STANDING COMMITTEE ON HUMAN SERVICES

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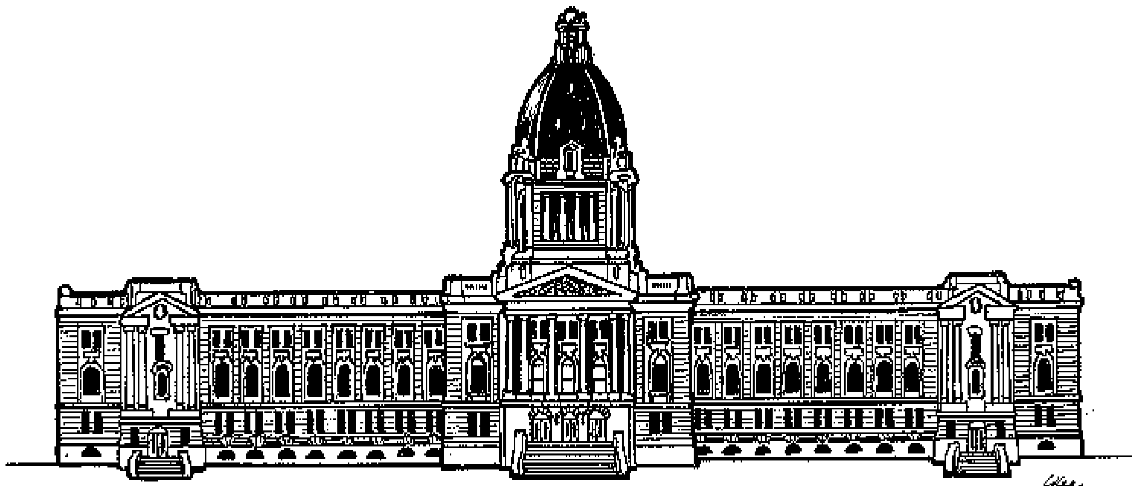

Legislative Assembly of Saskatchewan

Twenty-fifth Legislature

STANDING COMMITTEE ON HUMAN SERVICES
2007

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Mr. Wayne Elhard, Deputy Chair
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Published under the authority of The Honourable P. Myron Kowalsky, Speaker

[The committee met at 15:05.]

Bill No. 31 — The Regional Health Services Amendment Act, 2006 (No. 2)

Clause 1

The Chair: — Good afternoon and welcome to the Standing Committee on Human Services. The first item on the agenda is just a bit changed from what is printed. We're going to do consideration of Bill No. 31, The Regional Health Services Amendment Act, 2006 (No. 2). We have the minister with us. And any officials you'd like to introduce, and any statement you'd like to make to the Bill.

Hon. Mr. Taylor: — All right, thank you very much. I appreciate it. I have with me at the table here specifically for discussion of the Act in front of us on my right, John Wright, the deputy minister, and on my left David Smith, from the department.

For our opening remarks let me just say briefly that The Regional Health Services Amendment Act has been on our plate for sometime in development. There've been a number of meetings and consultations held over the course of the last two years working on pulling things together.

I think that the members of the committee have expressed some concern about the need for the Act. And I think I should mention to begin with that, really the amendments in front of us today come out of direction partly presented to us from the — I was going to say the Provincial Ombudsman, but that's not correct — from the auditor, from the Provincial Auditor, thank you very much.

The accountability requirements of the regional health authorities and the agreements that they have in place with health care organizations since the regional health authorities were established some years ago. The Provincial Auditor has indicated that the agreements have not necessarily been consistent across the piece and that we should be working at building a greater consistency into the system, and that we need to address these so-called third party agreements with long-term care facilities, addiction services, mental health services, hospitals, and originally the EMS [emergency medical services] services or ambulance operators.

So we've been working over the last couple of years preparing the amendments to the Act and the results of these discussions are what's in front of us today. Essentially this is to ensure consistency to provide for quality of care and to ensure that we have accountability and transparency in agreements across the entire system. I'm prepared to answer questions in lieu of further comments.

The Chair: — Mr. McMorris.

Mr. McMorris: — Thank you, Madam Chair. Certainly the Bill has been in the works for quite a long time. I know in the legislature I believe it was introduced and we spoke to it for the first time on November 14 of '06. Since that time it's been up six times, seven times, and we finally moved it to committee. And the reason why it has taken so long to get to committee is because we've been hearing concerns, mainly from the ambulance operators, of what the impact this Bill will have on their operations and the contract operators what the Bill, what type of impact this Bill will have for them.

And so we've held it up and held it up because we were under the understanding that there was some talk between the department and the contract operators that may alleviate some of the concerns that they have or there may be some amendments to the Bill that will alleviate some of the concerns, but unfortunately that hasn't happened in the number of months, the seven months, that this Bill has been in second reading or in adjourned debates.

And I think it's evident the concern that a number of operators have, or I would say all the contract operators have. But a number of them are represented here today in the room just to see and hear first-hand the responses of you, Mr. Minister, as far as the impact this Bill will have on their operations and you can certainly understand the concern. The member from Cypress Hills, to my left, spoke on the Bill as recently as of about a week ago, a week and a half ago, and raised those concerns very, very well; very articulate and certainly can understand.

So I guess my first question direct then to the minister is: what type of impact will this Bill have on contract ambulance operators?

Hon. Mr. Taylor: — I'm very happy to answer that question. Just for those people who are watching the proceedings here today and who don't really have any background on what it is we're talking about . . . and I regret that I did not make it more clear in my opening comments. But for all intents and purposes these amendments are designed to assist with bringing greater accountability and transparency to agreements between regional health authorities and affiliates. Ambulance operators or EMS providers are one of numerous affiliates. And for all intents and purposes the affiliates in all other cases, other than the EMS providers, have indicated support for the amendments that are in front of us.

Secondly, I want to welcome Ron Dufresne from the organization known as SEMSA [Saskatchewan Emergency Medical Services Association] and to other providers here, including Wally Dutchak who's from WPD Ambulance in my constituency who I have met with on several occasions individually with regards to the Act in front of us and others. So specifically to answer your question, and let me try and be as clear as possible because I think it's important that the intent of the department is as clear as possible on this, and I'll just back up a little bit.

In the spring of 2005, the department initiated discussions with representatives of SEMSA in an effort to determine whether a consensus could be developed that would allow the department, regional health authorities, and SEMSA to move forward with the new framework for regional health authority ambulance operator contracts. In the spring of 2006, departmental officials began working with SEMSA to develop a legislative and regulatory framework based on the aforementioned consensus.

It was envisaged that changes would be made to contract provisions of The Ambulance Act as well as sections 34 to 37 of The Regional Health Services Act.

To date the department has not received sufficient support from SEMSA regarding these changes. As a result, regional health authority, private ambulance operator contracts will continue to be governed by The Ambulance Act. So I hope that's clear.

Mr. McMorris: — Thank you, Mr. Minister. That is clear. I understand that. But there are some concerns then when you look through the Bill. When you look through the Bill and section 34(1)(a)(ii), it talks about — in the Bill itself that we're talking about, Bill 31 — talks about "any other prescribed health care organizations". It's stated right in the Bill.

If we go back to another Act here where it talks about health care organizations and then there's a definition of what health care organizations are, it specially talks about other health care organizations. And there is a list of them here, table 1. They're identified as health care organizations. and they're listed on table 1 which names all the private, or contract — I should say — ambulance operators in the province, and they're listed as health care organizations.

So that's how we're describing them in previous Acts. They fall under that description. So when we look at Bill 31, I think that's where the concern comes in because it could very easily be interpreted under section 34 to "any other prescribed health care organization". So that this would apply to them. You're telling me that it doesn't. That only The Ambulance Act is what is going pertain to the private . . . contract operators. But when you look at the Bill before us it talks about prescribed health care organizations. And when you go further back to say what does that exactly mean, it means ambulance operators as according to table 1 in the regulations. Section 5 here, table 1 of the regulations talks about that very thing.

So on one hand you're saying, and, you know, love to trust, you know, and believe and agree with everything that you're saying that it won't affect them, but the Act and the regulations, previous regulations, puts them into this piece of legislation.

So I guess what I would suggest is as we go through the Act, I have a couple of amendments written that would certainly clarify that, because it's not clear right now. That's your interpretation, Mr. Minister, and your officials, but according to people that have talked to some lawyers on this it's not clear to them. And if there became a conflict the letter of the law here looks . . . And when I looked through it, I'm certainly no lawyer, but when I looked through it it looks like contract operators would be subject to this legislation.

And so I think if when we go through this, and I'll certainly give you a copy of the amendments that I've put forward, they're very friendly amendments. It's just a couple of wording, some wording change that then clarifies it so that we know for a fact that contract operators are not subject to this legislation. Because we have your word on it but that doesn't necessarily . . . what would that carry if there was a conflict in the courts? And if we cleared it up in the legislation right now it would make it much easier.

Hon. Mr. Taylor: — Thank you very much. We are quite prepared to look at amendments. It's a little unusual to raise amendments at this late stage in the process but we are looking to build a consensus so that we can proceed, so we're willing to take a look at that. If there's something we don't understand we simply will not proceed given the amount of time we've had to review the wording that you're suggesting. But if there's something there that clarifies matters and it's easy to see it on the surface, I have no problem. So we'll take a look at this while this process is proceeding.

But first let's be absolutely clear, there is a letter between Sask Health and SEMSA which clarifies our position as much as we can.

Secondly, again I have met with individuals on this matter and have indicated very clearly — and I'm going to get one of my officials here to clarify it even further for members of the committee — but there is no question that for the provisions relating to contract, there are health services organizations outlined in the Act. That's what you're referring to in your comments. But for the purposes of this piece there must be prescribed health organizations. And it's only for the purposes of this legislation that those prescribed will be put there.

And we have indicated that the EMS services, the ambulance operators, will not be prescribed for the purposes of this Act. It's not a matter of exemption; it's a matter of not including the names. So the section that you are referring to will simply not apply to the provisions of this Act dealing with contract.

And to our legal folks, this is perfectly clear. The fact that it appears not to be clear elsewhere is a matter of perhaps further discussion. But for the purposes of the record today, for any judge wanting to look at intent, it is not our intent to prescribe ambulance operators for the purposes of contract provisions. And I'm going to call on Mr. Smith just to clarify this even further.

Mr. Smith: — Thank you, Minister. I'm going to draw you attention, Mr. McMorris, to section 9 of the Bill. It actually talks about here in subclause:

> "(n) for the purposes of clause 34(1)(a), prescribing health care organizations as designated health care organizations;

So what is contemplated here is that you actually have to additionally prescribe any other health care organizations for the purposes of this section.

So in reference to the section you're referring to is where we prescribe ambulance operators in the first instance of the health care organization. To have this section apply we'd have to further prescribe them as a designated health care organization. So there's basically a two-step process here.

So for the purposes of this Bill, the two groups that are planned that would cover are affiliates, and the "other prescribed health care organizations" would be for the for-profit special care homes, the Extendicares, and the one in Langham that do not fall within the definition of an affiliate pursuant to the Act.

Mr. McMorris: — But I think that's, I guess to me that's

where the conflict comes in. I mean you explained it very clearly. That's fine. I understand now what you're saying by a prescribed health care organization. But nowhere in the Act does it say that. And when you go back in regulations and you look at, in the department's regulations, health care organization and then point (ii), "a prescribed person that receives funding from a health region authority to provide health services," you can see where people — contract operators — would think that they would fall into this and obviously they don't find it's very clear. They don't feel that it's very clear. It's not quite as clear as what you've explained there because nowhere has it been explained like that in the regulations or in the Act.

I mean I can understand that, you know, you mentioned the four prescribed health care organizations, but nowhere does it explain that except when you go back in regulations and look at health care organizations and the contractors are listed.

Mr. Smith: — All I can say is, sir, is that when we have gone through and when we're working with SEMSA, we have made that distinction with them is that we agree that they were originally prescribed as HCOs [health care organization], then this would further require further prescriptions.

So, you know, for several months we've been very clear with them as how this would work. The real concern, I guess, in their mind is, would we actually do that prescription and we on numerous occasions said we would not go in that direction. Because what we would end up doing is be creating a conflict between the provisions of The Ambulance Act and what's contained in this Bill. In particular the mediation and arbitration provisions that are set out would you have direct conflict. So you'd basically create a legal quagmire if you were to actually prescribe them for these purposes.

Mr. McMorris: — Thank you for that. The concern is though, you have said that there is no intent for the department to then prescribe contractors — the second tier — and you've said that a number of times, but there's nothing to stop you. I mean for example, if there's a change in officials and an official comes in that says yes, but we really would like them as prescribed health care organizations. What would stop that from happening if for example, you or the minister or the deputy minister — heaven forbid — was no longer there? What would prevent that from happening?

Hon. Mr. Taylor: — Well I think first of all, as was indicated, if there's a direct reference in this Act, it puts it in conflict with another current Act. The official, Mr. Smith, used the term quagmire to indicate a legal quagmire. It would not be in government's interest to create that quagmire because we're trying to relieve pressures within the system and not create additional ones. Therefore we would not wish to do something that would create a legal challenge and tie up the credibility of the Act, the credibility of the agreements, processes, etc., etc.

I think SEMSA understands and recognizes the need to clarify and simplify things, primarily because most if not all of the contracts in the province are currently up and regional health authorities are now in a position of negotiating these new contracts. And as a result it's in both parties' interests to have a non-quagmire effect in place, ensuring that these contracts get dealt with in the business relationship that must exist as that's being delivered. So we're just having a look now at the amendments that you're putting forward because indeed we want to ensure that it's a simple system, a simple system that clarifies, doesn't muddy the waters that exist around us.

And I just want to say on behalf of Sask Health, despite the fact that we haven't reached conclusions in our consensus building, Ron Dufresne and SEMSA have worked very well with Sask Health. And one of the reasons this is taking so long is because the parties want to reach a consensus. Both interests are represented as we . . . And if it takes a little while, it takes a little while. But if you give us a few minutes here, we're just consulting over the amendments that you've brought forward.

Mr. McMorris: — If I could just speak to the one amendment that I think would fit the best. As I've listened to your, you know, rationale as to why we are where we are, and it does make sense. But the one that I, that amends part (ii), that "any other prescribed health care organization that does not include a . . . [contract] ambulance operator," then that clears it up.

And I don't know what the other ramifications are and maybe you can explain that to me. But what we do then is you named the organizations that this is to be affecting, the prescribed health care organizations. You may have named four — I can't repeat what they were — but does not include ambulance operators because that would I think clear it up. I don't know what the other ramifications . . . I don't think there'd be any other ramifications. But would that clear it up so that it's stipulated in the legislation that it isn't by word of mouth or could be subject to change in the event of change of personnel? That it is then prescribed in the legislation.

We'd certainly be glad to take a bit of a break if you want to look at that and see the impact.

Hon. Mr. Taylor: — Okay. Well let me just throw something on the record so that you also can think about this. And I don't know if the Chair wants to take a break or if we just want to carry on and go because we find that the clause that you've just submitted to us could be acceptable with the addition of some other words to further clarify sort of the affiliate side of this. So that . . .

Okay. We're looking at narrowing, narrowing the parameters here. So we're actually looking at changing the wording so that it begins, "(ii) any other prescribed health care organization." And then we change the wording to: "that operates as a special care home designated pursuant to the facilities designation regulations." So that it's a positive as opposed to a negative wording and it is specific to the special care homes and hospitals, which is what the intent was in the first place.

Mr. McMorris: — Yes, I think that would be sufficient because what that does is it defines what prescribed health care organization is. It narrows the term down which again, as I say, was subject to some interpretation and that was where the concern was. But if you narrow it down and define it which, you know, I think that your wording was fine and as you said it's on the positive side. And as a critic we seem to be on the negative side far too often, but on the positive side, that certainly . . . And I'd be interested if — you know we've got

some time here before this Bill has to move through — if we can get the wording and all agree on that, that would be excellent.

The Chair: — Mr. Prebble has a question and then we could have a short break.

Hon. Mr. Taylor: — Okay. Let me just say one thing first, specifically to Mr. McMorris if I could, because I think I'm being told that the representatives from the sector who are here have indicated this might be acceptable wording and indeed we'll run a few of these things by. I just want it clear and on the record as we proceed that we are prepared to accept this amendment sort of being created on the fly here. And there might be some additional thoughts from members as we proceed through this.

The purpose of all of this is to ensure clarity and that we have a capacity to move forward. I think the representatives from SEMSA are aware that the interest of ensuring that consistency, accountability, transparency carries over throughout the health care sector, and that while we want to ensure that the provisions of this Bill move forward in a way that affects all of those covered by it, we continue to have an interest in the provisions of The Ambulance Act and continuing to work with the representatives of the sector to ensure that we're able to make further progress in that field as well.

The Chair: — Mr. Prebble.

Mr. Prebble: — Yes, I'm very happy with how things are proceeding. I'd wanted to suggest that we have a short break so that the drafting work on this can be done so that it can come back properly to the committee. But I'm happy with how it's proceeding.

I do want to, Don, just comment on one comment that you made, and that is that actually the minister's remarks are extremely important when legislation is being reviewed before the courts. And the intent of Bills, you know, will be gauged in part in the courts by comments that the minister makes in second reading and during committee. So I think that will be a further reassurance in terms of the concerns that ambulance operators have.

But I would propose, Madam Chair, that we take a short break so that the redrafting work on the Bill can be done.

The Chair: — Mr. McMorris.

Mr. McMorris: — Can I just add to that a little bit is that, you know, certainly thanks for those remarks but if we can clear it up in legislation then we don't have to worry about interpretations in speeches in second reading.

But one other question . . . And I don't know how involved the minister has to be in the wording. I would just be very interested to know the issue around the 14-day cessation of payment and the issue around the one-year contracts, how that applies to the organizations that this Bill is targeted — you know, the prescribed health care organizations. Those two issues, the time frames of 14 days cessation of payment if things aren't, you know, done properly, or the one-year contract. Why were those time frames and those two sections added to this Bill, which of course created some concern with the operators? But of the prescribed health care organizations, why were those put in place and what was the reasoning, rationale for that?

Hon. Mr. Taylor: — Thank you very much. I guess first and foremost, you know, given the context that we've just gone through here, we should recognize that in fact the clause that you're referring to, because of the non-prescribed nature, does not apply to the ambulance operators, it applies only to affiliates. So that's in part of the argument with regards to the ambulance operators. It's not on the table here currently. But one has to remember that we're trying to allow the system that's recently been consolidated and brought together in a number of different ways providing some consistency but also allowing the system to evolve. Currently there is no time frame for these sorts of things to happen. A health region could snap its fingers and involve itself in a legal dispute with an affiliate.

What the Act now does is actually provide some certainty and benefit to both sides indicating that there's now a prescribed time frame in which you can undertake a notice, response, and action to be taken. Under the current contracts of course there's no provisions whatsoever for those types of things to roll out. So we believe that for the purposes of the system to evolve and for legal relationships to exist and move forward, that in fact providing a prescribed period for a notice, response, and direction to be taken, that this is a benefit for both parties. That having been said, the 14 days is something that was felt to be sufficient in these circumstances. That's 14 days more than currently exists and so that's simply where that comes from.

The one-year provision that you referred to. . . Just one moment. Before I put my comments on further record, let me just check something. Actually, yes, just to clarify things, most of the contracts currently are 180 days so the one year actually extends the provisions. So it's again allowing for the system to evolve and providing more time for the circumstances to unroll — roll out, pardon me.

The Chair: — Done.

Mr. McMorris: — Well do we need some time now to . . .

The Chair: — Yes.

Mr. McMorris: — Five minutes.

The Chair: — Is five enough?

Hon. Mr. Taylor: — Somebody will need to type it, I guess.

The Chair: — Actually the Law Clerk is coming down as well. We've asked him to come down to make sure that whatever we put together is sound. So five minutes is good for you? Well we'll say a quarter to. That will give us about eight minutes.

[The committee recessed for a period of time.]

The Chair: — If everybody has their copy now of the amendment, we'll start going through the Bill, unless there's any more questions from any members. Seeing none, then

clause 1, short title, is that agreed?

Some Hon. Members: — Agreed.

[Clause 1 agreed to.]

[Clauses 2 to 5 inclusive agreed to.]

Clause 6

The Chair: — Now clause 6 is where the amendment goes in. Under 34(1) the amendment is to:

> Subclause 34(1)(a)(ii) [Okay, I'm going to read it and then you can move it.] of *The Regional Health Services Amendment Act, 2006 (No. 2)*, as being enacted by Clause 6 of the printed Bill is struck out and the following substituted:

If Mr. McMorris would like to read his motion.

Mr. McMorris: — Okay, I move that:

> "(ii) any other prescribed health care organization that operates a special care home designated pursuant to the facility designation regulations".

The Chair: — That's moved by Mr. McMorris. Any questions? Are there any comments, questions? Seeing none then, on the amendment, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay then. Clause 34, clause 6 as amended, is that agreed? Or section 6 as amended.

[Clause 6 as amended agreed to.]

[Clauses 7 to 11 inclusive agreed to.]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows. Could I have somebody move that we move this Act, The Regional Health Services Amendment Act, 2006 (No. 2) with amendment?

Mr. Prebble: — I so move.

The Chair: — Mr. Prebble. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Agreed. So report this Bill to the House with amendment. After all that, yes, Mr. McMorris.

Mr. McMorris: — I just wanted to first of all thank the minister and his officials for working through this. I don't think this happens very often in committee and I really would like to thank you and tell you how much we appreciate you looking at that and changing the legislation as you have. I think it certainly clears it up for all parties involved and that's extremely important. So thank you, personally, very much for allowing the amendment to go forward.

Hon. Mr. Taylor: — Thank you.

The Chair: — Thanks to the minister and his officials.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — The next item up for business before the committee is for the consideration of Health estimates, vote 32, on page 85 of the budget book. Questions? Okay, we'll let the minister change officials. Mr. Taylor, if you have any introductions to do before we start questions.

Hon. Mr. Taylor: — I will. I think we're getting sorted in here. While we're getting sorted, I will introduce, again to my right, Deputy Minister John Wright; directly to my left, just moving in here, is Max Hendricks, one of the ADMs [assistant deputy minister], and Lauren Donnelly, another ADM in the department. And we have a number of other officials behind me that I will introduce more fully should I need to bring them forward for further consultation.

The Chair: — If Ms. Donnelly wants to take a chair from the end, you don't have to sit so low then. Ms. Draude's going to start our questions.

Ms. Draude: — Thank you to the minister and to your officials. I just have a couple of questions and the first one involves MRIs [magnetic resonance imaging]. I have an individual in my constituency who needed an MRI but because of his size there wasn't a machine in Saskatchewan that would handle him. And I'm wondering how often this happens, how many cases have to go out of province in order for this procedure to be done.

Hon. Mr. Taylor: — Let me try to answer that question. We don't have that data immediately available but I'm informed by the officials this would happen infrequently — three, four times a year. And the nearest facility or where the usual referral is, is Winnipeg.

Ms. Draude: — Is there any help for the costs then for travel when someone has to go out of the province for an MRI when it's not available here?

Hon. Mr. Taylor: — Keeping in mind the role of Sask Health is to provide quality care within sustainable limits, working with the resources available to us, currently for services we pay for, in a publicly funded, publicly administered system where, in the case of MRIs, approval has been reached in advance, we pay for all of the testing and physician and hospital costs. But as applies to all other cases, we do not pay for uninsured services, meals, accommodation, or travel.

Ms. Draude: — So if someone that was a SGI [Saskatchewan Government Insurance] person and needed a larger MRI machine, would that same, would the same procedure happen with them when it came to the costs?

Hon. Mr. Taylor: — I can't speak for SGI just as I can't speak for WCB [Workers' Compensation Board], both of whom

contract MRI services. Their contracts, insurance programs, and other things may designate other types of costs that will be paid for, but Saskatchewan Health does not pay for accommodation, meals, or transportation. If we started down that road, I can't begin to imagine the additional costs on the health care system to do that.

There would also have to be consideration of costs for travel within the province were we to make decisions like that. For example we currently do not pay someone who lives in Prince Albert travel, accommodation, or meal costs for referrals to Regina or Saskatoon or Nipawin. So to move into uninsured costs would be a considerable cost to the people of Saskatchewan and we simply are not in a position to recommend that to government.

Ms. Draude: — So can you, are you going to let me know how many times a patient has to be referred out of province when it comes to, for reasons really regarding the size of the person that needs the MRI?

Hon. Mr. Taylor: — We've made a note of that, and we'll let you know what information we have available.

Ms. Draude: — Okay. I really don't have a lot. Don.

The Chair: — Mr. McMorris.

Mr. McMorris: — Thank you. I just have a couple of questions. It's for my colleague from Melville-Saltcoats. He's not able to be here right now, and I have an idea of the issue. I don't know all the details, but it's regarding an ambulance.

There was a motor vehicle accident I believe where a number of people got carried in one ambulance. The bill came times the number of people, and it was talked about a couple times. And I guess just recently they've received a call from a collector, and we had thought that it had been resolved. But obviously it hasn't. So if you could maybe put on the public record where that stands?

Hon. Mr. Taylor: — I will do that. The question was raised in estimates last year around this table. In response, in fact, we had provided a letter to the committee members with a very specific answer to this question. Apparently the member didn't see it or didn't remember seeing it and thought the response was somewhat different than the one that actually was conveyed in the letter. So to the best of my recollection, I will try to repeat what was indicated in the letter to committee members.

For all intents and purposes the fees charged by the ambulance are done under contract. The ambulance operator is given the authority to charge multiple fees should the ambulance operator feel that those fees are necessary. This was a case where the ambulance operator — not by rule of Sask Health, not by rule of the health region — where the ambulance operator felt that five people transported, the fee should be five times the maximum. One can indeed argue whether the types of injuries sustained warrant those charges, but indeed the ambulance operator had the authority to send separate bills to each of the five people carried. The ambulance operator also had the flexibility not to do that.

So we have simply provided the operator with the ability to charge multiple trip costs to any that are being transported. And in this case the ambulance operator chose to issue five separate bills. As I understand it, four were paid and one had to be sent to collection. That's it.

Mr. McMorris: — So there is no — and I don't know whether there should be, I'm just asking the question — there is nothing in the regulations as to . . . I mean you can't overcrowd the front seat of a half-ton. There is nothing on how many people you can fit in an ambulance as far as, you know, I mean you can take it a little bit further — instead of five there is eight or nine. There's nothing to limit that at all as far as what the provider can carry?

Hon. Mr. Taylor: — I might stand to be corrected here or someone might tap me on the shoulder with some additional information. There are safety issues and there are protocols in place. For example the operators may choose for safety reason not to have anyone ride in front with the driver. The staff people on scene may be allowed to make decisions with regards to who can and who cannot be transported safely, whether other vehicles need to be summoned, what the conditions are at the time.

The bottom line and the guiding principle is — with some protocols in place under contract with the regions or even internal to the operation — the bottom line is ensuring the safety of the people being transported and ensuring that they arrive at their destination within a timely, within a reasonable period of time.

But I'm not aware of specific provincial rules regarding how many people can be transported. But like I say, there may be people in the room who can tell me differently.

Mr. McMorris: — One final question then on that. And, you know, we'll use the example of five people being transported and five people being charged for one, for the one trip. What is the determination, how does it work as far as injury? Like for example if there was one person injured in a motor vehicle accident, can a loved one go with them in the ambulance? They're not charged.

In this situation where there was five people, they certainly couldn't have been severely injured by any stretch of the imagination because it just wouldn't have the equipment; it wouldn't have the capacity to deal with five transported to a facility. So, you know, in this situation where is the line? How do you know whether it's a chargeable trip as opposed to a person riding along for comfort, of the patient that is?

Hon. Mr. Taylor: — It's a very good question. Certainly you raise it with some conviction. I know the member from Melville-Saltcoats raised it with some conviction. I know that the individuals that he was represented certainly would have conveyed their conviction and their comments to him in that regard.

We recognize that there needs to be some discretion in this matter, which is why the agreements between Sask Health and the operator provides discretion. And it is the operator who utilizes that discretion to determine who or who does not travel

with the ambulance and who is charged.

I simply acknowledge that that discretion exists and the discretion rests with the operator. And I believe that there are cases where discretion is absolutely critical and important, which is why the discretion exists in the first place. But on the other hand I think that the operators must be sensitive when they are utilizing their discretionary principles in practice.

Mr. McMorris: — Just some other questions then until the other minister comes for Healthy Living. I think he was to be here at 4 but we can certainly carry the time. There's no shortage of things to talk about.

One of the issues that we raised in question period today was the use of paramedics in the ICU [intensive care unit] wards of our hospitals and I used the example at Royal University and paramedics being used there. And I was aware of that quite a while ago but I wasn't aware that this is not uncommon. This is pretty common in many health authorities. Could you tell me how many health authorities are currently using paramedics in their ICU facilities?

Hon. Mr. Taylor: — I'm going to get some additional information. I've been aware of this for some time as well. I support the use of paramedics within the facilities. I think paramedics have certainly indicated an interest and desire to utilize their skills to full scope. But I also recognize that paramedics are paramedics because they have other interests and working inside a facility, whether it's an emergency room or ICU or wherever they can utilize their credentials to their full capacity. Certainly regional health authorities and the ambulance operators, where most of the paramedics come from, have been very creative in working together to relieve some of the pressures in some very critical and sensitive units within the facilities. But just one moment, Madam Chair, while I get the answer to this specific question.

Like some other questions that have been asked in forums other than this one, my answer is that I can't give you specific answers, how many paramedics might be working. The reason for that is this generally . . . This is under the authority of the regional health authorities. They do the staffing. They manage the day-to-day operations of each of the facilities. The use of a paramedic in a facility under contract like this is usually on a temporary basis and it's meant to manage on a short-term basis some of the stress that exists because of shortages.

In some cases that I've become aware of, these temporary placements almost seem like they're becoming permanent because the length of time is longer than originally expected. But that having been said, for all intents and purposes paramedics have indicated a desire to see their capabilities used to their full capacity, and the human health resource managers within the facilities are using that to help out in important circumstances.

So we don't keep those records, and the regional health authorities are not required to provide us with that type of information. But we can do an informal review for internal purposes and let the committee members know what it is that we've come up with, if that's the desire of the committee.

Mr. McMorris: — Yes, thank you, Mr. Minister. I would be interested to know. I don't need to necessarily know the numbers — the exact numbers — but I would be interested in knowing how many health authorities are using paramedics. And I would agree with you that certainly paramedics are, you know, highly trained and if they can be used in the acute care settings, that's great.

I just am concerned and I guess caution that they don't replace nurses and, you know, I don't think they expect to, or anything else. But they do complement the nursing staff, just as you can carry that one step further with nurse practitioners. Nurse practitioners will play an extremely important role but they won't replace doctors in rural Saskatchewan. We can't kind of come into the false pretense that, well it's being handled because we have filled the gap for now. It doesn't substitute or replace the need for more physicians in rural Saskatchewan and urban, and certainly more registered nurses throughout the province.

Hon. Mr. Taylor: — I agree.

The Chair: — Ms. Draude.

Ms. Draude: — I have one more question I'd like to ask you and that's on the facility at Foam Lake. For a number of years the town of Foam Lake has been promised that they're going to receive a primary health care centre after there was cuts in the long-term beds and the acute care beds. And they are still waiting to hear what's happening in their town. Could you give me an update of what's happening in the Foam Lake area?

Hon. Mr. Taylor: — Let me try my best to answer this because there's a number of things that are involved in the development of a site. Basically our information here indicates that of course Foam Lake has been approved as a satellite site and a physician and a nurse practitioner have been approved back in 2006. Our notes do not indicate whether or not the recruitment on those two positions have been completed at this point in time, but the approvals and the funding is in place, pending the arrival and putting into place the physician, the nurse practitioner, and the team that works with them.

Ms. Draude: — So if I understand correctly then, it's up to, the ball is in the court of the health district at this time because the funding is there and everything should be available for them to have their primary health care centre set up.

Hon. Mr. Taylor: — I would say yes, the ball's in the regional health authority's court. Yes.

Ms. Draude: — I'm sure that the town people and the community are going to be pleased to know that because they've been waiting for a number of years. And we've all heard the town name, Foam Lake, come up many times in this last session with the horrific experience they've had there this spring and the fact that they don't have a health care centre. It's very difficult for them. So I'm hoping then we can see a change in the status of their health care situation real quickly.

Hon. Mr. Taylor: — And I'll also review this more fully. I hope you understand that I'm working just off the best notes that are available here at this table. I will make inquiries with

the region and get a complete update as of today, and I will provide that to you as well to confirm or to add to what I've been able to provide you with today.

Ms. Draude: — I appreciate that. Thank you.

The Chair: — Mr. McMorris.

Mr. McMorris: — I think that's all the questions that we have before we change ministers. I would like to thank the minister and all his officials for the work and all the help that they have been for me over the last two years as the critic for Health. I appreciate the answers that you've supplied us, and, as I said, all the work that you've done. Who knows whether the situation will be the same after the next budget, whether we'll be asking questions or receiving questions? But I'd like to thank all the officials for their time here.

Hon. Mr. Taylor: — Okay. And Madam Chair, I want to thank Mr. McMorris, who has demonstrated that he is a very able critic, and I know he'll be able to continue in that role for many years to come. And I don't want to shut down all of the friendly banter in the room.

And I want to thank my officials as well. This is an incredible department. It manages 37,000 people and 269 facilities across the province. It is now spending in excess of $3 billion a year to maintain quality health care for the people of Saskatchewan. They do a tremendous job. I'm grateful for the assistance that they provide me here at this table in helping to answer questions. But more importantly I'm grateful for the work they do outside of this room every day, working with the regions and the people of the province to ensure our system is providing quality care. Thank you to the committee for having us here and good luck with your further deliberations.

The Chair: — Thank you very much for that very positive note. We'll now change ministers and invite the Minister of Healthy Living to step forward and take questions.

Welcome to the minister. And you have some new officials that perhaps you'd like to introduce to the committee and then we'll start the questions.

Hon. Mr. Addley: — Thank you, Madam Chair. I'd like to thank the committee for this opportunity to present the estimates relating to Healthy Living Services, as well as Seniors, and then to answer any questions about the plans for the fiscal year for matters within the portfolio.

I'll be presenting the estimates for Healthy Living Services and Seniors, and the cost to these programs are in the totals for the Health department. I'd like to introduce the department people. They've sort of rearranged where they're sitting. So as you know, John Wright, Roger Carriere. John Wright is deputy minister; Roger Carriere, executive director, community care branch; Dr. Louise Greenberg, associate deputy minister.

And back there is Rick Trimp, executive director for population health, Ted Warawa, executive director of finance and administration branch, and Tracey Smith, assistant to the deputy minister of Health.

Programs and services to support Healthy Living Services will amount to almost $170 million this year, and that's an increase of $12.8 million over last year to fund mental health and addiction programs. In addition, as Minister Responsible for Seniors, I'm pleased that this budget provides the most significant expansion of health services for seniors in a generation with the new seniors' drug plan.

Priorities in this budget include: implementing Project Hope initiatives, continuing to improve access and reduce wait times, protecting and promoting and improving the health of our children and youth, and supporting our seniors.

In 2006-2007, several advancements were made in improving the quality, quantity, and access to children and youth mental health services. Together with the regional health authorities, we've hired a psychologist for distant specialized consultation in southern Saskatchewan; hired three social work psychology positions for family-based therapeutic residential services for children and youth with mental health disorders in Moose Jaw, Prince Albert, and Lloydminster; hired a social worker to provide child and youth mental health services in the Melfort, Tisdale, and Nipawin area; hired additional resources to reduce the wait list at the Autism Resource Centre in Regina by 40 clients over the next year and a half; begun to contract with individual service providers in community-based organizations to provide flexible outreach and respite services to children, youth, and their families with mental health and wellness challenges, thereby extending the treatment and interventions into their homes and communities; and finally developed and distributed province-wide depression and suicide booklet for youth.

This booklet assists youth in the identification of depression and suicide concerns, when and where to refer for help, and what to do in the meantime. The booklet has been distributed to schools, doctors' office, tribal councils, and other organizations, and is also available online.

The Premier's Project Hope remains a key priority. On October 3, 2006, Regina became one of six cities in Canada with a drug treatment court. Day treatment programs have been put in place and are available to individuals who live in Regina and whose criminal behaviour is deemed by Crown prosecutors to be motivated by or caused by addictions.

In addition, six interim secure detox beds were opened in Regina and since that time 120 young people were treated and released. There was also six interim youth stabilization beds in Saskatoon, as well as six interim treatment beds in Prince Albert. April marked the one-year anniversary of The Youth Drug Detoxification and Stabilization Act. And since that Act came into effect, as I indicated, 120 youths with serious addiction issues have been provided a safe place to detox, stabilize, and link with community resources and supports within their home community. And it's actually been a very rewarding place for the staff to work as well.

And today we've hired about 90 positions to support Project Hope initiatives throughout the province. These positions improve access to health care, prevent substance abuse, and assist others on the road to recovery.

Positions hired include outreach workers, methadone counsellors, youth mental health and addiction counsellors, as well as mobile treatment coordinators in the North. We'll continue our efforts toward maintaining and improving existing programs and services within existing budgets.

The total budget to support Healthy Living Services will amount to about $170 million this year, which I indicated is almost a $13 million increase to fund mental health and addiction programs. Saskatchewan Health will make a $5 million investment in children's health and these funds will enable us to provide improved mental health services and funding for the treatment of children with autism.

This has been an overview of some of the highlights from the Department of Health's '07-08 budget, and I'm here to answer any questions, with the department's senior staff, for the programs throughout the year.

And I'd like to conclude with a big thank you to the staff here as well as in the department. It's been just over a year that they've had to deal with two ministers. We haven't created a separate department. I'm sure there's days that John would think that would be a good idea. And that means there's two times the work for these people. And not only that, they had to create, carve out a whole new department and also break in a brand new minister.

So I just want to say publicly a big thank you to the hard work that they've done and the professionalism they've shown. It's been a real rewarding year working with them. And as was said earlier, I look forward to many years of working with them. So with that, I'll stop. Thank you.

The Chair: — Ms. Draude.

Ms. Draude: — Thank you very much. And thank you to the minister and to your officials. And I've been looking forward to an opportunity to discuss estimates in Healthy Living and specifically Project Hope, and to get some idea of what's happened in the last year.

I still get letters or phone calls from people who have children who are trying to get into a program. And I'm wondering . . . I think you'd indicated there was 127 young people?

Hon. Mr. Addley: — 120.

Ms. Draude: — 120.

Hon. Mr. Addley: — Approximately 10 per month.

Ms. Draude: — Have been going through. Is the program that is available through Project Hope, is it a 28-day program?

Hon. Mr. Addley: — Most of the programs are. But the philosophy behind it is whatever . . . The help they need is the help that they'll provide, based on evidence-based best practice. So for example, the detox is a five-day program but then that can be renewed an additional two times. There can also be 30 days order in the community. There's stabilization time. There's treatment time as well. So I think a lot of times it's 28 days, but it's not necessarily restricted to 28 days.

Ms. Draude: — I have so many questions I want to ask, so I'm going to end up jumping around a little bit.

Hon. Mr. Addley: — I'll try to speed up my answer then.

Ms. Draude: — That's a good idea. The youth detox Act that was passed last year, I believe it was, how many times has the Act been used?

Hon. Mr. Addley: — How many times has it been used?

Ms. Draude: — Yes.

Hon. Mr. Addley: — There's been 120 young people that have gone through so . . .

Ms. Draude: — Because of the Act?

Hon. Mr. Addley: — Yes. Yes. The Act was passed April of last year. And since that time approximately 10 young people a month have entered that facility here in Regina at the Paul Dojack Centre. And that's a direct result of the passing of the legislation.

Ms. Draude: — Has there been any of the young people been admitted, readmitted?

Hon. Mr. Addley: — Yes. We can give some specific information, and it looks like Roger's ready to do that. But I just would caution the member that because the numbers are so small — 120 — I know that's not so small. But we're very careful about what statistical information we provide because we don't want to identify any of the individuals. So if Roger's a little bit vague, that's the reason. But Roger, go ahead.

Ms. Draude: — Okay. I just want to ensure the minister that I'm not asking for details.

Hon. Mr. Addley: — Oh, I didn't think that you were.

Ms. Draude: — And I'm not asking to invade anybody's privacy.

Hon. Mr. Addley: — Absolutely.

Ms. Draude: — But I'm just trying to, I want to see what the outcomes are.

Hon. Mr. Addley: — Sure.

Ms. Draude: — The measurable outcomes.

Hon. Mr. Addley: — Absolutely. About 15 youth have been readmitted and some of them for the full three times.

Ms. Draude: — One of the young people whose parents or grandmother has actually written to me is very concerned because the moment the girl turned 18, there was no way to get her back into the system again. Have you had calls from people asking that there be a way to look at the Act and increase the Act so that this Act is able to capture more young people?

And I'm asking this because addictions, once somebody has a

severe addiction, age limit isn't the huge issue any more. It's whether they are actually able or capable of making decisions. So I'm wondering if there has been any pressure on your department to look at this.

Hon. Mr. Addley: — I just wanted to clarify with Roger. We're not aware of any formal requests to expand it beyond the age of 18. I know in some of the consultations, Roger was just sharing with me that in some of the consultations there was some questions about whether it would apply beyond the age of 18. And at this point we've made the cut-off at 18 because we believe that society has a special expectation on it to protect children. Now once you turn 18, you're not a child any more, and so that Act wouldn't apply.

Now there still are other Acts that can be utilized for three-day, you know, interventions — potentially the mental health Act maybe if they're in imminent danger beyond that. But that is a different Act than this one and this one's geared specifically up to the age of 18. So at this point there's no plans on expanding that.

The whole philosophy behind this was to get the child into a place where they're detoxified and stabilized so that they can make and be empowered to make health choices. And that was the concern and the safeguard for parents. So at this point there are no plans to expand it beyond the age of 18.

Ms. Draude: — You had indicated that there was 15 young people who had been readmitted, and out of 120 that's getting to be 15 to 18 per cent of the young people have needed more time than the 28 days or whatever they were in there for.

From some of the information I've received, I know that AARC [Alberta Adolescent Recovery Centre], Calgary, for example, has a year program. And some of the parents are saying that the 28 days isn't long enough. Would those 15 readmittance indicate, show to your government that there is a need for a program that's longer than 28 days?

Hon. Mr. Addley: — Well I would just clarify to the member that this is detoxification and stabilization. This isn't actually treatment. This is just getting the child into a place where that they are ready for treatment.

And one of the amendments that we passed in this session is that we develop a care plan and we provide linkages to their home community. And that could include and most likely would include that treatment, whether it's on an in-patient basis or more likely on an outpatient basis.

Now we were already doing that but the Children's Advocate had wanted it explicitly in the legislation and so we responded to the Children's Advocate and included that in the legislation. So those individuals are getting the linkages to their home community. We've hired additional people specifically for that task.

With regards to AARC, you're right; it is a year program. But what a lot of people don't realize, that's actually an outpatient program. What happens is parents who've had children that go through AARC, they actually room and board the children in their own home and then take them to the centre during the day and then sleep at night. Now there are no plans at this point to bring AARC here, but there's also no restrictions that if people want to bring AARC here and implement AARC here, there's no reason that they can't set that up.

At this point there's no public funding involved in that and from when I've spoken to the family members and people that have gone through AARC, it's not fully funded by the provincial government in Alberta, from what I understand. Now that may have changed since I last spoke to them.

Ms. Draude: — Is there any plans for this government to look at Teen Challenge and to put some funding into that?

Hon. Mr. Addley: — Well we've had some requests by Teen Challenge for different supports. I know that the Minister Responsible for SaskEnergy has worked with them because there was some renovations and have put some of the repayments for the expansion beyond and reduced some of the costs. So there's been those kinds of supports. But that is a much longer program and it's actually for adults. It explicitly excludes people under the age of 18. They're also providing care to a specific segment of the population. They won't accept those that have mental disorders. It's quite a series of restrictions that they will take on that.

At this point they are able to provide the help that they want without government help and so at this point there's no plans to fund Teen Challenge.

Ms. Draude: — Can you tell me how many detox beds there are for children under the age of 18 and for those over the age of 18? And also how many treatment beds there are for both categories?

Hon. Mr. Addley: — Now do you want that right now or could we give you a breakdown?

Ms. Draude: — You can give me the breakdown, if I can receive . . .

Hon. Mr. Addley: — Okay. Because we could do that but it would . . . I know you're in a hurry. Or do you have it right now? We can get a letter to you or . . .

Ms. Draude: — Okay.

Mr. Carriere: — Detox beds right now in the province are 103, of which you could probably consider 12 are dedicated to youth. There are the six secure beds in Regina and then there're six stabilization beds associated with Calder in Saskatoon. So 103 and then . . .

A Member: — And six in P.A. [Prince Albert].

Mr. Carriere: — Those are treatment.

Hon. Mr. Addley: — Were you asking treatment?

Mr. Carriere: — You asked detox and treatment, right. Okay. And then in terms of treatment we have 168 beds total. And there are 12 youth beds at Calder and six interim beds in Prince Albert.

Ms. Draude: — And can you tell me, has the waiting list decreased for the beds? I know for a while there was a huge waiting list. Once someone was detoxed, to be able to get into treatment was a considerable amount of time. And I'm wondering what the average time is now for waiting.

Hon. Mr. Addley: — Well the actual waiting time wasn't as great as some had expected. It's a matter of several weeks at most. I think part of the problems were when families wanted a specific facility and they were waiting for that one, and that there have been some cases that their wait has been fairly lengthy. But generally if it's a dire situation where somebody needs help, a bed can be found for them to stabilize them.

Oftentimes once they're stabilized they're not actually ready for treatment, and they should be in their own home for two or three weeks while they . . . You know, they've detoxed. They're now stabilizing and, you know, sleeping and eating, and then they can come in for the treatment. Because it's, you know, quite intense to go through the treatment.

So my understanding is that the waitlists are generally two or three weeks, but that's manageable for when the care is required for those people.

Ms. Draude: — When there is an individual who has gone through detox but doesn't have a home that would be appropriate for relaxing and becoming available to, getting a person ready to go into treatment, where does that individual go?

Hon. Mr. Addley: — Well I would just say the vast majority of people that have an addiction don't require in-patient, and in particular the vast majority of young people don't need an in-patient, and for those that do that isn't a concern. What you're talking about is on a case-by-case basis if that's the situation, and they can usually find a workaround solution, whether that's in Saskatoon or Regina or in Prince Albert. They can find a place for that person if it's as you describe. But that's not often that that's the case.

Ms. Draude: — When you say they can often find, who do you mean by they?

Hon. Mr. Addley: — It's usually the addiction professional that they're working with. So if they're located in Prince Albert and there's no immediate beds in Prince Albert, what they do is they phone around to the different health authorities, find a place, and then can arrange the location for that.

Ms. Draude: — You had mentioned the introduction of the drug court. Can you give me an update on what's happening with the drug courts and how many young people have actually used it?

Hon. Mr. Addley: — The drug treatment court became operational on October 3, 2006 and as of May 8, which is just last week, there were 14 individuals enrolled in the program.

Ms. Draude: — And from my understanding, if someone goes to a drug court instead of being given a court sentence, they actually go into treatment. Is that correct?

Hon. Mr. Addley: — Yes. The whole idea, and it's identified by Crown prosecutors, that if an individual they believe can be, that the main reason that they're committing a crime is because of an addiction or in related of the substance abuse, that they can apply to go through the drug treatment court process.

It's actually much more restrictive, and they have to follow a series of conditions. And they can actually go and get the treatment as opposed to the justice system. So it's quite effective. It's been shown to be very effective in other locations. When I was doing my review talking to police officers, they estimated that a large percentage of crime is directly related to substance abuse and people getting money for drugs. So it's been effective, but we're monitoring it and . . .

Ms. Draude: — Can you tell me, when an individual goes to a drug court, is their treatment in-house at that time then? Or can they still be treated as an outpatient?

Hon. Mr. Addley: — Yes, it's an outpatient program.

Ms. Draude: — So from the number of people who have used the drug court, has there been people who actually have had to go back into the court system because the drug court didn't work for them, or the treatment didn't work for them? Or are you monitoring that?

Hon. Mr. Addley: — Yes. We wouldn't have the stats at this point because it's still too soon. They're still going through the process. So from what we understand there've been no failures because it's still too soon for that, so.

Ms. Draude: — It's been about a year now so . . .

Hon. Mr. Addley: — No, it's only been since last fall.

Ms. Draude: — So, okay, six months or so. So then I would imagine that there is a process in place for monitoring and determining, you know, the outcomes and what you consider success or not having success. Is that correct?

Hon. Mr. Addley: — Absolutely. There's a monitoring process. This is creating best practices. As I indicated, there's only six of these in Canada. You know, we're quite fortunate to have this in Regina and we're working very closely with the Justice department who's actually overseeing this as well. So, you know, the anecdotal comments are that this is a very refreshing change in the way that we're dealing with those that are committing crimes because of an addiction, not because they're criminals in that definition.

Ms. Draude: — If a young person under the age of 18 has been diagnosed with schizophrenia and they need to . . . I understand they need to be 18 years old to be placed into a group home. I have a case of a family who is at their wit's end trying to deal with the young person with this condition. What is your department, what do you recommend to someone who comes to your department and asks for help to deal with a young person?

Hon. Mr. Addley: — And they're under the age of 18? Okay. Well we've expanded some of the services for that. The best thing to do is to work with the region that they're in. That service is provided in most of the regions and if that is, if

they're having challenges . . . Because what happens is a location can be found. It's working well and then a change occurs and then it's not working well and so then there has to be an attempt to find a new location or try to find the supports to stabilize that individual.

I guess the example that I've used in the past is that if you go to a doctor for an ailment and he or she writes a prescription and you take it, most people it works just fine but for some it doesn't and you need to go back and get a different prescription or get different treatment. And in that case the ones that are successful we don't hear from, but the ones that we hear from are the ones that are a bit more stubborn or having problems. And we just can keep trying new locations and trying to find supports. So if they can't get the help from the regional health authority, we have quality care coordinators. If that doesn't work, I'd be more than happy to look into it.

Ms. Draude: — But there really isn't a place for them to go if they're under the age of 18. They have to stay with family and if family isn't capable of keeping them, then where do they go?

Hon. Mr. Addley: — I think what we'll do is we'll have Roger answer the questions, as opposed to just telling me because that's probably a little more helpful. But what we're trying to do is provide the supports in the community for that young person. And just recently this spring, we did expand some homes in Moose Jaw which are for people over the age of 16. But you're quite right in the sense of an in-patient residential location — that's not the model that we've been following. So it has been more to try to provide the supports to the families so that the person can live at home if need be.

Ms. Draude: — So then for the individual that has this issue, what do I tell them? They can no longer keep this young person at home. He's getting to be a larger young man, difficult to handle. The family is burnt-out. There is no place for him to go in the community, and the doctors in the area don't know where to send him either. So what do I tell them?

Hon. Mr. Addley: — Have they exercised the use of respite care and all of . . .

Ms. Draude: — There isn't any in our area.

Hon. Mr. Addley: — Okay.

Mr. Carriere: — As well, there is some further residential support, in addition to the Moose Jaw one, in Prince Albert and Lloydminster that was put forward last year through to the children's mental health initiatives.

Depending on the situation, of course, a youth may be admitted to in-patients, a psych unit if they actually require that. They may not. But overall, work is done with the family to try to support that child at home. There really isn't a permanent place for an individual to have their children go to on a long-term basis, but there is in-patient psych units if they need that stabilization period and such.

Ms. Draude: — Probably this is one that I will talk to the minister about off camera and we can see if we can help the individual.

I'd like to go to the issue of fetal alcohol spectrum disorder. And there was a conference this spring in British Columbia I had an opportunity to attend. Can you tell me what your government has learned from that and if there's going to be any initiatives to this brought forward that were discussed at that conference?

Hon. Mr. Addley: — What was the last thing you said? Sorry.

Ms. Draude: — What did your government take back from that conference? And is there any changes in the programming that we have, either in the education, in the diagnosis, or in — there isn't a treatment — but in the lifestyle that families who have a child with that disorder, that they will be encouraged to use?

Hon. Mr. Addley: — Well we actually have increased the budget in the cognitive disability strategy to I think 4.15 million this year. And we're actually part of a network of provinces, Manitoba, Saskatchewan, Alberta, BC [British Columbia], and the territories. And we meet quite regularly, also have conference calls. And what we're doing is working on a coordinated approach. And we've divided up the work so that different provinces are investigating the best practices for that certain area.

And Saskatchewan is on the prevention side. We've got the Saskatchewan Prevention Institute that's doing very good work in that area, also data collection, best treatments, whole hosts of things. It's a very exciting strategy. We've got some very good people that are working on that and we're starting to see some fruits of our labour, as it were.

There's also some published articles that are coming out in the not too distant future in peer review journals that are directly resulting from that. So it's an incredibly challenging area to work with because this is a very preventable situation. And some of the reviews that we've seen that, if you can intervene with a young person that has a child with FASD [fetal alcohol spectrum disorder] and then you can work with them, you can actually diminish the severity and in some cases stop the situation from occurring in future pregnancies.

But the downside is that if you don't intervene, research has shown that subsequent pregnancies are almost always FASD and the severity only gets worse as subsequent pregnancies occur. So I guess I would say there's a lot that we've learned and a lot more to learn. But we've put some resources to it; we'll continue to monitor that and some good people will keep working on that.

Ms. Draude: — I agree, Mr. Minister. It's one condition that is 100 per cent preventable. And a young person who has FAS [fetal alcohol syndrome] is most at risk at teen pregnancies and the other social problems that come as a result of not being able to deal with the condition that you're given.

One of the things that's very, very important is diagnosis. And I know that we have one team of doctors in Saskatoon that's working hard. And I believe that the one in Regina is working, there's a couple of doctors working on it. Do we have more doctors in this area? What is the government doing to ensure that their diagnosis is possible?

I know that when Judge Turpel-Lafond was in Saskatchewan, she was frustrated with the fact that many of the young people that kept coming before her in the court system had some FAS or FAE [fetal alcohol effects] and they had never been diagnosed. And it took being in the court system before they could recognize it. What do we have in place now for diagnosis, and what do you have for a program to actually be able to enhance our capacity?

Hon. Mr. Addley: — Well just a comment and then Roger can answer. With Judge Lafond, who's now in British Columbia, I believe is the Children's Advocate there, if I'm not mistaken. And one of the things that we've learned is that what originally may or may not have been FASD — the diagnosis of what would have to occur for it to be an official diagnosis — now we're finding that that's not the case at all, that it's a much more nuanced diagnosis than was thought. But I'll let Roger answer the specifics.

Mr. Carriere: — Over the last couple of budget cycles, there's been about $1 million provided to regional health authorities to enhance assessment and diagnosis services. You know, as you mentioned, there was funding provided for a physician in Regina. Saskatoon did have one. There are some funds for an additional physician services in Saskatoon, although the region at this point hasn't been able to recruit one. But there are dollars there for that when they can find one.

And as well, assessment and diagnosis involves a team, and so it's not only physician services but some of these things like occupational therapy and speech and language pathologists that assist, and so that $1 million has gone to increase services primarily in Regina, Saskatoon, and P.A. — the main centres — to have funds to have a more enhanced team to assist with the assessment and diagnosis piece of FASD.

Ms. Draude: — Okay. Thank you.

The Chair: — Thank you. Any further questions? No? Then thank you to the minister and his officials. Oh sorry, Mr. Prebble.

Mr. Prebble: — Yes, I have one question and it relates to vitamin D, and what I'd really like is a report back on this question. Yes, I'll be brief here in light of the time. But I am concerned that Saskatchewan residents are not able to produce naturally vitamin D during the winter months and it's becoming, it's clear that all residents in the province will not be able to naturally produce vitamin D in November, December, January, February, probably early March. And there are therefore risks to all residents in the province from not necessarily having adequate vitamin D levels.

And then for anyone who is shut in in Saskatchewan, there are health risks associated with not being able to get vitamin D on a year-round basis and of course this includes residents in nursing homes, anyone who is in hospital for a long-term stay, many elderly people who are shut in in their homes and receiving home care services.

And a lot has been published in the international literature over the last couple of years with respect to vitamin D levels. And it's now I think unequivocally clear that a lack of adequate vitamin D leads to elevated cancer risk. It leads to elevated risk of heart disease. It leads to elevated multiple sclerosis and it's directly linked to a wide array of health problems. Therefore it's my personal view that it is very much in the interests of public health in Saskatchewan and particularly in the interests of populations who are at elevated risk by virtue of their circumstance, that we have adequate levels of vitamin D made available to all Saskatchewan residents and particularly to at-risk groups.

I think this is an important matter of, sort of, population health, and it's important in terms of a prevention strategy for our province.

My request is that the Department of Health prepare a report to the committee on what is being done with respect to ensuring that adequate levels of vitamin D are made available to the population, and what the plan is in light of this international literature that's emerged over the last year or two; what the plan is over the coming year to ensure that we address this question, which I think is a non-partisan issue, but it's an important preventive public health issue.

And of course the front-line folks here are physicians themselves. It's physicians' practices in this regard that are going to be the most important. But it's clear to me that these at the present time are very variable, depending on the individual physician.

So I think this is a matter that the Quality Council, the Health Quality Council should examine. And I think it's a matter that the department should examine internally. And I would appreciate it if at some point, at the convenience of the minister, that the committee could receive a report on what the plan, what the current state of planning is around vitamin D, and what future plans the department has with respect to ensuring that Saskatchewan residents get the maximum benefit from a health strategy that would help, would support physicians in ensuring that their patients have adequate levels of vitamin D as a, just a matter of basic public health prevention policy.

So I don't really need a response, Mr. Minister. What I need — of course that would be very welcome — but what I'm really requesting is some kind of a report back to the committee at your convenience.

Hon. Mr. Addley: — The short answer is yes. We can get a report back but it would be from the chief medical officer. That's probably the best route to do. And just a quick comment. I know that committee's wanting to move on. But I agree with the member that there's exciting information on the whole area of vitamin D, that the body produces more than enough during the summer months, but in the winter months that we're not able to produce that.

Just some of the comments, I mean, the Health Canada does set the guidelines of what a safe level is. But 5, 10 minutes in the sun in the summertime you produce something like 10,000 units, which is something like more than 10 or 20 times what the safe level is.

So what I would suggest to people is talk to their doctor about this as to what the safe level of vitamin D supplements would

be, and just to be cautious that not to be in the sun with their face in the summer months, and use very much caution for skin cancer. But I think the member is quite right on the whole list of health benefits that can come from a proper amount of vitamin D, and the chief medical officer will produce a report and will table it with the committee in the not too distant future.

Mr. Prebble: — That would be great. Thank you very much, Mr. Minister.

Hon. Mr. Addley: — Thank you. And I just notice that we're done so I would like to again thank the members of the committee for their good questions, and for the officials here that have done very good work, not only today but throughout the past year, as I indicated in my introduction. So thank you, Madam Chair.

The Chair: — Thank you to the minister and his officials.

The next item up before the committee is resume consideration of all of the departments that we have under our committee. And we're going to do them in the order that they appear in the budget book.

General Revenue Fund
Advanced Education and Employment
Vote 37

The Chair: — So we're going to start with Advanced Education and Employment which is on page 29 of your budget book.

Central management and services (AE01), 19,113,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Student support programs (AE03), 75,338,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Post-secondary (AE02), 491,946,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Immigration (AE06), 8,490,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Training programs (AE05), 37,799,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Career and employment services (AE04), 35,511,000, is that agreed?

Some Hon. Members: — Agreed.

General Revenue Fund
Lending and Investing Activities
Advanced Education and Employment
Vote 169

The Chair: — And the capital assets we don't vote on. But on page 170 of your budget book is another part of Advanced Education and Employment, which is vote 169. It's the student loan aid fund (AE01), 56,000,000. Is that agreed?

Some Hon. Members: — Agreed.

General Revenue Fund
Community Resources
Vote 36

The Chair: — Okay. The next one is Community Resources on page 41 of your budget book. Moving to 42 is central management and services (CR01), 35,582,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Community inclusion (CR06), 99,480,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Employment support and income assistance (CR03), 310,677,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Office of disability issues (CR09), 246,000,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — That's 246,000. Sorry, 246,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Child and family services (CR04), 88,244,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Supporting families and building economic independence (CR05), 64,373,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Housing (CR12), 26,812,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Capital assets again we don't vote on.

General Revenue Fund
Corrections and Public Safety
Vote 73

The Chair: — Corrections and Public Safety which is 47, starting on page 48 for the vote. Central management and services (CP01), 14,848,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — (CP04), 76,017,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — (CP07), young offender program, 46,125,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Public safety (CP06), 6,805,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Regina Provincial Correctional Centre (CP03), 26,602,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Again the capital assets, we don't vote on. Okay.

General Revenue Fund
Advanced Education and Employment
Vote 37

The Chair: — We need a motion for each time, so we'll go back to Advanced Education and Employment and have a member move that:

> Be it resolved that there be granted to Her Majesty for the 12 months ending March 31, 2008, the following sums for Advanced Education and Employment, 668,197,000.

Could I have a member move that please? Mr. Borgerson.

Mr. Borgerson: — I so move.

The Chair: — All agreed?

Some Hon. Members: — Agreed.

[Vote 37 agreed to.]

General Revenue Fund
Community Resources
Vote 36

The Chair: — For Community Resources, which we just finished, 625,414,000, is that agreed? Or somebody move that, sorry. Mr. Borgerson again.

Mr. Borgerson: — I so move.

The Chair: — Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Agreed.

[Vote 36 agreed to.]

General Revenue Fund
Corrections and Public Safety
Vote 73

The Chair: — Then we're in Corrections and Public Safety which we just did as well, 170,397,000. Could someone move that one?

Mr. Prebble: — I'll move that.

The Chair: — Mr. Prebble. All agreed?

Some Hon. Members: — Agreed.

[Vote 73 agreed to.]

General Revenue Fund
Culture, Youth and Recreation
Vote 27

The Chair: — Okay. Now Culture, Youth and Recreation on page 52. Starting central management and services (CY01), 7,751,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — (CY03), culture, 17,115,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Recreation (CY09), 1,141,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Policy and youth (CY05), 1,102,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Community Initiatives Fund (CY06), 6,125,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Building communities (CY11), 40,000,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Heritage (CY07), 10,942,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Saskatchewan Communications Network (CY08), 5,997,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — And again, the capital assets we don't vote on, so could I have a member move:

> That for Culture, Youth, and Recreation, be granted the following sum, 90,173,000.

Ms. Crofford: — I so move.

The Chair: — Ms. Crofford. Thank you. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Agreed.

[Vote 27 agreed to.]

General Revenue Fund
Health
Vote 32

The Chair: — Now on Health, it's page 85. Starting on 86 (HE01), 16,224,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Provincial health services (HE04), 161,583,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Regional health services (HE03), 2,323,175,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Medical services and medical education programs (HE06), 612,000,000, is that agreed? 990, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Drug plan and extended benefits (HE08), 322,855,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Early childhood development (HE10), 9,323,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Provincial infrastructure projects (HE05), 17,450,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — And the capital assets again. Could I have somebody move:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31, 2008 the following sums for Health, $3,463,600,000.

Mr. Prebble, thank you. All agreed?

Some Hon. Members: — Agreed.

[Vote 32 agreed to.]

General Revenue Fund
Learning
Vote 5

The Chair: — Then for Learning, starting on 118 for the vote.

Central management and services (LR01), 13,408,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Pre-K-12 education (LR03), 626,871,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Early learning and child care (LR08), 41,311,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Curriculum and e-learning (LR10). We're changing this. 5.915 isn't the number. To be voted is 5,890,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Literacy (LR17), 3,127,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Provincial Library (LR15), 9,641,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Education property tax relief (LR09), 107,850,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Teachers' pensions and benefits (LR04), again the amount to be voted is different than the amount that's showing. We're voting 29,543,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — And amortization we don't do. Now the bottom one is back to the student loan.

> Be it resolved that there be granted to Her Majesty for the 12 months ending March 31, 2003, the following sums for Learning, 837,641,000.

Could I have a member move that please . . . [inaudible interjection] . . . For 2008. Did I say 2007 . . . [inaudible interjection] . . . '03. Did I really? Oh my goodness. All right:

> For the months ending March 31, 2008, the following sums for Learning, 837,641,000.

Ms. Crofford. All agreed?

Some Hon. Members: — Agreed.

[Vote 5 agreed to.]

General Revenue Fund
Lending and Investing Activities
Advanced Education and Employment
Vote 169

The Chair: — Then the last one is the student loan lending and investing activities for Advanced Education and Employment which we voted on, the 56 million. Could I have a member move that:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31, 2008, the following sums for Advanced Education and Employment, 56,000,000.

The Chair: — Mr. Elhard. Thank you. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Agreed.

[Vote 169 agreed to.]

The Chair: — You all have a copy of the 10th report. Can I have someone move:

> That the 10th report of the . . .

That's this one with all the numbers. Have someone move:

> That the 10th report of the Standing Committee on Human Services be adopted and presented to the Assembly on May 15, 2007.

Mr. Prebble: — I so move, Madam Chair.

The Chair: — Mr. Prebble. Thank you. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Agreed. I think that concludes the business of the Human Services Committee for today. We're back I believe on Wednesday, probably at 3. So I'll entertain a motion to adjourn.

Mr. Elhard: — I so move.

The Chair: — Mr. Elhard. Thank you very much. We even beat our deadline.

[The committee adjourned at 17:11.]