STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 14:45.]

The Chair: — Welcome everyone. Seeing as it is now past 2:45, the agreed-upon hour for our committee to begin, I will call the committee to order. For those of you at home, welcome as well. I would also like to welcome to the deliberations of the Standing Committee on Human Services all those in attendance today.

On the agenda we have first to be considered the estimates for the Ministry of Social Services and the Ministry of Health afterwards. However I'd first like to introduce the members of our committee. Normal committee members for the Human Services Committee are myself, Greg Ottenbreit as Chair. We have Mr. Glen Hart, Ms. Christine Tell, Mr. Gord Wyant, and substituting for Ms. Doreen Eagles, we have Ms. Nadine Wilson. And on the opposition side we have, substituting for Mr. Cam Broten, Mr. David Forbes, and substituting for Ms. Judy Junor is Ms. Danielle Chartier.

Also in attendance today we have some Saskatchewan legislative interns. Welcome to you today. And we also will be welcoming some educators here for the Saskatchewan Teachers' Institute on Parliamentary Democracy. Educators from across Saskatchewan are participating in this five day professional development opportunity focused on parliamentary democracy. They were introduced in the Chamber today and have observed routine proceedings and question period, and they will now be joining us for our committees. This is the Human Services Committee, and we are looking at the estimates again for Ministry of Social Services.

I now wish to table the following documents: our document HUS 70/26, Ministry of Advanced Education, Employment and Immigration. These are responses to questions raised at the November 24th, 2010, meeting of the committee re: *The Saskatchewan Indian Institute of Technologies Amendment Act, 2011* dated January 5, 2011.

Committee members, pursuant to the rule 146.1, the following estimates were deemed referred to the Standing Committee on Human Services on March 31st, 2011: main estimates, vote 37; and 169, Advanced Education, Employment and Immigration; vote 5, Education; vote 32, Health; vote 20, Labour Relations and Workplace Safety; vote 36, Social Services. And supplementary estimates: vote 37, Advanced Education, Employment and Immigration; vote 5, Education; vote 32, Health; and vote 36, Social Services.

General Revenue Fund
Social Services
Vote 36

Subvote (SS01)

The Chair: — Committee members, we are now looking at the estimates for Social Services, vote 36, central management and services (SS01) outlined on page 131 of the Estimates booklet. Ms. Minister, would you like to introduce your officials and make any opening statements you would like. And as the officials speak for the first time, I'd just invite you to introduce yourselves for the purposes of Hansard. Ms. Minister, the floor is yours.

Hon. Ms. Draude: — Thank you very much to the Chair and committee members, everyone here. Welcome. I'm very pleased to be here today to discuss the child and family services portion of the Ministry of Social Services budget for 2011-12. I'd like to thank the member opposite, the critic for Social Services, who has agreed to discuss portions of the budget rather than all of the Social Services budget at a time. Thank you very much. I think this makes a lot of sense, and it's good for the people that are working in the ministry as well. I appreciate it.

I'd like to introduce my officials with me here today. Marian Zerr is the deputy minister of Social Services. Louise Greenberg is the associate deputy minister of child and family services. We have Alan Syhlonyk who is the assistant deputy minister of corporate services; Lynn Allan, executive director of child and family services, program and service design; Andrea Brittin who is the executive director of child and family service, delivery; Wayne Phaneuf who is the executive director of child and family community services; Miriam Myers who is associate executive director of finance and administration, corporate services; and Lori Mann who is the director of financial planning, corporate services.

Before I talk about child and family services' budget for this year, I want to tell you about some of the accomplishments we have made in this area in the last few years because they are significant and because they've had a very positive impact on Saskatchewan's most vulnerable people, and that is our children.

Since November of 2007, we've invested more than $84 million in new funding for the child welfare system. Between November of 2007 and March of 2011, we've created 308 new out-of-home spaces for children and youth. We have already invested more than 14 million in a new electronic case management system to better track children in care. By the time this year is through, we'll be closer to $20 million. The system is currently being piloted, and the full provincial rollout is expected by March 2012.

The best news of all is that we are seeing results. Thanks to our investment, as well as improved case management practices and focuses on seeking permanent placements for children who are in care, we are seeing a downward trend in the number of children coming into care. The number of children being placed permanently with extended family is steadily increasing. For two consecutive years, there's been a decline in the number of foster homes with more than four children in placement and a decline in the number of children in these homes as well.

Family Finders continues its success in securing placement for children in care with the extended family or with First Nations foster homes. Saskatchewan is being recognized for our work in implementing the PRIDE [parent resources for information, development, and education] foster parent training model and working collaboratively with First Nations and Métis partners to ensure that this program meets our province's cultural needs. I also want to mention the success we're having with the unique initiative in Prince Albert called the hub, the partners between

my ministry and Prince Albert Police Service, the school division, health region, and First Nations and community partners focusing on working together on prevention rather than reaction. I'm sure the member opposite will have questions because this is a very exciting initiative.

These are just a few examples of the tremendous progress we are making in the child welfare system. Our budget for '11-12 is going to allow us to continue on this successful path. I'm very proud of the budget. This contains the first ever Saskatchewan child and youth agenda budget. This new cross-government approach is in direct response to the recommendations of the child welfare review panel which was received in December. Our government's initial response to the panel's report was to establish the cabinet committee on children and youth and to create a Saskatchewan children and youth agenda — significant steps towards developing a new vision for child welfare in our province.

One of the committee's very first tasks was to develop a joint budget submission in order to take a more coordinated and strategic approach to investments, to programs, and to services for our vulnerable children, for youth, and for their families. The proposal incorporates provincial strategies focusing on improving the key determinates that drive child welfare, First Nations and Métis education, employment, autism, and fetal alcohol spectrum disorder. In addition, the Saskatchewan police and partner strategy to reduce crime and violence will continue to support children and youth agenda through initiatives involving police services and community leadership.

There's a very strong rationale for taking such an approach because these issues, challenges, and solutions regarding each one of these strategies are linked by common themes. For example, we know that clients common across the sectors, that prevention is key, and that we must work differently with First Nations and Métis partners towards shared leadership and responsibility. The children and youth agenda budget for 2011 and '12 includes $34 million in new funding right across ministries, and it's going to allow for a comprehensive, targeted approach to challenges.

Out of the $34 million in the child and youth agenda, 15.3 million represents the child welfare review investments to fund areas that have been most urgently needed, identified by the child welfare review panel.

This funding includes — and I'll go through it quickly — $1.5 million to support First Nations child and family service agencies to provide case management for children in care on-reserve; $1.25 million to develop new services for the community-based organizations to provide therapeutic foster care services and home assessments for foster care, extended family placements, and for adoptions; $1 million dollars for the development of 24-7 intensive family supports; $750,000 for 30 new child protection workers; $500,000 for the development of CBO [community-based organization] managed visitation, supervision, and transportation supports for children in care with the families.

Four hundred thousand dollars to consult and plan for the next phase of the minister's response to the child welfare review report; $350,000 to increase the capacity of Family Finders program to find First Nations families for First Nations children in care off-reserve; $350,000 to provide funding to help First Nations and Métis representatives participate in dialogue with government across the key inter-ministerial strategies.

Three hundred thousand dollars to increase the capacity of First Nations Family and Community Institute to support capacity building and training for standards and policies for First Nations child and family service agencies; $8.4 million to provide new funding for out-of-home residential and extended family care; $280,000 for increased funding for early childhood intervention and development programs as well as KidsFirst; $200,000 to provide funding to enable further pilots of the Aboriginal courtworker program with emphasis on supporting child welfare cases; and $50,000 to provide funding for the transportation of northern women and children in abusive situations to shelters.

The children and youth agenda also includes $17.1 million for several initiatives focusing on First Nations and Métis education and employment, $1.6 million for enhanced strategies and supports for autism and for fetal alcohol spectrum disorder.

We believe that this new approach to inter-ministerial planning will provide better coordinated, comprehensive, and responsive strategies to critical issues. Most importantly we believe this approach will result in better outcomes and brighter futures for the children in Saskatchewan, for the youth, and for their families.

The total ministry budget for child and family services for 2011-12 totals $197.8 million. This represents $15.5 million or 8.5 per cent increase over last year. This total includes a further 1.5 per cent or $800,000 increase for community-based organizations. Over the last four years, we've increased funding to CBOs by a total of 14.8 per cent.

While we made some great progress, I know there's still a lot more that needs to be done in the area of child and family services. I believe that we are starting this fiscal year on a firm foundation both in terms of the investments we continue to make and the initiatives that we've identified as priorities for our government.

In June we'll release a more detailed response to the Saskatchewan child welfare review panel report and their recommendations. Making life better for Saskatchewan's children and youth and setting a new direction for child welfare system is one of our government's top priorities. With the work that we've done thus far, we've made a good start.

I'm pleased to take your questions, but I would be neglectful if I didn't mention the people that are working with me, not only within the ministry but also the leaders within the First Nations. Vice-chief Dutch Lerat, I know, has taken another portfolio, but he did a lot of work on the child and welfare agenda so far. And the Métis Nation, through President Robert Doucette, has been instrumental in the discussions as well. So I'm looking forward to our work and I'll be pleased to take questions.

The Chair: — Thank you, Madam Minister, for your opening comments. Mr. Forbes.

Mr. Forbes: — Good. Well thank you very much and I appreciate having the officials and your opening remarks. And we appreciate the opportunity to have a good discussion about this very, very important critical area. I think that all sides of the House feel that this is an area that we need to do as much as we can and work as well as we can on this.

And so in the spirit of that, as I try to understand the initiatives, and there's an awful lot there . . . I know I was busily writing down and I was thinking, you were going cross government as well, some of the initiatives that you were naming, like the court. There's some court numbers and stuff like that which I assume . . . I probably won't ask about, and I don't know whether I should ask because I would be under Justice. But regardless I think that's a good move to go into the cross-government areas so that we're not working in silos.

I do have . . . I may be all over the map. I'll try to really focus my questions so that they make some sense to you folks and you can help us out. So right off the bat you're talking about a response in June, and it sounds like a phase 2 of the report. And how will that role out? And is there a consultation period, or is that a phase 2 of the response?

Hon. Ms. Draude: — Thank you to the member. We've already had a number of discussions at three levels with the First Nations and Métis leaders. We have the political table where we've been having discussions with some of the chiefs, with Vice-chief Lerat, and I'm hopeful that we'll have an opportunity to meet with Vice-chief Whitefish in the near future. And then we have a table with my deputy minister and officials with FSIN [Federation of Saskatchewan Indian Nations], and there's been discussions with the Métis Nation. And then at the technical level, the people in the Child and Family Services, the workers are having discussions as well because we know it's important for the workers within our ministry to be working from the same page as the workers within the Child and Family Services, the First Nations.

So as we roll out this . . . as we go further on this . . . [inaudible] . . . these discussions will come to the political table in some areas. In some ways, the political table will make a difference on the discussion that's happening on the technical table as well. We're very hopeful that all the work that's being done right now is actually . . . it's something that everybody is working on very well. It's an immediate response. This budget that we're doing right now is an immediate response. And as we go forward, I'm hopeful that by the end of June we'll have the input of the people that are very important to us, and that's the First Nations and Métis stakeholders.

Mr. Forbes: — Now will that be a public document, public forum? And I'm not sure in terms of how public, but I'm thinking of ourselves on the other side. Will we get a chance to examine and get to further understand this issue, you know? Part of what I often say to stakeholders is, you know, we try to . . . What we understand, we can support. What we don't understand, it's hard to support because we just don't know the details. And so I'm curious. What happens in June from our perspective? What will we see? Will we see anything different?

Hon. Ms. Draude: — Yes, actually what we're doing right now is the short-term discussion. And in June we'll have the mid-term and basically a long-term solution. I shouldn't say solution. There will be steps towards the solutions. There'll be strategies.

So I think that what we're hoping is there will be a roll-out document that we will, somewhere near the end of June, that we will be able to present to yourself. But also we want to make sure — to yourself and to the public — we also want to make sure that we're on the same page then, that we can sit with the table with the leaders of both communities and say this is part of the strategy that we need to accept.

So we haven't finished the finite details on when it will be and what it's exactly going to look like, because what I am envisioning has to be the same thing that the First Nations leaders and Métis leaders are thinking about as well. I want to make sure that they are . . . that we can have a common front.

Mr. Forbes: — Now on that, will that have . . . There were 12 recommendations in the booklet and some that you've addressed full on and some that they haven't been to the same degree. So will there be a response to each of the 12 recommendations? Is that the kind of thing we're looking at?

Hon. Ms. Draude: — Thank you to the member for . . . Really when we looked at the recommendations, basically we can put them into three different categories: the prevention and key determinants; and working differently with First Nations and Métis partners; and changing the child welfare system, doing things differently.

So there will be the report that's, you know, *For the Good of our Children and Youth*, we know that they . . . We will working with the leaders under those three themes and there will be discussions on each one of them as we go forward. There's not one single area that's more important than the other one because we can't be doing them independently.

So the discussion that we've been having now is so different than what the government has operated with First Nations and Métis all along. We are saying that we need to do things differently and make significant change. So these three themes are the basis of the way we'll be working and that's what the budget has been addressing this year. And we know that there is more work to be done.

Mr. Forbes: — So we won't be looking for recommendation no. 1, a check list, recommendation no. 2 . . . There'll be a discussion about how those 12 might fit into those three themes that you're talking about?

Hon. Ms. Draude: — That's correct, because it's not, it's not . . . We're talking about little people. It's pretty hard to say that this is definitely what happens here. And they actually overlap as well. We do need to make sure that we look at them all independently, but at the same time, what's the big picture?

Mr. Forbes: — Now you had just mentioned in your introductory remarks about this institute. Can you tell me a little bit about this institute?

Hon. Ms. Draude: — I'm going to give you an initial statement about it because they're so important, but then I'll ask some of

the people that I work with to make sure they can give you further information. This institute is working . . . they work with First Nations and Métis partners — First Nations partners mostly. We have Dexter Kinequon from Lac La Ronge Indian Band is on the board. He's actually one of the First Nations that has received the funding of CARF [Commission on Accreditation of Rehabilitation Facilities] accreditation. It's an international accreditation meaning that they've met 2,500 standards. That means for care. And this, the institute is going to be helping us work with group homes, with First Nations families to make sure that the standard of care is not only appropriate but standard right across the province.

So this is a step recognizing that the institute is doing a great job and that we can maybe not only learn from them, but help make sure that everybody's on the same page when it comes to standards of care. So I'll ask Marian to give you further information.

Ms. Zerr: — Thank you very much, Minister. Mr. Forbes, the approach with the First Nation community institute is one that I think really strengthens both the Indian Child and Family Service agencies, but also the many group homes that are now operating on-reserve. And so the example I would give you is this: we had the First Nation institute support a couple of those group homes, one in particular, in really looking at the policies and standards that need, that we have for group homes and how those need to be tweaked to make sure that they are culturally appropriate yet meeting the standards for delivery of care on-reserve in those group homes.

[15:15]

That process went through, and there was good consultation between the institute and those group homes and ourselves. Once that happened, the standards and policies went to the First Nations, to the FSIN assembly. So they were passed in the February assembly and, subsequent to being passed in the assembly, we then go back to the institute and have them work then with all of the group homes to roll them out, to start the training and the process and then further, to work with the Canadian association of . . . or the Canadian Accreditation of Rehab Facilities association to have them start to work with the group homes on the next step. And so part of what needs to happen in the upcoming year is to continue that work across the continuum of care, not just in group homes.

Mr. Forbes: — So they could be working with First Nations families on-reserve? That they may be a long-term . . .

Ms. Zerr: — That would be certainly further into the distance. I would anticipate that the next couple of years would be very much on working with the Indian Child and Family Services agencies.

Mr. Forbes: — How do you think . . . Now part one of the issues that came up in the fall with the auditor was the accountability within the First Nations sphere.

Ms. Zerr: — Yes.

Mr. Forbes: — Will this happen with that? Or how will this play into that?

Hon. Ms. Draude: — Mr. Speaker . . . To the member, sorry. I think that the agreements that we have with the First Nations agencies is critical when it comes to making sure that the children . . . that there's care that's continuous and across the spectrum. So we know that we've had the chance to meet with and talk about protocols with 15 of them. I've had a great meeting with Chief Thomas and the discussions that they're having to make sure that we have protocols that we can all identify with right across the whole spectrum. I'm going to ask Marian to give a better explanation.

Ms. Zerr: — Thank you very much, Minister. And joining me at the table is Wayne Phaneuf. And I'm sorry I neglected to introduce myself at my first speaking — Marian Zerr, deputy minister. Wayne Phaneuf is the executive director of community services and will join me on this answer.

So the 18 child and family service agreements that were referenced by the auditor, really the concerns focused on two areas. One of them was a particular agreement where we have had some challenges getting data. However the issue hasn't been the quality of the service being delivered, and I want to make sure we all understand that.

This particular agreement was signed by a minister of a former administration and it had no end date. And so the consequence of trying to manage within that agreement was that we seemed to go round in circles on whether there should be a new agreement or not, rather than really sort of starting to focus a little bit differently on the real service needs.

We have, I am pleased to say, successfully concluded the initial framework discussions on the data-sharing protocols which was the critical piece here and — with some thanks to the minister for her work with the chief of that particular tribal council — are in, I think, a very good spot now in terms of the go forward.

At the same time, what I want to make absolutely crystal clear here is that of those 18 agreements, there were audits, file audits completed on 16 of the 18 agreements and a partial audit on the 17th agreement. The 18th agreement was not audited, not because it couldn't have been, but because it was a new agency that had just started up and it makes some sense to give them some operating before you audit.

The process is that after the audit is completed, now that we have a good and solid quality assurance unit in the child and family services division who go out . . . So it's not an audit that they do themselves. This is a very comprehensive process, quite different from the smaller sampling that the Provincial Auditor takes. The audit comes in, and some time is taken with the quality assurance folks to compare the audit and the information from it to standards. A report, very similar to the way accreditation works, a report goes back out to that child and family services agency. And once that report is out there and discussion has been taken place on next steps, then a final report is completed. So of those audits, we now have eight final reports completed as well. So a very good piece of work I think happening there.

Mr. Forbes: — So have you been working with the auditor along the way to, you know, assure that the kind of things you're doing would meet the kind of expectations that they're

looking for?

Ms. Zerr: — We have a meeting scheduled with the Provincial Auditor — in fact it's been scheduled a couple of times and had to have been cancelled — but scheduled upcoming to discuss the next audit and making sure that there's a very good and solid understanding of how quality assurance works in a child and family services organization.

Mr. Forbes: — Yes. Now when you . . . So with this institute, how long has it existed? Is this a relatively new organization? Is this a . . . What's its background and what's its mandate?

Mr. Phaneuf: — Thank you for the question. Wayne Phaneuf, executive director of community services. The institute has been in existence for I believe three years now. I've only been with the division for a year and a half now so . . . but three years. The mandate of the institute is to assist the First Nations agencies with policy development, training, all of those kinds of things that will lead to better outcomes for individuals receiving services from the agencies.

Mr. Forbes: — Okay. And so where does it receive most of its funding from?

Ms. Zerr: — So the Ministry of Social Services and the Department of Indian and Northern Affairs Canada both provide some core funding to this organization. And then we both provide additional funding on what I would call more of a project basis.

Mr. Forbes: — Now was this funding, did it come about . . . I guess when you say three years, it was about three years ago there was a major announcement of federal funds into this area. I don't remember the number, but it seems to me it was in the 16, $17 million, but a big amount of money that came. There was some money that went into Manitoba. Are there similar institutes across Canada? Is this something that we're seeing? Because you were talking about this . . . [inaudible] . . . Canadian association of . . .

Ms. Zerr: — Facilities.

Mr. Forbes: — Rehab . . . Oh, CARF. CARF, right. Okay, yes.

Mr. Phaneuf: — Okay. The federal money, this was not part of the prevention announcement which I think you're referring to do, which was for the Western provinces. And there was a huge influx of money which the agencies are doing some prevention work on reserve with their members.

CARF is simply an accrediting body. It's not related to . . . So the institute came about to ensure that, or to try and bring about a better relationship between the ministry and the First Nation agencies and to be able to deal with some of those issues of common interest in regards to operational policy, those kinds of things. So it's not as a result of that funding.

Ms. Zerr: — Just to clarify. The CARF association is no different from the Canadian Council on Accreditation that health care organizations would use. It's an arm's-length body not connected to government. It's a standard- and policy-setting organization.

Mr. Forbes: — The Lac La Ronge Band family services, it's accredited? Is that what I heard?

Hon. Ms. Draude: — Yes it is. And I'm apologizing to the member because I brought up Lac La Ronge Band and used the word CARF because I know that he works with the child and family institute. And I'm really proud of the work they're doing, and he's a leader in that area. So if I misled you, thinking that CARF was part of this, I apologize. But it is exciting that we have a leader in the province that is meeting these type of standards and is a model for other agencies. And they are working hard with the institute.

Mr. Forbes: — I just find this quite exciting. It sounds like there's a lot of potential here. I'm just trying to understand it. And now where is the institute actually? Where is its physical offices?

Hon. Ms. Draude: — It's in Saskatoon.

Mr. Forbes: — Okay. Is it downtown or is it out in the . . .

Ms. Zerr: — It's quite a small organization. We're not talking a large bureaucracy. It's a very small organization. And so it tends to, when it works with First Nations, it tends to do so from what I would call, not necessarily a virtual capacity but certainly a going-out into their areas and/or renting facilities to bring them in. It's not a big stand alone.

Mr. Forbes: — So is the institute then, is it promoting being accredited? Is that the goal that they see as a long-range goal, that the 18 other agencies, service providers would at some point become accredited?

Hon. Ms. Draude: — It is just one of the projects that they're working on at this time.

Mr. Forbes: — As it fits their need?

Hon. Ms. Draude: — As it really fits the needs of the First Nations communities. So I had the opportunity to talk with one of the leaders, and they're excited about how they can work with the ministry to make sure that we are bridging a cultural gap as well when it comes to standards of care and the work that we need to be doing.

Ms. Zerr: — I would encourage you to consider the institute to be a tool just like many others that we have to advance the care and safety of children.

Mr. Forbes: — No, I appreciate that metaphor. And so how would the relationship be with the Children's Advocate office? How would the institute . . . Do you know how, how do they view each other?

Hon. Ms. Draude: — I can't speak for either one of them, but I can't see that there would be a type of relationship. I think the overall theme is that they both care about it and they both have an interest in it, but I don't see . . . I don't know how there would be a relationship.

Mr. Forbes: — Yes. Okay. That's very interesting. You know, as this goes forward we need more tools, that's for sure. But we

have to make sure we have the right tools, and hopefully this will be one that can really do the job, help do the job.

I don't know if you want to, you were, Minister, giving us some of the numbers and how we've seen some . . . If you want to update us on some of the stats. I have a December 10th, December 31st, 2010 stats if you wanted to go through some, especially the first, or page 2, when we have children in, out of home care.

Hon. Ms. Draude: — I would love to. I'm just going to make sure that I have the latest one here. February 28th of 2011, the number of children that we have, I'm going to read the children in care of the minister is 3,201. In the wards . . . Okay, I'm going to read the non-wards is 1,533. And so the total of this is 4,734 overall. And this is in January, it was 4,797. So we've gone down from 4,797 to 4,734. And that's January of 2010 to February of 2011.

Mr. Forbes: — Do you have the children in care on reserve?

Hon. Ms. Draude: — The one I think that the member knows that we only get them on an annual basis. The last number that we had was March 31st, 2010, and that number was 1,176. And that is down from March of 2009, and that was 1,206.

Mr. Forbes: — Do you have the foster homes?

Hon. Ms. Draude: — Yes we do. The number of foster homes we have right now is 691, and that was the end of December of 2010. And again at the end of December 2010, the foster homes with more than four children were 79. And the children living in foster homes with more than four children, the number of children was 483.

I think the good news is that all of those, the number when it comes to foster homes with more than four children, we were . . . In 2008 the number was 136; we're down to 79. And the children that were in those homes who went from 925 to 483.

[15:30]

Mr. Forbes: — When I look back on the stats that's on the website, the ministry website, they have slashes for December 31st, 2006 and December 31st, 2007 under foster care, foster homes with more than four children. Why is that?

Ms. Zerr: — Because they weren't counted that way at that point in time — until 2008 the number of foster homes over four and the number of children in foster homes over four. And I want to reiterate that being in a foster home with more than four children is not necessarily a bad thing, and we shouldn't jump to that conclusion. Being in a foster home with more than four children with the appropriate approvals in place simply means that that home is well able to take care of those children. They may be a sibling group, whatever may be going on. But overall we still are certainly trying to focus on bringing those numbers down. And they weren't counted that way until we started counting them.

Mr. Forbes: — Thank you. Just wanted to make sure I understood why those numbers, or why that . . . Okay.

Now when we had, a year ago, and we were looking at the budget for the report, you had set aside $800,000, I believe, and it came in at 650,000 according to the written answer I had got. So part of the expenses, I understand, were that there were many reports, many reports written by significant researchers in this area across Canada. And of course the public didn't get to see them. And I had asked about that in December at the technical briefing whether or not there was an opportunity that some of the background work would become public because it would be very worthwhile, and especially when so much money had gone into it.

Now I don't have the written answer in front of me but, gee I think, well over half of it . . . You know, I'd asked about Mr. Pringle's per diem and his expenses, and I think that was in the 100 to 200,000. I don't know if you have the answer. Do you have the answer in front of you? I should have the answer in front of me, but you could be exact. Why don't I ask you to explain how you spent $650,000, and I could frame my question more accurately.

Ms. Greenberg: — Sure. I'm Louise Greenberg, associate deputy. The question you asked, you had the total cost. I'll go through the questions and the answers; we'll do it that way.

The first question, what was the total cost of the child welfare panel's report? The first one was, to be exact to the penny, $651,899.66. Second question was how much money did Bob Pringle receive for salary and expenses? So per diem, that he was paid for the work he did amounted to $120,600. His expenses were $16,858.74. Third question was how much money did other panel members receive for salary and expenses? That was $47, 925 and their expenses amounted to $10,800.27. Fourth question was asked about the printing costs of the panel report. That was $23,781.49. And then you asked about what other costs were incurred due to the work done by the child welfare panel. And that amounted to $431,934.16. And there's a lot of expenses in there related to First Nation consultation. There are some administration dollars, and there's also the costs paid for the work that the panel hired to do some of the research and the report writing.

Mr. Forbes: — I guess that's what I'm getting at is the background work, the researchers. How much, what was the cost of the background?

Ms. Greenberg: — One of the researchers, the total expense for report writing and doing research was $171,440. And then there was a First Nation consultation of $49,580, other consultation of $118,745, and there was administration of $92,169.

Mr. Forbes: — Now was the 92,000, there was basically an office set up for a year and . . . Gee I wonder if, Mr. Chair, we should welcome all the teachers here. All of a sudden I feel like I'm . . .

The Chair: — Yes, we can officially welcome them again. We kind of got ahead of ourselves here earlier, and I welcomed the teachers before they were actually in attendance. So I would like to welcome the educators from across Saskatchewan that are participating again in our five-day professional development opportunity focused on parliamentary democracy. They again

were introduced in the Assembly earlier and have observed routine proceedings and now are here joining us to observe our committees. So I'd like to welcome the teachers to the proceedings of our committee. And we'll continue on. Thanks again. Mr. Forbes.

Mr. Forbes: — Thank you. And you may note that I don't want to draw you folks into . . . But, just welcome you know, to people. And it's a very different format we have as opposed to question period. So I'm glad that you're here to see this kind of work in action. And this is a couple of hours so it's very, very good.

So my question is around the . . . Now I've lost my train of thought. The expenses. But there was one group that I wanted to ask about in terms of the one report, was it one researcher or one group that got 171,000?

Ms. Greenberg: — No, it was a number of researchers that were paid to produce the papers that are available, that should be available on the website.

Mr. Forbes: — Okay. Do you think right now currently it is?

Ms. Greenberg: — I believe they are.

Mr. Forbes: — And you would probably have to go to the report website to get that?

Ms. Greenberg: — Yes.

Mr. Forbes: — Not through your own website.

Ms. Greenberg: — Yes.

Mr. Forbes: — Okay. Okay, well that would be very helpful, I'll look for that.

Ms. Greenberg: — So that 171 included a number of people hired to do the research that was requested by the panel. And I should sort of clarify. The admin costs paid for someone to act as secretarial support to run the office. It paid for rent. It paid for your Internet, your setting up what you'd run for an office, but it did include salary costs for admin.

Mr. Forbes: — Right. And that was the 92,000?

Ms. Greenberg: — Yes.

Mr. Forbes: — Right, okay. And then you had 49,000 for consultation processes with the First Nations.

Ms. Greenberg: — That's correct.

Mr. Forbes: — Okay.

Ms. Greenberg: — So that would have paid for travel. That would have paid for paying for rental location and also would have paid if we had to pay for any of their, if they had individuals that they wanted to include. And we also provide some support for elders to attend. It was a wide range of people that were consulted with. There was over 1,200 people that the panel consulted. They had actually separate briefings with First Nations and FSIN and also had briefings with Métis.

Mr. Forbes: — Of that, now you had, Minister, referred to 300,000 that's in this year's budget for First Nations consultations, I think. But that is not just within Social Services. I think it's province-wide?

Hon. Ms. Draude: — To the member, yes it was. I'm just going to take a moment to also thank and to welcome the teachers that are here. We're having discussions on the Saskatchewan child and youth agenda and children in care. It's an important discussion. And last year we had the review that came out, and we are discussing the background for the review.

The member asked about the money that I had mentioned earlier, $350,000 for engagement related to the children and youth agenda. This is an opportunity through First Nations and Métis Relations. This is the money that they are putting forward to make sure that at the political level the chiefs from right across the province will have a chance to talk not only to us but to make sure that we're working with their directors as well. This is an important part of the discussion. We also have in this money, is money for the Métis Nation as well.

Mr. Forbes: — Now I'm thinking of the breach of trust report. What is the status of the breach of trust report vis-à-vis this report?

Hon. Ms. Draude: — I'm going to ask Lynn Allan if she will give us the information.

Ms. Allan: — Good afternoon. I'm Lynn Allan, executive director of service delivery . . . I mean program design. I moved over. I'm sorry. With the breach of trust report, one of the very first recommendations was that the ministry would report twice annually to the Children's Advocate office and report on the recommendations and report numbers. And so actually we just met with the new Children's Advocate last week to review our numbers and review the recommendations for them. And they will be doing their report.

Mr. Forbes: — So that report, that will be a public report that he'll put forward?

Ms. Allan: — Yes. That's what he's been doing.

Mr. Forbes: — Okay. Now at that time, you know . . . And we've met with the Children's Advocate as well just towards the end of February and of course we find this as an interesting position and maybe a very good position but, you know, doing the report before Christmas and then coming into this position as Children's Advocate and then evaluating from that perspective as the Children's Advocate.

So we'll have two reports really to evaluate in terms of how the ministry is meeting the recommendations and deciding to go forward. So will he be reporting on both, do you know, or on just the one?

Ms. Allan: — I think he will just be reporting on the breach of trust . . .

Mr. Forbes: — The breach of trust.

Ms. Allan: — Yes. And so the original report had 45 recommendations. And so we meet and review where we're at with those and provide an update. As well, they request a number of statistical information from us in terms of foster homes or homes that have more than four placements, etc.

Mr. Forbes: — Okay. Now one of the . . . When the task force was sent out for the child welfare review panel — and I'm looking at the home page, April 1st, 2010 — one of the themes, the very specific themes on the website, protect children and youth from maltreatment and sexual exploitation, and that was very, you know, very clear. What will be the actions that this government will be taking in regard to that particular theme of sexual exploitation, protecting children from sexual exploitation?

Hon. Ms. Draude: — I'm going to ask Lynn to answer this and then I'll follow up with a bigger picture answer as well.

Ms. Allan: — Thank you. There's been significant amount of work completed in the area of sexual exploitation. There is an inter-ministry committee that is addressing this issue. And of the recommendations that were initially put forward, 44 of the 49 recommendations have been addressed, and four of them have been responded to indirectly.

I think it's important to say that this file has been taken very seriously. As well, the issue of sexual exploitation is an issue that's been addressed through the directors of child welfare across Canada and our staff are involved on that initiative as well, working and looking at this issue across Canada. As well we're working very closely with the Ministry of Justice because there's a number of initiatives that they have under way to address this.

In November we brought in the Canadian Centre for Child Protection. And they're out of Winnipeg. And they came and met with our inter-ministry committee to talk about the issue of sexual exploitation and some of the issues and what we could be looking at. One of the key areas is some of the prevention work, the advertising and promotion to prevent it. So we will be looking at our work plan in that context and working with that association, keeping involved with them.

Hon. Ms. Draude: — Thank you to the member for this very important question because this is one that I dealt with in opposition. I was on the committee that was dealing with child sexual exploitation. One of the recommendations that's very difficult for any government to say, that you're going to implement zero tolerance. We want to say that and we've got it as one of the recommendations, but how do you actually do it? So we're sending . . . That's one of them where I can't say that we've fully met it. Because as long as there is something like Internet child exploitation, it can be going on without seeing it ourselves.

[15:45]

But last summer I had the opportunity to meet with Egadz, and I know that the member is aware that there are . . . On the street, Egadz in Saskatoon is doing a lot of work. They told me that they keep track of the children that mobile crisis talks to and that they speak with. And for a while, the children that were on the street were as young as the ages of 10 and 11.

In 2000 and — now I might have to correct myself; I can't remember if it was year '09 or '10 — they found that the youngest child they had dealings with on the street was 16. Still too young, but still it's part of the Criminal Code amendments that a child age 16 is considered legal. So we are working hard and working with other players that are working with the children on the street, to make sure that we're watching that on the ground as well.

I'm really pleased with the work that Corrections is doing on the ICE [Internet child exploitation] unit. It's the Internet exploitation that are keeping track of what's happening in our province and across the country as well. So this issue is front and centre for us in a lot of different ministries. The inter-ministry committee that's set up right now is well aware of the fact that this is something that all Saskatchewan people care about. And we are keeping an eye on it and it's something that I'm pleased you've asked about.

Mr. Forbes: — Right. So to Ms. Allan, some of the things you had mentioned were things that already were in existence, having in play for a year or two or actually several years. But this was a new report, a new theme that the government was asking Mr. Pringle to take a look at in his work. So I'm curious on two fronts. One, what did he bring forward in terms of this? And what new can we to expect to see because of the panel report?

Hon. Ms. Draude: — I think that the member is asking through the child welfare review where we had talked about what we were going to do for child exploitation. I've given you some of the things that we're doing right now. But I also am expecting that we will hear more as we do our consultations right across the province. The First Nations and Métis groups that we're meeting with as well as the workers, the social workers that we have, are also bringing forward ideas. We don't have a single new silver bullet that's going to talk about or deal with it but we are aware as we go through the child welfare review, making sure that we have strategies in place to deal with the children that are on the street.

Ms. Allan: — Perhaps I could just add to that that the child sexual exploitation inter-ministry committee is actually meeting later this month in April. And so they will be looking at their, you know, their work plan and what they will be looking at during the year.

Mr. Forbes: — And I know the minister alluded to the fact that she was on the committee, the all-party committee some 10, 11 years ago now and the good work that they had done. And they actually were very public about this and I think this is an important issue to have public meetings, public . . . a way to consult with people across the province not only to gain a better understanding — and I appreciate the work that Egadz does; I truly think as a CBO, they are leaders in innovative thinking — but quite often we have situations in our own communities where this kind of thing happens and we just don't know where to turn. And we're not a member. We don't belong, we don't work for a CBO. We don't belong to a stakeholder group. And we don't have an opportunity to be able to hear that the government is very concerned about these issues.

And I was struck when I was taking a look — and you've heard me say this, Minister — about the two words that were not in your report. And the report is only 10 or 11 years old. The two words that were not in that report — Internet and gangs. And boy the world has changed in the last 10 to 15 years. You know when that report, the work was being done by both parties — it was an all-party committee — that we really need to get out and educate the public, because actually kids aren't necessarily on the street as much as they're behind the computer monitor and being engaged in that process.

So I think this is a very important area and I think that there's been some very, very good work. We think about the ICE unit. It's being led out of the Saskatoon police department. I think that it's incredible, and especially the kind of worldwide results they've had. We've read about them in the news in the last month or so. But I would really encourage the ministry to think more about this area. I know that there was a campaign promise even to reconvene the all-party committee on sexual exploitation of children. And I think that it's important that we engage all members of the public.

Hon. Ms. Draude: — Thank you to the member opposite. And it was a discussion that we had and one of the first things that I did as minister was talk about this, about the reconvening of the committee. The people that I have spoken to, like Bill and Don from Egadz, have said, you can go out and do that if you want to, but are we focusing on action? They are watching the street for us in this area. In Regina we've had the same type of comment saying, we're not seeing it on the street. The all-party committee was important at the time because it raised public awareness and it made every ministry and every elected official deal, talk about the issue.

Right now what we need to do is make sure that the professionals in the areas of sexual exploitation that's happening on the Internet, which wasn't something that was a big deal, believe it or not, 10 years ago . . . Maybe it was but I'm not a technical person. I think at that time it wasn't something that was huge. But I am really pleased right now that the group that we're working with, inter-ministry, is doing the work. You and I, as elected officials, care about it but we're not going to be doing the work that the professionals who are online are looking at.

And also the gang activity is something that was there at that time but maybe not to the same extent. What people are telling me now is that what we need to do is talk about prevention and get the health determinants up and make sure that we have other avenues to dealing with our children.

That's why an important part of the child and youth agenda is the education and employment part of it. I know you'll be talking to ministers about that initiative when their estimates come up. But we know that it's important to make people, make our children know that there is alternatives and that prevention is a big part of it.

Mr. Forbes: — But you know, and I hear, and Don has given me that same argument, and I've heard that except for . . . But we do committee hearings. Or we do hearings about housing. We do hearings about child welfare. So why is this one so different that we can't. We can do two things at the same time. And they can continue and even get more funding because I think they do good work. But it doesn't mean we don't do the other one because I think it is important. Because the thing is, we have people out there who experience this and they don't know, and we sure hope they don't get to a stage.

But I also want to make sure . . . I'm not saying that the folks from the all-party committee missed some things. I'm just saying the world has changed in the last 10 years, and that's what happened. I thought the report was very thorough and was good work, and it wouldn't hurt to be doing something like that again.

My next question, because you did talk about health determinants, is are there or will there be any kind of benchmarks in terms of . . . It's good to see the numbers going down, with children at risk. But will the government, you know, with some of the work they've done around waiting lists and saying we're going to tackle waiting lists and we have benchmarks, will the government be entertaining that type of planning over the next few months?

Hon. Ms. Draude: — Thank you to the member and I'm just, I'm going to comment on his last comment before I go towards health determinants. We can have all the committees we want as elected people. What we need to do is have work being done on the ground. I know that a child that could be involved in the sex trade on the Internet is not going to come to an elected official. They're not going to phone David Forbes or June Draude and ask them. What they're going to be doing is, the people that are on the street that they are comfortable with, that they have a relationship with, that's where they go. So the work that we need to do is follow it up right now by the people that are . . . That's where their professional experience is.

As far as the health determinants, this is something that the member opposite has talked about in the House, and we know that in the big picture we have to make sure that there is money in people's pockets and that there is opportunities for them to have work and that there is . . . and that overall we're making a difference in the lives of people.

I can bring forward the discussion we have on more people working and wages and that type of thing, but it really . . . overall we would like to focus on action. And we'd like to focus on making sure that in the big picture people are better off in this province.

Mr. Forbes: — Well I appreciate that answer. But it reminds me of some of the letters I receive, and I've received some of the letters that you've got as cc's, carbon copies. And I know that the answers have been thoughtful. But when families go under very stressful circumstances, whether there's a pedophile involved with the family or some sort of thing, and we have to trust the ministry, and I do trust the officials and the civil servants who are working with the children's interests, at best interests.

But what happens with these families or extended families is that they're feeling, what do we do? What are some of the things . . . How do we overcome what's happened to us? And what's happened to them, maybe their family's been caught in a circumstance where there's been somebody who's been charged

with a child exploitation. And they just have to trust the ministry. In their heart, they know that's what they have to do. But they may feel like they would like to contribute to this conversation. They have a lot of thoughts about how this system could work a lot better, but they don't belong to a stakeholder group. They don't belong to a CBO. They aren't part of the group that often get the ear of government. And they may even be a little emotional because this is their children that they're talking about.

So how do you reach out to those folks and say, listen we understand what you've been going through, and we total . . . And it's a very sensitive issue. But somehow we have to . . . This is becoming a very significant issue for too many families. I don't know what the numbers are, but you know, it's a case of any numbers are too many I think. But if you would respond to that.

Hon. Ms. Draude: — The member is right. Any family that's going through the stresses that we can't see when we look at them, they're not the physical stresses that we often deal with . . . But we do know that through the work that we're doing through this child and youth agenda, we've got for the first time seven ministries talking together. We're no longer talking about a child or a family trying to find help through seven different areas. We're saying that the ministries go to the child.

So we are removing the duplication, the work that was done, the applications that were filled out. We're trying to make sure that the child is the focus of what we're doing. And that is a new way of looking at things, a new way of working, even a new way of presenting a budget when we go to government and say, we have to think about children differently. So this is a . . . This was one of our first steps as a result of the panel's suggestions. I'm also going to ask Marian to talk about the work that the deputy minister's committee is doing when it comes to the follow-up work that we as ministers are doing.

Ms. Zerr: — Thank you. Thank you very much. So there's two or three things that I think we need to perhaps separate out here. One is the empathetic response that you have to have on an individual basis for a family that's in that kind of crisis. And so that's got to be the ongoing work of the front line of the ministry in terms of how they deal with individuals, families, and in communities as they move forward. And we need to do that in an approach that ensures that the appropriate supports for that child and/or family are put into place.

That's why I think the example of what's happening in Prince Albert with the Hub is so interesting because it is a pragmatic and practical approach which in some respects one would think was something that was very easy to do, and yet it's incredibly difficult to do when you bring a number of organizations together to try and support a child and/or a family. So that's something that you may want to hear more about.

But at the same time when we want to talk about benchmarks, there are a couple of things that we should flag. You will recall when I did the opposition briefing of the child welfare review I talked about some of the things like the statistics around children who are in care in terms of whether or not they were neglected and what the profiles of their parents and/or caregivers were like.

[16:00]

That information is part of a longitudinal study that happens every five years through the Canadian critical incident study. It is a well-benchmarked study, and I am very proud to say that Saskatchewan did just one heck of a job in participating in that study in 2008. Because when we participated in 2008, as opposed to 2003 and 1998, we used an extremely large sample, as in all our files. Other provinces simply provided a sample, something like what the Provincial Auditor does. But when you look at all your files, you get some really deep and useful information. And so the next longitudinal study will be in 2013. And so part of as you benchmark, are we making progress, we'll be able to see some things in 2013. I would say to you, however, that some of the changes that need to happen across the system are generational changes.

And so in some respects, although I wouldn't plan it so to be, it would be interesting to be the deputy in about 2018 because I think that's sort of the real, you have that real long-term change in health determinants, and that's got to be where we focus. If you want to make change, you can't make it after the bridge has collapsed. You've got to make sure the structure of the bridge is strong. So that's another important piece to me in terms of how we go forward.

And lastly the minister referenced the deputy's committee, which is supporting the cabinet committee on children and youth. And part of our work as we engage with First Nations and Métis in sorting out what are the mid- and long-term actions and strategies that we need to jointly undertake to really appropriately respond to those three key themes in the chid welfare review, part of what we have to get ourselves around is, how do we appropriately set targets? How do we set those targets and measure against them?

And one of the real challenges, as you would be aware, from a research and statistical basis is, how do you set targets and know that your action creates a change, that you can say I did this and it caused this? The causation is really challenging in prevention and key determinants. And so likely what we will end up are actions that contribute to changes as opposed to can directly cause change. That's simply the nature of the business. But it is a very challenging task we've set for ourselves on this one. I expect this to be a good year of discussion on how we start to do that benchmarking.

Mr. Forbes: — Now is that study . . . That sounds very interesting, that longitudinal study. Is that a public document? Is that something that's out there that we could . . .

Ms. Zerr: — I believe the information is now public. I don't know if other provinces share their data. We were waiting to get our amalgamated data. And so I will agree to have that answer provided to you in terms of whether or not that data is on a website somewhere. I'm not aware of the actual . . .

Mr. Forbes: — It takes a while to analyze all the data too.

Ms. Zerr: — Absolutely.

Mr. Forbes: — It's not one that comes . . . The turnaround is not one month. It's when you do it every five years. But yes,

that's helpful.

Ms. Zerr: — It's on the Internet at the Canadian data . . .

A Member: — Well no. The Canadian data is available on the Internet.

Ms. Zerr: — Where . . . [inaudible interjection] . . . We'll get it to you.

Hon. Ms. Draude: — [Inaudible] . . . some information to the member. I just want to say that Marian talked about the Hub in Prince Albert, and I think that this is an important, a really exciting initiative. Chief McFee from Prince Albert actually started this initiative, started this initiative where he is sitting around the table with members from Health, from Social Services, from the school system talking about when a family or child may be in need or requiring help and the interventions that could take place. He does an interesting presentation talking about the opportunities to intervene at various points in a child's life to make sure that we can change what could be happening to them in the future if we as government and as officials actually get together like we're trying to do, as we are doing through the child and youth agenda, through our committee.

We have, we have people talking to each other about a child that may be seen in the school system and seen in the health care system, and their family may be seen in another one of our systems like the corrections system. How do we put all that information together to affect the lives of the child in a positive way? This is something that he's only been doing for a number of months and it's already seen some really great changes. And how do you actually measure what could have happened? But we do know that a child's life is made better because we are sitting together and talking about opportunities. What he's doing is what we should be doing across the province.

Mr. Forbes: — Now I see our time's going to be starting to slip away. There are some very specific questions I have. I don't know whether Ms. Brittin looks like she's about to give an answer or something . . . [inaudible] . . . is. But you had talked about 30 new employees. Is that front-line workers? And who will these people be, and what will they do?

Hon. Ms. Draude: — Yes, it's 30 new front-line workers dealing with children, with children cases.

Mr. Forbes: — So they're direct. They're employees, caseworkers? I'm not sure what their titles are.

Ms. Zerr: — So what we will be doing over the course of the year is bringing in 30 front-line people in a variety of capacities on the front line to make sure that we have the best skill mix in place to support children and provide for their care in a safe and accessible manner. And so we will be doing that in a staged way, primarily because we want to be strategic about how we do this. We've come to the philosophy that just adding more of the same gets you the same result. So we've taken a very thoughtful approach in terms of looking at, what does the front line need? How does the front line need to be configured?

We had an interesting conversation with our front-line staff. For example just last week they were involved in a lean process about family services and moving families through the court process. And really the conversation was around, so what does our child prevention worker spend his or her time on and is that the best use of their time? And so we know that they spend a great deal of time process serving — not the best thing. Perhaps what we need on the front line is someone doing that and freeing up that much more expensive and much more valuable child protection time.

That's why you'll find in the child welfare budget that some of the initiatives don't look like . . . They're not tagged as FTEs. But if you have someone else doing some of the running around visitation . . . So when a child is to visit its parents, a foster child, often the social worker will drive out to wherever the foster family is, pick up the child, bring them back, and then they'll visit their family in a government office. Not the best way to start to rebuild that family structure and support it.

And so what we're trying to look at are . . . what are the best ways to do that? And if we do that, what's the time that we free up on the front line so that we can have them vested in doing the work that is really valuable and important to us? So the commitment is 30 FTEs [full-time equivalents]. Those 30 FTEs will be on the front line without question, and then the skill mix will be appropriate as we take this very thoughtful approach that Andrea has embarked on in terms of how do we best do this.

Mr. Forbes: — Now in Saskatoon I understand that you have a process or a system working with families through the foster family association, and that's working well. You know, I've just heard about it so I don't have all the details, but could you describe that?

Ms. Brittin: — Sure. Yes, the in-home help — sorry, Andrea Brittin — the in-home help program is designed to give foster families the support that they require to care for the children in their home. So not every foster parent requires . . . It's based on the needs of the child. It's based on the capacity of the foster parent and what other supports that foster parent may have.

Mr. Forbes: — So that's sort of what you're getting at in terms of that mix.

Ms. Zerr: — In one sense, but I think more importantly, the distinction that we would start to make as a result of the child welfare review is that we put those in-home help supports into foster families. How do we need to turn the system on its side and instead put those in-home supports in with our families so the child doesn't get apprehended?

Mr. Forbes: — I think it's often referred with section 5 type of thing, that pre-emptive work.

Ms. Brittin: — Sometimes it's referred to as that, yes. It's in-home support to child protection families.

Mr. Forbes: — Right, okay. So well, you know, because I did want to raise this because I understand the situation in Saskatoon with the support workers for the foster families is kind of unique to Saskatoon though. You don't do that in other parts of the . . .

Ms. Brittin: — No, the in-home support program is available throughout the province. It is one area where we're wanting to bring more consistency in terms of application across the province, but certainly there are other foster homes throughout the province who do have in-home support as well.

Mr. Forbes: — And when you say consistency, you know, we think that Saskatoon does a pretty good job. Would that be the kind of . . Is that the bar you want to raise it to, the Saskatoon model?

Ms. Brittin: — Well we're certainly examining the whole area of in-home support in foster families in making sure that we find the right balance in terms of that level of support.

Mr. Forbes: — How do you do at other areas? How do you do it in Regina?

Ms. Brittin: — Well the policy is the same across the province. It's just that the application of that policy is a little bit different throughout the province. And that's why, as I said, we wanted to bring clear policy and more consistency in terms of application so that a foster family in Saskatoon can expect the same level of support if the needs are the same as a foster family in Regina.

Mr. Forbes: — So how does it work in Saskatoon when they apply your policy? And the foster family association is part of that.

Ms. Brittin: — That's right, but the assessment happens at the case worker level.

Mr. Forbes: — Right.

Ms. Brittin: — And so the case worker would be examining the number of children in the home, the needs of the children in the home, the capacity of the foster parent, what other either family supports or community supports the foster family may have to assist them, and based on that, come up with hours of in-home support that may be required.

Mr. Forbes: — And does that . . . That's where the foster family association comes in. They provide somebody. They've hired somebody to provide those hours.

Ms. Brittin: — That's right. Once we have determined the level of support required for the foster family, then the application is made to the Foster Families Association to assign an in-home support worker for that family.

Mr. Forbes: — Okay. Right. And that doesn't happen in Regina?

Ms. Brittin: — No. The Saskatchewan Foster Families Association, that process that I just described, is specific to Saskatoon. That's right.

Mr. Forbes: — So what happens in Regina?

Ms. Brittin: — So in Regina there would be the . . . Basically the in-home support workers are made known to the resource workers in Regina. So they would be assigned just through our ministry staff, through the resource unit essentially.

Mr. Forbes: — They're ministry staff these . . .?

Ms. Brittin: — No, no. The ministry staff, though, rather than it going through a third party to secure the in-home support worker, the ministry staff, our resource workers are aware of the pool of in-home support staff available in Regina, and those resource workers would draw on that in-home support pool of staff. They're a third party.

Mr. Forbes: — It's a third party? And what's the name of that third party?

Ms. Brittin: — There isn't an organization that these in-home support workers are affiliated with.

Mr. Forbes: — So you have a list of people, but they've been vetted by . . .

Ms. Brittin: — Oh yes, like the proper checks and balances would be done.

Mr. Forbes: — All have been done. But it's sort of like a substitute teachers list type of thing.

Ms. Brittin: — I suppose it would be similar to that.

Mr. Forbes: — Call them up and say, family X over here needs 10 hours a week.

Ms. Brittin: — Certain hours of support. That's right.

Mr. Forbes: — And there's all the deductions and all of that kind of stuff? Or are they paid on an honorarium? Or how do they get paid?

Ms. Brittin: — It's an hourly rate that they would be paid.

Mr. Forbes: — What is their hourly rate?

Ms. Brittin: — I don't have that hourly rate with me.

Mr. Forbes: — And they get deductions, and they're workers like everybody else and . . .

Ms. Zerr: — No, they're independent. They're independent.

Mr. Forbes: — Independent contractors?

Ms. Zerr: — So they're getting an hourly rate and they would be . . .

Mr. Forbes: — Independent contractors.

Ms. Zerr: — They're not our employees.

Mr. Forbes: — Okay. So it sounds like they're independent contractors. But why . . . It would seem to me the Saskatoon model, if it's working well . . .

Ms. Zerr: — To the member: the approach that Andrea has taken in all other areas of the operations of the child and family

services delivery since she's taken the position, which is now just a year and bit ago, has been to work very hard to standardize the policies and practices across the province, to take those best practices where we find them, and to make sure that we implement those across the province, and where we don't find them, to bring others up to standard. And so what she's trying to say is that that's one of the things that's under examination right now. What's the best way to do this consistently across the province? And she's trying not to draw conclusions because she hasn't got them yet.

Mr. Forbes: —You know, when we talk and we go to the foster family Christmas thing and they're pretty proud of the work they do, and I'm just actually quite impressed with that organization and the good stuff.

So I would say that would be just pretty straightforward. If it works in . . . not that everything that works in Saskatoon is the best thing . . . and the three members here. But I think it would be worthwhile taking a look at that because this is such a critical area, and clearly we need to have something that agreed on the standardized approach right across the board because there are times for localized, unique features, but this is one that I would really think would be good because it's so important.

I don't know where we were going with . . . got down that road. Now I've totally lost my train of thought here. We were talking about the 30 employees.

And the other question I had . . . because when I looked at the front of the budget here, there was at the end, the increase is only . . . Now I know we're just talking about child welfare, but the total increase is 18 FTEs. So that must mean that you're losing some others somewhere else.

[16:15]

Ms. Zerr: — There's an expectation that we will continue to manage our FTEs appropriately across the ministry. And so child and family services has consistently been going up but you would think of other places where that might not be the case. And so for example, we're certainly learning through some of the lean initiatives that there are some things we're able to do better. We are managing our vacancies and our retirements quite well. But we are also faced with the situation of decreasing clients in some of our institutions. And as clients decrease, the staff that are there to support them also decrease.

Hon. Ms. Draude: — To the member: I think that what Marian is saying, is talking about, is the workforce adjustment strategy that we've been looking at right across government. Every ministry had to put forward their plan over time. And we also know at the same time that the number of front line workers that we need in Social Services . . . we needed to make sure that there was an adequate number.

So we've been adjusting to make sure that our children are looked after and at the same time we can, through the lean process . . . And I'm hoping that I'm leading you to ask me this question, is about lean, because there are a number of processes that we've been undertaking within our ministry right now that has saved a lot of time for the staff that work with us and has increased client services, but at the same time made sure that there was less paper to go through in some cases. One of the lean initiatives that we talked about allows people to go from 47 applications to 7. That's the type of work that allows us to meet our strategy.

Mr. Forbes: — I don't think I have to ask you the question, do I? You've answered it.

Hon. Ms. Draude: — Actually I would like it if you would . . . And Marian would. I think it's interesting to let the people of the province know.

Mr. Forbes: — Well I do have one. You referred to . . . And I don't mind hearing a bit about the lean process and what the implications are because we'll meet again, and I'll think about that more. But you did refer to an institution. Where do you think the . . . is there one area or one part of the programs that Social Services provide where we'll see a dramatic decrease or we can notice that there's a decrease of FTEs as opposed to across the board just lowering of the number of FTEs? Is there one area that there's . . .

Ms. Zerr: — I'm certainly looking in the area of community living service delivery where we have institutions.

Mr. Forbes: — And that would be Valley View?

Ms. Zerr: — That would be Valley View. And so today there are 217 clients in Valley View. At this time last year there were 232. If you've got 15 fewer clients, you will have fewer staff to look after them.

Mr. Forbes: — Okay.

Ms. Zerr: — Just an expectation.

Mr. Forbes: — All right. Minister, if you want to tell me about the lean initiatives within Social Services?

Hon. Ms. Draude: — I'm pleased with it not only because it makes a difference to the clients that we serve but to the people who are working within Social Services. Right across all the ministries, basically they're saying that they have a chance to implement some of the ideas that they've thought about for a long time. But the process has been in place and there hasn't been an expectation to change the process.

So the Premier had a discussion with some of the people that work with us in government, and the Ministry of Social Services was able to show a pile of paper, application forms that at one time had meant that people had to look at 47 different steps. We're down to seven now. And that means it's not only better for our people but for the people that work with us. Marian, maybe you can just go over a couple of them.

Ms. Zerr: — So there are two that are related to this particular division of the ministry, and Andrea has better information than I have on them. But what I wanted to say was this. One of them is called FYAP [family and youth automated payment], but it's the payment process for foster families.

And so the way a lean process works, the group has got together. We brought together an across-the-province group

because that's the most important, and always from the front line. And I have to say, one of the best days I've had as a deputy minister was sitting with that group at the end of their first five-day session because they're enthused and they've figured out what it is that really needs to be done and somebody's listening to them and change is actually going to happen. So it's one of those rare occasions when you get to sit there and really hear that enthusiastic and positive response from your staff. It's a tremendous feeling, and I felt privileged to have been able to have done that.

In the foster payment process, they value stream mapped, which is the first five days. And in that five day process, you have to know that when the group gets together Wednesday is clearly hump day. Wednesday everything feels like it's kind of falling apart, and that's often when we see challenging conversations taking place because people own processes. And particularly when you bring people in place from across the province, one of the real challenges as we just referred to in terms of the in-home workers, is standardizing policy and process across the ministry. And in the previous iterations of this ministry, particularly when they were regions, processes were very specific to regions. It's how we ended up in what I would call such a diverse approach.

And so when you bring those folks together who are kind of married to old processes, Wednesday's the day when they challenge each other. And then all of a sudden on Thursday night, we're all married up and we're good to go again. There's something magic. I've seen five of them now. Something magic happens on Thursday. I'm not sure what it is, but by the time you get to Friday morning when they're able to start to talk about what they see as the future state . . . And in that process, they identify both the quick wins — the things that could happen fairly quickly, they need to get together for a day to design a form — fairly quick things that can happen or the kaizen events which is sort of those bigger, longer term processes. But they identify them very clearly, and they're committed to the process for the upcoming year to bring that through for the rest of their colleagues.

So the two that have happened in child and family services are the foster payment process and the other one that I mentioned earlier was the one around family services to court, the court process, getting people into the court process. And so in the FYAP one there were 11 quick wins, 11 things that could be done really quickly to sort of move things along. Andrea, do you have all the examples, or do you want me to go there and then . . . [inaudible interjection] . . . Okay. So there were things like changing a duplicate approval system for signing. So you signed and then you signed again, pushing payment through even if you were missing information from that caregiver, so that the caregiver got paid and you did the follow-up. A daily collection of the required documents instead of trying to batch them. And of course clerical staff would batch because that made sense. But if you're not batching often enough, people go without being paid.

And the other thing that I thought was remarkably interesting, as you put people from different parts of the system, not just different parts of the process, was the sort of the understanding that oh, I didn't know if I did that, that it had that effect on you and you further down the line. So it was reminding, particularly our administrative staff, that they are indeed client service staff, that the reason we all exist is that there's a client at the end of the line and that client depends on us. And we're the ones that put the supports in place for that client, so whatever you do affects the client. And I think it's really helped us to reinforce that message that we've been pushing very hard on the last couple of years — it's all about the client. And so to me that was really helpful.

But it was everything from making sure, who did what? Who initialled what? What does the form look like? We didn't have a consistent form across the province. We had varieties of forms that didn't even all ask consistent information.

So Andrea, go ahead and talk about what has this meant to your workers.

Ms. Brittin: — Okay. Yes, I'll maybe start out by just saying that the feedback that we've received from staff around the lean processes has been really, really positive. They are so excited to contribute to the changes that are being made in the organization. So it's a good example where we're engaging people in the front line, people that are closest to the processes, to design the change. They're the ones that best know. So it isn't sort of management coming down and saying, these changes need to be made. Those changes are being identified and developed right from the front line all the way up.

And so staff feedback has just been unbelievable. Staff are very, very excited about, number one, being involved in a lean process and then, number two, being able to communicate some of the quick wins and the changes to their colleagues and their peers. So it's just been tremendous.

I can talk a little bit about the child to court lean process because that just happened actually at the end of March. March 22nd to 25th, we had our first four-day process. And the participants that were involved in this process really speak to sort of the priority that this is given, because we had six ministry staff. We had a couple of Justice lawyers. We had Madam Justice Merri-Ellen Wright involved in one of the days of this lean process, and we had the Yorkton Tribal Council also there to participate. And so really the goal in this lean process, in this lean process was to reduce the time it takes to get permanency for a child.

We had identified a number of barriers to getting to . . . really looking at the root causes of the delays. And a number of the delays were as a result of adjournments and so it was examining to a granular level what are the reasons for some of those adjournments. And so it was excellent process that got at all of those details in terms of delays, and came out with a number of recommendations out of that lean process.

Some of it is around streamlining forms. Marian has already referenced sort of the whole area of process servers. A number of adjournments happen because one party or another hasn't been served with a notice of hearing. And so serving notices is absolutely key. So really looking at who actually does need to do that serving. Our front-line case workers spend inordinate amounts of time looking for people to serve. So even establishing a different process for process serving.

Creating an instruction sheet for child protection families who are attending court so that they know where is the legal aid office that's closest to them. Because often adjournments are caused by the parents not having legal representation. So we get to court. It's adjourned; they need to find legal representation. So giving them a fact sheet or a quick reference so that they can quickly identify a way to get legal representation.

The other is around streamlining our process for long-term ward reviews. We had identified that we don't have . . . These meetings aren't happening often enough, and so at times we don't have the proper plans in place. And so that causes delays as well.

We had a number of staff attending chambers each week and we really identified that one, probably one worker could identify or could attend to chambers and call the others if information is required from that worker. So that alone frees up workers for a couple of hours once a week to be doing other things.

Making sure that the documentation is in place. So you know, there's a great deal of documentation that has to be pulled together in order to present to court. And so we identified ways that we can expedite that, that kind of a process. What's another one here? Yes I think that's probably a good summary, I guess, of the changes.

Mr. Forbes: — I appreciate that. And you know, I was in chambers or court last year about this time. I took my legislative intern; I thought that would be very interesting to sit in. I think it's Tuesday afternoons in Saskatoon. And it was a real eye-opener.

And while everybody was working hard to make the system, I was very impressed actually by that but . . . So this is very good because it is intimidating when you have to go through the metal detector and all of that kind of stuff. It's quite an ordeal. I think everybody should go watch for a while. The end, her and I were the only people left. People said, who are you and why are you here? So it was very, it was really worthwhile.

I do have a couple of topics I want to . . . And I think you alluded to the Linkin system. Now what is the anticipated cost? Did you mention that when you were . . .

Hon. Ms. Draude: — We have spent over 14 million; it'll be getting close to 20 million by the time we're all, by the time it's implemented.

Mr. Forbes: — And the full implementation you think is March 12th, March 2012?

Hon. Ms. Draude: — March 2012.

Ms. Zerr: — We'll be working through this year.

Mr. Forbes: — And be working . . . Has it actually up and going? Are you seeing . . .

Hon. Ms. Draude: — We have the pilot project in place right now in Fort Qu'Appelle area and it's early but we're really pleased with the results. Basically what we're doing is we have the system in place, but we're still doing it the old way as well to make sure we have a check and balance in place because we are dealing with children and issues. But we're excited about the potential.

We also have, I believe it is Ahtahkakoop First Nation that's willing to take on the pilot for the First Nations reserves as well. So it's going to be our chance to integrate some of this data that hasn't happened before.

[16:30]

Mr. Forbes: — Now and we've talked about this a few times in terms of the lessons we can learn from the data, that that will happen in terms of developing policy. That is the long-range goal of this?

Hon. Ms. Draude: — Of course it is because a child's safety is of course the first issue. And one of the important discussions I had earlier on was with some of the First Nations workers who were saying, talk to us and make sure that we're aware when you have a child that needs care, to let us know about it so that we can make . . . contact family. So making sure that process works as well.

But data by itself isn't valuable if we're not going to use it. So our goal overall is to use this data to make sure that, as we move forward, we can decrease the number of children that we have in care, or increase the number of children that are with extended family and make and ensure that their home life is there.

Mr. Forbes: — Is one of the fields — I'm not sure if I'm using the terminology right — but one of the data fields going to be telling us a little bit about the housing, people who, you know, the families that are at risk, are living in? Because I often see that in my own riding, the kind of housing circumstances families find themselves in, whether they're really in a tough circumstance. And it's clear that Social Services is left with very little to do but to consider apprehension because of the circumstance they're in.

Hon. Ms. Draude: — Andrea was talking to me about the information, that if it's a concern, that is data that is being collected because everything that affects a child will be part of that report.

Mr. Forbes: — Because I just think that could be such an indicator, you know, because that was one of the things that Mr. Pringle talked about, poverty and housing. And if we have that data, that would be very helpful because I know it's just amazing some of the circumstances we have — overcrowding, three families in a house that's only made for one. Or even some of the basement suites that really, it's not a basement suite at all. I mean that's being very generous to call it a suite when it's, you know . . . So I'm hoping that we can see that.

Now any particular . . . What were some of the backgrounds? I know that we've had a discussion about the cost when we go forward. A few years ago when this was first announced, I think it was supposed to be around 15 million so we're up to approaching 20 million. Why is that?

Hon. Ms. Draude: — I would just start by saying, and my officials will give you the answer, but I know when we became government, the former minister talked to us about the fact that we really didn't have our children on computers. We had paper children and that wasn't acceptable. We had to make sure that we had the information at our fingertips. So the amount of money that we have spent and the commitment that our government is making to make sure that we can keep the appropriate data and collect it is crucial when it comes to sharing information again between ministries and with our First Nations partners. The background information on the costs, I'm going to turn to Marian.

Ms. Zerr: — So thank you for the question. The initial ask back in 2008-09, when there was really an idea of what it was we thought we needed, was 15 million. But then the work went into really figuring out what that would and should look like. And so if you went to the end of '10-11, you would find that the target was 19 million and change. And so certainly now that . . . And within the '10-11 there was some to-be-determined numbers. Particularly really part of our question was around some of the operating and particularly some of the training and firming up the cost for the software licences. So we're now at a spot where we're rolling out phase 1(a) after the Fort Qu'Appelle pilot is completed. And the minister mentioned that we're doing both a live and a paper pilot, a side-by-side.

The next stage will be the live pilot, and that will happen over the summer, I believe. And I'm going to ask Andrea to give you a bit more information. Andrea chairs the governance committee of the Linkin project on behalf of the ministry. So that would be the next piece. Then we will roll out 1(a).

The next phase will be 1(b), which will integrate the payment system. So we just talked a moment ago about leaning out the existing payment system. But we're going to be using that for another couple of years until we get phase 1(b) in place. And then phase 2 is the integrated case management, which would really expand the case management tool and the plans and the risk assessment tools.

So what we will have as we roll it out this year is the basic case management, the client information, starting to get that into place. And we will be faced this year with significant work on change management. As you roll into the technical system, you have to make sure that those paper processes you used to have and the systems that supported those paper processes now begin to adapt to the new technical system. And so this will be a very challenging year for us, as whenever you introduce a large system. Those things are a challenge to undertake. So that's where we'll be. Andrea?

Mr. Forbes: — Well just a couple . . . To help with the questions here, there's . . . And I do have one more set of questions, so I'm looking at the clock here. So I'll interrupt, you know, because there is one more point I want to make. And that is around the, I guess, you know, how many people are involved in this.

The issues around privacy. Once a child's name's on the database, has the Privacy Commissioner been involved with how long do they stay on that? Because I think it's important that there has to be a way to, you know, when the children become adults that this isn't something that's left for records, whether that's been thought of and . . . I've wrote down parameters. I'm not sure what I meant by that. But we'll go with those. I think what I was thinking about is, will this be used for other sources? So you're talking about the lean process in terms of payment for foster families, that type of thing, but will it then be connected into the income assistance branch, that area? Will it go right across the system?

Ms. Zerr: — Ultimately there will be because we have in this budget received funding to begin the initial work on the assistance side. However it's important to remember that those client files already exist in paper and they're in the automated client index, the ACI system, so this is simply a much better, much smarter system. But the same rules apply in terms of privacy. The rules don't change. We're transferring from a paper file to a technology tool. Andrea?

Ms. Brittin: — Yes. I will just add that we have had the Privacy Commissioner involved. We have provided updates. We, I believe, have another update scheduled with the Privacy Commissioner, but I also want to just be clear that we, as part of the rolling out this process, have done what we call a detailed privacy impact assessment. And so that's ensuring that we've classified the data that we're going to be collecting and that we have the proper, I guess, security in place to ensure that that data is protected in the best way possible.

So we have been working with the ITO [Information Technology Office] on developing that privacy impact assessment, and certainly all the securities will be built into the system. User IDs [identification] will only be providing certain pieces of information, that sort of thing. So all those security parameters are being very closely examined to ensure that we have the right level of privacy and the right level of protection of the data in place as we move forward.

Mr. Forbes: — Okay, good. I wanted to move to the unfortunate circumstances around the Aberdeen and the Pense situations. And particularly I was a little concerned about the . . . A year ago we had talked about the quality assurance group that was working within the child and family welfare branch to ensure certain standards were being met. And the former minister, we had talked about there is 12, potentially up to 12 people in this branch.

When the media was talking about the Pense situation, that group wasn't referenced. I thought that they would have been part of the group that was involved in ensuring that the different . . . the standards of care were happening. That group is still in existence, and what do they do? And how many people are working there?

Ms. Zerr: — So let's start first of all with reminding ourselves that this very unfortunate incident happened in December of 2009, just as we had created the quality assurance unit. And so the role of that work, of that unit is to do the child death reviews. And that work was in fact under way and largely completed but not finalized for this particular incident, because it actually can't be completed until the coroner's signed-off documents are part of the review. So that unit is in place.

We are working with the Children's Advocate to make sure

they understand the role and the function of that unit because it is in that particular division. And in fact, in all of the divisions, it's a pretty strong message around our value of standards and policy. And so when, for example, when I talked earlier about the file audits of the child and the Indian Child and Family Services agencies, you need to know that we do the same audits on our own service delivery areas.

And in fact, rather now than having . . . In a prior world, in the world of the previous administration, the service area would audit itself. That's no longer the case. Now that quality assurance unit has responsibility for auditing the service areas. And so in 2010, in May and August, both the centre and the north areas were audited extensively. And those results then, the same way, get fed back in terms of consistency of standards and policies being implemented. So the unit is there.

At the time of this incident, which was just the first week of December in 2009, that unit was just newly formed but had been involved in the child death review.

Andrea, is there further you would like to add to this?

Ms. Brittin: — No. I think you've covered that off.

Mr. Forbes: — Okay. So what's the name of the unit?

Ms. Zerr: — This is part of the program effectiveness side. It's actually in Lynn Allan's division.

Mr. Forbes: — Okay.

Ms. Zerr: — So Lynn has program and service delivery from an operational policy perspective. And so within that, she has a program effectiveness unit which does that quality assurance work. It's not called the quality assurance unit. That's my old Health background . . .

Mr. Forbes: — Yes. That's what I'm getting at it, because that's what I was thinking of and I just want to make sure I use the right terms.

Ms. Zerr: — It's my old Health background. They do quality assurance work.

Mr. Forbes: — Right.

Ms. Zerr: — They're called the program effectiveness unit.

Mr. Forbes: — Okay. Program effectiveness unit. And how many people are in that unit?

Ms. Allan: — In that unit, there's five analysts as well as a manager.

Mr. Forbes: — So six. And were we not talking about 12 last time?

Ms. Allan: — That probably was in our branch. In terms of under the whole program effectiveness unit, there are other people in that unit but this is one part of it. We also have people that do some of the reports and some of the briefings and letter writing. That's included in that whole area under program effectiveness.

Mr. Forbes: — Now, and who . . . What background do they have as policy analysts? Are they trained in or . . .

Ms. Allan: — The workers there all have a strong child protection background because they are doing reviews of child deaths and critical incidents, so they need to understand our policies and practices very well. As well, this is a group, like our deputy said, that does the file reviews, so they're looking at all of our contact standards and the measures that we're looking at. So they have to understand and have a good understanding of child protection policies and practices.

Mr. Forbes: — So now will they be doing home visits? Or do they just . . . What kind of work do they do?

Ms. Allan: — So this unit will do a review of child deaths. Any child that the ministry has been involved with in the past 12 months, we will look at in terms of doing a review. When they do a review they will look at . . . It's a comprehensive review, so they review all of the files that have been involved with that child. So it's all the foster care file, the child care file, the child protection file. They will also interview relevant players including the workers that were involved. It may involve interviewing foster parents. It may involve interviewing any family members as well. They will then write the report based on that. And it's important to know as well that if the child was involved with a child and family services agency, we will invite the agency to have a representative work with us when we do the reviews.

[16:45]

Mr. Forbes: — And they only do it in terms of child deaths?

Ms. Allan: — We also do all of the critical incidents as well. So in '09 when this unit was formed, it was all centralized and so to ensure consistency with all of the reviews that we do.

Mr. Forbes: — How many child deaths were there in, say, 2010?

Hon. Ms. Draude: — While my officials get the number, I'm going to remind the member, and I know he knows this, but the number always includes any time that a child has had any kind of . . . anything to do with the ministry at all. And a lot of the child deaths that we encounter are because the children are medically fragile.

And while the information is being gathered, this is an opportunity to talk about the foster parents that do a tremendous job when it comes to looking after children that they're aware that they might lose. And it's heartbreaking and it's a difficult job for them. So I'm going to ask . . .

Ms. Allan: — Okay. For 2010, is that what you're looking for? So as I mentioned, in 2010 there were five child deaths of children that were in care at the time, and there were 20 that had been in receipt of family services within the previous 12 months, for a total of 25.

Mr. Forbes: — And I do want to thank the minister for

pointing that out. I think that as an education to people who are watching that, you know, I was shocked. But really when we understand what the makeup of those children who are passed away, as you say many, many by far are in a fragile state. And so it's a tough circumstance. So yes.

Could you tell us how many critical incidents there were?

Ms. Allan: — In 2010, in care at the time of a critical injury, there were 14. And in receipt of family services within the last 12 months, it was four, for a total of 18.

Mr. Forbes: — Okay. Thank you. Now . . .

Hon. Ms. Draude: — Member, can we maybe again for the sake of education and making sure people understand what we mean by this, I'm going to ask if you can explain what critical incidents mean because it's a . . . When we have children in care, they're the responsibility of all of us as government.

Ms. Allan: — Okay. Critical incident often will involve hospitalization or something that's going to have a long-term effect on a child. So it may involve a sexual abuse, sexual assault or . . .

Mr. Forbes: — I want to go back. I did find this in *Hansard*, what Ms. Senecal said last year, and it's page 1057. And I'll read her quote. I asked, I said, "Five? Because I was thinking six or something, but it could be five." And then she says:

> There's five individuals. Actually when we take the whole unit, there's a total of 10. So there's five consultants, three program effectiveness consultants — I didn't want to use the acronym — plus the director, Jennifer, who's with us this evening.

So she left me with the impression there was 10 and one, with the manager, 11. And so you're telling me that there's five?

Ms. Zerr: — No. She was saying that the total unit is larger.

Mr. Forbes: — Okay.

Ms. Zerr: — But the portion that focuses specifically on child deaths and file audits . . .

Mr. Forbes: — Okay. That's good clarification then. So this program effectiveness unit has just five?

Ms. Zerr: — No.

Mr. Forbes: — Ten?

Ms. Zerr: — Lynn can speak to it.

Ms. Allan: — Jennifer Colin was the director of the program effectiveness area. As the quality assurance unit is one of the units in her area that has a manager as well, so that's six. We then have an area that looks after our communication in our area and there are four other people there.

Mr. Forbes: — So the communication part has four and . . .

Ms. Allan: — And the quality assurance . . .

Mr. Forbes: — And the program effectiveness also known . . . PE [program effectiveness] also known as QA [quality assurance] has . . .

Ms. Allan: — Yes, program effectiveness is both of those areas . . .

Mr. Forbes: — Oh, the total of ten.

Ms. Allan: — That's right.

Mr. Forbes: — And then the QA part is five.

Ms. Allan: — Is five, plus the manager is six. So that's all part of that. It's the program effectiveness unit that's made up of two separate areas, two team areas. One is the quality assurance area and one is the . . .

Mr. Forbes: — Communications area.

Ms. Allan: — Communication research area, yes.

Mr. Forbes: — Well I have one more question. But so that's interesting because I know one of the big issues in the Pense report or fallout from that was better communications and the need for better communications. So when we have four people working on communications and research?

Ms. Zerr: — That is particularly about ensuring that we have accurate briefing information and materials. So it's not about communication as in case management . . .

Mr. Forbes: — Not internal.

Ms. Zerr: — Communication. What that particular situation spoke to was the need for improved case management. And it really spoke to the challenge of paper files, because what it said was if you don't have workers who are talking to one another, if you don't have information that's consolidated in one place where everyone can see it, you have communication gaps. And so that was one of the very clear challenges in that case. And so when we're talking about communication around case files, that's what we believe the technology will absolutely help us improve as that system is implemented.

It is not about either what we what we would call traditional communication units in government, which is the whole piece around working with the media, and that's not what this unit does. That is not what this is.

Mr. Forbes: — Fair enough. You're talking about research. But I do have one question I . . . I wanted leave if Danielle has a question. But so when this incident happened or this situation happened, am I hearing that the quality people come in after the fact, or do they come in during just to do sort of spot checks? Who does spot checks on foster homes, on individuals that may be under section 5? Who does that?

Ms. Brittin: — Not the quality management area.

Mr. Forbes: — What's that?

Ms. Brittin: — Not the quality management area.

Mr. Forbes: — Okay. Well that's good because I was thinking they do it after the fact, after . . . They're more like . . .

Ms. Brittin: — Yes. As Lynn indicated, the quality assurance unit does the reviews of child deaths and critical injuries. And so they would be doing an after the fact, sort of, an audit. So what's important of course is the day-to-day management of the files and the cases and making sure that there's adequate oversight. And so in this case, of course since the unfortunate death, there has been a reorganization of the ministry. And so I am responsible for service delivery province-wide. I do have all the service delivery staff throughout the province that report up through a management structure up to directors, up to my position, and then up to an ADM [assistant deputy minister] that's responsible and of course up ultimately to a deputy minister.

And so since the death we've restructured the ministry. We have also made some changes to the unit in Regina that was overseeing this case, that we have developed some new processes. We have developed, there's new policy that's been implemented since then. So one example of that is that for the annual review that is done on a foster family, it is now mandatory that the resource workers speak to every single child care worker that has ever had a child in that home over the last year to gather information about their experience with that foster home in order to do the annual review. And so that's a new policy, a new process that is in place.

They also have, I guess, implemented a process whereby all critical injuries or critical incidents relating to a particular foster home are discussed with a number of staff involved from child protection, from the resource units, supervisors, a manager involved to determine what process the investigation of the matter is going to take, whether it's going to be the formal mandated child protection investigation or whether it's going to be a quality of care investigation. And so each one of those is reviewed to ensure that the proper process takes place there.

So there's a number of things that have happened and that have been put in place, and a number of things that are yet to take place.

Hon. Ms. Draude: — I would just ask the member . . . I know that the member is well versed in what happens within the ministry in some areas, and I appreciate that. I think that there are people maybe watching and even sitting here today that don't understand the bigger process. And I think that it's important to know that the process that's taking place and the information that comes up to the deputy minister at the end of the day, as minister and as government we recognize that every child death is a tragedy and that we're trying to look at the big picture. So there is an internal review so people should know that all child deaths can trigger a comprehensive internal review by the ministry.

And that means we're looking at the competency of the caregivers. And we're talking about oversight by case workers and the supervisor and the policies that we have within the ministries and then recommendations on avoiding future tragedy. And we have to ensure, if need be, that there's representation from the First Nations agency if the child is First Nations. And we have the child advocate who reviews it and the RCMP [Royal Canadian Mounted Police] and the coroner also do so.

Lately we've had the tragic death and the coroner's inquest. And we know that we already have a new foster family safety checklist that's in place. We have communications protocol that's changed. We have child history forms that's changed and a more rigorous annual review. We have more child care spaces and the case management system that's in place, first aid training for foster homes, and additional staff. There is the process that we're looking at within the ministry is huge. And what comes to the general public is knowing, needing a sense of security that we are as government doing whatever we can to avoid it.

Mr. Forbes: — Thank you. I think Danielle has a question.

The Chair: — Ms. Chartier.

Ms. Chartier: — Actually I have two, if I can squeeze them in. Just taking a step back here, the program effective in this unit then, so you've got six in the quality assurance side of things, and with respect to communication there are four. And you said, Marian, accurate briefing materials, and what was the second part of that?

Ms. Zerr: — This is a research . . . Go ahead, Andrea. This is not communication.

Ms. Brittin: — I'm going to clarify the 10 positions that the previous ADM, Cheryl Senecal, would have been referencing. She would have been referencing the three program effectiveness consultants that we have. And there's one in each in our service areas, so the North, the South, and the centre. The six quality management folks that Lynn referenced, so five analysts and one manager, and then the director of the quality management, the whole quality management area. That would be the 10.

The communications people that Lynn spoke of are other staff that are within that unit, but it's not my understanding that those would have been included as part of the quality management team because they are really communications folks.

Ms. Chartier: — And one more quick one here. I know this . . . If the minister would entertain this question because it doesn't fall under child and family services, but it doesn't actually fall anywhere but under central management. I was just wondering about the Status of Women office and where it is now. And it was a line item in the last budget.

Hon. Ms. Draude: — Yes the office is . . . It was within Social Services. Now we're on the main floor of the Social Services building. And we have, the work that we're doing right now includes three staff members. I have an opportunity to speak to them on a fairly regular basis about the work that they are doing. And one of the important issues that they are dealing with right now is the Habitat for Humanity Women Build. It's the first time that we've actually had the ministry or the Women's Secretariat looking at women who are, besides being vulnerable and needy, we have women that are professionals

and want to be involved in changing the lives of other women.

So I, as minister, I'm really excited about the work that they're doing, to make sure that we have women right across the province looked at and saying, okay how can we help women? And how we can make sure they are peers to other women as well?

Ms. Chartier: — Just a couple of quick ones here. So why is it not a line item anymore? And you talked about the Habitat for Humanity build. Is this unit still doing the gender-based analysis, which is why it was in existence in the first place? The whole idea of looking at policy across government, and this is what this unit is supposed to do, is a gender-based review with a gender-based lens.

Hon. Ms. Draude: — It's a good question and you're right. They are doing that gender-based analysis, and they are a very busy group of people. They're working right across ministries to make sure that they can put a lens from the women's focus on policies that are being looked at and programs that are being looked at. I'm proud of the fact that across ministries, it is an initiative that's important, as is the First Nations and Métis and minority groups. But the women's issues, putting a women's perspective on it is critical to making sure that we have a balanced policy.

So they're no longer a line item as such, but the FTEs are there. And the work that they are doing has a big influence on what we do as government.

Ms. Chartier: — The question about why it isn't a line item, I'm just curious about the rationale behind that.

Ms. Zerr: — So they've been rolled up into our client area, into the client . . . pardon me, the corporate service area, where the rest of our policy folks are. And so it's not that they've disappeared. It's not that the office has changed at all, but from a budgeting perspective they're in the same area as the office of disability and the rest of the strategic policy staff within the Ministry of Social Services. So a logical place in terms of the budget approach, but the three FTEs remain.

The office continues to do gender-based analysis, as opposed to the office of disabilities which provides that disability lens, and as opposed to the other parts of our policy unit which apply ageist lens, so the lens of the senior, the lens of the Aboriginal, whatever is appropriate, which is the way of course policy should work — rural versus north versus urban.

Ms. Chartier: — Well thank you. I'll ponder that for, I guess, till the next meeting. So thank you.

The Chair: — Thank you committee members and ladies and gentlemen at home and Madam Minister and your officials. Do you have any closing comments, Madam Minister?

Hon. Ms. Draude: — I want to thank the opposition for their comments and their insight. I'm well aware that the member deals with the details in the ministry, and that's important. In the big picture, I can't thank the people that are working within this area enough because they've initiated and worked on a huge amount of change. And I'm very excited about the year coming up.

The Chair: — Mr. Forbes.

Mr. Forbes: — And I too would like to thank the officials and the minister for having this very good conversation, discussion, and questions. I appreciate the extra time this year because that helps understand the issues. And thanks so much for this and look forward to next time.

The Chair: — Thank you very much. And with that we will recess this committee until 7 p.m. when we will reconvene for estimates for the Ministry of Health.

[The committee recessed from 17:00 until 19:00.]

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Good evening ladies and gentlemen, and welcome to the estimates for the Ministry of Health, Human Services Committee meeting this Monday at 7 o'clock. Committee members present are committee member Ms. Judy Junor, and substituting for Mr. Cam Broten is Mr. John Nilson. And on the government side, we have Ms. Doreen Eagles, Mr. Gord Wyant, Ms. Christine Tell, and Mr. Glen Hart. And I'm the Chair, Greg Ottenbreit.

I welcome the ministers and officials to the meeting tonight. I just ask the minister for some opening remarks. Before that though, I would just invite officials as you speak to the camera for the first time, just introduce yourself for the purposes of Hansard. And then after that, it'll be okay. Mr. Minister, do you have any opening comments?

Hon. Mr. McMorris: — Thank you, Mr. Chair. I have a lengthy opening comment. First I want to introduce some of the officials that are around me. We have quite a few officials. I won't go through introducing all of the officials unless they need to come up and speak to specific issues.

But on my left is Dan Florizone who's the deputy minister of Health. On my right is Max Hendricks who is the associate deputy minister of Health. Back over my left shoulder is Duncan Fisher who is special adviser to the deputy minister; beside Duncan is Lauren Donnelly, assistant deputy minister; and on my right side is Ted Warawa, executive director, financial services branch. And as I said, there are a number of other officials behind me that I'm sure will be able to assist us as we go through this lengthy three and a half hours of estimates on Health.

I want to begin by, as I said, making some opening comments regarding the Ministry of Health and what we plan on doing over the next year and what we have done over the past year.

The theme of our government's budget this year is *The Saskatchewan Advantage.* At first glance, one might assume that the Saskatchewan advantage refers solely to the things like our abundant natural resources or a terrific quality of life we

enjoy. As Minister of Health, I believe a large part, I believe a large part of the Saskatchewan advantage applies to the services that the health system provides to patients and their families who use our system and the health care providers who work within it. We are continuing our focus on putting the patient first to ensure Saskatchewan people receive timely and quality health services.

This year's health budget recognizes our government's commitment to health care and to the health of our residents. It allows strategic investment while recognizing that more efficiencies in the health sector is possible.

I'll begin with a basic overview. The Government of Saskatchewan has introduced a $4.46 billion health budget. The largest portion of our government's investment in health: 73 per cent of the 2011-12 budget goes towards paying health care workers. Another 16 per cent, or $706 million, is for drugs, medical, surgical, and laboratory supplies. The final 11 per cent, or $494 million, funds other health costs like out-of-province medical services, air ambulance, and extended benefit plan. This is an increase of $260 million, or 6.2 per cent from the previous fiscal year, reflecting the government's commitment to health care.

I'll explain what makes up the $260 million increase this year. $172 million can be attributed to compensation costs for health sector workers and ministry employees. $23 million is due to the increased costs and use of medication and medical, surgical, and laboratory supplies. $65 million is attributed to the net growth in other non-salaried operating costs, including increases in physicians and out-of-province medical services, air ambulance, and other utilization programs.

The dedicated women and men who provide the care within our system are both our greatest strength and our biggest asset. Naturally they represent our largest investment. More than 800 nurses have been hired across Saskatchewan, fulfilling government's election commitment to address the province's nursing shortage and provide better care to patients. According to the Saskatchewan Registered Nurses' Association, we now have more than 10,000 nurses working in the province — an all-time high, and I'm very proud of that fact.

We want to do the same on the physician front. Access to physicians is a top priority for Saskatchewan people, which is why we have established our physician recruitment strategy. Our efforts are getting results. Currently we have more physicians working in this province than ever before. As of December 2010, there were 1,970 physicians licensed in Saskatchewan, a 7.3 per cent increase over March of 2009. Of those, 1,049 are general practitioners and 921 are specialists. That said, we always strive to improve.

The physician recruitment agency is fully operational with a CEO [chief executive officer] and seven staff including three recruiters. The agency is open for business, actively recruiting physicians with a special emphasis on recruiting our own graduates. The agency is also developing a brand that will make Saskatchewan stand out as a destination of choice for local, national, and internationally trained physicians.

There are also a number of items in this year's budget that address physician recruitment. The 2011-12 budget includes funding for more physician positions along with other health initiatives. It continues with education, recruitment, and retention efforts for health providers including an additional $1.5 million for the clinical and medical teaching unit at the U of S [University of Saskatchewan] and Regina General Hospital to ensure students have access to appropriate training. And it funds an additional 800,000 for faculty positions at the College of Medicine to ensure a stable supply of pediatricians.

Saskatchewan's growing population is a reflection of our strong provincial economy. It also has results in increased demands on our health care system, and our budget provides significant investment to help meet those demands. In 2011 and '12, the health region authorities, the regional health authorities will receive $2.8 billion from the Ministry of Health, an increase of $250 million or 9.7 per cent increase, to better deliver health services to Saskatchewan people.

I would like to take a moment to give some acknowledgement to the excellent work our Saskatchewan health regions are doing. Last year was a difficult budget year; at least that was our expectation when putting together last year's budget. Every ministry had to take a hard look at the services it wanted to provide, and even ministries had to make . . . Every ministry had to make some difficult choices. At the Ministry of Health, we asked health regions to find efficiencies wherever they could, and we asked them to do so without sacrificing patient care. They more than rose to the challenge. Regions were asked to achieve $15 million in savings through improvement of attendance management. They exceeded this target by over $3 million.

I'm pleased to report that all health regions are forecast to end the fiscal year in a surplus position. Even though our financial picture has improved for this budget year, we are still focused on making the health care system as efficient as possible. Later in my remarks, I will talk about the transformation our system is undergoing as we strive to achieve the best value for money while improving the patient experience and population health.

Of course health regions aren't the only ones who deliver health care. Another vital part of the equation is the Saskatchewan Cancer Agency, which is responsible for planning, organizing, delivery, and evaluation of cancer care and related health services throughout the province. The Cancer Agency will receive operating funds of $121.9 million in 2011 and '12. That's an increase of approximately $12.6 million or 11.5 per cent over last year. Almost half of the agency's increase or $5.6 million is for drugs. The remaining funding is for salary increases, increases in operating costs, as well as funding bone marrow transplants and increasing colorectal cancer screening.

I will briefly cover some of the other highlights when it comes to the health funding in the 2011 and '12 budget. Five million dollars in 2011-12 will go towards the establishment of a helicopter air medical service in Saskatchewan. The service will focus on care and transport of critically ill or injured patients in rural and remote areas of the province. The funding model relies on a partnership between government, corporations, and the communities. STARS [Shock Trauma Air Rescue Society] Alberta currently receives only 25 per cent of their funding from government because of their successful fundraising

efforts. And we continue to explore fundraising arrangements with the private sector.

We're spending $10.1 million to address increased volumes in diagnostic imaging services, cardiac care, and chronic kidney disease. $4.2 million dollars will be spent on bone marrow transplant, bone marrow transplant patients to undertake treatments in Saskatchewan and to help reduce the number of patients being transferred out of province and country. $780,000 will also be used to expand the colorectal screening program to the Regina Qu'Appelle Health Region. Currently it's under way in Five Hills/Kelsey Trail health regions.

$493,000 will go to the Ombudsman to establish a dedicated health care unit within the province, provincial office. This fulfills a mandate commitment made by our government in 2007. We are providing an additional $1 million for autism spectrum disorder assessment, intervention, and training as part of government's child and youth agenda. This will increase the ministry's . . . The Ministry of Health will spend a total of $6.5 million this year, specifically targeted to autism treatment and support. In addition to these funds, there are a number of services and supports offered by health regions to individuals with autism spectrum disorder that is supported by the ministry's global funding.

We are funding an additional 600,000 for fetal alcohol spectrum disorder prevention, diagnosis, and support, also part of the government's children and youth agenda. Total targeted ministry funding for prevention, treatment, and support of primary FASD [fetal alcohol spectrum disorder] is $2.1 million.

$2.8 million will go towards additional specialist services in Prince Albert, Saskatoon, and Regina. $2.5 million will be allocated to a provincial HIV [human immunodeficiency virus] strategy. And $2.1 million will go towards the electronic medical record expansion into physician offices. Our government has set a goal of 50 per cent of all practising physicians to have implemented electronic medical health records by the end of 2011-12 fiscal year.

Two million dollars will go to the kidney transplant program revitalization to recruit and hire more specialists and resume deceased donor transplants in Saskatchewan. As you know, the kidney transplant program resumed in Saskatoon late in 2010 for living donors. Patients who receive kidneys from deceased donors will still have . . . donors still are having surgery out of province in Edmonton. And we are committed to achieving the resumption of the deceased donor program here in Saskatchewan.

[19:15]

850,000 will go to tobacco reduction activities, including social marketing, and to influence behaviour.

As part of government's continuing commitment to addiction support, an estimated $57 million is being allocated to alcohol and drug services in 2011 and '12. The money funds a full range of alcohol and drug treatment services including detox, in- and outpatient treatment, long-term residential services, day treatment, and community mobile outreach, as well as substance abuse prevention and health promotion activities across the province.

Funding builds on the recent investments, including a 45-bed detoxification facility in Regina, six youth stabilization beds at Saskatoon's Calder Centre, and 14-bed detox facility in Prince Albert, as well as two other facilities soon to come on board in Prince Albert: an eight-bed family treatment facility and, in co-operation with the Prince Albert Grand Council, a 15-bed youth in-patient treatment centre.

I would be remiss if I didn't mention some of the pre-budget announcements made in the fiscal year of 2010 and '11 that were possible thanks to the improvement of the government's financial position. Those announcements include some major capital infrastructure announcements and funding towards further reducing surgical wait times.

High-quality diagnostic imaging services are a high priority for our government and our health system. We were pleased to announce a month ago today a partnership with the Royal University Hospital Foundation to purchase the first PET [positron emission tomography] CT [computerized tomography] scan to be located on the University of Saskatchewan campus. The province will contribute $4 million and the foundation $2 million. The PET CT scan will provide Saskatchewan patients with the highest standard of medical imaging. PET scans are particularly useful in treating cancer patients and assessing whether treatment is effective. Renovations and installation of the PET CT scan will begin in the 2011-12 fiscal year and is expected to be operational by 2012-13.

A new children's hospital is a key priority for our government. By providing $200 million to this project, we are ensuring it will best meet the needs of Saskatchewan families and health care professionals today and into the future. A state-of-the-art centre will also help attract and retain specialists and other valuable health care professionals, which will mean enhanced services for Saskatchewan people. Our goal is to design a lean facility that creates maximum value for patients and their families through the provision of patient- and family-centred care and improving quality, efficiency, and safety.

In February we announced $40 million to accelerate increases in surgical capacity and make longer term plans for diagnostic and surgical services. This funding enables the regions to more quickly ramp up surgical capacity and make longer term plans for diagnostic surgical services. This includes funding for a fourth MRI [magnetic resonance imaging] in Saskatoon, OR [operating room] nurse training, renovations to operating rooms and patient recovery wards, purchase of surgical equipment, more funding for physician services and home care and rehabilitation programs, among other initiatives. The funding will enable health regions to complete an additional 5,700 surgeries over the next year, an increase of approximately 8 per cent.

Saskatoon Health Region will provide approximately 1,750 more surgeries, Regina Qu'Appelle Health Region approximately 1,700 surgeries, and the other health regions combined account for the remaining 2,300 additional surgeries. By the end of 2011 and '12, the initiative's goal is to reduce all surgery wait times to less than 12 months. We know the work

we are doing takes time, but we are seeing a big difference. Saskatchewan's surgical initiative goals are to transform the surgical patient experience and to ensure that by the year 2014, no surgical patient in Saskatchewan waits more than three months for surgery.

Since we became government in 2007, the number of patients waiting longer than 12 months for surgery has dropped by 40 per cent and the number waiting more than 18 months has dropped by 62 per cent. From the time the surgical initiative was launched in April 2010, the number of patients waiting more than 12 months has declined by 22 per cent and the number waiting more than 18 months have declined by 36 per cent. Huge improvement.

We've also reduced the share that communities will have to put towards regional health facilities. Communities asked for a change in the funding formula for health facilities. We listened and took action. The provincial government will now pay 80 per cent of the cost for regional health projects like long-term care facilities, up from the traditional 65 per cent share which was the government's responsibility. An 80/20 split lowers financial barriers to the revitalization of health facilities in towns and cities across Saskatchewan. I am hearing words of support and thanks for this change from communities across the province.

We know that health care infrastructure in our province has been neglected for years. On the same day we announced the funding formula change, we also announced $133.1 million for numerous infrastructure and access improvements. That number includes $49.3 million for design and construction costs of the 13 long-term facilities redevelopment projects. This funding is in addition to planning dollars already allocated as the province's share of the project costs to replace those aging facilities. One project is already well under way and 12 are expected to go to tender in the 2011 fiscal year.

The February announcement also included $24 million in new capital equipment and upgrades and $18.7 million for infrastructure, maintenance, and improvements. It includes another $8 million for continued development of an electronic health record. Work by the new Treasury Board Crown, eHealth Saskatchewan, will support electronic health record development like those recommended in the 2009 . . . by the Patient First Review.

We also put $5 million towards the redevelopment planning of the Moose Jaw Union Hospital, and we're investing $7.1 million to renovate and repair the Parkridge Centre long-term care home in Saskatoon. As well, we allocated $500,000 for CT services in Melfort. Finally the February announcement included $10.5 million to support physician recruitment and retention and another 10 million to support the increased number of physician services.

I'd like to shift gears a bit before I conclude my remarks. There's something very exciting happening in Saskatchewan health care, and I'd like to take a moment to talk about it. In Saskatchewan, we started the journey to transform the health care system with the simplest of concepts: the patient comes first. That principle is driving quality, safety, and service throughout the system and to the front lines where service occurs.

We have built on the foundation by embracing quality improvement and fostering innovation by establishing the Patient-First Initiative Fund to support the health system by adopting patient- and family-centred care. Our goal is to improve excellent service and programs to all citizens while providing taxpayers with the best possible value.

Since 2007 our government has realized a number of successes and firsts in health care quality improvement. We are the first province in Canada to implement lean across the entire provincial health system. Lean is both a philosophy and a methodology used to increase value to the patient by eliminating waste in the process of care. Lean is a proven methodology for improving quality without increasing costs and while improving financial sustainability.

Implementation of lean reflects a patient-centred approach of care. The results are extremely promising. We've seen examples of shorter wait times for patients, improved patient safety, and increase in the amount of time providers spend caring for patients. It also increases productivity, enhances staff safety and morale, and controls costs.

Saskatchewan is also the first provider to adopt Releasing Time to Care, which is based on lean methodology. It is being introduced in in-patient settings and special care homes and is focused on improving the quality and safety of care, enhancing workforce morale, and bending the curve of health care spending.

Saskatchewan, like all other provinces, spends almost half of its provincial budget on health care. Finding ways to deliver the services residents need by empowering the people who deliver those services to make the changes they need, to me that is true transformation. To date, the health regions have launched more than 90 lean initiatives focused on improving a wide array of programs and services including patient flow, laboratory services, medical administration, and patient safety.

Our quality improvement efforts are starting to attract attention outside of Saskatchewan. This past February, Saskatchewan's deputy minister of Health, Dan Florizone, received the 2011 Canadian Health Services Research Foundation Excellence Through Evidence award for accelerating change and strengthening health care in Canada and in Saskatchewan — only the second time this award has been awarded, so congratulations.

We recognize that transforming Saskatchewan's health care is a journey and not a destination, and we continue to seek new ideas and inspiration. In fact on April 20th and 21st, Saskatchewan will record another first when it comes to hosting the first ever health quality summit with internationally recognized leaders in health quality from across North America and Saskatchewan. This is also an opportunity to showcase the amazing success stories from our own quality improvement initiatives right here in Saskatchewan. I've invited the federal and provincial Health minister colleagues from across the country to come and hear about what's possible, and we're hearing positive results from those invitations.

I am proud of the leadership shown throughout all levels of our health care system in Saskatchewan and embrace the change that leads the country in the pursuit of quality agenda. I believe this will be the next great revolution in health care.

Here in Saskatchewan we are moving forward on our commitment to revitalizing health care across the province. Our $4.46 billion investment in health care this year means that we are able to maintain health services for Saskatchewan people and continue to make strategic investments to improve the health of our residents. It means we will continue to make progress on our priorities and, above all, we will continue to put patients and their families first.

Thank you very much for the time that I've been allowed to outline our initiatives as we move forward in health care. My officials and I would be more than happy to answer any questions that may come from the committee for the next three hours.

The Chair: — Thank you for your opening comments, Mr. Minister, and congratulations to Deputy Minister Florizone on your award.

Committee members will now consider the estimates for Ministry of Health, vote 32, central management and services (HE01) outlined on page 87 of the Estimates booklet. We will now open up the committee for questions. Ms. Junor.

Ms. Junor: — Thank you. Welcome to the minister and his officials, and again congratulations, Dan, on your award.

I have quite a potpourri of questions that won't have any theme, I don't think, at this moment. I tried to take a few notes when you were making your remarks and one thing I do want to ask. I have seen various presentations of how much the actual increase is to the health districts. In the news release it's 6.2 per cent. I've seen as high as 9 and as low as 5 point something. So could you tell me what it actually is?

[19:30]

Hon. Mr. McMorris: — I guess the discrepancy is the overall lift for the Ministry of Health or the health budget is 6.2 per cent or $260 million. When you break that down what goes out to health regions, the health regions from their previous budget will see an increase of about 9.7, or the lion's share of the health increase at about 250 million will be the increase that will go to the health regions.

Ms. Junor: — So is the 9 per cent increase on top of the 3.5 per cent last year that was given at the beginning or is it on top of what was actually spent in the budget?

Hon. Mr. McMorris: — The increase is blue book to blue book or budget to budget. So the 9.7 is off of the budget from last year, not the actual spend by the end of the year, but the budget book from last year.

Ms. Junor: — Thank you. And then just another thing, well there's a few things I noticed that I will ask questions just randomly. I notice you said in your totalling out of what the 260 contained, was a $22 million increase in drugs. And on page 90 of the budget book under Saskatchewan prescription drug plan, it shows a decrease in what's going to be spent. Can you tell me the difference of that?

Hon. Mr. McMorris: — I think I'll let Max Hendricks take a shot at it.

Mr. Hendricks: — Hi. The difference is that the RHAs [regional health authority], the drug amount in there refers to increases for hospital-based drugs for Canadian Blood Services as well as the Saskatchewan Cancer Agency. The Saskatchewan prescription drug plan is your community-based pharmacies and drugs are accessed through that program, and that is actually experiencing a decrease largely due to the introduction of generics that replace some of your brand name drugs.

Ms. Junor: — While we're on drugs, are we currently experiencing a shortage or a delay in receiving drugs in Saskatchewan?

Mr. Florizone: — Thank you. Dan Florizone, deputy minister of Health. First off, I just wanted to clarify something on a previous question, and that is the lift last year to regional health authorities. The lift was just over 6 per cent to regional health authorities, even though the overall lift for the Ministry of Health last fiscal year was just above 3 per cent. So much like what we've encountered this year, last year the majority of the lift went to regional health authorities. This year the lion's share went to the regions.

With respect to drug shortages, there have been reports from time to time, and we are aware and have been working with the pharmacists' association, the College of Pharmacists. They have obviously indicated that certain drugs were in short supply. We have not encountered an overarching problem. It hasn't been significant in Saskatchewan. We've been able to manage through that.

These were fairly common, or what we thought to be fairly common compounds, and our sense, the sense of the college itself was that they had some difficulty with supplies because of manufacturers and their ability to run those types of drugs — manufacture those types of drugs — when they were manufacturing other more popular or emerging drugs. So it was something that we were monitoring for some time but hasn't been a significant issue.

Ms. Junor: — Moving to your comments, Minister, on the long-term care facilities that were announced in '09 and taken out of the budget in 2010 and now are moving forward. You said one is on the go — I'm assuming that's Watrous — and 12 others are going to tender in this year. Where is the money shown for those, the capital money?

Hon. Mr. McMorris: — The money regarding the long-term care facilities, the 13 long-term care facilities that we announced and have been moving along at the regular pace as communities work to come with their funding, and scoping is done to determine the size and the scope of the facility, what we had is about $30 million roughly left in health regions after the facilities didn't move ahead initially. So there was $30 million left in the health regions.

In this past fiscal year, we've put another $40 million . . . $49 million that would be out into health regions to continue on with the construction of those facilities. So there is well over $70 million, almost $80 million in the health regions to continue on with the construction of the 13 long-term care facilities.

Ms. Junor: — When the original announcement was made, it was 156 or 7 million, I believe. What happened to the rest of the money and where is that $79 million displayed in the budget? My first question. And then what happened to the rest of the money?

Hon. Mr. McMorris: — They wouldn't be displayed in this year's budget because it was money that was put out in last year's budget, the 49 million, as I said, at end-of-the-year spending. And the 30 million would have been in the year previous, money that went to the health region, so it wouldn't be displayed in this budget year.

There is roughly 79, close to $80 million to continue on with the construction of these facilities and that will take some time, well over a year, for that money to be spent. And as the facilities need more money to complete construction, the money will be there at that time.

Ms. Junor: — So when you're talking about the 80 million that's going to be coming, is that the one . . . I'm looking at supplementary estimates for March. Is that the $80 million under facilities, capital transfers, on page 5?

Hon. Mr. McMorris: — The number that you're referring to would be money that was spent at the end of last fiscal year, and that was made up of about $49 million that will go to long-term care facilities, and the other dollars would be going towards capital equipment as well as repairs to a number of facilities. I think, you know, not quite, but roughly about $40 million was going to . . . it was capital equipment and repairs.

Ms. Junor: — I think I'm still not getting the answer. I want to know where that money is displayed. You've got 30 million from somewhere, 49 from somewhere else, 79 from someplace. Where will we see it?

Hon. Mr. McMorris: — You won't see it in the . . . this budget, in this budget.

Ms. Junor: — When will we see it then and where?

Hon. Mr. McMorris: — You saw it last year in estimates in the previous year's budget as well as the year before.

Ms. Junor: — This is the money you transferred to the districts to . . . not to capital, but to offset their deficits, right? That's what you're talking about?

Hon. Mr. McMorris: — No.

Ms. Junor: — Because you told them they couldn't do long-term care facilities, but they could use it for their operating budgets.

Mr. Warawa: — I'm Ted Warawa, the exec director of financial services for the Ministry of Health. In '08-09 the ministry put out 156 million for the long-term care facilities. In '09-10 we did claw back 122 million of that funding from the regions by reducing their operating grant and allowing them to move that money that was held there, paid for capital, to operating. So that's correct. So the balance that's remaining from that payment is 30 million, and the regions hold that money.

In the '10-11 special warrant, we paid out 49 million for long-term care facilities to the regions, so the regions hold that 49 million as well. So they hold the 30 and the 49.

Ms. Junor: — And then the 79 that you were you talking about that's coming up, where's that?

Mr. Warawa: — That is the money that's being held by . . . That's what's being held.

Ms. Junor: — So then my question at the beginning was, 157 was what you needed to build 13 long-term care facilities when you announced it in '09. Now it's 79 to build those 13 facilities. Where's the other money?

Hon. Mr. McMorris: — The money is remaining to be paid as the facilities move forward with construction, and when that happens the rest of the money will be paid out. There's 79, almost $80 million for construction right now, and as they move forward the rest of the money will be paid to the health regions. It's not in this fiscal year. It may not be paid out in this fiscal year. It may be paid out in the next fiscal year, and depending on the progress of any particular project, it may be the year after that.

Ms. Junor: — So it would be safe to say it's an outstanding liability then because they are all going to go forward.

Hon. Mr. McMorris: — Yes, we believe they will. Yes.

Ms. Junor: — So it's an outstanding liability that isn't shown in any budget document.

Hon. Mr. McMorris: — Yes, I guess that would be correct.

Ms. Junor: — So it's not shown as a debt of any kind.

Hon. Mr. McMorris: — No.

Ms. Junor: — It's just an understanding. Okay. So in Supplementary Estimates, the March document, again on page 5, facilities, capital transfers, what's that $80 million there for? What does that mean? What does it pertain to?

Mr. Warawa: — That amount will add to the 49 million for the long-term care facilities, 24 million for system maintenance, 5 million for Moose Jaw Union Hospital regeneration, and 7.1 million for Parkridge long-term care facility renovations.

Ms. Junor: — Does that total 80 . . . [inaudible] . . . because you also have 24 million under that for capital equipment or capital transfers for equipment.

Mr. Warawa: — I apologize but I don't have that page with

me. What was the total that you're looking for?

Ms. Junor: — One is facilities capital transfers. It's 80.596 million. The other is equipment capital transfers, 24 million, for a total of . . . Oh no, it's not. It's 104.596 million for capital equipment and transfers or facilities.

[19:45]

Mr. Warawa: — I had two numbers mixed up. Sorry. It's 49.3 for long-term care, 18.7 for maintenance and infrastructure, 7.1 for Parkridge long-term care facility renovations, 5 million for the Moose Jaw Union Hospital. And that will be, that's the total.

Ms. Junor: — And so Parkridge was what? Sorry.

Mr. Warawa: — 7.1 million.

Ms. Junor: — That's for the renovations. And the purchase of Parkridge, I noticed in . . . 5.1 for Parkridge. It was back in last year's budget book under the Saskatoon Regional Health Authority. They were talking Parkridge Centre capital grant funding was $5.1 million. Was that to purchase Parkridge?

Mr. Warawa: — Yes.

Ms. Junor: — Thank you. Now again to . . . I'm just going to ask some general questions now before I go back to specific to the minister's remarks. Oh, before I leave the infrastructure, I notice in the budget book on page 87 there is no money at all in the budget for provincial infrastructure projects. Is that correct?

Hon. Mr. McMorris: — That's correct. I think, you know, the money that was put out at the end of last year, the 24 million for capital repairs, the monies that Ted just mentioned will be money that the health regions will be spending over the next year.

Ms. Junor: — Okay. Then the general questions. I would like to know if you could provide the name, the job title, the salary, and any moving allowances provided for each staff person in the ministerial office. And if any new employees were added and a moving allowance was provided, please provide the details of the allowance, including the location the individual moved from and any conditions for reimbursement.

Hon. Mr. McMorris: — Including what was the last part?

Ms. Junor: — Including any conditions for reimbursement.

Hon. Mr. McMorris: — So what we can provide tonight, we don't have that level of detail with us as far as the detail part of the question. We have kind of the general numbers as far as salaries paid to . . . Were you asking just for the minister's office staff, I think? Or all or any new employees to the ministry?

Ms. Junor: — New employees.

Hon. Mr. McMorris: — To the ministry?

Ms. Junor: — To the ministry, yes.

Hon. Mr. McMorris: — Okay. Again we wouldn't have that level of detail, but that will be in the globals. And we can commit to the committee that that information will be provided once we are able to gather it all, including whether there is any expenses covered for travel and so on. We do have kind of the wages, but we can provide all of that in a response later.

Ms. Junor: — I have several questions like that, so I think I might just give them all to you, probably written then because I have some that are pretty detailed. And they do include lists of all boards and committees and councils that the minister is responsible for and the names and the authority and the organization and all that sort of thing. So I think I'll do that.

I do have one more question though before I leave this type of questioning, is how many employees of the ministry will be designated as essential services under the new legislation?

Hon. Mr. McMorris: — Again we don't have that detail, and I'm not necessarily sure that it falls under the Ministry of Health as much as it falls under the Public Service Commission. We'd have to determine the in-scope through the Public Service Commission and then determine how many were deemed essential. And I'm not sure that work has been done, but it certainly wouldn't have been done necessarily through the Ministry of Health but more through the Public Service Commission.

Ms. Junor: — So it would be useful to ask them.

Hon. Mr. McMorris: — Sure. Yes.

Ms. Junor: — Okay. Then to your comment during your opening remarks, was that all health districts for this year are projecting balanced budgets or close to? Is that correct? I notice in last year's operating fund financial statements that there was a total of $132.253 million in deficits for all the health districts. What happened to that debt?

Hon. Mr. McMorris: — I remember Ted answering these questions very well last year through estimates, and it is more of an accounting issue than actual deficit. And it refers back to the long-term care facilities and monies that were pulled back to the health region and how that was needed to be shown. There wasn't actually a, I guess you'd call, a structural deficit as much as it was a deficit through accounting principles. And so what I can say is that, you know, they didn't have to go to the bank because they had debt, that wasn't the type of deficit that they had. It was an accounting process.

As with this year as we move forward, they're all running at break even. We are projecting — there's still some time to finalize the numbers — but we're projecting a break even to a net positive for all health regions.

Ms. Junor: — So we don't have on our books any debt, accumulated debt from health districts any more, or do we?

Mr. Warawa: — So what you'll notice in the summary financial debt, if that's what you're, if that's the table that you're looking at, is that we have a $92 million forecast for '11-12 for debt of the health regions. And that's comprised largely of CMHC [Canada Mortgage and Housing Corporation]

mortgages still are on those, within that debt amount . . . [inaudible interjection] . . . Well we don't have to, but it's primarily for a number of those. But 92 million is the debt number for the health regions.

Ms. Junor: — That's not made up of deficits that the districts have run up for the previous years and it's accumulated debt that shows up on this table.

Mr. Warawa: — There will be . . . Some of the regions still have line of credit. Sunrise still, I believe, at the end of last fiscal year still had a line of credit amount. So about 7 million of that 92 might be associated with past deficits. But there's not an increase in deficits as a result of this budget.

Ms. Junor: — Now since you brought this up about the mortgages, we had this discussion last year. There was some pretty high mortgage rates, 26 per cent, something like that. And did you make any undertaking to look at that and see if there's some way we can actually get out of some of those so we don't pay this atrocious amount of money?

Mr. Warawa: — We did. We did this year undertake to look at those mortgages with the regions and to encourage them to look at them. They are their mortgages, and so it does take the region to go and do the renegotiating. But we have been in discussion with CMHC and also our Sask Housing Corp., who has interest in those mortgages as well.

So far we haven't had, other than to stir a fair bit of interest, there hasn't been a significant amount of activity in renegotiating. Part of the reason is that in about a third of the cases the rates are subsidized so that it's not beneficial. You might as well just leave those mortgages go for . . . In those cases, I think about some of the rates, especially in the larger regions, actually have subsidized rates because Sask Housing Corp. pays a subsidy on the interest right now as well — from zero to 2.5 per cent in the Reginas and Saskatoons.

Of the other regions, so far Cypress has reviewed one of the potential mortgages and has renegotiated. Five Hills has reviewed and found no opportunity for renegotiation in its debt. And there's several regions yet to undertake a review. But there's been some work done to look at the mortgages and some activity in one region. But we're finding that either between the penalties or the interest subsidy through Sask Housing Corp. that it's not . . . The savings aren't actually there to renegotiate some of those mortgages.

[20:00]

Ms. Junor: — Well Sask Housing subsidizing health districts, it's still public money. So there should be some disincentive for Sask Housing to subsidize them so that they would have some incentive to renegotiate those mortgages because it's still public money that's subsidizing that debt or that high cost. And maybe you could just do something again. It seems like an awful lot of money wasted when mortgages nowhere are they 26 per cent in anybody's recent recollection. So I don't know if there's some incentive that can be given, but a disincentive would sure be to take Sask Housing's subsidy away.

Mr. Warawa: — I think we'll continue to work on that.

Ms. Junor: — I have some specific questions. I think I'm going to focus on things that have been of interest recently. And one of the things that have, one of the issues that has really, I have spent a fair amount of time on is Sun Country. And no one's surprised to hear the word Wawota.

There have been some interesting developments in Sun Country. And we had some look at the vacancies in the regions, and Sun Country came out extremely out of sync with the rest of the regions, really out of sync.

For example, well, do nursing. There's 58 vacancies in Sun Country, and looking at Saskatoon, there's 12. And so in support services in Sun Country, there's 27 vacancies. In Saskatoon there's nine. And in other disciplines, they're not doing much better. There's 48 in Sun Country, and Saskatoon 29.

So as far as I understand, the vacancies, those positions are funded. So the Sun Country would be getting the money to fill those positions, and they're so far out of whack with everyone else — and I use Saskatoon — but they're way over everyone else, no matter how big or small they are. It just begs the question as to what's wrong with this district. And do you have any explanation for why their numbers are so out of whack with everyone else's?

Mr. Florizone: — Thank you. In taking a look at vacancy rates across regions, I think first off it's important to note that the ministry doesn't fund nor does it control for full-time equivalents. There are some exceptions, and the exception there is in the incremental allocation of 800 additional nurses to this sector.

In general what has happened is we've funded and looked at the baseline funding and added incremental funding to that base. We have a very good idea of payroll, so we certainly can calculate full-time equivalents. We can calculate both their growth or, if there were a reduction, we can monitor that reduction as well. But we don't ask the regions to hire a certain quota of staff.

Now some of the regions have used vacancy in the past as a means, and in fact it's almost anticipated, as a means of controlling their budgets. We've seen far less of that in recent years.

But I can say that Sun Country in particular has had some real challenges on the recruitment front. The former administration, the former CEO and that team, had some challenges in filling the vacancies that they had and filling the positions that we've allocated to them. They have assured us in recent weeks that they're taking another revised approach that, you know, takes a look at a little more aggressive approach by way of . . . They have been attending the recruitment fairs. They have been putting themselves out there, perhaps being a little more aggressive on a variety of fronts, including speaking to new grads, connecting earlier with students, being able to not just attend recruitment fairs but follow up with particular potential employees who have an interest, and also attempting to market their area. It's a little less of a challenge to recruit into areas like Saskatoon or Regina or even regional centres, larger regional centres.

And the one thing we know from the evidence, and they know quite well, is where you are taught, you have a far greater propensity to practise. So part of our strategies and theirs is to be able to think about where we train particular providers. Now this is more of a long-term issue, but there's no doubt that Sun Country has had some very big challenges in recruiting staff into their region.

Ms. Junor: — Well that's very tactfully put. Sun Country has had lots of problems. I'm not sure if they're all on recruitment. I think management is something they've shown no aptitude for. Just for context, there's 133 vacancies in Sun Country in all disciplines — in all areas or all employment categories — and one management vacancy. So they've got their full complement of managers and 133 vacancies through the system.

That speaks to a very high level of mismanagement in that district. And I know that there's been continual calls from the community in many, many public meetings and letters and letters and letters to the Premier, the minister, everywhere, that this board be removed and that it has lost the confidence of the community that it serves, and that the minister has the authority to take the board out because the minister appointed the board, and they serve at the pleasure of the minister through orders in council. And I just wonder how long you're going to let this district flounder under this totally inept board and management structure.

Hon. Mr. McMorris: — I guess I would first of all . . . Where did you get that number of vacancies? Where did you come up with that number?

Ms. Junor: — I added it up here from the four that were pulled off the website on the Saskatchewan Ministry of Health.

Hon. Mr. McMorris: — Just recently?

Ms. Junor: — Yes, I think it was about two weeks ago. I brought it up in the House. I had these just given to me that day when the people from Wawota were here.

Hon. Mr. McMorris: — I'll just answer some general questions regarding the health region there, the Sun Country. Definitely they've had some difficulties with maybe the hiring practice of, for example, their chief financial officer which then was relieved. And then the health board looked at the hiring practices by the former CEO that was hired under a previous government — under your government the CEO was hired — as well as the board that was in place to hire that CEO. That is the sole responsibility of a board. The only employee they hire is the CEO. And the CEO then in turn hires the rest of the employees, and so on down the line.

This board realized that the due diligence hadn't been done when they hired their last chief financial officer. He was removed, and the board had lost confidence in the CEO, so then removed the CEO and have an interim CEO who has worked in the system for a very long time, Marga Cugnet, and is the acting CEO at this time.

You know there are concerns with Wawota for sure. They've raised some concerns, but there is also, I've found, and I certainly found that . . . [inaudible] . . . a lot of misinformation that is being spread by some people in that area, you know, such as were saying that the health region was $20 million in debt. And they were making accusations of expense cards that certainly have been looked into and are unfounded.

So there is some, there is some concern with the closure of three long-term care beds and two respite beds in Wawota that certainly generated some other, I guess you'd almost say, accusations towards the board that are unfounded. You know, the board has had some difficult times, absolutely, regarding their CEO, their only one hire, and have decided to relieve the former CEO, Cal Tant, of his duties, again hired under a previous administration and under a board set up under the previous administration. This board realized . . . And one-third of the board that makes up the Sun Country board was appointed under your government. Two-thirds were appointed under ours. The board Chair, who is the Chair now, was the board Vice-Chair under the previous government and, because of continuity and experience, was moved up into the position of board Chair.

So having said that, certainly they face some challenges in that health region, but I would say that, generally, delivery of health care in Sun Country . . . be it in Estevan, Weyburn, Carlyle, Redvers, concerns in Wawota with the closure of five beds, three long-term and two respite beds. But the overall delivery of health care in that health region I think is very strong, and the board has my confidence.

As I said, we've appointed two-thirds. One-third came from previous appointments. They've decided to move on the CEO, and I respect them for that. They have some fences to mend certainly within the health region, and some confidence to rebuild. I believe that the health board that is in place will be able to do that.

Ms. Junor: — Just for clarity, you were talking about people spreading misinformation. The inappropriate use of the cards was by . . . The Provincial Auditor said that in his report. So the people are quite right to say that, that there was inappropriate use of the cards because the Provincial Auditor cited that in his audit of this district.

And the second point, talking about a deficit in the annual report of Sun Country, their own financial summary for '09-10 said they posted a deficit of $25.477 million, so people are not spreading misinformation. They had this information right from the financial statements and also from the Provincial Auditor, so I think it does a disservice to people in the community to say they're spreading misinformation. They're not.

Hon. Mr. McMorris: — Well I would trust, though, we've gone through the issue on the long-term care facilities, that it isn't an operating deficit; it is an accounting deficit. And I'm sure that you would've corrected that as you have been through that here. It's not a structural deficit. They're not running with more expense than they are revenue. It was an accounting issue through the long-term care facility.

And the information that I was referring to that was certainly being talked . . . was at SUMA [Saskatchewan Urban Municipalities Association] when they were naming however many expense cards that were still being used by employees

that were no longer employed at the health region. That is not what is being done at that health region.

Ms. Junor: — I just want to make sure that people know that the Provincial Auditor had some serious concerns about this board and its activities and the management structure. And I do want to clarify, since you think it was my job to tell people about this deficit, that the district posted a deficit of $25 million plus. And the government, as you said, gave them the long-term care money that was allocated to their three facilities and told them to use it to pay down their operating expenses.

[20:15]

They had a deficit. There's no two ways about it. You paid it down by giving them the money for the three long-term care facilities and told them that you were committed to the funding for those facilities when the projects were ready for construction, admitted already in these questionings, in this question period today, that it is an unfunded liability for these facilities to be constructed. But it is no myth that this district ran a $25 million plus deficit in '09-10.

I don't think the people are wrong to have less than absolute faith in the board and its management. And I don't know how you can deliver good services when you have 133 vacancies. I don't know how you can have your services continue on in a way that meets the needs of the communities.

And at the last meeting I was at in Wawota, a doctor from Moosomin got up and spoke about the impact of the bed closures on Moosomin and the Moosomin hospital. He also mentioned the impact on Broadview, which is in another health district, in Regina Qu'Appelle. So closing five beds in Wawota has absolutely disrupted health services in that area, but it was a symptom of what was wrong with the management structure and the board, and that has not been fixed.

Yes, they chose to close five beds for $110,000, and yet they had all this money to pay people, keep their management structure flush, and chose not to spend $110,000 on five long-term care beds. The community has had no answers and has had no assurance that this district is running for the good of the communities that it serves. And they're not giving up. I mean you've seen it. You've seen how many meetings they're having. Their letters are still coming; I got two more today.

And so this is something that you really do have to deal with in a way that . . . I think you might have to be a little more forceful. And if our government appointed a third of the board, you have my permission to fire them. We have no attachment to them. If they simply cannot do their job, then they should not keep that job, and I think that is the . . . The minister has the authority to make that decision, and I think that that's what the community at large is asking for.

And this isn't just Wawota. There's municipalities meeting at the call of the reeve of Walpole, I believe it is. And there's many, many, many rural administrators getting involved in this because it does affect more than just one single community. And they do not have confidence in this board either.

Hon. Mr. McMorris: — First of all, I mean the health region in '09-10 ran a surplus of $622,000. That's the actual fact. Yes, they will show a $25 million deficit because of the transaction for money for three long-term care facilities in that health region, which was Redvers, Radville, and Kipling. So the transfer of money, which is an accounting issue, would show a deficit. The actual actuals is that it ran a $622,000 surplus. That is the actual dollar figure as far as where that health region ended up the '09-10 fiscal year. So for anybody to run around and say that they're running a $25 million deficit, a structural deficit, is absolutely wrong. They ran a $622,000 surplus in '09-10.

As far as some of the, a number of the positions that are vacant, many of them are part-time; many of them are relief. Some of them are just term positions. To say that it is . . . Absolutely they need to do work on more staffing. They have committed to do that. We are working with them to do that. But to say that they are severely understaffed I think is certainly an exaggeration as well.

I understand a strong lobby. I've certainly seen it before, and they are a strong lobby for long-term care in their community and that surrounding community. But if you looked at the Sun Country beds, long-term care beds per population over the age of 75, you would find that they are the second highest bedded region in the province. The health region made decisions to close those beds not on a financial decision but also, but mainly on other areas such as location and infection and a number of those concerns. It wasn't necessarily a financial decision. Again that is the decision of the regional health authority. They are the best to make those decisions in their area. No doubt they looked at the number of long-term care beds they have compared to the provincial average, which you could then compare to the national average. But according to the provincial average, that was a decision that the health region has made.

There are concerns with the health board in that area, no doubt. It is a big health region and, you know, it services two major communities of Weyburn and Estevan and a number of other areas, Radville and Bengough. It's the same board that services those areas. I haven't heard the concerns from the whole health region as I have from Wawota and surrounding RMs [rural municipality].

Ms. Junor: — Just one comment. You mentioned reasons for closing the beds was infection. I was at one town hall meeting where the acting . . . She's now the acting CEO, and I forget what her position was at the time. But the infection issue was brought up, and in the audience was the infection control nurse for the district who stood up and said she was never consulted or made aware of any concerns. And the now acting CEO responded she could make decisions on her own; she didn't need any input from anybody else. And this was to a group of 400 or so community people.

So you can see that the manner of dealing with the people's concerns is less than optimal in this area, and it's not doing anybody any good for some of the personalities to continue to have the authority and to actually speak to people like that. It doesn't help. And I think that goes a long way to the decisions of the board of who does what and who stays where, that keeps this issue moving and continues to grow. And if it's spreading out into other RMs and municipalities then I don't see . . . It

doesn't have an end, I don't think, until there's better resolution than what we have now.

But moving on to something else, in your remarks I think you also mentioned, or maybe I thought you mentioned, a CT scanner for Melfort. And when is that on the books for?

Hon. Mr. McMorris: — So regarding Melfort, there's $500,000 that will go to the Kelsey Trail Health Region that will look at planning dollars for the possible implementation of a CT scan in the Melfort area.

As you would know, Kelsey Trail Health Region would be one of three health regions that currently do not have a regional hospital, and as a result do not have CT scan services. The other ones would be Heartland and Sun Country because those two health regions, neither have a regional hospital.

So this would be the first kind of venture into a CT scan that isn't connected with a regional hospital. This $500,000 will go to the planning and perhaps some renovations. It doesn't go to the purchase and operation. That will be down the road once we look at how we can implement that into the Melfort area, the CT into the Melfort area.

Ms. Junor: — What is the cost of a CAT [computerized axial tomography] scan?

Hon. Mr. McMorris: — So these are kind of rough numbers but ballpark numbers. The cost of a CT scan is about $800,000. Then there's also the installation and making sure the facility is properly designed so that it will fit a CT scan. Roughly about $1 million then when that's all said and done, an extra couple hundred thousand. And then there's the operations year over year as we move forward. So this 500,000 is just kind of the planning and perhaps some of the cost for preparing the facility.

Ms. Junor: — The last time I was in Humboldt, before the hospital opened, I was toured around through the Humboldt hospital and asked — when we were in the diagnostic area and what would be the X-ray department now I presume — if that hospital, being brand new, had the capacity to have a CAT scanner in it. And the answer was no. And I think they were quite shocked that they hadn't thought of that. So I'm wondering if it changed before it opened or if it still has no capacity to have a CAT scanner in it.

Hon. Mr. McMorris: — You know, I wasn't part of the design work on the Humboldt hospital. But, you know, maybe it stems a little bit from the fact that it isn't a regional hospital. It's a district hospital and therefore the design work wasn't put into place as far as a CT scan. Having said that though, it's not that you couldn't put a CT scan into the Humboldt hospital. You'd have to do some design work. I don't know. As far as space, probably have to add on. It seemed like all the space was quite well utilized when I did the tour on Friday.

Having said that though, if it was, you know, a decision of the health region and government to move forward and have a CT scan located in Humboldt, that is a possibility into the future, but the hospital wasn't designed . . . because it wasn't designed on the regional hospital basis who have CT scans.

Ms. Junor: — I understand that. I thought it was just unfortunate that in a new hospital, with CAT scanners going to be the norm in I don't know how many years, that there wouldn't have been consideration of making this hospital semi-ready for it. Because to retrofit it is obviously going to cost a lot more money than it would've to put it in the original plans. And hopefully if there's any other new hospitals coming around, that we do look at making sure we do have some long-term planning for the capacity, especially in diagnostics, because that does take a lot to retrofit.

Another question that you talked about in your opening remarks, so a question I have about the Ombudsman is, there's money being given to the Ombudsman's office to take on the sort of duty now of being a health ombudsman as well. And I always hoped that we would have the quality of care coordinators taken out from the health regions and put into that, into a reporting mechanism to the ombudsman if we ended up having one, a health ombudsman.

The quality of care coordinators, although they do a great job, they have certainly got limitations. They are basically in a position of looking at either the system that they work for or people that they work for and reporting on them, and it makes it difficult for the public to see this as an unbiased or objective review of their issues. And I'm wondering if you have any thoughts on if that is going to happen.

[20:30]

Hon. Mr. McMorris: — You had mentioned about the quality care coordinators and the great work that they do — and they absolutely do — in the health regions. They are more than just people that deal with complaints. They help individuals navigate. They help individuals find out where they are on the list and, you know, whether that can be sped up or what they can expect. They are excellent ambassadors, I think, for the health regions. They work very diligently for the patient in the patient-first atmosphere.

That is different than we see the Ombudsman and the health care ombudsman as we move forward. The health care ombudsman is usually . . . generally doesn't act as quickly as what a quality care coordinator can because the Ombudsman looks at if there are complaints within a health care system — you know, whether it's systemic — and do much more of an in-depth investigation than the quality care coordinators certainly do.

I know after talking to the Ombudsman, Kevin Fenwick, and Kevin talking about the work that they do with the quality care coordinators — they're in conversation and communication back and forth on a regular basis — I don't see ever taking the quality care coordinators out of the setting that they're in simply because they do great work and it needs to be on the ground, real time.

If a patient or a person doesn't feel that they have been treated correctly by the system and, you know, the work that the quality care coordinators have done or the health region has done, that's the opportunity then to move towards an ombudsman and have a formal investigation as to their complaints. So I really see them working kind of hand in hand, but really from a

different perspective. Ombudsman does more in-depth investigation. Quality care coordinators are real time, day-to-day advocates and help guide patients that are struggling through the system that we have.

Ms. Junor: — I have some general questions about long-term care. I've been through a lot of the Releasing Time to Care units that are being set up around the province. And before I actually get to my long-term care question, I want to ask a question about the total cost of the Releasing Time to Care initiative to date. I know I asked in a written question because I heard from the units that the department pays per bed to use the materials that the patented owners hold. And the answer was, you couldn't give me that number because of confidentiality in contracts, etc.

Can you give me then an idea of the total cost we've paid to date for the Releasing Time to Care initiative?

Mr. Florizone — Just by way of background, right now we are operating in 74 sites in the province. That includes 10 mental health wards, three long-term care sites, and two emergency departments. The remaining 59 sites are acute care wards or facilities in the province.

Our investment to date since 2008 is $630,000, and that breaks down . . . That's an upfront investment through Health Quality Council, investment in training to teach the new method. It's all implementation costs, staff replacement costs, salary replacement. That is the amount that HQC [Health Quality Council] is using to fund RTC [Releasing Time to Care].

You're correct in stating that the NHS [National Health Service] England has restricted the HQC from announcing the actual cost of the Releasing Time to Care trademarked modules. They aren't the significant part of these costs, I can assure you. But what they do is they provide a boxed set of 13 modules, 2 leader guides. What they do as well is provide the rollout, the initial training, and the release. So it'd be those kinds of costs that would be associated with the original modules, and the trip over to kick off the training in the various waves as this is implemented.

Ms. Junor: — Thank you. Can you tell me — I do want ask some long-term care questions — the cost per patient per year in a long-term care bed, the cost to the government?

Hon. Mr. McMorris: — So the cost, it's hard to nail it down as far as a specific cost. There are a lot of variables that will go into it. It's an average of about $75,000 a year total. There's the patient or resident's share that would come off of that because they do pay some towards that. So it really could vary anywhere probably from 45,000 to 65,000, depending on the facility, for the cost of a long-term care resident. It's hard to pinpoint it, but we, you know, we can average. And generally average is 75,000 total. Probably anywhere, you know, 55, 50, I know 52,000 was used for a while. It's probably gone up from that a little bit on an average, but that will vary from facility to facility.

Ms. Junor: — Well that's interesting. So that means that it's a different, there's a different level of subsidy for where you are?

Hon. Mr. McMorris: — It's not necessarily a different level of subsidy. What it is is the costs. If you're asking what it costs, which you did, in a facility of under 30 residents compared to a facility of 100, the costs are higher in the facility, let's say of under 30. And we have some that are 12 or 13, the cost would be higher, the true costs of keeping the person in that long-term care facility.

Ms. Junor: — Well I think that . . . I don't think I'm actually after the true cost. I guess I'm after the subsidized cost. Does it stay the same?

Mr. Florizone: — The cost to the resident is standard across the province. It's a range that's income tested. Our actual costs, in other words what we subsidize through the regional health authorities to each home, depends on their actual costs. So we fully fund the remainder for the facilities. What it really comes down to is those smaller facilities with minimum staffing standards end up costing more per bed than others. They're between 30 and probably up to at least 200 beds. And then there are some additional costs for some of our larger facilities.

Ms. Junor: — So which place is the cheapest and which is the most expensive?

Mr. Florizone: — Did you want the sweet spot for long-term care? Probably the optimal size is about 180 beds. There's probably a range in there, anywhere from let's say 100 to 180, but we can give you a more refined number. What's the most expensive? It would be anything fewer than 30 beds just because of the fact that there'd be minimum staffing standards.

Ms. Junor: — So a 100-bed facility would be cheapest. The cost per resident wouldn't be the highest in a 100-bed facility; it would be higher in a 30-bed facility.

Mr. Florizone: — It would be higher in a 22-bed facility or a 10-bed facility. Again 100 is in that nice average where our costs are decent, yes.

Ms. Junor: — So the cost per resident should be lower in a 100-bed facility. Is there any difference between the costs that the government pays to affiliates or district-owned?

Mr. Florizone: — Once again the affiliates, I would suggest that there's quite a range that goes out to affiliates as well. So going from my past history, we had Extendicare in a previous region that I was in that cost us substantially less than Providence Place, but again it's within the range.

Ms. Junor: — I had a question last year, and I followed it up with a letter to the department, actually to Roger, and haven't received an answer yet. The specific question was about people going into long-term care with supplements and complementary medicines and what are we doing for that because some long-term care facilities, I mentioned at the time, are not allowing people to take them. And there have been some meetings going on so that a doctor can order a vitamin or complementary therapy. And the concern was that many of our generation going into long-term care facilities will be more attached to herbalists or natural therapies, and there doesn't seem to be a mechanism to allow that to happen. And I wonder if there's been any work done since my questions last year and my follow-up letter.

[20:45]

Hon. Mr. McMorris: — I'll start just commenting on the fact that we received your letter in December of '10, and I'm not sure why a response didn't get back to you. I think one was drafted through the ministry, and so we'll have to check and see why that didn't get back to you. But I will let Roger talk a little bit more on the issue itself that was raised in the letter.

Mr. Carriere: — Roger Carriere with the ministry. One of the issues you raised was about *The Naturopathy Act.* And there has been discussion within the ministry. It's quite an old Act and the sense is that we probably need to look at that Act first and any revisions to that Act before we can proceed a lot. There was some discussion with regional health authorities about the issue. They have indicated that it doesn't come up a lot. They usually can work out arrangements with the physician in most situations if that is the resident's desire. And there is concern that there has to be a fair amount of caution taken, given that there can be drug interactions and you want to make sure that it's safe.

Ms. Junor: — So I'm reading in *Hansard* from last year that you agreed that the ministry could work with the RHAs and look at if there could be a protocol that could be implemented. So is that something that we see coming?

Mr. Carriere: — Yes, and that discussion did occur with the regions. The sense was that given *The Naturopathy Act* has to be really looked at probably first before they can develop those protocols. So the idea is to review that Act and then yes, there would be . . . [inaudible] . . . protocols. But there was reluctance to proceed with protocols given that that Act is somewhat out of date now.

Ms. Junor: — Are you undertaking a review of the Act as we speak?

Mr. Carriere: — That has been discussed for that Act to be reviewed, and it's in the queue of revisions . . . [inaudible].

Ms. Junor: — You don't have any idea when we could actually see some actual protocol coming into long-term care to deal with these questions that are coming up? That's a year now. I'm getting the same questions again and asking exactly why, because I sent *Hansard* out last year to those people, and now there's still really no answer for them. And I'm wondering if you do have some idea of how long this will take.

Mr. Carriere: — The actual timing of revisions to that Act are not certain now. It's not that these things cannot occur. The way they have to occur now is they have to go through the physician.

Ms. Junor: — Okay, can you tell me the waiting times for long-term care per district?

Mr. Florizone: — We don't have the breakdown with us today by region, but I can tell you the average wait last year was 26 days. There is some variation by region, so I'll get you that detailed list forwarded to you.

Ms. Junor: — And then could you also give me how many people are on the list of each of the districts? So the wait time and then the number of people waiting.

Mr. Florizone: — Sure.

Ms. Junor: — Okay, thank you. I think we're going to have a break in a few minutes, but I guess I'm going to start on a different topic.

I know you're not going to comment, Mr. Minister, on negotiations that are ongoing, but I do want to talk about the PAIRS issue, our Professional Association of Internes and Residents. The issue of their contract has been ongoing, and it has caused them no end of grief. And they have presented — I don't know if you got this — this book of personal testimonials to what it means to them, them being fourth-year residents in various specialties. And I'm just going to read a few of the handwritten ones here:

> The current negotiations with PAIRS and the Government of Saskatchewan portrays the province's lack of appreciation for resident doctors training in Saskatchewan. Overall the current negotiation process makes me feel devalued, overworked, and unappreciated. Saskatchewan has a great training program that continues to have poor physician recruitment and retention. We deserve to have nationally competitive physician training programs that attract resident doctors across Canada and retain graduate medical students.

This is a year one resident from general surgery. The handwriting's not all that clear:

> I feel unsafe in a province that tells the public they are working for them, creates flashy publicity, but then refuses to value their future doctors equal to any other province in Canada. I cannot train a doctor treated this way. It is beneath my moral compass to allow such lack of value relative to the rest of Canada. As such, this offer by the Government of Saskatchewan required me to leave the province I had hoped to call home.

Here's one from a radiology student, a resident:

> To whom it may concern, the offer provided by the Saskatchewan government suggests that they are not truly concerned with physician training and retention. We are simply seeking fair treatment in line with that shown to neighbouring provinces, such as Manitoba.

And there are a book of them. And they continue to tell their stories, sign petitions. Ninety-seven per cent of the residents, as well as med students, signed a petition saying that the residents and medical students of Saskatchewan are very alarmed that the employment contract for resident physician training in Saskatchewan has not been resolved:

> We believe the absence of a fair and competitive contract encourages current resident physicians to seek employment outside of Saskatchewan following completion of their training. In addition, this encourages medical students from Saskatchewan and elsewhere in Canada to pursue residency position training elsewhere. This has and will have a significant effect on our health

> human resources as we are in the midst of a physician shortage. The quoted position of the Saskatchewan Minister of Health is incorrect, and we encourage him to use any and all influence he wields to prevent the undesirable outcomes above.

And signed by many, many, many, many residents and med students who have come to the legislature and will probably come again. I know that you're not going to be able to comment on negotiations. I have no idea what's being offered at the table, nor do I care to know. What I do care to know is that the students and the residents feel that they are not valued. And I've spoken to them, and they absolutely feel this. They feel disrespected. And I can't understand why we can't get a contract with them. So just philosophically, tell me why it's taken this long.

Hon. Mr. McMorris: — Well you know, like with other contracts, I would say that it's taken longer than what's optimal. But having said that, you know, generally the PAIRS settle after the SMA [Saskatchewan Medical Association]. The SMA recently has settled. We expect PAIRS to settle in the near future.

You can say, why isn't there a contract? Why isn't there an agreement? Well it takes two parties to agree. You know you could go to a car dealership and say you want the car at a certain price, but you don't get it. And it could drag on forever in that you've got to have the two sides agree. I am not going to get into the nuts and bolts, nor am I privy to. It's the university that is the negotiator not the Ministry of Health, not SAHO [Saskatchewan Association of Health Organizations]. It is the University of Saskatchewan that is the negotiator with the interns and residents.

I will say, though, that from my experience . . . and not that they don't have valid concerns and not that they're not frustrated. I truly believe that they are. And they would like to see a contract settled. It is not unsimilar to any other negotiations that have gone on in the past. I've had the opportunity in three and a half years to be through a number of rounds of negotiations, whether it's CUPE [Canadian Union of Public Employees], SEIU [Service Employees International Union], SGEU [Saskatchewan Government and General Employees' Union], SUN [Saskatchewan Union of Nurses], and other providers in the health care system. And there's frustration before you get to a contract. That is pretty general.

We haven't seen any job action. That was certainly the case in the past where, you know, the nurses went on strike. And others went on strike in previous government. Obviously they felt undervalued at that time too, enough to take job action. We haven't seen that in the province. We've seen some frustration.

But when the contract is put in front of the membership in the past — be it SUN, be it CUPE — the agreement of that contract has been, the ratification vote of those contracts have been very high. The most recent one is the SMA, huge support for the contract once it got in front of the membership. Certainly the negotiators will push as hard as they possibly can for their membership, and that's fair and just, as we have to hold that taxpayers' money in trust and make sure that we come up with a good and fair and reasonable offer.

I think we're getting to that point. I think the university is getting to that point. With PAIRS I certainly hope they do. We absolutely value the work that the residents do in our province. If we didn't, maybe we'd still be at 60 positions for residents in our province. That hasn't been the case. We value them so much that we've doubled the number of residency positions in this province in three and a half years since we took over government. So to say that we don't value them, we absolutely do value them.

It is a negotiation that is going to take time. I was pleased to see through the recent CaRMS [Canadian resident matching service] match that a higher number of residency matches for . . . It was the highest number of residency matches this province has ever seen. Seventy-nine residents were matched in the first round of CaRMS — higher than any province.

So again I sympathize and hear the residents saying that they're frustrated, but it hasn't stopped people from here in Saskatchewan, medical students or medical students from other jurisdictions, looking at Saskatchewan as their first chance — 79 matches. We'll go through the second round of CaRMS, and I think we'll fill all the residency positions at 120 which will be great for the province, which I think will allow us in the future to have a much better retention rate.

We're working hard with the residents on a distributive education model, many down here in Regina. As recently as a few months ago, being in Swift Current and announcing, I believe, four residency positions in Swift Current, hasn't happened before . . . so we're moving the residency positions around the province, trying to give them a better and a broader education when they go through that process.

But I will say again that we value them. That's why we've doubled the number of seats. I think that by the time if and when a contract or an agreement is taken to the membership, I believe that it will — and this is just me going out on a limb — I think it will be very positive. Just as the contract with CUPE was at 95 per cent, the doctors were roughly around 95 per cent acceptance once that's taken to their membership.

You know, again the university is the one that's negotiating. I would believe that the university feels that they've offered fair and reasonable. They'd like the membership to vote on it. And once that vote is taken, then we'll see where it lands. But I can tell you I've heard the concerns on a regular basis when we get into negotiations, and it's been dragging on, and we get closer to the contract, some of the frustration. That seems to be the process through negotiations. But I will say that again: we've settled with the vast majority of health care workers in the province at a very high percentage.

Ms. Junor: — Just to quote some of the information that's been shared with me, an analysis of the CaRMS match program. They did a national comparison, and in each of the past four years, the University of Saskatchewan has had the second highest rate of vacant positions of the 17 Canadian universities who participated in the CaRMS match with the five-year average unmatched rate of 29 per cent. In 2011 Saskatchewan remained at this position, second highest unmatched in the country, second only to the Northern Ontario School of Medicine. And even though the rate has gone down, it still is

second highest in the country.

So the programs that did poorly in the 2011 match cycle include pathology and, interestingly enough, family medicine. Pathology did not match any applicants, and family medicine performed poorly in several distributed learning centres. So this is not speaking well to family medicine graduates that we want to attract to work in rural Saskatchewan.

And the College of Medicine, you were talking, Mr. Minister, about adding so many more seats. And over the past two years, the College of Medicine has graduated 116 resident physicians. Of those 116, only 45 chose to remain in Saskatchewan to live and work following graduation. So we have a retention rate of 39 per cent. It doesn't really help to continue to add the seats if you do nothing to improve the retention. And according to the analysis, the number of the residency positions filled is indeed higher, but it did not improve. The university did not improve on its performance in 2011. It does remain the second highest vacancy rate residency training program of the 17 medical schools, and we have yet to see a significant improvement in year over year of the CaRMS success.

[21:00]

And they say the improvement in absolute residency positions can be explained by the increased amount of medical training positions across the country leading to greater applicants. But the end result is we still end up not having any better retention rate than we did in past years. And Saskatchewan was among the provinces in Canada identified as physician donors. So I don't think that's a ringing endorsement of our program.

The 39 per cent retention rate over the past two years, despite expanding residency training positions and increase in incoming resident physicians, six in ten graduating resident physicians still choose to practice elsewhere. So this is what's happening under your watch, and it doesn't appear to be getting any better. In fact it has not got any better.

The Chair: — Committee members, we'll let the minister respond to this question, then we'll break for a short recess.

Hon. Mr. McMorris: — Thanks for that, Mr. Chair. Yes, a number of comments regarding where we're at right now today in Saskatchewan and where we need to get to. Lots of work to do. We need to have a higher retention rate. It wasn't too many years ago that we had the worst retention rate of nurses in our province, and over the last three and a half years we've been able to turn that around to have one of the best retention rates in Canada, and I believe that we'll do the same with the physicians.

You know, you could say that 79 is a low percentage of the 120 that we have. I would say yes, but 79 is a pretty nice number compared to the 60 that we used to have in the past. I don't know if you're suggesting that we should go back to the 60 residency positions or not. I think that we're on track by increasing the number of residency . . . and eventually as we move forward increasing the number of medical seats. We have a physician recruitment agency that's working closely with the residents. We have health regions that are working closely with the physician recruitment agency, as well as the College of Medicine and the residents to make sure that they know they're needed here in Saskatchewan.

We have a contract now with the SMA that, when residents are done, is competitive with anywhere in Western Canada. In fact I think in a couple of years you'll see it as probably the leader, as we have with nurses, a contract that is the leader in Western Canada. And I think you'll see that in a few years with the SMA contract that we have in place that will be a leader. If it's wages that they're looking for, they can't look anywhere else but Saskatchewan to find some of the best wages.

So it's a combination of things. It takes time. It takes effort. Our government has committed to that effort. We are looking at improving the numbers over time. It wasn't too long ago that not only through health care but in many, many occupations, people looked outside the province far sooner than they ever looked inside the province. That whole attitude is changing today in Saskatchewan. Saskatchewan is looked at as a place of opportunity, the place to be. I believe that as we move forward with the work again through the recruitment agency, through the health regions, through an SMA contract, that you're going to see the numbers of retention on specifically residents, and eventually on medical students taking the residency here, only continue to increase. So I'm quite positive we're moving in the right direction. Absolutely more work to do, but we're moving in the right direction. Max, did you have something to add?

Mr. Hendricks: — I just want to add one more point, is we were able to increase post-graduate residency positions very quickly. We took them up to 120 over a very short time period. The undergraduate positions have taken longer to increase, and we're still dealing with the class size coming out of your fourth year of 65 students or 60 students. So the percentage that actually are applying into our positions is very small in comparison. So it's distorted by the fact that our undergrad class sizes that are coming out of medical school are much smaller than our post-graduate seats we have available.

The Chair: — Okay. Thank you, officials and Mr. Minister. With that we'll take approximately a five-minute break and reconvene back here at 9:10.

[The committee recessed from 21:03 until 21:11.]

The Chair: — Welcome back, ladies and gentlemen, to our Human Services Committee meeting tonight and considering estimates for Ministry of Health, vote 32 (HE01), outlined on page 87 of the Estimates booklet. We concluded with the minister answering the last question. Ms. Junor.

Ms. Junor: — Yes, I just want to restate what I had said before the break. I think the minister might have misheard me. I read that over the past two years the College of Medicine has graduated 116 resident physicians. Of those 116 physicians, only 45 chose to remain in Saskatchewan. That's a retention rate of 39 per cent. I just wanted to make sure that we were clear.

I also have a question about the medical residents because the minister did mention, I'm sure not in any provocative manner, that we haven't seen any job action from this group or others, but this group in particular who we're discussing right now. So

it led me to think of the question, are the medical residents going to be deemed essential services under the new legislation?

Hon. Mr. McMorris: — The answer is yes. They are deemed and have already been given their notice.

Ms. Junor: — So are they 100 per cent, 100 per cent of them?

[21:15]

Mr. Hendricks: — I actually don't have the details, but the University of Saskatchewan and the Saskatoon Health Region have been working on a plan. It wouldn't have all post-graduate residents as being essential. In fact the thought is it would probably be a fairly low number because there are specialists there to cover for them. In programs like family medicine, that sort of thing, obviously those wouldn't be regarded as essential under the legislation.

Ms. Junor: — It would be interesting, because the residents tell us that they're the ones that actually do most of the work on the units, so it would be interesting to see how that would all work out. It probably wouldn't work for long. Anyways I do think that given the many, many stories that . . . I only read a couple which were quite, just quite indicative of what the students, the medical residents are feeling.

And the medical students that came the other day to the legislature actually had a different concern. And their concern was that there's not enough preceptors or mentors for them when they go out to do their clinical practice, and that is stopping them from having the experiences that they feel they could use. Many of them feel that they could and would work in rural Saskatchewan, but they're not having that experience. So they understand that there's a value to having more seats in the medical program, but the actual support systems for those medical seats hasn't kept up with the increase in the seats, and that was their concern.

And they came to talk about the distributive practice model last year and they quite like it and they would like to see it expanded. But they need to have more in the preceptor support and the mentorship support, in particular in rural Saskatchewan. And I'd like you to comment on that.

Mr. Hendricks: — So the ministry is working with the College of Medicine to advance distributive medical education in the province. One of the first sites out of the gate was to expand post-graduate specialty training in Regina, and there's been significant improvement there, but we've also expanded into rural Saskatchewan. We now have four seats in Swift Current which all filled in the first round of the CaRMS match. We also have six seats in P.A. [Prince Albert] which have also all filled in the first round of the CaRMS match. So we're making progress.

The idea is that we would actually push this out into other communities like Estevan and Meadow Lake, and so we're in the process of expanding this. There will be more opportunities because, as we have expanded the medical school class size, there is a need to practise in more locations so the students can get the experience that they need. So this is a significant priority of the ministry over the next couple of years.

Ms. Junor: — I think they were looking for something more immediate in the support of physicians in communities who could be mentors or preceptors, which they didn't feel would be that difficult to ramp up. And I understand the commitment and the distributive practice model and all of that, but to actually make it work and make it work for the students that are in there this year. The ones that came to the legislature were year 1 and 2 and they really want to see something happen right away, which I don't know how much of an investment it would take, but it doesn't seem to be something that would be a bad investment and would have fairly good returns in your physician recruitment endeavours.

So I would expect that it would be something that could be looked at very quickly or certainly quicker than the two years you're talking about or out years you're talking about. Is that something that you would see happening sooner than later? I mean, and understand the philosophy, that distributive practice and all of that. What I would like to see is a commitment to look at the ratio of physicians to students and increasing that and increasing the incentives or the support for physicians to do that.

Mr. Hendricks: — And that is part of the distributive medical education. One of the challenges that we have is, in order for this to work, we have to rely on community physicians who then would have to have a part-time appointment or a faculty appointment with the university and be comfortable training these students and providing the curriculum that they need. So we are trying to expand that and it is part of it. And there is compensation associated with being a preceptor to these students and for actually providing the training programs. We're shifting total gears. No longer are full-time faculty actually providing the training. It's more and more community-based physicians. So we're trying to change the culture out there where more and more physicians have an involvement in the academic training.

Ms. Junor: — So before we totally leave this topic, the physician recruitment agency, I have been around when the CEO, Ed Mantler, has given a presentation to PAIRS and didn't have any . . . He had a slide presentation and he told the students that that's all he had. If there was any questions, he would just be referring to his slides. And then I was in Wakaw when he sat in the audience for the town hall meeting of the Wakaw community that was seeing their hospital close. And you did mention in your opening comments, Minister, that the physician recruitment agency was having some success. I would like to know exactly where their success is.

Hon. Mr. McMorris: — The recruitment agency that I've talked about, and has been doing its work over the last number of months, really is quite young. Ed started in August of 2010, so we've had this agency up and running for about seven months. And it has done a number of things in those seven months that has worked with their College of Medicine, with the residents here in Saskatchewan, attended numerous recruitment fairs across Canada. It's really been working hard on the image of Saskatchewan as a place to come and practise for physicians by taking out advertising in many different . . . for example the medical journal. Ed's been very active in

keeping in touch with the medical students and the residents. He was at the cloaking, was a cloaker at the graduation ceremonies.

I just have one, one story that not only are they working very closely . . . And that's our number one priority is the medical students and the residents here in Saskatchewan. They need to think of Saskatchewan first instead of other jurisdictions. So that's our number one priority. But there are others. I mean there are other areas to try and attract physicians from across Canada, internationally, and a big market is Canadian citizens that are taking their medical training outside of Canada and United States, some in the Caribbean.

In fact I received . . . Actually it was one of our members received an email from a friend of his who is from Ontario. They're taking their medical training down in the Caribbean. And they sent back an email to the MLA [Member of the Legislative Assembly] from Lloydminster about how impressed they were. They hadn't seen any recognition from any other province. The only province that was talking to the Canadian medical grads or students in this area was Saskatchewan. In fact he never had really thought of Saskatchewan to come back and practise, but because of the work of the recruitment agency in that area, he was not 100 per cent sure, but was thinking of Saskatchewan as his first option if he comes and when he comes back to Canada.

So there are a number of things that the recruitment agency has been working on. It's met with all the health regions. It's met with many, many communities. It's working with communities that are looking for doctors to make sure that if you get a doctor, it's a match for the community — the doctor knows what to expect; the community knows what to expect. We've had too many situations where a community will just attract a physician. The doctor was expecting something different; so was the community. And it just doesn't last. You know, it doesn't do anybody any good to have a physician move into a community for three months and leave, or six months and leave. So the physician recruitment agency has been working closely with communities to make sure that they understand what to expect from physicians, and also with incoming physicians, what to expect from the communities.

So it's done a number of . . . It's done a lot of work in that area. It's also completed an ethical recruitment framework to ensure that the agencies recruit fairly and openly in local, national, and international workforces. That's something that we did through the nursing recruitment piece when we recruited from the Philippines. It was ethical recruitment. That's what we're doing on the physician side as well.

I think, you know, I could certainly go into . . . We have, you know, a four-page of what it's done, what its goals were, and the activities around those goals, communicating openly, effectively with the public. It's working on that. As I said, it's a new organization, just seven months old. It's done a lot of work. It's got a lot more work to do. But people are realizing it's an agency that is there for them as far as communities, as well as physicians.

What I will say is that when you look at where we are in Saskatchewan compared to what other jurisdictions have been doing for years, other jurisdictions had a recruitment agency specific for physicians for many years. We have got ours up and running. It's one part of the overall physician recruitment and retention strategy. It's done great work in the seven months that it's been there. More work to do — emphasizing on our local students, number one, our local residents, and then expanding across Canada and internationally to make sure that people realize the Saskatchewan advantage.

Ms. Junor: — Are you finished reading it? You're reading from a report, I gather. This is a report of the physician recruitment agency that will be tabled with the legislature, or how do people see it?

Hon. Mr. McMorris: — Like all other organizations and Treasury Board Crowns, for example, they do an annual report that identifies and itemizes all their activities for the past year. As I said, it hasn't even been a year in operation. But that annual report will identify the work that it's undertaken over the past year, and its successes. You know, we have more physicians practising in Saskatchewan today than we've ever had in the history. That isn't because, or all of, because of the recruitment agency, but it's part and parcel.

There is no one specific policy change or recruitment agency that's going to tackle the issue around physician shortages. It's an issue across Canada, around the world. But as I said, between the strategy that we've put in place, which has many, many elements, one of which is a physician recruitment agency, another is a strong contract, and there are many other initiatives of the physician recruitment strategy. This is one of them. We look forward to its annual report and we will look forward to the successes that we think it will have as we move forward.

[21:30]

Ms. Junor: — I understand that PAIRS pulled their representative off the recruitment agency board, protesting that it's really doing nothing for them to in any way demonstrate that it's interested in them as physicians to work in Saskatchewan. So I think that was a fairly strong statement. How is this physician recruitment agency working with the long-term human resource strategy that is ongoing?

Hon. Mr. McMorris: — I want to answer the first comment. I realize that PAIRS have pulled their person off the physician recruitment agency. I truly believe that was a, you know, a decision more around a contract and the frustration around the fact of whether a contract had been reached or not, not the effectiveness of a recruitment agency.

As the dean of medicine has said and written in a letter, that it seems strange that the very organization that will help them settle in Saskatchewan, the very organization that will work with communities and work directly with the medical students and residents to ensure that they have a proper transition into the province is a recruitment agency. As Dean Albritton said, he found it strange that they would be backing off.

I can understand trying to make a point as far as negotiations and speed up negotiations. I don't know how effective it is when you are trying to jeopardize the very organization that's trying to help a person establish here in Saskatchewan.

And after answering that, I forget the second part of your question. So if you could re-ask that.

Ms. Junor: — How is the physician recruitment agency fitting in working with the . . . I understand there's a long-term human resource planning strategy going on.

Hon. Mr. McMorris: — I'll start, and while Max is looking for a little bit more information, I'll talk a little bit about the human resources planning that the ministry has been working on. And you know, I don't have an exact date, but within the next few months, we'll be reporting out of the findings.

But the physician recruitment agency has been involved. Ed has been involved with that. There has been also a presentation, some work done with the board, a presentation to the board, another one to go to talk about the findings of . . . and the work that is being done regarding the 10-year human resources plan. But the physician recruitment agency has certainly been part of it, and the CEO Ed Mantler has had input as we've moved along on the process. And I don't know if I have to stretch any more.

Mr. Hendricks: — Well specifically the physician recruitment agency was given four specific targets to try and achieve, and that was to reduce the turnover of physicians, to increase the number of physicians practising in Saskatchewan, to increase the number of Canadian physicians practising in Saskatchewan, and retention from our own College of Medicine.

Now the board has had presentations from the group that's actually working on the human resource plan because they kind of go hand in hand. The minister talked about needing to have physicians settle in practices in communities where it's sustainable, and so the recruitment agency has been out consulting with communities and has developed a position on this. And we've been sharing that information back and forth as the health human resource plan has beginning or continuing its work. And we're providing input, and they're providing input in terms of the number of physicians that Saskatchewan might need. So we are working together with them. I sat through a presentation to the board, and they're working, as the minister said, with the CEO very closely.

Ms. Junor: — Thank you. You were talking about the ethical hiring. And I know Pat Atkinson, when she was minister of Immigration and was going to the Philippines, had put out an ethical hiring statement or process for hiring nurses. Did you actually use the same one, or is it something different that you could share?

Mr. Florizone: — So we have a number of ethical guidelines that are being worked on. First of all with the recruitment that occurred in the Philippines, that was a guideline that was developed and modified by the Saskatoon Health Region and then further refined it and adopted for that recruitment effort. Those, just for the record, happen to be nurses, as you're well aware, that were recruited.

We have had the recruitment agency working away. They've adopted and refined a WHO [World Health Organization] standard, and that certainly is available to you. It looks like you're familiar with that standard.

I can also say that as deputy ministers of Health across the country we've tasked an ADM group with further refining and coming in with a national standard that would allow for the ethical recruitment from countries that would either be positively or in many cases negatively affected by our recruitment efforts. So that's the standards that's being used right now.

Ms. Junor: — So is it a piece of paper that we could see?

Mr. Florizone: — Absolutely. I would be pleased to share with you. The first one has been made available and can. The second one, adopted by the physician recruitment agency, we'd love to provide you a copy of it. The third one is still a work in progress. But as soon as it's complete, you're free to see it, and we'd like to hear comments on it as well.

Ms. Junor: — Thank you.

Hon. Mr. McMorris: — If I could just add one more comment to the piece around the Philippines and recruiting there, the health regions were very aware of, you know, the issue around ethical recruiting. And as Dan mentioned, it was led by the Saskatoon Health Region, and kind of the protocols, as well as the U of S in Saskatoon. There continues to be work between the U of S and the Philippines on education. So it wasn't just a kind of a one-time shot, go over there, see what we can do for recruiting, and then leave. There has been ongoing work through the educational institutions, and especially the U of S here in Saskatchewan, to continue the dialogue and continue to assist through dialogue as we move forward. So, very, very proud of the work that not only the Saskatoon Health Region has done but also the University of Saskatchewan.

Mr. Florizone: — I wonder if I may add something on the health human resource plan and the timing or rather the delay, somewhat of a delay in the release. We have presented to the committee in the past that we had hoped to have the health human resource plan released by March 31st. The reason for the delay at this stage is really some interesting work that's going on within the system around system planning. You may or may not be aware, but our lead-out initiative, of course you're aware of, is the surgical initiative that flowed directly from the Patient First Review, access being the number one issue.

But what came out crystal clear in the Patient First Review as well, and while they didn't use these words, primary health care — that first contact, those everyday services — were an area that was of high interest, high need. And the relationship with primary health providers was of high and utmost importance to the patients that we talked to.

What's important here is that you can't really develop an HHR [health human resources] plan, a health human resource plan, without understanding what the plan is for the system. And as we are working away, what we're realizing is the health human resource plan is more of a model or a modelling of the system than it is, here's the solid plan. So what we'd love to be able to do is every year update the health human resource plan to feed into it the new parameters for the health system as we move forward.

And I know that you're well aware of the emphasis on team and

the work that we need to do through team delivery within primary health care. That will change up the mix of providers. And also as we move to full scope of practice, a fuller scope of practice, modified scopes of practice, that will obviously influence that plan as well. So we are spending the next several weeks in dialogue, further dialogue with the system to allow ourselves to have the type of plan and framework that would be useful into the future.

Ms. Junor: — I want to go back to the physician recruiting because places like Wakaw who've lost their doctor and who have lost their acute and emergency services and places like Spiritwood and Big River and Shaunavon is cutting back on . . . they're turning away some people at the emergency on occasions and, I hear, now Watrous.

So the physician recruitment agency, I think there was some expectation from those communities that there would be some help coming. And like I said, I was in Wakaw at the town hall meeting when the announcements were made about the future of the hospital, and the Saskatoon Health District was quite front stage with the discussions and taking questions. The physician recruiter CEO, Ed Mantler, sat in the back of the room and said nothing.

And I think that people, even on the tour that Andy Iwanchuk and I took this past summer, expected something — if they even knew about it, which most of them didn't actually — but would have expected something more concrete from the physician recruitment agency than a bunch of meetings and all the things that you have detailed that they have done up to this point. Those communities are still, as far as I can tell and far as they can tell, basically are on their own to do the recruitment with incentives. And the latest one I've heard is Kindersley building their own clinic for doctors.

[21:45]

So the first one we actually saw was — not that this was the first one, but this was the first one I saw — was in Turtleford where there was a clinic owned by a municipal holding company that basically supplied a turnkey operation to doctors that they recruited. And that municipal holding company had a health levy on its constituents. Then from there on, we saw many iterations of that concept and have heard since that many communities are adopting this.

So down in the southwest corner, I think it was Coronach, they were very clear about telling us that rural Saskatchewan is paying twice for health care. They're having health levies; municipal tax is used for recruiting doctors, where people like most of us are getting our physicians and our health care through our just general revenue and our taxes that we pay to the GRF [General Revenue Fund].

So they're not seeing anything. And you really haven't told me that anybody has been hired by this agency for Wakaw or Spiritwood or Watrous or Big River or Shaunavon or any of the other — Leader — many of the other places that I could name that I visited that are, some are just on the brink of going to have to close their services. So as far as I can tell, this agency is going to do nothing for those communities other than coordinate perhaps.

But there is no money from the province. There is no tangible help. The communities still . . . And basically we're told, I know the member from Cannington at some public meeting told communities to start bidding. And basically then communities like Wakaw lost their doctors. Arcola bought them. And Arcola has the money to do that; Wakaw doesn't. And communities were also saying that very thing — we don't have the money to build a clinic and give all these incentives. So the physician recruitment agency, from what I can see, is not going to address any of those concerns that we saw.

Mr. Hendricks: — So as you may know, I'm the Chair of the board of the physician recruitment agency. And one of the very first things that we wanted to do as an agency was try and look at best practices in terms of recruiting and retaining physicians. We knew about all of the incentives being provided by communities, and quite frankly these incentives take away from the tax base that builds roads and does that sort of thing. So they do provide these incentives at some hardship to themselves, and it is very inequitable across communities in terms of the level of incentive being provided.

One thing that's clear though is that while you can provide a large recruitment incentive, that doesn't address retention. And so we've seen that even in those communities that did provide large lump sums of money to get physicians in there, they haven't stayed very long. And so what the agency has been focusing on is developing a statement about those types of practices that it believes are sustainable and that it will assist. And what we believe it is are group practices of four or five physicians. They don't necessarily have to be located in the same community, but they have to be in a group association — a virtual practice, so to speak.

And so we will work with those communities. In places like Big River and Spiritwood, the work that Ed Mantler has been doing out there and that I've actually been doing a bit too, is trying to get those communities to collaborate into something that is sustainable over a long term. Bringing a solo physician into Spiritwood has a very short life, and so we need to have communities working together to actually retain physicians over the longer period.

So will the physician recruitment agency address all of those? No it won't. In terms of physicians that it actually has recruited, one thing that I should mention is that actually the recruitment agency has let a contract with a recruiter to recruit 20 physicians into areas of immediate need. Now those areas would have to actually demonstrate that they're working in some sort of collaborative practice.

But to think that this is going to be, that the physician recruitment agency is going to start recruiting solo physicians into communities, I don't think that that's its priority. Its priority should be focusing on those central communities that are going to be sustainable into the future. Because the worst thing that we can do is recruit physicians into a lifestyle that they can't, that they're not happy in and that they burn out in and that they leave quite frankly, and we have another disruption of service.

Hon. Mr. McMorris: — I think also it's extremely important to know that communities are offering incentives for physicians

to come and, as Max said, no guarantee on retention. And some communities are building clinics, and some communities do a number of things to try and attract physicians. This is in no way anything new. This has been going on for years. For example: Assiniboia back in 1997 put up $100,000 for a doctor; Central Butte offered a house and a car in the '90s; Stoughton, a free clinic in the '90s; Gainsborough, Oxbow, cars and clinics, houses. This has been done for many, many years. I think the implication was that it's just recently happening and people in rural Saskatchewan are paying twice.

If that is the attitude that . . . It certainly has been the situation in many rural communities for many, many years. What I would say the difference is between the year 2011 and the 1990s is the government realizes this is not acceptable. The government has put a physician recruitment strategy in place. They've put a physician recruitment agency in place. They've increased the number of seats in the College of Medicine. They've increased the number of seats for residency positions. We have taken a number of steps in three years to try and alleviate some of these practices that communities are falling into that stem from years and years of a College of Medicine that simply was just not anywhere close to meeting the needs of our province.

We in Saskatchewan rely higher than any other province in Canada on internationally medically trained grads. That being said, we're going to continue; they've offered great service. But sometimes it hasn't worked out very well where you get a physician in, they take the incentive, and then they move on as soon as that incentive is over.

And Spiritwood is one of those communities that under, you know, back through the '90s they offered, I believe it was $50,000 for a husband and wife to come to the community. Part of the agreement was that they would take call. After about a year or two and the $50,000 was spent, the husband and wife didn't want to take call anymore and hence the hospital was no longer able to function. So it's extremely important that the committee knows that this isn't a recent phenomenon. This has been going on for decades in this province.

The only difference is that starting in 2007, I believe, things were taken seriously and policies and government funding was put in place to try and start to address the problem. Fixing the problem isn't done in two years or three years or five years, but there are more physicians practising today in Saskatchewan than ever before. Far more work to do.

And it is a supply and demand issue. When the supply is short, the demand is high. And communities would do whatever they can do to muster, whether it's a clinic, a car, a house, or pure cash, to entice them to their communities. What we're working on is trying to work to alleviate some of that shortage by increasing, again, the College of Medicine, the residency positions and attracting physicians from other jurisdictions that will fit a community so we don't have the turnover that we've seen in years and years.

Ms. Junor: — I don't think any of the communities that Andy and I visited expected to have a solo practice start up or continue in their communities. They didn't expect to have no help. And you may say that this has been going on for quite a while, and it has come and has ebbed and flowed because I've been there and seen communities that have lost their services and then got them back. But what is different is that there has been a promise to fix it, and in three and a half years it isn't fixed. And the people in Wakaw are saying that and the people in Spiritwood are saying that and the people in Big River are saying that. People in Watrous are saying it, the people in Leader are saying it. Everybody is saying it. And when they told us that they are paying twice for health care, it isn't something I suggested to them. It was a comment from a reeve in Coronach that this is what's happening.

Other communities told us quite clearly that they are on their own to do this. So I don't know how you can suggest that you have changed anything. The physician recruitment agency, if you have an agency that doesn't produce anything, if you have increased seats and don't retain any more doctors, and if you don't have anything that actually produces a doctor or a practice in a community, then all the stuff you talk about really doesn't mean much.

What means something to these communities is to get their hospital open because what happens in Wakaw affects Saskatoon. And one person stood up in Wakaw and said her aunt in Saskatoon cannot get a doctor to see her in Saskatoon. And the, I don't know, 1,000 people in Wakaw — I'm not sure how many people live there — they will now have nobody to go to. So they're all going to have to migrate to some other community, and some of it will be in Saskatoon where they already can't get a doctor. So what happens in one small community impacts a lot of other communities.

As you saw in Wawota, that happens to affect Moosomin and Broadview. And when emergency backed up in Regina, then people wonder, you know, what causes this. Is it a flu, big flu epidemic, or whatever? It's people in long-term care taking up acute care beds. It's no mental health services, and it's closure of hospitals in rural Saskatchewan. So people are coming to bigger centres. It's cause and effect. And it is something that you haven't done anything to fix. You've said a lot of things but you haven't done anything. It hasn't resulted in any of these communities that I saw that can tell me that has made a difference. And it has a lot of words for promise but no delivery.

Hon. Mr. McMorris: — Well thank you, Mr. Chair. I find that pretty rich coming from a party that closed 52 hospitals in rural Saskatchewan. You know, to say that the closure of Wakaw because they aren't able to find physicians, and we're going to work hard to ensure that we do. But it was intentional to close 52 hospitals and the hundreds of health care workers that left the province because those facilities were closed, not to mention closing the Plains hospital as well — huge impact in rural Saskatchewan. I don't think I need to take any lessons from you as far as the impact that has had in rural Saskatchewan, especially the Plains closure for southern Saskatchewan. It was the previous government that decided to close that and try to redevelop the General Hospital with its issues around parking and everything else. We're paying for it now, and we'll continue to pay for it into the future.

But you know, I guess we could have continued on like things were in 2005 where the College of Medicine or 2004 when the

College of Medicine was under probation and the fact that we may lose the College of Medicine here in Saskatchewan being the only province in Canada other than PEI [Prince Edward Island], I believe, that doesn't have a college of medicine.

Thank heavens that didn't happen. We've put money into the integrated health facility in Saskatoon to ensure that never happens under our watch especially. We've increased the number of seats. That wouldn't have happened under the previous government. We've increased the number of residency positions. That wouldn't have happened under the previous government. To say that we have done nothing in three and a half years quite frankly is absolutely incorrect.

I have said from the outset that this problem has been stemming in the province for a very long time. It can't be solved in three years. But the steps to make things better in the next 5 and 10 years are under way. To ensure that we have more Saskatchewan students graduating from the College of Medicine and more residents graduating from residency positions in order to fill spots in our province is definitely the goal as we move forward. It takes not one year or two years to train a doctor. It takes seven years to train a doctor. What we are seeding now, we will harvest down the road.

If we were to have had 100 medical seats ten years ago and 120 residency positions 10 years ago, the benefits in this province would have been significant. Unfortunately the foresight was not there to do it at that time. But I, we can tell you that the foresight is there now, so we can reap the benefits into the future.

As far as facilities and the impact in rural Saskatchewan, absolutely. And that's why it is so important that we work as community of communities and not a community as an individual that will attract a single- or a solo-practice physician. It needs to be a community of communities that work together on a primary health care team. There are examples around this province that that is being very effective. We need to spread that. We need to do more work on that, absolutely. But that is the way of the future, and we are well on track to seeing those results in the future.

[22:00]

Ms. Junor: — So if we're going to have a history lesson, then let's go back to the '90s and look at why those 52 hospitals were converted. Because this province got a debt and deficit that was almost bankrupting the province, so those decisions were necessary to save the province. And that was by a Conservative government — Grant Devine's, to be specific.

So what we were left with were major, major tough decisions. I visited many of those 52 sites. Many of them, I think almost all of them, are now health centres or special care homes. And I have never, in all the times I have heard the minister stand up and talk about the 52 hospitals closing, suggest that he has a plan to reopen any of them.

And on my tour I had only — of the 75 facilities and many, many community meetings where hundreds and hundreds and hundreds of people were there, including places where I was asked to speak — two, two people mentioned to me it was you that closed this place. One was Neilburg; one was Kamsack.

Any place else was interested in, what are we doing today and tomorrow for those communities? So to go back and talk about, we closed the 52 hospitals or we did whatever, it doesn't matter to those people any more. It matters to them today why they don't have a hospital in Wakaw and why they don't have a hospital in Leader and why they don't have a hospital in Spiritwood or Big River. It matters to them about that. And when you go and your 16 years, it doesn't matter to people. What they want to know is what you are doing today for them so that their tomorrow will be better.

Hon. Mr. McMorris: — Well you know, the communities that you've closed 52 hospitals in have got past that. They've adjusted. I can tell you that I hear on a regular basis the issue around the Plains closure.

You cited a few hospitals that were closed. You said at Leader. That's not the case. They will be . . . Physicians are there and soon to be fully functioning. And as you said, and I'll use your words, there's an ebb and flow where there are doctors that will come and leave. There is an ebb and flow. Just prior to the two thousand and . . . election, you could've gone around and named a whole pile of emergency rooms that were closed in rural facilities. Doctors will come, and those facilities will be up and running.

But what I can tell you is that if we would have remained with the U of S complement of health care professionals the way it was; if we would have remained with the fact that you don't want to set targets for nurses because you'd never meet them . . . If you would've looked at the number of training seats for nurses, which has increased by 300 up to 700 now — that has been done in the three years — the future looks much brighter as we move forward after 2007 than it ever did before 2007.

Mr. Nilson: — I'd like to make a comment here. I've been listening carefully to what the minister has said, and I have the action plan that was set out 10 years ago as to what was going to happen in the province. And I don't think I've heard anything tonight that wasn't in that action plan as part of the long-term goal. And I know that many of the people in the department who were here will acknowledge that this was the long-term goal.

And what is absolutely useless in this situation is where the minister, every time he can't get an answer, he flips into this 16 years, 52 hospitals kind of conversation. And we have heard it about once a week for three years. And what everybody in the province wants, what the people who work within the health system want, is somebody who will say, okay, we're going forward; we're building on the things that are there.

The 84 seats at the medical school — I'm not sure what the number is right now; I think it's 84 going up to 100 — that was part of the plan three or four years ago before the new government was there. So you're following through on that. You go through and you look at the health human resources plan. It's the basis of where we're going. And frankly it basically, you know, is accomplished as you get the resources each year, both the human people to actually organize it and the dollars. But what is absolutely not of help is when the minister

flips into this kind of rant almost and doesn't acknowledge that this is part of a long-term plan within the province.

Now the primary care discussions around working with the physicians, this is something that's very clearly in the 10-year-ago plan. And we're moving there. You go and look at all of the health projects that have come, the most recent one Friday in Humboldt. That was all part of the budget before this minister showed up.

But I think what everybody would like, and I know that I would like, but more importantly the citizens of the province would like, is somebody who says, okay, I'm working, I'm building, I'm going forward.

Now one of the things that was included in the plan was going to be a review of where we were at. Well that's the Patient First Review and it provides some very good insights which were to assist this. And there can be chuckling from members opposite, but practically the name you might have come up with, but the fact that there was going to be review was part of the long-term plan.

So, Mr. Chair, I think that it'll be to an advantage of everybody if we look at where are we going, how are we going to provide the best care for the people in the province, how are we going to use the very good work that everybody did to set out a long-term plan, and how do we make sure that where we get to 10 years from now is something that we can all be proud of? Because I know that the people within the health system are proud of the work that people have done over the last number of years.

The Chair: — Mr. Nilson, thank you for your comments. I do believe the minister from my own judgment was going down that road. Ms. Junor opened up the comments with commenting on a closure of a hospital. So I'll just entertain the minister to answer and continue on with questioning.

Hon. Mr. McMorris: — It's interesting. After two and a quarter hours, I think I mentioned 52 hospitals once, and you would like to say that that's what this conversation's about. Not at all. You like to talk about the 10-year plan that under your government was set out. And it was a good 10-year plan, but a plan is only effective if it's implemented. And that's what our government has done. And if you want to try and take credit for some of things that we've implemented, that is perfectly fine. Increasing the number of seats is what needs to be done and is being done.

I don't understand the cynicism then that comes from the members opposite. If we are following through on the plan that your government set out, I would think that there would be some positive feedback. Not once have I heard a positive feedback that we've increased the number of seats, that we've increased the number of residency positions, that we're working on primary health care delivery in rural Saskatchewan and across the province.

If we're following through with your plan — and that's fine with me because if it's going to mean better health care and a Patient First Review that was part of your plan, I'm fully accepting of giving you the credit — then why the cynicism which is all we get from the members opposite?

Mr. Nilson: — Well I appreciate your comment. I don't know if I've ever heard that before in the three years that are here. All I know is that yesterday when you couldn't answer a question, you flipped into the 16 years kind of rhetoric. But I agree, I agree with you. In question period. In question . . .

Hon. Mr. McMorris: — It was Sunday yesterday, John.

Mr. Nilson: — Well or then last Thursday. Yes, well the last question period. But I guess what the point I want to make is that the public appreciates work that's done in a positive fashion. And I'd have to say that I'm pleased that many of the initiatives have been continued and developed and the resources have been put there, and I think I've said that to you before. And I've said, you know, the positive thing is that you continue with the plan.

And I know that I have said that before, but what I also recognize is that there has to be continual discussion around where we go and what we do. And the important part of a budget is to understand where the resources are. And I know that last year it was extremely frustrating for everybody with the budget where basically half the increase that was needed was received. Fortunately there was some more money that came in but there has been some real challenges.

Now the frustration relates to a lot of the workers who feel like they're not being valued in the system as the bargaining goes forward. And I hope that gets resolved soon because otherwise we're going to have a lot more difficulty. But the important part I think of any system is to acknowledge that you build on the work of people who've come previously, and there are too many times where there's, like I say, this flip into a standard response.

The Chair: — Thanks for your comments, Mr. Nilson. Ms. Junor.

Ms. Junor: — Well I'm kind of surprised that the minister has forgotten the role of opposition. I'm not here to be your cheerleader. I'm here to ask questions that I hear from people that either they send them to me, they phone them in, I see them as I visit. I'm not here to say rah-rah to you and pat you on the back. That's not my job, and it wasn't your job when you were the critic. And I don't remember ever getting that from you. So I'm surprised that you think that I should be doing it.

So the questions I ask, I try to present them in a fairly professional manner. I've taken some personal insults from you about my previous work and that I should know all these things because I was SUN president. I've ignored all that and I continue to try to ask questions that I think are relevant, especially budget questions, money questions, questions that people bring up about their personal circumstances. I continue to bring those up. And that's what I think my job is to do. And people do want to have an opposition that can do that. So I don't think anybody expects a lot of praise and compliments to be flowing around here. I've never seen that when you were the critic so I'm not sure why it should happen now. It's hard to take criticism. I remember being there. But that's your job.

So I think I have several more questions that I think we might as well get to. When we're talking about places and in particular when the deputy was talking about primary health teams, when I was in Big River there was a concern raised about nurse practitioners who cannot practise in Big River using their credentials the same way they do, or their competencies the same way they do 40 miles north or 40 degrees north. There's a line that somehow prevents them from practising to the full range of their competencies, and it's something that we have put in. It's an artificial line. And that they can do more in the North than they can do in the South.

And in Biggar they would have certainly seen a better level of service from the nurse practitioner if we would fix that, or you would fix it now. Do you have any intention of doing that?

[22:15]

Mr. Florizone: — The short answer is yes. We do want to move to a place where all team members work to the top of their licence. And in fact what you will see is that we've been making some moves with a number of different providers to allow them to move their scope of practice even further. So pharmacists would be a good example in terms of some of the early days, by way of prescribing, and we hope to be able to do the same with nurse practitioners.

Now just to be clear, the difference between the North and the South isn't that their scope is different. It's the same. But we've been operating in a different way in the North and what we need to do is — and it's probably been more by circumstance than it has been by any legislative or regulatory difference — what we need to do is make sure that we're permissive both by way of legislation, regulation, standards, but operations as well.

So our intent is to continue to move there. I have to say, and this is where ten years of credit needs to go. The nurse practitioners have been very well received in both northern and rural Saskatchewan. And if anything, they've been the newest of the care team to be able to deliver that real, everyday service to folks along with some highly specialized nursing skills.

Ms. Junor: — So the answer to the Big River question, can you fix that fairly quickly?

Mr. Florizone: — I just have to figure out what we're fixing, what it is that we're needing. Did you have a specific ask on what it is that you would like to see nurse practitioners do?

Ms. Junor: — I'm trying to remember if the nurse practitioner couldn't do something that her counterpart 40 miles to the North could do and that patient had to be transported to Shellbrook.

Mr. Florizone: — [Inaudible] . . . who is our principal nurse advisor, Lynn Digney Davis, would be pleased to speak with that nurse practitioner. So if you'd like to just share that with her or him, whoever it is, we'd be pleased to sort that out. Maybe this is something that could be a very quick win for both.

Ms. Junor: — Yes, I think that Big River would be quite happy to see that, because they were very frustrated with this difference of practice, ability to practice. I have a . . . We only have a few more minutes left, so before I actually leave sort of general budget questions, the Health budget as presented here in the book has no line or no consideration for upcoming contract settlements with PAIRS and Health Sciences. That would come after in a special warrant or supplementary estimates or whatever. So this budget shows nothing . . . The health districts' allocation of money, their increase of 9 per cent, does that presume the settlement of the contracts or does . . .

Mr. Florizone: — Well as you're aware, we would never profile in that way. There is something built in. I'm less than specific on it. But if we do end up with a settlement, if and when, we'll have to sort that out. So we'll either fund it within existing budget or be back to the legislature.

Ms. Junor: — Thank you. On page 90 of the vote, transfers for public services have gone up considerably — 82 million by my mathletics. Can you tell me what that is, what that line means? What those are for?

Hon. Mr. McMorris: — Perhaps you could be more specific. We're not quite sure where you're . . .

Ms. Junor: — Page 90.

Hon. Mr. McMorris: — Page 90 . . .

Ms. Junor: — Of the vote, of the budget book. Of the vote.

Hon. Mr. McMorris: — Which subvote?

Ms. Junor: — It's classification by type it says . . . [inaudible interjection] . . . No, here. Classifications by type under medical services and medical for (HE06).

Hon. Mr. McMorris: — I guess what I'd say is that number is, it encompasses a lot of different things including out-of-province services, expansion of physician training seats, and there's some other agreement costs, utilization. It covers a number of different aspects.

Ms. Junor: — So in my page it shows all of the allocations under optometric, dental, out-of-province, but then it's displayed in a little box like this that seems odd. That's what I'm wondering. Why is it displayed like that? It's just different from . . . Well it's hard to read the totals. It's just the total of all these allocations above. That's what it is, right? It's just displayed different. Okay.

I have one question about the surgery centres, and I probably have more questions than one, but I'm only going to probably get one right now. The RFP [request for proposal] that went out, what's the status of that for the surgical centres, for the surgeries performed in the private sector?

Hon. Mr. McMorris: — The RFP date for closure has passed. The health regions have received interest. The health regions right now are working through those expressions of interest or tenders, and we have heard nothing from the health regions as far as any decisions that they have made yet that is yet to come.

Ms. Junor: — Can you tell me if any of the responses have

been from out of the country?

Hon. Mr. McMorris: — You know, we won't disclose where the tenders are from or how many tenders they receive. That is the health region's responsibility. But I think it's pretty general that that information is not disclosed.

Ms. Junor: — Ever? Like you can't get at it through the health district in any way either?

Mr. Florizone: — I think it would be fair to say that once the decision is rendered, there'd be full disclosure on that particular submission.

Ms. Junor: — So was it . . . Would the intent when the request for proposals went out that it would be a wide competition so that there would be no . . . you would entertain out-of-country proposals?

Mr. Florizone: — I wouldn't suggest that would have been our intent. But it certainly was our intent, given the agreement on internal trade and other trade provisions, that it be a cross-Canada tender. So I honestly couldn't speak to, even if I . . . I don't know, but even if I did know, I couldn't say where the particular tenders are from. But most certainly the minimum standard with such tenders would be across Canada.

Ms. Junor: — And you think that once the vendor is chosen, then it would be . . . you could ask the question and have that disclosed.

Mr. Florizone: — Well not all the tenders, but the tender that's awarded . . .

Ms. Junor: — The successful tender.

Mr. Florizone: — The successful one, absolutely. Yes.

Ms. Junor: — Whoever it is. Yes.

Mr. Florizone: — Yes.

Ms. Junor: — All right. I do have many other topics. I hesitate to get into them at five minutes left, but maybe I could just start one, which is the paramedics who have come to the legislature and talked about their issues, in particular in Saskatoon. And it leads to the recommendations of the report, the EMS [emergency medical services] report that was commissioned by this minister. And the report was presented in 2008 with recommendations — I think there's 19 of them — none of which, I understand, have been implemented. Could you speak to that from your . . . In your opinion, are any of them in the works or being worked on?

Hon. Mr. McMorris: — There have been a few recommendations that we've implemented. The main one is the mobile health services committee that has been struck and will be meeting. That is kind of the precursor to all the recommendations, but it has been struck and will be meeting soon.

But having said that, some of the other recommendations have been followed through. It talks about a couple of pilot projects. One is under way in the Eastend area where the EMT [emergency medical technician] is more integrated within the delivery of health care in that area. Not just manning, for example, the ambulance, but more integrated into the delivery of health care. Another pilot project we hope to be starting soon.

Also it talked about fees. It talked a lot about inter-hospital transfers. That hasn't been moved on, but it also talked about other fees and so that was changed, that increase in fees of $25, for all but the senior program.

The majority of the costs, when we increase fees like that, are borne by the provincial government or by insurance companies. But I know as a provincial government because, you know, of the senior subsidy, a large portion of those costs are borne by the provincial government. So some of the recommendations have been followed through on, but most of them will be contingent on the mobile health services committee doing its work and charting the course for the future.

Ms. Junor: — What recommendation was that, the mobile whatever you're talking about? Is that no. 16?

Hon. Mr. McMorris: — I don't have the report in front of me. I don't have the exact number of the recommendation. It's no. 2? Okay. It's no. 2.

[Interjections]

Ms. Junor: — Oh yes, let's not go there again. You lost on that one. Can you give us an update on the recommendations by number? Is there a way that you could do that? I think it would be useful to the paramedics who are interested in this, following the recommendation, since they're a year and a half old. Could we maybe have an update on . . . You've mentioned several of them offhand. Could you maybe do a . . .

Hon. Mr. McMorris: — We could probably do a bit of a written report as to where we are on the recommendations, and how many. As I said, most are contingent on no. 2. And as we move forward on no. 2, most of the other recommendations kind of fall into place. But we can give you a bit of a written report as to the progress that has taken place since the report has been received by government.

Ms. Junor: — Thank you.

The Chair: — Well seeing as it's 10:29, our appointed hour of wrapping up this committee meeting for this Monday night, I'll just take this opportunity to thank committee members for sitting these long hours today, and the minister and his officials and everybody at home that tuned in. Look forward to seeing them next Monday night. Mr. Minister, any closing comments.

Hon. Mr. McMorris: — Just in closing, I want to thank my officials for the great work that they do all year long including the three and a half hours that they've been able to enjoy here tonight.

The Chair: — Thank you, Minister McMorris. And Ms. Junor, you have some closing comments.

Ms. Junor: — I want to thank the minister and his officials too. I'm not sure if we enjoyed all three and a half hours of it, but for the most part. And I look forward to, I think we have five or four and a half more hours to similarly enjoy. Thank you.

The Chair: — Thank you, Ms. Junor. I'll now entertain a motion to adjourn the committee. Ms. Eagles. This committee stands adjourned until the next call of the Chair.

[The committee adjourned at 22:30.]