STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Batoche

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Saskatoon Centre

Mr. Mark Docherty
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Regina Qu'Appelle Valley

Ms. Nadine Wilson
Saskatchewan Rivers

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[The committee met at 19:00.]

The Chair: — Good evening, ladies and gentlemen. It is the time now being 7 o'clock, we will begin the Standing Committee on Human Services meeting. I'll first introduce the members. I'm Delbert Kirsch, and I'm Chair of this committee. And we have Mr. Mark Docherty. We have Mr. David Forbes, Mr. Greg Lawrence, Mr. Paul Merriman, Ms. Laura Ross, and Ms. Nadine Wilson, and Mr. John Nilson here.

The first item of business will be the election of a Deputy Chair. I just want to remind the members of the process. I will first ask for nominations. Once there are no further nominations, I will then ask a member to move a motion to have a committee member preside as Deputy Chair.

I will now call for nominations for the position of Deputy Chair.

Mr. Merriman: — I move:

> That David Forbes be elected to preside as Deputy Chair of the Standing Committee on Human Services [Mr. Chair].

The Chair: — Are there any other nominations? Seeing none, Mr. Merriman has nominated Mr. Forbes to the position of Deputy Chair. Are there any further nominations? Seeing none, I would now invite one of the members to move that nomination.

Mr. Docherty: — I move:

> That David Forbes be Deputy Chair of the Human Services Committee.

The Chair: — Thank you. It has been moved by Mr. Docherty:

> That David Forbes be elected to preside as Deputy Chair of the Standing Committee on Human Services.

All in favour of the motion?

Some Hon. Members: — Agreed.

The Chair: — All those opposed? I declare the motion carried.

Okay, now we'll get into the real business here. I would like to advise the committee that pursuant to rule 146(1) the estimates and supplementary estimates for the following ministries and agencies were deemed referred to the committee on March 20th, 2013 and March 20th, 2013 respectively: vote 37, 169, Advanced Education; vote 5, Education; vote 32, Health; vote 20, Labour Relations and Workplace Safety; and vote 36, Social Services.

This evening we will be considering the estimates for the Ministry of Health. We now begin our consideration of vote 32, Health, central management and services, subvote (HE01). Minister Duncan and Minister Weekes are here with their officials. Ministers, please introduce your officials and make your opening comments.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

Hon. Mr. Duncan: — Thank you very much, Mr. Chair, and members of the committee. Good evening. It's a pleasure to be here, for Minister Weekes and I to be here to speak on the Ministry of Health's budget and the estimates.

With us tonight are a number of officials from the Ministry of Health. I won't identify everyone at the beginning. We'll make sure that if there are new speakers that come up to the microphones that they identify themselves beforehand. But I do want to take a moment to introduce some of the senior officials that are here with us this evening. To my left is Dan Florizone, the deputy minister of Health. To my right is the associate deputy minister of Health, Max Hendricks. Behind us is Lauren Donnelly, the assistant deputy minister; as well, Duncan Fisher, the special advisor to the deputy minister. With them are a number of other officials who, as I said, will be able to assist us this evening with the 2013-14 Ministry of Health budget estimates.

I'd like to take a few moments to provide an overview of what we are doing this year to improve health care for Saskatchewan people. As you know, our budget theme this year is about balanced growth. Broadly this refers to using the province's economic strengths and growth and sound fiscal management to improve the quality of life of all Saskatchewan people.

Saskatchewan is well positioned, but there is no doubt that this is a challenging but responsible budget. We are continuing on our path of controlling government spending and balancing the budget while making sure patients are well looked after. Fiscal responsibility is our foundation, a key part of our plan for growth to keep Saskatchewan moving forward.

With growth comes challenges. Growth can place a heavy burden on our health care system, and we are certainly seeing that with respect to capacity issues in our larger hospitals. At the same time, the provincial budget clearly reflects our government's commitment to health care. As you'll know, health represents the largest component of most public sector budgets, and Saskatchewan is no different. Health spending accounts for about 42 per cent of the total budget in 2013-14.

We are investing a record $4.84 billion in the health system this year. This is a 3.5 per cent increase or $162 million spending increase to provide strategic investments to improve the health of Saskatchewan people. We want to provide better access to quality health services while also recognizing that more efficiency in the health system is possible.

In terms of percentage increase, our health budget is not the highest among Canadian provinces this year nor is it the lowest. Alberta increased spending on health by 3 per cent in its most recent budget and BC [British Columbia] announced a 2.3 per cent increase. Manitoba's budget will be delivered tomorrow. On the other side of the coin, Quebec's health spending increased by 4.8 per cent in this year's budget.

This major investment will support our highest priorities in the health system: shorter surgical wait times for patients; improved innovative primary health care; better access to physicians, especially for people in rural and remote areas; and more efficient patient-centred health services.

If I could break that down in very general terms how Saskatchewan's residents will benefit from a 3.5 per cent increase: of health's $161.7 million budget growth, 146.8 million is attributable to cost growth in base programming, including health sector salary increases, drug and medical costs growth, and program utilization changes; 50.1 million is due to population growth, new initiatives, programs, and service enhancements; and $19.4 million is attributable to capital equipment and facility investments. This will be offset by a $54.6 million reduction for program, service, and administrative efficiencies, and I will provide additional details about that shortly.

We are ensuring in this budget that priority programs are funded. At the same time, we are asking the health sector to build upon the significant work already done and continue to find innovative ways to alter the steep increase in health care spending. We are very focused in Saskatchewan on bending the cost curve and engaging and encouraging the regional health authorities to work together as one system, always bearing in mind that our overarching goal is to ensure that we are putting patients first. With that in mind, I'd like to focus on some of the key investments that we'll be making in the health budget this year.

The province's regional health authorities, which handle much of the day-to-day delivery of health care in the province, will receive a total of $3 billion in funding. This is an increase of $132 million or 4.5 per cent over last year. We have designated $29 million to help regional health authorities deal with pressures that come from a growing population. Very simply, more people means a greater demand for acute care and community services.

Health region funding increases vary from 1.8 per cent to 7.3 per cent, depending on each region's particular needs. Some of the factors considered include collective agreements' inflationary increases, funding provided for population growth, volume pressures and program expansions, the transfer of existing funding from other program areas to the RHA [regional health authority] base for established ongoing programs such as the surgical funding, and specific efficiency targets and other reductions. Health regions provide the day-to-day health services Saskatchewan people need, and all health regions have received a funding increase.

I'll now speak about some of the ministry's strategies to improve access to quality health services and how this budget reflects these priorities.

As you're aware, one of the top priorities in health has been improving wait times for people who need surgery. We have made huge strides, having started with some of the longest wait times in the country. Since November 2007 there are 61 per cent fewer people waiting more than six months for surgery and 46 per cent fewer people waiting more than three months for surgery. Ninety per cent of patients who had surgery between August 1st, 2012 and January 31st, 2013 received their procedure within six months; 78 per cent received it within three months.

In budget 2013-14 we are building on that momentum by investing a total of $70.5 million in the Saskatchewan surgical initiative. This is an increase of $10 million over last year's budget. The money we're investing in the surgical initiative will provide for an additional 7,000 surgeries and improve the quality and safety of patient care.

Most of the province's health regions are on track to meet our goal that all patients are offered a date for surgery within three months of seeing a specialist by March 31st of 2014. Regina Qu'Appelle is not going to hit this target for a number of reasons, but we fully expect Regina Qu'Appelle to achieve the three-month target. It'll likely take that region an additional year.

We place a great deal of importance on caring for cancer patients. In this past year, we expanded the screening program for colorectal cancer to every single health region in the province. The 2013-14 budget includes $150.7 million for the Saskatchewan Cancer Agency to provide enhanced cancer care services. Again that's a significant $12 million increase over last year or 8.6 per cent; $4.4 million or 3.2 per cent to ensure timely access to treatment for an increasing number of patients; $3.8 million or a 2.7 per cent increase for increased drugs and medical costs; $1.9 million or 1.3 per cent for other non-salary costs; and $1 million or 0.8 per cent for increases to colorectal and breast cancer screening programs. That will be offset by expenses. These expenses will be offset by $3 million or 2.2 per cent in savings from increased efficiencies.

Cancer patients will also benefit from the new PET/CT [positron emission tomography/computed tomography] scanner at the Royal University Hospital. This diagnostic tool is used primarily in planning for effective treatment for patients with cancer and can provide information that other diagnostic tools cannot. Because Saskatchewan has not had its own PET/CT scanner, patients from this province have had to travel out of province for these scans. In 2011 we announced a $6 million investment to bring PET/CT scan services to Saskatoon, $4 million of that coming from government and $2 million of that coming from the Royal University Hospital Foundation. Renovations and insulation began later that year, and we expect that the PET/CT scanner will be operational early in this fiscal year. Accordingly this budget invests $3.7 million in operational funding for the PET/CT scanner, which includes $1.7 million to procure the specialized medical isotopes required for the service.

I'm pleased to note that the PET/CT scanner is far from the only investment that we're making in health care infrastructure this year. A total of $163.9 million have been included in health's 2013-14 budget to continue investments in health care infrastructure. We are investing in facility and equipment improvements that will benefit patients and staff in health regions across the province.

In the 2013-14 budget year, $121 million will be invested in government-owned or co-owned capital. This includes $50 million for design and construction of the replacement hospital

for Moose Jaw. The new hospital in Moose Jaw will be truly a patient-first facility, with a model of care and facility design that allows for services to come to patients rather than requiring them to travel throughout the facility. Site work is beginning this spring and the expected completion date is December of 2014. This new hospital in Moose Jaw will have 115 acute care rooms and treatment spaces. It will be the first fully lean facility completed in this province, and patients and staff have been heavily involved in the design of this facility.

The 2013-14 budget invests $85.5 million in the work progressing on the long-term care replacement projects. The third party capital budget also includes $14.7 million for repairs to our health care facilities. That money will be used to replace or upgrade things like fire alarms, sprinkler systems, nurse call systems, generators, roofs, windows, and other structural work.

Of course we're not just investing in bricks and mortar; we're investing in the providers who care and who deliver that care as well. The province's 2009 physician recruitment strategy is paying off with overall physician numbers increasing and physician turnover decreasing. As of March of 2012, there were 1,985 physicians licensed in Saskatchewan. That's more than 270 physicians practising in Saskatchewan today than compared to just six years ago, and the turnover has decreased by 2.8 per cent.

Since the release of the physician recruitment strategy we are training more doctors, recruiting physicians through Saskdocs, working harder to retain Saskatchewan-educated medical students, and opening our doors to qualified IMGs [international medical graduate] through our new assessment program, the Saskatchewan international physician practice assessment or SIPPA. Through SIPPA, the Saskatchewan-based assessment program to assess foreign-trained physicians, 54 have successfully completed the assessment with 94 per cent of these physicians practising in a rural or regional community.

[19:15]

I'd like to highlight some of the key initiatives that is driving our success. Our agreement with the Saskatchewan Medical Association is one of the best in the country. It has strengthened recruitment and retention efforts through fee increases and programs aimed at attracting and keeping physicians in the province.

We have continued to support a strong and viable College of Medicine to meet our health provider training needs, our research initiatives, and the delivery of clinical services to the people of Saskatchewan.

Saskdocs, our physician recruitment agency, has been working hard and has participated in numerous provincial, national, and international job fairs. Most recently Saskdocs was part of the government's job mission to Ireland.

This year's budget contains $17.8 million, an increase of $2 million, to support postgraduate training seats, to help boost physician numbers in Saskatchewan, and improve access for residents.

Also shortly before the budget we announced the rural physician incentive program, and we've set aside $250,000 to fund the initiative for this first year. This initiative will provide a total of $125,000 over five years to recent graduated physicians who practise in rural Saskatchewan. Physicians will receive the payment at the end of each year of practice. This incentive is designed to ease the financial burden for physicians who finish their years of study with a large debt load, and it will complement our other efforts to address physician shortages in underserved rural areas. Those efforts include enhancing distributed medical education, essentially providing opportunities for medical students and postgraduate students to train in communities other than Regina and Saskatoon. Currently residents are training in Prince Albert, Swift Current, and La Ronge. Residents will also be trained in North Battleford as of July of this year, and we have planned expansions to Moose Jaw in 2014, with further distribution in further years.

We also support the family physician comprehensive care program, which is a part of our SMA [Saskatchewan Medical Association] agreement which provides incentives for family physicians who provide a full scope of practice.

All of these initiatives are connected to our broader goal of improving health services in rural Saskatchewan. We are making a $23.6 million investment to help accomplish this. This includes $3 million, an increase of 1.5 million, to support the implementation of a 20-physician locum pool to serve rural areas. The locum pool will support patient access to physician care by handling the duties of physicians who are temporarily away from their practice.

In last year's budget alone, we provided funding for the first five full-time locum positions at $1.5 million. This year we are investing $3 million for rural locums, an increase of 1.5 from last year's budget. Once the four-year plan is fully implemented, we will see 22 full-time locum positions. After getting a few of these locums in place, the program showed success and the health regions appreciate having funding to specifically provide rural locum coverage. We have had discussions with both the Saskatchewan Medical Association and our health regions to decide how to best design our locum pool. The SMA does operate their own short-term locum program and we know that they will continue with that work but we've decided to create our locum pool with region-based locums.

Additionally we're investing $10.5 million in continued supports to the STARS [Shock Trauma Air Rescue Society] helicopter ambulance to enhance emergency coverage. STARS now operates 24-7 from bases both in Regina and Saskatoon and has flown approximately 370 missions, transporting over 250 critically injured or ill patients in the province. STARS commenced operations in Regina on April 30th of last year at noon and began flying 24-7 on July 30th that same year.

Services began in Saskatoon on October 15th of 2012 and STARS commenced 24-7 services out of Saskatoon on February 25th of this year. STARS works in partnership with our ground ambulance operators, first responders, and our fixed-wing air ambulance Lifeguard to provide the best in critical care and transport of those in need in rural and remote areas of the province. As well this budget includes $1.3 million

for construction of a helipad at the Regina General Hospital.

We're also investing $9.8 million, an increase of 4.3 million, for innovative approaches to improve access to primary health care, including the introduction of collaborative emergency centres to improve health services for Saskatchewan people. CECs [collaborative emergency centre] are designed to enhance access to high-quality, comprehensive primary health care and consistent emergency care through a team of health professionals. This year's budget provides $9.8 million for primary health, as I said, a $4.3 million increase from last year. This increase in primary health funding will allow us to establish four to five collaborative emergency centres in rural Saskatchewan in this budget year.

We know that maintaining 24-7 emergency coverage is one of the biggest challenges in our rural communities, so we looked around the country for a model which could alleviate some of these pressures. Last September a delegation of Nova Scotia officials came out to Saskatchewan to make a presentation on what they were doing to address this concern, to other health regions and health care providers and municipalities. As well, Minister Weekes travelled to Nova Scotia to see them first-hand.

The model used in Nova Scotia has proven to be successful at alleviating waiting lists, actually reduced emergency room visits, provided predictability, and overall improved access for patients. The Nova Scotia CECs are staffed by a primary care paramedic and a registered nurse, with access to an emergency doctor via telephone. We are looking at this time at how we can adapt this model to make it more effective for Saskatchewan needs. The model will be flexible to adapt to the needs of individual communities and it represents the kind of team-based approach that we're looking for in Saskatchewan. We know that there are communities in Saskatchewan that are ready to innovate and we hope to have the initial site up running late spring, early summer.

Another priority for health in this budget is improving services for seniors. The 2013-14 budget includes an incremental $3.1 million investment in some targeted initiatives that will benefit seniors in the province. The biggest part of that is $2 million for a new Home First/Quick Response home care two-year pilot here in the Regina Qu'Appelle Health Region. This program helps prevent avoidable hospital admissions, facilitates earlier hospital discharge, and provides crisis intervention in the community. The program may include such things as short-term case management, medication management, skin and wound care, mobility aids, rehabilitation, and other support.

Also included in the new money for seniors is $750,000 to fund 24 additional beds at Pineview Terrace Lodge in Prince Albert. This will assist the region in reducing wait-lists and better meet the increased demand for care.

I'm also pleased to note that the budget contains an additional $350,000 for expansion of the Alzheimer Society First Link program, a significant enhancement to the previous funding of $50,000. This $400,000 total investment will benefit individuals living with Alzheimer's and related dementias, of course, as well as their families. This new funding will support expansion of the First Link program to four additional sites — North Battleford, Swift Current, Estevan, and Prince Albert — as well as establish six dementia advisory networks to improve the system of care and support for people with dementia, their families, and caregivers. We have worked collaboratively with the Alzheimer Society in identifying the additional sites, based upon their work with existing dementia advisory networks.

In the past, the cost of health care has risen faster than the rate of inflation. Since this administration took office in 2007, health budget increases averaged 6.2 per cent. Clearly this is not a sustainable path. We must, as a system, continue to find efficiencies. Regional health authorities have done tremendous work in this regard and we are asking them to keep pressing for these savings.

But where are those savings supposed to come from? They will be achieved through the application of principles like lean and administrative efficiencies. Fifty-one million dollars savings are to be achieved by regional health authorities. This includes $43.6 million in general efficiencies such as shared service models utilizing group purchase discounts and reduced duplication, and general efficiencies through initiatives such as lean that streamline processes to remove non-value-added steps.

As well, we are expecting regional health authorities to find $7.2 million for improved attendance support, to reduce overtime costs, sick time productivity losses, and workplace injuries. We are also asking the Saskatchewan Cancer Agency to find $3 million in savings through greater efficiencies and better coordination of services and purchases.

We know that this will be a challenge. It will require a great deal of commitment and leadership, demonstrating our goal of better health, better care, better value, and better teams for our patients. And we know the people in our system are up to that task. Their commitment to quality improvement was demonstrated once again by the success of the third quality summit hosted here in the province last week. More than 600 people attended, including front-line providers, managers, and senior leaders. I think that that underscores the value that people see in quality improvement.

Even more remarkable, it is my understanding that more than 60 patients participated, the most ever. This speaks volumes about the importance of patients in health system transformation and their high level of interest. That's exactly how we started our journey to transform the health system, with the concept that the patient comes first and needs to be actively involved. That principle is driving quality, safety, and service improvements throughout the system and at the front lines where services occur.

As you are aware, the improvements made in our health system are making a difference for patients and will continue to do so. Within the ministry, the investment in lean management system is already paying off and benefits will grow significantly in the coming years.

It takes time and resources to embed lean methodology across the system. The Ministry of Health has invested approximately $10.5 million from 2008 to January 2013 in lean. These costs benefit the entire provincial health system. The Ministry of Health has saved almost $16 million from 2008 to January 2013

from these lean initiatives, including $14 million in the blood products system, $1.3 million in vaccine management, and $570,000 through laboratory initiatives. In addition, $30 million in capital cost savings have been achieved through application of lean to facility design of the Saskatchewan children's hospital.

In the past year, we've worked hard to embed lean into the system and this will mean more efficiency gains in the future. Long-term commitment to lean has achieved dramatic success in many sectors, including health care. We're confident that we can continue to achieve that both in the ministry and throughout the system. Lean is very much driven by the people who work on the front lines of the health system. Whether it's operating teams in Regina or food services in Yorkton, lean has empowered people in the system to innovate, eliminate waste, and improve the patient and provider experience. Their efforts and support in identifying and leading key transformation initiatives will continue to make a difference as we move forward together to improve health care for all our residents.

To date, close to 300 lean initiatives have been launched by health regions, the ministry, and the Saskatchewan Cancer Agency. These include, among others, patient flow, laboratory services, medication administration, and patient safety. Results have been promising. We're seeing shorter wait times for patients, improved patient safety, and streamlined management of our blood supply. We know that they will serve patients better and we are hearing repeatedly from patients and family that we are on the right track. And we believe in what we are doing.

We should all be inspired and enthusiastic about what we have achieved and what we will achieve here in Saskatchewan. We are already health care leaders in Canada in so many areas and our health system is only getting better, but we continue to strive to work together as one system and always put the patient first.

In closing, Mr. Chairman, and members of the committee, I am incredibly grateful to have the opportunity to serve in this role at such an exciting time in the health system. I am grateful for the hard work of the people that work in my office and the Ministry of Health.

We would be very pleased to take your questions. Thank you.

The Chair: — Thank you very much, Mr. Minister. With that detailed description, there might not be any questions, but we'll ask anyhow.

Mr. Nilson, I believe, has some questions for you.

[19:30]

Mr. Nilson: — Yes. Well thank you very much to everyone who's prepared all of the information in the budget process and obviously in the presentation tonight. And I think I agree with the Chair that there was a lot there in the presentation which we all should be very proud of, and so we thank everybody for that.

I have some questions, like usual. And I'm going to start just in an area so I can understand kind of the bigger picture of the budget, because that's the one that's been causing me a little bit of difficulty in trying to understand what the big picture of the budget is.

And I guess if you can go to page 85, which is the regional health services page, it's clear from what you've said and from what is here on the page that the amount for operating the regional health authorities has gone up $131 million approximately. And the amounts are set out there, and every one of them goes up except I think the regionally targeted programs number that's on that page, but otherwise everything else is . . . And that's just below the addition of the 3 million.

But my question is that in the budget summary and in your speech, you talk about $54 million in savings. Is that anywhere on this page or where is it? I don't understand where that number is. Perhaps you could answer that question.

Hon. Mr. Duncan: — Thank you for the question, Mr. Nilson. Thank you for the question. So you won't see the 50 . . . So for regions, it would be $50.9 million. You don't see that in the book. What we are doing is we are increasing the base budget for the regional health authorities. We're adding in what regional health authorities would receive for specific projects like the surgical initiative that would be over and above the base budget, but from there, from the base funding from last year, essentially what it works out to is capturing about 1.5, 1.7 per cent in a reduction in their base funding from the year prior.

Mr. Nilson: — Okay. Maybe, can . . . You might have to explain this to me again. So the numbers on this page are not what they get then.

Hon. Mr. Duncan: — So the dollar amount that you would see for each region on page 85 is net the reduction target, the efficiency target. So we've taken the base from last year. We've added in the base increases for this year. We've added in the increases for volume pressures, inflation, and so the dollars that you would see on 85 is the dollars that they will receive.

Mr. Nilson: — Okay. So then when you get to regionally targeted programs and services — that's what you indicated — that money, that number is 40 million less because you've spread it out among all of the regional health authorities. Is that right?

Hon. Mr. Duncan: — So in that case . . . And we can get some specifics of what is in that. So that would be any continuing program that would have been a targeted program from last year would then now be built into their base budget. So for example, the surgical initiative, the amount from last year would now be put into their base budget and then that targeted program would have a small, for an example, that targeted number would be smaller because there's only an additional $10 million on the surgical initiative because the previous year is now essentially baked into their base budget.

Mr. Nilson: — And okay, so if we were comparing apples to apples, if we had the numbers on the . . . that are from the estimates in '12-13, they would be, they're different. They would be different than what's in '13-14. Is that correct?

Hon. Mr. Duncan: — Mr. Chair, I'll have Max Hendricks, the

associate deputy minister, give a response.

Mr. Hendricks: — Thank you. So from '12-13 to '13-14, the regional base operating increases by $131.8 million or 4.5 per cent. Included in that is $68.6 million or 2.4 per cent of transfers to the RHA base from regional targeted programs, from programs such as fee-for-service, non-fee-for-service to recognize physician agreements. In addition, there is 44.8 million for inflation; 35.7 million for volume pressures, demographic growth; 33.7 million for compensation costs. And then we reduce that by $50.1 million. So regional targeted, you're seeing that go down by $40 million because we're transferring programs such as the Saskatchewan surgical initiative, $10 million, primary care redesign, 4.2 million, and a number of others are being transferred into the RHA base operating.

Mr. Nilson: — Okay. So if we tried to construct a budget that's directly comparable, then all those numbers that you just explained, except for the 48 million in inflation, would actually be in other budget lines last year. Is that correct?

Mr. Hendricks: — No. The volume pressures would not be. The compensation costs would not be. Some of these programs, the surgical initiative, 10 million, these are expanded amounts for that program. So there's a $10 million expansion for the surgical initiative, the expansion for primary care, and increase in the seniors funding. So this is new programming that's being put into that budget.

Mr. Nilson: — So I guess what I'm trying to figure out is, I've never seen a description like this where you basically say that the budget is a certain amount but then there's $54 million missing. I'm trying to figure out how you show that in your books.

Perhaps you can take me to one health region and show me what happens in one health region.

Mr. Hendricks: — So in Saskatoon the 2012-13 estimates were 920.99 million. To that we add total compensation and CBO [community-based organization] increases of $9.9 million; total other standard increases, and this would be for inflation, drug, surgical, laboratory of 15.6 million; so the total compensation and CBO increases is 25.6 million. We add new programs into that totalling 13 million, and that includes things like demographic funding, cardiac care, diagnostic imaging for the PET/CT that's being added. And so the total new programs, as I said, is 13.975 million.

They have a reduction target for attendance support of $1.3 million and then a general efficiency target of $13.8 million, for a total of $15.1 million in reductions. That gives Saskatoon its total increase before transfers of $24 million or 2.7 per cent.

And then there are a number of other transfers that go into the budget. For example, we are transferring money. I spoke incorrectly before about the $10 million for surgical initiatives. It's being retained and regional targeted, but we are transferring money out of regional targeted into the region's base budget totally 16.475 million.

Mr. Nilson: — You know, I guess I'm asking these questions because it feels like talking to people in different regions of the province that this is really tight. The documents seem to say that there's a substantial hole in the budget and the reporting of it is very difficult to follow, if I can be kind about it. It's very difficult to follow. So I don't understand why you made all these changes in the reporting of it so that it's very difficult to follow. Other than, you know, I mean the only reason I can think of is that you wanted to have, make sure there was a positive number after each of those regional health authorities. Is that the reason?

Mr. Hendricks: — So maybe I'll just start out by saying prior to the reduction for efficiencies, the overall funding increase for regions is $182.7 million or 5.2 per cent. After the $50.9 million of reductions or 1.7 per cent, it's $131.8 million which gets us to our net operating increase. Now included within that net operating increase is our transfers from regional targeted programs. As I said, this reflects programs that have not previously been recognized in regional budgets, so as they become part of the ongoing operations of a region, they are transferred. We have held money for compensation prospective settlements in regional targeted programs in the past until that amount has actually been awarded, and in the subsequent year that amount has actually flowed into the region's operating budget. So this isn't a new practice. This is something that we've done for years, and it's not meant to be misleading or in any way try to confuse folks.

Mr. Nilson: — Well I mean, as you know, I know these budgets well. And I have to say it's not clear what's going on here. And, I mean, I guess the best way is what you just described is that the budgets that came from the regional health authorities basically totalled up to an increase of 182 million, and so that those are the budgets that are they're sort of working with, except they've got this imperative to try to reduce the amounts. And I don't know, I don't think that we've ever had anything quite like that before as a method of budgeting. You know, was there other years where it's been done like that?

Mr. Florizone: — Yes, just to clarify, we have done this in previous years. The one step that we did take in this year's plan and in the last several years is to actually be very transparent about that target. So whereas you would've seen increases, those increases may have had built-in targets embedded in them but we weren't as transparent as we've been, for instance in this past year, about saying the exact amount, approximately $50 million.

So what we've done is we've taken these regional health authority budgets and very much built them up based on population, pressures on what we know about collective agreements, whatever the givens are, about inflationary increases. And so that what we used to refer to as the status quo, it has some growth and some pressure built into it. So it's not quite the same as last year. It is the same building in population, building in those various pressures.

So we knew for instance several years ago that diabetes was putting pressure on some of our programs, dialysis for instance. So we could build that into the status quo budget, knowing that in order to maintain our programming, we'd need to offer an increase. So we built all that in and built the regional health authority budgets up, and then we established the targets. So the

targets are a reduction from what traditionally would be the status quo budget.

And what we've done with the reduction targets has been very clear, in working with the regional health authorities, that in order to bend the cost curve — in other words to bring costs more in line with growth of the economy and overarching government spending — what we needed to do is take a look at areas like attendance management, overtime, sick time. So when we look at, for instance, those attendance management numbers, overtime and sick time alone were about $120 million system wide. So we felt by sending and setting some very realistic targets there that could be achieved.

Some of the other target setting was around shared services, 3sHealth, some of the work that's being done there. Group purchasing, we've had our own experience internal to the ministry around pricing for generic drugs. We hope to have something soon to say about pricing around brand name drugs. But these are the types of push targets that we've established within the system.

So I want to clarify our aim was never to display in a way that's inconsistent with previous years or misleading in any way. It's actually the opposite. It's to be fully transparent that yes, we did . . . When regions are saying they've got some real challenges before them, those challenges are absolutely real.

Mr. Nilson: — But I mean it's interesting that you talk about overtime and sick leave. Now have those numbers come down at all with the special concentration on that over the last five, ten years? And so, you know, if they have come down already, you know, where are they going the next time? Because I mean I know that this was a concentration 10 years ago.

Hon. Mr. Duncan: — Mr. Chair, so we've seen over the last three years on some specific attendance management initiatives just overall: a 21 per cent reduction in wage-driven premium hours; six and a half per cent decrease in compensation paid during premium shifts; 6.2 per cent reduction in sick leave hours; and a 20.5 per cent decrease in lost time, Workers Compensation Board claims.

We know that for example, just to pick out two examples, just in this last year though, Regina Qu'Appelle Health Region paid out roughly $33 million just in overtime. Saskatoon was at about 18 million. And so we've seen — those are overall numbers, the percentages — we've seen, I think, some good work by some regions, but we've also seen where from one year they'll reduce some of those numbers, but then the next year they pop back up. So it's trying to put a more concerted effort into decreasing and then keeping those decreases in place.

Mr. Nilson: — Okay, so it's part of a negative reward system, if I can put it that way. It's kind of like your SGI [Saskatchewan Government Insurance] claim. If you get in a few accidents, you get a little bumped up on it. Normally budget is sort of, tries to be as realistic as possible, as you'd said. This one has got an extra kind of zing to it that maybe it'll work, but sounds like from what you just said, the numbers went the other direction this last year.

Mr. Florizone: — So to clarify, this is a third year of similar targets. We have established these goals and these objectives. And as you're aware, these are not the only targets that we set. The triple aim — better health, better care, better value — and we've added a fourth dimension, better teams. We've set targets across every dimension. In fact a system this past year had 1,000 people involved in the target that was set on the financial parameter. The system goal was to bend the cost curve by 1.5 per cent. So take the status quo, the costs that would be required to maintain the system, and reduce that by 1.5 per cent. That was the goal established by the system.

So there were about 1,000 people involved in the dialogue about what that would take throughout last year, leading out to the release of this year's budget. That is approximate to what we've set for regional health authorities overall. The budget, bending of the cost curve, is 1.8 per cent. With the regional health authorities, it's approximately 1.5 per cent that they seek to be able to establish as their target, their goal.

In terms of being realistic, it actually was set on the basis of what's sustainable into the future. What we're trying to do is, obviously, respond to future streams of revenue. We've got targets that have been established under health transfers into the future. We've got a need to make sure that our spending stays in line with, you know, general inflation or very close to it or at least the growth of the economy.

So that's what it's been established on the basis of. I don't want to leave the impression that we've just pulled these out from nowhere. We're aware of the overtime costs. We're aware of the sick time costs.

We're also very aware, in terms of the work that's being done right now, that there's considerable improvements that could be made in the system. Now that's not to say that people aren't working hard — they're working very, very hard — but what we're trying to do is wherever possible avoid cost-cutting, avoid lay-offs, have people work towards attrition, be able to plan out these service reductions. We feel that 1.5 per cent is a reasonable pace. It is push. It's not easy. It's a lot easier to get your full funding. Having said that, we're asking people to innovate and be creative around that.

Mr. Nilson: — So you've indicated the last two years have been about 1.5 per cent. So what is the actual number? What did they accomplish? Did they hit 1.5 per cent?

Mr. Florizone: — What I said was, we've set targets in the last three years. I didn't say it was 1.5 per cent each year. So '08-09 . . . We'll actually give a breakdown, just one moment please. We'll give you a breakdown of what those targets are.

Now it's quite clear that this past year Saskatoon, Regina, and Prince Albert have not hit their targets financially. Prince Albert, I can tell you for one, was looking at attendance management and a growth in overtime and sick time as being the prime driver of almost $1 million in forecasted deficit. We have Saskatoon and Regina that are both around the $24 million mark, and there's a whole host of other reasons why those deficits occurred.

Now it's very easy for decision makers to jump to the conclusion that a deficit is simply the result of funding. There

are management decisions that need to be taken throughout the year. We are impressed with some of the positive changes that have been made, but less than impressed that at year-end we ended up with deficits that carry forward into future years and compound the challenge of meeting these targets.

Hon. Mr. Duncan: — The specifics to your question, Mr. Nilson, about targets as a percentage of the RHA's funding over the last number of years: so in 2010-11, the target was 1.4 per cent; '11-12, it was point nine per cent; '12-13 was 1.6 per cent; and then in the proposed '13-14 budget, it works out for RHAs to 1.7 per cent.

Mr. Nilson: — Okay, so those are the targets. And then for the previous three years, did they hit the targets?

Hon. Mr. Duncan: — Thank you, Mr. Chair. Just looking back at the past three years, so in '10-11, the regions would have achieved their efficiency targets. All the regions were in a surplus position. In '11-12, they all were in a surplus position except for Saskatoon. And then of course in '12-13, we know that particularly Regina and Saskatoon are in a deficit position.

[20:00]

I just want to just also comment, just give the members just a more fulsome explanation, especially around sick leave hours that regions are paying out. If you consider, for example, Cypress is I think one of the leading regions in terms of reducing sick leave hours. Over the last three years alone, they've reduced their sick leave hours by 35 per cent. They are now down to 55.11 hours per paid FTE [full-time equivalent] in sick leave. That compares this year, using the same numbers, to Regina, which is at 85.33. So a 30 hours per paid difference in FTE sick leave hours is significant and has caused, I think, gone a long ways towards Regina's issues that they have this year. What we're saying is working with the regions to try to drive some of these numbers like sick leave down. Even if Regina could get closer to where somebody like, a region like Cypress is, it would result in significant savings for that region.

Mr. Nilson: — Well thank you for the explanation. I may have some more questions about this, but the reason I'm asking this is that there are people who, all over the system, who are under pressure — whether they're the workers or more importantly the patients — and people are feeling the pressure for I guess lots of different reasons. But some of it relates to this, where there isn't . . . Well I guess there is the flexibility to hire more people if you need them, but there's a strong central pressure to hold the line, try to do the work with short staff or less staff — somebody's away — and so that's where it affects individuals. And so some of the sick leave may relate to the pressure built up here in the system, and clearly patients are, and clients, depending where they are in the whole system, are suffering because of this.

And so there's lots, you know, there's lots of positive things we can say about the system, but there's an underlying tension in the system right now. And I need to try to figure out why and where that comes from. And it may be that some of this kind of central pressure on the whole system is actually creating a sick system, if I can put it that way, where people . . . I mean what you're doing is actually counter to your goal of getting people to have less sick leave. I mean there's lots of specific questions that I can ask, and I guess I will.

Now when you talked about rolling fee-for-service monies into the regional health authority, I assume that's for the salaried doctors who work for the regional health authorities. Or you move money from different categories, but you still end up having a huge amount over on the next page. Is there a steady flow of these medical services dollars into the regional health authorities' dollars each year so that that's observable? Or what, you know, maybe you can just explain how that whole shift is taking place.

Hon. Mr. Duncan: — Thank you, Mr. Chair, and Mr. Nilson, for the question. I'll have Max Hendricks speak specifically to the second part of your question. But I just would like to say that I think what system leaders and people involved in the health care system — in fact it was pretty clear last week with the health quality summit that was held in Regina over two days — that I think there's a real, real acknowledgement by people within the system that you can improve quality and reduce costs at the same time, and I think we're seeing significant work along that path. I think if you . . . Had we not looked at embarking upon the work in quality improvement and continuous improvement and some of the work through the lean initiative, we would not have come across a way to better inventory our blood system. It's saving us $14 million a year. I think that that is just one example of some of the work that we're seeing that we can improve care for patients and it can result in less costs.

I think in terms of pressures, and we certainly know that this will not be a particularly easy year for regional health authorities, but overall they will see a four and a half per cent increase. Over the last number of years, FTEs within the regional health authorities and the Cancer Agency have gone in just six years from 28,000 to nearly 32,000 FTEs. So this is not about cutting back on the number of people that are employed in the health care system.

And I would just say overall, I think this is something that, and I think you perhaps, Mr. Nilson, would acknowledge as a former Health minister, that this is an issue of sustainability is an issue all Health ministers grapple with. I think that if even looking at over the last number of years, if in 2006-07 when the budget of the province for Health went up by 10 per cent, 9.9 per cent, there probably were challenges even at 10 per cent increase in funding. So while we know that this will be a challenging year, we certainly know that our regional health authorities and our leaders in the system and our front-line workers are . . . They're up for it and we will be working hard to see the sustainability of the system. I'll ask Max Hendricks to comment on the second part of your question.

Mr. Hendricks: — So in response to your question about fee-for-service and non-fee-for-service transfers to regions, typically what we do is we provide the same increase to regions that is negotiated through the SMA agreement for non-fee-for-service physicians. For '13-14, we have no SMA agreement. The agreement expired March 31st, 2013.

For transfers, there was a total of $6 million of transfers in '13-14. And so these would be for new alternate payment

projects that have been added, monies that have been transferred from fee-for-service to non-fee-for-service.

Mr. Nilson: — Well thank you. So if somebody who asks what are the medical services cost for the province, it includes those two numbers on this page which is the fee-for-service, not fee-for-service, and then also amounts that are in all of the regional budgets. So it's not an easy number to get I guess would be the best answer, but it is possible, I suppose. But I'm not necessarily going to ask you for that but I just want to make sure we understand that that medical service . . . [inaudible] . . . I would say to the minister that I'm very strongly one who believes that you can make changes around efficiencies, and that's part of a strong legacy. But I think you also end up having to ask lots of questions about how you report what you're doing so that everybody can see where some of these things are, and that's my concern here. Because I agree that there are different ways that things that can be done. I agree that there are new opportunities; hence a lot of them do relate to budgets and how money is spent, so I will keep asking questions like that.

Now I notice in this particular budget that the number of FTEs in the department have decreased by about 25. Can you explain where those decreases are, and are they actual people or are they empty positions or what's happened there.

Hon. Mr. Duncan: — Mr. Chair, thank you for the question. So this year our target is 24 reduction within the ministry itself and that will be achieved through attrition and through vacancies that currently exist within the ministry.

Mr. Nilson: — Can you tell me how many of each?

[20:15]

Hon. Mr. Duncan: — At this point where exactly those 24 positions will come from hasn't been yet identified. Some of it is around timing with upcoming, pending, or upcoming retirements or things of that nature. So as those positions become vacant, then the position would be eliminated. So at this time we don't have a clear breakdown of where that will come from, but we're confident that we can achieve that 24 this year.

Mr. Nilson: — Okay. Well thank you. I notice that you have $1 million for the vital statistics eHealth Saskatchewan initiative. I'm not sure of the exact date that that returns to the department and how many jobs are going to be coming back. And are they accounted for in your numbers here?

Hon. Mr. Duncan: — Mr. Chair, we'll endeavour to get a number, a specific number in terms of the FTEs. Because vital statistics is being transferred to eHealth, that doesn't appear on the ministry's FTEs. That would be separate from the ministry's FTEs.

Mr. Nilson: — So where do the eHealth FTEs appear in the book? Are they have a separate vote or what? How does that work?

Hon. Mr. Duncan: — The dollars for eHealth, as it's a Treasury Board Crown corporation, would show up in the summary financials. But the FTEs, because it's a Treasury Board, the FTEs do not show.

Mr. Nilson: — They don't show anywhere?

Hon. Mr. Duncan: — Thank you, Mr. Chair. eHealth FTEs will be at 180 FTEs this year and, as a Treasury Board Crown, they are not reported in the estimates.

Mr. Nilson: — So there is 180 employees there, so they don't . . . So they get paid, though, right?

Hon. Mr. Duncan: — That's correct.

Mr. Nilson: — Yes, okay. So they're paid out of your budget because you've got 10 million for eHealth. Is that correct?

Mr. Hendricks: — If I could answer that one. There are 180 FTEs. We make a grant out of the General Revenue Fund to eHealth. In addition, eHealth secures revenues from Canada Health Infoway. So yes, we do make a grant, direct grant to the Treasury Board Crown corporation for development of the electronic health record. As well, they secure funding from outside sources as well.

Mr. Nilson: — So there is 180 employees there that are part of Sask Health in some format. They may be a little tenuous. Are there other places where there are employees that don't show up in the books anywhere?

Hon. Mr. Duncan: — Yes. Certainly while we fund regional health authorities in the Saskatchewan Cancer Agency, the FTEs of the regional health authorities or the Cancer Agency would be other entities that wouldn't show up on the government FTEs included in the budget.

Mr. Nilson: — And a little earlier you said there was an increase of 4,000 in those numbers over the last three years. Is that correct? But as far as the overall agenda of reducing civil service by 15 per cent, this 180 is included in that in some fashion. Is that correct? When did the transfer take place of these people?

Mr. Florizone: — It's within the last two to three years. Those numbers are not reflected . . . Obviously they'd be reflected in the denominator, but the Ministry of Health is expected to meet its target with FTE reductions. And we will meet this target this year, separate and distinct from that transfer to eHealth.

The transfer to eHealth, it's extremely important to keep in mind they're not the Ministry. 3sHealth isn't the Ministry. eHealth isn't the Ministry. Regional health authorities aren't the Ministry. But the Ministry certainly funds, you know, absolutely the vast majority of our funds go to third parties, and in this case a Treasury Board Crown.

Mr. Nilson: — And I think practically everybody in Saskatchewan, except maybe the technical people, say that they're part of your operation. You know, people don't differentiate whether it's regional health authority or the . . . And I think the Minister hears about that pretty regularly. But I guess, you know, I appreciate that.

So then with the vital statistics return, there will be a number of people that move with that particular initiative. And there's $1 million here in the budget. Is that money for physical plant or is that for actual employees, or maybe it's broken down between the two? Can you provide me with that information?

Hon. Mr. Duncan: — Mr. Chair, we're going to . . . We'll look for some more detailed information. It is to, as we're transitioning those individuals into eHealth, it'll provide for the additional operating costs for eHealth to now take on that service. As well, we believe it's 18 to 20 FTEs, but we can look for a specific answer.

Mr. Nilson: — Just while we're on that topic, do you have target date for the transfer?

Mr. Hendricks: — We're targeting to have the employees transferred to eHealth in June or July.

Mr. Nilson: — Of 2013?

Mr. Hendricks: — Yes.

Mr. Nilson: — Yes? Okay.

In that particular area, the only, I guess there's a bit of an increase for provincial targeted services on page 84, and the $4 million decrease in blood services. So that probably is related to what you said before about how it's managed, and that's good news. I mean, one of the big issues there is always making sure you use the blood while it's still in good shape, and that's clearly what you've done. So that's positive for all of us, both the donors and the ones who have to receive the blood.

Are there any staff within the whole of the ministry that are seconded to other departments or Crown corporations or to Executive Council?

Mr. Florizone: — Thank you for the question, Mr. Chair. I wanted to just respond by saying I'm not aware of any of our staff that are seconded to either Exec Council, any Crown corporation, or any other ministry. With respect to other ministries, it does happen from time to time where secondment agreements would be arranged, and I know that we're trying to promote that interchange and exchange. So we have seconded from in the past, and I wouldn't rule out seconding to as a way of exchanging that knowledge. So I know that within the human service sector we have an interest in seeking secondments from and having people embedded within the Ministry of Health. Likewise those exchanges are something we promote, but I'm not aware of anyone as of today that's seconded to.

[20:30]

Mr. Nilson: — Well thank you. It's a general question. I notice the restatement schedule is one of the most interesting parts of the whole budget. If you haven't read it, there's so many pages of restatement. But I congratulate Health. You only have two really minor ones, but one of them is moving to Executive Council, communications, two people. Is that correct? So what does mean?

Mr. Florizone: — So those weren't two people; those were two positions. And that's part of a government undertaking to look at centralized web posting. So it would've been and is a function carried out by government that just made sense to have centralized. Those are two vacancies that we've committed this year to Exec Council.

Mr. Nilson: — Thank you, and congratulations on not getting caught into that restatement sort of mire because it's often quite hard to follow.

While I'm on a fishing trip, I'll ask you another one. See if you can answer this one. Can you give me a list of all of the lawsuits that have been filed against the department and against the minister, past, present, and future?

Mr. Hendricks: — So just for clarification, would you like to know the specific legal actions or the nature of the legal actions?

Mr. Nilson: — Well probably both.

Mr. Hendricks: — We have an action that seeks damages for refusal to provide a person with coverage for multiple sclerosis for drug therapies, an action that seeks damages for refusal to provide an approved home licence under *The Mental Health Services Act*, an action which seeks damages for a death caused by a fall from a wheelchair — claims that the wheelchair was faulty and the instruction on the use was negligent.

We've closed two lawsuits in relation to JMPRC, joint medical professional review committee. There's one currently open right now. Or there are a few . . . Sorry, there are three cases that are currently open right now. We have a lawsuit that has been settled in relation to a dismissal, a few others related again to JMPRC, medical professional review. And then one that relates to an arbitration which alleges Health was engaged in contracting rather than hiring staff with health information solution centres. The complainant in that one is SGEU [Saskatchewan Government and General Employees' Union] and that's in arbitration.

And then the government has agreed to participate in FPT [federal-provincial-territorial] financial compensation program for people affected by hep [hepatitis] C virus through the blood system between January 1st, '86 and July 1st, '90. As well we have several claims related to people who have been infected with hep C in relation to the receipt of blood or blood products.

Mr. Nilson: — Okay. So those last two about the blood products, that means basically you responded to the lawsuits that I guess have been developing over the years and are attempting to resolve them . . . [inaudible interjection] . . . Yes.

Mr. Hendricks: — Developing over 10 years, the last decade.

Mr. Nilson: — Yes, okay. Okay. Well thank you for that. It's you know, given the magnitude of the operations that you've got, I think that there's a positive sign in the very small number of lawsuits that are there, but in any activity that's public activity like this, it can be part of the whole system.

I checked one of my notes — as some of you recall, I used to say, well I was at a volleyball game or a basketball game or I

went to the symphony and I heard something, and I want to try to get an answer — and one of the things I heard in the last couple of weeks was that, as it relates to this transfer of vital statistics back to Health or to eHealth, that they're rationing the number of birth certificates that they give out because they're running out of forms, so they're only issuing 10 a day. And so it's delaying the system. Anybody know anything about that? If you don't, I'll let you tell me when you come back the next time.

Hon. Mr. Duncan: — We will seek to get an answer on that, but not that we're aware of.

Mr. Nilson: — That's what I was hoping your answer would be, but it was a sincere concern and that doesn't help any of us when those kinds of things are asked.

Just on another aspect relating to I guess it's regional health services or . . . Maybe you can tell me where it fits in; I'm not totally certain. But I know that Sask Health is a major participant in the CommunityNet, the Internet across the province. And it's funded somewhere in here but I don't recall for sure exactly where it is. And I know that in some parts of the province there appears to be a pulling back a bit of Internet services.

And my specific question is, I was wondering if it's affecting any of the health facilities or, I mean it's not your area but educational facilities because it's clearly a major asset for Saskatchewan that Sask Health has been a strong supporter of for many years.

Hon. Mr. Duncan: — I'm sorry, Mr. Chair. Mr. Nilson, could you just repeat your question? I think we have the information you're looking for but if you'll just repeat it.

Mr. Nilson: — Okay. The question is, I know that Sask Health is a strong supporter of CommunityNet as part of health services in the province. And I'm not quite certain where it would show up in the estimates here. I think maybe in the regional health authorities or maybe in one of these other areas around . . . You know, I'm just not certain. But my concern is that there may be some pulling back of funding or services in the system, especially in the rural parts of the province.

Hon. Mr. Duncan: — Mr. Chair, Mr. Nilson, so those specific dollars, that would come from provincial health services, the (HE04) vote. It would come out of the eHealth budget, and in fact the contribution to CommunityNet from Health or from eHealth has increased this year. This past year would be $5.5 million. That's an increase from about the 3 to $3.5 million range over the last number of years. And it's as our bandwidth is growing our costs are going up as well.

Mr. Nilson: — Okay. So it's 5.5 million out of that 55 million for eHealth is where it is? Okay, that's exactly what I was interested in. And I just have been hearing some questions about some, I don't know, consolidation or reduction of some of those services, and I'm glad to hear it doesn't appear to be affecting Health.

I'll go now to the central management and services budget, and I can see that having two ministers costs twice as much as one, at least in the first line. Is that second line, under executive management, does that then include the cost for a minister's office, effectively? And those are basically the increases that we see in that section?

Hon. Mr. Duncan: — Right. So under central management and services, I can confirm that I'm not getting paid double. And the increase under executive management is essentially the budget for an additional minister's office, the staff and the overhead of the office.

Mr. Nilson: — Okay. Thank you very much. I was assuming that that was the case. Then further on that page, I mean basically there's pretty well status quo budgets all the way down the line except for that extra million for the eHealth Saskatchewan. I guess I haven't been around the budgets, but the provincial laboratory budget, is that all related to the Saskatchewan disease centre? Is that just their budget?

Hon. Mr. Duncan: — Yes, that's correct. That's the provincial lab.

Mr. Nilson: — Okay. And basically it looks as if that's being maintained without much difficulty. So then I'll go over to the next page. And the amount of money for capital projects, I know in your information at the beginning you laid out a number of amounts for capital projects. And that amount, is that effectively the amount that's the capital transfers amount on page 85 under the regional health authorities, or is there some other budget line that I'm not seeing?

[20:45]

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson. So the capital transfers for facilities is 31.922 million identified in the budget. So 15.9 million of that is to continue progress on five long-term care facilities. Those would be Heartland Regional Health Authority, the Rosetown facility; in Tisdale, the Shellbrook integrated facility; and then two facilities in Sun Country Health Region, Radville and Redvers. And then the balance of that would be made up of 14.7 million budgeted for maintenance and repairs in existing facilities. And then the 1.3 million, that is for the helipad at the Regina General Hospital.

Mr. Nilson: — Okay. So then the amounts that you described earlier totalled, I think, 164 million approximately. So where do those other amounts show up then in the regional health authority budgets, or where do we see those amounts?

Hon. Mr. Duncan: — Mr. Chair, Mr. Nilson, thanks for the question. On page 83 of the Estimates book, the capital asset acquisitions amount of $121 million, so that's broken down into $70.6 million to continue progress on seven long-term care facility replacements. Those are Maple Creek, Biggar, Kerrobert, Kelvington, Prince Albert, and Kipling. As well, $50 million for beginning construction on the Moose Jaw replacement hospital.

Mr. Nilson: — So my question is, they're on the summary page, but do they show up then in the allocations to the regional health authorities? Like the 50 million for Five Hills, is that in there, or where does it show up? Or is it only on the summary page? It must be on page 86. Is that right?

Mr. Hendricks: — Actually we have two different types of ownership arrangements here, so RHA-owned facilities would appear under (HE03) in the transfers for capital. And then on page 83 of the book that you're looking at, you see summary of capital investments and transfers . . . or, sorry, capital asset acquisitions, 121,018. And that was what the minister was referring to. So that's government-owned capital. So the government owns 80 per cent of the facilities; the regions own 20 per cent based on their local share.

Mr. Nilson: — So perhaps maybe you should explain it to me again. So that the $50 million for the Moose Jaw Union Hospital, is that in that 120 million?

Mr. Hendricks: — It is, yes. So we have $70.6 million for seven long-term care facilities replacements, one in Cypress, one in Heartland, Kelsey Trail, Prince Albert Parkland, Prairie North, and Sun Country. And then we have $50 million to continue the construction of Moose Jaw Union.

Mr. Nilson: — And you report them differently because of their ownership structure? Is that what you said?

Mr. Hendricks: — That is correct. And then if you look under (HE05) as well, provincial, on page 86 of the government Estimates, it says provincial infrastructure projects. And again that number is listed, capital asset acquisitions.

Mr. Nilson: — Okay. And so then the money for these projects though flows through the regional health authorities. Is that correct?

Mr. Hendricks: — Actually it's a joint contract that we have. We have a co-ownership arrangement with the contractor, so Health will actually be paying a share of the bill to the contractor.

Mr. Nilson: — Is that a different way of doing it, or is that how it's always done? Or I don't quite understand what you're saying.

Mr. Hendricks: — Yes, it's a different way of doing things. These seven projects plus Moose Jaw are unique. Because they are government-owned infrastructure, they'll amortize on government books. We're in this co-ownership arrangement with regions, so as a result, because they're not RHA-owned facilities, we are involved differently in these projects.

Mr. Nilson: — Okay. Can you give me a, you know, three-minute, five-minute explanation of how these projects work?

Mr. Hendricks: — So this was a decision that was made in the '12-13 budget. And this change was made to try and treat the capital cost for the provincial share of health infrastructure projects similar to that of a government-owned capital such as highways, government buildings, and SIAST [Saskatchewan Institute of Applied Science and Technology]. Right now, when capital investments are made in those projects, they are amortized on the government books over the useful life of the building. When we make grants to regional health authorities for capital projects, the regions amortize those over the life of the project. So this was done last year to more accurately reflect, on a GRF [General Revenue Fund] basis, grants that were being made for capital projects.

Mr. Nilson: — So is there any money that shows up here in the books on that 120 million as a payment?

Mr. Hendricks: — So the answer is no. Once the facilities are open and they are actually being used, there will be an amortization amount that shows in the Estimates.

Mr. Nilson: — Okay. So presumably somebody's borrowing the money to build the place. No? Nobody. Maybe we could . . . So they're going to, I think I saw somewhere that they're going to start construction in Moose Jaw in a few months. So is there money available to start that construction, or is somebody going to wait a year or two to get paid or how does this work?

Mr. Hendricks: — The money isn't being borrowed. It's actually, government will pay the expenses. We have $50 million budgeted in this year's budget for the Moose Jaw facility. Government will pay expenses as they are incurred this year in that project. Similarly government, once that project is completed and the hospital is opened, will amortize the costs of that project over the life of the project, 30 years or whatever. So we will spend the money in this fiscal year and expense it. Nobody's borrowing any money.

Mr. Florizone: — Mr. Nilson, the only, the only difference, and just to try and clarify here, the only difference with these facilities is government will retain ownership, a portion of the ownership in these facilities. Therefore they're on our books as assets. Therefore they're depreciated. So this isn't about the cash that goes out. That cash is contained in this budget. It's about, at the end of the day, government retaining 80 per cent of the ownership and therefore amortizing those expenses over time.

Mr. Nilson: — Okay. So that's the new policy on long-term care is 80 per cent ownership by the province?

Mr. Florizone: — Mr. Nilson, it was the policy. Right now for us to say it's the new policy, we have not, it has not clearly been entrenched as the path forward. We are still looking and continuing to seek different avenues with respect to capital financing and capital amortization. This was something that was tried on these projects, but I wouldn't want to suggest at this time that this has been adopted as the path forward.

Mr. Nilson: — Okay. So I guess I'm just thinking back over 10 or 15 years there were some facilities that were . . . Trying to remember the percentages, 80 per cent maybe, like the Swift Current facility. There were others that were 65 per cent funded by the province and . . .

Mr. Florizone: — So we've always . . . The new policy of government is 80/20. So 20 per cent is local share; 80 per cent is the provincial share. The only exceptions to that would be within the major centres. There are some exceptions with respect to the population that they serve.

To be clear here, in the past there have been government-owned facilities. So Sask Hospital North Battleford, for instance, was government owned, continues to be, historically it was. So even

though it's long past being amortized, it originally showed up on the government's books. It was amortized over the useful life of that facility. We had some other examples, you'll recall, where the government retained ownership of the buildings. This was simply a policy adjustment in that single year that said we will retain 80 per cent of the ownership in the facility. So yes, Moose Jaw Union Hospital will be 80 per cent government owned, 20 per cent locally owned.

[21:00]

Mr. Nilson: — Okay. And by locally owned, that's the regional health authority and so they . . .

Mr. Florizone: — That's correct. It is a reflection of a similar financing arrangement, but it is the regional health authority that holds that ownership. So we have a dual ownership interest in that facility.

Mr. Nilson: — Okay. And this is different than some of the other non-profit long-term care facilities that have a different ownership structure.

Mr. Florizone: — Right. So right now in the province we have a bit of a mix. The majority are RHA-owned facilities. We have some government-owned facilities that are managed through what was formerly known as Government Services. And now we have this new breed which is 80/20, a co-ownership model.

Mr. Nilson: — Okay. And so that's what we're talking about here with the financing of these ones, and I guess the auditor will help us all record them the correct way. But right now they're a little bit confusing to figure out how they're funded.

So then in Moose Jaw, the allocation from the provincial government will be the $50 million which will be paid out as it's needed in the project on an 80/20 basis then. Would that be an accurate way to describe it?

Hon. Mr. Duncan: — Right. So 50 million for this budget year and then there would be an expectation in next year's budget that there would be another allotment of money that would be required.

Mr. Nilson: — Okay. And then that's the same with these other facilities. Now this is different than some of the proposals that are coming from some of the faith-based groups on building facilities. Is that correct? Like we have a few of them that are in the works, if I can put it that way, where people are requesting money?

Mr. Florizone: — Perhaps you could clarify. I'm not sure . . .

Mr. Nilson: — I'm just thinking of the new facility that was built in Saskatoon with the Catholic health authority.

Mr. Florizone: — Oh yes, Samaritan Place. Yes. So that was a pilot that was undertaken. And again that was a bit of a hybrid as well. At the time we had a 65/35 split on local and government share. That has been since changed up to 80/20, as you're familiar with.

That facility is a 100-bed facility. It would have cost us, for construction, we estimated as the Ministry of Health, it would've cost us 40 million to build. And the proposal that came forward that was accepted by government was to construct that 100-bed facility at a cost of 27 million. So it turned out to be about 65 per cent, given the construction costs.

It also was put up on time and we did something different there in terms of looking at how we fund, and we funded a capital portion to that facility as well as an operating portion. So that at the end of the day the investment would be returned back, the capital investment would be paid back over time. So it was a kind of a pay-over-time type of arrangement.

Now the differential on interest rates was something that we're interested in looking at. One of the benefits, obviously, on the plus side was this facility was done quickly, it was done on budget, and it was done at a lesser cost than it would've cost us to build a facility of similar size. The differential on interest I can get to you. I know that we've reported in past estimates and in public accounts, but the differential was a very small difference between our cost of borrowing and what the Samaritan Place was able to achieve, borrowing over the long term for that facility.

Mr. Nilson: — And with these long-term care facilities which will be similar in nature, especially the ones that you're talking about here — Biggar, Kelvington — similar type facilities, will they also then have similar payments to them to operate them?

Mr. Florizone: — So we piloted in Samaritan Place. We piloted an approach that looked at a different cost structure and a different funding approach to get those beds up in Saskatoon. We are far more traditional with respect to the rest of the long-term care that's going on.

Now we are entering into a new era of analysis around P3 [public-private partnership] and its potential application. So we're looking at a number of policy options here, making sure that there's value for money in those investments.

Mr. Nilson: — Okay, so we're looking at a new era of P3. Are there any proposals that are in this budget that are, I guess, SaskBuilds or P3 type facilities?

Mr. Florizone: — No.

Mr. Nilson: — But that's a prospect for years to come? Was that . . .

Mr. Florizone: — Yes. Value for money, we're looking at three facilities as a potential. The three areas that we're looking at would include Swift Current, replacement of the three facilities there. You're familiar with those.

Mr. Nilson: — [Inaudible] . . . behind the hospital.

Mr. Florizone: — Yes, so there's a community concept of looking at providing . . . You recall . . . You've been in Swift Current lately, Mr. Nilson? The school's gone up there. They're looking at a bit of a complex, a community and with some of the expansion in Swift Current to be able to co-locate. So we are looking at value for money to see, you know, whether P3 is a possibility. And they're in that process right now of

examination. No decision has been made.

The other two facilities that have potential — and again it's all based on value for money — would be Sask Hospital North Battleford, looking at that as a potential. And the third would be the plains ambulatory centre in Regina. Again these are all at various stages. Swift Current and North Battleford are progressing. And the ambulatory care centre in Regina is a little bit behind because we're still working on the concept and fine tuning. But we're looking forward to it progressing to that analysis soon.

Mr. Nilson: — So the North Battleford hospital basically is being delayed because of the looking at the new way of financing. Would that be an accurate statement?

Mr. Florizone: — I don't think it's that in and of itself. There is some work, as you're aware, with that facility. There has been some forensic and corrections facilities that have been co-located on those grounds. And one of the areas that we have an interest in doing is just making sure that we get this right in terms of the co-location and any of the shared services that exist between those two services.

Now we're not talking about necessarily, you know, patients flowing between. What we're really talking is some of the ancillary services that should and could be offered on those same grounds. So it is an unfortunate delay, but it's really important to get this right. So we met as late . . . One of the ADMs [assistant deputy minister] was out on Friday with Corrections and with the local health region trying to work through the functional program and the adjacencies that are necessary to get that building moving forward. The government and the ministry have been fully committed to this project, so this delay would be more related to that than anything else.

Mr. Nilson: — I just recall that that sort of shared service has been around for probably 30 years — isn't that correct? — between the correctional centre and the young offenders facility and the hospital.

Mr. Florizone: — Yes, but . . .

Mr. Nilson: — And so I guess I'm surprised that it seems to all of a sudden come up now. Because in the '80s, that was how it was done, and so I always assumed that that was part of the planning over the last 10 or 15 years at least.

Mr. Florizone: — Well there are many things that have been done in that facility since 1907, or sorry, I have to go even earlier than that. I guess what I'm getting at is this is our chance to design it so it fits with that shared service. I'm not suggesting or signalling that there's something boldly new about those adjacencies. But when you're reconstructing, it's a matter of getting it right rather than what we've been doing for 100 years now, which is working around a facility that most of that time has been outdated.

Mr. Nilson: — Okay. Well I think that one of the only new mental health facilities built in North America is in Massachusetts, so I don't know if anybody's been down there to look but it's . . . They were able to build a new facility, and like it might be the first newer one in 40 or 50 years. So I suggest that somebody might want to go down and take a look.

Now I don't know if we should take a break or is . . . I'm fine to go but either way here.

An Hon. Member: — Keep on going.

Mr. Nilson: — You're okay? We can keep going? Okay. Lots of good questions. So just in this whole area of working on the contracts and sort of some of these facilities, I think I have a picture of what you're trying to do as far as new ways of financing or new ways of organizing. Will you have public documents available so we can actually see what the arrangements are, say for example in North Battleford around who might be a partner in this or how it's going to work? Because I think that there's lots of people that are very interested in that and probably better for everybody that we get it out front rather than have it as a surprise later.

Hon. Mr. Duncan: — Mr. Chair. Thank you, Mr. Nilson, for the question. I think I'll just speak just generally, briefly to this as it would most likely be a question that probably be more appropriately directed to SaskBuilds as they're the lead agency for any of the P3 work that's being done.

But I think if you look across Canada where P3s are involved, typically what takes place is that work around the value-for-money audit and things of that nature is released if that is the route that the government would choose to go. And once a contract is awarded, then that information would be made public. It typically isn't though if that's not the direction that governments go just because it contains certain proprietary information and information that typically wouldn't be released. But it may be something that SaskBuilds would maybe be able to comment further on because they are the leads when it comes to the P3.

[21:15]

Mr. Nilson: — Well I raise that question around the availability of the contracts because I know that there is a lot of discussion in the health field around the appropriateness of doing this kind of contracting. It works well when you're doing something that's quite easily defined. And I know just in the last month or two, there has been an interesting article in *Health Affairs*, the magazine on contracting related to health facilities.

And the point . . . This is based on experience in Europe where they've been having quite a long experience of doing this. But they seem to say very clearly that there may be some place for some of this kind of contracting, but where it makes the most sense is if you also tie it in with the service that's provided over the longer term. And I don't hear that from what you're saying; it's more that you just get the facility which then eventually the government will own. And that may be an area where it's not as helpful.

So I think that the more eyes that you have on these projects, the better for all of us in Saskatchewan. I know that one of the big difficulties over the years is that often we don't have sufficient experience in doing this kind of work, and that's why doing it in a much more open way is probably better for all of this.

So I am happy to welcome my colleague, Cam Broten. He couldn't stay away for too long from all of the Health questions. So he may have some questions in a minute or two.

And I think I will . . . Well just while I'm on this one, I'll ask one more question. And I don't think you will have an answer, but you may. I noticed that the Wolseley facility is now owned by, I guess, the regional health authority, or there's been some kind of a transfer from it being a private facility, with all its troubles and problems, to the regional health authority. And I was wondering if you in the ministry had done an analysis of the 30-year history of that facility, which has a lot of characteristics of some of this private build and then pay for over 30 years, to see how that one faired out for the people of Saskatchewan. Because my gut feeling was that it maybe cost us more doing it that way than some other way.

Mr. Florizone: — We haven't done a full analysis. But I think that what you're referring to, in terms of the due diligence that's required and the importance of that risk assessment because it isn't just about a transfer of ownership or a relationship with a third party vendor, there has to be a transference of risk as well where the obligation would fall on whoever that third party is, whether it's a community-based organization or a for-profit organization. So when we look at risk, we're really interested in building up the competency to know exactly what it is that we expect to be delivered and then holding to account those that we contract with.

I think it'd be fair to say that what the government has done in the establishment of SaskBuilds — and they'll be in a far better position than I to speak to this — that competency is . . . The need here is for that competency to be built within that organization. There's been enough of a track record — the very positive projects that have been under way, but also some learnings on the failures that have taken place — that that knowledge will allow us to avoid those missteps.

So I can't comment on specifics because we haven't done those types of look-backs, in order to look back 30 years of what was done that led us to what has occurred today. But I can say that all of those warnings and all of those observations you've made are really the drivers around wanting to make sure that SaskBuilds gets this right and that no single ministry thinks it can hold, you know, in a delegated way across every ministry, hold that kind of competency.

We need to operate a building, to own a building, to maintain a building. It's a different competency to contract for those types of services and those types of approaches. When it works well, it's a beautiful thing to be able to see facilities go up on-budget and on-time, to be able to see that the next time the roof needs to be repaired it isn't constantly people coming back on government asking for additional funding, additional money to have that happen. And all of those cautions that you've listed absolutely need to be factored in and mitigated in terms of good, strong contracting.

The Chair: — The Chair recognizes Mr. Broten.

Mr. Broten: — Thank you, Mr. Chair, and thank you to the minister for entertaining some questions this evening. I'd like to have a conversation first about construction projects or renovations that a health region may do and some of the parameters and guidelines that are around those projects, relating specifically to the issue we had a chance to talk about in question period related to Phil Froese and Visionary Concepts and the St. Mary's Villa project.

So what is the normal procedure for these types of projects when a health region engages with a contractor to do a project? What are the requirements that a contractor must meet upon receiving the project?

Hon. Mr. Duncan: — Mr. Chair, Mr. Broten, we're just endeavouring to find the information that you're looking for. Would it be an appropriate time, Mr. Chair, to just take a break? We didn't have a break at this point. So would that be okay?

The Chair: — Definitely, that's fine. We'll have a five-minute break . . . [inaudible interjection] . . . Ten you're hoping for? You've got 10 if that's sufficient. Ten minutes then.

[The committee recessed for a period of time.]

The Chair: — Being the time, we will now continue. And back to . . . Mr. Broten I believe has the floor.

Mr. Broten: — Sure. Just before I have the floor, I know a member on the other side was just curious about the length of the break because I believe whatever was taken up in that needs to be added on to the end. So I'd just like that noted, what the . . . Thanks.

So my question before the break was, what is the procedure for contracts for companies that are doing renovations or construction projects for a health region? What's the protocol? And I know . . . Carrying on to the discussion we've had in question period and in other places.

Hon. Mr. Duncan: — Thank you for the question. And thank you, Mr. Chair, and committee members, for allowing us a break this evening. In this, typically what will take place is that each region will have a tendering policy that's put in place. They will tender out to either a general contractor or a series of tenders, depending on the size of the project. I believe in the case that the member raises that was indeed followed. The region followed their tendering policy. It was tendered to a general contractor who then will, depending on the level of . . . or the different varieties of skills that the general contractor will have within their own firm, they may go out to subcontractors, and that was indeed the case. So that's really the . . . In this case or cases like this, it's the relationship between the health region is that with their general contractor, and then the general contractor would have a relationship with subcontractors in some cases, not all.

Mr. Broten: — Okay. So in the case of St. Mary's Villa, what company received the contract to do the project?

Hon. Mr. Duncan: — Taylor Building Services received the contract as the general contractor.

Mr. Broten: — So as the general contractor, what are the steps that the general contractor would have to follow if the general contractor was going to use subtrades?

Mr. Florizone: — I'm not familiar with all of the steps, but I can say that there is a requirement, not so much on the contractor but on the owner, in this case, Saskatoon Health Region, under *The Builders' Lien Act* for a holdback. Generally that would apply. It would be in the amount of about . . . or of 10 per cent that would be held back on the total amount of the contract until 40 days after substantive completion. Now that's my recall of legislation that, as deputy of Health, I don't use on a daily basis. It's really reflecting on my past experience as a CEO [chief executive officer] contracting for these types of services.

So what would happen within that 40 days is we would wait to ensure, after substantive completion, that there were no outstanding liens from subcontractors. That legislation allows liens to be placed on facilities against ownership interest in the buildings, and if there were no such liens or claims, the 10 per cent would be released to the contractor. So that was protection to subcontractors. That legislation is intended to protect them so that they receive at least a portion of their payment.

Mr. Broten: — So with the 10 per cent holdback, just so it's straight in my head, the health region would have a total budget for the project, and that funding would come from the province for the project. Would that come within the global budget that's given to the health region and they would decide to allocate X million of dollars for the project? Is that how the dollars would come?

Hon. Mr. Duncan: — Because of the small size of the work that was being done, this would have been just funded out of Saskatoon Health Region's budget. It wasn't . . . Government didn't grant them money to do this work because it was a fairly small number, under $100,000 project.

Mr. Broten: — Okay. So on a $100,000 project, it would be, the health region would have to hold back $10,000 in order to ensure that there were no liens placed on the building and that the subtrades have been paid. Is that correct?

Mr. Florizone: — That's my understanding.

Mr. Broten: — Okay. So when the health region decides to release the 10 per cent holdback, is the only factor they look at as to whether or not a builder's lien has been placed on the property?

Mr. Florizone: — Remember or recall it's based on substantive completion and enough time after substantive completion to make sure that there are no outstanding claims or liens. So that 40-day period under that legislation, my understanding is that's the time frame that they would seek. Substantive completion is that opportunity to make sure that the work has been substantively completed, that any outstanding issues are dealt with at that phase in the project.

This would have to be a significant change to the facility, a significant renovation to the facility. It's not cost that is, as I understand it, the paramount importance here. It is that it's actually not just a piece of equipment that's being purchased, that something's being changed to the capital nature of the facility.

Mr. Broten: — Okay. So there's the issue of the 10 per cent holdback and there's the completion and then the 10 per cent is released after 40 days if there's no flags that the health region is aware of.

Mr. Florizone: — That's my understanding.

Mr. Broten: — What about the issue of or the topic . . . I'm not an expert when it comes to building projects, but I've heard about a builder's bond that needs to be placed with the region in order to ensure that the subtrades are paid. And then that bond is placed by the general contractor, and it's not until the health region knows all the subtrades have been paid that that bond is released. Is that the practice of health regions in the province?

[21:45]

Mr. Florizone: — I can't speak to the requirement for that because I'm not familiar with it, but I can tell you that it is standard practice for large-scale projects as a mitigation against any liens or claims that you would want, that a contractor would mitigate — once again we were talking earlier about risk — that that risk is mitigated by carrying a bond. On a project of this size, I would think it's unusual to have such a bond in place. But once again it would be really important for that individual, that contractor that's making this claim to seek legal advice.

Mr. Broten: — Could the minister or an official please provide the dates of the project at St. Mary's Villa, the construction dates when work occurred?

Hon. Mr. Duncan: — Mr. Chair, we'll endeavour to get to Mr. Broten the exact dates when construction would've taken place. We don't have that information.

Mr. Broten: — Does the ministry know when the holdback was released by the health region, the date of that?

Hon. Mr. Duncan: — Mr. Chair, we'll endeavour to get that information from Saskatoon Health Region.

Mr. Broten: — Okay. Before I go down the line of questioning, following when we discussed this in question period and when the minister had his meeting with Mr. Froese, what Mr. Froese told me was that the minister, or I assume someone from his office, was going to contact the health region that day to deal with this matter. Did that follow-up with the health region occur following the meeting with Mr. Froese?

Hon. Mr. Duncan: — Mr. Chair, when I did meet with the individual, we did endeavour to have the ministry reach out to the health region to provide additional information or certainly the health region's perspective on this. And so we did, we did reach out to the health region.

Mr. Broten: — Was information forthcoming from the health region to the minister's office about the situation?

Hon. Mr. Duncan: — Yes. I think it was similar to what we had already heard, that what in the mind of . . . The perspective of the health region is that this comes down to a matter of a disagreement between a general contractor and a subcontractor that the general would've hired, as it relates to fulfilling

obligations between their agreement.

Mr. Broten: — Is there any way, like based on information that has flowed — and I mean there was subsequent conversations on this topic — is there a way of ascertaining right now when the final 10 per cent was released from the health region to Taylor Building Services? Can we find that date, please?

Mr. Florizone: — We can find all those dates just by making a request of the regional health authority. We'd be pleased to provide that to you. What it is is as simple as finding the dates that the cheques were issued against invoice.

Mr. Broten: — Is there any sense of when it occurred; if it was in the spring, the summer, or the fall or . . .

Mr. Florizone: — Well we're having some difficulty just . . . We've got an answer from the regional health authority, but I don't feel it has enough specificity in it to tell me whether the 10 per cent is included. I can tell you that there was an invoice paid on the 1st of April, 2012. It would appear to be in the amount, the full amount including the 10 per cent, but I can't say that unequivocally until we check with the regional health authority.

Mr. Broten: — Okay. So the builder's lien that Mr. Froese registered with ISC [Information Services Corporation of Saskatchewan] was on July 16th, 2012, according to correspondence I have from the lawyer he was using at the time. So if there was any disbursement of funds past that date, the health region can't say that they did not know about this issue as a concern for the subtrade. So that's why I'm curious about the actual date, the timelines of the work when dollars flowed, how long the 10 per cent holdback occurred, and whether or not Mr. Froese has been treated fairly in the process. Do you have any dates that can shed some light on it as it relates to the July 16th?

Hon. Mr. Duncan: — Not, Mr. Chair, not to the July date. No. We would have to get further information from the health region.

Mr. Florizone: — There may be a discrepancy in these dates. I've got an invoice date of April 1st, 2012, and then a potential payment here of 10-02-2012. I don't know if that's . . . But it probably is October 2nd, 2012. If we can go back and get you all of these dates . . . It's a bit confusing the way it's come in, so I want to make sure that we're really crystal clear on invoice date, payment date, date of substantial completion, and what transpired here. If we can get that for you, that would be great.

Mr. Broten: — Okay. And what about . . . So this is the 10 per cent holdback issue. The other issue that could help out an individual in this situation is the bond that needs to be placed. I think what I heard in an earlier response from the minister was that a bond is placed on really large projects. What is best practice? Do all the health regions operate in the same way? Would it not make sense that any general contractor that's using a subtrade would in fact have to put up a bond in order to have some safety measures in place to ensure the subtrades are paid? What is the policy here?

Hon. Mr. Duncan: — I think typically what would take place is that the health region that would be involved would need to make a determination based on the size and the, I think, perceived risk of the project, whether or not they would require a bond. We don't have as the Ministry of Health a policy requiring a bond on a certain size of a project. That's the discretion of the health region to make that determination.

Mr. Broten: — Okay. What sort of avenues are in place if an individual, if a company is upset with the administration of a contract by the health region on a project like this? What avenues of addressing the issue do they have, in the minister's view?

Mr. Florizone: — What I'm really struggling with . . . I think these are really important questions that need to be answered. Unfortunately the best answers come from legal counsel to be able to take a look at the legislation, what the rights are of a contractor or subcontractor. The nature of that contract to make sure that the provisions of that contract are upheld is really a matter between the subcontractor and the contractor, between the subcontractor and the owner. The ministry doesn't have the expertise to be able to answer your questions.

And I certainly don't want to sound like I'm dodging them. I'm trying to do my best. We're trying to do our best in answering them. We can provide the dates, the information, the disclosure that's necessary. What we can't do though is substitute for sound legal counsel so that the subcontractor has his or her best interests taken into account.

Mr. Broten: — With respect to the subtrades being paid, that a general contractor needs to provide evidence that they have been paid, I've heard of a statutory declaration where the general contractor says, you know, subtrades have been paid; it's all good to go. And then the health region can release the funds. Where does that fit into the process? I mean based, not even specifically to the situation, Mr. Froese, but as contracts go for the health region, how does that work? Where does that fit into the process?

Mr. Florizone: — Once again that wording and those provisions are under *The Builders' Lien Act*. And again it would be available through legal counsel to be able to seek that information. If I were giving you answers, I'd be reading it off the Internet just . . . It wouldn't be appropriate, and it'd be well beyond my ability to practise without a licence so . . .

Mr. Broten: — Okay.

Mr. Florizone: — Sorry about that.

Mr. Broten: — No, that's fine. I understand. I mean I know we've talked about this in question period, so I'm not . . . It's not like it's coming out of left field. Like it is a topic that you know the ministry and the minister's office has been looking at. That's why I'm asking the questions now. But I'm happy to carry on in other round of estimates.

My main concern . . . This is my understanding of the situation based on Mr. Froese coming to me to try to get help and then based on the interaction that the minister and I have had through question period. So there's the project at St. Mary's Villa in Humboldt. Taylor Building Services gets the job. It's a health

region project, so I mean the subtrade who is Phil Froese, Visionary Concepts in this case, when you're doing a project for the health region, it's not really a fly-by-night organization. So you know, if you're doing a project on a public health facility, one would assume that the cheques will be there when work is provided.

Work was done and then there's some rabbit trail discussions about salvage rights and all sorts of different things which we won't muddy the waters right now with, but work was done. An invoice was provided to Taylor Building Services by Visionary Concepts for work completed — an invoice in the amount of 58,000 altogether, something like that. Fifteen thousand was paid only of the amount, so there's remaining 40-some thousand that needs to be paid or that Mr. Froese and Visionary Concepts feels like they're owed.

So when payment wasn't coming for work that already had been completed, recognizing that Phil Froese had sent out workers to Humboldt, did the work for a number of days, paid all the wages, incurred all the costs with respect to the boiler removal, and didn't actually salvage the boiler and the materials which was part of the original agreement as well . . . Something may have gone south in that situation as well.

So he did the work, paid the wages. He's a small-business person, not a big, huge construction company. So you know, 40 grand is a really big deal to the individual and to the company, as it is to anyone. When money wasn't coming from Taylor Building Services, having done the work on a public facility with a contract administrated by the health region under the scrutiny of the ministry, he approached a lawyer. The lawyer, through ISC, put a builder's lien on the project, based on the wages or the payment that he was owed as he saw it. Then he received correspondence from ISC saying that the lien had been discharged, so there was no avenue there with respect to the lien that had been placed.

[22:00]

Subsequent correspondence or somewhere in that mix, Phil Froese, I know he had written the minister, had contacted the MLA [Member of the Legislative Assembly] in Humboldt, had contacted the associate, the other, the Minister of Rural and Remote Health as well and had contacted me in the process as well, looking for ways that he could get payment, thinking that, well if I did work on a public facility, surely the money is there to pay me for the work that's been done.

And then time passed as well, waiting for answers and so on. Then we had question period where we talked about this, and then the minister met with Mr. Froese. And Mr. Froese, at least in the discussions that I've had with him since, was very positive about the meeting and appreciated the minister's open ear and the willingness to talk about it. But Phil was definitely left with the impression that money would be coming, that payment would be made. That was his impression from the discussion. So without putting words . . . The minister can comment on that but that's what was relayed to me in the information.

So I realize it's complicated and there's many players here. But I'm only spending so much time on this because the individual's case really speaks to me, that he's a small-business person, working hard, trying to pay the bills, and he's owed about 40 grand, and the money means a lot to his business, as everyone can understand.

So I know that more information needs to be received, but if more thorough follow-up can be done with Mr. Froese and if some of that information can be communicated, I think that would be very important. Because what really needs to be determined here, in my view, is if the health region was not as diligent in the administration of the contract with respect to a bond, with respect to the builders, or the holdback. You know, I think when you do work on a health region facility there should be a reasonable expectation that a contractor, a subtrade, can in fact receive payment.

So I realize that was a rather long statement I just made. But I wanted to get my understanding of the whole situation being completely open. And I would like some type of resolution for Mr. Froese. Because we're having a decent discussion here. I think this is . . . I don't see the minister objecting to the statement here, so I can stop if the minister wants to make a remark, but I'm towards the end of what I want to say here if the member is okay with that.

So the issue here is because it's $40,000, I understand in the deputy minister's response, well he can pursue legal action if he's concerned, but it wouldn't take long for $40,000 to stack up in legal bills in pursuing the amount. And so that's a real consideration for a small-business person.

So having made these statements, I thank the minister and the officials for their attention. And if perhaps the minister or the officials want to make a comment on this situation on what will happen next, then we can move on to another line of questioning.

Hon. Mr. Duncan: — Mr. Chair, and I want to thank the member for his questions on this. I don't want to at all minimize the dollar amount. I certainly know that after having met with Mr. Froese, heard his concerns, I hope I didn't leave him with the impression that a cheque was going to be forthcoming. Certainly I just wanted to hear his point of view and side of the story. We will endeavour to get some of the, to get that information in terms of some of the time frames that you've asked for that we weren't able to provide this evening.

Again though I would just say that this, to my mind, really seems to be an issue where what was required by the subcontractor to fulfill the agreement that he had with the contractor, the general contractor, was not to the satisfaction of the general contractor. It really is just a difference of opinion, but we will endeavour to get the information that we weren't able to provide this evening. Thank you.

Mr. Broten: — Thank you very much to the minister for those remarks. And perhaps we can have a discussion behind the bar tomorrow or in the next day or so, and then we can carry on in committee in another estimates round if need be.

Okay. Moving on to another topic, and I know the member from Lakeview spoke about this a little bit earlier on, but I wanted to spend a bit more time on the issue of the fiscal year

in health regions and deficits in the health regions. So looking at a *StarPhoenix* article, March 21st, 2013, ". . . the Saskatoon region currently faces a $24-million deficit and the Regina-Qu'Appelle region is $25 million in the red."

And I know the member from Lakeview touched on this briefly, but just very . . . So it's all together in one place, could the minister please provide an overview of all the regions in the province that are in a deficit situation from the pervious year as in the situation outlined here for Saskatoon and Regina, please, the regions and the amounts?

Hon. Mr. Duncan: — Mr. Chair, to Mr. Broten, thank you for the question. For the 2012-13 year-end, fiscal year-end, we have three health regions that finished the year in a deficit. As you've mentioned, Regina Qu'Appelle, 25.1 million; Saskatoon, 24.4 million; and Prince Albert Parkland, $915,000. The balance of the health regions were either in a surplus or a balanced position.

Mr. Broten: — Thank you. I thought I read somewhere else in the Saskatoon situation there were accumulated deficits from earlier years as well. I suppose that could also be referred to as debt. What . . .

Mr. Florizone: — No.

Mr. Broten: — No? Are there accumulated . . . Is the 25 the accumulated deficits from previous years or are there deficits from previous years? Could you please expand on that?

Mr. Florizone: — First of all, while we get that number for you, I want to clarify that an accumulated deficit is not a debt. You go long enough, you're going to end up in debt.

But what it is, is a situation where past deficits show up and continue to accrue on the books. Those deficits are not necessarily against cash. In other words, you don't have to borrow because there may be cash within the organization to handle them. But you accrue a deficit long enough, it's going to end up pushing you into a debt situation. So just like a deficit in a single year may draw down your cash in your bank account and you can take that maybe for a little bit, eventually you're going to end up running out of money. But as long as you have cash in the bank, you're not borrowing. Does that make sense?

Mr. Broten: — Yes. Yes, I understand what you're saying. So what's the best way to refer to it then in accounting terms if there are multiple deficits year over year over year?

Mr. Florizone: — Accumulated deficits.

Mr. Broten: — And so what are the amounts of the accumulated deficits for the regions identified?

Mr. Florizone: — Specifically you mentioned Saskatoon. I have numbers, we have numbers that we can provide going back to 2002-2003. At that point, their accumulated deficit would have been $22 million. And so in the last 10 years that's remained relatively stable growing over the last, looks like two, three years. Would you like me to go through all of the health regions' accumulated deficits?

Mr. Broten: — Yes, please.

Hon. Mr. Duncan: —The most recent numbers that we would have, and again going back to 2002-2003, six of the health regions would have accumulated deficits. Those would be Kelsey Trail, Prairie North, Prince Albert Parkland, Regina Qu'Appelle and Saskatoon, Sun Country and Sunrise. And the other six would have . . . I believe that was six, five? The other health regions would have accumulated surpluses.

Mr. Broten: — So we'll see a total accumulated deficit in the Saskatoon situation, for example?

Hon. Mr. Duncan: — Saskatoon's accumulated deficit would be 65.164 million.

Mr. Broten: — So what is the course of action for the health region in Saskatoon to take to address the $65 million accumulated deficit?

Mr. Florizone: — The first course of action is don't run a deficit. So one of the things that we've been very clear with with Saskatoon, Regina, and Prince Albert is that there is no future in running deficits, that we'll continue to set targets, both on the quality side on improving the health status of the population, but also on bending the cost curve.

The expectation of regional health authorities is to balance their budgets. These are billion-dollar organizations in terms of Saskatoon and Regina. A surplus, one could argue, of $20 million in the size of a billion-dollar organization may not sum up to much, but it's big coin when it comes to most ministries. What we expect is that they are going to balance their budgets so that the next year when they get a target, it's not additive. It's not compounding the issues. So yes, there are some pretty good push targets that we've established along all fronts, whether it be wait-lists or quality or safety, any of the indicators. And certainly there have been some targets that need to be met on the financial side.

But the regional health authorities came into this knowing that if they're wondering if this same pressure will be on them next year, it will. So it's a matter of dealing with those deficits this year.

How do you deal with the past deficit? It becomes even more challenging. Obviously, they have to watch their cash position closely. If they are in debt — and we've had some regions, some authorities in the past that have been in debt; Regina and Yorkton have been longstanding in that situation — we ask that they first of all deal with their debt situation by running a surplus to be able to get the kind of cash that's necessary to start paying that down. In terms of the accumulated deficit, they may never deal with that, depending on whether their cash situation is positive or not. Their best position is to have it zero or surplus, but there may not be that urgency to deal with it. The best approach, and I didn't mean it facetiously, is to not run deficits.

Mr. Broten: — Okay. So looking at . . . This is a *StarPhoenix* article on March 21st, 2013 and the title is "Health region starts in red," and it talks about the $24 million deficit. In the article, around in the middle, I'll read the line here from the article, and

it's the CEO of the health region, Maura Davies. The article states:

> She admits Lean solutions won't be enough and says the region will now embark on a process to review all of its clinical services to "see what changes, if any, are made."

So what discussions or what information does the ministry have, does the minister have with respect to what clinical services, in this instance the Saskatoon Health Region might be looking at as they address the $24 million deficit for this year?

[22:15]

Hon. Mr. Duncan: — Thank you, Mr. Chair, and to Mr. Broten for your question. I'll have the deputy minister expand on my comments further. But what I think health regions will be tasked to do this year is to, as they have in the past, is to develop a plan that will be shared with the ministry going forward. We want to make sure that as . . . And we know that this is going to be a challenging year for many health regions, but we want them to look at the services that they're providing and try to address some of these fiscal issues without negatively impacting patient care.

We know, and we talked earlier in the committee, health regions across the province are going to be looking closely at what . . . for example, in areas of sick time and overtime and premium wages. We had a discussion earlier where if you look at a number of health regions, comparing them to each other, some are doing, I think, great work when it comes to reducing some of those payments where others are trending not in the right direction. So I think that's an area of focus that the health regions are going to be looking at closely. I'll maybe have the deputy minister go into further detail.

Mr. Florizone: — Thank you, Minister. Some of the areas that have been identified — and these are areas that have been identified provincially, locally, at the regional level, provincially, and nationally — which could be looked at include clinical areas. We know for instance that there was a study out of Ontario recently released by ICES [Institute for Clinical Evaluative Sciences] that looked at 5 per cent of the population that utilizes 34 per cent of health care resources.

So if we took a look at our total budget and were to apply that research to it, we would see that there's a vulnerable population that's being served by the health care system, that's suffering from multiple illnesses and issues: chronic disease, mental health, addiction issues. And what we end up, in terms of a system, is a very strong acute care focus but not a very good response to those with multiple health issues and those that may need other types of social supports. So we've got an interest in taking a look at that vulnerable population and seeing how we can better serve that population.

So by looking at the clinical areas, a part of it is really a response to how our primary health care system is defined. Part of it is looking at the ER [emergency room] and theoretically and in a real way asking the question, what crisis brought you here today and how can we reconnect you back with care and service? We may find on a multi-ministry basis that it may be the work of other ministries that's necessary to provide the types of social supports that are necessary to care for those individuals. So that's one example of where we know from the literature and know from the work that's being done. This is an Ontario study. It was repeated in Manitoba, by the way, with similar results.

The other area that we're aware of has to do with appropriateness. While we haven't talked a lot about this in the past, some of the clinical work that's being done is not necessarily consistent with evidence and evidence-based practice. Now I'm certainly not being critical, and as a non-clinician it's not my place to say this is the right way and this is the wrong way, but we see quite a bit of variation right across the country.

We have now some of the professional organizations that are stepping up and assisting us with setting up care pathways and management protocols. So I'll give you one example. The radiologists in the country as well as the CAMRT [Canadian Association of Medical Radiation Technologists], the medical radiation technologists, have indicated that 10 to 20 per cent of the exams that they undertake in this country either add no value or may be contributing to harm for patients — in other words, radiation that could end up being more harmful than good.

So we have a real keen interest in looking at some of the specific approaches and modalities that they've identified. I'll give you a couple of examples. One has to do with the CT of the head for a common headache. Another has to do with lower back pain and use of those types of modalities. When we start to take a look at the use of CT or MRI [magnetic resonance imaging] and the numbers that they speak of with respect to what could be inappropriate and how we could set up protocols, there is significant improvement to care, a bending of the cost curve, a lowering of utilization. But the key here is that patient care doesn't deteriorate. It actually gets better by utilizing these clinical resources more effectively.

We've also seen, on the clinical side, improving throughput in some of our modalities. We've improved the efficiency by which we can do things. Some of it is about technology. Not all of it, by the way, is about lean. There are some improvements that have occurred in the technological aspects of care, where what used to take an hour now takes literally minutes.

So we're seeing some of those improvements that need to take place. I had an update just today on our use of home dialysis, for instance. So whereas 10 years ago we would have been building on and doing more and, by the way, we are doing more, but we wouldn't be building as large as we had been in the past because home dialysis is now something that's available, home hemodialysis.

So there are some technological aspects. And what the minister has asked us to do and challenged the regional health authorities to do is bring in those best practices, that best evidence into the work that we're doing. Yes, we are looking at clinical areas. No, we're not trying to reduce the care or create longer wait-lists or restrict access. What we're really trying to do is redesign, reformulate, and make sure that clinicians are at the forefront designing that approach.

Mr. Broten: — Thank you. So in the same article that I've been referring to, a few lines down it says:

> Davies said although the region hasn't chosen a method, it will look at whether each service is "core to our mission" and whether the right person is providing it in the right place.

So the right person, right place perhaps is tied to many of the comments that the deputy minister just said. I am curious though on the issue of "core to our mission." So what would be some examples within the Saskatoon Health Region where there are health care services in a clinical way being provided that are not core to their mission?

Hon. Mr. Duncan: — Mr. Chair, Mr. Broten, thank you for the question. I think we're certainly very interested and eager to have a look at what Saskatoon and all the other health regions are planning for this year. I wouldn't want to speculate on what the CEO had been referring to because at this point they're still developing those plans. And at some point, they will be forthcoming to us, but they haven't shared those plans with us yet. So I wouldn't want to put words in the CEO's mouth.

Mr. Broten: — Thank you. In earlier comments, so I guess a few things that the CEO of the Saskatoon Health Region said in her remarks in the article and then a few things that the deputy said with respect to lean — and I know this is lean activity as a system-wide activity and it's in other ministries as well, but within Health it's system wide — does the ministry track the amount being spent on lean activity with respect to contracts with consultants and in-service and whatever the different avenues might be as the ministry embarks on lean initiatives?

I'm wondering if there is tracking of how much is being spent, and if that is being tracked, I'm not sure how long the list is, but if there could be a bit of a description for some of the contracts that have been awarded for providing this instruction and paradigm shift to individuals within the region.

Mr. Florizone: — I have a breakdown of the costs. I can go back a ways. How far back do you want me to go?

Mr. Broten: — It depends how long the list is.

Mr. Florizone: — It's not bad. One page.

Mr. Broten: — Yes, please go ahead.

Mr. Florizone: — So because we've led out and have modified our approach along the way and actually accelerated the work that we're doing, it does . . . it escalates. And I'll give you a sense of what it is.

So a lean within the ministry first off. The costs were incurred since 2008. We developed 28 active lean initiatives. We trained senior leadership. We provided some cultural change management embedded in that contract. And we used a firm; it's Lean Advisors. It morphed into Kaizen Lean Advisors, and I think right now it's back to that original Lean Advisors title. We spent $574,417 in total. That's the consulting side of it. Now obviously we have staff, staff time, salaries. I don't include that. This is the consulting portion of it.

We also did some foundational training within the Ministry of Health and regional health authorities. So this is as much the system . . . And this was into the era of trying to do things similar in the ministry as we were doing in the system, knowing full well that if we were going to be far more effective, we needed to be with the system in terms of the changes. The ministry and the regional health authority contracted for 3,856,192. That was for some 300 lean improvement events and initiatives that have been completed or are currently active.

We went through . . . In the spring of 2011, there was some additional funds that were provided to Regina Qu'Appelle and Saskatoon Health Region and provincial initiatives to advance lean improvement efforts. And again, now we're starting to get into the territory of . . . We were accelerating in some of the work around. We weren't quite yet into our strategic planning with hoshin kanri deployment. If you've been into . . . Well maybe you saw *the fifth estate* news story.

[22:30]

Mr. Broten: — No, I didn't.

Mr. Florizone: — You didn't? Okay. Have you been in a health facility lately? Recently?

Mr. Broten: — Yes.

Mr. Florizone: — Okay. So if you . . . Sounds like I'm asking the questions now; I'm sorry, Mr. Broten. If you take a look in the hallway of any of our health facilities throughout Saskatchewan, you notice a series of metrics and measures and targets. These now cascade right from the T.C. Douglas Building all the way through to the floor or the unit, the workplace. So the targets that we've been setting, whether they're around health or care or value actually cascade all the way through.

So there was an additional 2,217,053 that went into lean advancement. And then we moved into something that was called Releasing Time to Care. That was a module established in the series of modules that were established in the national health system in the UK [United Kingdom], which is lean-based. And we deployed that to every acute, every medical and surgical unit across the province.

So that was really the first buildup of that daily visual management that you see, and the huddles of nurses and other staff on these stations to improve care. That was 630,000 in licensing fees. So since 2008, we now have 100 per cent of those wards covered with improvement, and these modules have been fully deployed.

The new method of strategic deployment that we're using throughout 30-plus thousand staff, we involved, I mentioned earlier, 1,000 people last year in establishing the targets and time frames. This year we estimate there have been 10,000 people involved. That was $890,806, and that was for cycle one.

Cycle two and the work that we're now undertaking, which is now ubiquitous right across the system, our plan in the next three to four years is to have 1,000 improvement events, to have

800 people trained, certified, as in being able to lead this work so we wean ourselves off of consultants.

We also have thousands of people — and we can give you exact numbers trained because we measure them. They're on those walls I spoke of and are certified. So that cost was just over $11 million.

So if we were to take a look at the total. I'll give you a total of what that is . . .

Mr. Broten: — Okay. And then I'll talk. Yes.

Mr. Florizone: — Yes. The total is $19,177,945.29. So I've got it right down to the detail.

Mr. Broten: — Since 2008.

Mr. Florizone: — Since 2008.

Mr. Broten: — 2008 to what date?

Mr. Florizone: — Today.

Mr. Broten: — So that includes . . . That doesn't include, as you said, staff time. For example you know, for an RN [registered nurse] or any health care professional that's involved in the training, that's normal region expense. Those are all the, as I understand, these are the contracts with consultants for lean expertise provided to the health regions throughout Saskatchewan.

Mr. Florizone: — That's correct. Including all licensing costs and all . . . It's all in.

Mr. Broten: —And there would be no other stand-alone contracts that health regions would enter into for lean stuff?

Mr. Florizone: — Not that we're aware of. There may have been the odd contract that regions had as carry-overs, but the contract that we have right now is a single-contract, province-wide system and ministry.

Mr. Broten: — Okay. And so it's a system-wide contract that is broken down out into the regions.

Mr. Florizone: — This is the total including the regional health authorities, yes.

Mr. Broten: — Okay. Thank you. Thank you for that detail. I appreciate that a lot.

Switching gears a bit, on to the issue of locum physicians. Off the top of my head — I apologize, I didn't review *Hansard* on this, but I'm just going from estimates last year — when we talked about the rollout of the new locum program that was promised, I believe, in the Throne Speech following election, it was one of the election promises that was made. Is it 20 locum physicians was the promise overall?

Last year, when we talked about the detail of what development had occurred, I seem to recall there was something like 1.5 or 2.2. I remember it was a half a doctor or something like this that were currently meeting, working towards that goal of 20 additional locum physicians. And we had a fairly lengthy discussion about how the new locum program would interact with the existing SMA locum program. And I recall the minister talking about how . . . We talked about different models, how it could be sort of an add-on to the existing locum program, but also that there were some sort of stand-alone efforts through the Cypress Health Region and how a health region could employ a physician within this category to do coverage within a region. So I would just appreciate it if the minister or an official could provide an update of how we've moved along from the 1.5 out of the 20. And also what model of delivery is being used? Is it through an add-on to the SMA program, or is it sort of continued expansion at the regional level such as we saw in Cypress?

Hon. Mr. Duncan: — Mr. Chair, Minister Weekes will be responding to this area.

Hon. Mr. Weekes: — Thank you for the question. What we've . . . We have supplied funds to the health regions to allow them to go out and look out for two locums per region. So that's two for each of the southern 10 regions and two for the North, so 22 locums. These locums would be on top of what the SMA is doing. These locums would be regionally based for that region. And those locums would be used in communities for a longer period of time than the SMA plan is, so that would give them the ability to fill in for, you know, service disruptions and those types of issues that may be longer in duration. We currently have seven locums in various health regions, so that's seven locum FTEs, and that makes up 12 to 15 actual doctors that are working part-time to make up those seven FTEs.

Mr. Broten: — So as the target of 20 additional, the opinion is that we're at seven now FTEs, recognizing that it's part-time arrangements for some?

Hon. Mr. Weekes: — Correct. Yes, that's right.

Mr. Broten: — So the physicians that are in this locum pool within the regions, how are they paid? Are they salaried physicians or what's the mechanism and the contract that's entered into with the physicians?

Hon. Mr. Weekes: — Equivalent to the SMA pool, so service contract.

Mr. Broten: — I can't hear with all the side talking.

Hon. Mr. Weekes: — They're paid equivalent to the SMA pool as a service contract.

Mr. Broten: — Okay. And so the dollars flow from the ministry to the regions to cover those expenses. So they'd be on the SMA pay grid for whatever the SMA physicians would be receiving?

Hon. Mr. Weekes: — That's right.

Mr. Broten: — Of those physicians, do you have a breakdown of where they're coming from?

Hon. Mr. Weekes: — As an example we have in Sun Country,

a Sun Country locum group has been serviced by Regina and Sun Country, so there's the six physicians covering to fill one FTE. The same thing is happening in Regina Qu'Appelle where there's five physicians covering one FTE and . . .

Mr. Broten: — So in the situations where you have six physicians creating one FTE or five creating one, these are practising physicians, I think the example you gave for Sun Country, like Regina physicians have a regular practice, then they're doing weekend coverage or coverage outside of their regular practice. Is that correct?

Mr. Hendricks: — So it's a variety of things. It might be, it might be a family physician that's practising in Regina that has some spare time on their hands that goes out and does locums there on the weekend. In some cases it's a retired physician and only wants to work a quarter time or that's winding down their practice. In some cases it might be somebody that's doing shifts in the Regina hospital and again has spare time. So it's a variety of different mechanisms.

Just to add to one, you know, one other thing is that with distributed medical education, one of our first recruits in Cypress Health Region to this program was actually a resident trained through the Swift Current residency program who then served as a locum. So it actually offers a really good opportunity for some of these residents who are practising all these or training in all these rural areas to actually practise and experience the region. So we're seeing that as another potential growth area for this.

Mr. Broten: — Maybe the briefing note doesn't have this detail but out of the 12 to 15 people that make up the seven physicians, the seven FTEs, how many of those 12 or 15 are like one person filling one FTE? Do you know what I'm saying? I'm just curious. Out of the seven additional locums that are practising, how many are like one person working full-time in this program and then how many are, you know, people working a point two five or something like that?

[22:45]

Mr. Hendricks: — Almost all of them would be working part-time except in the case with Cypress where that was a dedicated locum.

Mr. Broten: — Okay. So there's one actual, like one person who would say when you ask like where they work, they'd say I'm a rural relief locum physician in the Cypress Health Region in this locum pool.

Mr. Hendricks: — Correct.

Mr. Broten: — And then the rest are already currently practising within the province?

Mr. Hendricks: — Yes.

Mr. Broten: — So how does the program in getting to the 20 locum mark . . . I mean the goal . . . I mean what's commonly heard from physicians is that, you know, we're working lots already and there's only so much more that we can work. And in this instance, I mean I guess the situation has been enticing enough either monetarily or practice-wise that they're willing to do weekends and evenings, but at some point that maxes out and we need actual people, the one FTEs, not the point two fives.

And so this pool of 20 that is the target is also competing with the SMA's pool of physicians along with . . . I mean the ADM used the example of the distributed model where the individual stayed in the Cypress Health Region and worked within the region and that's a great option, you know, great exposure to the region. I mean those individuals in many other instances would also, would in many situations work with the SMA's locum program or join northern medical services as other options as well. So there's competition for these physicians to provide this type of relief coverage. What's the ministry doing to, I suppose, ensure that they're not stealing from one program like the SMA's program to meet the goal of the 20 in this other program?

Hon. Mr. Weekes: — Thank you for that question. I think the point has to be made that I don't believe that they're competing with the SMA program because the regional-based SMA's locums are . . . First of all they're working on a different, they're working longer terms in the region where the SMA's locums are made for a shorter period of time. And the other thing, the region-based locums are, generally speaking, are region-based so they're working in the region now. So to date I don't believe that there's a competition between the two groups.

Mr. Broten: — Okay. How is this different from, I mean in other situations . . . Like it sounds like in the minister's remarks there that, you know, it's for longer service, especially in an area where a family physician has left the community, and you know, you're working out a situation for the Spiritwoods to make sure that you've got coverage in the area — or whatever community it may be. I mean the SMA's program I think covers like 4 to 10 days. It's something like that. It's designed for continuing medical education or holidays, that sort of thing.

But for the longer service, I mean health regions, as I understand it, have for many years when in a pinch, needing a physician in a community, you know, found a group of physicians that were willing to provide coverage to a community to ensure that medical coverage stayed there. I mean the health region would take that lead and find a group of physicians that were willing to provide coverage in an area. Is this program sort of similar to that but under a different banner, or would you disagree with that assessment that I just made?

Mr. Hendricks: — So when this program was originally being developed, one of the things that we looked at was trying to actually merge the two programs, the SMA program and this one, and have actually the SMA operate them. As you know from your previous experience at the SMA, that's a heavily subscribed program. There's a lot of demands on it for short-term locums and provides opportunities for a physician to take a short leave for a vacation or CME [continuing medical education] or something.

And what regions really were looking for is the flexibility within their own region to deploy resources to communities. Right now we have doctors, as you know, that will leave for six weeks now to be on vacation, all in one stint, if they're from

overseas. So that was a problem. A lot of times too in a rural community a disruption will happen for some unexpected reason; a physician will often resign very quickly, and for good reasons in a small community, may not let the community know. This gives the regions the opportunity to actually balance a little bit better, so they like the opportunity.

This locum program, you know, it's not for everybody. Our hope is that as we do, as I said earlier, as we do have more medical learners trained outside of Regina and Saskatoon, who have the experience and the training to practise in rural Saskatchewan, that they'll seize on this opportunity to kind of find where the right fit is. And it also allows the region to make a good impression on them.

So it's a growing program. It's new. We'll see how it works, and eventually, you know, we have asked the SMA to look at its locum program as well, with the eventual idea of having a streamlined service that works together.

Mr. Broten: — Okay. Thank you. Yes, it's just an interesting observation with respect to whether it's adding capacity with the number of physicians working in the program or whether it's the existing physicians in the province working weekends and evenings, which is their choice, and certainly it's good that they do it. But it's an interesting observation.

Mr. Hendricks: — Just one other observation on the retiring physicians or those who are winding down their practice. To maintain a practice or to continue one going in Regina and Saskatoon, you know, they have to maintain overheads. They have to be engaged in their practice. There's an expense associated with doing that. And if you're only interested in practising a quarter time, this provides a nice alternative for them too. And so they might otherwise wind down completely.

Mr. Broten: — In those situations I guess for the location where there's six making one and five making one, what communities are those two examples, and what's the set-up of the practice? Is it within a hospital or is the health region running the practice and it's just turnkey? Or what's the situation?

Hon. Mr. Weekes: — I have a list here if you'd like to . . .

Mr. Broten: — Please.

Hon. Mr. Weekes: — I could give the whole list to you. Prairie North has been using four local North Battleford physicians to cover the positions since September 1st, 2012, and they are in discussions with a University of Saskatchewan graduate who can start practising in July 2013.

In Heartland, four physicians have been assisting with the locum services as they are available. And in Heartland RHA, Kindersley, since November 2012, two are from Prairie North; another two are from within Heartland. In addition, coverage was provided by the Cypress locum and a Saskatchewan Medical Association locum, and they are not included in the count above.

Northern medical services, since September 2012, one physician from British Columbia has been providing the majority of the locum services for NMS [northern medical services]. In La Ronge and Ile-a-la-Crosse, a second physician from Saskatchewan has been providing service as needed.

Sunrise is hopeful to recruit a U of S [University of Saskatchewan] FM [family medicine] resident that will begin providing full-time locum coverage in July 2013 following graduation. And Prince Albert Parkland indicated they may have a U of S Prince Albert FM resident interested in the position. This candidate would not be available until July 2013. Saskatoon has a couple who are trying out a locum in mid-April, and if they like the opportunity, they will sign a more permanent contract. And the remaining two RHAs — Kelsey Trail, Five Hills — is still in the recruitment phase for these positions.

Mr. Broten: — Thank you. So it's basically . . . I mean if the normal . . . I mean that description there, or what I hear as, you know, the physicians that would be normally be going in a health region or with northern medical services, as is the case with the one person, like do the health regions, is there any . . . I apologize. Let me restart. What role does the ministry play in recruiting these individuals? Or is it basically the health regions take the lead, find the people, and then the health region just funnels some dollars to cover it, and then it's called the locum program?

Mr. Hendricks: — It would be a combination. The locums would be recruited by the region in conjunction with the Physician Recruitment Agency. So they would be working together to recruit locums to these programs.

And so the way it is different is that previously for a doctor to set up a quarter-time practice in a community to assist in providing coverage, they would have to make some sort of arrangement with the physician there, probably pay overhead, do all that sort of thing. It's kind of a complex. And what the region does is it kind of says, we have a problem here. Here's your salary or your contract for services. It's a fixed amount. You don't bear any financial risk when you go in there. You know what you're going to get paid as a locum. Right?

And so it works out well. And then they can deploy resources as they need them across the region. So if Kindersley is experiencing a difficulty or Rosetown, they can move these folks around. That's I think the key difference.

Mr. Broten: — Okay. So I realize there's increased flexibility I guess for the regions to decide how they want to use the physicians, but the regions are still the ones chasing or finding the physicians, and the dollars flow from the ministry.

But what about with northern medical services? I mean northern medical services always brings in out-of-province people to provide coverage in the North. I've met lots of physicians coming in for stints of time with northern medical services providing coverage. How is this situation with this northern medical service physician that's been, you know, is under this locum program banner, how is that any different than what they always do?

Mr. Hendricks: — I think typically the situation in the North has been that they hire a physician to work in La Ronge or

Ile-a-la-Crosse or wherever. In this case they're able to move them around, and they cover off shortages in specific communities or vacations or whatever. So it's more of a mobile position.

Mr. Broten: — Okay, thanks. Switching gears very much again with the minutes that we have left, could the minister please describe the relationship between regions and — very different topic — the Meals on Wheels program, how that works with regions and Meals on Wheels.

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten, for the question. Typically through regions that deliver home care, they would have arrangements or agreements with perhaps volunteer organizations. So the region would, either through their own dietary programs or perhaps contracted out, provide, prepare the meals, have the meals prepared. And then typically what would happen is volunteers would be engaged to deliver to home care clients.

Mr. Broten: — Is there any funding that flows from the health region to the volunteer organizations for the delivery of the program?

[23:00]

Hon. Mr. Duncan: — It would — thank you again for the question — it would depend on just the different arrangements that that particular region would have. Some of the activities that would be provided by the volunteers or by the volunteer organizations would be merely a voluntary contribution to the program. There may be regions that perhaps would provide some reimbursement of expenses or some sort of payment but that would depend on how the region structures the program.

Mr. Broten: — Thank you. Does the ministry track how many individuals would be receiving program services through Meals on Wheels in the various health regions? And if you ask, could that list be provided?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten. In 2011-12 would be the most recent numbers that we'd have, 3,311 clients would have been served under this program. And it would have been, that equates to 348,769 meals.

Mr. Broten: — If someone wants to get on the program, how do they go about doing so? And can people access this program in all the regions?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten. My understanding is that it would be available in all health regions and that it would be a part of the assessment for home care, whether or not somebody would be eligible for the program, and that may depend by region to region on how, basically, how high the bar would be to access that service.

Mr. Broten: — Are there any regions which aren't accepting new applications to have access to the program?

Hon. Mr. Duncan: — Not that I'm aware of, but we could certainly . . . We'll endeavour to get that information.

Mr. Broten: — Are there waiting lists for service to access the program in some regions, or is the service there if it's needed?

Hon. Mr. Duncan: — Wait times in terms of accessing home care in general or the Meals on Wheels portion of it?

Mr. Broten: — The Meals on Wheels portion of it actually.

Hon. Mr. Duncan: — Not that we're aware of.

Mr. Broten: — Okay. Thank you very much. With a few minutes left so I'm covering off a few things here that I wanted to touch on. In previous rounds of estimates since this has been going on a while . . . Actually I have a question related to the hearing sales and services Act. I think I've sent some correspondence on this over the years, perhaps to the previous minister even. I'm not sure if we've corresponded on this or not.

But there was questions around changes to the Act and the lag time with respect to regulations coming down and the industry — those that are providing services, businesses providing services to clients here in the province — wrestling with the uncertainty about what the future will look like with respect to what the detail of the regulations are so that they can make the HR [human resources] plans that they need to for their staff.

Could the minister, if it's available, provide an update of where the regulations are at with respect to this Act, and if they haven't come down, when they may be coming down and when the information might be communicated to those that are working in the industry?

Hon. Mr. Duncan: — Thank you, Mr. Broten, for the question. I think you'd be correct in saying that most likely you corresponded with the former minister on this. It's been going on for a number of years.

We are I think trying to strike that balance between the different stakeholders in this area, particularly around not only ensuring that people are provided with an appropriate service by a trained professional but also in the recognition of educational requirements. We haven't moved forward at this point on regulations. We're still consulting with stakeholders, but I think decisions, certainly decisions need to be made soon because it has been a number of years that the ministry has been working on this file. At this point the regulations haven't moved forward, any changes to the regulations haven't moved forward.

Mr. Broten: — I appreciate the minister's remarks about striking the right balance, but what's the main roadblock in not having the regulations come into being yet?

Hon. Mr. Duncan: — I think at this point — and I think it would hold true for the past work that's been done in consulting — it's really just whether or not, before regulations move forward and are put in place, whether or not we are able to strike that proper balance between those that come to it from one point of view in terms of ensuring that there are the proper educational standards as well as those that already are in the industry, and so how do you recognize their education but also their experience. And so we're just . . . That's where we're at at this point — just trying to make a final decision on that.

Mr. Broten: — What's the timeline for when a final decision could be expected?

Hon. Mr. Duncan: — I would think that over the course of this, you know, this first part of this calendar year. I think that, you know, over the next number of months I would hope to be able to bring forward regulations for approval.

Mr. Broten: — Thank you very much for that information. How much time do we have as I consider topics?

The Chair: — A few minutes more. We wanted to go to 11:13, so quarter after.

Mr. Broten: — Okay. Well I'll talk quickly then. What topic? I will ask the Advanced Education minister this as well, but it's the topic of a training program for occupational therapy and speech language pathology at the University of Saskatchewan. The number of OTs [occupational therapist] in the province has been identified as lower than other provinces. And it's been identified that a training program is a key part to improving the numbers of OTs in the province.

In various discussions I've had with Advanced Education ministers over the course of the Sask Party's government, there has been commitments to a program and even some timelines trotted out that have come and gone, but with some of the uncertainty around the Health Sciences Building and a lack of . . . For whatever reason the program is not yet coming along. What is the Health ministry's position on this and what interaction has the Health ministry had with Advanced Education in pushing for this program here in Saskatchewan?

Hon. Mr. Duncan: — I think that . . . Frankly I'm not familiar with some of the commitments that you're speaking of. I think just in general terms we know that certainly both myself and the Advanced Education minister have received correspondence requesting that the government relook the way that . . . providing a training education program here in the province.

I think — I'm just going off the top of my head — I think while our numbers may be lower compared to other provinces, I think in the last few years we've actually seen an increase while other provinces have seen a decrease in the number of OTs that are registered in the province. At this point while I would say that the Minister for Advanced Education probably is maybe a better person to ask the question to, we are, our plan is, going forward, is to continue with the way that we have been training, doing education for occupational therapists with purchasing the seats out of province.

Mr. Broten: — Well thank you. I won't go right into another topic because I think the buzzer is about to go. And I would thank the minister for his responses and thank the officials for flexibility in allowing me to wander fairly widely within the Ministry of Health and thank the member from Lakeview for the chance to use some of his time in estimates.

The Chair: — Mr. Minister, if you have a few closing remarks.

Hon. Mr. Duncan: — I just, knowing the, seeing the lateness of the hour, I know that we'll have another appearance before the committee, perhaps in a . . . I'm not sure when that's been set. But I just want to thank the members for their questions, thank all the members of the committee for their attention, and most especially want to thank our staff and the ministry staff for the countless hours of work that go into preparing all the information for this evening and for the subsequent committee meetings and for all the work that they do each and every day in between. Thank you.

The Chair: — Thank you very much to the committee members. The time is now 11:13 and that being past the hour of adjournment, this committee stands adjourned until Tuesday, April 16th at 7 p.m. Thank you. Good night.

[The committee adjourned at 23:13.]