other on these recommendations?

Mr. Fyke: — I believe the consultations have been very thorough. You can always have more consultations, but I had extensive consultations. I put a plan to the Premier and the government. The government is now seeking input from the providers and the public, and that to me seems reasonable. And it is up to others to decide whether my report should be implemented.

My mandate was to place recommendations in front of the Premier for an action plan for the delivery of health services in this province that is sustainable. I believe that I have fulfilled that mandate. And it is now up to the government, indeed members of this House, to say how they wish to proceed and whether they can improve, whether others can improve on my report to bring about improvements in the implementation.

Ms. Julé: — Mr. Fyke, I have received a number of concerns from a doctor in my constituency, and of course that's a rural area; this is a rural doctor. This doctor has made reference to your comments on NTR's (News Talk Radio) talk show regarding your findings. And he states that you stated that people in rural areas will get a higher quality, good or better emergency health services from emergency medical technicians than they will from doctors in rural hospitals. There is no doubt that this doctor took offence to that.

The very fact of the matter is that even with advanced training, maybe of four months, emergency medical technicians couldn't possibly have the kind of expertise that rural doctors or any doctor have as far as diagnostic ability, as far as having access to patient files and their history.

Rural doctors in rural hospitals, in emergencies, have patients come into the hospital, or patients come in. These doctors stabilize and they monitor patients because they need immediate care, and they shouldn't be moved great distances until they are stabilized.

In the event that EMTs would be responsible for this, picking up a person at the site of an accident, trying to stabilize them at the same time that they're moving them would be dangerous. It is after the original diagnosis and stabilization and the monitoring of patients that rural doctors would put them in ambulances and transfer them to tertiary centres.

Mr. Fyke, are you saying that you really believe that EMTs can offer the same professional and knowledgeable services as a doctor could?

Mr. Fyke: — My report does not compare the relative value of any health provider. We need physicians, we need nurses, we need qualified emergency medical technicians. I don't believe I would have ever said that on any open-line show. Because I do

not believe it, that emergency medical technicians were better than doctors, or in some form like that. If that was interpreted by a physician, I would certainly give him my apologies.

I would likely have said that rather than a farmer who is injured in the field being brought into the local hospital in a half-ton truck and then treated in a hospital where the hospital doesn't necessarily have a lot of emergency cases, that is not as good as an ambulance with a trained technician who arrives on the site and can stabilize that patient and then transfer him to a hospital.

The work . . . the training programs and the qualifications and what an emergency medical technician do across this country are clearly delineated. I believe physicians have emergency medical . . . emergency room physicians . . . emergency room specialists have a lot of input into the program for emergency medical technicians.

So I certainly stand by the comment that emergency medical technicians provide a much superior service at the site of an accident. I'm not comparing that person to a physician who may happen to be there. But, indeed, physicians are not riding in ambulances. Physicians are in the hospital, maybe in a regional centre, receiving the patient or in a current site receiving a patient.

So I will certainly stand by my remark that emergency medical technician upgrading will enhance the quality of services for rural Saskatchewan when they have an accident.

Ms. Julé: — Thank you, Mr. Fyke. Mr. Fyke, one other contention of the doctor I talked to was that his understanding is that these recommendations that you put forward after doing your study would be achieving overall cost savings. His question is: where is the rationale in closing rural hospitals because rural hospitals were not an overall . . . one of the overall highest cost items in health?

And he maintains that what we save in closing hospitals, we'll be putting into ambulance services. Now what is the point in doing this?

Mr. Fyke, where will you . . . or how many ambulance services, rather, and how much extra staff will be needed if your recommendations are implemented? Have you counted the cost? Have you done the study on how many ambulances would be filling the roads of Saskatchewan and rushing into the tertiary centres to arrive with their patients? You know the other point, there's a four- to six-hour emergency wait for people when they come into emergencies in the tertiary centres right now in Saskatoon and Regina.

With the increased load from the rural areas, and loads of ambulances coming in with people, one can be sure that the city hospitals will not even have the physical space to accommodate patients. More ambulances will not cut down waiting time in emergency. That is the contention of this doctor.

But I would just revert back to my question regarding how many ambulances and staff will be needed if your recommendations are implemented, and have you counted the financial cost?

Mr. Fyke: — The financial cost of an ambulance program is outlined in the report of the ambulance . . . report on the ambulance services which I believe were tabled in this House several months ago.

In regard to the cost issue that the hon. member raised. When I'm looking at rural Saskatchewan this is not about saving money, it's about in making the services better, it's about improving the services for rural Saskatchewan.

Many, many people told me during the process of this consultation that what they really needed in rural Saskatchewan is better ambulance service. Those ambulances right now were not there 24 hours a day and that people were not trained.

So I go back again to the fact that my report recommends better services for rural Saskatchewan through primary health services, better services through improved emergency services, more enhanced home care, and telephone line to call 24 hours a day, 7 days a week.

(20:00)

Ms. Julé: — Thank you, Mr. Fyke. Mr. Fyke, I just want to make one final comment. And people in rural Saskatchewan particularly, and urban Saskatchewan, the ones I've spoken with, are not buying this. They say that it is a continuation of the system that started in 1993. That has been a disaster. And this is just a continuum of that.

People are very distraught because they know that if responsibility and the ownership of health services remain at the local level and determination of those health services, that they would be able to run a very good system.

In fact many people are saying that they would like to abolish the whole district idea and go back to the model that we had prior to the wellness model — the district formation. At that time communities had autonomy over their services. They were the ones that determined what they needed and they took the action to put it in place.

And so they feel that there's very little rationale backing your recommendations. There's very little common sense and there's a lack of understanding as to the situation in rural Saskatchewan.

So I thank you, Mr. Fyke. And I needed and wanted to make that comment on behalf of the people in my constituency. Thank you.

The committee recessed for a period of time.

The Chair: — Order. The committee will come to order.

Hon. Mr. Lautermilch: — Thank you very much, Mr. Chairman. Mr. Fyke, I will be very brief in my question.

I just want to say on behalf of myself and the government members that we really do appreciate your time spent with us here today. You've been in that chair since 2:30 this afternoon and some would suggest it might have been very informative — I being one of them.

I do have a question though with respect to the document that you have presented. Some people have suggested that it's very much compared to what has been called for in this legislature — that being a value-for-money audit. And I'm just wondering if you might be able to respond to that?

Mr. Fyke: — My report, my report is about change. It's about a sustainable, better system and it's about quality and it's about teamwork. Part of quality is making sure that the system is effective and efficient and produces the — what I have referred to this evening several times and my report refers to it as well — is one of the foundations of a sustainable health system is one where we do get value for our money in the system.

And that is a theme of my report. I recognize there is other aspects to the report that we've discussed here in the last number of hours, but that is the whole issue of sustainability, efficiency, effectiveness, and quality. Value for money — that's what the report's all about.

Hon. Mr. Lautermilch: — Thank you very much, Mr. Fyke. Mr. Chairman, as I indicated a little earlier this has been a fairly long day and Mr. Fyke has spent a considerable time answering questions of the legislature. And I do note that it is past the hour of adjournment and I would ask that you call the clock.

The Chair: — It being now past the hour of adjournment, the committee will now rise and report progress and ask for leave to sit again.

The committee reported progress.

The Speaker: — Pursuant to rule 3(2) it is incumbent upon me now to adjourn the House. The House will stand adjourned until tomorrow at 10 a.m.

The Assembly adjourned at 20:26.