STANDING COMMITTEE ON HUMAN SERVICES

Hansard Verbatim Report

No. 6 – April 26, 2012

Legislative Assembly of Saskatchewan

Twenty-seventh Legislature

STANDING COMMITTEE ON HUMAN SERVICES

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Published under the authority of The Honourable Dan D'Autremont, Speaker

[The committee met at 13:15.]

The Chair: — Good afternoon, ladies and gentlemen, and welcome to the Standing Committee on Human Services. Due to prior engagements, we're going to be adjourning this meeting at 4:15 today, so that's our time frame. And welcome, and we're going to introduce the members. I'm Delbert Kirsch; I'm the Chair. Mr. Cam Broten is Deputy Chair. Also on the committee is Mr. Mark Docherty, Doreen Eagles, Greg Lawrence, Russ Marchuk, and substituting is Mr. Warren Steinley.

This afternoon the committee will be considering the estimates of the Ministry of Health. Before we begin, I would like to remind the officials to introduce themselves when they speak for the purposes of Hansard.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We will now begin our consideration of vote 32, Health, central management and services, subvote (HE01). Minister McMorris is here with his officials. Minister McMorris, would you please introduce your officials and make your opening remarks.

Hon. Mr. McMorris: — Thank you, Mr. Chair, and thank you to the committee members. It's always a privilege to be here on hour number one, but it's actually even a bigger privilege when you're on hour number eight when you're getting closer to the end.

But I have a number of officials with me today to help me go through the budget and answer any questions that maybe arise from my opening remarks or anything else that's in the budget documents.

Of course I have a number of officials, as I said, with me. To my left is Dan Florizone who's the deputy minister of Health; and to my right is Max Hendricks, the associate deputy minister. Over my left shoulder is Laurie Pushor, my chief of staff; and also over my left shoulder is Lindell Veitch who also works in my minister's office. Over my right shoulder to the furthest right is Lauren Donnelly who is the assistance deputy minister; and also to her left would be Brenda Russell who is the director of finance services branch.

As I said there are a number of officials who will be here to assist me and as they approach the mic or questions that are directed into their area, they'll try to remember to have them identify themselves as we go through the next number of hours.

I do have a number of comments to make, a bit of an extended comment because of the size of the budget. And so as a result, I do have a number of things that I want to identify and highlight as we go through. So bear with me as I go through my opening remarks.

As I have said many times, our government is focused on putting patients and families first. That is the drive behind everything that we do. A big part of that is ensuring that people have access to timely and quality health care. Our triple aim is better care, better value, and better health, with the help of better teams. To get there we are transforming the health care system in this province. We are setting bold targets and testing innovative concepts. We have embraced concepts like lean and continuous quality improvement.

We are empowering health professionals and patients throughout the system to make changes that improve the quality of service provided while helping to control costs and ensure sustainability. We have made strategic choices, some of them difficult, in an effort to ensure that our system is viable into the future. Ultimately it's about bringing better care, better value, and ultimately, better health for the people of Saskatchewan.

The Ministry of Health's budget is a reflection of our government's focus on improving access to health services. It also lays the foundation for the work the ministry will be doing over the next five years. Last year, you may recall the theme of the provincial budget was *The Saskatchewan Advantage*. This year the theme is, keeping Saskatchewan's advantage.

As you know, Health represents the largest portion of the provincial spending across Canada, and that remains the case in Saskatchewan as our ministry accounts for over 40 per cent of the total budget expenditures. In dollar figures that amounts to $4.68 billion which is, for Health, a modest increase of 4.9 per cent from last year.

We have slowed the rate of year-over-year growth. Last year the increase was 6.2 per cent, but that is still an increased investment of $218 million this year. Most of the increased investment — 186.7 million — is attributable to growth in costs of operating base programs such as salaries for those working in the health care sector, drugs, and medical costs. Approximately 77.5 million is due to new initiatives, programs, and service enhancement. Finally we're spending just over 23.5 million to construct new facilities, maintain existing ones, and provide medical equipment.

Now you're probably doing the math in your head and saying that sounds like it adds up to more than 218 million, and you're right. We're also finding $70 million in savings through efficiencies in various programs, services, and administration. You can attribute that to the better value from the triple aim. When you factor in those savings, you're left with an additional increase, investment of $218 million.

Before we go into more detail around the budget numbers, I will also give you a very high-level overview of where the Health dollars are going. Of Health's total — 4.68 billion in the 2012-13 expense budget — our biggest investment is in the people who work in the health care system. Seventy-one per cent or 3.33 billion of all health care spending pays for physicians, nurses, and a wide number of people working in health care. These are the people who keep our system functioning around the clock, 365 days a year.

Another significant proportion of our investment pays for drugs, medical, surgical, and laboratory supplies. This accounts for 15

per cent of the total health budget or $716 million. The total includes drugs and supplies used by regional health authorities, the Saskatchewan Cancer Agency, the Saskatchewan Disease Control Laboratory, Canadian Blood Services, immunization programs, the provincial drug plan, and the Saskatchewan Aids to Independent Living program or SAIL.

Thirteen per cent or 609 million funds other general operating costs incurred by the ministry and its partners in health care delivery. This category also includes the four out-of-province medical services, extended benefit plan, air ambulance services, and the senior citizens' ambulance assistance program. A large portion of the total health care budget flows through the regional health authorities, as they are responsible for the day-to-day delivery of health care services in our province. The province's regional health authorities are receiving $2.9 billion in this 2012-13 budget, an increase of $98 million over last year. I would now like to highlight some of the key investments contained in this year's budget.

The Saskatchewan surgical initiative. A major one is our $60.5 million investment in the Saskatchewan surgical care initiative. I spoke about ambitious goals earlier, and I don't think there are any that are more ambitious or that we are more committed to than our government's commitment to reducing surgical wait times. By 2014 our goal is that all surgical patients will have their surgery offered to them within three months. It was a key outcome of the Patient First Review, and we are now two years into the surgical care initiative. Our first two years as a surgical initiative focused on serving the long waiters and really targeting the lists of people waiting more than 18 months and people waiting longer than 12 months.

We are doing more surgeries and we are improving the quality and efficiencies of surgical care. And people are getting surgeries sooner. The latest data, updated on February 29th of 2012, show that 96 per cent of patients now receive their surgery within 12 months of the booking for surgery, and 88 per cent receive it within six months. In 7 out of 10 health regions that perform surgery, all procedures were performed within the 12-month target. Since 2007 the number of patients waiting more than 18 months decreased by 91 per cent, and the number waiting over 12 months decreased by 80 per cent. The number waiting more than six months also has dropped by 56 per cent. That is amazing progress, but there is still lots of work to do in order to reach the 2014 target of having no patient wait longer than 3 months for surgery.

The 60.5 million we are investing this year in the Saskatchewan surgical care initiative is over and above surgical funding that health regions receive in their base budgets. The funding will help health regions complete 4,380 more surgeries this year, compared to our projected total of 2011-12. That's 8,000 more surgeries or 10 per cent more than the 2009-10, the year before the Saskatchewan surgical care initiative began. Other planned expenditures include lab services, staff training, quality improvement and safety initiatives, home care services, and rehabilitation services. Because this important initiative is not just about sooner; it's about safer and smarter care.

Saskatchewan is making surgical care safer for patients. Health regions are working towards universal implementation of the surgical care, surgical safety checklists in all hospital operating rooms. These checklists save lives, reduce complications, and significantly improve patient safety. Surgical care is also getting smarter through innovative measures like patient pathways which are being utilized in several specialty areas.

Patients considering hip or knee replacement surgery are referred to a multi-disciplinary clinic where they are assessed, prepared for surgery, and educated about what is expected after surgery. The clinic also helps identify patients who may not need surgery. This helps shorten the wait to see a specialist and improves preparation for surgery. We will continue to pursue greater efficiencies of care through the clinical practice redesign and pooled referral initiatives.

In the coming year we also will be supporting work with the physicians and other partners to ensure patients are receiving the most appropriate care. When we talk about the better part of the triple aim, the Saskatchewan surgical initiative is a big part, a big part of that.

The improvements in access to cancer treatment that we've seen will continue to be seen. It's another example of better care. Cancer care is one of our highest priorities. Statistics tell us that more than four out of every 10 people will develop cancer within their lifetime. We want to give Saskatchewan people access to the best cancer care available anywhere. The province's budget underscores that commitment. We're providing $138.8 million in funding to the Saskatchewan Cancer Agency this year. Over the term of our government, the agency's budget has increased by 76 per cent with an additional 16.9 million provided this year. Part of that will be providing an expanded colorectal screening program, providing early detection tools and thereby supporting early treatment and improved patient outcomes. Colorectal cancer kills about 270 people in Saskatchewan every year, but it's highly treatable if caught early.

The screening program for colorectal cancer program uses a simple test that helps detect colorectal cancer in the early stages. It is mailed to residents between the ages of 50 and 74 to use in the privacy of their own home. People at risk for colorectal cancer can be treated quickly and avoid future, more invasive cancer treatments. We appreciate the leadership of the Saskatchewan Cancer Agency and the support of the health regions in expanding this screening program.

When we talk about improving access to care, the Cancer Agency has accomplished a lot. The numbers don't lie. Two years ago there were 495 people waiting for their first appointment with a medical oncologist. Despite a growing number of new patients, there's been an approximately a 49 per cent decrease in patient waits for first appointment with medical oncologists. More importantly, over the past two years the number of days a patient waits between referral and first appointment with a medical oncologist has been reduced from 155 to 55 days, significantly improving . . . Significant improvement has been achieved, but improvements will continue to be made.

Primary health care. We are investing $5.5 million to test new models and strengthen existing services, both intended to improve access to primary health care. Primary health care makes better use of a full range of health care professionals

working to their full scope of practice, with a physician as a key team member. As you may know, the Patient First Review called for changes to primary health care. Strengthening primary health care is a key priority for our health system's leaders and providers. The money we are investing this year will increase access to primary health care, improve the patient's experience with the health care system, make and keep Saskatchewan people healthier, and be stable and sustainable into the future.

[13:30]

We are going to be testing new approaches to primary health care in a number of innovative sites across the province. These approaches could employ new uses of technology that would allow patients to remotely consult with doctors or nurse practitioners via phone, email, or Skype. Another innovative approach is looking at new roles and new ways to use health professionals to create the best teams as we referred to in our triple aim. This includes enhancing roles of pharmacists, paramedics, or emergency medical technicians, the introduction of nurse care managers, and the integrating mental health and public health services into primary health care teams. This is not going to be a one-size-fits-all solution. We are involving communities and giving them a voice in the design of the delivery of health services and supports needed to best address local needs.

The locum pool. Another election promise commitment was to implement a rural physician locum pool to support access to physician care. In addition to the existing short-term locum pool operated by the Saskatchewan Medical Association, people in rural Saskatchewan need safe, consistent, and appropriate access to care. We've all seen how disruptive it can be for a community when the local doctor is on vacation or away from his or her practice. There is $1.5 million in this year's budget that will go towards developing that locum pool. My ministry is working with stakeholders including the SMA [Saskatchewan Medical Association] and regional health authorities to make this a reality. Having a resource like a locum pool will also assist in attracting and retaining physicians in rural Saskatchewan. Again it all comes back to improved access, improving or better care.

Diabetes support. While we work to ensure the needs of acute patients are addressed, we must also make sure we maintain a focus on issues like chronic illness. One of the chronic diseases that is a significant concern to Saskatchewan is diabetes. It is estimated that approximately 75,000 in Saskatchewan have been diagnosed with either type 1 or type 2 diabetes. Of this number approximately 10 per cent have type 1 diabetes. An incremental $2.5 million has been included in Health's 2012-13 budget to meet the election commitment to provide more support for people with diabetes. These monies support enhancement to the drug plan which adds long-acting forms of insulin to the formulary. That change also was effective December 6th, 2011. We've also expanded the children's insulin pump program to people 25 years of age and under. That change was effective January 1st, 2012. Both of these changes were welcomed by the Canadian Diabetes Association.

STARS [Shock Trauma Air Rescue Society]. As we know, there are times when trauma occurs and medical treatment of a more critical nature is needed urgently. We are proud to add STARS helicopter program to our EMS [emergency medical services] service in Saskatchewan. The Health budget includes an incremental $5.5 million in funding for the STARS helicopter program, bringing the total amount to $10.5 million. This service will focus on care and transport of critically ill or injured patients in rural and remote areas of the province. We're very excited about the improvements in service and the capabilities that will result in having STARS added to our existing EMS team of ground ambulance and fixed-wing Saskatchewan air ambulance services. Helicopters will be based in Regina and Saskatoon, and the Regina-based service is scheduled to begin operation April 30th.

Capital investments. This Health budget also contains a significant investment in health capital infrastructure. We are investing in facilities and equipment, improvements for the benefit of patients and staff of health facilities across the province. Work continues on the long-term care facilities as well as the innovative projects — in Saskatoon, the children's hospital; North Battleford, the provincial hospital; and the new hospital in Moose Jaw.

Savings. I've talked a lot about what we're spending in this year's budget, but I should also talk about where we'll be saving. This year's Health budget echoes what the Premier and Finance minister have been talking about when they say, austerity and prosperity. As I mentioned earlier, Health represents over 40 per cent of the total expense budget in Saskatchewan, and these numbers are not going down. If we want meaningful spending restraint as a government, then we must find a way to keep the growth under control and sustainable. There are a number of ways we are going to be doing that.

Regional health authority efficiencies. Regional health authorities and the Saskatchewan Cancer Agency will be expected to find $48 million in savings. Changes may result in reconfiguration of some services but will not compromise patient care. There will, however, be better value for our investment in the health care system. Approximately 30.2 million in savings will come from administration efficiencies, supply savings, and services redesign, and again do not adversely impact patient care. Another 7.2 million will come from attendance management, which will reduce the costs of overtime, premium pay, sick time productivity losses, and workplace injuries. Shared services will account for savings of approximately $7 million through coordination of purchasing and services across the region.

The Ministry of Health. We're not just putting these expectations on the regions. The ministry is also finding savings through efficiencies and elimination of waste. The ministry continues to lead efforts in advancing lean in the health system to eliminate waste and create better value for people we serve — patients, families, residents, clients, and providers. Through the adoption of lean, Saskatchewan has an opportunity to revitalize health care and to be a leader in Canada and around the world. The results have meant better service and better value for the people of Saskatchewan.

Drug plan cap changes. With every budget, tough choices have to be made. This budget was no different. One of those tough

choices was to increase the cap on the senior and children drug plan by $5 per prescription to $20. This will result in $10 million in savings to the government. This was not a decision that was made lightly, but this change will help us to ensure that the future viability of the senior and children's drug plan continues. The cap has not been increased since 2007 when the program was introduced, even as government's drug costs have risen.

The senior drug plan began five years ago. When the program began, the government's share of the cost of prescriptions represented just over half of the total prescription costs, 55 per cent. Seniors paid the remaining 45 per cent. This has changed over the past five years to the point where the government's share had risen to three-quarters or 75 per cent of individual . . . with the individual contributing one-quarter or 25 per cent. With the increase from $15 to $20, seniors will pay approximately one-third or 33 per cent of the cost of their medication. The number of prescriptions for seniors is increasing, almost a 20 per cent increase over the past five years. We expect that the number of prescriptions will continue to increase as our population ages. The number of seniors eligible for coverage will also continue to increase.

Even with these changes, Saskatchewan will continue to have one of the most comprehensive drug plans in Canada. Our programs designed to assist low-income seniors, including those receiving the guaranteed income supplement and senior income plan support, will not change. Approximately 15,000 seniors receive these enhancements, enhanced benefits, and will continue to do so.

Standardizing special care home supply charges. Another change contained in this year's budget was standardizing the fees for hygienic supplies in special care homes. Currently there is no standardization in charges for these supplies, and it is unfair as residents are being treated differently in what they are charged. This change to a standard $20 per month fee brings equity and equality and becomes effective July 1st, 2012. Most of the residents of special care homes, approximately 5,800, will not see any change or they will see their costs actually reduced. About 2,700 seniors who pay a lower fee, or no fee at all, will now be paying the $20 fee.

The senior citizens' ambulance assistance program. The ministry has also increased its deductible under the senior citizens' ambulance assistance program by $25 per trip to $275. This is the first increase of the deductible in 20 years.

As I said, these were not decisions we arrived at easily. We understand that fee increases are rarely seen as good news. We tried to strike a balance between ensuring the sustainability of the program and minimizing the impact that these changes will have on the people affected by them.

In a broader picture, I believe that the 2012-13 Health budget sets the stage for a very exciting year ahead. But we're not just looking at the year ahead or a year into the future. I also will have mentioned about five-year strategic priorities that we will perhaps cover into the future, but that really concludes this year's remarks on the 2012-13 budget. As I said, there are certainly strategic plans as we move ahead over the next five years, but that is a, I would say, brief outline — others who are listening would say a very extended outline — of the provincial budget for 2012. Be glad to take any questions that you might have.

The Chair: — Thank you, Mr. Minister. And I believe Mr. Broten will be asking questions. You have the floor.

Mr. Broten: — Thank you, Mr. Chair, and good afternoon to committee members, to officials who are here, and to the minister. Thank you, Mr. Minister, for your opening remarks. And when you said they were going to be long, I thought you might beat the Minister of Advanced Education but I think you were still a few minutes under last night's remarks. But I do understand it's a significant portion of the budget and an overview is appropriate.

We'll have a few opportunities over the coming days or couple of weeks perhaps to go through Health estimates, and from time to time there may be colleagues that I have interested in coming in and asking questions on a certain issue or topic. But what we'll do today, at least the plan for now, go through some of the specific items in the budget document, and then there may be some tangents into specific themes or topics as we go through those items.

Starting off on page 85, this year's budget shows a reduction in the FTE [full-time equivalent] staff complement from 553 to 533.4. Could the minister please outline which positions are being eliminated, and will there be any implications with this reduction, please.

[13:45]

Hon. Mr. McMorris: — So what you're referring to is, yes, from the '11-12 to the '12-13 budget, a difference of about 19.6 full-time equivalents. So what it is is there is no one laid off, but they are managed through vacancies and attrition, not filling positions. I don't know if you're looking for the exact type of position that they were in, but it is just, you know, managing the vacancies through attrition and making sure those responsibilities are spread out.

Mr. Broten: — So the reductions are not within a specific branch or unit but it would be spread out across the ministry. Is that correct?

Hon. Mr. McMorris: — Yes, that's correct.

Mr. Broten: — And with the reduction in the number of FTEs, were there any layoff notices provided, or was it strictly through retirements or people choosing to leave the ministry on their own terms?

Mr. Florizone: — So the whole plan was to do this through attrition, and the principle behind it was it no job loss in terms of the . . . or employment loss. So the idea here was that these were either vacant positions or retirements that were upcoming, and some have yet to be realized because of planned retirements that are occurring throughout the year. These were spread throughout the areas, throughout the branches, and there's only one layoff that I am aware of that I want to make sure that you're aware. The individual was offered a position, decided not to accept, so there was one layoff and it was for a part-time

position. Other than that, we've tried to really stay away from those types of layoffs that have occurred.

There is also some changes. There are some changes that are going on as a government-wide initiative around accounts payable. Now rather than having every ministry involved in processing payments to vendors, government took on through the bureaucracy an initiative, a look at how many people were actually involved in these types of transactions.

So there are several positions that have been identified. Whether or not the collective agreement and discussions with labour or with the union will allow us to move the positions, whether or not the individuals are interested in making that move, may dictate whether or not a layoff would be required there. The impact with the Ministry of Health would be three full-time equivalents with respect to accounts payable.

So it would be the opportunity for these three individuals, if they decide that they don't want to be transferred to a job, which is a job within the Ministry of Finance, to exercise their rights with respect to the collective agreement.

Mr. Broten: — As the openings come up in various parts of the ministry based on retirement or whatever the case may be, how does the ministry ensure that it has the right people doing the right jobs, recognizing that when someone with 30-plus years of experience retires that that is a lot of skill and expertise that is there within the civil service? In what situations would the ministry be prepared to provide a new posting to bring someone on if they don't have the right person to fulfill the job duties?

Mr. Florizone: — I failed to introduce myself. Dan Florizone, deputy minister of Health.

Thank you for the question. And, Mr. Chair, what we have done — and of course that's always a challenge with attrition — is that while we're very confident that we have sufficient attrition to avoid layoffs, attrition doesn't necessarily happen in the areas of least priority or areas where you hope a vacancy to occur and a position to be eliminated. So we have been very thoughtful about looking out at what potential retirements could occur, what resignations and opportunities, but we're not freezing every vacancy that occurs.

So for instance there are some priority areas that the minister has spoken to — primary health care, the surgical initiative, some of our quality improvement initiatives where, irrespective of vacancies occurring in those areas or not, they're actually areas of potential growth. So we're looking at an internal reallocation, at the same time filling vacancies in priority areas at the same time as we're looking at opportunities around attrition where we can meet our targets with respect to FTEs.

Mr. Broten: — Thank you. As this process occurs, and it's been going on for two years? Three years? A while? And as it occurs, could the minister please give his view on the current level of morale within the ministry? Is there opinion that there is good buy-in among civil servants with this approach and that it's working well? Have any flags or concerns been raised or has it been fairly, fairly supportive?

Hon. Mr. McMorris: — I think overall it has been supportive. I haven't heard anything directly, and that doesn't mean that there may not be some concern, depending on the area where there has been some changes, but I certainly haven't had anything come to my office. I know we challenge the ministry a lot to do a lot, and sometimes with less. But you know, whether it's the surgical care initiative, whether it's primary health care redesign, whether it's lean — all these innovations over the last couple of years has challenged the ministry as well as continued to challenge them to do it with a staff, perhaps less staff. But they've met the challenge extremely well and, you know, again I haven't heard any negative feedback that has come past me.

Mr. Broten: — Thank you very much. Looking at (HE01), under central management and services, so that's on page 86 of the estimates, the funding allocated to central services is being cut 571,000 from 7,027,000 to 6,456,000. My question to the minister: how is this reduction being achieved?

Hon. Mr. McMorris: — So the reduction is achieved because the new lab building is up and running fully, and before we were having to rent two places, I guess, for lack of a better term. We've been able to now move everything, consolidate into the lab. So we don't need . . . It's Lloyd Place that we had a lease. Lease, I guess it would be?

A Member: — Through Government Services.

Hon. Mr. McMorris: — Through Government Services, right, that we don't need any longer. So that is the drop in services there.

Mr. Broten: — So just to be clear, the amalgamation or the lab services brought in under one roof, and therefore the ministry has saved rent or lease payments.

Hon. Mr. McMorris: — Yes, that would be the case.

Mr. Broten: — When it comes to lease payments and rent and that sort of thing, why is that item under central services and not under accommodation services, which is the line item just below? I'll state clearly. For central services, what is included in that, please? What expenditures?

Mr. Hendricks: — Max Hendricks, associate deputy minister. So when the minister gave you the number before, with the reduction in accommodation for Lloyd Place, that was actually a combination of all those items across those subprograms. So in central services what you see, there was a $69,000 reduction due to employee attrition as part of the attrition that we were talking about before, and then a 502 net reduction in supplier payments because we did things like last year, 425 of that was we renew the health card once every three years. So in central services there was a net reduction of $571,000.

In accommodation itself, 942,000 was a reduction in rental paid to the Ministry of Government Services, 702 of which was for Lloyd Place and Mistasinihk Place, and then a $240,000 decrease to the Ministry of Government Services rates for accommodations also. So we slightly over-stated that there at 1.4 million.

Mr. Broten: — Okay, so just to be clear that the changes in the accommodation amounts that were just provided, is that within

the central services line item here, or is that within the accommodation services?

Mr. Hendricks: — Accommodations.

Mr. Broten: — Okay. So the savings between the amalgamation of the lab under one roof, that doesn't affect the changes for central services?

Mr. Hendricks: — No. The accommodation services reduction of $887,000 which is a combination of the lab and other reductions in rates. And then in central services, that's a reduction for one FTE. And then we have supplier reductions for health card renewal and that sort of thing there.

Mr. Broten: — Sorry, after the FTE I just couldn't hear.

Mr. Hendricks: — $425,000 reduction for health card renewal which we only do once every three years. So every three years, we get an increase for health card renewal and then it drops off in the subsequent year.

Mr. Broten: — Okay, thank you. So the $571,000 is health card renewal savings because it's not being done this year, as well as the elimination that you said of one FTE.

Mr. Hendricks: — Yes.

Mr. Broten: — Thank you. And so we've touched on this a bit. On the accommodation services, it's being cut or reduced $887,000 from 5.035 million to 4.148 million and that is all through the lab as well as . . . What was the other change?

Mr. Hendricks: — That we had a net rate reduction in our accommodation cost from the Ministry of Government Services. We had a rate reduction of $240,000. There was a $240,000 decrease in the rates we pay on some of our accommodations, and then a $55,000 increase on other ones for tenant improvement.

Mr. Broten: — 51,000 . . .

Mr. Hendricks: — 55,000 increase for tenant improvement in other facilities.

Mr. Broten: — Okay. So that's the tab for the many buildings that Government Services would negotiate on behalf of the ministry for lining up office space and everything else. That all is occurring within the accommodation services.

Mr. Hendricks: — Yes.

Mr. Broten: — It was interesting that you said on the reduction in some cases was for where Government Services was able to negotiate or come out with a lower amount. Was that because lease rates changed or space was given up? Because last night in Advanced Ed, for example, we actually saw this accommodation services line jump 21 per cent. So to see it go the opposite direction is interesting.

So how is that components of the reduction are being achieved in Health? I know you can't comment on Advanced Ed, but in Advanced Ed we saw a very significant jump.

[14:00]

Mr. Hendricks: — So in looking at the details, we have approximately the same space less the lab, but there have been fluctuations in the rates that are being charged on various facilities by Government Services. So actually I would have to defer you to them. They kind of work out those rates and what they charge us.

I should correct one thing I said. The $701,000 accommodation estimate for the provincial lab, or the Saskatchewan disease control laboratory, is actually under (HE04), provincial health services. So that's separate from our accommodation.

Mr. Broten: — Okay. So that health lab amalgamation under one roof, that actually doesn't account for the reduction of accommodation services.

Mr. Hendricks: — So they reduced the charges that we were paying for Ministry of Government Services under (HE01) on our accommodation services, but those now show up in (HE04) with the new Saskatchewan disease control laboratory.

Mr. Broten: — It's a shuffling from one column to another. The expense is still there but it's not showing up in (HE01); it's showing up in (HE04).

Mr. Hendricks: — Correct.

Mr. Broten: — Thank you. I know the ADMs [assistant deputy minister] said that they weren't able to comment on Government Services, but is it an accurate statement . . . I know the amounts that are negotiated by Government Services, that's given to each ministry and that's included in this budget for each ministry. There have been a number of instances then where the rates that the ministry is paying for leased space is actually lower than what the previous lease agreements were. Am I correct in understanding that?

Hon. Mr. McMorris: — So you'd probably be looking at a number as a whole for accommodation but, as you can imagine with the Ministry of Health, there are a number of facilities, and it's fluctuated. There are some that have gone up per square foot and some that have gone down.

For example in the T.C. Douglas Building, according to Government Services, it has dropped and that's what they're charging us at a lower rate, but the Ratner Building had gone up. So I think probably to determine the costs and why some are going up and why some are going down, I mean my officials can speculate, you know, whether it's housekeeping changes because what Government Services will charge us is their actual costs and, depending on what they do on some of those services provided, that will fluctuate. And I think these would be best answered by Government Services as opposed to us because we don't have all the variables that go into their determining what a square foot rate would be.

Mr. Broten: — Thank you. Under accommodation services, the number of buildings or spaces that are occupied by the Ministry of Health, I assume it's across the province obviously because the Ministry of Health serves the entire province. So across the province, could you please identify . . . I don't need the specific

communities, but how many separate locations are within, fall under accommodation services, please?

Hon. Mr. McMorris: — The vast majority of space that we would rent through the Ministry of Health would be here in Regina, like by far the vast. It would be up to health regions and other, you know, because we have delivery within their area, but as a provincial organization, vast majority are in Regina. We're adding it up. We believe about 14 buildings. Now sometimes there's building and then an extra space. You know, you would rent two spaces in a building. So you know, I mean that is a very close ballpark figure, but we believe 14. And some of those will have two or three spaces within the building rented.

Mr. Broten: — Thank you very much. Are any Ministry of Health departments or branches or people moving into the Hill Tower III or is that exclusively an AEE [Advanced Education and Employment]? You don't need to comment on the AEE. Is that . . . Any plans for any Health moving over?

Hon. Mr. McMorris: — None of ours, no. No.

Mr. Broten: — Okay. Thank you very much. For provincial health services on page 86, it says (HE04), the funding allocated to Canadian Blood Services has been reduced by about 5 per cent, from 49.505 million to 47 million. Could you please explain the rationale for this reduction?

Ms. Jordan: — Thank you for the question. My name is Deb Jordan and I'm the executive director of acute and emergency services with the Ministry of Health. And liaison with the Canadian Blood Services and our ministry is primarily through our branch.

I think there have been a few opportunities as we've been at estimates before where our deputy minister has talked about a lot of the good work that is going on in the health system related to lean, and blood utilization is really one area where I think we're very proud of what has been achieved.

In the 2009-10 fiscal year, the spend in the Saskatchewan Health budget was — and the actual was — about $52 million. Through the good work . . . There's a transfusion medicine working group that was formed which has representation from all of the health regions across the province. Saskatchewan was one of the jurisdictions in Canada that had the highest utilization of blood product, and we knew when we talked to our partners in other jurisdictions across the country that a lot of that inventory was not being, the inventory controls were not being well managed and a lot of the product was being returned. There's a 42-day period, for example, for fresh blood product where if it is not being utilized it has to be returned and it's not appropriate for clinical use.

Through the good work of folks in the ministry, working with regional health authorities, with Canadian Blood Services, in the ensuing two years we've looked at better inventory control and management, how blood product is ordered, handled, making sure inventory levels across the province are appropriate to utilization.

So we have been able to reduce the amount and the utilization of our blood product. We're working with two hematopathologists — one based out of Regina, one based out of Saskatoon — who are experts in the area, to make sure that what we're doing is clinically appropriate and that patients are continuing to be well served. But it was an area where there was a lot of room and improvement and, using the lean methodology, we've been able to achieve some really significant savings in the system. At the same time patients are getting fresher product, if you will, and that provides better patient outcomes.

Mr. Broten: — Thank you. How exactly does it work? Could you give some examples of how the inventory control or how some efficiencies were gained? I'm genuinely curious here because there's obviously the demand side where someone needs the blood product and it's coming from somewhere else. So how are you . . . Are the savings mostly realized simply by shuffling product around between regions as it's needed, or is it influencing recruitment of products, or how does this happen?

Ms. Jordan: — Through a combination. So I'll maybe take a look first at the inventory management. So a lot of the sites were ordering at a historical inventory level as opposed to updating on what their more recent utilization would say needed to be in place. So that was one adjustment. Certainly working better together across regions to ensure that, you know, if in fact there was a surge and product was needed, what was available in the province, and being able to get that to the site that requires it, but really taking a hard look at what's the inventory level that needs to be maintained at each site where transfusions are taking place. And ensuring that the inventory management is there, that what is being ordered and stocked is current to current need.

The other area of significant improvement was with respect to the ordering of appropriate product by clinicians. And this is where we're fortunate in Saskatchewan to have the two hematopathologists, and where their work with clinicians about ordering of particular blood product — what is appropriate for that patient's need — has also helped to effect some change in our utilization rate and what we need to order.

[14:15]

Mr. Broten: — Who sits on the transfusion medical working group? I believe that was the name that was provided.

Ms. Jordan: — Transfusion medicine working group.

Mr. Broten: — Medicine.

Ms. Jordan: — Typically the individuals who will have responsibility for blood services within a particular health region will be the same individual who is also responsible for laboratory services. So typically it will be the laboratory services managers in most of the regions.

Mr. Broten: — Okay, so . . .

Ms. Jordan: — I don't have the names here with me, but I could certainly get that if you would prefer.

Mr. Broten: — The names aren't necessary, thank you. So with

the savings, this is what is projected within this fiscal through the changes that have occurred to date. It's anticipated that there'll be a reduction in the necessary expenditure for this fiscal compared to last. Is that correct?

Ms. Jordan: — Yes. And I think the group is very keen. They're moving into their next wave of lean work. And they feel that some further progress may be made. But taking into account what they've achieved thus far, also allowing some of the blood product that comes into Canada is ordered from the US and so also ensuring that if there's any fluctuation in the exchange rates that we've accounted for that, but we're very comfortable that it's achievable based on the good work and the progress that has been made to date.

Mr. Broten: — The work that's been done to date, when did that begin and how long have the results from the changes been rolling in?

Ms. Jordan: — The transfusion medicine working group was formed in 2009. And so it takes a period of time for the group to come together, to take a look at working together where the potential efficiencies could be achieved. Using the lean methodology, there was obviously training of the group involved. But they're a very keen group and very highly motivated. They've had very good support, work closely with the senior medical officers in each of the health regions. So it takes a little while to get the practices in place.

I would be remiss if I did not also say what tremendous support . . . Canadian Blood Services personnel in the province have been full partners in this and have worked with us and are actually looking to take some of what we've learned in Saskatchewan about utilization and inventory management into other jurisdictions to benefit partners nationwide.

Mr. Broten: — On that point that was just made, is Canadian Blood Services used by every province for the purchasing?

Ms. Jordan: — With the exception of Quebec, yes. Following the Krever Commission, Canadian Blood Services was formed. It includes all of the jurisdictions with the exception of Quebec which has Héma-Québec as its blood service agency. So it would be the shareholders, if you will, are the provinces and territories, and the ministers of Health are the board.

Mr. Broten: — Is Canadian Blood Services the sole provider of blood products to the provincial ministry or are there other suppliers?

Ms. Jordan: — Everything is done through Canadian Blood Services.

Mr. Broten: — Okay. Thank you very much for those comments.

Moving on to a different topic, eHealth Saskatchewan will see about a 55 per cent increase in funding from 35.482 million to 55.151 million. Could the minister please provide an explanation as to what this increase will achieve.

Hon. Mr. McMorris: — So I think what we'll do is we'll kind of tag team this one. I can talk a little bit about the funding and the increase, the large increase that you see.

Part of that increase would be because two years ago we were able to prepay or pay forward from the previous fiscal year, so it wouldn't have shown up on last year's budget numbers. This year, we're restoring it. So we prepaid two years ago. Last year it wouldn't have shown on that and this year we're bringing it back to where it should be, and that's why the increase you will see there. So it's not a year-over-year increase although that's what it looks like, but on a dollar spent per year, it's an increase. But it brings us, it's more in line.

And as far as what it's going to achieve, some of the different initiatives that this extra money and where eHealth is going, I'll let Max talk more about those initiatives.

Mr. Hendricks: — Sure. So this year the major areas of focus for eHealth Saskatchewan will be the implementation of a new laboratory system. As you know, with the electronic medical record as we're pushing that out into the health system, tremendous demand for laboratory results in the office. So we're really focusing in on that. We already have 15 million records in our repository and we're adding approximately 50,000 a day. So it's really growing quickly, that database.

We're going to further expand our provincial radiology information and picture archiving communication system. This year we'll be going into Regina and fanning out into the other locations. This is already a significant repository and is really paying benefits in terms of radiology workflow, our ability to maintain services in regional areas and share services, radiology information services. So it's quite a positive, quite a positive thing.

We have several accomplishments. eHealth Saskatchewan supports almost 20,000 health care users in 100 . . . Sorry, 32,000 health care users in over 120 applications. Through our EMR [electronic medical record] program we've been successful in pushing out the electronic medical record to 47 per cent of all physician offices in Saskatchewan, which sounds really great but actually the demand is huge too. Physicians want to get their hands on this as quickly as possible so we're looking at ways to even speed that up further, but we're on schedule. So in addition to that, we're hosting PIP, the pharmaceutical information program, and then all of the, all of the, like Sunrise Clinical Manager in health regions and a number of other applications. So actually the electronic health record is reaching a point where it's starting to reach a fairly good level of functionality and we're actually trying now to better integrate it and make it easier for end-users, our health providers, to make an effective tool.

Mr. Broten: — Thank you very much. The first part of the response had to do with, or the minister stated, with prepaying, buying a two-year chunk of services. What services or what products were purchased for that two-year amount? Is it, is it like a . . . Pardon me, but is it like a software contract for two years or what is the . . . What was the item that was purchased on a two-year basis and why was it purchased on a two-year basis as opposed to year to year?

Hon. Mr. McMorris: — No, it wouldn't be an item that was purchased. It would be money that was moved forward from the

previous year into the fiscal year to continue on with all the development of the electronic medical health records, whether it's RIS/PACS [radiology information system/picture archiving and communication system] or whether it's the PIP program, to make sure that continued on.

So it's an accounting issue. So it didn't show up in the fiscal year because it was prepaid from the year prior. This year, it brings that base budget back. So it's not a purchase of one thing over two years; it's a continuation of all we do in eHealth. And as was mentioned, it's a continuation on. This year the lab results will be part of the electronic health records. We've done a lot of work on the RIS/PACS or the imaging and as well as PIP. So it's the three pieces to the electronic health record is what we're trying to achieve, and it's been moving ahead steadily, year over year over year. The number variance is simply an accounting issue. It wasn't a purchase of one particular piece, even though there would be software as part of a purchase through eHealth.

Mr. Broten: — Thank you for that clarification, for myself. So out of the funding right now, the minister stated that this is restoring it more to what is expected on an annual basis for the level that is needed. Is it anticipated then that there wouldn't be the type of banking or the type of carry-over this year? Would the funds being allocated in this budget be exhausted? Is that the expectation?

Mr. Hendricks: — Yes. Well yes. One of the things that we're always subject to is we develop projections about where we think projects will advance during a given year. It's interesting. We had a board meeting of eHealth Saskatchewan this morning — I'm the Chair of the board — and we discussed a number of risks this year in terms of our ability to advance and therefore utilize our budget funding. The health system is very busy this year. We're rolling out lean in a big way, trying to make a number of transformative changes which will take a lot of time from people. So we're optimistic that this is the level of funding that we actually will need.

But in part the answer . . . You know, when we talk about previous years, SHIN [Saskatchewan Health Information Network] and then eHealth has carried over deferred revenue. And we were able to in the last couple of years bring money forward because we actually were advancing projects and needed the money in that fiscal year. So we are progressing very well with projects, and I'm confident that it will have enough money for this fiscal year to achieve what we have set.

Mr. Broten: — In the 2010 budget, so that year that there would have been the eHealth money two years prior, was that a specific line item in the budget? I know it's a couple budget documents ago, but would it have been explicitly listed as an item or would it have been a part of a larger pool of funding?

Mr. Hendricks: — It used to be under the subprogram Saskatchewan Health Information Network and now it's eHealth Saskatchewan.

Mr. Broten: — Thank you. The minister in his comments talked about the three pieces to the EMR. Could you just expand on that and please detail what those three pieces are please?

Hon. Mr. McMorris: — I will give a broad overview, and if you want to get into further detail, certainly Max . . .

Mr. Broten: — Broad's probably okay.

Hon. Mr. McMorris: — But it really is the PIP, the prescription information program, which is, you know, again tracking of prescriptions through pharmacies and physicians, where pharmacists can access that information and see what a patient or a person is on. Physicians also have access to that so that they can also see what the person is on. I was wrong. It's pharmacy information? No, that's . . .

Mr. Hendricks: — Pharmaceutical information program.

[14:30]

Hon. Mr. McMorris: — Program, yes. You're writing there for me. So that would be the one piece of the electronic medical health record that has been in place for a while and has been serving well, about 97 million prescriptions are held on that. So it's really tracking — you know, the benefit, there are many, many benefits to this — but for pharmacists to see, you know, how many prescriptions the person is on. And the interaction is very, very useful for all those within the medical community that have access to it.

The other one would be the lab, or I'll go with the diagnostic results, would be RIS/PACS and the storing of all those digital images so that if you have an X-ray or a CT [computerized tomography] scan in a regional hospital, for example, it could be read anywhere. It could be sent anywhere to, you know, the appropriate specialist. If there is a scan done in Regina, it could be sent back to the physician's office if they're equipped. So it, the digital imaging, be it X-ray, CT scan, or MRI [magnetic resonance imaging] and ultrasound would all be part of those diagnostics. There's more work to do, and as Max had mentioned, Regina had its own system prior, but it will be coming on the provincial system, I believe, this year. So that will also help.

And the last piece that there's been much work on is the lab results so that, you know, laboratory results can then be accessed by the physician, by a specialist on your electronic medical record. So those are really the three pieces that make up the medical record — 221 million images, representing over 27 million studies . . . or two thousand seven hundred million studies.

So these are huge systems that . . . And some people will question, and I certainly would have in the past, we've taken a long time to get here. But if you look at the capacity that we need and the security that needs to be built into it, it's a major system. I would say that, you know, every province is at a varying state, but with our lab results going . . . You know, there'll be more to be said on that in the very, very near future. Being up and running, we're as well positioned as any province in Canada, I think.

Mr. Broten: — Thank you very much. I believe it was the ADM that said out of this line item, the lion's share was going to the new lab system and the radiology system. Are there other components? Are those the only two things? Obviously they're

not the only two things, but what are some of the other sizable expenses within that pool of money, please?

Mr. Hendricks: — Okay. First of all, those are the major initiatives this year in terms of money. Fifty-one per cent of the Health budget is related to operations. So as I said, we support 34,000 users in the health care system in over 120 applications, so as we increase the number of applications that we roll out in the health care system, the costs of supporting that increase as well.

I have the '11-12 totals in terms of the different registries. But just to be clear, so we're spending approximately, of our total money, approximately 39 million on operations. We also support CommunityNet, which is the provincial internet infrastructure. We're the largest contributor to that, along with Education. And then for various projects, I'm just looking down here to see. Regional lab and provincial lab, we're spending approximately $2.2 million in this fiscal year rolling those projects out.

Mr. Broten: — Okay. Thank you very much. The minister spoke a little bit about the rollout of EMRs to physician offices, or someone did, one of the individuals. It was stated that 47 per cent of physician offices are currently on board. Some of the incentives that have been negotiated with the SMA for facilitating and encouraging docs to move on to EMRs, those funds, are they within this or is that separate, those are all separate agreements negotiated with the SMA?

Mr. Hendricks: — The EMR program is actually funded out of the non-fee-for-service subprogram in (HE06). As you're aware, that's an agreement that was negotiated with the SMA, and there's a co-management committee involving the Ministry of Health and the SMA. The budget for 2011-12 is 6.4 million. It's increasing to 8.1 million as a result of increased adoption of EMR.

Mr. Broten: — Is the adoption of EMRs by physician offices going as well as planned or better than planned? What sort of adoption rate are we looking at, and are there goals set in place with respect to how soon it would be at 100 per cent or at a certain target?

Mr. Hendricks: — Yes, our goal is to by 2014 to have, I think it was 80 or 90 per cent of physician offices on the EMR. Today we stand at 47 per cent of physician offices have access to an EMR. As I said earlier, the biggest challenge is the demand is greater than our vendor's ability to provide the rollout of this. So when you introduce an EMR into an office, a vendor has to go in there and teach the staff, that sort of thing. So I would say that we're on schedule and in fact, you know, if we could advance that schedule, we would try and do that. But that's a subject of vendor capacity.

Mr. Broten: — Thank you. On the topic of vendors for physician offices, is there a preferred vendor? Are there a group of options the physicians can choose from? How does that work, please?

Mr. Hendricks: — Okay. When we went through vendor selection, we approved four vendors. One has dropped out because of failed conformance testing. So currently Optimed Software Corporation, Med Access, and MD Physician Services are the three vendors that are currently active. And Med Access is the one that has been chosen as our primary care solution, but we're kind of looking at the other ones to expand the number of primary care solutions as well.

Mr. Broten: — Are the vendors that were selected, are those the most dominant players in health care in North America? Or would there be . . . How wide is the field, is my question. And does the ministry have confidence that they've selected the correct three vendors for the long-term?

Mr. Hendricks: — Certainly, especially . . . Yes, these vendors are active all across Canada. In fact that's another challenge that we're having in terms of capacity is that they're distributing their resources in a number of jurisdictions. So we do have confidence that these vendors are, you know, sort of top quality ones that we can work with. One of the things Canada Health Infoway is doing with its latest tranche of funding is trying to expand vendor capacity in Canada. So in terms of developing the e-health agenda across the country, they're trying to provide funds to improve vendor support of that mission.

Mr. Broten: — Thank you. Could the minister please state what sort of incentives are in place for physician offices to go to EMRs, please?

Hon. Mr. McMorris: — So there are a number of things. And just to touch on the previous answer regarding three vendors, we have three vendors — had four — three vendors. It's interesting when you look across the country because every province has kind of gone at this maybe a little differently. I know there are mixed opinions on whether three is the right number. That's what we have chosen in concert with the SMA.

There are other jurisdictions that have certainly opened it up wider. And I know Alberta was one of them, so that they had a number of vendors which was, I guess, a better selection which is one thing, but then being able to communicate and integrate has been a nightmare for them.

So there are, you know, certainly at times I guess a bit of a debate that can happen, but this is where we've landed. And I'm sure you're aware of that in Saskatchewan, and I think it's served very well. The physicians are moving in that direction. And as we continue to populate, you know, our overall electronic medical records with labs, PIP, and imaging, the demand from physicians is going to continue to grow. And I think we're seeing that.

So what our program covers is a transaction fee of $1 for each EMR eligible service documented in the qualifying EMR which contains sufficient information to meet the professionals' generally accepted standards for medical records. Now you can probably, we could probably send . . . because this gets a little detailed, but I'll read it out in the record: a monthly fee of $300 paid quarterly to commence once the physician's successfully documented and maintained 50 per cent of approved visits in a qualifying EMR and will be paid for 12 months, so once they get it up and running. There was an early adopter for people that got into it early. That has changed down to, I guess, $100 a month but paid quarterly.

So there are a number of initiatives, or incentives I should say, that we are working in concert with the SMA to have physicians move in this direction. It's funny sometimes the incentives get them there, physicians, but I think what happens as more physicians see the benefit of EMRs, there becomes a tipping point and the incentives aren't nearly as important as they see it as a benefit to their practice. And I think we're getting close there.

Mr. Broten: — Thank you very much. The issue of diagnostic results specifically on digital imaging and how that plays a role with what radiologists do, is there any . . . With the technology and the ability now, as I understand it, I mean, a radiologist looking at an image could be in many locations, not necessarily right here. Is there any sort of application of that right now within the ministry? Or within the province? Or is it simply, the technology being used around digital imaging for radiologists, is it simply within the province's borders right now?

[14:45]

Mr. Florizone: — So there have not been any significant arrangements made outside of Saskatchewan for the reading of digital images, radiographs, plain film-type radiographs or CT or MRI. The exception would be where we had radiology reviews both in Sunrise Health Region out of Yorkton and also in Cypress. The capability of an electronic image allowed us to send either CDs [compact disc] or to be able to provide those digital images for reread without having to package up plain films. So there was a huge benefit in being able to do that.

Now there are other jurisdictions who have looked at the use and application of providing coverage for radiology. It has to be clear here that, made clear that radiologists are required on site for certain procedures. So not everything can be done remotely. The exceptions or the examples of where a radiologist would be on site . . . One example would be in the areas of invasive radiology where the radiologist, perhaps with any guided type of procedure, would have to be there on site.

The regional centres in Saskatchewan have talked, and my understanding, have recently met. They have not developed a proposal around this, but have met around their interest in seeing if they could provide coverage for each other. Now that right now is an in-Saskatchewan type of arrangement, but they're thinking through the possibility. When you have one or perhaps even two radiologists and you're trying to operate a CT service on an emergency basis as effectively as we're attempting to, it becomes really, really important to figure out how you can provide that kind of coverage and still balance, have a life.

So there are some, we're hoping, innovative and creative ideas that might come forward in concert with our radiologist groups here in Saskatchewan, but it could take a form of someone who would have to be licensed within the province of Saskatchewan, perhaps providing that kind of service.

One other point, just in terms of the jurisdictions that have looked outside — and you'll hear this as anecdote — but there are arrangements that we're aware of where night coverage is provided by someone else on the planet where they're actually during daytime hours, awake, alert, and ready to receive. So you can use a time-shift to the advantage of providing that kind of coverage. Now we haven't gone to that extent, but I did want to share with you that in the UK [United Kingdom] and Australia some of those possibilities have been explored.

Mr. Broten: — Thank you very much. In the cases of the reviews that occurred in Sunrise and Cypress, what province did the review take place? The radiologists came from which province that did the review of the images?

Ms. Jordan: — In the case of the review of interpretation of images in the Sunrise Health Region and the Cypress Health Region, those regions contracted with providers in Alberta to be able to review and assist them with the review of interpretations that have been previously done by a radiologist on site, and where concerns had arisen through the quality assurance process that's in place with the quality of the interpretation and the clinical variances that were evident.

Mr. Broten: — Thank you very much. There were comments made about the possibility of in the future or other jurisdictions who are utilizing radiologists to do readings from different areas, whether that's in, I imagine whether that would be in India or Europe or California or Manitoba. Is this something that the ministry is considering or is anyone requesting these types of changes or additions or is it simply a fairly theoretical discussion at this time?

Hon. Mr. McMorris: — Well certainly the possibility is there. But I think, you know, we need to kind of look at what we're doing here in Saskatchewan first. And as the deputy minister answered, they need to be licensed here in Saskatchewan. We're looking at Saskatchewan first. You know, there's lots of capacity here and that's where we would certainly look for any services that we need into the future, would be in Saskatchewan.

If we were to go outside of that, we would probably be looking inside Canada before we would ever start going out. That's again down the road, maybe in the future. But that hasn't, you know, we haven't moved in that direction — only under specific situations, such as the review of radiologists in Sunrise and Cypress, which were done in Alberta. So we believe that the capacity is here right now and I think the radiologists would believe that as well, that there wouldn't be any need to start looking out too far past our borders.

Having said that though, that will the beauty of having the RIS/PACS system and digital imaging. That is a possibility into the future. But we don't foresee that in the near future, having to do that in the near future — not that we can't, but having to.

Mr. Broten: — Well thank you for that answer. It is an interesting concept because if you look at, you know, a family doctor . . . For example, there are Toronto physicians that will come to Saskatchewan with Northern Medical Services for a period of time, so there is that approach in other specialties for widening the pool of available physicians. Anyway I'll leave that for now.

Moving on to regional health services, page 87, $365,000 less is going toward salaries in the regional health services subvote, so a reduction from 15.036 million last year to 14.671 million this

year. This number increased between 2010 and '11. So could you please give a bit of an explanation as to why we're seeing a reduction this year?

Hon. Mr. McMorris: — So what this would be is it's our people that work within the ministry that support the regional authorities, and it would be . . . That reduction is found through, due to a reduction in employees through attrition. Again it's part of that 19.6 that we had talked about earlier.

Mr. Broten: — Okay, thank you.

Hon. Mr. McMorris: — [Inaudible] . . . full-time equivalents. I mean 19.6 full-time equivalents.

Mr. Broten: — So those salaries, just once again state who are the individuals that fall under that salaries line, please.

Mr. Hendricks: — This comes off a number of branches. Regional health services and support includes our acute emergency branch, our community care branch, strategy and innovation, population health and research services, patient safety, primary health services, surgical initiative unit, risk and relationship management, regional financial services unit, and the regional program centralized program support. So it includes a number of branches across the ministry, or the majority of them. So does that answer your question?

Mr. Broten: — Thank you. And so the vacancies represented by the 365, that would be vacancies, retirements across those variety of branches.

Mr. Hendricks: — And the areas that the minister talked about before.

Mr. Broten: — Thank you very much. There's also a $5 million reduction in what is going toward goods and services in the regional health services subvote — 12.202 million last year versus 7.135 million this year. This line item was also increased between 2010 and 2011. Why are we seeing the reduction this year and what does it entail?

[15:00]

Hon. Mr. McMorris: — So it's important that we make sure that we distinguish between services that are charged to the ministry as opposed to services that are charged out to the health regions. And this would be more on the health regions side of it. And the lion's share of that would be no longer having to, for lack of a better term, rent space from Government Services for Parkridge and Lakeside — Lakeside in Wolseley, Parkridge in Saskatoon. Because what had happened is the regional health authorities took those facilities over, purchased those facilities, so they were under Government Services. Now they're within the health regions — Regina Qu'Appelle and Saskatoon — and as a result then rent wouldn't be paid to Government Services. But that's on the region's side. It's different than your first questions which were on the Ministry of Health's accommodation charges. Does that make sense?

Mr. Broten: — Yes, so basically the transfer of title has occurred from Government Services for those two facilities to the RHAs [regional health authority]. So therefore it doesn't show up in accommodations as determined by Government Services, but health regions would still be paying or responsible for those buildings, but they would do it through the transfers that they receive as health regions.

Hon. Mr. McMorris: — Correct. And we're just checking on the owner of those two facilities, whether it was Government Services. I believe one was . . . I'm not sure that they were both owned by Government Services. The result being though, the end result is the same whether the health regions purchased those facilities from Government Services or who owned those facilities, which was an agreement set up many, many, many years ago. Do you want us to find that out?

Mr. Broten: — Sure, I can wait for that.

Hon. Mr. McMorris: — So I will continue to try and explain this. What these two facilities . . . The actual owner would best be asked . . . but to Government Services because Government Services were managing them regardless of who the owner was, and you would have to ask Government Services who owned those two particular facilities. But Government Services were managing them. That's where our rent was going, so as we backed away from that rent, it would be rent that was going to Government Services for those facilities. And the health regions now have taken those facilities over through Government Services and whoever owned them privately.

Mr. Broten: — When did that occur for those two facilities? When did that transfer or switch occur, please?

Hon. Mr. McMorris: — So it's our recollection, and I believe it was in January of 2011, last fiscal year. But we can check on that to make sure.

Mr. Broten: — Thank you. What was the motivation to have this switch occur?

Hon. Mr. McMorris: — I guess probably the major motivation is that the contracts had come up through, the contracts through Government Services and the private owner. We in the Ministry of Health still needed those facilities, one, as I said, being in Wolseley, one being in Saskatoon. And so it was a matter then of the health regions then taking those facilities over because, number one, they needed the beds. But as well as the contracts that were entered into a number of years ago were expiring.

Mr. Broten: — Who owned the Parkridge facility?

Hon. Mr. McMorris: — Again you'd have to ask that of Government Services because Government Services would be managing that contract and just charging us. Or in that case, it be the health region which then would be factored in in our payments to the health region. But it would be the Government Services that would have a better knowledge of those contracts, as well as who the owners were.

Mr. Broten: — Thank you very much. For the Parkridge facility, when the title was transferred to the health region, were there upgrades and modernization expenses that were experienced by the RHA as it is a somewhat, I won't say dated, facility but it had been present for a few decades, I think?

Hon. Mr. McMorris: — So as you can imagine and as you said, the facility was built, you know, a couple of decades ago. So there would be upgrading. And there was some of that that has been entered into by the health region. We don't have that exact number right now, but we could certainly work to get that number, again through the health region.

As to the upgrading that they have done, I think it's an ongoing process. It hasn't been complete yet, as they obviously have ownership now and will continue to try and improve the living space that we're providing. There may be more upgrades as we move forward. But yes, there were upgrades needed on that facility.

Mr. Broten: — Is that the same situation for the Wolseley facility?

Hon. Mr. McMorris: — Yes, I believe so. I'm not quite as familiar with the Wolseley facility, but you know, if you'd like some more detail on that, we can certainly work towards it. But it's our memory or understanding that Wolseley was not . . . or Lakeside was not requiring near the renovations that Parkridge was. But we can certainly talk to the health regions and find out what was done in that area.

Mr. Broten: — Yes, if there was some information on the two, especially the Parkridge one, in terms of how much was spent in renos, that'd be helpful, please.

Hon. Mr. McMorris: — Okay.

Mr. Broten: — When looking at the $5 million difference between the two fiscal years, I believe it was said these two projects represent the lion's share of that $5 million. What makes up the remainder of that 5 million? Could you please detail what that 5 million is or represents?

Hon. Mr. McMorris: — As I said, again we have to keep in mind that this is within the regional health authorities, not the Ministry of Health. But as I said, the lion's share was that change in the long-term care facilities.

And then there was, you know, other facilities that are rented or leases paid by the regional health authorities. And that space again, as with the ministry, some of those spaces went up and some of those spaces went down on a square footage or on a lease or on a rental rate. So that's what I say. There is some fluctuation from facility to facility — some more expensive, some less expensive. But the lion's share of that $5 million was through the changeover in those two long-term care facilities.

Mr. Broten: — Okay. Just on that $5 million difference, you said this is occurring within the health regions, or representing expenses within the health regions. So what determines when an expense is delivered: when funding is provided to the health region to pay for something and then it shows up in this budget document; and in other situations, when the health region just does something and it's within their normal budget and reporting process. How does that distinction work, please?

Mr. Florizone: — So if we were to refer to *The Regional Health Services Act* and look at the basket of services that regions have responsibility for, what we endeavour to do is make sure that we transfer the property where their staff, their programming, their services were housed in, and that's the primary distinction. So where a contract or a service is directly delivered by government, by the Ministry of Health, we would for the most part use Government Services to manage that accommodation.

Where there are services and programs undertaken by regional health services, we and authorities, we look to the regional health authorities to manage their own accommodation.

Mr. Broten: — Okay. And so since, in the cases of Parkridge for example, since that's primarily, well it's regional health authority activity in Saskatoon, therefore it was transferred over to the regions?

Mr. Florizone: — The transfer of ownership was transferred to the regions because . . . And again they're always a few exceptions to these rules, but this is the move that we've attempted to undertake.

So I'll give you just a few examples of some of the exceptions. One example would be North Battleford, Saskatchewan Hospital, that was a Government Services owned and operated facility. So we did not transfer. That didn't occur in that case. And there are a few, select few others that the full transfer didn't take place, but the general rule of thumb is that we attempt to transfer both ownership and management into the regional health authorities where possible and practical.

Mr. Broten: — Thank you. So for the goods and services line item on page 87 for 2012-13, it's listed as 7.135 million. What goods and services does that represent?

Mr. Hendricks: — So of the $7.1 million, as was mentioned, this particular subprogram includes funding to branches for operating. So approximately $3.73 million is for supplier payments to the various branches and this includes things like just . . . They're general operating costs for travel, that sort of thing. The remainder of that is the accommodation cost of $3.4 million.

Mr. Broten: — Accommodation cost, you said for three point . . .

Mr. Hendricks: — 3.4.

Mr. Broten: — Which facilities would that represent? Is it a long list or a short list?

Mr. Hendricks: — Well most of it is Saskatchewan Hospital, North Battleford. But it's Battlefords District Care Centre, Cumberland House Health Centre, Swift Current Palliser Care Centre, and Sandy Bay health clinic. And so those are those government-owned facilities that the minister and the deputy were talking about that we pay Government Services on behalf of regions.

Mr. Broten: — So it's facilities that either have a provincial mandate such as the Saskatchewan Hospital in The Battlefords, or it's facilities that might have a unique story with how they came to be within the system such as Parkridge.

Mr. Hendricks: — Correct, yes. It's historical mostly.

[15:15]

Mr. Broten: — Thanks for that clarification. Turning to page 88 under medical services and medical education programs, there's a 27 per cent reduction in this budget relative to what was spent last year on medical services that are non-fee-for-service — $192.088 million last year versus $140.45 million this year. Could you please explain why we're seeing a reduction of about $51.6 million here please.

Hon. Mr. McMorris: — So what again the vast majority or the vast majority — I don't want to use lion's share again — but the vast majority of the reduction is when we have physicians that are working within health regions that are on alternative payment, are paid through the health regions, so we put that money out into the health region to cover those costs as opposed to when the physician was fee-for-service and they're paid through the ministry. If it's fee-for-service physician paid through the ministry, once they go on a contract or alternative payment, they're paid through the health region. That money then is given out of our overall pool to the health region to cover those costs. That's where the major reduction was. It actually was $71 million that would be put out into health regions now to pay for alternative payment.

There have been other things added such as $7 million increase to the Physician Long Term Retention Fund. Again this is stuff to the SMA. 4.937 million increase for agreement costings include the SMA increase, increase in market-related fee increases, and program increases. So there's a number that we've added to, but the overall would be a reduction because the majority of it goes out into the health region land.

Mr. Broten: — So if I understand this correctly, for the non-fee-for-service expenses, most of that is for payments to physicians on contract or alternate payment . . .

Hon. Mr. McMorris: — Salary basis.

Mr. Broten: — Salary basis. So the $50 million reduction between the two years is because the health regions are picking up some of those payments as opposed to the ministry traditionally doing it. My question is, why this $50 million change?

Mr. Hendricks: — So there are a couple of things happening here. First of all as you recall, we settled the SMA agreement last year, right? And so there were funds held in the non-fee-for-service subprogram that paid for SMA increases. We provide the same SMA increases to non-fee-for-service physicians that we do fee-for-service. So there is a combination of things here. We're transferring the money out to health regions and then we're transferring . . . Because when we go for a mandate for non-fee-for-service sometimes we'll put . . . or for the fee-for-service, the overall estimated bargaining, we put some of the money in the non-fee-for-service, we distribute amongst the physician subvotes and so this transfers mostly to health regions but also into fee-for-service a little bit as well.

Mr. Broten: — Well it's a $50 million change from one year to the other and so, as I understand it, based on — I'm not saying it's not been explained well; I'm just trying to digest it here — for the $50 million change it's less this year than last year because? Because why, is my question. Because a contract finished so the same payments aren't going out or was it more that . . . Please just restate that. And I apologize. Why the $50 million change from one year to the other for medical services, non-fee-for-service?

Mr. Hendricks: — Okay. Maybe what I'll do is I'll go through this line by line. Is that okay? The overall $51 million change, $71 million was a decrease for net transfers, 2 were from appropriate subprograms. And this is for SMA compensation so some of this is being transferred, the majority of this is being transferred for non-fee-for-service programs that were held by the region. So physician compensation that was being paid by the region, it's been moved into (HE03). You'll see an increase there for physician compensation.

Some of it is a result of bargaining that is being moved in from non-fee-for-service into the fee-for-service subprogram right above it. So we're redistributing the money to where we're actually spending it.

So it's no secret that when we establish a mandate, we put funding in the budget in the previous year. We distribute the mandate across a couple of physician subvotes, right, because if you showed it all in one, it would be pretty obvious to know what the mandate was. So we do that. So that's a restatement of that.

And then $10.5 million . . . So there's a $71 million decrease, $10.5 million increase for SMA programs to reinstate one-time funding from the agreement. So we have 7.2 million for the Physician Long Term Retention Fund that we pay to the SMA that you're familiar with, 3.3 million that we pay to the SMA for continuing medical education, a $4.9 million increase for agreement costs, two point million for market-related fee increases and program increases, and one point million, $1 million again for continuing medical education, a $1 million increase for alternate payment projects for the new gynecology, oncology contract split between Regina and — oh geez, I lost my second page here — split between Regina and somebody. Excuse me for a second.

Mr. Broten: — So while you're digging for it, if I can just do a . . . the minister.

Hon. Mr. McMorris: — Just kind of on a general overall, so you see it coming out of this one area of the budget subvote, but it's gone in in other areas. It's gone into the regional health authorities, into the Cancer Agency, into some other areas. So although you see it drop down here, it's not that the budget has dropped. It's been taken out because it is in fee-for-service. It goes into the regional health authority's budget, or the Cancer Agency's budget. Does that make sense?

Mr. Broten: — Yes, that does. Thank you. So with that disbursement of, we'll say the $50 million because that's the amount that's less, in thinking about where the $50 million went, those disbursements to, as the minister said, to the Cancer Agency or to wherever it's going, that's in keeping with the settlement of a contract. And so in future years when bargaining is up, the funds would be placed once again in this spot while

decisions are being made and then disbursed? Or is this disbursement of $50 million, are they more structural changes where the $50 million will always be showing up in those various spots? Does that make any sense?

Hon. Mr. McMorris: — Well I think I'll try and answer it. So if you were saying, in the event of the next SMA contract where there is an increase, some of that increase will go into the fee-for-services piece, some will be sectioned off, hived off, and go out through the Saskatchewan Cancer Agency and the regional health authorities, depending on the mix of fee-for-service and/or alternative payment.

Mr. Broten: — Thank you. And I don't mean to be painful on the point, but just when we're looking at budget numbers from one year to another, when there's a big drop . . .

Hon. Mr. McMorris: — Yes.

Mr. Broten: — Or spike, it's helpful to know if that would be coming next year or if it's more of a one-time thing.

Hon. Mr. McMorris: — Yes. Or if it's taken out completely, where this hasn't been taken out completely; it's just been diverted into other areas.

Mr. Broten: — Okay. Thank you very much. The funding allocated to dental services is being cut by 29 per cent from 3.09 million to 2.183 million. Could you please state what the rationale is for this reduction? This should be on page 88 as well.

Hon. Mr. McMorris: — So I would just simply say that the reduction in the budget reflects the I guess decrease from what we had projected the year before for dental services that were needed. It's just simply a utilization adjustment. We had budgeted the year before for whatever the number you had given, 3 million. We noticed that it wasn't fully utilized and we have a more appropriate budget reflecting what we think the utilization will be moving forward.

Mr. Broten: — What are the types of services that are provided under this budget line?

Hon. Mr. McMorris: — Well anything that is . . . I mean there are a number of services, but that is services covered by government, by health services. Do you want specific procedures?

Mr. Broten: — I don't like the dentist too much, so not specific procedures, but just generally what's a — my brother-in-law's a dentist so I can say that, I suppose — but more, the instances when coverage will be provided. You know, I can think of the, you know, certain question period examples we've had over the last four and five years when we talked about dental procedures. But generally speaking, are there some categories or examples that the minister could please provide?

Hon. Mr. McMorris: — I'll just kind of read from the sheet here and I may struggle over some of this terminology. The dental service program insured residents for maxillofacial surgery resulting from accidents; certain services in connection with abnormalities of the mouth and surrounding structures; abnormalities of orthodontic care for referred cleft palate patients; certain X-ray services when provided by a dentist who is a specialist in oral radiology.

Mr. Broten: — Thank you. So it's instances where the type of dental care is tied to very significant health things, health conditions or situations when there's a real implication into the patient's life, quality of life.

Hon. Mr. McMorris: — Yes.

Mr. Broten: — That's a fairly significant drop though from the 3 million to the 2.1. Is that prior to the 2011-12 year, that $3 million figure? Was that fairly constant for the types of expenditures? My question is, you know, usually when you think of health care demands, they're increasing either by the types of procedures or the expenses of them or the number of people requesting them. So why the drop? That sort of seems to go against most other trends with health spending.

[15:30]

Hon. Mr. McMorris: — I think I'll try and answer this as best I can and then perhaps the officials can add more to it or correct me if I've kind of gone off base. But if you look at the numbers over a number of years of where we were, this is not a large budget item. So by changing it by a couple of hundred thousand dollars, there can be some huge fluctuation as far as a percentage amount. But if you look, we've been pretty standard for a number of years in around the $1.6 million mark. It bounced up a couple of years ago and then bounced back down. So if you look at it historically, the numbers will stay fairly consistent.

It went up in '11-12 for some anticipated costs that we thought were going to come into the system. Those costs didn't come into the system, i.e., like the dental implant program if you're familiar with that. We thought there would be certainly, would be much, I won't say much more uptake, and it's not a uptake, but eligibility. And we haven't seen that and so we're just trying to go off of what we learned from last year. And so that's why the numbers would have dropped down on utilization we're projecting. And that's what this is, is projection forward on utilization. We may be wrong this year, and there may be more eligible clients coming forward for something like that. So the number may bounce up next year. But we're projecting off of what happened last year, that we obviously don't need the budget as we had projected the year before.

Mr. Broten: — For the services provided through this item, how many patients and/or procedures would be provided on about, on an annual basis?

Mr. Hendricks: — So for dental services, the information that we would have been basing the forecast and that Finance would have basing the forecast on for the program, for '10-11 there was a 16.3 per cent reduction in the payments for dental services. As well there was a 20.3 per cent change in utilization. According to our annual report in '10-11 again, what Finance would have been basing forecasts on and we would have been basing forecasts on is the number of services per 1,000 beneficiaries — and we don't have the exact patient numbers with us right now — decreased by almost 23 per cent.

Mr. Broten: — Thank you very much. On this issue of changes that occur within what is estimated and what the reality is, does — and I'm just curious about this — does Health operate the same as other ministries with respect to those amounts? I'm thinking of AEE estimates last night, for example. So there are instances in the budget documents from the year before, for '11-12, when there was an estimated amount and when the ministry spent more or less in this year's budget document, under the previous year that number was adjusted, stated differently. So one could ask questions and say, well you predicted it would be this much, but in reality it came in at this level. Does Health operate the same, say, in terms of providing that update? Because there's been a few examples where you've said, well we spent less and we've carried it forward or we've allocated. And it's a little harder to track what was predicted, what was spent, and where that money went. Am I off base here with how it operates or could you just provide, shed a bit of light on that, please.

Mr. Hendricks: — Okay. There are a number of programs. Like you have fee-for-service, dental, out-of-province services. All these programs are entitlement programs. So what we do there is we use historical information to try and predict what future payments will be. We're not ever 100 per cent bang on. Some years you'll go over; some years you'll be under. And we balance across the programs. You have a single thing like a pandemic or a bad flu season and your fee-for-service goes way up. Non-fee-for-service, despite what we just talked about, is more predictable in that it's, you know, a salaried compensation amount.

When you get into other programs, like when we were talking about eHealth, you're talking about the pace of the program and your ability to actually implement based on what your forecast was and that's more . . . That one is different in that in the fee-for-service role, we're trying to predict what patients will do based on history, right? And one anomaly like a pandemic will change that.

In eHealth or a program like that, we're trying to predict our ability to advance a project and sometimes there are other variables that come into account. So at the end of the day, the first objective of the ministry is to, across those programs, to balance its expenditures. So if we're over in fee-for-service and under in out-of-province, we'll move money between the two, right, to account for that. If at the end of the day we're $10 million short overall on our fee-for-service payments and can't balance it anywhere, we would have to seek a special warrant at the end of the year.

Mr. Broten: — Okay. But for example, using this dental line here as an example, where it came in perhaps $1 million under from what was predicted, perhaps, is that ever updated in looking back over what happened the year prior? Is that ever updated in the current budget document?

Mr. Hendricks: — So we continually update our forecasts as we go through the year for each of those programs. At the end of the day because this is a small program, we would look internally to see whether we could balance the program, and then next year's budget would be updated. So we would say we have had a different experience in this year if it was significantly different. And so the '13-14 budget would be different for that subprogram. But we are continually monitoring it and updating it, and we do have to occasionally move money between subprograms to balance the variations in programs.

Mr. Broten: — I completely understand the moving and shuffling of money because in a huge budget like this it's understandable how there might be, you know, a bit of give and take between programs because it's within the general Health budget.

But my question is more, when there is a change — say if it is higher, if it is lower — why is that not reported in the new budget document? For example the . . . wherever it is here. For the dental services, if 3 million wasn't needed, if it was only 2.1 million in the previous year, in this year's new budget document, why doesn't it state for 2011-12 that . . . [inaudible] . . . was only 2.1 as opposed to 3?

Mr. Florizone: — So we do have the process through Public Accounts in terms of reporting actuals based on budget and going through kind of the progress and the outcome of the year.

With respect to budgeting, we do try and make those adjustments. But it's a process of going through it and trying to figure out whether the change was an anomaly in a single year, whether it's an actual trend. We do have some common cause variation that occurs. And particularly with these utilization programs, you're going to see some bounce both up and down, depending on certain factors. In fact it's probably surprising that they're as stable as they are. And it's just, given our size and magnitude, that a fee-for-service budget, while it may vary quite a bit on the ground, as it rolls out there's far less variation than one would think.

We try through our own predictive analysis to kind of put a number to it. And what I'm held to account on is both the overarching number and then the votes and subvotes. So we will look at . . . I mean what I'm deeply concerned about as deputy minister is obviously making sure the budget is balanced, making sure that there is no overspend in a particular vote or subvote without proper authorization of the legislature. And if there is a million or two, just given the magnitude of our budget that maybe one utilization program is high and another one's low and they happen to be within the same subvote, that's less concerning in the short term and would be adjusted out, maybe not in a single year but over a trend of a couple of years, depending on the magnitude.

Now if we have something that we know is coming about, you know, imminent within the next short while, we will make those adjustments and propose those budget changes immediately. But I want you to . . . What I want to convey is that, while the detail is really important and it's very important to the people that sit behind the minister, very important to me that someone's looking at it, when we — the minister and I and ADMs — gather, we're very interested in looking as well at the roll-up and just making sure that we're meeting our accountability obligations in that regard.

Hon. Mr. McMorris: — And just one other, one other piece of that is, and as Dan mentioned, it is further analyzed through Public Accounts and through the blue book. That's kind of what

reconciles; so that's where we know. I think you're asking how would anybody else know that if the dental program was budgeted at 3 million and it came in at 2, how would anybody know that? And how would, you know, that be taken into consideration? We in Finance or we in Health do and Finance does, but through Public Accounts and the blue book is kind of the one that a person could look at and see how we're doing as opposed to what we budgeted.

Mr. Broten: — Yes, I understand the Public Accounts process. I'm not . . . I realize it's a huge amount of money. I'm just curious about what appears to me to be different practices in different ministries with respect to what is reported with respect to what happened the year past. Because it's my experience, in going through AEE estimates, is that even when it is a few million dollars, not hundreds or billions, when there is a change from what was predicted to what was spent, that change is actually reflected in the current budget document. And it's my understanding here in the Health one that that adjustment isn't made. Am I out to lunch, or is it just different practices between ministries?

[15:45]

Mr. Florizone: — Well I think it's a great observation. But once again I would say that probably the prime difference is the utilization programs. And if Advanced Ed, and I don't want to speak on their behalf, but if they were looking at programs where they're being billed on a piece rate basis, they may be looking at, you know, less of that reaction each and every year to make those adjustments.

I think the practice you describe for Advanced Ed is the practice that we wish to all emulate. What it comes down to is, with respect to fee-for-service, it's a little less . . . We have a little less ability to predict exactly that it's going to be $1 million less or $1 million more. Last year is not necessarily the predictor for next year.

Mr. Broten: — But I'm actually . . . I fully understand that point. But it's actually not the issue of predicting that I'm curious about. I'm interested in the issue of reporting what was spent and what did occur after the fact. And so in situations where I've seen in AEE, in preparing for budget estimates, you can go through the two documents between the two years. They predicted this much but then it's shown in the current document, well actually spent less than that. So it's shown there so you can see, well why was there over-subscription here, or why was this not utilized as much.

But my experience in going through the Health ones is that those types of adjustments in reporting aren't made. So if I understand the deputy's response, it's basically AEE is doing it a bit different than what Health is doing. Am I correct in that?

Mr. Hendricks: — I guess maybe a couple of things. AEE displays in the same estimates format that we do generally. We do, actually for the program that we're talking about — fee-for-service, out-of-province, dental — every year about two months after the end of the fiscal year, release a statistical report that talks about all the variations by age group, geography, by physician type, everything. So you can actually look in this book and see the trends year over year and kind of get an idea of what we're basing our estimates on. And that's, like I said, generally available within a couple or a few months after the end of the fiscal year.

Mr. Broten: — Okay, thanks. I'll leave this for now. Perhaps I've had one too many hours of estimates in a row. So I'll move on to the next topic right now. The funding allocated to provide for out-of-province medical and hospital costs incurred by Saskatchewan residents is jumping by about $4.2 million from 113.443 million last year to 117.623 million this year. Why does the ministry assume that out-of-province expenses will increase so significantly?

Hon. Mr. McMorris: — I can answer this one. It's really about the rate increases from other jurisdictions. For example, $2.4 million increase in hospital reciprocal rate increase, 1.38 increase in medical physician reciprocal rate charges, and a 391,000 increase for hospital non-reciprocal rate charges. So that's where that would come. That's again, it's out-of-province; of course we have reciprocal agreements with all provinces, you know, our charges to other provinces if somebody is utilizing our system.

Mr. Broten: — Okay, thank you very much. Backing up a little bit, when we were having a discussion a topic or two ago on the non-fee-for-service amounts, and the issue of different funds and pools for physicians, there was reference to the retention fund that was made or retention payments to physicians. And I was wondering if the minister could provide some comments, or officials, on where the retention fund program payment is currently at with the SMA? And also there are additional pools of funding that were negotiated with the SMA for CORP and SRR, committee on rural and regional practice and specialists recruitment and retention. And once upon a time, those funds had surplus dollars sitting in them that were being carried forward over a few years. On those three things that I identified, could the minister please provide a bit of an update to the committee?

Mr. Hendricks: — So the long-term retention fund is a program that is designed to pay an annual contribution for physicians, and after 10 years of practising in the province the contributions that are made each year to that fund become vested. It's approximately $3,500 per year per physician, if my recollection is correct. And I'm not 100 per cent because I don't have that written down.

There's an increase at 15 years and an increase at 20 years. So at those intervals, physicians are allowed to draw on the fund. In the most recent round of the SMA agreement, funding for that program increased from $6.6 million to $7.2 million. Obviously one of the things that that fund looks towards is the market for return on investments. And because of the downturn in 2008, there is a bit of a shortage now.

The ministry and government doesn't actually participate, so to speak, in that fund; like, we're not responsible for its liquidity. That's the SMA that's responsible for that. So when they consult with an actuary and define the benefits under that program, that's based on a certain return and that sort of thing. And they're responsible to either make up for shortfalls in the fund or to negotiate differences or to change the benefits.

In terms of the other programs with the SMA, in the last round of negotiations there were several new funds added, ones that focused on chronic disease management, quality and improvement, the full-service family physician fund which are in the process of being implemented. But I think what you're referring to is the recruitment and retention programs under the committee on rural practice and the specialist recruitment, regional specialist recruitment and retention program. I don't have the exact number in front of me but those programs are in surplus with the SMA. They provide us with a financial accounting. They haven't done so for the last fiscal year. I haven't seen the December 31st, 2012.

One of the things we were working with the SMA on, and in conjunction with the recruitment agency, is to look at how to best target recruitment and retention dollars. We've looked at a couple of programs that we've used with the SMA over a number of years, like the bursaries and such, which actually are not providing a good return on investments. So we're trying to be creative about how to best use those dollars to achieve the outcome of retaining and recruiting physicians. So there's a lot of work under way to look at how we can, to best tailor those programs.

Mr. Broten: — Those discussions that are under way, are changes coming soon or in what stage are the discussions when looking at those, the existing programs? Because there would be commitments on the table to a number of students or residents who have received funding through different programs. And when might programs be changing, at what stage are the discussions?

Mr. Hendricks: — So there are continuous discussions at the committee on rural practice about funds that are paid through that fund.

If you're referring to the issue of interest payments for PAIRS [Professional Association of Internes and Residents of Saskatchewan], for students, that sort of thing, that's actually funded separately. So the SMA is sharing in the cost. But we're currently looking at a long-term solution for that program. We have till the end of June. We currently have that program settled to the end of June, but we're looking towards long-term strategies for that.

As you know, a couple of years ago the federal government said that they weren't responsible, or sorry . . . that medical residents weren't considered full-time students at the university and so weren't eligible for interest-free status on their loans. So we've had to correct this. We as a province have had to step in and correct this a bit.

Mr. Broten: — Okay. We'll leave that for right now. Looking at page 89, the drug plan and extended benefits. The Saskatchewan prescription drug plan is being cut by 5,410,000 from 314,962,000 to 309,552,000. Could the minister please explain why there is this decrease?

[16:00]

Hon. Mr. McMorris: — So this is kind of an interesting area, the whole drug plan and the changes that we've seen in the increases in the drug plan in past years to kind of where we're getting to now.

So there is a $14 million increase on some prices and utilization. That includes the, I believe it was $2.5 million . . . Well that wouldn't be quite right, but the $2.5 million that we put in to cover the commitment for diabetes, and I had talked about that. But some of that $2.5 million would go into the expansion of the insulin pump up to the age of 25. So those are some increases, but there's also reductions.

The reduced cost of generic drugs, those are continuing to be driven down. As well as then of course this is where the senior and children drug plan coverage comes in. A reduction there as well.

So when you add it up overall, you know, with the generic drugs dropping down, not quite as much exposure on the senior drug plan and children drug plan, offset by the price and utilization increases such as the long-acting insulin drugs, that's why there would be a bit of a decrease in the program.

Mr. Broten: — Okay. So savings through generics is one example, and then increased revenue coming in through higher amounts that people are paying is the other amount that would lower it?

Hon. Mr. McMorris: — Yes. It wouldn't be increased revenue because it would just be a reduction in cost. Right?

Mr. Broten: — Okay, but the reduction allowed because it's being covered in some other way.

Hon. Mr. McMorris: — It's a savings of $10 million as opposed to . . . When you say extra revenue coming in, it wouldn't be looked at as extra revenue coming in. It's a reduction of our subsidy.

Mr. Broten: — Thanks. The benefit plans program support line is also being cut by 276,000, from 4.7 million to 4.4 million, thereabouts. How's this reduction being achieved and what are the implications?

Hon. Mr. McMorris: — So that would, that reduction would be explained by again the workforce adjustment strategy which we've already touched on. There would be some savings there as well as a decrease to the centralized information technology fund. In other words there is some centralization in there so the, I guess you would say the IT [information technology], there would be a reduction in the cost of IT.

Mr. Broten: — Because of different approaches or because of fewer people?

Hon. Mr. McMorris: — So what this is is, as I said earlier, it's a consolidation of services so that instead of each area paying their own bill, it's consolidated. So it's a reduction here, but it would show as an increase on the provincial program support. But instead of being just kind of necessarily a line item, it's moved; reduced here and there would be an offset.

Mr. Broten: — That was specifically for the IT component?

Hon. Mr. McMorris: — Correct.

Mr. Broten: — And the benefits component, as I understand it, fewer employees so less amount needing to be paid out. Is that correct?

Hon. Mr. McMorris: — Yes.

Mr. Broten: — Okay. What types of benefit programs would that represent, just so I have an understanding?

Mr. Hendricks: — So the staff covered under benefit plans and program support would be the Saskatchewan prescription drug plan staff, Aids to Independent Living, supplementary health program, family health benefits, and — well this is actually just a program, but it's actually administered out of the branch — the multi-province HIV [human immunodeficiency virus] assistance. So this is generally those extended health benefits and drug plan.

Mr. Broten: — Thank you very much. While we're talking numbers and expenses, sort of a general question here, but what does it cost on average to keep someone in a hospital for one day? Is there an average amount that the ministry uses in calculations?

Ms. Jordan: — The amount will vary among the different categories of hospitals, community and northern hospital, regional, provincial. But on average across the province, a typical patient day — again this is the average across all categories — would be about $1,000 per day.

Mr. Broten: — Is the minister able to provide a bit more detail with respect to the different categories and some of the breakdown of what average amounts are for levels of care at different locations?

Ms. Jordan: — Certainly, that is available. I don't have it with me here today, but I believe we're returning on Monday evening so we'll make sure that that's available to you.

Mr. Broten: — Yes. Even if it was just a tabled document, that would be helpful to have on hand.

Ms. Jordan: — Yes, it's in a table.

Mr. Broten: — Thank you very much. And a similar question for what does it cost on average to keep someone in long-term care for a month.

Hon. Mr. McMorris: — So your question was, what is the per month based on a 30-day month, what is the average fee? Is $6,300 and, a little over $6,300.

Mr. Broten: — Thank you very much. On the topic of average amounts per day and health care expenses, how often or how prevalent is it within the system that medical care is provided to someone who doesn't have coverage because they don't have a Saskatchewan health card or they're not a Canadian citizen? They show up at a hospital, receive care because they're very sick, they need care, and obviously then the bill comes in the mail because they were not covered under a provincial program. Does the ministry track how common of a situation that is across the province? And I'm thinking of actually certain instances I've come across through constituency work, especially with new Canadians coming and being in the province and having, visit people here. Is this something that's on the ministry's radar at this time?

Hon. Mr. McMorris: — So there's really I guess a couple of things here. First of all, the numbers aren't very large at all that are using our facilities that aren't Saskatchewan residents. And even if they are, there's really two different kind of streams. If they're from another jurisdiction in Canada, for example, then there's reciprocal billing, so then that person would be covered.

The other stream of people that would come into our health facilities would be out-of-country which would . . . For example, you know the fishing and hunting is very popular. So they would come to Saskatchewan and he — you know, the fisherman or hunter — broke his leg and needs to be treated. So that there is a billing process for that. Under the *Canada Health Act* nobody is to be turned away regardless, and we'll work the billing out after. But if it's a non-reciprocal issue — in other words don't have a health card for example, another jurisdiction such as an American — then it is on a billing rate. And we in this budget have increased those rates quite significantly to truer reflect the costs that we incur when a person enters our system.

Mr. Broten: — Thank you. Maybe we'll carry on that discussion another day, but I see we're at the buzzer now. So I would like to thank the minister and the officials for the many answers today. Thank you.

The Chair: — Thank you and, Mr. Minister, have you got any closing remarks?

Hon. Mr. McMorris: — Just thank you for the questions and the interest of all committee members. Thank you for that. And also all the officials that were here from the ministry — obviously a huge wealth of information and knowledge. And every time I go through this, I think I may know a little bit about health until I realize I don't. So thank you.

The Chair: — Thank you very much. I would ask a member to move a motion of adjournment.

Ms. Eagles: — I so move.

The Chair: — Ms. Eagles has moved. All agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This meeting is adjourned. Thank you, one and all.

[The committee adjourned at 16:15.]