STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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

[The committee met at 19:00.]

The Chair: — Good evening, ladies and gentlemen, and welcome to the Standing Committee on Human Services. And my name is Delbert Kirsch and I am the Chair. Deputy Chair is Mr. Cam Broten. Also on the committee is Mr. Mark Docherty, Ms. Doreen Eagles, Mr. Greg Lawrence, Mr. Russ Marchuk, and Mr. Paul Merriman, and there are no substitutions. So this evening the committee will resume its consideration of the estimates for the Ministry of Health. As always, ministerial officials, please introduce yourselves when you speak for the purpose of Hansard.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We will now resume our considerations of vote 32, Health, central management and services, subvote (HE01). Minister McMorris, please introduce your officials and make your opening remarks.

Hon. Mr. McMorris: — Thank you, Mr. Chair. I had some fairly lengthy opening remarks on Thursday, I guess that would've been Thursday afternoon, so I won't have any opening remarks.

But I will introduce the people that are seated to my left and right and directly behind me. Dan Florizone, the deputy minister of Health of course, is to my left. And Max Hendricks, the associate deputy minister, is seated to my right. To my right behind me is Lauren Donnelly who is the assistant deputy minister, and beside her is Brenda Russell who is director of finance services branch. Over kind of my left shoulder is Deb Jordan who is executive director of acute and emergency services, and then also Lindell Veitch who is a ministerial assistant in my office. There is also a great supporting cast in behind the first kind of tier or two, row or two — and I wouldn't say tier or two, I'd say row or two — a great supporting staff that will be able to assist if there are questions in specific areas. And we'll endeavour to introduce ourselves before we start for Hansard.

But as I said, I had made a number of opening remarks and not a lot has changed since Thursday afternoon till Monday evening, so we'll leave it at that. And I'd be glad to field any questions that the committee may have.

The Chair: — Thank you, Mr. Minister. And I believe Mr. Belanger will take the floor.

Mr. Belanger: — Thank you very much, Mr. Minister and Mr. Chair. There's three particular areas that I want to talk about this evening, if I can. And obviously I want to thank my colleague for giving me some of his time in the committee hearing today.

The first item I want to talk about is the dialysis services in the Northwest. I think that's something that's really important to this region. The second item I want to speak about is Canadians living in the States and wanting to come home for treatment. And of course the third item I want to speak about is the alcohol and drug abuse services in northern Saskatchewan as a whole.

So I just want to give the minister an update as to those three items I want to talk about, so it gives him a bit of time to get the right people in front. So I'll start off with the dialysis issue. As you probably are aware, Mr. Minister, dialysis services are something that is not being offered in northern Saskatchewan communities. And I've noticed over time that there are more and more people that are subjected and are in need of dialysis treatment. And when I use the word subjected, I want to point out that it requires a great amount of travel for some of these people that are suffering through kidney failure. Again not being a medical person, but for a number of reasons, they have to travel to points south. And as I travel in our particular area in the Northwest, in particular Meadow Lake to be exact, I know there was a number of different groups of people and organizations that were lobbying for a dialysis unit in Meadow Lake.

And at one time, I had the opportunity to bump into a gentleman by the name of Frank Fechter. I think Mr. Fechter has since passed. But Frank — I think it was Frank — Frank championed a petition, and I think they had something like 50,000 names if my memory serves me correct, where Mr. Fechter, who was suffering and I think needed dialysis treatment, spoke to me about it, and another gentleman that was assisting Mr. Fechter from Green Lake also spoke to me about it. So between both of them, they showed me the plebiscite, and the simple request that they had at the time was we need to have dialysis services in Meadow Lake for the whole Northwest. Because the amount of work that Mr. Fechter did in terms of bringing the petition to the level that it gained support from the public, but more so in contacting the different people that had to travel to Saskatoon even from Meadow Lake for dialysis treatment, it was just a great number of people and a great problem.

So he put a lot of effort into the plebiscite and I did get a copy of it, but I instructed him at the time — both the gentlemen — that I couldn't present the plebiscite as it was given to me because the plebiscite was a xeroxed copy, and by the rules of the Assembly you cannot present a plebiscite unless it's in its original ink. So I asked them to get me the original copies of the plebiscite. I told Mr. Fechter that, and that I would present them to the Assembly every day.

But I guess the question I would ask today is that — given the rigours and demands of the folks that are travelling from as far north as Descharme Lake or La Loche, from Meadow Lake, from Ile-a-la-Crosse, from Buffalo Narrows, Beauval, and all the points in the Northwest to travel all that distance for dialysis treatments which are done on a regular basis; maybe two or three times a week they're on the road to get their treatment in Saskatoon — is there any way that we can look at getting dialysis treatment in Meadow Lake as a good, solid measure to help ease the travel burden that many of those people suffering from dialysis . . . or in need of that treatment, sorry.

Hon. Mr. McMorris: — Thank you for that question, and it took a little bit of time to get the answer because really the

answer isn't just yes or no to Meadow Lake. It's really a much bigger issue as to just whether we have a satellite set up in Meadow Lake. It really, really starts with prevention and the whole piece around prevention. I mean we have, you know, a greater dependency on dialysis and the different forms that that may take, whether it's at home or the different forms of dialysis that we offer in the province. But if we step back a few steps or years, the most important issue is the whole issue around prevention. And so we work with the northern health regions — all health regions, not to specifically single out northern health regions but all health regions — on chronic disease management and diabetes being one of those chronic diseases. But the whole management piece, but upstream the whole prevention is extremely important.

So we have, you know, diabetes educators in the various health regions to help people if they first have diabetes well before they get to dialysis. All of that prevention piece upstream. And, you know, it goes back to diet, and it goes back to exercise, and it goes back to all of those things because so much of this really, if you look upstream, is preventable. So we can continue to build and build and build to treat people, or we can put as much emphasis as we do or even more emphasis than what we have on the whole prevention piece.

And that is far more important, I think, is a prevention piece because, I mean, it's one thing when a person has to travel to get dialysis, but by the time they've got to this point it's really affected their life. If it's diabetes or whatever the reason for dialysis, their life has changed significantly over the past number of years. And so to do more work in the years leading up to the need for dialysis is what needs to happen because quite frankly I don't know if you could ever build enough — dialysis satellites is what they've really become, a satellite of a mainstay hospital — enough satellites across the province.

I certainly hear you when you talk about the North and some of the needs in the North because of extra travel. But I also hear those same stories in southern Saskatchewan. I think if you're familiar at all with the group from Broadview who had been lobbying for years, has been lobbying for years, because it is a fair jaunt. They have to either access their services from Regina or up to Yorkton. But it is a huge inconvenience. I mean you could name, I could name a number of different areas. I mean, I just had a group in from Fort Qu'Appelle who would be saying the same thing, a high number of people having to travel into the major centre, be it Regina. Or some from Fort Qu'Appelle could probably go, you know, northeast towards Yorkton.

I hear you though when you talk about the North; the distances are even that much greater. And so we have a committee in the province, the chronic kidney disease program steering committee, that directs us in this whole process. And that committee includes reps from the Kidney Foundation, physician specialists, health region authorities, the FSIN [Federation of Saskatchewan Indian Nations], and the ministry. So it's a pretty well-rounded committee that makes recommendations to ourselves as government as to where we need the next step, the next set of services to be provided.

One thing that has changed, I would say, over the last number of years is the way dialysis can be offered. I mean there's certainly a lot more people receiving their dialysis at home. There's 173 patients on peritoneal dialysis. So it has shifted from everybody having to go to the major centre, for example Regina or Saskatoon. There is still more work to do on that. There are satellites in Estevan and in Yorkton and North Battleford. I may stand corrected as to whether North Battleford is a satellite or if it's a major station, and I think maybe somebody will kind of straighten up that if it's inaccurate but . . . [inaudible interjection] . . . It's a satellite? It is a satellite, yes, North Battleford. And there's only so much capacity of the home station to handle satellites, and so you have to build capacity in the major centres in order to continue to offer more and more satellites around the province.

[19:15]

Having said that, as I said on the outset, prevention, prevention, prevention to stop, prevent people to get to this point. Once they are to the point of needing dialysis, looking at the various options to try and make their life as enjoyable as possible without having to travel every second day. And some of that is, again, home dialysis. And, as I said, 173 on peritoneal and then the others having to access the centres that we have.

As far as Meadow Lake, I would say that I was just up in Meadow Lake on Friday of last week I guess it was, or the week before, and they have just started a new primary health care clinic which will really, really have a great impact across the whole community and certainly benefit. It isn't what you're looking for as far as satellite dialysis, but it is kind of the whole team working together to treat the whole person, as opposed to one particular issue. And you know, it isn't always a physician or even a nurse practitioner that someone coming in to Meadow Lake may need. It may be education to know how to handle the chronic condition that they're suffering from.

So you know, we're looking forward to that having an impact. People that are on dialysis, that won't have the impact that what you're looking for, but it will have an impact on hopefully preventing people having to get to that point.

Mr. Belanger: — I would certainly concur with the notion that prevention is the key. But obviously the people that are taking the dialysis treatment now are far beyond the prevention perspective, I guess. So they obviously need to be treated for this chronic health condition.

And I think you made the point in terms of the travel demands. We know that the health is compromised of these patients already, and to subject them to four, five, six, seven hours of travelling, and this is not just once per week. I sure wish it was once per week. Sometimes they go two or three times a week for dialysis treatments, whether it's from Meadow Lake or whether it's from Buffalo Narrows, La Loche — the list goes on to the northern communities that have this problem. So I can't understate the incredible travel demands that someone that's quite ill and going through this chronic illness, the demand it has on their bodies and their minds and so on and so forth.

So when the region gets together and lobbies for — well obviously they lobby for prevention, no question about that — but they also lobby for a service within a defined period or defined distance. And whether it's Broadview or Fort

Qu'Appelle or Meadow Lake, I guess the question I would ask you is that, understanding your message of prevention — I appreciate that; I think they appreciate it as well — but on a go forward basis for those that do have the disease, and it's in its chronic state and consistent state and they need the dialysis treatment, what kind of parameters or what kind of criteria would you need to lobby for a dialysis satellite service in Meadow Lake, as an example from my area, that could help these people that need dialysis on an every second or third day basis? And I'm not exaggerating when they say they sometimes have to go to Saskatoon three times a week.

And at the outset I mentioned 50,000 names on a plebiscite. I meant to say petition. This petition has a lot of support. So I guess my question would be, what kind of numbers do you need to justify a dialysis satellite centre in Meadow Lake? Is there a number? What are the costs attached to that satellite? And a third question is, the other satellites, how did they become designated as satellites? If I can get answers to those three questions.

Hon. Mr. McMorris: — What I'll do is I'll start out again and just talk a little bit of where we are at today, and then I'll let Deb Jordan kind of talk a little bit more as to the chronic disease steering committee and some of the things that they have been working on.

I identified a couple of centres where there are satellites, but of course the two home stations are Regina and Saskatoon. And people have to access those until there is room in a satellite or until they're stable enough to go to a satellite because you just can't put them into a satellite until they're stabilized. And there's a lot of work that needs to be done prior, and there also has to be availability at the satellites. There are satellites in Prince Albert; a satellite in Lloydminster, which is run through the Alberta northern, the northern Alberta renal program, but we can access service through that, of course being on the border; Tisdale; Yorkton; Swift Current; North Battleford; Moose Jaw; and Estevan.

And as I said, and I'll let Deb talk more to the issues around expanding, but there needs to be capacity at the home sites before you can expand into another satellite. So it isn't just the numbers that you need in Meadow Lake, it is the capacity, be it in Saskatoon if that's the home station, or Regina if we're looking at a Broadview, for example. I think I'll leave it at that, and Deb, if you want to just identify yourself.

Ms. Jordan: — Thank you. Good evening, I'm Deb Jordan, and I'm the executive director of acute and emergency services with the Ministry of Health.

As the minister had indicated, there are home units in Regina and Saskatoon. All of the regional hospitals in the province have a satellite unit, as well as the district hospitals in Estevan and Tisdale.

As the minister also noted, for many years, the ministry has worked closely and takes strong heed of the advice that we receive from the chronic kidney disease steering committee. And that steering committee includes the two medical directors of the home units in Regina and Saskatoon, patient representation through the Kidney Foundation of Saskatchewan, regional health authorities, and the Federation of Saskatchewan Indian Nations.

Through that committee, over the past few years the highest priority after prevention — and working more through our chronic kidney disease clinics based in Regina and Saskatoon who provide telehealth services then out to other parts of the province — following the highest priority, which is prevention and early detection so we can prevent or delay the need for dialysis, has been to expand home dialysis services.

In September of last year, Saskatchewan hosted the annual Canadian chronic kidney disease collaborative, and across the country the target is to have approximately a third of patients who require dialysis receiving home dialysis, whether that be peritoneal or home hemodialysis.

The peritoneal dialysis has been provided for many years, and it's only been within the past two years that home hemodialysis has started to be available in the province. And what that takes is a patient who is willing to take the training and then have the equipment installed in their home. But the physicians who are responsible for the program have been extremely encouraged by the much-improved outcomes patients have when they're on home hemodialysis than when they're receiving dialysis three time a week in one of the in-centres. And the reason for that is the patient will hook up to dialysis before they go to sleep at night and it's a much gentler form. So the patient outcomes have been much improved.

With respect to the northwest part of the province, I will just make note that the satellite in North Battleford expanded its capacity in January of 2012 — so, three months ago — again trying to address the situation of patient travel. I know it's not in Meadow Lake, but it is closer to home. And we're also investigating, while some patients may not be comfortable on their own at home doing home hemodialysis, we are also looking at perhaps a couple of pilots. We've had meetings in two communities — the minister mentioned Broadview earlier, and as well, we've met in La Ronge — about the possibility of some patients coming into one of the health centres or smaller hospitals and, if they're a bit uncomfortable, helping them transition, and maybe some assistance there, but then transitioning to home hemodialysis.

Mr. Belanger: — Now the question I would have is that I understand the home base being Saskatoon for our region, and obviously I would assume it's a centre of excellence for delivery of dialysis services in general for our region. I understand that perspective. So in a sense of capacity, it's nice to hear that North Battleford's increasing capacity.

So when you mention capacity, one would assume that there's an increase in that particular disease or perhaps greater management of that particular disease. So which is it? Is it a greater incidence of the disease or are the numbers going up? Or is it better treatment for the sufferers that are out there now, or is it a combination of both? Because what I'm trying to get at is that in Meadow Lake's situation, if we're able to justify based on (a) an increase or better service or more people needing dialysis, then it would be nice for them to know that. So that's my question.

Ms. Jordan: — So in Saskatchewan over the past two years, we're starting to see the increase in incidence not levelling, but at least dropping, typically in Western Canada and especially among the Prairie provinces. The numbers of patients requiring dialysis each year over the past decade, decade and a half, has grown by 8 to 10 per cent per year. And we're starting to see a decline in that incidence in the province of Saskatchewan.

And you know, it's early days yet. Two years does not an ongoing trend make, but we are hopeful that we're starting to see the impact of the good work that is being done, you know, in the community with primary care providers and their heightened awareness about monitoring patients who are at risk and better supporting them and managing their care, as well as the chronic kidney disease clinics that I mentioned earlier that are based in Regina and Saskatoon and their ongoing support for patients. So it's increasing, but the rate of increase is starting to slow. And I think that's a good thing for Saskatchewan patients because while the service, dialysis service is certainly there, it is not the lifestyle that patients would choose to have to be on dialysis.

Mr. Belanger: — And I guess the other question that I would have on this, because I've got tons of questions but I've been given a certain amount of time so I'm trying to keep it as concise as possible here, but in terms of establishing a satellite, you obviously need equipment, you need corroboration with your home satellite — in our instance being Saskatoon — and you also need the technical people, or the trained dialysis equipment operators, I guess you can call them. So could you break down what would be required to establish a satellite and what the costs would be and what would the human skill that would be needed to set up a centre?

Ms. Jordan: — To most of the dialysis satellites in the province, some began as three-day-per-week operations, and they would have two runs serving probably anywhere from 10 to 14 patients per day in the units. The operating cost for a satellite, there's a fixed cost associated because obviously once you train the staff, even if there is a fluctuation in the number of patients, the staff are there. So the annual operating cost for a three-day-per-week operation runs in the neighbourhood of 600 to $650,000 per year; contrast with having a patient who is at home on either peritoneal or home hemodialysis where the cost would be obviously less than that.

There is special training that is provided for the nurses who work in the dialysis unit, and that is provided through the home units of Regina and Saskatoon. And that training typically is two to three months prior to the satellite opening. And the satellite also requires the oversight and agreement of the medical director at the home unit to provide that oversight.

Mr. Belanger: — And the cost of the equipment?

Ms. Jordan: — A typical dialysis equipment — and I'm going to be cautious on this because regions have moved into group purchase so that brings the price per unit down — but you would probably be looking in the neighbourhood of about 30 to $35,000 per machine.

[19:30]

Mr. Belanger: — The other thing I would ask is that how many people do we treat in the dialysis program, so to speak, in the province today?

Ms. Jordan: — As of December 31st of 2011, we had 784 patients on dialysis; 173 of those patients are on peritoneal dialysis, so they do their own dialysis at home. Twenty patients were on home hemodialysis, and the remainder, 591, were receiving in-centre dialysis either in the home units in Regina or Saskatoon or one of the satellites across the province.

In addition to that, through the chronic kidney disease clinics that are operated through Regina and Saskatoon but serve a larger population, we had 1,356 patients who were being actively followed and supported through the chronic kidney disease clinics.

Mr. Belanger: — So in looking at the satellites that are there now, really if you look at the cost of equipment being 30,000 and the staffing being 600, when you look at the potential of having a satellite centre in Meadow Lake, it's really not the staffing nor the equipment that's a major issue. It's just really the system itself. If it has enough capacity now, it would be hard to justify adding more satellites when really your numbers are definitive and they are dropping. Is that a correct assessment?

Ms. Jordan: — Just to be clear, the increase or the annual increase is dropping. It is still increasing somewhat. But again, speaking earlier of the advice that we received from the chronic kidney disease steering committee, clearly when physicians are seeing the types of patient outcomes associated particularly with home hemodialysis in comparison to in-centre, the preference is . . . and again it's up to the patient, the patient makes the final choice. But if the patient is willing to be able to contemplate training or having the dialysis equipment installed in their home, that for the best patient outcome, it's increasingly a home hemodialysis because that's a gentler form of dialysis.

Mr. Belanger: — My final question on this front is that the breakdown of the folks that are receiving dialysis — not just their location but their ethnic origin — are you able to break that down for us today, or do you need more time to do that?

Ms. Jordan: — I don't have that information with me today, but we can certainly provide that to you.

Mr. Belanger: — Is it safe to assume that the majority of these folks that are receiving dialysis are of Aboriginal ancestry because it appears, just based on the numbers, that the diabetes epidemic is primarily being faced by the Aboriginal community? Is that a fair assessment to make between the two?

Ms. Jordan: — I don't know that they're the absolute majority, but certainly Aboriginal people would make up a much higher proportion of dialysis patients than is the representation in the general population, so yes.

Mr. Belanger: — Thank you very much. The information has been great.

And I wanted to just maybe close off this particular aspect of my questioning with the message to the minister that Meadow

Lake has been long advocating for a satellite centre, and I appreciate the information this evening. But speaking with Mr. Fechter and others in that region over a period of several years, I know that they worked very hard to try and bring that issue to the forefront, and obviously we said we would do what we can to assist them in that regard. And obviously my prayers to Mr. Fechter and his family since his passing. He really championed this particular service, and it had a positive effect for many people in my constituency as well. So I just lay that information today with the minister.

If I can just shift gears a bit here, I wouldn't mind now speaking about out-of-country or what do they often refer to folks that live in other countries, as expatriate of Saskatchewan? Just in terms of medical services, because we know that we have a lot of folks that either are moving back to Saskatchewan from within Canada or contemplating moving home after years abroad or in different countries such as United States.

And a number of them have questions that they really wanted me to ask. So I'm just going to ask these generic questions in general, and then we can go from there. What I'd like to do, following the question and answer period, is to present to the minister the contact information of this particular couple. But at the outset, I don't want to use their names, obviously because that wouldn't be fair and proper. But I'll share that information with the minister following the question and answer period.

I guess the first question that I would ask: are there circumstances or instances where the minimum residency requirement for health care coverage would be waived?

Hon. Mr. McMorris: — I think just one comment on the dialysis piece that I would just finish off with, and then we'd go to the out-of-province, was the fact around . . . You touch on a number of areas. Is the equipment the deterrent or the reason why there wouldn't be a satellite dialysis? No, that wouldn't be the reason. Are there enough patients in the area? You know, that certainly is one of them. But can they be managed, as Deb had mentioned, through home or in other means certainly is a large factor.

When you look at the number of people waiting in Prince Albert, Lloydminster and North Battleford, it isn't a lot. I mean people are being served. Your point isn't necessarily that they're not getting the service — they have to travel so far to get the service — because we're coming very close to meeting the demand that there is. I think there is one person waiting in North Battleford right now. So it isn't that we are not meeting the demand. I think your point more is, though, is the travel time and the inconvenience to the family and trying to be able to deal with that, through other aspects such as home dialysis is so much more effective than even a satellite piece.

Regarding the out of country, or out of province, generally the rule of thumb is after three months they're able to have full benefits here in Saskatchewan if they're residing here in Saskatchewan. If they're moving back, they will have coverage.

Here's an example. If you arrive in Saskatchewan, January 1st, 2009, and your spouse — well I could say — joins you in June of 2010, your Saskatchewan coverage begins January 1st, 2010, at the end of the 12-month period. Your spouse's coverage begins September 1st. I know that probably doesn't clear it up. We'll have to kind of go through that a little bit more of detail. But you asked if there are any exceptions to the rule, and I would say, for the most part, it's pretty clear cut, and those are, you know, the expectations when people move to our province. I mean quite often if they're only gone from their province, for example, that they're moving from . . . It's different if it's out of country, but if they're moving from their province they would have some coverage, I would think, until our coverage cuts in.

But having said that, I can remember just shortly after becoming the minister about four and a half years ago, a situation of a soldier that came back with his wife who was pregnant and needed some extra medical care, and at that time she was not covered. Well we were able to make an exception in that case because there was some, you know, some extenuating circumstances. I mean the guidelines are set out. But you know, I would be very glad to see the information in the case that you raise, and we won't do it in camera or over . . . through Hansard or anything else. We can talk off line, and we'll certainly look at it and see what can be done. But having said that, there are guidelines.

And Max, do you want to kind of touch on it a little bit further and maybe kind of describe it a little bit better than what I did.

Mr. Hendricks: — So normally if you're moving from within Canada, as the minister said, your coverage starts on the first day of the third month after you move to Saskatchewan. There are certain classes of newcomers where coverage can apply on the first day that they actually are resident in the province, and those would be permanent residents, landed immigrants, people discharged from the Armed Forces, spouses — as the minister used the example — of Canadian Forces members who are returning to Canada. So there are these specific categories where coverage can begin first day.

Mr. Belanger: — We made reference to the soldier and his wife, which I think was a very good choice because obviously there is extenuating circumstances, and, you know, the person I'm making reference to has lived in the States, the US [United States], but their home is Saskatchewan. She's been born here in Saskatchewan and obviously, I believe by way of marriage she ended up in the States. Now I think, you know, she wants to come home.

So is there any kind of circumstances . . . and I appreciate the soldier example being one good circumstance, but is there other circumstance that could make a shorter residency in the province for an individual to receive medical assistance and treatment, like shorter than the three months? Is there any example of that?

Hon. Mr. McMorris: — You know, again, I think we'd probably need to know a little bit more specifics before I want to say yes or no. If I say yes and I didn't have all the specifics, that's a little difficult. For example there is . . . Max had talked about a couple of examples where it can be kind of on the first day or immediate, such as international students, returning Canadian citizens — she may fit under that — returning residents, you know. So there are a number of variables or examples where she may fit. It's hard for me to say yes until I know all the details, but it looks like there is possibly some

options for sure.

And for those that . . . you know, hypothetically if she's coming back and she knows she needs medical attention right away, that is one thing. I would suggest to some that if they're moving back to Saskatchewan and they don't feel they're covered, there is lots of private insurance that could cover them for a month or two if they felt that they weren't going to have the proper coverage, and to leave it to chance is maybe not good enough. And, you know, depending on circumstances, it probably wouldn't be a great cost for a month or two if they were healthy coming back.

So there is just a lot of different possibilities and until I have the exact detail . . . This is right on our web page, the Ministry of Health's web page, as to the criteria. And if it fits in there, great. I just would need to know exactly.

Mr. Belanger: — Yes and I certainly appreciate that the, you know, the circumstances of this particular client is important to assess, you know, what possibilities are there for her. And I share the questions today because there's obviously other groups of people that may have an interest in this. And this is something that's really important.

And so I've only got about five or six more questions just in terms of her general area of confusion. And then it'll help a lot of the other people that may be watching. And I'm assuming right now, today as we speak, that this lady is watching online from the US, because she is obviously quite interested in this. So I don't want to . . . I don't want to share her name here. I just want to share her questions and I'll share the name privately.

But the third question I have is, does a person who has never given up her Canadian citizenship — has never given it up — does she still qualify for health care from the province in which she was born and lived in until her departure for the US? She's never given up her citizenship and she was born and raised here in Saskatchewan. Does that qualify her for immediate treatment?

[19:45]

Hon. Mr. McMorris: — I think I would just kind of stay with my previous answer. It's difficult to adjudicate and to be specific because again there are a lot of variables. If she was moving back and setting up residence and was planning on being here for a long time, that would have some bearing, depending on how long — and I don't even know if this factors in — but how long she is away for. A person hypothetically is away for, I mean . . . You can use the example of a Canadian, never given up their citizenship to Canada. They're still Canadian living in the States, United States, and they come down with whatever serious disease there may be, you know, and you can imagine whatever that would be. And they have very little coverage in the United States or no coverage, no insurance. So they come back to Saskatchewan just for treatment. Is that appropriate?

You know, I think we'd all probably say well that, you know, that's probably cutting across the line. But we need to know all the information. I mean it may not be that situation at all. But if it was that situation, and I said yes she should be covered, or they should be covered because they're moving back into Saskatchewan . . . But we don't really know if they're moving back. I mean there's just too many unanswered questions.

And I mean you can ask more questions on a specific case which you're trying to do, but I can't give a specific answer until we have all the information and certainly look at it on the whole as opposed to, you know . . . I mean if she's a Canadian citizen, she's still eligible but there are some limitations around that as well.

Mr. Belanger: — Now that leads into the second question because obviously I think the minister has certainly ascertained that there is the reason that they want to move home is because they do have a challenge to their health. And I think the question that they would or she would ask in this instance is that, I'm a Canadian citizen, born, raised in Saskatchewan. Yes, I've been living in the US but I've never given up my Canadian citizenship. I want to move home for a variety of reasons, one of which is, you know, is a health care support that's there because I would assume they're not getting the health support that is necessary where they're living now. But it could be one of many, many reasons as to, and probably one of the most important reasons why she would want to move home.

So the question that she is asking is that if the need for health care in her situation is critical and they need to be here to get that support mechanism and she is from Saskatchewan, is a Canadian, her question is she wants to come home and for a number of reasons, but one of the reasons being for good health care service, how would the ministry accept that particular assertion on her?

Hon. Mr. McMorris: — Well again I'll answer the third time hopefully very similar to the last two times is that we would need to know . . . What I can assure her is that or that person, if they move back to Saskatchewan and establish a residency and plan on living in Saskatchewan, after three months they'll be covered. Absolutely. Once they've established a residence, like every other person moving back into Canada or a Canadian resident moving back, and that would probably apply I think pretty much across Canada. That person doesn't necessarily have to move back to Saskatchewan. That person could move to British Columbia. They could move to any other province. They would be eligible once they set up residency.

There are examples where health care will cover, will click in or start sooner but until I know all the circumstances . . . What they would have to do is apply to the ministry. And I would, if I was, you know, counselling, I would say that get as much information to us as possible so that we can make a decision before they get here and expect to have coverage right away. You know because there are, there are situations where that wouldn't probably be appropriate and I used the example of one already. Again that's a pretty broad example but what I would say, which is definite, if they move back to Saskatchewan and set up a residency they'll be eligible for our health services after the three months.

Mr. Belanger: — Obviously being a Canadian citizen would be different from being an American citizen, right? So if they decided to move to Saskatchewan for, you know, for good, would their treatment be different to accept, to get our health

care, any different? Obviously it would be different if they were originally a Canadian resident. So what's the difference between an American resident coming to live here in terms of the requirements for them to get health care versus a Canadian coming home, so to speak?

Mr. Hendricks: — So normally for an American to qualify for coverage in Canada, they would actually have to be a landed immigrant, become a permanent resident of Canada. In some occasions when there's a specific trade or profession that's in high demand, they would go through the same three-month rule that would apply to Canadians.

Mr. Belanger: — So there's no difference between an American asking to move to Saskatchewan versus a Canadian to move back to Saskatchewan where she was born and raised, in terms of the minimum qualifying period of time for medical services?

Mr. Hendricks: — Actually a big difference. To get your permanent resident card in Canada takes a very long time. These are specific professions that are in high demand that have been identified by our immigration ministry. So professions that are in short supply where people and workers are needed, they can come up and get coverage. So getting landed immigrant status in Canada if you're just applying from the US takes a fair amount of time.

Mr. Belanger: — Okay. The final question I would ask in this regard, because obviously I think it's time we do share the information privately, in the instance that this individual is fairly ill, has the ministry made any effort to transport any critically ill patients back home? The example I would use, if I, suppose I left the province and went to work in the States and was there for 10, 12 years working there, and I became quite ill, there's no provisions within the ministry to say, look I'm coming home, I need to be transported because of my medical condition. Is there any program that would allow that to happen?

Mr. Hendricks: — Currently there are no programs that allow for repatriation of Canadians abroad whether they're resident of another country or whether they're actually vacationing. That's why it's very important that Canadians travelling outside of Saskatchewan I will say, even within Canada, have health insurance if they want to be assured of repatriation to their home province by ambulance or air ambulance.

Mr. Belanger: — So the answer is, is there's no program at this time or . . .

Mr. Hendricks: — No.

Mr. Belanger: — Okay. Well I think one of the points I would make is that we really want to, well I certainly want to support the application because there's some various, you know, there's some, a lot of human emotion attached to this particular file.

I do know that this couple are intending to come back to Saskatchewan for good. This lady wants to come home. She's certainly been away for a while, but she wants to come home and it's for a variety of reason and would implore the minister to support her effort to come home to Saskatchewan, and to certainly be entitled to the benefits that she would as a Saskatchewan and a Canadian resident. I think it's really important we take that into account.

So on those points I'll share the information with the minister and I would ask the minister if you would kindly get back to this couple ASAP [as soon as possible], and also if they so wish — I have to ask them first — if they so wish to also let my office know as to the progress and an update on their file as it works through your system.

Hon. Mr. McMorris: — No problem.

Mr. Belanger: — My final couple of points I just want to make and I'll thank my colleague for giving me the time — I told him half an hour; we've been here for 50 minutes.

But anyway in northern Saskatchewan, if I can shift gears a bit, in northern Saskatchewan there is a lack of alcohol and drug abuse programs. And while I don't use illegal drugs, I have a beer now and then . . . White rum and 7 is my favourite. But anyway, so I'm not going to speak too much about alcohol or alcohol abuse because, you know, it's a very serious matter. But I don't want to diminish that point. At the same time, I don't want to be a hypocrite as well. I want to make sure that, you know, people that are in that field are supported, people that are facing that challenge are recognized. But I want to focus on the drug abuse problem we're having in many of our northern communities.

If you're a mother or a brother or a sister of somebody going through severe drug problems, illicit drugs, and you're trying to get them help, right now in northern Saskatchewan there is no help. There's no specific program or centre that you can take them to if it's alcohol abuse or drug abuse. I think the only centre we have in our region right now is the Clearwater Indian First Nations has a drug and alcohol abuse centre. They did have a drug and alcohol treatment centre in Ile-a-la-Crosse but they changed the model and they went to more of a home care style of model. And I don't know if it's working as effective as it should because taking people out of their community or out of their homes and put in say an 18- or 20-day program — I think it's much more successful as to going to a day program where you go to counselling or services and then you're put back in the same environment where there is, you know, family breakdown and family problems and you're subjected to a lot of other outside influences. And I think it hurts the family a bit. It also hurts the offender, or the person that needs treatment.

So sometimes when they're actually taken out of their community and taken out of their family for a period of 28 days, it gives both perspectives — the offender leaving the home, and the home itself — time to heal. And right now the stay away from their homes is not being afforded to residents in that particular area. I think the closest now they can go for drug treatment I think is in Lloydminster or North Battleford. And again the distance and the cost and the factors of being so far away from home adds to the challenge of trying to rebuild your life.

So I guess the question I would ask the minister, is there any kind of consideration or thinking around the notion that in the Northwest — especially where you have a lot of young people

that are subjected to the abuses of drugs, illicit drugs, and of course the constant challenge of alcohol abuse — there's no services there for now? And I would suggest that perhaps the high rates of youth suicide in the North is a symptom that these outreach programs to deal with drug and alcohol abuse simply don't seem to be working as effective as they once were.

So I guess this is my appeal to you to look at trying to establish services in the North where young people are trying to kick the drug habit in particular, but also deal with the alcohol challenge. They really have no place to go. I think they need a physical facility where they can go and get counselling, get support, get some good advice from different people, professional people. And that doesn't exist to the extent that it should in the Northwest, and I believe the problem might be in the Northeast as well. But those are the questions I have for the minister on that front.

Hon. Mr. McMorris: — Maybe I'll just start with a general statement and then maybe I'll turn and get some more details, particularly as it pertains to the two northern health regions.

What I would say first of all is that, when you're dealing with alcohol and drug addiction, they become very complex social issues. The ministry has worked hard to try and make sure that we have the proper programs available in every health region. But having said that, I know there are always. . . And I get calls, and know of people that will come in to my constituency office, and know of people that I've dealt with personally that have — you know, maybe we say this term too often — but have fallen through the cracks, maybe haven't received the type of care that they needed to have. And so I know that there is always more work to be done there.

But it is a very, very complex issue. I mean there is alcohol addiction. There is drug addiction. And often accompanying some of that is some mental health issues. So it isn't usually just a issue that is needed to be dealt with throughout, you know, throughout the health care system. It's a combination of things.

I would also say that I may take your assertion as correct in that it doesn't seem to be working as well as it used to. I would say that I think it's working as well as it used to; the complexity of the problem has increased significantly. The complexity of the amount of drugs that are available, the different types of drugs, the potency of drugs, the availability of drugs along with alcohol, and along with some mental health issues, I would say that the issue is far more complex today than it was even 10 years ago.

[20:00]

And so if it's not working as well, it may be that it's working as well, but the problems have become far more complex. And that isn't specific to the North; it would run throughout the whole province. I can tell you that, you know, some of the social determinants that factor into this certainly can be poverty. But I would also suggest to you that, you know, it isn't necessarily poverty alone. I think you could probably go down to some areas of the province that are doing very well through the advancement of oil and gas in the area or whatever, and there are far more drug and alcohol issues where there's a lot of money now than there ever was before. So social determinants are definitely a factor, but they're not the only factor because you can take from one extreme to the other, and they both create problems.

We've put $48 million in this budget. 2012-13 is expected to spend $48 million on alcohol and drug service programming. That's a record amount going into drug and alcohol service programming, and some will say it's not enough. And that's a mix between health-region-run facilities. It's also CBOs that are involved — community-based organizations that are involved. It is a mix.

And every health region — you said you're not sure and you identified maybe one in the northwest — but every health region has, offers some service. The difficulty of course with the northern regions for sure is the large expanse, of course. And to have the services where the people actually need them very close to home is always difficult. But I can face those criticisms from southern Saskatchewan too, that people don't feel that the range of services they need, to be able to address the issues that they have, are ever close enough to home.

We are working of course with the Prince Albert Grand Council and the new treatment centre, the youth drug and alcohol treatment centre that I think construction is almost complete. I've been to the sod turning and I've also been to . . . And construction was almost complete when I was in Prince Albert. Had the opportunity to walk around. It wasn't complete. I'm sure we're getting close there, and it's just another resource.

We've increased the number of beds, you know, for the whole expanse. You know, whether it's out-patient, counselling, detox, in-patient treatment, long-term residential services, day treatment, and transitional housing support, all of those, we're working with health regions. We're expanding. Has it met the need? I would probably say, no it hasn't, and especially in specific areas.

But again, I'll go back to my original comments. The issue is far more complex today than it ever was a number of years ago, and it's trying to deal with those complexities. And the person really does need to be treated as a whole person, not just on one specific issue that it may be alcohol or it may be drugs because it's probably not just one. There's probably a number of issues and, you know, also the whole issue around mental illness. And we've had discussions with that before. So we're working on it. More work to do.

Maybe I'll stop there, and I'll just have somebody talk a little bit more about kind of the specifics of an area such as what you're asking.

Mr. Carriere: — Good evening. I'm Roger Carriere, executive director of community care branch at the Ministry of Health. I think the minister has described quite well that this is quite a complex issue and that there's a lot of issues in terms of income, employment, individuals having hope in their lives, that really affect their situation in terms of mental health and addictions. And it isn't solely more health services that will fix some of those problems.

In terms of the North, there are eight addiction beds in La Ronge, and then there's four detox beds in Ile-a-la-Crosse, and

four detox in La Loche. So there is some bed capacity. You are correct that most investment in the North has been more in the community piece and having youth addiction outreach positions, having more prevention resources, having outreach workers in connection with *The Youth Drug Detoxification Stabilization Act*, community mobile outreach. And in many ways that will assist individuals.

Certainly concur that some people do need more longer-term, in-patient treatment. The minister mentioned the youth treatment centre in collaboration with Prince Albert Grand Council is expected to open in probably a couple months. It'll be 15 beds for youth there.

As well in Prince Albert, there's the development of a family treatment centre, primarily targeted to women with children, so that women needing treatment can actually bring their children with them. There's often a concern that sometimes women don't seek treatment because they are concerned that their children will be apprehended in that process. And so that is a facility that will hopefully be opening later this year, probably about the end of 2012.

In terms of mental health, there have been some additional resources put in the North. Recently the ministry funded the Métis Nation — Saskatchewan about $150,000 to do suicide prevention. Those dollars went out in March. As well, we've done some suicide prevention initiatives. There were some suicide prevention comics developed that were focus tested on Aboriginal youth. There were radio spots on Aboriginal radio stations and banners on social networking sites, and they were promoting the use of HealthLine as a first responder for suicide. There was a second run of those radio spots this year over a four-week period. And as well we're putting out about 5,000 more prevention comics.

As well we've tried to increase, through Prince Albert, the consultation and child psychiatry, psychology, and social work to support staff in the North, and a telemental health project has been implemented to support that. So there have been some additional supports over the last few years put towards the North in terms of mental health and addictions.

Mr. Belanger: — Okay. Thank you very much. I just want to thank the minister for his time and the officials as well for their information. I would close on this front, Mr. Minister, is the fact that, as was alluded to by the official, there are four beds in La Loche, four beds at Ile-a-la-Crosse, and eight beds in La Ronge for the entire North. That while I appreciate some of the home-based remedies that may be in place for dealing with the alcohol or the more challenging drug abuse problems in the North, that I think it's almost time that we call for a facility that has specialty in dealing with youth drug abuse and suicide attached to drugs and a course in alcohol. And the family support centre, somewhere where you can have a concentrated plan to have supports for those that are struggling with this because as we speak, Mr. Minister, there are families out there that want help for their kids.

And I agree, it's all over the province. There's rich schools that have a greater problem than inner-city schools. I appreciate that point. And this challenge is not diminished to anywhere, but in the North we lack the services, whereas Saskatoon may have services; other communities may have services. We, you know, have family supports there, but many times those family supports are challenged. So there are young families out there, moms and dads and grandpas that are trying hard to find services or a place for their young child in their life that are going through this struggle to go and get help. And four beds in La Loche and four beds in Ile-a-la-Crosse for the entire region just doesn't cut it.

So I would implore you to look at that. And my closing comment is that families need help to deal with alcohol and especially drug problems with their young people, and there's nowhere for them to go except out of the region, and that adds significant challenge to that young person and to the families that they're leaving behind. Thank you.

Hon. Mr. McMorris: — Thank you for those remarks, and I appreciate that. You know, I would probably echo your comments on, you know, the size of the area, population, and the number of beds.

What I will say though is that in '11 and '12 fiscal year there is over 30,000 admissions to addictions services across the province, which is an amazing number — over 30,000. There are over 300 treatment beds in the province and the outpatient services can be accessed in over 50 centres throughout the province. So you know, we're trying to address it. I think we could probably agree that there is more work to do, and you can identify a couple of areas. Having said that, you know, we have made some progress in the front by increasing the number of beds, but there's more to do.

The Chair: — I believe now Mr. Broten has some questions.

Mr. Broten: — Thank you, Mr. Chair. Thank you to the member from Athabasca for those questions and to the minister and his officials for covering off those items.

I'd like to begin tonight please with the discussion about funding provided by the ministry to non-profit organizations in Saskatchewan, in the funding from the Ministry of Health. Could the minister please provide us with a list of which non-profit organizations receive funding through the Ministry of Health?

Hon. Mr. McMorris: — Receive funding from?

Mr. Broten: — Yes.

Hon. Mr. McMorris: — So I'll kind of do a broad overview of the funding that goes to CBOs and then if you want to get into more detail we can certainly do that. Because there is always, as we had talked on Thursday afternoon, there is also a divide between ministry-funded CBOs and then there are health regions that will put money towards CBOs. You could say it's the same money but it really is, the relationship is between the health region and the CBO in some and not so much directly with the ministry, the ones that we fund. So roughly about $26 million budget to 25 CBOs provide direct service. The ministry funds approximately, as I said, $26 million to community-based organizations to provide early childhood development, mental health, addictions, training, education, and various other services.

[20:15]

And I just kind of have a broad overview breakdown of CBO funding, include: 10.6 million supports to the KidsFirst programming; 5.9 million to the Saskatchewan Abilities Council providing equipment to persons with disabilities and providing orthopedic services to qualifying residents; $4 million to MACSI [Métis Addictions Council of Saskatchewan Inc.] which we had just kind of had a little bit of a discussion before, and the St. Louis rehab providing addiction services; 2.6 to SAHO [Saskatchewan Association of Health Organizations], providing labour relation services to the RHAs [regional health authority] and the ministry; $500,000 to the Schizophrenia Society of Saskatchewan providing mental health services; 2.4 approximately 20 other CBOs funded under 500,000. They get under 500,000 each to provide programming and training in various other services. Okay, also and CMHA [Canadian Mental Health Association] as well as the Schizophrenia Society of Saskatchewan.

So that is just a real broad overview. I think there is roughly — I hear like 100 — maybe not quite that many CBOs that we are directly responsible but there are others . . . 25 sorry, 25 CBOs that we have direct service delivery for and then there are many more under the health regions. But if you'd like to get into more detail as far as each CBO we'd certainly, Max would certainly be glad to answer those questions.

Mr. Broten: — If the minister and official could list the 24 — or was it 25? — with the amounts that they received for each, that would be appreciated, please. And I'm not sure if you're in a position this evening to table a document detailing it but if you could read it out for the record, I would appreciate that please.

Mr. Hendricks: — Okay. The AIDS Program South Saskatchewan Inc., 86,190; AIDS Saskatoon, 91,220; All Nation Hope AIDS Network, 35,915; Canadian Mental Health Association in Saskatchewan, 246,723; College of Dentistry, U of S [University of Saskatchewan], 123,547; College of Pharmacy and Nutrition drug information services, 188,103; drug evaluation support — roving professorship program, 60,000 . . . Am I on the right line?. 60,416. Yes, I need a line thing.

Métis Addictions Council of Saskatchewan, 3,113,759; Persons Living with AIDS Network of Saskatchewan Inc., 64,644; provincial prescription files, 463,946; Saskatchewan Association of Health Organizations, SAHO, 2,751,321; the Saskatchewan Association of Optometrists, 110,000; the Saskatchewan Impaired Driver Treatment Centre, St. Louis Rehab Centre, 1,044,583; Saskatchewan Towards Offering Partnership Solutions to Violence, 46,375; Saskatchewan Pediatric Auditory Rehabilitation Centre, SPARC, 74,920; Saskatchewan Prevention Institute for Sexual and Reproductive Health, 291,447; Saskatchewan Prevention Institute, 250,685; Saskatchewan Prevention Institute for FAS/FAE [fetal alcohol syndrome/fetal alcohol effects], 107,781; Saskatchewan Prevention Institute for Infant Mortality, 144,847; Saskatchewan Seniors Mechanism, 48,754; Saskatchewan Council on Aging, 50,716; the Schizophrenia Society of Saskatchewan, $232,001.

The Avenue Community Centre for Gender and Sexual Diversity Inc., 143,654; the Canadian National Institute for the Blind, 420,171; the Saskatchewan Abilities Council, equipment loan program, 4,854,996; Saskatchewan Abilities Council, orthopedic services, 1,208,341; Saskatchewan Lung Association, 82,507; early childhood development, KidsFirst, 10,899,445; early childhood development, cognitive disability, 117,420; and other CBOs, smaller little grants, $13,404 all totalled.

Mr. Broten: — That 13,000 is sort of a catch-bag of small disbursements to a number of CBOs, is that correct?

Mr. Hendricks: — That would be correct, yes.

Mr. Broten: — About how many would be identified there, about?

Mr. Hendricks: — These are very small grants that we give to third parties for conferences and that sort of thing, or other functions. So the association of Saskatchewan home care auxiliaries, $3,000. And I don't have a comprehensive list, but I'll just give you a flavour here. The Alzheimer Society of Saskatchewan, $2,000; federal . . . or sorry, the first responders conference, $3,000; Saskatchewan Approved Private Homes Association, $3,000; Saskatchewan Down Syndrome Society, $1,000. And they're little, you know, conferences like that and stuff that we're supporting.

Mr. Broten: — Thank you. In the list, I just missed jotting down the amount for the Saskatchewan Lung Association. How much was that, please?

Mr. Hendricks: — The Saskatchewan Lung Association was $82,507.

Mr. Broten: — Thank you. In looking at the list provided — thank you for reading those off — just sort of my initial impression, some of them, some of the organizations belong to fairly large groups which would be well known to . . . That's not really the definition. Some are fairly . . . part of large groups. Some are more smaller operations, and the amount of the grants or the funding sort of indicates that.

For example with the Schizophrenia Society, could you provide an explanation as to what that $232,000 is used for? What type of programs or positions?

Mr. Hendricks: — Okay. So the Schizophrenia Society of Saskatchewan, the agency provides the project entitled consumer support and advocacy, public education and a partnership program. This program addresses issues and challenges relating to schizophrenia. It also facilitates and conducts public education and support meetings and participates in provincial and national informational workshops. This program improves access to and availability of information on schizophrenia to all areas of Saskatchewan.

In addition it provides information to the members of the agency and the general public concerning current developments and research and public awareness initiatives relating to schizophrenia through the distribution of newsletters, publications, and communications.

Mr. Broten: — Thank you very much. And could you please provide a snapshot of the services provided by the $420,000 that goes to the CNIB [Canadian National Institute for the Blind]? What kinds of programs would that support, please?

Mr. Hendricks: — So it provides vision, rehabilitation services for qualifying Saskatchewan residents, as well as purchasing housing and maintaining and distributing equipment and supports to persons with a visual disability who meet a certain criteria. In 2010-11 it provided 586 mags, 210 canes, 107 watches, and 113 tutorials were distributed as well, so it's actually providing direct services.

Mr. Broten: — Thank you very much. I know a few of the MLAs [Member of the Legislative Assembly] got to see some of the things that they're doing at the reception they had I think just last week. And just one last example, please. For the Sask Lung Association, I believe it was 82,000. What services or programs are offered with that 82,000?

Mr. Hendricks: — So it provides the following support: it provides training and consultation to health professionals in carrying out oximetry testing where access to these services is not available; it manages the oximetry overnight service, including housing, maintenance, shipping, and receiving; funding provides registration and documentation of oximeters; collation of the oximetry study information; and sharing of such collated information with the requesting physician.

In '10-11 it provided 199 certification and review workshops, it provided two newsletters to all the testers, and the overnight oxygen oximetry service had 393 people tested. Phone consultations are provided on a regular basis to health professionals and testers.

Mr. Broten: — Thank you very much. My question to the minister: how does the ministry determine whether or not to fund one of these non-profits, one of these CBOs? Is there a set criteria to be eligible and to receive funding? And if so, what is that criteria, please?

Mr. Florizone: — Just in terms of the criteria or the rationale for funding, much of the justification dates back . . . In fact I'd have to draw my assistant deputy minister experience. That list is very similar to the community-based organizations that were funded a decade ago.

They were established for the purposes of either providing a direct service where there was a gap or a need; could have been an emerging issue that was resolved through partnerships with community-based organizations. But there was never, at least to my knowledge, a specific criteria that was established across the ministry to determine what should be funded and what shouldn't be funded.

We have gone through a variety of iterations, reviews from year to year around budget time to take a look at who we fund and for what, and whether that service and program offers value to the system. And the determination is that this list is bona fide in terms of providing value for patients, residents, clients, and citizens within the province.

I would love to tell you that we have a very specific criteria within which to fund new initiatives. I can't recall in my time as a deputy minister that we've actually added new CBOs. There may have been some enhanced funding, however, for specific initiatives around tobacco, around HIV [human immunodeficiency virus], in other words, in those areas of emerging need and then of course through regional health authorities, mostly on the addictions front. But in terms of new, brand new community-based organizations, I can't recall a new one coming along since my time as deputy minister.

Mr. Broten: — So if I understand that correctly, is the answer basically, what's funded now according to this CBO list is mostly based on past practice?

Mr. Florizone: — A lot of it is history. There are a few exceptions, as I've said, where there's been emerging need, where we've identified an enhancement to funding because of that emerging need, but the majority, the vast majority of this funding is past practice.

Mr. Broten: — Is the minister at this time content with that approach to funding CBOs?

Hon. Mr. McMorris: — I guess what I'd say to that is that, you know, the organizations that we've kind of referenced today are longstanding whether it's the lung association, schizophrenia. I think as specific issues come to light, and, you know, this certainly would have happened a number of years ago, but some of the CBOs that we fund to the greatest amount are around the AIDS [acquired immune deficiency syndrome] issue both in northern . . . Saskatoon and Regina as well as a couple other programs. Those would be perhaps some of the newer organizations. And so if an issue came to light and it was felt that the best way of addressing that would be a CBO and funding a CBO because they were on the ground level, that may be the situation.

[20:30]

But I would say that, you know, on a very regular basis, I would have organizations that would come to my office and say, you know, we have this idea as a CBO. Would you fund us? What tends to happen with that is that it would tend, for the most part or quite often, flow through health regions because it may be a specific program that might work within the health region. And one of the areas, and it wouldn't be funding the Heart and Stroke Foundation, but the Heart and Stroke Foundation had an idea as far as a pilot project in the Sunrise Health Region. Money would go to the Sunrise Health Region that then would fund a specific program, maybe not a CBO but a specific program.

So you know to say . . . and Dan is right. The deputy minister's right as saying, you know, we haven't added any. That doesn't mean that we haven't funded through a health region specific initiatives that certain CBOs may have. Some money may go to the CBO. Quite often it's a program delivered through a health region that the CBO is supportive of or an organization is supportive of. So you know, I'm not saying that because these are the ones that we've funded and they're the only ones that we fund that we'll never fund anything else because if that was the case, I don't think AIDS Saskatchewan would be funded.

So you know, depending on the need within the province or within a specific health region, it will vary. But again, you know when it comes down to delivering services, direct delivery of services, most of that is done through health regions and the relationships that they build with CBOs.

Mr. Broten: — Thank you. Were there CBOs or non-profits that specifically asked for increased funding in this last budget, but they did not receive funding?

Hon. Mr. McMorris: — So I'll just kind of start with a broad statement in that in four and a half years — and it doesn't need to be necessarily CBOs but other organizations — I've never really had anybody that's come to the office and said they want less money, you know, they want to give some back. That has never happened. And some will come with specific program, ask that maybe, again, delivered through a health region or the relationship with the heath region. There are, as we said, 25 that we directly deal with and we're just trying to remember if there was a specific proposal, but quite often it's just a generic increase across the piece.

If there are, for example, issues around HIV/AIDS [human immunodeficiency virus/acquired immune deficiency syndrome] that we need to, feel that we need to shore up and help a specific CBO in that area, I mean they may get a bit bigger increase. Now if you've got an organization that has come with a proposal and they're not happy that it wasn't funded, I'd be interested to see that or to hear that. But generally, of the ones that we deal with, it's a general lift unless it's in a specific area that we feel we need to put more resources into. And they may see a larger lift. Again that would be the CBOs that we deal with, but there are a vast number of CBOs that we don't deal with directly as a ministry, that health regions would deal with that would be asking as well for more resources.

Mr. Broten: — Thanks. So the health region CBOs aside, out of the ones that the ministry funds, the 24 here, were there specific proposals from some of these organizations on specific programs or initiatives that were not funded in this year's budget?

Hon. Mr. McMorris: — I think . . . I mean, that's a tough question to answer. You know, did anybody ask for an increase? You know, they probably all would want an increase and some would phone and say, can we get an increase? There'd be many that probably didn't submit any paper that we know of. But what we did is we, you know, we went across the piece and it wasn't a budget for handing out a whole lot of extra money. I mean the organizations, the CBOs that have been operating are still continuing to operate with a slight increase from the ministry. And, you know, we can't offhand think of a proposal that came from one of the CBOs that we fund for a huge, huge increase or a huge expansion. I could stand to be corrected.

And as I said, there would be many other organizations that would come to the ministry on a regular basis, that we don't fund, that would like funding. It seems quite often that where they start to look for funding is through government first. And then if that doesn't work, they may look somewhere else and quite often are successful.

So, you know, it's a general answer. To be specific, you know, on what each one asked for, their proposal, many hadn't . . . or all that we know of, didn't have a specific, you know, laid out business plan asking for an increase that we know of, again not that that would be the criteria for an increase. I mean we put in, you know, a lot of money into these right now and they offer great service, absolutely. But that's where we stand today.

Mr. Broten: — Well most certainly they offer good service. Anyone who's been involved with a CBO on a volunteer basis or as an employee knows that they work hard and do a lot of really good work and often on budgets that are tight.

Getting back to the issue of those that are basically grandfathered in or those that are funded based on past practice and those that may be receiving a degree of funding or may want to get on that list of funding as a CBO, is there any thoughts by the minister of opening up that process and developing more criteria that is sort of a bit more open and transparent? Or does the minister feel like it's working pretty well as is?

Hon. Mr. McMorris: — I think, you know, as was mentioned, some of these CBOs are historical. Many of them are historical. We need to look at it from the Ministry of Health's perspective, knowing that we're not necessarily the deliverer of services. And so we sometimes would even question, instead of expanding groups that deliver service funded directly from the Ministry of Health, they should be looking through the health region who delivers service.

And some of these could probably, you know, if we were looking to change things . . . and we haven't this year and, you know, we don't have necessarily any plans next year. But some of these organizations deliver services that are specific to health regions, and so one would question why the Ministry of Health would be funding them and not being funded through a health region where the health region knows what services it needs in any specific community, for example, probably better than what the Ministry of Health would know.

And so you know, if it's service delivery, which most of these organizations are — and some of them are very specific into certain communities — one would think that maybe they fit better under a health region, as opposed to the Ministry of Health. Not saying that we're, you know, moving them out at all, but instead of looking at bringing more under our funding, we would tend to say they should be looking at the health region and influencing or convincing the health region that service is needed. And then the health region would come to us for their overall budget to cover any addition to CBOs and CBO payments that they would have.

Mr. Broten: — I thank the minister for his answers on this particular topic. At this time I'd like to move on to another subject, one that we haven't talked about yet, and that's the new physician locum program that has been announced. I'm not sure if there's a changing of the guard that's required or not, but I'll start off. It was announced in the Throne Speech, and I believe there was some reference to it in the budget as well. Could the minister please provide . . . Well I'll say in the Throne Speech; it wasn't too detailed with respect to what this will look like and how it will, what it will look like and how it will roll out

throughout the province. But could the minister please provide some opening comments or some statements, some more detail about the plan and how it's developing and some of the dates that will be involved, please?

[20:45]

Hon. Mr. McMorris: — So it was a campaign commitment that we're following through on, we started to follow through on within our first year in this budget, with $1.5 million in the 2012-13 budget that will go to the rural physician locum pool. The targets that we set will not be reached in the first year. It is a four-year commitment to continue to increase the locum pool. And there are a number of reasons why it needs to be set up over four years, and just the simple fact of making sure that you have enough physicians to fill the full commitment. And that's why only $1.5 million was put in this fiscal year.

We are working closely and exploring opportunities with the SMA [Saskatchewan Medical Association]. Of course they have a locum pool right now. So we're working very closely with the SMA to see, explore what can be done in this area, not to mention many of the other stakeholders that will benefit from this locum pool, such as many of the rural and even urban but many of the . . . I guess I should just leave it at all the health regions across the province, not just rural or urban, but all the health regions across the province. We are having input with them, talking to them as well as the physician recruitment agency.

So there's a number of, quite a bit of work that is started. The money is there. The program is moving ahead. And you know, we think that as we work, again with the SMA to develop this and explore options, we'll be in a better place to answer that question, I would think probably a month or two down the road than we are right now. The budget was of course in March, and we're in the process of . . . You can't do a ton of work on this before there's money to back it, and so we're in that position now.

Mr. Broten: — So what's the $1.5 million in this budget being used for, with respect to getting the program going?

Hon. Mr. McMorris: — So the 1.5 will be used to, well obviously to cover the cost. We expect to and hope to recruit anywhere from three to five physicians in this year. That will start that process going. So that would cover salaries, as well as some of the base start-up costs as to administering the program, which again we're exploring with the SMA.

Mr. Broten: — What's the goal for the number of physicians working in the program over the four years of the role that the minister identified, and what are the targets with respect to adding physicians each of those years to get up to whatever the final promised number is?

Hon. Mr. McMorris: — So the campaign commitment was a total of 20, increasing the locum pool by a total of 20. And as I say, we're hoping to hit the three to five number in this first fiscal year. And once we have, the basis to expand on that and reach the 20 by the end of the 4-year term of our government.

Mr. Broten: — Thank you. So the pledge of 20, that's over and above whatever locums currently exist within existing programs? That's 20 new locums?

Hon. Mr. McMorris: — Yes.

Mr. Broten: — Okay. The minister in his remarks talked about the existing SMA program. Is it the minister's view right now that this would simply be expanding what the SMA does in their rural relief program or would it be something that runs parallel or in addition to? Could you please elaborate on that?

Hon. Mr. McMorris: — Well what I'll say is that there are a number of different options that are being explored right now. There could be a parallel program. It could be, there's a possibility it could be run under the SMA program. There are a number of different options, as I said, and those are being explored right now. I mean, you could even get . . . If you really wanted to kind of let your mind wander, could it be run through a particular health region? Could they have a locum pool and could we set up locum pools in each health region that would cover? So there's many different varieties of how the program could look.

And it's too early. As I said, this question would be easier to answer once more work is done on this process, once we nail down exactly how it's going to look into the future. What we do know is we need to right now be working to recruit physicians, look at physicians that would be interested in going into this locum pool. As I say, we're exploring with the SMA what the options are through them. You know, I would say in first blush, it would make sense that they have a locum pool already and this would complement the locum pool that they have. Having said that though, we're in discussions with them. We'll see how it all shakes out.

If it was a parallel system, there are some benefits there. There would be some benefits within a health region system as well. We're looking at all options, but as I've said, kind of on first blush, if you're to look at it running, you know, a complement to the SMA would tend to make sense. But we're exploring those options.

Mr. Broten: — Thank you. How many physicians are currently working through the SMA's program?

Hon. Mr. McMorris: — Currently the SMA have nine locums within their locum pool.

Mr. Broten: — Is that number fairly constant with what they've normally had? Or is it higher or lower than what the last few years has been?

Hon. Mr. McMorris: — There is very minor variance, variation, I think in the SMA locum pool. As I've said, right now I think you could probably say on an average, roughly about 10 locums within their pool. Right now presently we have nine full-time locums and two part-time, so I guess maybe you could average that out and say it's 10. They may not want to look at it that way, but there are two part-time, nine full-time. And that will fluctuate or vary, but slightly.

Mr. Broten: — Does the ministry have in front of it what the highest number in the locum pool has been so far through the

SMA?

Hon. Mr. McMorris: —I don't know if we have the exact numbers dating back because it would vary even through a year, so to say that in 2010 it was this, but it might have varied throughout the year. You could kind of pick one date and say where was it at, but you know, we're thinking maybe 11 may be the top, maybe 12 would be the top. And so we're running at 10 right now. As I said, it would vary, fluctuate by a physician or two on any given year or any given month depending on, you know, people that may be in the locum pool then decide to practice permanently in one spot. Some other person would come in and fill out a spot within the locum pool, so it will vary from year to year, but not greatly.

Mr. Broten: — Thank you very much. What is the form of payment for most of the physicians currently working in the rural relief program? Are they employed or self-employed? Is it salary or contract, fee for service? How are the dollars flowing through the program, please?

Mr. Hendricks: — So right now they have a grid that they pay locums based on, and the grid ranges on a daily rate of 1,030 to $1,120 is a daily rate. There's also a travel rate for days that they're travelling or time that they're travelling which is slightly lower, ranging from 865 to 940. And there are also a number of other supports. They provide a lot of their associated . . . Well they have no direct overhead, but overhead costs is a vehicle, you know, a cellphone, that sort of thing. So it's actually a fair amount of work on the part of the SMA to supply and manage this locum pool.

Mr. Broten: — So if a locum physician is engaged on a full-time basis through the program, and it's about $1,000 day rate, what's the dollar figure per doc per year for a full-time position?

Hon. Mr. McMorris: — We don't have that specific number, that exact number with us, but we can work on it and get it to you.

Mr. Broten: — Okay. Thank you. What is the current eligibility criteria for communities or practices requesting the services of a rural relief physician? And I ask this because if the plan for the new locum pool is to mirror or to add on to what the SMA program is looking . . . how it currently functions and operates, I think it has relevance for what physicians and the people in the province could expect.

So what's the current eligibility if a physician is requesting coverage through the program?

Mr. Hendricks: — So the current program provides replacement coverage when there are fewer than five physicians in the practice. Five or more and it's thought that the practice should be able to provide cross coverage. The idea with the new locum program is to provide longer term relief. And we're actually in our discussions viewing this as a retention-type program because a lot of times a physician when they actually do go away they go away for an extended period either to do CME [continuing medical education] or to return to their country of origin.

We actually think that this will serve the rural populations very well because one of the challenges that we even face with the current locum program is that it's oversubscribed, and you have to plan very far ahead to actually get a locum to cover you for a period of time. So the idea here is that it would allow for longer extended periods of time which would actually provide the breaks that physicians in rural Saskatchewan need to make the lifestyle more reasonable.

Mr. Broten: — What's the current maximum for the amount of time a physician can request coverage for through the existing program?

[21:00]

Mr. Hendricks: — So the SMA is currently reviewing the program parameters because they're not written in stone, as I will say. Some physicians are accessing the program far more than others which is impeding those who use it less frequently from accessing it. The time frames, it is generally shorter term, like less than 30 days. But some of the, you know, the time frames and how much a particular physician accesses in a given year is currently under review. And it's actually probably a good time to do it while we're considering the parameters around this long term so that they actually do flow well together.

Mr. Broten: — So the current parameters to be eligible, there needs to be fewer than five physicians working in the practice, or is that practice and community, if it's a community with one medical practice?

Mr. Hendricks: — It would be it would be in the community because generally within a community they would provide coverage for each other. Now presumably there would be special consideration if you have an elderly physician who's not part of the call coverage rotation or something. So I think they consider those types of issues.

Mr. Broten: — Okay, thank you. So that would currently exclude communities like Meadow Lake perhaps, as an example, or do communities like that currently access the program? I think there's more than five physicians in Meadow . . .

Mr. Hendricks: — Yes, so that would exclude Meadow Lake. As a rule of thumb, any category, a community under the emergency room coverage where continuous coverage is required probably would not be eligible for the current SMA program.

Mr. Broten: — Okay. And is this one of the considerations in the development of a new program that coverage would be expanded to include more communities?

Mr. Hendricks: — We need to think about this very carefully because we have had situations where, even in some larger communities, you'll have a husband and wife couple leave — they're both physicians — and that pulls the service down by two, or two that are on vacation at, you know, the same time or taking the same course somewhere. And these tend to be some of the issues that we face when trying to provide continuous coverage.

So I think we want to look at the whole picture. The idea here as I said earlier is, you know, improving the retention rate and making it more desirable to practice in rural Saskatchewan but also stability of service which is a key issue.

Mr. Broten: — Thanks. So will physicians in regional centres — I'm thinking of Swift Current and North Battleford — they'll definitely be out of the running for this program, the new 20 physician program?

Mr. Florizone: — I would never say never, but right now they wouldn't be the first priority in terms of . . . as we move stepwise through. As Max Hendricks had mentioned, the concern that we have is, the growing concern is some of the larger centres — and when I say larger, you noted Meadow Lake as one, Estevan, Weyburn, Humboldt — these community centres, larger, relatively larger rural centres, have had their moments where they've struggled. We can add to that list. Nipawin in the past. So there's a whole range of significantly sized communities that require the kind of coverage that the rule of five has not been, you know, kind of serving that interest.

And we have real examples where multiple physicians leave at once, or husband-wife teams leave and gaps are created within the community. So we're looking at the locum pool and in terms of its expansion beyond what the very successful SMA pool has contributed. We're looking at perhaps longer duration, perhaps more communities, and moving in stepwise fashion from smaller communities into larger communities.

So when I said never say never, we could, depending on once we're up to full force on the locum pool, we could then conceive, depending on demand, conceive of a day where we might be looking at coverage into larger communities.

Mr. Broten: — Thank you. In finding the physicians to work in this program, who does the ministry think will be the likely candidates to join this type of program? Is there some thoughts as to the types of physicians that you'll be looking for?

Hon. Mr. McMorris: — I think it's probably a pretty broad range, very similar to the physicians that are in the locum pool right now. We're working hard and have worked hard over the past four and a half years to attract more physicians to the whole province, not just one specific area or not one specific program.

And it would depend on the physician. For some physicians, this isn't attractive; for some, entrance into the province perhaps. They don't necessarily want to set up a practice in any one area yet and they're learning the province, and this will be attractive for them. Other physicians, you know, may be centred in a community but don't mind going out for up to a month or a couple of weeks to fill in. So I think it's a broad range of physicians that will fill this. But overall what we're working hard to do is make sure that we have enough physicians for all, you know, not every community, but all the . . . a greater number across the province whether it's in Meadow Lake or even in the smaller communities to serve, Fort Qu'Appelle, for example.

So it's a broad range, and we've done a lot on the whole piece on recruitment and retention, and more work to do in that area. But the evaluation process, you know, instead of having physicians practise in the province for six months under a probationary licence, no evaluation at all, to where we are now through the SIPPA [Saskatchewan international physician practice assessment] program, more work to do on that . . . But I think it's going to be a large improvement into recruiting and attracting physicians. And eventually we're getting very close, but when we open it up to more countries other than the seven Commonwealth countries that we accept from now, you know, I think this locum pool will be attractive to some. Others will be recruited right into a community for sure. So I think it's a real broad range of physicians that will be looking at this particular program.

Mr. Broten: — Thank you. Is it the ministry's intention that physicians joining the program would have the same bursary repayment options as the recent grads going into the rural relief program? It's a fast-track option for paying back one's bursary commitment for receiving funding. Is it the thinking that the new program would mirror that option?

Hon. Mr. McMorris: — Yes.

Mr. Broten: — And would that be whether or not the program is in fact though the SMA or whether it's delivered through a health region?

Hon. Mr. McMorris: — It wouldn't necessarily matter. I mean they would be eligible for the program. It's a program that we have set up. They'd be eligible for the program as they are right now. Some that may enter the locum pool are eligible, and that would be the case into the future.

Mr. Broten: — Okay, thank you. If the ministry goes the route of not adding on to the SMA program — I won't say adding on is going to be the wrong way, but directly complementing and having it under the SMA program — does the minister have any concerns about recruitment efforts for physicians joining the program?

Because I know with the nine or so . . . and it sounds like there's some turnover based on the minister's remarks for the numbers in the rural relief program, and it's pulling from a certain pool of physicians in the province and in Canada and maybe internationally. If there's a parallel program, that too would be pulling and which could affect the efforts that the SMA would have for attracting physicians into their rural relief program. And I guess there's the other factor, is physicians that may be recruited by Northern Medical Services for serving the North which is yet another pull that potential physicians in this program, where they could be going. So any thoughts on how, if it's a parallel program outside of the SMA, how it would relate to the existing program?

Mr. Hendricks: — So one of the reasons that this program is taking a little while to set up is because we're trying to consider all of these issues. We need to strike the balance. We don't want to compromise. We don't want to be recruiting physicians into an extended locum program at the expense of other rural communities so that they experience troubles maintaining services. We don't want to recruit into it at the expense of the SMA program that does provide the short-term relief.

One advantage about the SMA program is that if we were to expand the number of physicians providing service through that program and change the parameters of it to allow for longer service or longer periods of time to the physician providing that service, they wouldn't distinguish between that because normally, through the SMA, they go in, they work a couple of weeks, and then they rotate back out for a week. Right? It would give you a larger pool to draw from.

And I think one of the other things that we need to think about with this program, the minister mentioned, you know, it could go either way. It might not be a one-size-fits-all program. So you may have a stable of physicians working through the SMA that provide the longer term coverage, but in certain areas of the province it might make sense to have a regionally specific locum pool so that they can actually manage resources within their regions. So there are possibilities here. And that's why, you know, we want to grow this program slowly and assess the effects and look at options that may come that suit certain situations better. It doesn't have to be all one.

Mr. Broten: — Thank you. So the 1.5 million that's provided now, essentially it would be about $200,000 per physician per year. Would that be about right for a physician within the rural relief program?

Hon. Mr. McMorris: — You could say that would be a ballpark, but it's a pretty big ballpark we're playing in right now. So as I said, we're going to work to try and get you a closer number on a previous question that you had asked. But if you are to extrapolate at a million and a half and five doctors, it's probably closer to 300,000. But again those are ballpark numbers and it may, depending on how well are at recruiting . . . not that we divided the million and a half if we only recruit three. We don't divide it by three and say they get 500,000 now. But you know, that number will be worked out. It's on a contract basis, and we have some of those contracts in place already. We hope to be able to use all of that on five physicians. As I say, that's our target for the first year.

Mr. Broten: — Okay. Thank you. Is the minister content with the progress that's been made on the development of this program so far? And I say that only because it seems like after the initial introduction where the statement was made by, I'm not sure if it was the minister or one of the officials, but you're looking at all the options. The question of whether or not the ministry chooses to go with the existing rural relief program or to create some other structure through a health region or a variety of health regions or something else altogether, that sounds fairly fundamental to . . . sounds like a starting point. It seems pretty basic in terms of the steps that need to occur in getting the program up and running. So is the current plan going according to plan, or is it a bit slower than what the minister expected?

Hon. Mr. McMorris: — So I mean it was a campaign commitment in the last general election. It was touched on in the Speech from the Throne, saying that we want to move on this. As I said previous, it's tough to go too far down that road with structure until you know that there are dollars behind it. I mean we could have gone a long ways down the road on structure and then through the budget process say, well we're not going to implement this program for a year and a half or two years. So the vast majority of work that will be done on this locum pool has been since the budget was read and passed.

Are we happy with the progress? I guess it would be nice to be able to snap our fingers and say it's up and running right now. That isn't the way these programs are developed because there needs to . . . I mean, number one, you're playing with — not playing — you're working with a number of other organizations. You're dealing with health regions. You're dealing with, really, the physician recruitment agency, and most importantly you're dealing with the SMA. And so those meetings have to take place.

I said earlier, in one of my first answers, that I would be able to answer these questions probably a little bit better within a month or two because those — not negotiations — those discussions are going on as we speak. And so I think we'll probably land fairly soon as to what the program will look like, and then we'll move from there.

[21:15]

Mr. Broten: — Thank you very much. I didn't know the budget vote was so close that that could hold . . . that the ministry would be worried about whether or not the budget would pass and that that would hold up some of the planning. I wasn't aware of that.

Hon. Mr. McMorris: — We were never really too worried about whether the budget would pass or not.

Mr. Broten: — I just remember the count. I don't remember it being a nail-biter.

Hon. Mr. McMorris: — I remember the count as well, if you'd like that. But it does, I mean there is a budget process that starts, you know, months before that budget is read, and, you know, you touched on a little bit on the CBOs. There are competing interests, absolutely. There are a ton of competing interests, as you can imagine, for health care dollars, for all the government dollars, and so you have to make sure that you have the commitment from government and from the Ministry of Finance that you're going to fund the programs that we committed to.

This was a commitment over four years. Finance could have said . . . And it's not whether the vote passes in the House. It's whether the dollar figure is put in the budget at all. And to do a lot of work before the budget number is put in the budget and read, you know, not that it would be premature, but I think really the work starts in earnest once you see it in the budget book and then moves through the legislature. And that's where that work is taking place now.

Mr. Broten: — Thank you, Mr. Minister. Perhaps having talked a bit about the locum program and physician recruitment, that's a good segue into the physician recruitment agency as a topic of discussion for the next bit. So could the minister please provide the committee with an update of what has occurred so far with the physician recruitment agency, please?

Hon. Mr. McMorris: — I will start by just kind of giving a broad overview of the physician recruitment agency and some

of the work that they've done over the past year or so. And then I think we'll probably get into some more detail, and I'll probably turn it over to Max or Dan or whoever. Unfortunately it is just the way it is. Ed Mantler who is the CEO [chief executive officer] was here on Thursday and listened to us talk for three hours, and then couldn't be here tonight when this topic comes up. But I know he would like to be here, and certainly could talk in the most depth and has the most certainly knowledge of the work that they've been up to and all initiatives that they've undertaken.

I'll start by kind of giving a broad overview of the challenges I guess with physician recruitment because it isn't just a Saskatchewan-only issue. It is an issue across Canada and for family physicians really around the world. So we've worked hard over the last four and a half years to try and address those challenges and be competitive with the rest of Canada and around the world.

And how we have done that, there's been a number of ways, I mean first of all by training more of our own. We have the highest reliance of international medically trained grads of anywhere in Canada, and we need to address that by increasing the number of seats in the College of Medicine, which we've done, increasing the number of residency positions, which we've done. All of that being done doesn't matter if we don't retain some of those or as many of those as possible.

So we're working to do that, and that's kind of where the physician recruitment agency is starting its work. It's doing a lot of work other than just at the U of S, but that's where it's starting its work. It needs to make sure that it's in front of our medical grads and our residents to make sure that they know that Saskatchewan is where they're wanted.

We think we have a very strong contract with the SMA that puts us competitive. We don't feel that physicians would be looking at other jurisdictions to say, well we can make so much more there, when they factor in all their costs of living and everything else. So we think we're very competitive on the wage front. We just need to make sure that they realize that they're wanted just as much in Redvers, Saskatchewan as they are in Red Deer, Alberta. And so the physician recruitment agency is, on a regular basis, in touch with medical students as well as the residents within the U of S.

The other area that the physician recruitment has been working on — and it's a changing environment — is the whole evaluation of international medically trained grads as they come to Saskatchewan, with the implementation of the new evaluation, the kind of made-in-Saskatchewan evaluation. So the physician recruitment agency is kind of working right now over the past few years in a changing environment, which is good because quite frankly if we were to do everything that was done before, we would continue to see some of the results that we saw that just weren't satisfactory. So it is working within a changing environment.

As I said, its work is to make sure that the Saskatchewan medically trained grads know that they're wanted here in Saskatchewan. Having said that, they've also done a lot of work outside the province and internationally. They've attended approximately 36 international career fairs and medical conferences in the United States, United Kingdom, and Canadian events outside of Saskatchewan. They've supported the settlement of international medical grad participating in the Saskatchewan international physician practice assessment program, or the new evaluation process, as I said. They're collaborating with the University of Saskatchewan, the College of Medicine, to launch a pilot project that will see up to seven Saskatchewan residents study abroad, returning to Saskatchewan for the third or fourth year of their medical degree.

So they've really undertaken a number of different programs and objectives to make sure that we have or continue to work towards having the proper complement of physicians. They've developed RHA, or regional health authority physician recruitment networks to promote collaboration and professional development opportunities. Quarterly meetings were held to coordinate career event participation and provide education on licensure, immigration, and retention best practices. They've launched a communication plan including a branding for the organization, a website, promotional materials, and social media to promote Saskatchewan as the place to practise medicine. It's called Saskdocs. And actually it looks very good, and the branding will be very important. We've done that in the past when we've been attracting medical professionals. This one is specific for physicians, and I think will pay dividends as we move forward.

That kind of gives a broad overview. They've worked with, you know, a specific recruiter too as far as bringing in physicians. You know, within the first year and a half to two years, the first year was certainly getting their feet on the ground. I think they've certainly done that — built strong relationships with the people that we need to build in Saskatchewan, looked at outside the province to recruit medical grads, IMGs [international medical graduate] into the province.

You know, I can tell you one story that it was an MLA, a cabinet minister that was talking to me. And actually the story kind of came through his wife who had a very good friend that was working over in Ireland that was practising . . . He was a medical student in Ireland, I should say. I think he was a medical student, not in residency yet. And the physician recruitment went and made a presentation. It happened to be in the area that he was at. He went to . . . This physician or medical grad was not from Saskatchewan. He was from Ontario but was telling this MLA's wife about what he saw in Ireland. And he said it was quite amazing. You know, you've got all these medical students from across Canada, and there was only one province asking them to come back to Canada, and that was Saskatchewan. It was through our physician recruitment agency. This was an unsolicited note that this medical grad sent to an MLA's wife and then kind of came third-hand back to me. But it did tell me that it is being noticed.

And I do know other parents of kids that are practising or taking their med school in other jurisdictions and notably, Ireland. And the only one that's really been working hard to make sure that they know that they're wanted back in Canada has been Saskatchewan. So it is making its mark.

Generally recruitment of physicians isn't an overnight deal. You need to build relations and relationships with the people

that you're trying to recruit. I've heard that from many, many communities that have been successful in recruiting physicians. It doesn't happen overnight. It's not a one-visit process — we want you to come to our community, and that's it. It usually is a number of visits to make sure that that happens. It happens over months, and it's only after relationships have been built up.

I think the physician recruitment agency is well on its way to building relations into many of the different jurisdictions, whether it's into the Caribbean, whether it's into Ireland, into other areas around the country that . . . around the world, I should say, that would be looking at Saskatchewan because they've built a relationship with our physician recruitment agency.

As I say, that is only one piece. By far the most important piece is right here in Saskatchewan. You know, with our Saskatchewan-trained grads, we're working hard with the distributive education model to have them spread out across the province so that it isn't just Regina, Saskatoon, but they'd get a component of rural practice. And we think that may, we believe that will benefit into the future as far as retaining and recruiting — more recruiting — into other communities rather than just Regina and Saskatoon.

So that's kind of a broad overview of what they've been up to over the last couple years. And, you know, more work to do absolutely, but I think a pretty good first start.

Mr. Broten: — In this budget, what's the allocation for the recruitment agency? How much does it receive, and how many FTEs [full-time equivalent] does it have?

[21:30]

Hon. Mr. McMorris: — What I'll do is, I mean, I'll give you a very close number. It may vary by one or two.

So first of all the budget this year is $1.5 million for the physician recruitment agency itself. There was more money that went into the physician recruitment agency to begin with, but it wasn't just specific for the physician recruitment agency. It was about recruiting, a recruitment and retention initiative which the recruitment agency took the lion's share to get set up and get operating. Now that they're operating, their allocation is $1.5 million.

We believe there are six FTEs. That may vary by one or two, up or down. It could be five; it could be seven. But I was told six. And unfortunately, Ed is not here. He would have that exactly. And if it varies from six, we'll get back to you on that.

Mr. Broten: — Where are their offices located?

Mr. Hendricks: — So their offices are in the old Athabasca Potash Corporation building on 110, 4th Avenue North in Saskatoon.

Mr. Broten: — Thank you. With the agency, could you please explain a little better? The minister in his remarks talked a bit about what he sees as some of the groundwork with building relationships. But how does it work with the existing physician community with respect to the types of physicians that are planned to be recruited through this agency?

Is it the vision . . . When coming up with opportunities to promote and to pitch to people, whether it's at home or abroad, is it mostly health regions that the agency is interacting with in terms of advertising employed positions, salaried positions? Or are there also private practice, fee-for-service physicians coming to the agency and saying, we want two more physicians to join our practice; can you help us? Do both of those situations happen, or is it predominantly an RHA thing?

Hon. Mr. McMorris: — The whole issue around recruiting is really multi-faceted. I mean, the best recruiter in the province right now are the physicians that are in the province right now that will talk to some of their colleagues. If it's back at home, be it South Africa or wherever the home may be, physicians are usually one of the best recruiters.

Communities still are working hard to recruit physicians. And some communities are working in a community of communities. Communities have banded together to recruit physicians. Certainly the RHAs play a major role in recruiting, and then the physician recruitment agency, the physician recruitment agency works very closely with the RHAs.

But if there are physicians that are interested in coming to Canada and they get in touch with the physician recruitment agency, that agency will work, you know, as hard as they possibly can to help them along through all the, you know, some of the hoops that the physicians have to get through in order to practise here in Saskatchewan, starting with immigration and making sure their paperwork is all in place and then through the assessment process.

So I think the physician recruitment agency works at a number of different levels. If it's an individual physician, absolutely. They're not going to say, sorry, don't talk to us. That's not what they're going to say. Or if it's a region or even a community, they work on many different levels. I do know that the agency has done presentations at SARM [Saskatchewan Association of Rural Municipalities] and SUMA [Saskatchewan Urban Municipalities Association] as well, talking to communities.

So you know, it's not just a relationship with the RHAs. It's relationship building with communities too as to what the physician recruitment agency can do and where it can help out and, again, then on ground level with the actual physicians. So it really does work on a number of levels, developing relationships.

What I was saying about it takes time to develop relationships, especially around when you're trying to convince a physician to come from wherever their home country is to Saskatchewan. That decision is not made lightly and it takes, and it's not made overnight. And you know, I think as trust is built up with the people that they're talking to, if it is the recruitment agency, there is certainly an element of comfort once that relationship is built up. And I think we'll see the results we already have and will continue to see the results of that relationship building on the multi-level area that they're doing right now.

Mr. Broten: — So when the agency is engaging physicians, whether that's an IMG or whether it's someone completing

their residency in Ontario, and they're talking about opportunities, are they pitching opportunity X, Y, and Z, specific opportunities? Or are they talking about Saskatchewan in general — here's our fee schedule and your CME opportunities? What does that look like?

Mr. Hendricks: — So as you know, as the minister said, the first option or the first priority for the recruitment agency is trying to foster relationships within our own College of Medicine. But when they are travelling outside the province to recruitment fairs or other events, they are always taking members of health regions with them.

Their first priority is to recruit to the province. So their objective is to sell the province, to tell physicians about opportunities that exist in regions here on health careers and to try and sell the lifestyle, the payment schedule, whatever, in this province. But sometimes when they have had the regional folks there, you know, the regional folks will identify a specific opportunity that exists in the region. But generally when they go, they go as representatives of the province more broadly.

Mr. Broten: — Okay. Well it's an interesting situation where if, and it's more than just a question of strategy, if there are, if the agency is using its budget, its resources to recruit physicians to specific opportunities, I think for communities — either the communities that band together at a rural level wanting to recruit docs or whether it's a smaller urban practice or a large urban practice or whether it's a health region position — it just, it begs the question, how one gets their opportunity to the top of the list in terms of promoting two students?

Now if it's really specific specialties, then that sort of can perhaps solve itself because you know that you're recruiting to maybe Saskatoon or Regina. It's one of two options. But when it comes to recruiting family physicians which are in demand throughout the province, as we know, I think it's just an interesting question which I know certain communities or practices would be interested in how it is determined, what opportunities are in fact promoted, as opposed to just sort of broad general things about the province that plays out in practice.

Mr. Hendricks: — So once you do actually have a physician that's interested in practising in Saskatchewan, one of the things that the recruitment agency does and they facilitate is that a physician will interview in multiple communities. And it's really important because the biggest thing for a physician, that's considering practice opportunities, is fit. And so you'll have a few communities that will come, and we get the community involved. The recruitment agency is involved. The physicians that are practising there currently are involved. And it's to try and market this community. Because if it's a poor match, if we just plummet someone into a community X and they don't know it, you know, from Adam, we're going to have problems.

So there's a real effort made to not only match, you know, to the community, to the physician, but also to the physician's family. Because one of the things that we know is you're not just recruiting the physician. You're recruiting the spouse and the family, and so they have to feel comfortable there as well. So a great deal of diligence is done to actually making sure that the match is actually a good one and is not one that's going to fail a few months down the road. So considerable effort.

So right now we have postings, and there are multiple regions that are interested in the same doctor potentially. But at the end of the day, it's the doctor's decision where he or she wants to practise.

Mr. Broten: — Thanks. So just to be clear, the agency will work with health regions, will work with physicians, and/or will work with groups of community people all involved with recruiting.

Mr. Hendricks: — It will work with health regions, but it does a lot of work with communities because communities are critical. And what we'd like to see is communities working with our health regions because one of the challenges that we face is when a community strikes out alone or the health region doesn't involve the community. You need both there at the table.

The communities have actually been super effective in selling their own communities to physicians and potential . . . And often the most effective thing that we see is that the community members will organize, will show the physician the community, show the amenities, what the educational opportunities are for the family. And it really has been quite effective in actually enticing a lot of doctors when that happens.

Mr. Broten: — Thank you. So in a community context, if it's a group of community members, even RMs [rural municipality] that have come together and funded a turnkey operation for a clinic, that's the type of group that could come to the agency and say we want help finding a doctor? Or is it more the health region would be spearheading a group of, spearheading recruitment and then once there's a potential candidate they would engage people on the ground?

Mr. Hendricks: — It would have to be . . . The regions have to work with the communities. Because as part of this, this is part of a larger model. We need to be establishing primary health care networks in our communities that work and actually promote stability. So to have a community that's doing something on its own without participating with the region, we generally would only work if they were working together. We'd only support them.

Mr. Broten: — Thank you for that answer. Just one of my last points or comments on this line of questioning. I believe it was the minister who talked about a pilot project taking third- or fourth-year international medical students and bringing them to the U of S. Did I understand that pilot correctly? And if you could just explain what that pilot is, if you have more information available here.

Because we've all come across instances where we have a community member contact us and say, I'm going to Australia or the Caribbean to do my medical school and I promise my life to come back to Saskatchewan. And so it's an interesting option there.

Mr. Hendricks: — So actually this is an area where a lot of attention is being focused because there are approximately 3,500 Canadians studying in medical schools abroad in Ireland and the Caribbean and several hundred from Saskatchewan. So

the physician recruitment agency has been travelling to both Ireland and attending educational institutions there. They formed a partnership with one of the larger Caribbean medical schools, Ross University, and have visited several others.

And the turnout at these events is amazing because right now these medical students who are studying in the Caribbean and Ireland and even in Europe and in Eastern Europe have a very difficult time getting into our matching process for residents. And so what we've been trying to do is bring them back to attend their final year of medical school in Saskatchewan, which improves significantly their chances of matching to a residency position.

And it's been very positive; there's been a lot of interest. In fact currently the PAIRS [Professional Association of Internes and Residents of Saskatchewan] representative on our board is one of the first ones that actually was attracted from Poland, not by the recruitment agents but prior to this, and is now studying to be a gastroenterologist here. But tremendous interest down in the Caribbean and Ireland. And it's something that we'll continue to explore because these are Saskatchewan students, and they know the province, they know what they're coming to work in. And so it's a win-win situation.

Mr. Broten: — For the selection of the six or . . . How many students in the pilot?

Mr. Hendricks: — Seven.

Mr. Broten: — In the selection of the seven, is it a merit-based application or is it a draw or how does that work? Because I mean I do agree, I would see the attractiveness that individuals would have if it meant they were more competitive through the CaRMS [Canadian resident matching service] process by coming out of the U of S.

[21:45]

Mr. Hendricks: — The U of S College of Medicine, one of the things that we have to do is we have to match our capacity at the U of S with the ability to bring these students in. So the College of Medicine indicated to us that they could accept seven this year, and so we're going to study the pilot through this pilot phase because we need to understand that these students can sort of seamlessly integrate into the undergraduate class and then go on to post-graduate.

But one of the other challenges too is that in the undergraduate programs at the College of Medicine we have students coming up through, and we only have a certain number of positions that could be supported by the faculty. So there were seven this time. And we'll monitor it and if it's successful, as we anticipate it will be, we'll look at adding more.

Mr. Broten: — Thanks. How are those seven selected? Through what process?

Mr. Hendricks: — Dr. Gill White, who's the associate dean with the College of Medicine, actually travelled to the Caribbean with their recruitment agency and interviewed the candidates down there and felt that these seven had the best opportunity for success, merit-based.

Mr. Broten: — Merit-based, but not a open application in the sense that people could apply from different locations to be part of the pilot. It was based on visits to one area.

Mr. Hendricks: — They visited four universities in the Caribbean and a couple in Ireland or a few in Ireland.

Mr. Broten: — Thank you very much. And with the recruitment agency, does the agency have a number that it touts as, we've recruited X number of physicians to the province to date?

Mr. Hendricks: — Right now what they've done is they've signed a contract with Global Medics who is recruiting abroad for us. And so that's a very specific number of physicians. The contract is for 25 and we've added an additional five. A lot of those are currently actually in stream that will be going through the SIPPA program in either May or in the September cohort. It takes several months, as you know, to get your immigration do that. But a lot of it is really difficult because they monitor contacts when they go to recruitment fairs and also their activities at the U of S. You don't really know the influence per se that the agency has had, you know, in a person's decision whether to stay or not.

One of the things that they do do in that, by having the Student Medical Society in pairs on our board, is we try and solicit regular feedback on things that we could be doing better within the province to attract our own graduates. So in some cases it's very easy to tell, and in other cases it's word of mouth — it's, you know, communications, image, the information it provides about the province, and those more passive techniques.

Mr. Broten: — Thank you. So how would the minister characterize the opinion of students and residents of the agency to date?

Hon. Mr. McMorris: — Who are you referring to?

Mr. Broten: — Well anyone. But my question is, do the students and residents at the U of S, for example, what is their opinion of the agency so far, based on the feedback you have received? Is it positive, lukewarm, or cold?

Hon. Mr. McMorris: — Well you know, I would say it would be positive, but I'll guarantee you that you'll find the odd student or resident that wouldn't be positive on the recruitment agency. It depends on their perspective and what else may be in their minds, you know, whether it's negotiating or anything else. So it would vary. I think they would all say though — I would hope they would all say, I don't want to put words in their mouth — that they've had more contact from Saskatchewan than they ever did before their agency was there.

I know that when I was the critic, in talking to a number of medical students and also residents, they had not ever heard, or heard very little especially from the overall Ministry of Health or government of the day, but maybe a little bit more through health regions. And I would hope that they would say that now they're certainly aware that there's a recruitment agency that wants them back in Saskatchewan, wants them to stay in Saskatchewan. Would they all say that it's an amazing agency and it's hitting all the marks? Probably not. I would probably

say that, you know, there would be some variation on that.

But what I will say is that I hope, for the most part, they realize that somebody's looking at what they're doing, has their contact information, and making sure that we want to help them in every way to make the decision to come to stay in Saskatchewan.

Mr. Broten: — Thank you very much. Backing up to a comment that was made by one of the officials, it was the discussion of using Global Medics for the recruitment of 25 physicians. So as I understand that, that's the physician agency, in a sense, contracting with Global Medics to help recruit 25 IMGs. What is the price tag associated with that, of the contracting of the services of Global Medics?

Hon. Mr. McMorris: — That information is, really is, not information that we can give out because they went through a bidding process like a RFP [request for proposal] process. These were the lowest bidder that were the most qualified when all things were taken into consideration. So it wouldn't be appropriate that we would release the contract or the number, the dollar figure because it will be a contract that will be up for . . . I'm not exactly sure of the term of the contract, but eventually will be going through another process into the future if we so choose. And it wouldn't be appropriate then to release that information. I'm sure you're well aware of that.

Mr. Broten: — Well thank you. My next question was whether or not there was an RFP, and so thank you for the assurance that that occurred. With that, I will turn over for a few minutes to, I believe, Mr. Forbes and then Ms. Chartier. And then I'll close off the evening. Thank you.

Mr. Forbes: — Well thank you very much. I just have two areas of questions I have, that I have some questions about. And one is we were talking earlier about addictions and just reminded me about the whole issue around gambling addictions. And what kind of resources does the ministry set aside for that, and what kind of activities do you do for the whole issue around gambling?

Hon. Mr. McMorris: — So we already had a little bit of a conversation regarding addictions. And we really talked about alcohol and drug and, you know, some mental health issues, but we never got into the gambling piece. And that's another area that there are definitely some, you know, huge impact onto families and some lives destroyed for sure. And I think we probably have all heard or seen or maybe know of somebody close that has had problems. So it definitely is an issue.

Right now, in the 2012-13 budget, $2.5 million will be spent in this area: 1.5 million is from the Ministry of Health; about 500,000 from the Community Initiatives Fund; and about 500,000 from the Saskatchewan Liquor and Gaming ministry. The funding allocation is roughly about 1.2 million is for treatment programs, research and training; $1 million is for prevention and education programming; and roughly about 300,000 for administrating these programs. These programs include in-patient and out-patient. It also includes a help line, prevention and education programs, and training and research. So that's what it entails. These programs again, as I had mentioned earlier, for the most part are run through health regions. The health regions are the deliverer of course, and so these programs are run through the various health regions.

Mr. Forbes: — Do you have a . . . Two parts. One is that more or less in previous years about the same? And the second part would be about is, how many people would this be treating or are we trying to reach? And is that going up and down?

Hon. Mr. McMorris: — So on the first piece, on the funding, the funding has stayed pretty consistent over the last couple of years and actually probably going back a bit further. But the funding has stayed fairly consistent around that two and a half million dollars. The number of people being treated through treatment admissions has increased over the last few years. Our latest number is roughly about 422 have been in treatment. And if you go back — you know, five years let's say — it's roughly about 165, so another 50 people roughly, 60 people.

They also have the gambling helpline that's in the province. And interestingly enough, and maybe it's a matter of advertising, but I do know that, you know, the gambling helpline information is . . . I don't hardly ever go to one, so I don't really know, but any time that I have been, I certainly see that number. Even though we're doing work to advertise that, the number of people accessing the gambling helpline has decreased over the last number of years. Last year about 1,072 people contacted the gambling helpline.

Mr. Forbes: — That's interesting. I'm wondering what the impact on some of the new forms of gambling, particularly online gambling, whether there's been much thought in the ministry about the impacts it's had in Saskatchewan.

[22:00]

Hon. Mr. McMorris: — So you know, your question is about online gambling, and it's relatively a newer form of gambling. I think if you wanted to kind of dive deeper into who is and who isn't and what type, the makeup of where their gambling addiction is coming from, perhaps Liquor and Gaming may be a better avenue. But what I will say is that we don't know — and I'm not even sure Liquor and Gaming would — but we don't necessarily know where the addiction is coming from because it could be from online gambling. There are many, many, many forms of gambling. It could be horse races. It could be online. It could be VLTs [video lottery terminal], or it could be through our casinos. So there are many different forms of gambling, and I wouldn't say that we, at the Ministry of Health, have it broken out as to, you know, these people are coming from this type of gambling or that type. Perhaps the Liquor and Gaming may have a better understanding of that makeup. We don't necessarily have that.

Mr. Forbes: — I appreciate the answer, and it is a very complex issue for sure. And it keeps shifting when you think you're getting a handle on it, something as a market and consumer-driven type of addiction. It's a huge area. So I think it is good that there's work being done. I really encourage you to keep doing that because it's one of those silent things. And it seems to be one that we don't see as much, especially the online stuff. But I appreciate those answers.

I wanted to ask some questions about family health benefits. It

seems there's more money going into it this year. I'd be curious to know how many families actually receive the benefits. How is the program going? Is it going up, about level, staying the same?

Hon. Mr. McMorris: — So I don't know how kind of in-depth you want to get into this, and we can certainly get much more in-depth and start going through the exact numbers.

What I will say, though, is over the last probably four or five years the number of people that are accessing family health benefits is declining, which is a good thing. There aren't as many families that are in that position that they are accessing the program. So that's a positive note.

On the flipside is that, you know, roughly if you could use it as a service utilization or . . . the dollar value of what each client is using is increasing, and that is reflective of cost increases, whether it's in optical or in chiro or dental. Those costs are going up. Of course those professional fees are going up. So even though the number of people are dropping, we're seeing an offsetting with the costs of each procedure going up. We can get into more detail if you'd like as far as the numbers of people.

Mr. Forbes: — No, that's fine. Yes, that's what I'm curious about more than anything. And I have written you about one particular situation and supplementary health benefits related to family health benefits because I think the family has to qualify first for the family benefits, and if they do, then they can apply for further.

And this situation, I find it very interesting because there's some real challenges for low-income people particularly when we think of some of the areas that we would take for granted. I mean I'm thinking of orthodontics particularly where we think of families . . . that's a big ticket price for any of us. But when you're in low income, it's a huge thing. But there are challenges around, you know, the whole issue of the reason we do for our kids is to make sure that they look and feel great, and so low-income families should have the same benefits. But it is a tough thing that the choices we have to have . . . but we're finding — where I'm learning anyways — what the connection between oral health and poverty, there's a huge real connection and orthodontics can play a big part.

So I guess my question is in terms of supplementary health benefits. Are you seeing an increase or more people applying for orthodontic supports for low-income families? And if so, what's the acceptance rate, or is it a tough one to call, or are we using old standards for making decisions on this?

Hon. Mr. McMorris: — We can get into a little bit more detail and if you want even a greater depth of detail, we're going to have to go to another level.

Mr. Hendricks: — So the supplementary health program provides a broader array of benefits than the family health benefits. The benefits are provided to low-income individuals nominated by social services, or the Ministry of Social Services, so with respect to your question about orthodontics, we actually do have an orthodontic consultant on staff who will review submissions by dentists and have a look. And we will cover orthodontics if certain criteria are met or it's felt that they're needed. So those benefits are extended to low-income individuals.

Mr. Forbes: — I understood that. But this person was having the . . . Her grandchild's situation was such it was sort of borderline, and so I've rewritten to say, ask, you know, take another look. And it's a tough one because, as I was saying, for many families they would just go and do it, get it done with. But what I hear you saying is that you have a consultant on staff, a specialist in this area. So there is an appeal process or a way to . . .

Mr. Hendricks: — So several months ago we announced the establishment of the health services review committee. The idea of this committee is to review policy decisions of the Ministry of Health mostly with respect to out-of-country coverage and that sort of thing. But the idea is that any decision made by the department or its agents on a policy or program criteria issue is subject to review. So if they did want to appeal the ruling of that orthodontic reviewer, I would suggest that the health services review committee can take a look at it. In fact if I'm not mistaken, I think there are dental surgeons or dentists on that committee as part of the large review group. So I would suggest they do that.

Mr. Forbes: — I appreciate that answer. That's sort of where I was going to go because I know that's always the one in the news is the out-of-province coverage. But for some of these folks, it's a big deal. I notice a grandmother's got some savings. She's willing to help out, but it's a choice of whether the kid goes to school, you know, post-secondary and that type of thing. Okay. I appreciate the answers. Thanks very much. And I guess we hand it over to you, Danielle.

The Chair: — The Chair recognize Ms. Chartier.

Ms. Chartier: — Thank you very much. I've got a couple areas of questions, and the first actually is around human milk banking. I understand, Mr. Minister, that you've had an opportunity to sit down with one of the proponents of human milk banking here, and in light of the growth of informed milk sharing that's been going on in the last couple of years here . . . and the reality is that the Canadian Paediatric Society has a position paper now as of 2010, I believe, on human milk banking. And Calgary actually just opened their milk bank, joining Vancouver. And I believe Quebec is in the process but not there yet. So we've got Vancouver and we've got Calgary. So I'm just wondering what your ministry is doing to either lead this or to support this.

[22:15]

Hon. Mr. McMorris: — Well after much deliberation, I seem to be the one at the mike.

So I had the opportunity to meet, about a year ago, a little over a year ago with the group that came in. And they had a number of areas that they were — you know, for lack of a better term — were lobbying for, that would like to see the government move. And one of them, of course you know, was the whole issue around supporting breast feeding and that process. And you know, we know the benefits, and they did a very good job in

presenting.

One of the areas they presented on was milk banking, and at that time there was only Vancouver. It's just recently that Calgary's come on. And we don't know . . . You'd mentioned Quebec. We haven't really heard much about Quebec. It's kind of iffy. So you know, it is an area that other . . . well I wouldn't say provinces because in Alberta, they've just gone within a confined facility, no doubt. That's where, I think, for the most part the lobby was . . . is that if we're building a new children's hospital, which we are, whether that would be appropriate then to start a milk banking program in that facility because it isn't just as simple as . . . Well I don't know how simple anybody would think that is. But it's just not as simple as it seems because there's a whole issue around health and safety, making sure that the milk is safe through that process.

So I would say — you know, through you — probably to that group, is that we haven't moved on it much since. I'm aware of it. We are aware of it. And I guess, you know, like many of these things, the first time through it probably doesn't . . . You know, how much we move on it, you know, it will vary from issue to issue. But we'd certainly be glad to again hear from them.

We don't have any money allotted for this, to start a milk bank. And I can tell you that it really has . . . I mean, it's been that group of individuals and only that group of individuals. There really hasn't been a huge push from others for this. So you know, having said that, it's not that we would necessarily say that we're against milk banking, but we haven't moved on it within the province or within the ministry which would come from direction of government.

Ms. Chartier: — Thank you for that. What would it take then to move on that? You talked about there not being a huge push, but obviously two thousand . . . It's just been two years since the Canadian Paediatric Society came out with its position paper. Calgary has moved on it now. Obviously you haven't been hanging out on Facebook or Twitter, heard the whole informed milk sharing has . . . At least on this issue perhaps, maybe other things. But informed milk sharing is huge, the Eats on Feets, I don't know if you're familiar with that or not. But it has been a big issue in the last year in the media.

So I'm just wondering what it would take to move to that next stage. Obviously it was on your radar because this organization met with you. But how do they take it to the next level?

Hon. Mr. McMorris: — Well I would say, get in touch with the opposition MLAs, and do a strong lobby that way. No, you know, we'd be more than glad, I'd be more than glad to meet with the organization again. That tends to be . . . I mean I've met with some organizations every year for five years, and you know, some of their issues we get moved ahead. Some of them they lobby again.

I mean, I'm not sure if you were at the breakfast where the Cancer Society went through their three or four issues. We've addressed some of them. Some of them we haven't moved on, you know, whether it was pesticide use in urban centres. That hasn't been moved on. It hasn't, you know, and other jurisdictions have.

But that's what the groups have to do, is continue to have that issue in front of not only just perhaps the minister but other MLAs to make sure that . . . Not that I want to kind of go through a step-by-step lesson on how to lobby government here right now, but I would say that there is more work to do on that front. And you know, we would have to look at, from the ministry's perspective, the cost-benefit of such a program, whether that needs government to do such a program or whether, you know, the certain organizations would want to take that on themselves. Does it have to be a government-run milk bank, or could it be, you know, the organizations that are in favour of that, lobbying and starting a milk bank onto themselves, you know, for the benefit of new mothers?

So you know, I would certainly not have any problem meeting with them again, but I would also tell them that there are other avenues that they probably need to pursue, you know. Are there other jurisdictions — and not in Canada but down in the States — that such a program is running that it isn't government run? There's always that option as well.

Ms. Chartier: — Oh, for sure and I think, I believe the Calgary milk bank is a not-for-profit organization. But the bottom line is I think the ministry still has to lead. It's the Ministry of Health, and this is a health issue. And that leadership I think is very important. But I will make sure to pass on . . . I actually do have a petition on human milk banking because I clearly, by some of the smiles or chuckles . . . It's not chuckles. I know they're not disrespectful, but a lot of people, if you're not in that world, you don't know what's going on, and there's misinformation or lack of information. So I think one of the goals is to make sure one is raising awareness with government MLAs and ministers for sure.

But on a similar topic actually, midwifery. Obviously we're having some . . . There's still a shortage of services. I know in Saskatoon where most of the midwives are concentrated, demand is far outstripping supply. Different numbers have been thrown around, but I've been told at one point, three times the amount of the . . . We're just not being able to keep up in Saskatoon, and that's where the majority of midwives are concentrated. So that is a real problem, not only for women in Saskatoon who are on a list, but women in rural Saskatchewan, in other parts of the province who don't have access to this provincially-funded program. So I'm wondering what the minister is doing to ensure that it becomes a service, a health service, that women who want this kind of birth service have access to it.

Hon. Mr. McMorris: — On the whole issue around midwifery . . . And it's been raised. You've raised it a few times in the House. We can kind of go through the history of it that, you know, legislation was passed but not proclaimed. We became government and proclaimed the legislation and then have worked on trying to make sure that we have an adequate number of midwives working in the province. The need for their services is continuing to grow because they supply a very, very good service.

We're working with primary health care redesign, and they are an excellent part of our primary health care team. And there'll be more on that in the very near future as far as looking at that primary health care redesign and the services that midwives can

provide through that.

I will say though that, you know, just kind of the way the questioning had been in the past and as we move forward, there is a shortage. Right now we have 11 licensed in the province. We have nine — because two are on maternity leave — we have nine practising in Saskatchewan. There is a need for more. We have one vacancy, but we have other health regions that are asking to increase the number of midwives within their health region, in other words, increase the funding so that they can increase the number of midwives.

We have vacancies in other professions as well, obviously physicians, nurses, and whatever the profession would be. We will never and do not change our standards as far as what is acceptable for education. We never will change that dependent on the number of vacancies that we have in the province. Those standards are set by, in this case, the College of Midwives. And you know, they just recently in a letter they sent to me based on a review, based on our review, the midwifery education program offered by the Midwives College in Utah does not meet the Canadian, not just Saskatchewan but Canadian standards. I know you'll say that in Alberta they will recognize, but they recognize it differently than just . . . If you want to, we can get into the detail on that. But we have to, again, go by the expertise of our professional associations, be it the College of Physicians and Surgeons or the SRNA [Saskatchewan Registered Nurses' Association] or in this case, the College of Midwives.

Because if we were to change standards, I mean we would've changed standards on the whole issue around physician recruitment because we have vacancies. We have vacancies in many communities, but we don't change standards to meet vacancies. We keep the standards at the level that those professional organizations set. In as far as midwives, that would be the standard that is set by the College of Midwives. And I have a number of, I have a couple of letters that I received after it was in the news recently as far as how important it is to make sure that professional organizations are independent and not dictated to as far as standards by politicians and that the college is comfortable with where they're at. And I would say the same, and I said that at the end of the news scrum. We don't change standards due to vacancies within the province.

You know, we want to manage those vacancies and we want to attract more midwives. We want to fund more midwives. You know, the number of nine practising in Saskatchewan, 11 licensed in four years is I think a pretty good start. It's not enough. We need to increase, but we'll only increase it as long as midwives meet the standards set out by the college.

Ms. Chartier: — Well thank you for that. I think around the MCU [Midwives College of Utah], I did see some of the correspondence actually that probably happened prior, well it did in fact happen prior to your scrum, that I think the thing that was lacking from the transitional council's response particularly to Diane Otterbein was how MCU was deficient and if there was the possibility of providing the support to ensure that those deficiencies could be easily filled.

But in light of that, I mean fair enough, but I still think we do need to do a much better job of ensuring that we have midwives here. So on that point, is there any thoughts or interest in a midwifery school here in Saskatchewan because right now obviously many women who decide to become midwives are often people who have had children in recent years. You look at the demographic of people who become midwives, and that's some of the issue of the women who are studying at a distance. They can't leave Saskatchewan. Their families are here. They're tied to this province. There's cost barriers. So are you interested in and where are you at with respect to possibly opening a midwifery school here in Saskatchewan?

[22:30]

Hon. Mr. McMorris: — So what I would say that, you know, again, we have 11 licensed, 9 practising — that's not a large number. We need to increase that number. Does it warrant a school for midwifery in Saskatchewan? I would say we're not looking at that at this time.

We have bursaries for people. In other words, we'll cover, we'll offer a bursary for a person to attend, for example, the school in Ontario. You can think of a province the size of Ontario that has a midwifery school with we think about 48 seats for a population of that size. So does Saskatchewan, do we warrant a midwifery school in Saskatchewan? I would say no. Again we would defer that to the ministry of post-secondary education, but I'm not going to kind of put it off on them because I would not be recommending a school for midwifery at this point in Saskatchewan.

Having said that, I would rather work on the issue around bursaries and buying seat allocation and that type of thing, which we do for many other professions. We don't train all professions in Saskatchewan. And you know, that opens the whole issue around occupational therapists and where we're at with that and the time that it's taken to get to where we are with that. I would say that, you know, a college for midwifery in Saskatchewan, not the professional college but a school of midwifery would be off in the distance a long ways.

Ms. Chartier: — I have many more questions, but I know that the time is here.

The Chair: — Yes, being the time is now 10:30, Mr. Broten wanted to make a closing comment.

Mr. Broten: — Simply thank you to the minister and the many officials for their time this evening. I understand we'll have one more opportunity to exchange questions and answers, so I look forward to that. And I wish everyone a good night. Thank you, Mr. Chair.

The Chair: — Mr. Minister, do you have any closing comments?

Hon. Mr. McMorris: — No. Same, thank the ministry staff, all the ministry staff for being here. I appreciate it. They have, again, an amazing wealth of knowledge. And I would thank all the committee members for being here too, well into the evening, so that we can finish our estimates up in good time, some time in the next week or two, with only an hour and a half left to go.

The Chair: — Thank you. Seeing that it is now past 10:30, we'll adjourn till the call of the Chair. Thank you.

[The committee adjourned at 22:31.]