STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 15:00.]

The Chair: — Good afternoon ladies and gentlemen. Welcome to the Standing Committee on Human Services. My name is Delbert Kirsch, and I'm Chair of this committee. With us today is Mr. Mark Docherty, Mr. Greg Lawrence, Mr. Paul Merriman, Ms. Laura Ross, and Ms. Nadine Wilson. And Mr. David Forbes is Deputy Chair.

This afternoon we will be considering Bill 70 and Bill 58. This evening we will resume our consideration of estimates for the Ministry of Health. We will now consider Bill No. 70, *The Education Amendment Act, 2012 (No. 2).* This is a bilingual bill. By practice the committee normally holds a general debate on clause 1, short title.

Mr. Minister, please introduce your officials and make your opening comments. Thank you.

Bill No. 70 — *The Education Amendment Act, 2012 (No. 2)*
Loi n^{o} 2 de 2012 modifiant la Loi de 1995 sur l'éducation

Clause 1

Hon. Mr. Marchuk: — Thank you, Mr. Chair, Mr. Forbes, colleagues. I'm pleased to be here before the committee to discuss the changes to *The Education Act*. With me today are, to my right, Cheryl Senecal, deputy minister; to my left, Mr. Drew Johnston, director, legislative services and privacy; and in behind me, Angela Chobanik, director, education financial policy; and Kathy Abernethy, director, early childhood education.

Mr. Chair, the Ministry of Education has consulted extensively with our education and government stakeholders to ensure the proposed legislative changes reflect the current needs of educators, students, and their communities.

Amendments to *The Education Act*, *1995* are recommended to amend the compulsory school age from 7 to 15 years of age to 6 to 15 years of age; update the definitions of school to reflect its current status and school day; clarify the minister's authority related to pre-kindergarten programs; remove or increase fines, including increasing fines in the general offences and penalties provision; clarify who is a provincial resident for the purposes of receiving educational services without cost and that tuition fees are calculated in accordance with the methodology prescribed in the regulations; clarify that boards of educations shall accept students from neighbouring school divisions and provide transportation when the student lives within a prescribed buffer zone from the existing boundary, as set out in regulations, in bracket, 5 kilometres without having to submit requests for boundary changes to the ministry; to update references to making capital grants with boards of education and the conseil scolaire; clarify the submission of returns to the Ministry of Government Relations; redefine property class to allow for property classes to be defined in regulations, which allows for more flexibility in the future. The change would be retroactive to January 1, 2013. Allow the Northern Lights School Division to change the representation on their board of education to better reflect the demographics of the school division.

The proposed amendments to *The Education Act* demonstrate our responsiveness to the changing needs of Saskatchewan families and school divisions.

Mr. Chair, I'll now take questions — and refer to my ministry staff when appropriate — you may have regarding the amendments.

The Chair: — Thank you, Mr. Minister, and I would remind your staff that their first time to the microphone, if they would say their name just for Hansard's records. And, Mr. Forbes, if you have some questions, the floor is yours.

Mr. Forbes: — I do. And thank you very much, and thank you to the minister for the introductory remarks, and for the officials. I do have a few questions.

Are there any implementation costs to this bill that will impact on school divisions or your own budget as the ministry? Any costs for the implementation?

Hon. Mr. Marchuk: — Thanks, Mr. Forbes. I'll just confer. Thanks, Mr. Forbes. At this time, we're not anticipating any costs.

Mr. Forbes: — Thank you. And at the consultations that you talked about, who were the stakeholders that you . . . What kind of process did you have for consultations here?

Hon. Mr. Marchuk: — Thank you, Mr. Forbes. In response to your question, the sectors that were consulted with include the Saskatchewan School Boards Association; the Saskatchewan Teachers' Federation; the League of Educational Administrators, Directors and Superintendents; Saskatchewan Association of School Business Officials. Government Relations and the Ministry of Justice and the Attorney General were consulted.

Mr. Forbes: — Now I'm sorry, did you say the northern school division, was it also . . . The northern school divisions, were they consulted about the change that they would have?

Hon. Mr. Marchuk: — Actually I'll let Mr. Johnston respond to that question.

Mr. Johnston: — Drew Johnston. We did consult with the Northern Lights School Division prior to putting forth the changes. They came forward with a recommendation and a consultant's report on the changes. And through our regional director at the time, we did let them know that we would be pursuing legislative change for this.

Mr. Forbes: — Can you describe that change and where it is in the legislation?

Mr. Johnston: — The change is to section 7. It entails an amendment to section 40 which previously restricted school divisions to having not more than one representative at large in a subdivision. This issue stems back to a report that was commissioned by the school division by some consultants back in 2009.

The composition of the Northern Lights School Division board of education, apparently it's been a long-standing issue with the current boards, a nine-member board with one member for each of the nine subdivisions. La Ronge is the only town located in the boundaries of the Northern Lights School Division. And the view of the board of education was that they live there under-represented with only one board member, and that it didn't reflect the distribution of population. However, currently the way in which section 40 is written, it restricts them to having one member per subdivision. This would allow them to increase to two. That was the recommendation of their consultant at the time.

Mr. Forbes: — Okay, thank you. Now you're changing the school age from 7 to 15 years — and then at 16 students can leave — to 6 to 15. So really the change is the earlier entry. And I think in your remarks, you did talk about research and this being best practices. Can you tell me a little bit about that and the consultations around that?

Hon. Mr. Marchuk: — Sure. Thanks, Mr. Forbes. The compulsory school age minimum is being changed from seven years to six to recognize, basically, current practices and is certainly more consistent with other provincial jurisdictions. For as long as I can remember, we've had six-year-olds in the school, in the school system.

Current references to pupils of course does not recognize that children not yet of compulsory school age, kindergarten children, also attend schools. So this recognizes that there may not be a separate entity . . . Sorry, Mr. Forbes. That's referring to another one. Basically it's the current best practice for six-year-olds.

Mr. Forbes: — Okay. And is this then consistent right across Canada? What is the practices, the national practices?

Hon. Mr. Marchuk: — Mr. Johnston just informed me that it is except for PEI [Prince Edward Island].

Mr. Forbes: — And PEI remains seven?

Mr. Johnston: — Yes.

Mr. Forbes: — Okay. And are they all at 15 for the age which they can leave school or 16 when they can leave school?

Hon. Mr. Marchuk: — Go ahead, Cheryl.

Ms. Senecal: — It varies at the higher end. So there are, we believe — and we unfortunately don't have that detail with us today, but I know when we looked at this previously — we seem to recall that there are two jurisdictions where the upper age limit is 17 versus 15.

Mr. Forbes: — Right. But the other age is 21, I think, where students can stay in school until . . . What is the regulation around that?

Ms. Senecal: — Twenty-two is our regulation in Saskatchewan.

Mr. Forbes: — Okay.

Ms. Senecal: — It may be different in other jurisdictions.

Mr. Forbes: — Is it legislation or regulation?

Mr. Johnston: — I believe it's legislation.

Mr. Forbes: — Okay. And that's where they can stay and . . . How is it worded for that? What is the proper . . .

Mr. Johnston: — I believe it's worded as that they're entitled to education without . . . till age 22.

Mr. Forbes: — Okay. Okay, that's good to know. And that's not . . . Neither of those top end parts are being changed or considered to being changed? That's very important. Good. And the pre-K [pre-kindergarten] is now being defined. And I also think when we had second reading debates, talking about how it allows school divisions to have policy development around this. Am I recalling that correctly?

Hon. Mr. Marchuk: — We'll just check on that.

Mr. Forbes: — Okay.

Hon. Mr. Marchuk: — Mr. Forbes, do you just want . . . Just restate your question, just to make sure that we've got it correct.

Mr. Forbes: — Sure. My question was that, from what I understand from the second reading debates that we had around the pre-K, that now the amendment would . . . Well, in fact I'll quote your speech:

> The proposed amendment would grant the Ministry of Education the authority to develop policies and regulations for pre-kindergarten programs which will continue to contribute to more consistency and accountability among the province's pre-kindergarten programs.

So you're defining it, and then it's also giving you the authority to make policies which up to this point the ministry's been acting in a bit of a piloting stage, I would describe it. I don't know if that's fair to say.

Hon. Mr. Marchuk: — I think I'd be correct in saying that the ministry now has responsibility for pre-kindergarten programming where it exists in the school.

Mr. Forbes: — So can you tell me a little bit about how do you define or how does the ministry define or what's their parameters around pre-kindergarten and what differentiates it from kindergarten.

Ms. Senecal: — So our program, our pre-K program in Saskatchewan is targeted towards vulnerable 3- and 4-year-olds, so it is a targeted approach. Is that kind of the nature of the response you were looking for?

Mr. Forbes: — How would you describe . . . What is your definition of vulnerability in terms of is it a cognitive or is it socio-economic?

Ms. Senecal: — It's socio-economic, but I am going to ask my official for detail. Okay?

[15:15]

Hon. Mr. Marchuk: — Thank you, Mr. Forbes. Yes, certainly socio-economic factors play a role in determining pre-kindergarten, but it's a combination of several other factors that we would consult with school divisions to determine their vulnerability and their availability for pre-kindergarten programming.

Mr. Forbes: — So will there be a fair bit of latitude in these pre-kindergarten programs from, you know, length of the day, the time the children are in school, what the programming is from school division to school division? I can remember what kindergartens . . . the range from what you would be doing in one school to another was quite amazing actually. And I don't know if there's going to be more standards that are going to be tied to this.

Hon. Mr. Marchuk: — Thanks, Mr. Forbes. There are several parts to the answer to your question. First of all we have an early childhood curriculum, and it's a play-based curriculum. And so it's expected that the teacher would be adhering to the curriculum across the spectrum where pre-kindergarten programs exist. The second important factor is the qualifications of the teacher. They must be a qualified teacher, preferably with an early childhood background so that they have that training to provide the best program possible.

Mr. Forbes: — Okay. And I want to ask a question about in your second reading speech you talk about the change to the school day definition intended to reflect the regulatory amendments that you enacted on January 1st regarding the new school year. Can you talk a bit about what those amendments were and what the impact . . . what the amendments were that you're referring to?

Hon. Mr. Marchuk: — I'm going to turn that one over to my officials, to Mr. Johnston.

Mr. Johnston: — When the first definition of school day was proposed, we did not have regulations in place around the new school year and the school calendar. So when we developed the regulations, the Ministry of Justice legal counsel pointed out to us that what we were missing from there is a reference to non-instructional time as also being part of the school day. It could be an entire day of non-instructional time, or it could be a part day. So after we developed the regulations, we had to go back and adjust this definition of school day to encompass the newer understanding.

Mr. Forbes: — So you were calling for a certain amount of time?

Mr. Johnston: — No, not specifically on a school day. It was just the definition basically was just referencing instructional time whereas it should have referenced both instructional and non-instructional.

Mr. Forbes: — Okay. And in terms of the new school year, is that referencing a particular time amount?

Mr. Johnston: — No. The regulations that we've developed and put into place do talk about a school day shall be a minimum of five hours . . .

Mr. Forbes: — Right.

Mr. Johnston: — Which is the same as . . .

Mr. Forbes: — Three hundred minutes. I remember the old 300 minutes.

Mr. Johnston: — Yes, 300 minutes.

Mr. Forbes: — We were really specific — 300 minutes a school day. There is out there, there's a lot of talk about 950 and that's a new number for me. What is that about?

Mr. Johnston: — That was actually proposed by the Saskatchewan School Boards Association and the LEADS [League of Educational Administrators, Directors and Superintendents], the league of educational administrators and superintendents. They had actually come forward with the recommendation that if we were to prescribe a minimum consistent level of instructional time, that 950 hours would be workable and comparable to what was currently taking place in the school divisions.

Mr. Forbes: — That's not in regulation then, are you saying?

Mr. Johnston: — That is in regulation.

Mr. Forbes: — That is in regulation, and it's 950 hours of . . .

Hon. Mr. Marchuk: — Instructional time.

Mr. Forbes: — Time per year. And this is causing some anxiety out there because there's a whole range of what's happening. And I may actually come back to this further in estimates, just to let you know, because this could be a couple of hours, and we don't want to tie up the bill because it's not the point of this bill.

But if you want to talk about the 950 and how you are helping transition some of the rough edges around that. Because we're hearing that some are 985; some are over 1000 hours. Or is it pretty consistent at 950? Are they all coming . . .

Mr. Johnston: — I do have a chart with me. We've had all of the school divisions submitting their calendars to us. They're to be finalized by May 1, so we have all of them submitted. Some of them may be still preliminary and waiting for board finalization, but what we have reported to date is that the average is 957 hours across the 28 school divisions.

Mr. Forbes: — And is there a range?

Mr. Johnston: — There is. Basically 950 to 984. There is one at 984. Most of them appear to be around the 950-951 range.

Mr. Forbes: — The regulation is calling . . . What does the regulation actually require?

Mr. Johnston: — It requires a minimum of 950 hours of instructional time.

Mr. Forbes: — When you decided upon this, what was the consultation process for that?

Mr. Johnston: — We started consultations back in 2011 with all the four major stakeholder groups, which the minister had previously referred to. We also have, since that time, consulted again with those groups on several occasions as well as all directors of education on a few occasions on the question of the 950 hours.

Mr. Forbes: — Okay. Good. Mr. Chair, I think that as I look through my notes, I think those were the specific issues. You know, we had flagged some in second reading speeches where we watch for temporary workers, the residents, which I think this'll be positive in terms of helping with that, the fines.

So we're ready to go. I have no further questions.

The Chair: — Thank you very much. If there are no further questions, we'll begin with clause 1, short title. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 1 agreed to.]

[Clauses 2 to 40 inclusive agreed to.]

[15:30]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Education Amendment Act, 2012 (No. 2)/Loi* . . . [inaudible interjection] . . . Okay, this is the . . . Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. That was the French part, I guess. I would ask a member to move that we report Bill No. 70, *The Education Amendment Act, 2012 (No. 2)* without amendments.

Mr. Docherty: — I so move.

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

Hon. Mr. Marchuk: — Thank you, Mr. Chair. Yes, just to say thank you to my colleagues, Mr. Forbes, and certainly my officials that were here to help present the information on the amendments. Thank you.

Mr. Forbes: — Thank you.

The Chair: — Thank you. Mr. Forbes, any remarks?

Mr. Forbes: — I just also want to join the minister in thanking the officials, and I appreciate their good work. Thank you.

The Chair: — Thank you very much. We will now have a short recess while we switch to another bill.

[The committee recessed for a period of time.]

The Chair: — Good afternoon, one and all. We will now continue with the consideration of Bill No. 58, *The Workers' Compensation Act, 2012.* By practice the committee normally holds a general debate on clause 1, short title. Mr. Minister, please introduce your officials and make your opening comments.

Bill No. 58 — *The Workers' Compensation Act, 2012*

Clause 1

Hon. Mr. Morgan: — Thank you, Mr. Chair. I am joined today by Deputy Minister Mike Carr and officials from the ministry: David Cundall and Pat Parenteau. Also from Workers' Compensation Board I am joined by Wayne Dale and Ann Schultz who is . . . Ann, you are the chief financial officer? And Wayne Dale I believe is their in-house counsel. Is that correct?

Mr. Dale: — Correct.

Hon. Mr. Morgan: — Mr. Chair, I can advise that the amendments that are before you today all come about from the recommendations from the committee of review. We are mandated by the legislation to have a formal structured review process once every four years. The process was chaired by a former Chair of the Workers' Compensation Board from British Columbia, and as a result of that there was over 50 recommendations.

Almost all of them were accepted by the Workers' Compensation Board and by the ministry. A number of them were policy and practice changes, but a number of them required legislative changes. The legislative changes are the ones that are before you today. The most significant one is the increase in insurable earnings from 54 to $59,000. This is done on a phased-in four-year period. In addition to that, the payments will be tied to the cost of living. So there will essentially be at the end of it two pools of workers — ones that had claims that were based on the old contributions and ones that were based on the new contributions that will start with sort of the base rate of $59,000.

Virtually all of the recommendations were received, accepted, and acted on. There was one or two that were not. The most significant one is a recommendation that they fall in line with the recommendations of the Privacy Commissioner regarding security of records and providing information to claimants. They have had for a long time an internal process which they have strengthened and increased and believe that the processes that they have are consistent with the recommendations of the Privacy Commissioner, but do not believe that it's appropriate that they be subject to the legislation of the Privacy Commissioner.

Mr. Chair, I don't have anything more that I wish to add by way of opening statement. And we have the officials ready and available and are certainly prepared to answer your questions.

The Chair: — Thank you. And, Mr. Forbes, if you have questions, the floor is yours.

Mr. Forbes: — Sure. I have a few, so they'll be all over the place. It does talk about, I know that in the minister's second

reading speech that did talk about an administrative penalty of, I believe, it was up to $10,000 that can be applied. Where would that penalty . . . Does it go into the GRF [General Revenue Fund] or is it payable to WCB [Workers' Compensation Board]?

Hon. Mr. Morgan: — The administrative penalties would be the property of WCB. They're not a penalty that's administered by the court system or subject to the . . . So that constitutes revenue to WCB.

Mr. Forbes: — Right, but it's tied to a conviction?

Hon. Mr. Morgan: — Not a conviction because it's not a court process. It's a determination by the officers at WCB that somebody hadn't filed their information or hadn't done something proper. So it would in the same . . . And an analogy would be a penalty under *The Income Tax Act* as opposed to a prosecution.

Mr. Forbes: — Oh, okay. Okay. "Moves from the current system of fines . . . to administrative penalties . . ." That's what you had said.

Hon. Mr. Morgan: — That's correct.

Mr. Forbes: — All right. Okay. And then does that . . . What happens to those funds? What is the plan? What is the anticipation of what that . . .

Hon. Mr. Morgan: — I'll let one of the officials do it. We're not expecting it to be a huge amount of money. It's there to try and induce compliance with the requirements of the Act rather than as a source of revenue. In an ideal world, the revenue produced would be nil. So anyway I'll . . . Wayne Dale, counsel for the board will . . . And if I was wrong, then he'd correct me.

Mr. Dale: — Thank you. Minister, you stated things quite accurately. The only point I was going to add in response to your question is the amounts that are recovered from the administrative penalties do go into the fund which is the term defined in *The Workers' Compensation Act* which is actually a carry forward of an existing provision. Those amounts that would've been collected under the old Act would've gone to the fund. And so it's just merely a carry forward into the proposed legislation.

Mr. Forbes: — And how much typically is that in a year?

Mr. Dale: — Well we haven't had administrative penalties prior to this. Prior to this the manner in which the board was able to, you know, affect the penalty was by way of summary conviction. And to the best of my knowledge that was very infrequent.

In my time at the board, it was perhaps a half a dozen times. But there was a limit there of course because that was a judicial process, so the judge would impose the penalty which was a maximum of 1,000. Of course, that wouldn't be imposed on a first offence in any case. So it's difficult to, I guess, point to a history because there isn't a history.

Mr. Forbes: — Maybe I'll rephrase this as I'm curious about the need for this. And are you anticipating that it will be used frequently, infrequently, that this is a last step?

Mr. Dale: — My anticipation is it's, I guess, a last resort.

Mr. Forbes: — Last resort?

Mr. Dale: — Yes. There's policy and practice currently in place which will be expanded to take into account the administrative penalties. The idea is to encourage employers to comply with the legislation without going to the step of administrative penalty.

Mr. Forbes: — And is there an appeal process for administrative penalties?

Mr. Dale: — For the administrative penalties, they would follow the same appeal process as any other decision that the WCB would take. So if an employer were advised that they were being subject to an administrative penalty, they could take that to the board administrative tribunal and, you know, appeal that decision. And then there is a piece in the new Act that says if at the end of the day they're not happy with that, they do have some resort to the Court of Queen's Bench on a question of law.

[15:45]

Mr. Forbes: — Good. Thank you. Now on another piece, last week in Labour estimates we did ask about part-time teachers or substitutes being covered by Workers' Comp. And I believe the answer was that they would now be, but I couldn't find it in the new legislation. So where is that referring to?

Hon. Mr. Morgan: — My officials tell me it's in regulation.

Mr. Forbes: — Okay. Because, you know, it was interesting. I was at the STF [Saskatchewan Teachers' Federation] council and substitutes were very happy about this because this is a change. This a new thing. I believe it is a change. Am I correct on that?

Hon. Mr. Morgan: — It is. It's one of the gaps that's in our current system. We've asked STF to look at whether they wish to include those teachers in their existing plan as opposed to the . . . And I think it would regard it as something we'd have to negotiate. We've also asked school boards to make a determination as to what their costs might be. And we don't have clear answers as to the number of teachers affected or what they think it might be, but it's a gap that should be addressed.

Mr. Forbes: — Now substitutes or part . . . no. Part-time teachers would be covered by the STF because they would be on regular contracts. They're not on . . .

Hon. Mr. Morgan: — That's correct. Anybody that's on a contract is under the STF plan. It's a non-contract teacher.

Mr. Forbes: — Right. Right. And so they're paid at various rates throughout the province, but I assume then their coverage would be based on what their employer pays their . . .

Hon. Mr. Morgan: — It's not a matter of the employer making

a choice of what they wish to pay. The employer's obliged to pay based on what the earnings are. So they submit at the beginning of the year an estimate of what their earnings are. The earnings are adjusted later in the year, and that determines what their premiums are. And I presume that WCB will have to determine what the classification of those are, because it's something that wasn't there before. And I can't speak to that.

Mr. Forbes: — So this regulation, has it been passed? When are we anticipating that it will be actually . . .

Hon. Mr. Morgan: — We need to do the reg review once the Act gets passed, so it forms part of the regulations to the Act. We would certainly regard it as something we would want to move forward with and in the near future because it is something we've talked about.

Mr. Forbes: — Right. Well I know substitutes are very excited about it. They say it is a real positive, because they haven't been covered. And it's unfortunate when you think you are covered and then you find out you're not. And so, good.

I also want to ask about the one recommendation that the committee of review . . . When is the next committee of review scheduled to be set up, and when will they . . .

Ms. Parenteau: — It would be 2015.

Mr. Forbes: — 2015? Okay. Now there was a recommendation made regarding funding to the office of the workers' advocate at no. 46. And so the ministry disagrees with this recommendation seeing that the WCB is the sole funder to the office of workers' advocate, and it's based on the OWA [office of the workers' advocate] needs and it's provided through WCB through Treasury Board, that it not be subjected to staffing limitations or financial restrictions that other, they say, taxpayer-supported ministries or agencies . . . I'm not sure if that's good wording.

But how is the office of workers' advocate funded, and how is that through the legislation? Is there a connection here with the office of workers' advocate about ensuring that it actually remains and has its integrity to do the work that it's supposed to do?

Hon. Mr. Morgan: — Mr. Carr will answer that.

Mr. Carr: — The annual budget of the office of the workers' advocate is contained in the budget of the Ministry of Labour Relations and Workplace Safety. We do review, on an annual basis, the adequacy of that in terms of the work that the office of the workers' advocate undertakes, and we send to the Workers' Compensation Board on an annual basis an invoice to recover the costs of operating that office.

Mr. Forbes: — So is there a legislative requirement that there be an office? And I see that there is. I look at section 161, "Appointment and duties." So is there a case . . . or what happens if people feel that there's just not enough resources happening to the office of the workers' advocate? What happens with that?

Mr. Carr: — We would want to consider that in the normal budget preparation process that we go through annually as a ministry. And what we would do is consider the business case for expanding greater resources in the office of the workers' advocate. We would then make that as part of our budget submission through the normal process and hope that it would be given the appropriate consideration.

Mr. Forbes: — Right. So this was turned down. I don't know if it's the first time it's come up. But why the disagreement with the recommendation?

Hon. Mr. Morgan: — The recommendation essentially would leave the office of the workers' advocate without any external control as to what the cost should be. Notwithstanding that this is not a fund that is being paid for by taxpayer dollars, it nonetheless is a cost that's borne by users of the system and by businesses and, indirectly, the taxpayers. So there needs to be some . . . We feel there needs to be some element of control or fiscal accountability. So even though it's not a GRF expenditure, it nonetheless is a societal expense that ought to have the same kind of accountability, workforce adjustments, and that type of thing. Having said that, you know, it does provide a very valuable service we would want to ensure that was adequately funded, but I think subject to treasury board appropriations and that type of a review process.

Mr. Forbes: — Now has it ever been reduced in size in the last 10 or 20 years and, conversely, has it been increased in size in the last 10 or 20 years?

Hon. Mr. Morgan: — I think we'll let one of the officials . . . They can talk about the historical analysis. I think we don't fund it as a . . . It's part of the workers' compensation larger envelope. My understanding is that it's regarded as being funded appropriately, but I'll let . . .

Mr. Carr: — The experience that I can speak to is the five-plus years that I've been engaged in leading the organization, of which the office of the workers' advocate is a part, and in that situation we have maintained the staffing levels. As we spent some time in conversation with Denise Klotz in estimates, she was able to share, I think, with you some very significant improvements in terms of the administrative practices of the office, their ability to manage to a pretty significant standard the requests of clients that come through the door, and their ability to in fact address a greater number of clients through an improvement in their process.

We anticipate that, at present levels of funding, that the resources of the office are adequate to meet the challenge of workers seeking their services. If in fact we get to a point where there's a need for greater resources, that's something that we would build into our business plan and our model for budgeting purposes and bring forward in the next budget cycle.

Mr. Forbes: — Good, thank you. I do want to talk about — and this, I think, is very critical — I do want to talk about the privacy aspect of Bill 58 and the comments made by the Saskatchewan Information and Privacy Commissioner. It was quite an extensive letter that I know you have received and I believe I received — I was cc'd [carbon copy] on it. And so I think that if we can have a conversation about that, because I do think that it is critical, and it's often one that we've heard

concerns about, especially around the privacy and the perceived imbalance of power that WCB has over the documents and how they share them. And so I don't know if you have some introductory remarks, Minister, that you wanted to say.

Hon. Mr. Morgan: — Very briefly. We value the Office of the Privacy Commissioner, the work that's done there, and the recommendations that are made. Having said that, the Workers' Compensation Board has existed for a long time and has got policies and procedures that are in place. The recommendations from the Privacy Commissioner are ones that are taken seriously and we feel should be applied, but to have the WCB subject to that, we think, goes contrary to the purpose for what they're doing. They're essentially an insurance model, and it's where they go to.

But I'll certainly . . . It's probably not appropriate for me to go on when there's officials that are better equipped, and we have several of them here so I'll certainly let you raise the issues.

Mr. Forbes: — Sure. And I would think though that as, you know . . . and it's why we're discussing a new bill. And as the Workers' Comp evolves over the course of time and was obviously quite a major initiative when we started out with the Meredith principles — that was a bit of a landmark coming together of the minds about how to do things in a more civilized manner, that actually moved the workplace and work injuries in a more positive way — so I would argue that clearly that it's come more and more apparent that privacy is an issue that people are valuing more and more.

And so when we have issues raised by the Privacy Commissioner, I would really encourage . . . And I do want to go through as much as I can, the letters, and specifically why the WCB has disagreed with this, and why it appears — but maybe I'm wrong — but it appears that there is a bit of a roadblock in just saying we won't go down that road; WCB is exempt from FOIP [*The Freedom of Information and Protection of Privacy Act*] and that's just the end of the discussion. And I think that I would like to see and hear that there's more discussion about where there can be some common ground to move this around, move this forward.

Hon. Mr. Morgan: — I think we're always willing to have the discussion. There are by statute a number of entities that are outside of the scope of the Privacy Commissioner, and the Privacy Commissioner takes the position that some of those things should be brought in. For example, he thinks the police should be subject to the Privacy Commissioner and their legislation. The police certainly disagree with that. Officials with the Ministry of Justice say there are things that would affect or impact ongoing investigations, the ability of sharing information between police services, and also the obligations on getting ready to conduct a prosecution.

Workers' Compensation Board does not have exactly the same type of considerations, but as an insurance model they have methods that they examine claims, obtain information. But I think the concerns that the Privacy Commissioner would have, that the medical information, health information of a worker and that type of information ought to have the same provisions that would arise out of HIPA [*The Health Information Protection Act*], that even though they may not be subject to it but that they maintain them, that they regard themselves as a trustee for those purposes. They should have that obligation, and I think that's the obligation that they have imposed on themselves.

The other side of it of course is sharing information with a claimant, with information that the claimant has. And there comes issues of what happens where there's multiple workers that were injured in the same accident. How much information gets shared as between those? How do you sort of firewall the information between them? How do you provide information for an appeal? What process do you have if the worker is or is not represented by counsel or alternatively by a family member that's there as a companion or a friend of them as they advance their claim?

I'm going to ask whether the officials from WCB are better able to address it. But if you have specific questions, we'd certainly . . .

[16:00]

Mr. Forbes: — I do. And maybe that'll come out as we go through because I do want to . . .

Hon. Mr. Morgan: — Mr. Dale is a lawyer and loves to deal with things legal.

Mr. Forbes: — Okay. Does Mr. Dale want to make opening comments? Or should I start with my . . .

Hon. Mr. Morgan: — In a general sense, feel free.

Mr. Dale: — I suppose, generally speaking, there's a couple of elements from the WCB's perspective. There's worker and employer access to the claim record, so that workers can advance an appeal, question decisions, and so forth. And likewise for employers; decisions that are made on injury claims affect employers as well. So the situation, as I understand it anyway, is that the way *The Workers' Compensation Act* interplays with FOIP at the moment, is when it comes to accessing the claim record that has been set aside under *The Workers' Compensation Act*.

And I think the concern that has been raised is that workers are having a hard time getting a hold of their file in order to advance an appeal. And I think that that would, I guess, classify that as the access piece of the question. And if I understand the issue correctly, the privacy piece. at least in part, is how much information an employer is entitled to receive from that claim file in order to advance the issues that they may have.

Mr. Forbes: — Now do you have, Minister or Mr. Dale, do you have the letter that I'm referring to, November 19th, 2012 from . . .

Mr. Dale: — I think I have that letter.

Mr. Forbes: — Did you bring it?

Hon. Mr. Morgan: — We apparently don't have it. We do not have it here today. As you're aware, we convened on very short notice.

Mr. Forbes: — Yes, and I appreciate that. So I do want to read some specific quotes from it, and that's what I will do:

> A fundamental problem is that WCB takes the position that section 171 to 171.2 of *The Workers' Compensation Act, 1979* are somehow paramount to the requirements of FOIP and that section 4(4) of HIPA operates as an exclusion of the records in the custody or control of WCB from HIPA.
>
> Our office receives a significant number of requests for review and complaints [about] . . . WCB; 44 WCB related files have been opened since July 2003. We also receive numerous inquiries about WCB which do not result in a file being opened.

And they have:

> In recent years, we have issued two Investigation Reports involving a breach of privacy on the part of WCB.

And then they talk about, one that:

> . . . personal information to an independent claims advisor without authority and that WCB failed to satisfy its obligations under section 27 of FOIP to ensure the claimant's personal information in its possession was accurate and complete.

In another report that:

> . . . WCB disclosed to the complainant's employer more personal information and personal health information than was necessary. [And they] . . . found that WCB failed to adequately safeguard the complainant's information when it sent copies of the individual's personal information and personal health information to the complainant by ordinary mail, which was not received by the complainant and could not be accounted for.

So then they hear about:

> WCB demands personal health information that is not relevant to the . . . injury;
>
> WCB shares more information about an injury with the employer than is necessary or relevant; and
>
> WCB does not let claimants see their own case management files unless and until an appealable issue has been identified, and even then may not allow the claimant to view their entire file.

And so essentially what they're saying is the track record of WCB is not great in terms of managing the privacy end of this because they've had 44 complaints, at least 44. Some haven't been turned into a file. And he's saying that there clearly is a job there to be done.

Mr. Dale: — I can speak to some of what's contained in the letter. As I said before, we have, you know, the access portion of FOIP and we have the privacy portion of FOIP. And we certainly do have a disagreement in terms of under which piece of legislation the worker accesses their claim file. And you know, the position we've taken, which I believe is a sound position, is that section 171.1 of *The Workers' Compensation Act* governs access to the claim file.

On the issue of determining breaches of privacy, in fact Mr. Dickson made a number of recommendations to the WCB in the two reports that he mentions in his correspondence to assist us in improving our practices. For example, one of his recommendations was that all files should be sent double-enveloped with the inner envelope having, you know, for your eyes only designation. We adopted that recommendation.

Now I believe both of those reports were from . . . One was from 2003 and one's from 2007. And we've made significant changes in our internal processes which I guess, if I can jump a little bit to the privacy piece, we've never disagreed with the Privacy Commissioner that the protection of privacy provisions in FOIP apply to the Workers' Compensation Board. Certainly we understand that we have an obligation under FOIP and under HIPA to protect the information that comes into the care and control of the WCB.

Where we may have the disagreement on the privacy front is the issue of, say, an employer's access to the claim record. It's our understanding that the WCB, its staff and adjudicators are in the best position to determine what information is relevant for that employer and the appeal, not the Privacy Commissioner or FOIP. And as well in terms of collecting information, I think again I would, you know, say that probably the staff with the expertise are in the best position to determine what information should be collected to make decisions on the claim.

Mr. Forbes: — And I know — and maybe you can talk a little bit about this — but I know many claimants have come in very concerned about the summary notes that are prepared for appeals, but they cannot even see their own notes. And that is a changed policy, I understand?

Mr. Dale: — Yes, that has been changed. And those notes, you know . . . Yes, and again it was in response to a recommendation that was made by the Privacy Commissioner. Those summary notes now form part of the claim files. So when the workers access their claim file, they do receive those summary notes.

Mr. Forbes: — I see that, right. The interesting thing — and WCB has a strong reputation and a good reputation of being rigorous in administering their Act, and so I understand how committed the board is to this — but it's interesting because the committee of review is a committee both of employers and workers, in terms of coming together for consensus decision items. And this is one where they thought privacy was one that they should move forward on. So this is what . . . I can't see why WCB wouldn't do this.

But I'll continue on, and say:

> In the case of the 2006 Committee of Review, the Committee appeared to accept our recommendations. In fact it addressed our concerns as follows . . . [And I go]

> The Committee can find no compelling public policy purpose or basis for the Board to continue to be exempt from, or have a special position with respect to, the legislation and administration protecting information or personal health information that applies generally in Saskatchewan.
>
> The Committee recognizes the unique mandate and decision-making role of the Board in the administration of justice, but does not consider the Board's mandate and role to be so unique or [so] special that the law and remedies that apply to other administrative agencies and public bodies should not apply to the Board.

And of course he makes then recommendations to the Act to specify that the board is subject to *The Freedom of Information and Protection of Privacy Act* and the repeal of the exemption of *The Workers' Compensation Act, 1979*, as from Parts II, IV, V of *The Health Information Protection Act*. And so I think that . . . While the board has disagreed, has it done any kind of thorough analysis to make its case? Is there a position paper that's extensive?

One of the, I think, the qualities I appreciate in the commissioner is his work is often thorough and the arguments are quite laid out. So has the board a policy about why it should be exempt from the Act?

Hon. Mr. Morgan: — The simple answer that I can give you is we received, I think, a total of 57 recommendations. The Workers' Compensation Board, to their credit, indicated when we met with them that a lot of them, as they were going through the committee of review process, adopted them as they were done if they were a policy or practising. So a goodly number of them they had accepted and responded to directly.

Almost all of the other ones, whether they were legislative, were ones that were accepted and they were highly supportive. This is one of the ones where they said, if we were to have this it would slow down the ability of an appeal. Now I'm going to read you just a little bit from notes. It says:

> The WCB has maintained that Workers' Compensation legislation was intentionally exempted from FOIP and HIPA in order to facilitate the appeal process under the Act. WCB notes that if exclusions were removed, the provisions of FOIP and HIPA would have to be applied which could mean delays in receiving information as third parties would have to be informed of the potential release of information, potential redaction of third party information, and potential review by the commissioner if the applicant requests a review. This could result in significant delays in the appeal process as there is no set time frame in which the commissioner must complete a review.

So the feeling was that they could accept the commissioner's recommendations as to doing a better job of maintaining the privacy, dealing with release of the information to the claimant, and still do it outside the operation of the Privacy Commissioner's legislation.

We looked at it. We made the decision. We were prepared to accept this as being one of the few things that WCB disagreed with the committee of review on. It would have been probably an expedient thing to say, oh yes, you're going to be subject to it. But their position — that they wanted to be able to deal with the claims in a quick manner and be responsive to those things without having to redact information, without having to go through a complex process — they felt they would better serve their claimants.

I think all institutions that deal with private information or confidential information as time goes on are improving their methodology and the breaches and the type of things that we saw a number of years ago, we're seeing less and less of them. We're not at a point where we're seeing none or that we're where we need to be, but we're certainly making progress.

And I think that says something about the nature of the public right now. The public are far more conscious of privacy than they were a couple of generations ago. I can remember being in public school and my mom had the door-to-door person for Henderson's directory going around. My mom gave them all the information they asked for: where everybody worked, whether they owned the house, how long they had lived there, and then had provided the information on behalf of the neighbour without contacting the neighbour. And when the neighbour came home from work, my mom goes over proudly saying, Henderson's were here today but I told them. Oh that's good. Thank you very much for having done that.

And that was the mentality that people had at that time. Nobody worried about it. There wasn't the same level of concern that this was proprietary information. The same with going to the bank. You know, you'd go to the bank, the teller would say, I saw your mom here, whatever else.

[16:15]

Well now you don't do those type of things. The awareness that something can or should be or that you should obtain the consent . . . And it's probably for the better. You know, the easy comfort that we once had, we don't have anymore. And that's certainly everybody's right to do that, and I think all of us should be vigilant about their privacy. We live in an age where Internet problems arise, where cybersecurity is paramount. We should do that. And I think government agencies are taking huge steps forward. Not saying that we're not going to have accidents, but it is a better and different time.

So anyway, that's a long answer to . . . We think we can achieve the same end that we need to with workers' compensation and give them the flexibility to deal with their claimants.

Mr. Forbes: — No. I appreciate the answer and the reasons in terms of the ability to be quick with appeals and the nature of third-party involvement, that type of thing, and of course how times have changed. I am also very cognizant of how WCB, they have a fair practices office to ensure there's fairness and as we'd talked earlier about the office of workers' advocate.

Now is there . . . And the minister may be more aware of this than I am, but as we know with all legislation, that it's reviewed from time to time. And the privacy, you know, that would be

legislation that I think at some point will need to be reviewed. I mean when you talk to the Privacy Commissioner, he talks about gaps in their legislation as well and shortcomings because it hasn't been reviewed for a number of years.

But I do want to raise a couple of thoughts that, seeing the limitations of WCB in terms of . . . or it's own unique challenges would be a better way of saying it, and we see this with the Ombudsman today, refining their work to do work around health care because there is a certain number of issues being raised around health care. So they're specializing, the Ombudsman, the office there, to deal with those issues.

Is there a way — and I don't have a solution today — but of thinking about how we could meet the needs of the Privacy Commissioner who is an arm's-length officer of the legislature who says something here needs to be done that's more transparent than the existing practice? And yet WCB is saying, we are doing things, but there's limitations. Is there a way of doing some sort of common ground that meets that need, i.e., you know, the fair practices office or something like that?

Hon. Mr. Morgan: — I would think that that's the position that we're at. We've looked at what the Privacy Commissioner's recommendations are as to how they provide the information, and I'll give you the changes: that all injured workers are able to access their personal information without the need to file an appeal; employers are only able to access the personal information of the injured worker that is necessary for the purpose of the employer's limited role in any particular compensation claim; and that all injured workers are able to raise any privacy concerns with the fair practices office, the WCB's internal ombudsman, as well as Ombudsman for the province.

So we think the concerns that they've raised on privacy, we've got a number of avenues that a worker could use to address those. But more importantly I think they're trying to streamline and have a better position with how they maintain their records and make them available.

I think I share the frustration that a worker would have. They want to appeal a claim, and then they're saying, oh well we're not going to give you all the information. Oh but yet we're going to share it with the appeal committee. I can't imagine anything more fundamentally unfair than doing that or saying that these things are internal to the board. Well if it affects a worker, it has to be in the worker's hands so they can have a meaningful assessment of their own position and decide whether they want to appeal. So I think that's where they've got it.

But I think where you're going with this is, would we be amenable to look at it or if there's further recommendations from the Privacy Commissioner or where that legislation is going in a general sense. Well we're always open to looking at recommendations from the Privacy Commissioner. We don't always accept his position, but we're always willing to look and always willing to value the advice of an independent officer. So certainly in that regard, we're willing to maintain the dialogue that would be going on. We may still have to agree to disagree on some points, but I think we're there.

And then you'd also asked where we were going with the privacy legislation, whether it was subject to an update. It has not been examined for a number of years. It now rests with the Minister of Justice. And I have a good relationship with both the current and the former ministers of Justice, and I know it's something that they probably will. I think both the present and the previous members have indicated that at some time in the reasonably near future, it's an Act that will have to be either brought forward either by way of a major overhaul or some mid-cycle adjustments.

Mr. Forbes: — What are other provinces, WCBs in other provinces, what's their relationship to the Privacy Commissioner?

Mr. Dale: — I can't speak to each province. I do know that in our province to the west, Alberta, my understanding is that the *Workers' Compensation Act* in terms of access to the file, it would be under the purview of the *Freedom of Information and Protection of Privacy Act*, and I've had some dialogue there. And it is a process whereby the files are vetted against FOIP [*Freedom of Information and Protection of Privacy Act*] and documents are redacted or removed prior to being given to the injured worker.

So I guess as Minister Morgan has said, that's part of the concern. Will the workers actually receive less than they do now? Because when they receive their file now, they receive an unredacted version of the file. Everything that's in there, they receive. So in addition to the matter of timeliness, there's a concern I guess about completeness of the file that might end up in the workers' hands.

And I'm sorry I don't have good knowledge of all the jurisdictions. I just happen to be a little bit familiar with Alberta.

Mr. Forbes: — I should have turned the page because the commissioner answers my question. He says, "To the best of our knowledge, in every other Canadian jurisdiction except for the Yukon, the provincial workers' compensation scheme is subject to oversight by the provincial Information and Privacy Commissioner . . ." So we're unusual in that that's the case. But I would leave that with you that I think that . . . to work further on that.

Hon. Mr. Morgan: — When there's a situation where our province is unique, I think it's something that's always worthwhile to continue to look at it. The WCB has indicated that they made changes, so they believe that they're giving the best possible service to both the workers and the others that would need the information. But I think it's probably appropriate that it be something that be monitored as we go forward. So your point's taken.

Mr. Forbes: — Thank you. I want to talk about the maximum benefit level, and that's one of the key pieces. And I know many people . . . And it's one — I don't have my written questions with me, but we talked a bit about it at estimates, so we don't need to go into a lot of details — but it is one, when I look back at the committee of review, and it was a non-consensus item about how to move forward with this. And it in fact suggested that there be further consultation on how to

best proceed with this issue.

But you've ended up with a plan, and if you could describe what that plan is, if you could review the plan or the process for it.

Hon. Mr. Morgan: — I'll do the best I can, but I'll let one or more of the officials do it. The current maximum allowable earnings are $55,000. The recommendation was that the maximum allowable earnings go to 59,000 and then be indexed thereafter. If we were to do an instant increase to $59,000, the question comes, do you make it retroactive for existing workers that are currently receiving benefits?

Well at the time their claims were made or at the time they were working, they were contributing with premiums based on the $55,000 rate. So the decision was that it would be phased in over a four-year period of time. This is a $4,000 increase. So it would go up $1,000 per year. So if you're, immediately after proclamation, if you're an injured worker, then your maximum allowable earnings would go to 56,000. If it was a year later, it would be 57,000 and so on until you got to the 59.

So you've got sort of the different categories of when the injury took place, and then all of the claims will have a cost-of-living increase. But you will have the ones that are pre-amendment to the bill because their contributions were made based on what the contribution rate was based on, on what earnings would have been based on a $55,000 maximum. So that's a complex and is that a correct . . . [inaudible interjection] . . . I am advised that I am correct.

Mr. Forbes: — So for the one group, it's $1,000 increase over four years plus the cost of . . .

Hon. Mr. Morgan: — The cost of living. And the cost of living . . .

Mr. Forbes: — So it could be $1,100 or it could be 1,250 or it could be 1,050?

Hon. Mr. Morgan: — I'm sure Ms. Parenteau will give us an answer that will be incredibly complex.

Ms. Parenteau: — I will try. The formula is to move from 55,000 to 59,000 right away for new-Act claimants, and then over a four-year period, bring it up to 165 per cent of the average weekly wage. And that will be for new-Act claimants, so from proclamation date, anybody injured after that point.

Mr. Forbes: — So there's one group that upon proclamation, if you're injured that day or the next day, you're going to get the 165?

Ms. Parenteau: — It'll go to 59,000, and then will start over a four-year period.

Mr. Forbes: — And then work your way up?

Ms. Parenteau: — Right.

Mr. Forbes: — Okay. And then the other group that's in existence right now will get $1,000 a year increase for four years.

Hon. Mr. Morgan: — No. Those people will only get a cost-of-living.

Mr. Forbes: — They will only get a cost-of-living. Okay. And then the . . . Okay.

Hon. Mr. Morgan: — I was wrong on the $1,000 a year. It moves to the 1 per cent. I'm sorry. Yes.

Mr. Forbes: — Right. Okay. And then last time we were here, I had asked for it in questions about the gross wage folks, the pre- I think 1985 group, and that there was some, and that seemed to be 16, 18, 19, and then last year there was 26 of them. And I think Mr. Federko was going to find out how come there was 26. It seemed to be an anomaly.

Hon. Mr. Morgan: — Apparently Mr. Federko is assembling that information. Mr. Carr indicates that they're working on gathering that information for you.

Mr. Forbes: — Okay. That would be helpful.

Hon. Mr. Morgan: — And I don't have an answer for you.

Mr. Forbes: — Okay. The folks back there don't have — no — any other further? Just I'm curious about this.

Hon. Mr. Morgan: — If you like, we'll provide you the information. If it leads to a follow-up question you want to discuss, I'll certainly make somebody available to you either from the ministry or from WCB.

Mr. Forbes: — Well it does seem like a bit of an usual number because in one sense it seems to me that that number should be shrinking as people hit retirement. And why that would be now . . .

Hon. Mr. Morgan: — Yes, whether it's people that, you know, had contact with something, whether it's a late-developing disease that ties back to a period of time . . . I don't think I would speculate. But I think it was a good question and piqued my curiosity, so I'll want to know as well.

Mr. Forbes: — So in the committee of review, they had estimated the cost of this item would be 138 million. And the WCB has set aside 80 million for the cost of . . . Well it doesn't say necessarily this provision of the Act. It could be for the whole Act. But I assume this is the largest cost item of the Act. Is that right?

Hon. Mr. Morgan: — The wage payment would be . . . Yes, that would be.

Mr. Forbes: — Well why the difference between 138 down to 80?

Hon. Mr. Morgan: — I think there was some reserves that they were using to try and deal with the people that were immediately affected. I think the goal was to try and implement it without having an immediate increase in premiums, so they had some money set aside in reserves. The CFO [chief financial

officer] is here. She would know better than I. She has, I'm sure, an enlightening answer. It's Ann Schultz that's here.

[16:30]

Ms. Schultz: — Hi. I'm not familiar with the 128 . . .

Mr. Forbes: — It was 138 million. It was part of the recommendation no. 8 in the cost item. That's what it was costed out to be.

Ms. Schultz: — Okay. Well I do know about the $80 million that we did put into reserve this year, and that was determined by our independent third party actuary based on the data in our system. Now that 80 million is to cover off the ongoing costs of injured workers that are in the system now, to cover off their indexing as they progress through their life and remaining on WCB.

Mr. Forbes: — Now on budget day there was a comment made that WCB had an extraordinary adjustment this year or day. Do you know what that's about?

Ms. Schultz: — No I don't. I'm sorry.

Mr. Forbes: — Okay. Fair enough.

Hon. Mr. Morgan: — An adjustment to what?

Mr. Forbes: — Well that's a term that, you know, when we were in a briefing — and I don't want to attribute it to anyone because I just thought it was an unusual term — but the WCB had in this year an extraordinary adjustment day or it sounded like a re-evaluation day.

Ms. Schultz: — It could be referring to the implementation of IFRS [international financial reporting standards] and . . .

Mr. Forbes: — Pardon me?

Ms. Schultz: — The implementation of international financial reporting standards and the recognition of unrealized gains and losses on our investments. But that doesn't sound like it would be to that . . . We did have a reduction in our benefit liability this year, but it wasn't extraordinary. So I'm not sure what the comment referred to.

Mr. Forbes: — It was just a term that I made a note and stuck it in my folder that . . .

Hon. Mr. Morgan: — I can't comment on what things you write in your folder. I'm not much help to you on that. But there is a change in accounting, and it's the international financial . . .

Ms. Schultz: — Reporting standards.

Hon. Mr. Morgan: — And what it requires the entities like WCB to do is on their year-end they value all of their securities even though they don't dispose of them. So you may have a security they paid $1 million for that's worth a million and a half dollars. So then they would, for purposes of their financial statements, show a half a million dollars of profit even though they have not received that half a million dollars of profit. Conversely, as it was a year ago, if at the end of the year they didn't plan to sell any of the securities but there was a bump downward in the valuation of securities, you could on paper show a loss that comes back out.

So the year before, there was actually shown a small loss on it, which actually a few weeks after the year-end worked out because you're required to do the valuation as if you had sold or disposed of all of them, which could be a plus or a minus. And it's sort of contrary to what the investment plan or investment policy of the WCB fund analysts or . . .

Ms. Schultz: —And we've been doing that kind of accounting since the 2010 year-end. So it's nothing new.

Mr. Forbes: — Fair enough. And that sounds like that could be. There wasn't much of a context to the comment other than, you know . . .

Ms. Schultz: — There was a large swing as a result of that because we did have a $33 million loss last year, and most of that was attributable to or all of it was attributable to the drop in the markets in 2011, whereas this year it's recovered.

Mr. Forbes: — Good. I want to talk a little bit . . . We had talked a little bit about this last time, about the gross wage earners and the fact that there were so few of them, and that in fact they were . . . The current situation really has two streams of workers right now, the pre-'85 and the post-'85 workers. And so now the pre-'85 will be rolled into the post-'85 group, which is the 90 per cent of net earnings group, and the one was before 75 per cent of gross.

And because it seemed to be such a small group, and I've been approached by some because it just seemed to be . . . The person felt it was unfair that they should be lumped together and what, and when I asked about this last time, apparently WCB has not done a financial model of what would be the cost to continue that group forward. Because it is a finite group, the group will retire and in theory it should be getting smaller.

Hon. Mr. Morgan: — The rationale behind workers' compensation, it's an insurance scheme. And it's based on what your premiums were paid during the time that you were working. And while you might want to look at it and say oh yes, these, you know, we feel sorry for these people or whatever, it would be a nice social policy thing to do it, it runs contrary to the insurance model that's there based on, your particular pool of people pays in this much or the employer pays it in on your behalf, so that's the benefits you would be getting.

So if they were to pay out to a different group of people or people that are in a related group, then it's one group cross-subsidizing another. The recommendations from the officials is that as much as it may seem like a nice thing to do, it's not the GRF that's paying for it. It's not a social program to use. It's a program driven by the different pools, the different groups within, and that you should follow to the best of the ability to try and follow that. So we've accepted that. Now if you've asked Mr. Federko for some information on that, it's certainly something that we could have a discussion about once, you know . . .

Mr. Forbes: — He didn't make a commitment to provide information. I felt it was that there should have been some financial modelling on this. The argument that this gentleman made to me was that pre-1985, premiums were paid for workers in the case of injury. And this is the lay of the land: they would get 75 per cent of their gross. And that would be, if something, if there was an injury, that would continue on into the future. And then in 1985 that changed to the . . . Now did that change in 1985 for the gross wage earners? Did they then become part of . . . Or what happened to them at that point in 1985? Did they become part of the 90 per cent group?

Mr. Carr: — My understanding is that individuals that were under claim at the time the new Act came in remained under the old provisions in the statute; that any new and subsequent claimants who filed a claim following that were under the new provisions.

Mr. Forbes: — Right. And so now they're saying, okay, so we continued under that 75 per cent, and the premiums were paid for them. And that was the deal when they were injured. But now they're getting close to the end of their working time — but it's just before their retirement — that they should actually continue on because that was the deal.

And so that's what I'm saying. I'm not agreeing with you, Minister, about how this changes this is an insurance deal. The premiums were paid at the time for them to have, and that was part of the pool of money and that was the plan.

Hon. Mr. Morgan: — I'm not sure specifically what you're asking on behalf of the workers. I know there was a group of workers that had launched a lawsuit that was unsuccessful because they were trying to sort of protect, you know, the pools that I had talked about.

But if you've got some specific claimants, we could treat it as constituency casework, and I'd certainly be glad to look into what the status of either an individual or a group of people and provide you with that.

Mr. Forbes: — No, it's not casework. This is a philosophical argument that this fellow is having, as he sees this as being a change. And I don't know how the numbers play out, but I see his point that I think that there should have been a better argument to the gross wage earners about why they are now being lumped in with the post-'85 group.

Hon. Mr. Morgan: — Yes, and without knowing the name of worker and being able to follow through what the history was with that worker, you know, the philosophical answer I gave you was one that, you know what, when you're in the pool that pays in, that's the benefit you receive. And the board is fairly rigorous at wanting to maintain that.

But if there is a specific situation that you think may have, that should be treated differently, I'm more than willing to look at it if you want to provide us with the particulars of who that is.

But from a policy perspective, they fall into the different pools or the different categories of what the benefits were at the time the injury took place. That was the basis of what their premiums were at that time, and that's what that worker would receive. And then I think the fairness approach is dealt with by way of indexing benefits beyond that.

Mr. Forbes: — Okay. Well I may write a letter just to get this on record when we get all of this straight and get this argument, so you have that.

Hon. Mr. Morgan: — I'd be glad to look at it.

Mr. Forbes: — Sure, good. Thank you very much.

Hon. Mr. Morgan: — Mr. Carr has pointed out that depending on which of the . . . You know, this was a divided recommendation on increases under COR [committee of review]. I'm not sure whether this is material to where you are on it now, was some of the COR members took the position that there should be retroactivity on the benefits paid. And for the reasons I indicated, that was a policy decision that the board has asked for and that's the one we're supporting, is that we not make it retroactive because the contributions weren't there at that time.

Mr. Forbes: — And I understand that part even though I do think that there were four years without an increase. With that, Mr. Chair, I want to thank the officials for their answers and I have no further questions. Thank you.

The Chair: — Thank you. If there are no further questions, we will proceed to vote on the clauses. This bill has 201 clauses and a schedule. Is leave granted to review portions of the bill by parts?

Hon. Mr. Morgan: — I agree to it. And, Mr. Chair, I'd point out that somebody has got House amendments as well.

Ms. Ross: — I have amendments.

The Chair: — Yes, we are aware of that. So is leave granted to review portions of the bill by parts?

Some Hon. Members: — Agreed.

The Chair: — Carried. Part I, preliminary matter, clause 1, short title, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 1 agreed to.]

[Clause 2 agreed to.]

Clause 3

The Chair: — Part II is scope of the Act. So clause 3 . . . I recognize Ms. Ross.

Ms. Ross: — Thank you very much, Mr. Chair.

Clause 3 of the printed Bill

Amend Clause 3 of the printed Bill by adding the

following subsections after subsection (6):

"(7) Nothing in this Act precludes a worker employed in an industry not covered by this Act or the worker's dependants from taking legal action to recover damages if the worker suffers injuries arising out of and in the course of employment.

"(8) A worker mentioned in subsection (7) is not, by reason only of his or her continuing in the employment of the employer with knowledge of the defect or negligence that caused his or her injury, deemed to have voluntarily incurred the risk of injury.

"(9) A worker mentioned in subsection (7) is deemed not to have undertaken the risk due to the negligence of his or her fellow workers, and contributory negligence on the part of a worker is not a bar to recovery by him or her, or by a person entitled to damages, in an action for the recovery of damages for an injury sustained by or causing the death of the worker while in the service of his or her employer for which the employer would otherwise have been liable".

I so move.

The Chair: — Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

Mr. Forbes: — Well I haven't seen the amendment, so I don't know how extensive the amendment is.

Ms. Ross: — The other ones are housekeeping, putting a "her" after . . .

Mr. Forbes: — Is that what it is?

Hon. Mr. Morgan: — Well this one . . . Let's take a minute so you can have a look at it.

Mr. Forbes: — Yes, I wouldn't mind having . . .

Ms. Ross: — Would you like to look at them?

Mr. Forbes: — I sure would.

The Chair: — We'll pause for a minute.

Hon. Mr. Morgan: — I apologize that . . . We assumed that you would have seen them, but I'll have Pat explain to you what they are. There's a series of them. They're most, virtually all are . . .

[16:45]

The Chair: — Okay. Now that we've cleared that up, do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 3 as amended agreed?

Some Hon. Members: — Agreed.

[Clause 3 as amended agreed to.]

Clause 4

Ms. Ross: —

Amend section (4) of Clause 4 of the printed Bill by adding "her" after "in the course of his or".

I so move.

The Chair: — Ms. Ross has moved an amendment to clause 4. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 4 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 4 as amended agreed to.]

Clause 5

The Chair: — I recognize Ms. Ross.

Ms. Ross: — Thank you very much.

Clause 5 of the printed Bill

Amend subsection (2) of Clause 5 of the printed Bill by striking out "city, urban municipality or northern municipality" and substituting municipality".

I so move.

The Chair: — Ms. Ross has moved an amendment to clause 5. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 5 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 5 as amended agreed to.]

Clause 6

The Chair: — I recognize Ms. Ross.

Ms. Ross: — Thank you very much, Mr. Chair.

Clause 6 of the printed Bill

Amend Clause 6 of the printed Bill by adding "of" after "within the scope".

I so move.

The Chair: — Ms. Ross has moved an amendment to clause 6. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 6 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 6 as amended agreed to.]

[Clauses 7 to 68 inclusive agreed to.]

Clause 69

The Chair: — I recognize Ms. Ross.

Ms. Ross: — Thank you very much, Mr. Chair.

Clause 69 of the printed Bill

Amend subsection (1) of Clause 69 of the printed Bill by striking out "for the purpose of subsection 68(1)" and substituting "for the purpose of subsection 32(2) and 68(1)".

I so move.

The Chair: — Ms. Ross has moved an amendment to clause 69. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Is clause 69 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 69 as amended agreed to.]

[Clauses 70 to 82 inclusive agreed to.]

Clause 83

The Chair: — I recognize Ms. Ross.

Ms. Ross: — Thank you very much, Mr. Chair.

Clause 83 of the printed Bill

Amend subsection (4) of Clause 83 of the printed Bill by striking out "$359.02 in 2012" and substituting "$376.61 in 2013".

I so move.

The Chair: — Ms. Ross has moved an amendment to clause 83. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 83 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 83 as amended agreed to.]

[Clause 84 agreed to.]

Clause 85

The Chair: — I recognize Ms. Ross.

Ms. Ross: — Thank you very much, Mr. Chair.

Clause 85 of the printed Bill

Amend subsection (2) of Clause 85 of the printed Bill by striking out "$359.62 in 2012" and substituting "$399.58 in 2013".

I so move.

The Chair: — Ms. Ross has moved an amendment to clause 85. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 85 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 85 as amended agreed to.]

[Clauses 86 to 88 inclusive agreed to.]

Clause 89

The Chair: — I recognize Ms. Ross.

Ms. Ross: — Thank you very much, Mr. Chair.

Clause 89 of the printed Bill

Amend Clause 89 of the printed Bill:

(a) in subsection (2) by striking out "$175 per month" and substituting "$356.19 per month in 2013 adjusted annually by the percentage increase in the Consumer Price Index"; and

(b) by adding the following subsection after subsection (2):

"(3) For the purposes of subsection (2), the

> percentage increase in the Consumer Price Index must be the percentage increase for the 12 months ending on November 30 in each year, and that percentage increase must be applied to determine the monthly allowance for the year following the year in which the calculation is made".

I so move.

The Chair: — Ms. Ross has moved amendment to clause 89. Do committee members agree with the amendment as read?

Some Hon. Members: — Agreed.

The Chair: — Carried. Is clause 89 as amended agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 89 as amended agreed to.]

[Clauses 90 to 201 inclusive agreed to.]

[Schedule agreed to.]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Workers' Compensation Act, 2012*. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. I would ask a member to move that we report Bill No. 58, *The Workers' Compensation Act, 2012* with amendments.

Mr. Lawrence: — I so move.

The Chair: — Thank you. And I believe that is the end. So any closing comments?

Hon. Mr. Morgan: — I would like to thank the members of the committee and also the officials that are here today. I know that this was put together on rather short notice because we subbed for another committee that was I guess storm-stayed. So I think the officials did a remarkably good job of rising to the occasion.

We've also given Mr. Forbes, or given David some undertakings that we're going to get him some additional information, and we'll do that. And I would like to thank, Mr. Chair, all of the committee members. Thank you.

The Chair: — Thank you. And if there are no other comments, this committee is in recess until 7 o'clock this evening. See you then.

[The committee recessed from 16:53 until 18:59.]

The Chair: — Good evening, ladies and gentlemen, and welcome to the Standing Committee on Human Services. The time now being 6:59, we will begin. And the committee stays the same except tonight we are with Health, and for the NDP [New Democratic Party] we have Mr. Cam Broten and Mr. John Nilson.

So, Mr. Minister, if you have any opening remarks and introduction of your staff, we'd ask for that now. Thank you.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

Hon. Mr. Duncan: — Thank you, Mr. Chair. Good evening to the committee members, as well to officials that are joining us from the Ministry of Health. To my left is Dan Florizone, the deputy minister of Health; and to my right is Max Hendricks, the associate deputy minister. As well, Minister Weekes is joining me at the table. I'll maybe, not at this time introduce all of the officials with us. We'll maybe wait for an opportunity, if they come to the table to the microphone to give a response, we'll have them identify themselves at that time.

Mr. Chair, members of the committee, at this time I think I gave a fulsome opening statement at our last committee hearing. And at this time I will just say that I'm very pleased, we're pleased to be here to answer any questions that members of the committee may have. And we're ready to take questions. Thank you.

The Chair: — Thank you. We will now resume our considerations of vote 32, Health, central management and service, subvote (HE01). And Mr. Broten is going to start with the questioning. The floor is yours, Mr. Broten.

Mr. Broten: — Thank you, Mr. Chair, and thank you to the minister and the officials for this evening. Can we start off with an update on the Phil Froese situation that we had talked about? Last time we talked about it in committee there were some question marks around the details, and since some time has passed, I'm wondering if the minister or the DM [deputy minister] could provide some more information about that. I spoke with Mr. Froese this afternoon, and he hadn't yet heard from anyone in the region or the ministry about his situation. So I'll turn the mike over to the minister at this time.

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten, for the question. I will be tabling a letter with members of the committee that was received to the ministry by the legal council of the Saskatoon Health Region that I think outlines the information that we had discussed at the last committee meeting. Before I do so though, I'll just reference the letter in a few spots.

As I said at our last meeting, that the health authority has, Saskatoon Health Authority believes that they have followed all practices that they needed to to tender this work. It was tendered to a contractor, Taylor construction. Taylor construction subcontracted to, in this case, Visionary Concepts.

At the close of the letter, and again I'll provide this to the members of the committee, the Saskatoon Health Region . . . I'll find it here: Taylor construction's lawyers have assured the health region as recently as today — which the date, the letter is actually dated for today — that they wish to resolve the matter

with Visionary Concepts, and they are willing to discuss this issue with Visionary Concepts at any time.

It is my understanding that they were going to be reaching out directly with Visionary Concepts. So I'll be pleased to table this letter with members of the committee.

Further to that, I don't know, Mr. Broten, if you wish to have the letter in front of you at this point or if there's further questions that may come from receiving the letter momentarily.

Mr. Broten: — Well I'll wait for it to come from the committee. We can keep talking about it just briefly while it comes and perhaps the content of the letter will address some of the questions.

When we discussed it last time, some of the issues I raised was whether or not the health region had followed due process in dealing with Taylor as well as Visionary. And some of the issues we talked about were the requirement for a builder's bond to be placed on projects. I believe at the time the deputy minister said for projects under $100,000 it wasn't common practice to require the builder's bond in order to ensure the subtrades were paid. I'm sorry, that's not a quote from *Hansard* so you can correct me. If I'm off base there, I apologize.

But my understanding was the construction project, the value for St. Mary's, was a lot more than $100,000. I think it was over the $1 million mark. So perhaps the letter addresses this, but I still have a question about whether or not the health region followed the right protocol for the requirement of a builder's bond to cover the subtrades as well as the holdback in order to ensure the subtrades were paid. And on what grounds did the health region release the final payment to Taylor, and were they aware of the fact that Visionary had a claim standing for a bill still. Is there any additional information that can be provided on that to me and Mr. Froese?

Hon. Mr. Duncan: — Thank you, Mr. Chair. According, Mr. Broten, to the Saskatoon Health Region, the statutory declaration was not requested from Taylor Building Services. The project was tendered and a purchase order was issued to the successful bidder, which was Taylor construction, and the final invoice from Taylor construction was paid based on the Saskatoon Health Region's determination that the work was completed. And a bond was not requested on the project, as we discussed at the last committee meeting, due to the small size and perceived low risk of the project.

Mr. Broten: — So in quickly reading the letter here just once over, basically says, for Mr. Froese who's watching at home, that it discussed the chronology of the builders' lien and the fact what was done through lawyers and that it was dismissed. And then the closing paragraph is:

> My understanding further is that the project was tendered and a purchase order issued to the successful bidder, Taylor Construction. The final invoice from Taylor Construction was paid based on this SRHA's determination that the work was completed. No statutory declaration was required as the general contract was not issued under CCDC terms and conditions.

So it talks a bit about the building lien, but it doesn't touch the issue of why a bond wasn't placed. And it doesn't touch the issue as to the declaration regarding the subtrades, whether they had been paid before the final disbursement was made to Taylor. Is that a best practice? Is this the common practice? Because I mean, I think the St. Mary's Villa project, the total tab was over a million dollars. I think it was. So while it may be smaller compared to some health care projects, it is quite large still. And why no builders' bond? Is there any other statement that the ministry wishes to make on this, or is it a case closed in the minister's view?

Mr. Hendricks: — Well our understanding for the region is that on a project of this size it isn't normal to actually . . . It requires the bidder to secure a bond. We have to remember that a bond protects the region against insolvency of the vendor. In this case the vendor isn't insolvent. So we've had a situation where there's been a dispute about the work that was delivered between a general contractor and a subcontractor. The general contractor has told us and told the region that they will meet with Visionary Concepts at any time to discuss resolution of this matter. So in our minds the offer has been extended, and we would encourage Visionary Concepts to get in touch with Taylor and try and work out this matter.

Mr. Broten: — Well working it out would be good, but I still think when the health region engages in projects, and when honest business people work on health region projects, there's a responsibility for the health region to ensure that people are treated well and fairly. And if there are checks and balances that can be in place to avoid situations where problems like this can come up, I think those are the types of practices that should be followed. So I thank the minister for the letter and for the remarks. And I will pass that on to Mr. Froese, and perhaps we'll talk about it on another occasion as well.

If I could ask some other questions, please. Switching gears a bit to the student wellness initiative toward community health, SWITCH, an initiative at the University of Saskatchewan, interdisciplinary, taking students from different colleges and then working and hands-on experience in Saskatoon. What's the level of funding that the Ministry of Health has been providing to the project in the last few years? And where is it at right now for the funding that Health provides to it, please?

[19:15]

Hon. Mr. Duncan: — Mr. Chair. Thank you, Mr. Broten, for your patience. The funding that comes from the Ministry of Health has been folded into the Saskatoon Health Region, into their budget, so we're looking to find that number for you. We'll endeavour to get that number for you. As well as there would be funding through the University of Saskatchewan through their budget as well. But in terms of the money that would come through the Saskatoon Health Region, we'll endeavour to provide that answer to you and to committee members.

Mr. Broten: — Thanks. Without discussion of the actual number, the figure, are you able to provide any comment on whether or not the support from the ministry, whether or not it's going through the health region or not, whether that has changed from the Ministry of Health, or is that . . . you need to

wait for more information on that?

Mr. Florizone: — Once again I apologize for the delay in response. We're not aware of any changes to the funding and in fact this is a program that is strongly supported by the ministry, just not only in terms of wanting to commit to its funding, but the program itself, the involvement of students, the population that's served, the experience and the training that is a result of this program. I just want to say on behalf of the ministry and the ministers, there is strong support for this. So if there is any issue that you're aware of, we'd be very pleased to follow up on it.

Mr. Broten: — So with that glowing endorsement of SWITCH, if there was a reduction in funding from the ministry through the health region to SWITCH, that would be of concern to the minister?

Hon. Mr. Duncan: — Yes it would be. It's my understanding that that's not the case. We would provide funding traditionally through the Saskatoon Health Region as well as through the College of Medicine and through the clinic itself. But as I said, we're looking to find that information for you.

Mr. Broten: — Thank you. I'll move on to another topic, but I would appreciate if perhaps some information could be tabled about funding levels through the ministry over the last few years. That would be very helpful. Thank you.

Hon. Mr. Duncan: — Sure.

Mr. Broten: — Another topic, and we discussed it a bit in question period, and that was the situation of Michael Lilley concerning home care through the Regina Qu'Appelle Health Region. There were a number of letters that were sent out to individuals receiving home care services in the region. And the letter that I read talked about reviewing what is being provided and that this would be . . . certain services would be ending and that individuals could find options in the yellow pages. In the situation that we talked about in question period, I believe the provision of services was going to be picked up by Social Services for that individual situation.

I guess my question is, the letter that was given or mailed to Michael Lilley about the review of home care services, how many individuals was that sent to in the Regina Qu'Appelle Health Region? And out of that number, is there an understanding of how many would be going to receive benefits through Social Services for similar services that home care once provided? So the first question, how many people received that letter? And second question, what sort of communication is occurring between the Ministry of Health and the Ministry of Social Services about the transfer of individuals from receiving benefits through one ministry to another?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten. The review that took place by Regina Qu'Appelle in terms of the home care services that they provide did result in 177 clients seeing the laundry and cleaning portions of the home care service discontinued. There may be a number of those clients that may be eligible for benefits through programs such as SAID [Saskatchewan assured income for disability], which is operated through Social Services. We wouldn't have the list of those 177 that are also SAID clients. That would be Social Services that would have that. The region has made a commitment that they will be following up with each of those clients, as well working with Social Services to determine what opportunities and services may exist after this discontinuance of services.

Mr. Broten: — So out of the 177, is there an understanding of how many would be already on SAID? Is that information known?

Hon. Mr. Duncan: — Not by the Ministry of Health, no.

Mr. Broten: — Has the health region started doing any of that follow-up with the 177 clients that received the notice of cut-off?

Hon. Mr. Duncan: — I believe that has started. I don't know if they have made contact with all 177 clients but they were going to be following up directly by phone with those individuals.

Mr. Broten: — And what's the intent of those phone conversations that will occur with clients? What will the nature of the call be?

Hon. Mr. Duncan: — The region will be . . . As I said, the region will be following up directly by phone with each of the 177 clients. They'll also be in the discussion with the clients, making some determination of those individuals that are eligible for benefits through Social Services — perhaps they're existing SAID clients — and then working with Social Services to determine if there are either existing services under Social Services or perhaps those individuals that are not yet beneficiaries of Social Services, to determine whether or not there are programs available for them through Social Services.

Mr. Broten: — Beyond the SAID program, and I realize you're not the Minister of Social Services, but what are the options available to individuals if they've been cut off of these services through the region? The SAID program is one option. Are there other ones or other places that they can be directed to?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten. So as I said previously, that the Regina Qu'Appelle Health Region is going to be following up directly with those clients, then working through to determine with Social Services if there are programs that can be accessed through perhaps the SAID program, making sure that what their focus is right now is putting a focus on those clients that would be in the greatest need for this type of service.

[19:30]

Mr. Broten: — In sending out the letter, I imagine there were budget considerations as part of the decision to send out the letter and review what services were being provided. Was there a target for how much was hoping to be saved or not spent with the change in services that are provided to individuals who have been accessing this or receiving this service through the region?

Hon. Mr. Duncan: — Mr. Chair. Thank you, Mr. Broten. I think in Regina Qu'Appelle, as they are looking to assess their clients each year that access home care, what they are seeing is an increasing number of clients that are accessing home care

service as well as a decision, a determination to focus more of the home care support on, more on medical needs. And so this was a part of that I think assessment of not just the existing clients but also seeing an increased number of clients coming into the system.

Mr. Broten: — So was there a dollar amount attached to the effort, or a target?

Hon. Mr. Duncan: — No I don't believe, I don't believe Regina Qu'Appelle set out to make these changes as a part of any budget target. What they were looking at is providing, focusing more on the medical care for their clients and knowing also as well that they are seeing an increase in the number of clients that they're serving through home care. So it was more of I think a realignment in terms of what home care services will be delivered.

Mr. Broten: — Have similar letters or a review of home care services that are provided . . . Have any similar letters, have they been . . . Have similar letters been sent by other health regions, or is there a review like this going on in other health regions or is this unique to Regina Qu'Appelle Health Region?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten. In terms of other health regions that may have sent out similar letters regarding the level of home care services that are provided to their clients, we're not aware of any other health regions that have sent out these letters, but we do know that on an annual basis, health regions reassess their clients to determine the level of need for their clients and the level of services that will be provided to clients. But at this time we're not aware of any other letters from any other regions.

Mr. Broten: — Thank you for that response. We've had a few discussions in question period concerning staffing levels in the health region. How frequent is the situation where in a unit or a ward, whatever the scheduling unit might be, that there is short staffing, where the target for what is appropriate staffing is not being met and there is an absence of a person there, whatever position that applies to? How frequent is that?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Broten. I think the best way to try to answer your question is that I think the situation at facilities will vary by facility by facility. There will often be times where, for whatever reason, that somebody cannot be at work during their shift, so there will be arrangements to be made for shifts to change, for casual employees to be called in; there is a registered nurse that would be on call to make a determination whether or not additional staff would need to be brought in to a facility. But in terms of just an overall number, it's not something that, I don't think that we as the Ministry of Health would be able to provide. As I said, there will be from time to time situations where employees would not be able to be at work at their shift, and so those facilities and the management of those facilities do what they can to make a determination whether or not that shift needs to be filled, and then fill it appropriately. So it's I think just more of a general observation rather than a statistic that we could provide.

Mr. Broten: — I believe in question period when we've discussed this a few times, you've made reference to some quarterly reports that you receive on the topic. Is that correct?

Hon. Mr. Duncan: — I believe what I was referencing was the assessments that take place on the needs of the residents. I believe that those generally are done on a quarterly basis to, as I said, to assess the needs of the residents, the level of care that they require. That would be information that we could then receive from the facility through the health region. But that would be something that would be done to, as I said, to assess the need of the resident.

Mr. Broten: — So in these quarterly reports, is there any information about the frequency of running short-staffed?

Mr. Florizone: — Thank you, Mr. Chair, and thank you for the question. I believe the question was, do we look at staffing on a quarterly basis. And the fact is the Ministry of Health does not have the monitoring in place to look at staffing on a quarterly basis. We do know the full-time equivalents that are funded. The payroll information is provincial in scope and regional health authorities are tasked with monitoring, measuring, and ensuring not only that they're meeting their budget targets but that staffing is appropriate and adequate. They too have contracts, agreements with affiliates and contracted agents, and that is an obligation of regional health authorities to measure and monitor.

With respect to staffing and appropriate levels, while some would suggest that there's an ideal standard, in fact all of it relates back to the need of residents. One of the things that we've learned through our work within the last four years with Releasing Time To Care is that we found, in the case of acute care, RNs [registered nurse] were spending about a quarter of their time with patients and three-quarters of their time doing other things. Those other things may or may not be necessary, but right now in terms of the work that they do, three-quarters of their time was doing everything in preparation for direct delivery of care to patients.

Our whole emphasis has been not on just simply adding more staff, which we have done, but not just simply that. It's redefining the work, being able to do work in different ways. So within long-term care, a lot of the emphasis has been on medication administration with RNs. We're looking at appropriate criteria for medication administration. We've taken a look. We've got several pilot initiatives in looking at how staff are being utilized, how care is being delivered, whether we could do that in a more appropriate way. And the whole ideal, the whole goal here is to get staff, give staff more time with residents.

The other part that I think is really important is with this work that we've been doing, the minister has set out a challenge for all regional health authorities. And this isn't a one-time challenge. This is an ongoing challenge for their teams, their administrators to actually go to every long-term care facility within the province, to spend time working the floor, being there on site, working a shift, working a few hours, to be able to make direct observations. And again not one-time only, but this should be part of being a leader within the health sector — being able to look at what is done, look at how care is being received, and provide for very much the kind of action steps that would be necessary and could be implemented today or this

week.

That information should be a regular communication through to resident councils, and we're pleased to say that the vast majority of facilities have resident councils. We're asking regional health authorities that if facilities don't have resident councils, to form those resident councils. We're asking the senior teams, the minister is asking that they meet with those resident councils, develop and present the action plans, and keep them up to date.

Literally the questions are this: what's going well, and would be better if? And getting that kind of feedback from I believe right now we're operating 158 long-term care facilities.

Mr. Broten: — So there was, after we discussed this in question period, there was a news report from a scrum, from CJME, April 24th, 2013, 5:23 p.m. And it says, referring to the minister: "He says each health region gets a quarterly report on staffing from each care home and he doesn't see reason for alarm."

So referencing the reports that care homes provide to regions, are those reports . . . I assume if the minister decides that there's no reason for alarm, does the minister or the ministry review these reports that come from a health region that talk about staffing? Or on what basis is the determination made that there's no reason for alarm?

[19:45]

Mr. Florizone: — Thank you, Mr. Chair, and thank you for the question. There are numerous paths and routes, sources of data that are available to take a look at the quality of resident care that goes on. The CEOs and their senior teams, for instance, twice a year will do a comparative look at MDS [minimum data set] RUGS [resource utilization groupings scores], a list of quality indicators that are collected and reported on a regular basis to the ministry. That data could include, and I'll give you an example, pressure ulcers. Now if there is a pressure ulcer that's a certain category of severity, it will actually be reported to us as a critical incident through to the ministry. So we do have critical incident reporting that is that type of report that could result in harm to residents. But there also is a level of reporting under MDS RUGS that could show less severity.

Also another example would be use of restraints, number of falls. These indicators are being more and more populated on to the units themselves. So for instance I came from Regina General. It happened to be an acute care unit but the rolling out to long-term care as well — daily huddles with staff. And one of the fundamental questions that's asked every morning is, was anyone hurt today? Were there any issues or incidents that need to be dealt with? They're reviewing what we refer to as a safety cross, falls that have occurred and who fell and what are the risks to the residents. So they're using it to drive quality and safety and improvement in these areas.

They've also — the example in Regina — they're also looking at whether a person wasn't able to show up at work this morning. So this morning as I drove in from Moose Jaw, I was held up by snow. It just so happens I'm not really critical to the health system, you know, performing well. But if I had been an RN, it would've been something that most certainly would require someone somewhere to say, well how are we going to cover to make sure that this contingency is looked after, that the staff member, this service, and the care can be provided in this arena? So they're doing daily huddles because a lot of these things need to be adjusted on a daily basis.

They're looking at whether or not staff need to be replaced, who are they going to be replaced with, who's available, who's on call. But they're also looking at what has occurred, what happened last night or throughout the evening. What are the incidents or issues that need to be dealt with and how can, in this case, resident care be improved?

Now they're also, for the sake of patients — and we want to get there with families and those residents that cognitively could respond — they're also asking them on a daily basis how're you doing, actually asking them to rate the care of that day. In the case of resident care, a lot of the time it's family as proxy. Family may not be there every day, but when they are there it's a matter of reaching out. They're also asking the staff in some of these units and we're starting to grow this and proliferate it. The difficulty right now is that it's not everywhere yet, but it is moving further and further as we set up these walls, this visibility, these measures around quality and staffing and safety.

Mr. Broten: — Thank you for that information on what's happening in the regions. That's interesting.

My question though is, the minister said . . . My original question was whether or not quarterly reports are received on staffing. And the information you provided was on critical incidents and other things occurring within the region, which is good.

The quote from the story says that the minister gets a quarterly report on staffing, and based on information received from those reports that there is no cause for alarm as it relates to staffing. So I just wonder how we arrive at that determination without looking at the staffing. And I realize there are many things that need to be considered such as critical incidents that you mentioned. So a comment can be made on that.

One other question. In the deputy's remarks talking about staffing levels and the work that is done, there was reference made to an ideal level of staffing in the . . . I think I heard ideal at one point, in targets for what is provided in staffing. Are there targets for what the appropriate staffing levels ought to be in the region?

Mr. Florizone: — No.

Mr. Broten: — Okay. So when the determination is made on how many individuals to have in a facility working in order to provide the service that is needed and that the proper care is provided, I suppose one benchmark or target that could be used for the number of people that are required would be the level stipulated through essential services when there is a labour dispute. And I would assume that mark of the number of people working would actually be lower than the ideal because it would be during a labour dispute. So you wouldn't have absolutely everyone there.

So my question is . . . Let's use one health region just to narrow the discussion a little bit. In the Saskatoon Health Region, for example, how often would the staffing levels in the region be below the mark determined through essential services?

Mr. Florizone: — So once again — just back to the previous question and then we'll deal with this one — the link to what I was suggesting with those measures and metrics and the quarterly reporting that the minister was referring to is all of that rolls up to a quarterly meeting with CEOs [chief executive officer] and board Chairs. The minister actually looks at all of that data with the system. And we do what's referred to as a wall walk, so we've got literally a room in the T.C. Douglas Building that's plastered with all of this information on the safety and the quality of the system. That has a direct correlation to whether or not we're appropriately staffed or whether the care is being provided in a appropriate way.

So once again it's evolving, but there is a quarterly look. As a CEO in my former life, I also had monthly information on full-time equivalents, so regular basis. Knew exactly, you know, kind of where things were at and with respect to utilization, quality, and safety. We're hopeful, in fact we're very confident right now that the system has far more information to measure and monitor.

Now on the issue of optimal staffing, the obviously optimal staffing depends on whose perspective, and what we're saying is it all depends on resident need. So where residents have come together and have certain needs, that will dictate what staffing ought to be provided.

So if I had for instance, let's take a number, 10 residents. And these are just fictional, but just for the sake of demonstration, if those residents are to a large extent independent, are able to ambulate, are a low risk of wandering, are able to socialize, the staffing levels would be much, much lower than if we were dealing with situations where we had 10 residents who were palliative for instance, who required constant monitoring, pain management, pain control. So we look at the care needs of residents.

There are other factors that are looked into. One is the facility design and layout. So unfortunately we do have structures that don't really lend themselves to the most efficient models of staffing. They're difficult to provide care, and we're looking at obviously redesigns, where possible creating pod-type care, where it's more of a family-like setting and less of an institutional-type setting — long hallways where staff have to walk to and from. The fact that, you know, whether there are lifts in that area, whether they're convenient, ceiling track lifts. How many two-person lifts would be required also dictates staffing levels that would be necessary.

So the models of care, in addition, how we deliver care, whether it's, you know, purely personal care or whether it's intense nursing care, the number of medications that residents are on, their care needs in general, and a lot of what's been set as the pattern has been based on the history of staffing. Now we do need to factor in the complexity of care, so it's a constant monitoring of care that's required. Whereas years past you might go into a long-term care facility and stay five or more years, it's much more common to live in long-term care for a year or two perhaps. So people are being supported in the community to a larger extent, which is great, but when they do end up in long-term care, most certainly we need to be on top of the care needs and the complexity that exists.

Mr. Broten: — Thank you for the context. So my specific question was and remains, when there are essential services that are set in a health region, how often — essential services which would be identifying roles and numbers of people — how often, in the Saskatoon Health Region for example, is the region operating below the numbers that are outlined in essential services?

[20:00]

Mr. Florizone: — So thank you, Mr. Chair. And thank you for the question. Just on reflection of essential services, that level that was set, I think the question, it really depends. So if you were to take the provider unions, which are by far the largest group within long-term care, I'd be very shocked that the staffing has ever dropped below the essential level overall in a facility.

Now it could be if you take a look at a particular area, they've pulled staff from one area to another. So you might have had, you know, within a particular unit of a facility, them drop down and have to pull staff in. But overarching on a facility basis, our numbers reflected or what the regional health authorities provided are about the high 70's in terms of percentage. It would be very difficult, if not impossible, to envision a situation where they would operate on a facility basis below that level.

I guess the exception might be a kind of contingency issue, very short term — the snow storm we talked about this morning, you know, something like that where they're waiting for staff to get through a closed highway might be a scenario. But I can tell you there would be a scramble on if that occurred. And I'm not aware of it occurring. I'm not aware of that scenario occurring on a facility-wide basis.

Mr. Broten: — A facility would, an example of a facility would be City Hospital or St. Paul's Hospital or a care home. What would an example of . . . When you say, on a facility basis, could you just elaborate on that a bit, please?

Mr. Florizone: — Yes. So what I'm looking at is, it would be a building. We were talking about long-term care, so it would be within the context of the building which would be the representative, you know, whatever the walls are that contain that building. We're talking about the structure proper.

So I mean we could drop below in, let's say dietary, and pull staff from other areas or try and make up for that in the short term. But on a facility basis, to see the staffing for unions such as CUPE [Canadian Union of Public Employees] and SEIU [Service Employees International Union] or SGEU [Saskatchewan Government and General Employees' Union] drop below 78 per cent, I'm not aware of that as ever having occurred without it being, you know, a very serious circumstance.

Mr. Broten: — Thank you for that response. I need to duck out for a while, so I'll hand the microphone over to Mr. Nilson, but

I thank the minister and the officials for the answers this evening. Thank you.

The Chair: — Thank you very much, gentlemen. Mr. Nilson, you now have the floor.

Mr. Nilson: — Good evening and thank you, Mr. Chair, for allowing me to continue. I'll continue a little bit in what Mr. Broten's been asking. Can you tell me what items are on the . . . I guess you have a three-month meeting of CEOs, but can you tell me what items are on the dashboard that are provided to the minister, deputy minister, and the CEOs at that meeting.

Hon. Mr. Duncan: — Thank you, Mr. Chair. Mr. Nilson, good evening. So if you were to attend one of these quarterly meetings and partake in a wall walk, you would see our hoshins would be laid out. They would be under . . . I'll just run through the list here.

So for primary health care, we've set five-year outcomes. So a 50 per cent improvement in the number of people surveyed who say I can contact my primary health care team on my day of choice; a 50 per cent reduction in the age standardized hospitalization rate for ambulatory care sensitive conditions. Under that we would have five-year improvement targets. So that would be Sask residents will be connected to their primary health care team; 80 per cent of primary health care teams are engaged in clinical practice redesign; 75 per cent of patients with chronic disease report an increase in confidence to self-manage their disease; 80 per cent of patients are receiving care consistent with provincial standards for the five most common chronic conditions; and 80 per cent of primary health care teams are using EMRs [electronic medical record].

Mr. Nilson: — Now I understand these are the goals that are in your annual plan, is what you're reading here. But what I'm wondering is, what do you actually measure? And are these things measured, or how does that work? Because I know I've read these things just in the annual plan. And maybe the point is, what are the top five that you're watching?

Mr. Florizone: — Thank you very much for the question. So what we've done is we've established bold targets around each of these areas, and you're familiar with them. What we're doing is we're measuring against them. So some of the measures have not yet matured, but these are the measures that we're populating and working on, and they all contribute to seeing progress around achieving these goals. So they're all connected back in that way.

In addition to these measures, we're also working on what's referred to as QCDSM [quality, cost, delivery, safety, morale] measures, daily management measures. And these have to do . . . I'll break that down: quality, cost, delivery, safety, and morale. And those measures are everyday measures that are being populated. I mentioned to you that many of them are on units, right at the unit level and they roll up right through to the T.C. Douglas Building. So while we, with our ministers, visit those walls with the CEOs and Chairs on a quarterly basis to talk about the progress, or not, on achieving those targets and getting corrective actions, those meetings are occurring monthly, weekly, and in fact daily at a variety of levels. So if you wonder what we're measuring, it's that which we set a target around and that which is important in terms of quality, cost, delivery, safety, and morale.

Mr. Nilson: — Thank you. So then under something like quality, that's where you would measure the number of reports of bedsores in a facility. Or is that the kind of thing that you measure? What is it that you measure?

Mr. Hendricks: — To explain our hoshin kanri process that's being implemented across the health system a little bit more deeply, there's a health system plan for the coming year. Our three major hoshins that we're focusing on are surgery, primary health care, and safety. Now within the safety bundle, we're looking at things like coordinating planning of a provincial safety alert system and stop-the-line process involving all regional health authorities. So this is where a patient, a family, anybody when they see something they don't like, they have the ability to stop the line.

So in the situation that you're discussing, if a family member saw something they didn't like, we would have processes so that they could actually take it up and investigate the problem with the staff.

We have developed measures for surgical site infections, and one thing that's really important to us is medication reconciliation in long-term care where we're also developing measures. But as we go through our hoshin kanri system, the province has a plan. The ministry has a plan. Each region has plan. And if you walk into any long-term care facility in the province now, they also have a plan.

So within the individual facilities you'll see measures like . . . or targets around falls. You'll see targets around medication reconciliation. You may see targets around bedsore management, that sort of thing. I don't have the details of what each facility has, and that might even be at the regional level too, where they have those specific patient care targets and safety targets. So because you don't see it in the large report, the provincial performance targets, doesn't mean that it's actually not a measure at the regional level because it's more relevant to them at the front line.

Mr. Nilson: — Okay, I understand what you're saying, but then there isn't an overall system analysis of some of these particular things in the way I guess that I had anticipated, years ago, we would go to that area.

Maybe I can ask another question. How many critical incident reports were there in the year 2012?

[20:15]

Mr. Florizone: — While we're looking for that information on critical incidents, I just want to be clear that there are system . . . there is a system sense of this. While we don't detract from units, facilities, regions from picking their own measures and working their own issues at a local level, so for instance, we may not be rolling up the temperature of food throughout the facilities and care homes. It's a very important quality indicator at the local level. I use that only as an example.

So some of the examples on safety that we actually have a

systemic overview of are rates of surgical site infections. We look at adverse drug events. We look at the number of lost time WCB claims. We look at the percentage of the use of a surgical safety checklist, so we're monitoring that in every OR [operating room]; the percentage and number of patients who receive all components of the Safer Healthcare Now bundle, which we can get into detail on; the percentage compliance with medication reconciliation at admission, something really important because medication errors, as you're aware, are the number one issue, followed very closely by infections. Percentage compliance with med reconciliation at admission to long-term care is another area we look at.

We could look through to surgical site infections. We have global trigger tools. We have audits that are completed, and we're monitoring those audits. We're looking . . . I mentioned falls. We have a safety framework that we've adopted system wide that we're using to monitor compliance with and improvements on. And that's staff safety. Those are a few of the examples where we have set out very much a system-wide emphasis. Now I'll just pause there.

Hon. Mr. Duncan: — Thank you, Mr. Chair. Mr. Nilson, specifically to your question about critical incidences. And I would just point out that at these quarterly wall walks, the practice has been, certainly the ones that I've attended, is the deputy minister begins each wall walk with a report on critical incidences. And as I'm sure you would probably agree, certainly it's my experience that it's probably the most humbling, sobering experience as a Health minister. Last year we recorded 161 critical incidences. That's in the fiscal year 2012-13.

Mr. Nilson: — Thank you. And I assume that number is somewhere in the annual report that comes out so you could look back over the years and see how it compares. I just know the number isn't that much different than what it was ten years ago — I guess if I could put it that way — or whatever . . . nine years ago when we started doing this. And you know, there could be lots of discussion about that, but I won't get there.

I have another question which I think is related but you might not see it at first. What is the number of people who have health cards right now, as of today or as of March 31, or probably the most recent date that you have, that number?

Hon. Mr. Duncan: — Thank you, Mr. Chair. And, Mr. Nilson, I'll just maybe, on the critical incidence number, perhaps just for comparison's sake — and you're right; it probably has not changed all that much over the last decade or so — I can give you numbers going back over the previous at least seven fiscal years. So 161 was the most recent number which I gave you, '12-13. So the year prior to that, '11-12, would have been 127, 146, 115, 143, 127, and for fiscal year 2006-2007, 171.

In terms of health cards, as of March 2013, 1,111,423.

Mr. Nilson: — Okay, thanks. And is that number recorded somewhere each year, so you'd actually go and look at it so you could go back over the years? It's just it sticks in my mind that the number, you know, about in 2004 or '05 was around 1,089,000, and so this seems to be in the ballpark.

Mr. Hendricks: — So I don't have those figures with me going back that far, but the numbers, or the registered population, the numbers are available online dating back for quite a long time.

Mr. Nilson: — Where would I go?

Mr. Hendricks: — Onto our website, to Saskatchewan Health website.

Mr. Nilson: — If I can't find them, I will maybe give you a call.

Mr. Hendricks: — Okay.

Mr. Nilson: — But no, I appreciate that because it's not a number that you see very often, but I know it's there as part of the system.

Now one of the issues that's arising in a number of cases is the Privacy Commissioner is concerned about the use of the health card numbers as effectively provincial ID [identification]. And can you explain what the Ministry of Health's policy is on this?

Mr. Hendricks: — So there are a variety of . . . The primary use, of course, of a health card is to secure insured health services within the province of Saskatchewan. But it is used and there are permissions within legislation, regulation for it to be used for other government purposes. For example, Social Services may use it to nominate clients for special care or for additional benefits. As well it is used for some other purposes, to validate residency for hunting permits, that sort of thing. So in total I believe the number is around 60 legitimate government uses for the card.

Now the card itself is not to be used or not to be requested by businesses as a form of ID. So it has no real purpose. If a business requests a card as a form of ID, it's pretty much useless to them because they cannot secure any additional information from health registration or anyone. The number in and of itself is a number and it would have to, in order to abuse it, you would actually have to have a . . . You actually physically need to present a card to a health care provider to make that a useful number.

Mr. Nilson: — Thank you. Is it possible to provide a list of the 60 legitimate uses?

Mr. Hendricks: — Yes, we can provide that to you.

Mr. Nilson: — Okay, thank you. And provide it to the committee. That would be great.

Now one of the issues that's arisen over the last, you know, few years is the issue around medical records and the quite, I guess, infamous situation in south Regina with medical records in the garbage bin that had both the Privacy Commissioner and others trying to retrieve them.

One of the specific issues that arose from that was the fact that there isn't really a repository for medical records of retired physicians or physicians who move out of the province. And at that time there appeared to be some discussion that there would be a solution coming from the Ministry of Health. And one of

the obvious rationales for that is that those medical records were all paid for pretty well by the citizens of Saskatchewan through the Ministry of Health and that there is therefore then a responsibility on the ministry, together with the doctors and the Saskatchewan Medical Association and the College of Physicians and Surgeons. Can you provide an update on what has happened with this and whether we are now close to having such a safe repository for all of these records?

[20:30]

Mr. Hendricks: — So the Ministry of Health takes the issue of protection of personal records, personal health records, very seriously. And as you're aware, a couple of years ago we had a situation of a few unfortunate breaches of that trust that they place in the public system, in the providers of the system.

In the wake of that, a working group was set up, tasked by the Ministry of Health, which includes the Ministry of Justice, the College of Physicians and Surgeons, the College of Pharmacists, and the Saskatchewan Medical Association as well as the Saskatchewan Registered Nurses' Association and a patient representative. The purpose of this group is to develop recommendations and provide advice on the mechanisms for enforcement of trustee responsibilities to protect records as required under HIPA.

They're working on three different things: changes to *The Health Information Protection Act,* which would enable greater likelihood of prosecution; to conduct an analysis on the definition of a trustee under HIPA to provide a fulsome perspective on the impact of trustee definitions in the Act on responsibility for patient records; and the options for a sustainable solution for abandoned patient records — or the repository, which you mentioned.

Just the other day I had the opportunity to talk to one of the members of this committee as they were exiting, and they're still working on this diligently. The debate is about whether to have a repository in each region, a central repository provincially, or how exactly to structure that. As you know, in the case of physicians and other private practitioners, they are actually paid. There is compensation attached to the payment schedule for retention of records for seven years and destruction of those records at the end.

At the end, you know, at the end of the day, it's very difficult if a provider chooses to not follow protocols. Even if we were to have a repository, if they didn't actually use that repository, that would be unfortunate. But the idea is that the committee's trying to make it easier so that they would have an easy number to call so that a physician or other provider would have a place where they could actually store the records because it is the patient's record. Not only is it an issue of, you know, the record becoming public but loss of a record that the patient may need down the road. So there are a variety of issues, and they are progressing towards a solution, but unfortunately at this time haven't nailed one down yet.

Mr. Nilson: — Okay. Two questions from that: how long have they been meeting, and the second one is how much does a doctor get paid for this job of keeping track of the records for seven years before they are destroyed?

Mr. Hendricks: — I couldn't nail down, I couldn't say the exact percentage that is included within what we would describe as their overhead component. So on average a physician's overhead, a fee-for-service physician, is 40 per cent of their income, maybe more, maybe less depending on their specialty and where they practise.

But included in that are a certain set of expectations that they keep and maintain a record of the patients. There are audits to make sure that they do actually, by the college, to make sure that they do have those records and that they responsibly destroy those records or find safekeeping for them after seven years. So it's understood.

I can't say whether that's 2 or 3 per cent of their total compensation. And you know, the committee's . . . And the idea of a provincial repository was really struck after the incidence of a couple years ago where records were found in a bin in south Regina, and it's taken a couple of years. Admittedly this is one that the Ministry of Health needs to get on top of and get this done.

Mr. Nilson: — Okay. Well you've made my comment which is, this is one where I think the public expects that there's something in place that would make sure that there isn't a particular problem. And it may be that because this expectation around these records may not be very specific — if I can put it that way — and I know from looking at the fee schedule, it's probably somewhere in one of the early pages of a 1,000-page document, that they don't see each one of those fees as including this particular item. And so I guess my suggestion would be that it might be prudent to be a little more direct on the payment, and then maybe take some money or add some money and set up a system on that.

Mr. Hendricks: — Just a couple more comments on that. I think the Medical Association acknowledges that they have a responsibility here, and so we will work with them so that they fulfill that obligation. The other thing too is that we now have 60 per cent of our physicians in the province with an electronic medical record. While that totally isn't in the place where it totally replaces paper yet, more and more, as we move towards the electronic systems, it certainly does help the issue of records retention. But we do have this backlog of records that are going to be around for a while, so we need to make sure that those are dealt with properly.

Mr. Nilson: — Yes, well thank you. That was going to be my next question was what happens with the electronic medical records because they're much more compact, if I can put it that way, but they're also probably subject to more chance of access in some ways. And so I know that there's been some very direct funding for information technology assistance to all of the medical practitioners. So does that funding that's gone to them each year include some conditions as it relates to this protection or development of a repository for both paper and for electronic records?

Mr. Hendricks: — The requirements of the practitioner with an electronic medical record do not change. It is a record. He or she is a trustee of that record, no different than they would be a paper record. One of the advantages with the electronic medical record is that we have three vendors that we're currently using

in the province. They provide backup security protocols. So it's standardized. It's not something that's being done individually in each shop.

One nice thing about an electronic medical record — and we also have portals where they're accessing provincial systems as well for lab, radiology, pharmacy results, and primary care — one advantage is that you can audit when a record has been accessed, and you can't do that with a paper file. So in some ways it does improve security, but many of the same issues and same challenges, albeit different in the sense that, as you said, they're very portable. We need to make sure that those records are as good or better than paper records.

Mr. Nilson: — Okay. Well I will look forward to a positive report on that whole issue of the old medical records soon because I think it's a very important issue.

I'm going to ask a couple of very specific short questions now. One relates to the event that the minister and I attended last week about the Saskatchewan Health Research Foundation. And I was looking at the numbers for the Health Research Foundation. This year in the estimates, and it looks like it's the same as last year, and I was curious to see well what was it like five years ago or six years ago. And my records show that it was 5.150 million which is greater than 4.871 million which it's been for the last two years.

I think the minister heard the same comments that I did, was that there are probably triple the number of applications of very capable Saskatchewan researchers who are in a position to work and develop even more positive things in Saskatchewan. And so can you give some idea of the plans around the possible request and need for more money, even in this year, as it relates to the health research money?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson. The Saskatchewan Health Research Foundation budget is allocated in the '13-14 budget at $5.584 million. That is, as I think you have indicated or recognized, that is the same funding level as it was last year and is up a very small amount from the '11-12 budget allocation of $5.42 million.

Certainly we appreciate the good work of SHRF [Saskatchewan Health Research Foundation] in funding, granting research dollars to researchers within the province. I think it's . . . I've had discussions with SHRF, with members of the board, with the board itself. Certainly they would say that there's a desire to see additional money so that they can fund more research in the province. And I think that obviously goes with the budget discussions and deliberations that take place each year. And I know that SHRF is looking to be able to leverage additional dollars from outside of the province and . . . but at this time the budget remains essentially static from where it was last year.

Mr. Nilson: — Thank you. I see I read the wrong line. What I was reading to you was the line for the Health Quality Council. The actual 2007-08 number for SHRF was 6.113 million, so it still hasn't gotten back to that number. But I encourage you to take a look at this and see whether there isn't some opportunity for some supplemental money this year, just given the dramatic increase in the number of applications that they appear to have received.

I now have some I think fairly straightforward questions just about STARS [Shock Trauma Air Rescue Society] and how STARS is funded in the department. Can you explain how the STARS funding is allocated? And it's my understanding that it all comes actually from the Health ministry, but perhaps you could explain how much is being spent in that particular endeavour.

[20:45]

Ms. Jordan: — Thank you for the question. I'm Deb Jordan. I'm the executive director of acute and emergency services with the Ministry of Health. So the funding that is being allocated for STARS for the '13-14 fiscal year is $10.5 million and that's the same amount as was allocated in '12-13.

Mr. Nilson: — Okay. Thank you. And is that just the operating amount from the Ministry of Health?

Ms. Jordan: — That's a portion of the operating cost. STARS has a foundation that raises a significant portion of covering the capital and operating costs for service, and that's the service model in which it started 28 years ago in Alberta and that's the arrangement that the province has entered into. So for example for the '13-14 fiscal year, in the summer of 2012 the ministry would receive a budget from STARS for both operating as well as for retirement of capital toward the cost of any equipment, etc. That would then be reviewed and would be considered as part of the budget review for the '13-14 fiscal year.

Mr. Nilson: — So does this 10.5 million include the money at the Regina Qu'Appelle Health Region for the helipad at the Regina General Hospital?

Ms. Jordan: — No. That would be strictly for the STARS service itself and the helicopter air medical service. The helipad at the Regina General Hospital is estimated to cost $3.4 million, and that will be funded in its entirety by the Ministry of Health. So there was some funding that was provided to the health region in '12-13, and then the current fiscal year's budget includes 1.3 million to complete that project.

Mr. Nilson: — So this year's budget would have 10.5 million for operating and 1.3 million for the completion of the capital project, if I can put it that way.

Ms. Jordan: — That's correct.

Mr. Nilson: — Okay. And in addition to that, there is $400,000 from each of five Crown corporations that we would add on top of this as coming from the budget of the government?

Ms. Jordan: — So STARS would have, through its foundation, it would have multi-year contributions from a number of major corporate donors. Certainly Crown Investments Corporation is among that number, but it also has multi-year commitments from for example Crescent Point Energy, Mosaic. Potash Corporation of Saskatchewan of course is a significant contributor having . . . It's underwriting the estimated $27 million cost for the hangar in Saskatoon as well as the acquisition of a larger, longer range helicopter.

Mr. Nilson: — And so the large donations from I think it's the

Potash Corporation approaching $30 million would be in addition to the, it looks like 13.8 million that comes from the provincial government through various agencies.

Ms. Jordan: — Yes. Some of the major donors such as Potash Corporation would identify a specific use for their donation. Others make a contribution and then it is then left, you know, to STARS and in discussion with the ministry about a component that would go toward capital equipment or what is used to offset some of the operating cost.

Mr. Nilson: — Okay. And when this 13.8 million — obviously the 1.3 won't be an expenditure next year — but is it anticipated that there will be a similar 10.5 million from the Ministry of Health and 2 million from CIC [Crown Investments Corporation of Saskatchewan], SaskPower, SaskTel, SaskEnergy, and SGI [Saskatchewan Government Insurance], so that it'd be 12.5 coming on an ongoing basis?

Ms. Jordan: — I can only speak to the funding process through the Ministry of Health. But certainly the 10.5 million would probably be approximately 50 per cent of the annual operating cost.

And so the service agreement with STARS requires the submission of the annual budget request. It provides quarterly financial statements as well to the Ministry of Health. But the model and the discussion that occurred at the time the service was coming to the province is that the foundation would raise a significant portion toward the ongoing operating as well as capital cost.

Mr. Nilson: — Okay. Thank you for that. If I or somebody that I knew happened to be a patient that required an ambulance service, would I end up having a bill from STARS for the flight?

Ms. Jordan: — Not from STARS, but you would receive one from the Ministry of Health, just as a patient would if they were transported by Saskatchewan air ambulance. And the amount is the same. It's $350 per trip for the air medical, whether it's Saskatchewan air ambulance or STARS helicopter, as well as the ground ambulance transport to or from the sending or receiving airport.

Mr. Nilson: — Okay. And that's the same amount that would be a senior's charge as well? Or is there any kind of subsidy for seniors on ambulance fees?

Ms. Jordan: — There is for seniors on ground ambulance through the senior citizens' ambulance assistance program; however the air medical portion of 350 is a flat charge that is charged to any patient directly. The only exception to that would be if there are third party insurers involved, and then there's a 5.29 per flown mile charge that has been long-standing for air medical service.

Mr. Nilson: — So that practically then, if there was insurance or if it was an industrial situation where they had insurance for their workers, then they would pay the $5.29 whether it's an airplane or a helicopter. And that money is then paid into your acute and emergency services budget and is used and applied on these kinds of expenses?

Ms. Jordan: — The funds go to the General Revenue Fund and through the Ministry of Finance.

Mr. Nilson: — So how many dollars did the General Revenue Fund receive last year for ambulance usage?

Ms. Jordan: — For air ambulance service in a typical year would be about 1.1, $1.2 million.

Mr. Nilson: — Okay. And so 1.2 million, and looks like about 12.5 million is going out from government on this part. So okay then . . .

Ms. Jordan: — Sorry. If I might clarify, that's for air medical services in its entirety, so air ambulance, fixed-wing service . . . yes.

Mr. Nilson: — So what's the budget for the fixed-wing part of the ambulance service?

Ms. Jordan: — For fixed-wing service this year the budget will be approximately $10 million.

Mr. Nilson: — And now we know we just had the one-year anniversary, and I think they announced the number of completed missions. Perhaps you could refresh my memory on that number.

Ms. Jordan: — Okay. So the Regina base started operation April 30th of 2012. And in the initial few months, it's a 12 hour per day, seven day per week. And then once the crews have enough experience with the terrain, then it moves to 24-7 operation. So I say that only to indicate that the number I'll provide is for a phased start to operation.

The Saskatoon base began service October 15th of 2012, and it moved to a 24-7 operation in February of 2013. So from April 30th of 2012 until early April, STARS completed or rendered care on over 250 missions to Saskatchewan patients.

Mr. Nilson: — Okay. And how many days during that 365-day year was the weather such that the STARS helicopters could not fly?

Ms. Jordan: — I don't have that information here with me this evening, but we can certainly endeavour to obtain that from STARS.

Mr. Nilson: — Yes. No, I appreciate that because I just know from visiting STARS headquarters in Calgary a few years ago that that was a statistic they always looked at fairly carefully because it was an important factor in the overall operation of the STARS program.

Hon. Mr. Duncan: — Mr. Chair, we'll endeavour to get that answer, Mr. Nilson, to you. I don't know if it . . . We'll endeavour to get that answer. I know that it has happened. In fact, I know even in my own constituency there was an incident, an accident that they couldn't respond to because of weather, but we'll get an exact number for you.

Mr. Nilson: — Yes. And I think in actual fact, in Saskatchewan it's easier for them to operate than it is on the edge of the

mountains, which was the big issue when I was in Calgary talking with the director about all this. But, so okay. Well I appreciate that information because it's helpful to understand how it fits together in the total scheme of care, and it's obviously something we're going to have to watch fairly careful. I think what was, I think my notes here have somewhere about this. Oh yes. The second one you' re measuring was cost, right; quality, cost, delivery, safety, when you're looking at the whole system. So anyway, I appreciate that. So thank you for that information.

Now I think a fairly simple question. But I understand that the chronic pain centre in Saskatoon is going to be phased out. Could you explain what's happened there?

Hon. Mr. Duncan: — Yes. It's my understanding that SGI, who was a co-funder with the Saskatoon Health Region, has decided, at the expiration of the most recent agreement, that they would not be participating in renewing that agreement. I think that from the information that I've looked at on that, that SGI, in terms of the number of people that were accessing that service as well as the number of people that were waiting on it, the SGI referrals were quite low. And so they made a determination that they weren't going to renew their agreement with the Saskatoon Health Region. So they are looking at reintegrating those patients that currently access the pain clinic into existing operations of the region.

Mr. Nilson: — Okay, thank you. How does that program mesh together with the spinal care program, which I think relates to back pain and the management of various solutions from exercise to surgery dealing with back pain? And then I guess perhaps a comment about where the chiropractors fit into this whole . . . Well basically you've got the pain and you've got the management of these issues.

Ms. Jordan: — The chronic pain clinic in Saskatoon predated the work that was undertaken around the Spine Pathway. But as part of the ongoing work that we're doing with the clinics in Regina and Saskatoon who do the assessment and support the Spine Pathway, there are a category of patient. So the assessment that is done by the primary care providers looks at patterns of pain, and the pattern 5 patients are those patients with chronic pain. So some of the work that we're doing with our colleagues who are part of the Spine Pathway — physician leaders and others in the health regions — is what we can be doing to, through the Spine Pathway, to support those pattern 5 or the patients with chronic lower back pain.

[21:00]

Mr. Nilson: — So does that mean then as the Spine Pathway is developed, there may be something that will replace that chronic pain clinic that's part of the Pathway?

Ms. Jordan: — We're certainly looking at that and wanting to ensure that it is more widely available. So one of the key aspects of the implementation of the spine care pathway was the educational component and the ability of primary care providers, physicians, nurse practitioners, chiropractors, physiotherapists who took the training to be able to identify those patterns of pain. And then as part of our work we want to, if we can, see what we can make available more widely, not just through the two clinics in Regina and Saskatoon, but how we can support the primary care providers in supporting those patients with chronic pain.

Mr. Nilson: — Okay, thank you. That helps. And as I understand, obviously it's in development and discussion. And from what you said then, the physiotherapists I assume who are in the private practices and then the chiropractors who are in their private practices that don't get the direct fees out of the system, are included in this plan as well. So does that mean there's a budget for these practitioners who aren't part of the regular payment system?

Ms. Jordan: — So the assessments would be done by the primary care providers in conjunction with . . . they would, you know, identify the pattern of pain and make a referral if necessary to the spine assessment clinics, but the model is to try and make sure that we're supporting patients as close to home as possible. So that work would be, you know, patients, if they're not moving on to a surgical consult, they would be then returning back and working with their primary care providers on more conservative management of their lower back pain.

Mr. Nilson: — And I guess my question is, does that include the chiropractors?

Ms. Jordan: — The chiropractors have certainly been part of the training of assessment. And then if a patient is going to be managed more conservatively and is not going on to a surgical consult, then that patient and their primary care provider, including chiropractors, would receive some of the assessment information from the spine clinic to help the primary care provider support their patient back in their local community.

Mr. Nilson: — And is there money in that whole system that then pays these individual providers, if they're not paid for out of the medical fund?

Ms. Jordan: — Once they return to their primary care provider it would be on the basis of whatever payment mechanism is in place or whatever arrangements. The assessment costs of the spine clinic itself are covered and funded, but the return to conservative management would be based on whatever arrangements are and coverage are normally provided for that care provider.

Mr. Nilson: — Okay, so if cost is a concern then, basically they stay with their primary care physician or nurse practitioner and not go to the chiropractors? The answer to that was yes.

Now I know Mr. Forbes has come back and wants to ask a few questions.

The Chair: — Thank you. Mr. Forbes you have . . .

Mr. Forbes: — Thank you very much. And my questions really centre around mental health, and probably the most tragic part of that is around suicide and suicide prevention. And I'm curious what kind of initiatives does the ministry have in that regard?

Hon. Mr. Duncan: — Thank you, Mr. Chair. Thank you, Mr. Forbes, for the question. There's been a number of initiatives to

provide greater ability for health regions to deliver these services. I can mention a few and then perhaps if the deputy can follow up. So for example, now with the Health Line — and it's now, I should mention, 811 for people that are watching that may need the services; it's now more accessible at 811 — so there is now a dedicated mental health professional that is staffing the Health Line 24-7. So that there is that specific mental health focus through 811.

As well I believe that the regional health authorities have looked at a number of ways to tackle this issue. One is to provide for training for their staff in suicide prevention and intervention. There's regional suicide prevention and intervention plans that are in place, social marketing campaigns that are aimed at youth.

As well it was through a contract with, I believe it was Sun Country Health Region that has been tasked with developing a provincial protocol for assessment and management of people that are at risk of suicide. And that is being rolled out to all the other health regions. I stand to be corrected if it wasn't Sun Country, but I seem to remember that Sun Country was the region that was the lead on this project. And so their work will now be moved out to the other health regions.

As well we're working with external partners to deliver programs that are aimed at youth providing, for example, the Métis Nation of Saskatchewan with dollars for a Métis youth suicide prevention strategy that is being rolled out to 12 different Métis communities across Saskatchewan, as well as funding to the Schizophrenia Society of Saskatchewan to pilot a project in Regina and Saskatoon, doing presentations on youth depression to raise awareness and to reduce stigma of mental health.

Mr. Forbes: — One of the reasons I raise this is particularly around cyberbullying, which your government is taking a lead and real interest in that and that's very good to hear. And just a couple of weeks ago we marked Pink Shirt Day and Pink Revolution. And I was at a presentation. It was just so sad to hear a mother talk about the loss of her daughter and how she didn't take that seriously because the way the daughter was presenting herself. And then the incident happened and she found her daughter. So you know, we always think about how we can reel these things back in.

So in terms of that specific area of bullying, and I'm glad to hear your focus on young people, how can we or what will you be doing as a ministry to do more in this area? Because I think it's so critical to help people or provide the opportunity to help as well.

Hon. Mr. Duncan: — Thank you, Mr. Forbes, for the question and for your comments. Certainly this is a serious issue and one that the Ministry of Health, working with our partner health regions, are taking an active role in.

I mentioned the social marketing campaign that's directed towards youth, that I'll speak a little bit more about that. So this is a campaign that is designed to raise awareness of young people of the signs of depression and suicidal risk and to be able to provide access points to where they may avail themselves of some help. So for further information on that campaign, so it does include Ministry of Health has produced 40,000 booklets on the topic of youth depression and suicide that can be made available to young people.

As well I mentioned, I think, doing a better job of ensuring that residents, regardless of their age, just raising awareness of the enhanced services that are available through Health Line through the 811 number, so that they know that if they need to, they can pick up the phone and there will be somebody that has a background and some expertise in the mental health field that can provide some assistance over the phone and direct them to further support services.

And we are distributing these different items such as the booklet through the regional health authorities through their mental health and addiction services. It is a priority of the ministry. Certainly it is a priority in my time as Minister of Health. And we know that there is more work that needs to be done, but certainly we're putting I think a renewed focus on mental health services, addiction services with a particular focus on young people.

Mr. Forbes: — Would you be able to mail some of those booklets to all the MLA [Member of the Legislative Assembly] offices?

Hon. Mr. Duncan: — Absolutely. That's a great idea, Mr. Forbes. Certainly I know from my own constituency office, from time to time we get information that we have a display stand that we can put information in for people to come in. And we'll certainly make sure that it's available as well to MLA offices. That's a great suggestion. Thank you.

Mr. Forbes: — I appreciate it. Do you have some statistics on how widespread this is in Saskatchewan and some of the trends that might be happening?

Hon. Mr. Duncan: — Mr. Forbes, if you could just perhaps clarify, are you looking specifically to suicide or just mental health issues in general?

Mr. Forbes: — Suicide.

Hon. Mr. Duncan: — And particularly to young people or to just all age groups?

Mr. Forbes: — Well suicide as a general and then young people and northern. I know my colleagues have been very strong about issues around the North, but I think that I'd be interested because it's a topic that we don't know a lot about. And I guess the follow-up to that is, has there been research done by the ministry or commissioned by the ministry to help understand those numbers?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Forbes. So just in general, we can provide statistics, we can provide numbers when it comes to the rate of suicide within the province. It's an overall number so it's not broken down by age group or by adults versus youth. So in Saskatchewan it is 12 per 100,000 population. And I think as you're probably aware, it's considerably higher than that in northern Saskatchewan and is considerably higher in Aboriginal youth compared to the at-large population within Saskatchewan.

Mr. Forbes: — Okay. So would we know how many deaths by suicide last year in Saskatchewan, the actual number or the year before?

Hon. Mr. Duncan: — We'll endeavour to provide that number to you. I should just clarify that number that I have cited is the average over the last five years, so it's not specific to, say, the 2012 calendar or the 2012-13 budget year. That would be a five-year average based on 2005 to 2009.

[21:15]

Mr. Forbes: — So do you have . . . I asked for . . .

Hon. Mr. Duncan: — Yes, sorry. So just further to that, but I believe that this is still not . . . I don't believe that the number that I'm using is for one individual year. It would be an average of those five years. So in Saskatchewan, based on the population average over those years of just over 1 million people, it was 121 suicides. But that's still, again that's not specific to any one year. That would just be over that five-year period.

Mr. Forbes: — So have you, has the ministry done any type of research or commissioned research into situations that are unique to our province?

Hon. Mr. Duncan: — I don't know if it's so much research that's been done that would indicate any factors that would be unique to Saskatchewan, but I think what we have done and what we are doing is recognizing that this is really is an issue that is just . . . It's greater than just the Ministry of Health. And so we're putting I think more of a focus on working across the other human services sector. So I'm working more closely, my deputy is working more closely, as well as at a ministerial level with the ministries of Social Services, Education, Corrections, Justice, Education as well. And so I think that you'll see more and more of that intersectoral, inter-ministerial approach when it comes to not just issues of suicide, but more generally of issues of mental health and addictions.

Mr. Forbes: — Speaking to interdepartmental or ministerial initiatives, one that when we talk to groups that talk about the impact of housing, and we know that there is Sask Housing, and Social Services clearly is the lead on that. But when it comes to folks who talk about one of the primary issues or challenges facing people who have mental health issues, is appropriate housing. And they talk about Housing First as an initiative. And I know that they're doing some work in Saskatoon about that. I don't know if in the Regina housing plan that was adopted, I think it was last night, actually, if that's the case. Have you been following or working with some of the community groups around Housing First?

Mr. Florizone: — Thank you very much for the question. I think your question is very timely, given some of the recent discussions that we've been having at a multiministry level with our regional health authorities and also at a pan-Canadian level among ministers of Health and deputies. It was sparked by research that was done through ICES [Institute for Clinical Evaluative Sciences] in Ontario, where when they started breaking down the population and its utilization, its complexity and utilization of health resources, there was a determination that 1 per cent of the population utilized about 34 per cent of health care resources.

Now what's really interesting about that is a similar study that was done in Manitoba showed a number that was very, very close to it, and it's now been emulated in the States. There's a growing realization that there's a very small percentage of the population with very complex needs.

Now I'm not suggesting at this stage that we know all of that, but we do know enough. And if we were to take a look at the canary in the coal mine with respect to the health system, if we were going into the emergency departments say in Saskatoon or Regina, we would see a reflection of that complexity. Not everyone, but there would be a nature of repeat visits, people coming through.

I also witnessed it when I was up in Prince Albert visiting their Hub and COR [centre of responsibility] concept, where a multitude of ministries and teachers, social services, police, and others are around a table dealing with very complex situations. And what this has been referred to — I hadn't known the term until a couple of months ago — but hot-spotting is the term that they're using. I think they probably took it from fire, or police more recently, where you can use the information to determine that there's certain core areas. It could even be right through to a particular neighbourhood or a housing unit where there are very intense needs, where we could go to them, provide the supports that are necessary.

So we've done a bit of work in looking at mental health and addictions. Obviously it's been a very passionate area for my ministers. When we started looking at the care journey, we found that for those with the most complex of care needs, they were getting probably good acute care, but it wasn't what they needed. And what we've found is a real gap was in the area of supportive housing. So supportive housing for the people with complex issues, whether it's a multitude of chronic disease issues or a combination with mental health and addictions, is very much an area that we would like to create far more by way of a multiministry approach.

We believe that what we're doing, siloed as a health sector, has a potential of building bigger emergency rooms when what we really need is much more appropriate support for those that are most fragile in society.

So there's more to be said on this. There is a real interest in a spread of the good work that's being done in Prince Albert, as an example. There is a lot of interest by my ministers in looking at those ERs [emergency room] and seeing if we can do a much deeper dive into the complexity that's emerging there and whether or not we could ask the question of everyone who comes through: what crisis brought you here today, and how could we better serve you in terms of either connecting you to what is needed, but preventing you from necessarily having to come back in crisis tomorrow or next week?

Mr. Forbes: — And Prince Albert's an interesting example because of the four deaths that happened this past winter. The irony is that they have a vacancy rate of 6 per cent, where you see in Estevan a vacancy rate of point six per cent. So there are challenges, and it's very complex, as you say. And how do we

make sure everyone's safe in a good place every night? And you're seeing shelters really being mental health shelters and the complex needs. So I appreciate hearing that because I know many community groups are really anxious to move on that. And if we can reduce the complexity of that and really move forward, that would be great.

And I appreciate your comments about how ministries of Health tend to build bigger emergency rooms. And actually it'd be better to get them way before that. So we'll be watching for that. And I know Saskatoon is moving forward, and if Health can be there strong and support that, that would be great, and right across this province because I think it's an important issue. So with that I think I'll turn this back. Thank you very much for your answers.

The Chair: — The Chair recognizes Mr. Nilson.

Mr. Nilson: — Thank you very much. The hot-spotting point, I know I listened to a doctor from New Jersey that really brought this together by, like you say, identifying apartment buildings where they had most of their business in the emergency wards in the hospital, and very, very interesting to follow that.

I note in your plan you have a goal of producing a comprehensive provincial health status report. Could you provide a update on where that's at and how soon we're going to see it? And also let me know if it's built on what Saskatoon has produced over the last few years as it relates to Saskatoon Health Region.

Ms. Magnusson: — Donna Magnusson, executive director for population health services branch. You had two pieces to your question. We are currently working on the health status report and its draft. It hasn't been through all of the channels yet. We hope to have the first three, four chapters up and published and on our website within about the next six months.

With respect to the health disparities report — I think those are the ones that you're referring that Saskatoon has done — they've been a bit more localized and have focused very specifically on, I would say, the underserved areas within Saskatoon.

And there is some similarities to the reports, but the provincial report will be much more, well it'll be more provincial. It'll have a much higher level to the report and the health disparities report in Saskatoon.

Mr. Nilson: — So once the first of these reports is done, will it be renewed on an annual basis? And will it eventually also include health disparities chapters so that we can see, like they have say in Scotland, how you can target your health care dollars and improve the health of the whole country?

Ms. Magnusson: — Because we use a lot of the national data as well to inform this report, so it does get to a lot of the same pieces of information. For instance it'll look at economic status, education levels, employment stats. They're not always done yearly because we tend to use the national data for that. But we do tend to . . . We do plan to update them on a regular basis and . . . [inaudible] . . . information is posted and available to the public.

Mr. Nilson: — Thank you. So I appreciate that, and we'll follow the progress of that report as it comes out and we'll look forward to seeing the first one.

Now as it relates to mental health and following on Mr. Forbes's questions, I know that one of the concerns about Saskatchewan now in light of the work done by the Mental Health Commission of Canada is that along with Prince Edward Island we're the only two provinces that don't have a mental health strategy. And I'm assuming that that's a bit of a red flag in that you actually are working on it and that we're going to get a mental health strategy. So can you perhaps give us a report on that as well?

[21:30]

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson. I think what I can say, Mr. Nilson, to your question is that there's a number of things, as I've mentioned before, that we are working on in terms of improving mental health and addictions services in the province.

I think I can inform members of the committee that certainly this is an opportunity that we're taking to, for instance, look at *The Mental Health Act* and see whether or not we need to update that Act. I think as well, looking at the Mental Health Commission of Canada's report and seeing where we may be able to improve our services based on the work that the national commission has done and where there may be appropriate changes that we can make in Saskatchewan.

As well I think at a regional level, as the regions deliver the services, we are seeing some improvements in terms of access for mental health and addictions services, some specific work by regions in implementing lean into some of their processes to, for instance, shorten admission times for inpatient in various regions. Overall though, I would just say that certainly my commitment and my interests are in areas of mental health and addictions, and it's one of my personal priorities that I've taken on in this role.

As well I would just, if I could, add to that which I . . . just to reiterate a comment that I made before, one thing that . . . another thing that we are doing is, I think, working more collaboratively with other ministries, not taking so much just a health-focused approach to improving the services for people that may require mental health and addiction services, knowing that it crosses across other ministries. And so I think we've put a renewed focus on working more collaboratively with other colleagues.

Mr. Nilson: — When will we see a mental health strategy for the province of Saskatchewan?

Hon. Mr. Duncan: — Well again I think that . . . I think what we are seeing is not . . . I think we're seeing progress being made addressing some of the areas that we know we see gaps in terms of access. And so some of those changes for instance that we're seeing at the regional level that deliver the services, those changes are being done without necessarily going to the step of a mental health strategy, but it's certainly looking at an intersectoral-interministerial approach. It's certainly something that's on our radar.

Mr. Nilson: — So there appears to be a recommendation from the Saskatchewan Mental Health Coalition which basically includes all of the various groups in the province that are involved in this area, and doesn't include the regional health authorities, but clearly it includes most all the partners that the regional health authorities have in the province to get a mental health plan for the province. And so I would strongly encourage you to figure out how you can develop a strategy to respond to that.

But when you look at the things that they point out in their material, some of them are parts of what you're doing. But I think what they are grappling with, in the same way that I think you've been grappling with in your answers, is that we've got all these little pieces all over the place without a simple way for somebody who's suffering from depression getting into the system. And so I know the things that they advocate are things like best practice treatment options, so no matter where you are in the province you're going to get the best treatment. And things like low cost and supportive housing initiatives like Mr. Forbes was mentioning. Also having systems navigators that can help make sure that the right community group along with the health region can provide some help. And then also making sure that there are some funds available for some of this connective part. And there are other suggestions as well that they have. But those I think are sort of a core of what could be grasped and used for us here in Saskatchewan. Because I . . . we know that depression, we know that other mental health issues are some of the biggest cost items in the health care system because of how long it takes to deal with them.

And I'm not sure if you want to make any comment about that, because I think you've said, well we're not doing it right now. But I think that's a bit of a mistake not to be more direct in dealing with these things, both in light of the Mental Health Commission of Canada and what they've done. I'd also recommend the recent report of the Australian mental health commission which has built on things from around the world.

Mr. Florizone: — Thank you very much, Mr. Chair, and Mr. Nilson, for the question. I had this great privilege of being a member of the Mental Health Commission of Canada when it released the strategy for the country, and that privilege was working very closely with not only stakeholder groups, but on the board of the commission itself in coming up with strategies and approaches that could really start to tackle these issues, these very complex issues in new and innovative ways.

The minister has tasked the ministry with some interesting work. I was signalling it earlier in terms of the multi-ministry aspect of looking through to see the problem through the client — the citizen, the resident, the patient — through their perspective. And the more we've looked at it, the more we've recognized that there are multiple touch points that are occurring and yet no single one is kind of feeling coordinated and connected.

So he's asked us to work very closely with other ministries as he has through the child and family agenda, worked with other human services ministries. So here's some of what we've learned. I mentioned the ICES research, 1 per cent of the population using 34 per cent of the health resource. It's interesting when you talk to Corrections and they start using some of their data, and Social Services and Education. We find that those that suffer from mental health and addictions issues are not only using health resources, they're using resources right across those human service sectors, and yet they're still not getting what it is that they need.

And you know, the idea, the notion is it may be housing and supportive housing that you need, and yet what we're giving you is an emergency department or more police on the street or whatever it happens to be. So what we've been tasked with is to start thinking about mental health as not just a health, you know, kind of a health care issue to solve, but rather a manifestation of a lot of problems that we need to be, collectively as a community and from a multi-ministry perspective, tackling.

So just some examples. First of all I'll give you a health sector issue that . . . and this is on the lower end of the spectrum, more on the upstream, preventative side. Mr. Nilson, you mentioned Scotland, and I had this great benefit with John Wright to go to Scotland and to see their primary health care system in action. And the one thing that was really obvious is mental health was so integrated with physical health right up front. You didn't see a separation. So when I asked them — it was in Glasgow — and I asked them a question, I said, what is your threshold for entry into the mental health system? They looked at me and they literally said, what are you talking about? Threshold? We take all comers. So everyone that comes to see them through primary health care, they have the supports and the staffing and the teams and the people that are there to prevent you from progressing through and ending up with higher need. So we catch the depression before it becomes, you know, a far more significant issue, or the anxiety before it becomes a far more significant issue.

Right about that time, we were looking at medications so we . . . Alberta had released a report, and I think you might have even given me this particular summary. It was the top five medications that were being used by family physicians, and two of the top five were mental health-related: depression and anxiety. Then we went through and, you know, going into the statistics, one in five people in Saskatchewan at some time during their life have suffered from mental health or addiction issues. We also have seen now the WHO [World Health Organization] indicating that by 2020 mental health issues are going to overtake physical health issues.

Family physicians right now are seeing, more than any other provider group, more mental health issues than any other provider group that's out there. So if we can get primary health care working well, integrated physical-mental health, that's where our emphasis needs to be.

On the more complex side, it's estimated right now from the literature, and this is from our colleagues in Corrections, they're saying 10 to 20 per cent of persons in the correctional system have a mental health-related issue. And that may be an understatement.

We've heard also more recently, FASD [fetal alcohol spectrum disorder]. And when we start to follow people with very complex needs, FASD included, their touch points throughout this system are . . . It's unbelievable. And what we could've

done to prevent it, that's what we need to really start focusing in on, as well as delivering the right care at the right place at the right time.

So those are just some of the examples, and I didn't want to appear and I certainly don't want it to seem that we're trying to dodge your question. The reason I'm smiling is because it's becoming all too obvious that we need to get our collective act together, but we can't do it as Health alone. This is a shared responsibility. So the real challenge for us is, how do we do this? We don't want to make it unwieldy, but we know the solutions are not just simply sitting in our silo.

[21:45]

Mr. Nilson: — That goes right into my next set of questions because I know years ago the goal was to get up to 61 primary care sites in the province. How many are there now?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson. So the number in the province at this point would be over 80. That would include the eight innovation sites that would've been funded, I believe, for the first time in last year's budget. And certainly I think what we're looking to do, in especially the innovation sites, is try to integrate more of those services within the primary health setting. So we know that, for instance, there's a number of those eight that were just funded in this last year that we'll have, are working towards having mental health practitioners right in the site. We probably could do more on that, but certainly that's where we're at right now.

Mr. Nilson: — The reason I ask that question is that I know one of the main goals of those sites is chronic disease management, which includes obviously the diabetes, all those things, and COPD [chronic obstructive pulmonary disease], but also mental health issues, the depression issues. So I mean, do you have statistics or can you show that that's actually happening in these sites, that the chronic disease management incentives, if I can put it that way, are getting back the information that shows that many of these mental health issues are being managed in the family practitioner, nurse practitioner world?

Ms. Donnelly: — Good evening. Lauren Donnelly, assistant deputy minister for community and primary health services. So with respect to anxiety and depression, I'll maybe go a little further on what the minister flagged with respect to the innovation sites.

Three of the innovation sites are already looking at collocating mental health professionals or looking at a new professional designation: that's Leader, Lloydminster, and Meadow Lake, three of the eight innovation sites, as well as using brief assessment tools. So we're not, not everybody is waiting to get into the specialty system, but can be assessed in the primary health care system.

So we're planning by the end of this fiscal year to have all eight sites using that tool and have lessons out of the innovation sites that we can replicate across other sites in the province. So this is an innovation year, but we're identifying the strategy to replicate across the province as well.

In addition to that, with respect to family practitioner clinics and the initiative, there's six chronic diseases. And you flagged two of them that we've identified that we'll be looking at having evidenced-based tools used routinely as part of chronic disease management. Anxiety and depression has been identified as one of those. We don't yet have that screening tool for the family practice clinics in place, but we do have the incentive system in place and we're launching two other chronic disease tools this year. And there is an incentive to fill out the forms that show that you've followed the best practice guideline.

So our long-term goal is to have 80 per cent of patients in five years . . . practitioners using best practice for 80 per cent of chronic disease patients and then also to reduce admissions to hospital for those six chronic diseases.

Mr. Nilson: — So, can you outline the six chronic diseases? You said I got two or three of them but I don't . . .

Ms. Donnelly: — You did get two of them, and I'll . . .

Mr. Nilson: — Two plus anxiety and depression, so that's three.

Ms. Donnelly: — That's three, plus coronary artery disease plus congestive heart failure. Have I missed one? I'll just take a look. I believe it's asthma.

Mr. Nilson: — So then basically the goal's there. But to actually have the one related to the mental health, anxiety and depression management, that's still a challenge goal, if I can put it that way. It's just on the verge of being developed.

Ms. Donnelly: — We have a clinical subcommittee, you know, looking at the screening tools available. We do look at those that are already developed in terms of guidelines that have been integrated with electronic medical records elsewhere so that we have both paper-based and electronic medical record processes for managing those, but it isn't rolled out yet across the province.

Mr. Nilson: — So where does the mental health home care fit into all of this?

Ms. Donnelly: — With respect to primary health care?

Mr. Nilson: — Yes.

Ms. Donnelly: — Broadly, so one of the goals of the innovation sites and some of the early lessons are actually that collocation of services locally — mental health and addictions and public health and primary health — brings a huge benefit to both patients and providers in terms of ready access to services.

So mental health and addictions, both collocations of some of the community mental health providers more closely is part of the deliberate integration. And in rural sites as you've mentioned, you know, how we integrate home care, some regions are looking at that as well. This year the deliberate process is around mental health and addictions.

Mr. Nilson: — I raise that issue because often, as we know,

with mental health patients, the medication can actually allow them to live quite well in the community, but sometimes it's that inability to take the medication on a regular basis that has them come back into the jail system or into the health system. And so I know that some of the concerns that we've been getting around the mental health home care part, the ones where they send a psych nurse or an LPN [Licensed Practical Nurse] or somebody to go out and make sure the medication is taken every day or every other day, those are some of the services that are being cut back. And I think they could end up having much higher expense in the system if that happens. So I just raise that and I want you to take a look at that.

So another question: I don't know if this is true at all but I know in the state of New Mexico, they're managing a lot of their mental health patients that are in remote and distant areas on Skype or on the Internet. And do we do any of that in Saskatchewan?

Ms. Donnelly: — So I'll answer that on behalf of my colleagues in mental health. We do have a research project under way currently at the U of R [University of Regina] collectively with the southern regions' health forum, an online cognitive behaviour therapy service. So that's in the early stages. And I would probably get someone else to answer the detail questions if you have those.

Mr. Nilson: — No, that's all I wanted to know is if there is some work on that. So I've visited and seen some of these other ones, and I know it's actually quite a positive thing in that people who need just the contact save a lot of travel to seeing their therapist if they can do some of that kind of work online.

Now I think I have a couple of questions that I'm not sure if it fits in your area or wherever, but one of the concerns that has been raised with us is that the ability to get rural blood transfusions for certain situations has changed. And so people are having to travel further to facilities to get blood transfusions. Do you know about that or do you know about policy changes around that?

Ms. Jordan: — Deb Jordan, and I'm the executive director of acute and emergency services. And some of the work that has gone on over the past two to three years, in terms of our utilization of blood product and better blood services management, has occurred through our area working with regional health authorities and with physicians.

So as part of the improvement of blood services and blood utilization and management in the province, the ministry funded positions both in the Regina Qu'Appelle Health Region to support the southern regions and one through the Saskatoon Health Region to support the central and northern regions. The positions are staffed by hematopathologists. So those are specialists who work with transfusion services. So the health regions look to those medical directors for advice on what is safe and reasonable to provide in what settings. The hematopathologists have also worked closely with the health regions. There have been changes to the federal regulations with respect to blood and transfusion services, so these medical directors have worked with regions on the implementation of practices to ensure that there's consistency with the new federal regulations as well.

Mr. Nilson: — So I interpret that to mean that there has been a reduction in the ability to get the kinds of transfusion services people were getting in some of the smaller health centres compared to say a year ago or maybe two years ago.

Ms. Jordan: — We're aware of one particular situation that one of the health regions had involved the medical director in looking at and assessing what was reasonable to provide in that setting. It also involved some discussion with staff in the setting who may not be providing that service on a regular basis and whether they're feeling competent to provide it. Most of the work that has been done centred around what level of blood inventory was being carried in a number of the rural settings and better matching what was maintained on site with what the actual or typical need for product was.

[22:00]

Mr. Nilson: — Okay, thank you. I appreciate the answer. And that's obviously part of that, as you say, overall assessment of how those services are provided in the province. I don't think this is necessarily directly related, but what's the latest ministry policy on the use of chelation?

Ms. Jordan: — That I'll probably defer to one of my colleagues to address that.

Mr. Hendricks: — So there actually is no change in the ministry's policy regarding the insurance of chelation therapy. Still there are issues around medical evidence to support the actual process, so literally nothing new has been done on this file for five, six years.

Mr. Nilson: — Okay, thank you. I still have people that assume I have some power to deal with these issues come and see me, so I thought I would just ask what the latest perspective is.

Then I have a question about the refugee health care issue. The question is whether we as a province have taken a direct stance and effectively said that we're going to provide care for refugees like some of the other provinces have. And perhaps you could let us know what's developed in that area.

Hon. Mr. Duncan: — Thank you for the question, Mr. Nilson. This is an issue that has been raised by the provincial Health ministers in our dealings with the federal Health minister, although knowing that's it not a necessarily the Health minister of Canada that is responsible for this decision, but it's an Immigration decision. So we've raised our concerns with the federal Health minister. As well I have written to the federal Immigration minister, asking the Immigration minister to review and reconsider the policy changes that took place a year ago by the federal government.

I indicated our provincial position. It's our strong desire to see the federal government change their policy and once again cover these benefits. With an indication from the federal minister that they are not going to be changing their decision on this, we have taken the position I think that other provinces — some other provinces — have taken to this point that we will be providing urgent and emergency medical care for these individuals, the same as if they were a citizen of Saskatchewan with little or no means to support themselves.

Mr. Nilson: — Okay. Thank you. So that's basically what Quebec and Manitoba have done. We're in the same ballpark as them, which I think is the right place to be. So I thank you for your answer on that. There aren't very many people in that spot, but when they are there, they sure need the help. So I appreciate that.

My next area of questions relates to the whole, very difficult issue around the Health Canada notice to hospitals from the health products and food branch on the use of surgical mesh for the stress urinary incontinence and pelvic organ prolapse issue. And I have in front of me the February 4th, 2010 notice that went to all of the hospitals and the medical staff in the country about the use of this mesh.

And I raise the issue because, as you know, there are a number of women in Saskatchewan who have been affected by this. I'm not certain if there are any men but there may be. But more seem to be coming forward each month. And so I'm interested to understand what the Ministry of Health in Saskatchewan's position is on this, especially as it relates to the complete mesh removal, which was part of that February 4th, 2010 notice as a concern. Perhaps you can update us on what has happened with this matter since it was very public last I think November or early December.

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson, for your question. You're correct that this is obviously something that we have discussed in the legislature I believe last fall. First of all, I think the notice that Health Canada would have raised, that would have been I think clearly communicated to hospitals, to physicians, the organizations that represent physicians. So that information has I think clearly been disseminated by Health Canada over the last number of years.

In terms of the removal of surgical mesh, as I've stated in the past, we do from time to time receive requests for out-of-country coverage. To this point, we haven't approved that out-of-country coverage. We believe that the ministry has demonstrated that the service is available within Canada, and so that's the information that we've provided both to patients as well to specialists in the province that would be looking to refer their patients to specialists outside of the province, that that service would be available, is available within Canada.

Mr. Nilson: — Now who has provided this advice to you? Because I know as — I guess I looked at it as a lawyer not a doctor — but I looked at the information that was provided, and it wasn't persuasive to me that there was anybody in Canada who was willing to do this kind of work or that had sufficient skill to do this kind of work. Going right to the point that we all know is that — and we learned with great horror in Winnipeg around pediatric cardiac surgery — that you can't do four or five or ten procedures in a year and call yourself a specialist. And so I look at this, and the information that was provided doesn't really have anybody in Canada who's done very many of the procedures that are involved here. So perhaps you can take a look at this.

Mr. Hendricks: — So normally when we get a request for out-of-province coverage, one of the first things that we try and do is we try and identify whether those services are available in Canada. In this case we contacted gynecologists in Saskatchewan and asked if they knew about anybody who possesses expertise in Canada. The information that we were given is that there is a physician in British Columbia who specializes in removing the mesh. Dr. Cundiff is his name.

And one of the challenges that we're running into here is that the physician in the US [United States] that people tend to look to for this procedure, Dr. Raz at UCLA [University of California, Los Angeles], performs a procedure to remove the total mesh using a translabial ultrasound. The doctor in British Columbia believes that it's not necessary to use that technique in all cases. So what we have is differences of clinical opinion here. Right?

We have no evidence to suggest that the procedures that would be performed by Dr. Cundiff would be of any less clinical benefit to the patient. So given that the service is available in Canada, we've asked these patients to actually seek out the services of this physician in British Columbia.

Mr. Nilson: — Well I guess the bottom line for me is that there's a number of people in a great deal of pain. They feel as if the health system really didn't put up the warnings around use of this particular material in appropriate ways, and they're suffering. It's identified by their physicians here, and some of the solutions have not assisted them.

And you know, if it was one person or two people, well you know, you'd end up being . . . I suppose taking a hard look at it. But there's more that keep coming around this particular issue. And I have to say that looking at the material that's been provided, I don't know if the Ministry of Health has done all of the homework that they should on this one yet, especially when we have women in Saskatchewan who are suffering.

So I strongly urge you to take another look at this and perhaps find worldwide evidence to deal with this particular issue. We know in the United States that they've been much more direct about not using this kind of mesh. I think some of the research says, we've got to find something better, is basically the line. So anyway I just say that I don't think you've done your job on this one, and I encourage you to keep working with these people. And frankly it's costing some of our citizens a lot of money to fix a problem that was created by our health system here and our doctors.

Hon. Mr. Duncan: — Mr. Chair, just a follow-up to that and, Mr. Nilson, I appreciate your comments. I think that in this case, as Mr. Hendricks has identified, the ministry in working with our specialists in Saskatchewan has identified several options that exist in Canada. Dr. Cundiff is one that has been indicated through the work of the ministry and through individuals that work in this field, has a high degree of knowledge in this field, has trained in the United States, is well respected, has the translabial ultrasound at his disposal, makes a clinical, I think rightly so, makes a clinical decision of whether or not that is the proper course of action in consult with the patient as well as the determination of whether or not that it should be removed in one procedure or several procedures, again in consort with, in conjunction with the consult with the patient, which I think is the appropriate thing to do.

Dr. Cundiff, to my knowledge, actually knows Dr. Raz at

UCLA knows him quite well. And we would take the position that the expertise does reside in Canada, and that would be the first course of action when there is expertise within in the country.

[22:15]

Mr. Nilson: — Okay. Well I guess I have a disagreement with you on that one, and I encourage you to do more looking, maybe find some other experts, some other places, and work at that one. Because I just know there are people, and I keep hearing about more of them. And you know, they haven't all come forward very publicly like some of them have and it's a problem.

Let's go on to some other areas here. I noticed also in your health plan that there was a goal of providing sealants on children's teeth in certain parts of the province. Has that happened? And how many children have received the sealants?

Mr. Florizone: — Thank you for the question. I thought it might be important to set a context for this one. When we launched the surgical initiative, there were approximately 28,000 people on the wait-list. And one of the areas and one of the bold targets set was that no one should wait longer than three months for surgery, so that option of having surgery within that time period. As we took a look across the 28,000 people, we looked at all of them but we also focused in year 1 at those that were waiting the longest. And these would be the categories that I would have expected, all of us would have expected — hips, knees, eyes.

But what jumped out at me, and maybe this isn't a surprise to others, but children's dental surgery came out as one of the top and longest waits. So this would be children that would require operating theatre time because of the extent of the dental issues that they were facing. We found that predominantly — and this isn't every child — but predominantly we had issues in northern areas, in remote areas. There was a real concerted effort to think about going upstream. So not only to do the surgery and reduce the time, but another part of the surgical initiative, of course, was safer and smarter and making sure we got upstream and prevented these four- or five-year-olds from having to come in in the first place.

So that's the preamble to why we ended up going down a path that really started to very much target and set clear objectives around dental care, dental sealants, and dental programming to this population. So I'll turn to Lauren Donnelly who will give you a little bit of a background on the sealant program itself.

Ms. Donnelly: — So the enhanced preventative dental services that were provided to high-risk communities across regions included oral health assessments provided through child health clinics, referral and follow-up to health professionals, fluoride varnish, dental sealants, promotion of community water fluoridation. So in the time period since it was initiated, a total of 18,000 children were seen in child health clinics over that time. And almost 7,000 were referred for a fluoride treatment and a little over 6,000 received the fluoride treatment, fluoride varnish. In the school-based program, the total number of students assessed was 4,300; 2,853 required dental sealants and another over 7,000 sealants replaced. Students may receive more than one sealant, which is the reason for the difference in the numbers.

So this program will undergo an evaluation in line with this. It was launched with the surgical initiative and it was a preventative program to reduce the number of children moving through to having to have a surgery to remove teeth. So there'll be an evaluation of the program undertaken this year.

Mr. Nilson: — Okay. So what year are we talking about with the surgical initiative, because I just know that we started this seven years ago. But maybe we didn't do any. Is that what happened?

Ms. Donnelly: — What year did it start and finish?

Mr. Nilson: — Yes.

Ms. Donnelly: — So phase 1 began in the fall of 2011. The regions included in that year were Saskatoon, Prince Albert Parkland, Prairie North, Regina Qu'Appelle, and the three northern regions. And that counted actually for . . . 80 per cent of the children receiving treatment in hospital were from those regions. And then the remaining health regions rolled out the program in the subsequent year. And the evaluation will occur this year.

Mr. Nilson: — So it didn't happen in 2007 as was budgeted then. Is that what happened?

Ms. Donnelly: — There was some programming in preventative dental surgery.

Mr. Nilson: — It was specifically sealants, I remember. That's why I'm asking this question.

Ms. Donnelly: — It might have been a more targeted program, even more targeted in '07, but in terms of the more province-wide program, that came with the surgical initiative.

Mr. Nilson: — Okay. Yes I mean I know in '07 there was money set aside to do this for grades 1 and grades 7 I think right across the province. But obviously it didn't start then.

Okay. Well I know we in Saskatchewan have really suffered, and you've pointed it out with the surgery issues and all that, with the collapse of the dental program we had 30 years ago. And we still have a generation of people that are cavity free, but it's only about 6 or 7 or 8 years worth that still benefit from that program.

But anyway, okay, well let me keep going along here. Then as it relates to the surgical initiative and the wait-lists and all of that particular work, much of it began years ago in the sense of what's happened, and then it's I guess rebranded, if I can put it that way, in 2011 around the surgical initiative with more money or resources such as was designed originally.

Can you tell me which of the surgical wait-lists targets were there and basically being dealt with through the federal money? And we had some of the targets that came at that point. And also, my memory's not totally accurate on this, but I think it was around 2004-05 that the actual surgical initiative in the

sense of monitoring wait times became much more serious, and I know some of the same people are working on that. Can you give me a little bit of a history of how it's evolved over the years?

Hon. Mr. Duncan: — Thank you, Mr. Chair. Thank you for your question, Mr. Nilson. So your question dealing with surgical wait times, I think you'll know that in, I believe 2004, there was pan-Canadian benchmarks for surgery target dates. Those were specific to five areas. So there were two emergency surgeries that were included in those benchmarks and then three electives. And I think that it's fair to say that progress was being made on those, although I think to achieve those targets would have been difficult.

What we've done with the surgical initiative is to, rather than just focusing on those five particular surgeries, to include all surgeries in our targets, accelerate those time frames getting . . . working towards our goal of three months by March of 2014. And as well, putting, including as part of our goal not just to shorten the wait times for surgeries but also to put a focus on quality and on safety as well.

And so we've put in place, for instance, a surgical checklist, that we are working with health regions to ensure the checklist is followed 100 per cent of the time. And I think we're pretty close to 100 per cent, maybe not quite there on all surgeries. And certainly just on the wait times themselves, I think you'll know from some of our public discussions that we will, we should be at our goal of three months for the offer of surgery by March of 2014 in all of our health regions except for Regina Qu'Appelle. And we have expectation that it will take Regina Qu'Appelle an additional year. But that's certainly what we're working towards.

[22:30]

Mr. Nilson: — Okay well, I would say that our goal always in Saskatchewan was to include all surgeries, that we disagreed with the pan-Canadian benchmarks. And I personally did that vociferously at that meeting in 2004. So I'm happy to hear that that's still the plan that we had and have, and appreciate the fact that resources have been put into this whole system.

I'm curious, has the definition or the standard of how you measure the wait-lists changed at all from the original version of this, I think, probably in 2003?

Mr. Florizone: — So thank you for the question. The 2003 SSCN [Saskatchewan Surgical Care Network], the surgical wait-list, the methods of measurement remain the same from time of booking to time of surgery. The website that was established at that time very much is emulated today. In fact I can remember those conversations in terms of the form that the patient signs, consenting.

Now one of the things that we've tried to do with the surgical initiative, and I think it was probably an area of concern even when we were working in 2003 at that website, is wait one, and we still have some work to do there in terms of . . . What I mean by wait one is that wait between a family physician and seeing the specialist.

We had this interesting meeting — I thought you would be interested in this — we met with the orthopedic surgeons as a group in Saskatoon. That was just last week. First of all, they were very gracious about the fact that wait-lists have been brought down, but what was equally interesting is that wait one has come down dramatically. They were talking two or three weeks to be seen, whereas in the past they not only had long surgical horizons from their booking to actual surgical date, but they also had long lists of people queued up to see them.

I'm sure for an orthopedic surgeon it's a different way of operating where you don't have this big wait-list that is almost like guaranteed work into the future. So it has been quite a remarkable cultural shift. And we do need to continue to work away with it to be able to sustain it into the future because the worst thing that could happen is you make these gains and then you start to see them slide over time.

What was really interesting when we looked at the numbers — and this is when I started as deputy just before the surgical launch, the surgical initiative — I mentioned to you there were about 28,000 people on the wait-list. And it fluctuated a bit, but from year to year it looked like 28,000, 27,500 — you know, kind of that kind of movement, which put us in really good shape in 30 years to be able to clear that backlog.

The really positive part of this is that supply and demand were in check. In other words it's not that we weren't doing sufficient surgery at that date to keep up with demand, it's that we had this backlog. And that's why we started referring to it as not just a wait, not something that grows and diminishes, but it's basically sitting there. So the investment of dollars were really to clear the backlog and now, with the aging demographic, keep up with demand and demand shifts that occur.

The other thing is we still continue to be interested in issues of appropriateness, so the quality dimensions. And this is really, these are clinical questions, not for a bureaucrat to indicate why, but just to ask the question of the clinicians: why is it that we seem to do more hips and knees than virtually anywhere in the country after adjusting for age? So these are now the questions that we need to continue to bring to the forefront, to be able to tease out the question of, you know, is there another way.

We also know, and this one you have to take credit for as well is the shared decision-making piece. So as soon as we caught on to the fact that if you involve, very much, patients in the decision of whether to have surgery or not for about 20 surgical procedures — hips, knees included — shared decision-making allows for a more informed decision. But also a patient would be able to weigh those risks — should surgery proceed or not — which was highly positive and has now been in fact embedded into every surgical pathway piece of work that we're doing and every clinic that we're establishing. It's got to be core. In fact it's part of that patient-first focus that we're trying to embed in everything that we do.

Mr. Nilson: — So I'm curious, I know I saw that in some of the material that it was a work-in-progress, but it sounds like it's more in progress than the report I saw, which is good. Yes. Pardon?

Mr. Florizone: — Sorry, Mr. Nilson. We still have a long ways to go. So I don't want to make it sound bigger than it is because, you know, even with the pathways and the clinics, we still have, you know, to . . . They have to grow. There has to be greater uptake. But I've got to say that we're convinced, more now than ever, that it's on the right path, and clinically led is the way to go.

Mr. Nilson: — Okay. And you're using some of the models from New England that we looked at before?

Mr. Florizone: — Yes, that's right.

Mr. Nilson: — Okay. Well that's good, because all of these different pieces contribute to meeting the goal that we all have in the community, to have these surgeries done quickly. But I'm sure some of the doctors also say, well oftentimes people need some time to get used to the fact they're going have the surgery, and in fact maybe get better and don't have the surgery. So it's too short a time; they don't have that proper reflection time. But I . . .

Mr. Florizone: — I want to say that it's an interesting dilemma to be in when a surgeon looks at you and says, the waits are too short. It's been very interesting because what we need to do is be mindful of the fact that it isn't about them; this is about the patients that are being served. And what we say when . . . And we have been confronted with that question of, well my patient may not want the surgery in three months. And we say, that's great. The guarantee isn't that you have to have surgery. It's that if you wish to have, we can do it within three months. So don't book them until . . .

And so what's occurred is whereas in the past people would end up on the list not because they wanted surgery right now, they thought they would need surgery by the time they got to the front of it. And now we're in a position where there's no rush to go onto a list because, you know . . . And we're talking primarily of regions outside of Regina. We're still struggling in Regina. But they know in Saskatoon, for instance, that they can get on the list within short order. So there's no rush to get on just in case.

Mr. Nilson: — Well I appreciate that report. I haven't had a chance to really ask it in a context like this before. It is interesting that you mentioned the letter that I was so adamant about years ago, that people would get something that they could actually have in their hand as to the date. It sounds like we still haven't developed that, that we use a different system. Would that be accurate to say or do people actually get the letter with a date?

Mr. Florizone: — Where we're moving next with this target of three months wait is that, you know, we've got this history of, well we'll get back to you. And what we'd love to be able to do is get to a situation now where you just book your day. And you have a choice of having it within three months, but you may opt because of personal reasons — because of your own, you know, it could be a farming cycle, it could be a wedding in the family. So you decide on the date that works for you. In other words, very much patient-centred and not, here's your date, take it or leave it.

So this is opening up a new horizon for us, and armed with EHR [electronic health record] and EMR, gives us the opportunity to book immediately because you can literally slot people in. That's the ideal. That's the ideal where we want to head.

Mr. Nilson: — I'm just smiling because the very original discussion that we had around these surgical, you know, lists was based on my experience as a lawyer when we shifted all of our systems from setting court dates to setting it on the basis of a lawyer certifying that he or she and his client were ready to go to court. Well it was amazing how many cases dropped off the list because the lawyer maybe didn't have enough money or he wasn't well prepared. More importantly, the client really didn't want to go to court that bad.

And so it sounds to me we're getting to that stage in the surgical side 20 years later which is . . . But still it's the right thing because, like you say, it's patient oriented and it relates to the patient setting out how they need, and the system then is able to supply that. So well, I appreciate the report and keep working away at it. And I thank the minister for advocating and getting the money because that was always the issue. You had to get the priority money each year, just that extra piece. And I know we got some this year. We got some last year, and we're going to need some more next year, so start your lobbying on that. So thank you very much.

Now one question . . . This is completely from a different angle but it's very important. Has there been any work within the Ministry of Health around security of water as a public health issue? And I raise this because the World Health Organization and the United Nations have been working together around the issues of security of water. And this time of year we have the boil-water orders coming on a regular basis. But across parts of the east coast of the States, most sort of dramatically with the big storm that hit New Jersey, New York, and Connecticut, one of the biggest issues, other than loss of power, was no potable water, and it caused huge problems in large populations. So I'm curious if there's any work being done about this in the department.

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson. Certainly the Ministry of Health has a role in the water file when it comes to issues around, for example, the public health aspect of boil-water advisories.

I can think of just in recent weeks with the threat of flooding, for example, we've indicated through the provincial lab that for private wells — drinking water wells — that may be impacted by the flooding this spring that we are once again going to waive fees for testing through the provincial lab. But I think the larger part of your question, I think, more deals in the realm of the new Water Security Agency, the former Watershed Authority.

[22:45]

Mr. Nilson: — Okay. Well I'd just say that the World Health Organization and others are looking at this, and I know that there's increased interest across the world around this particular issue. It's basically, you know, people say well what's the greatest medical or health advancement of the 20th century and

people go and list all these different vaccinations, but the answer is sewer and water. And we know that in Saskatchewan, for how well our health system works is when you get clean water and a good sewer system, it eliminates a lot of problems in the health care system.

I've got not a lot of minutes left, so I know that a national issue, and I think it's probably a Saskatoon and Regina issue, is the expense for parking at hospitals. And I also know that it's an area where you sort of give the Regina Qu'Appelle Health Region and the Saskatoon Health Region the ability to make money or try to make a little bit of money there. But have you been working on this particular issue? Because people who have loved ones in the hospital then end up with this bill of parking that often can be quite onerous, especially in Saskatoon.

Hon. Mr. Duncan: — I don't think we have as a ministry been too involved in this issue. I stand to be corrected by the deputy, but I think though the regions themselves are looking at ways of making it more convenient for patients and their families. Just off the top of my head, I believe that Regina Qu'Appelle has put in place a new program that provides some off-site parking for their staff members and then will transport them I believe by shuttle bus to I think to the General Hospital in this case, to perhaps free up some parking space for patients and their families. But in terms of a provincial ministerial involvement in this, I don't believe it's something that we're involved in.

Mr. Nilson: — Thank you. I know the Saskatchewan international physician practice assessment program is up and running. Can you tell me how many international physicians have been assessed, and how many have entered into residencies in Saskatchewan?

Hon. Mr. Duncan: — Thank you, Mr. Chair, Mr. Nilson. So I can give you numbers. So the total number of successful candidates that have completed the SIPPA [Saskatchewan international physician practice assessment] assessment since the first cohort in January of 2011 to the seventh cohort which began January of this year, so the successful candidates is 61 in that time frame.

Mr. Nilson: — Thank you. So it's, I know it's been a lot of work, but obviously it's working.

The minister was, along with me and others, at the event the other I guess a week or so ago around flavoured tobacco and some of those initiatives. And at that point they had some very specific requests about things that the ministry should make some fairly direct regulations about, and at that point I don't think that had been done. But has there been a reconsideration in light of that very good presentation and can we expect some regulatory change around some of these products here in Saskatchewan?

Hon. Mr. Duncan: — I think it certainly, I think it certainly raised the issue to myself and other members that were at the presentation. I think as well it perhaps makes us relook at the steps that we did take in the past in light of the federal government moving in a direction. And I think at that time the thinking in the province was that our sections of those changes that had been made, the federal government would essentially take care of those issues for us.

And so now in light of the changes that the industry has made to get around some of those federal, the federal regulations and the loopholes that were in them, I think it's given us the opportunity — as well as the presentation that the Canadian Cancer Society and the other organizations that were involved in the presentation — I think to pause to look at not just what we've put in place, but also how we may be able to move forward on that. But certainly at this point, no decisions have been made.

Mr. Nilson: — Okay. Well I encourage you to take steps as quickly as possible in that area because the goal obviously of the tobacco companies is to get young people, teenagers hooked on tobacco, and they're going around the rules that the federal government has set.

Now another question that I have comes out of some of the questions earlier that related to the letter going from the Regina Qu'Appelle Health Region suggesting that people should go and get some information about home care in the Yellow Pages, and then go and send the bill to Social Services.

And my specific question I'm asking is: are you seeing more cost shifting, I call it, between health regions, so that one health region's budget will say, well we don't really want that sick patient here, or between the Cancer Agency and health regions, or between Health-funded groups and Social Services, like what we see on the home care? I'm just wondering if that's becoming an increasing problem when budgets are as tight as they are across the system.

Mr. Florizone: — It's always an area to watch for as budget pressures emerge and these strategies around savings and efficiencies come about. I can tell you that the mantra has been: think and act as one. And what we've really been trying to urge is that the regional health authorities and the Cancer Agency work in concert and not off-load onto each other. It becomes very obvious to the receiving agency of that off-load that, you know, what's happening. So about 10 years ago we saw a lot of that activity going on. It's become too obvious now, for a good reason, because we don't want to either promote or encourage that sort of thing.

Now the exact examples . . . So I think in the past we would see rental charges go up or lease arrangements or costs per patient go up. And some of what you saw in the past would be one region in a more rural area deferring and stopping or not seeing patients, and people having to travel down the road into Saskatoon or Regina who didn't have that same option.

We're watching it very closely. There are good conversations that are happening among the CEOs. And I think that a lot of that good work that we did around bringing CEOs together on a regular basis to create those relationships is now starting to bear some fruit. We also know from their budgets what plans they have. We've got hopefully a tighter idea going in, say in June, what their response will be. And you know, the mantra has been around: look at the patient, look at efficiencies and wastes from the patient's point of view, and whatever you do, don't put the burden onto the patient. And what we mean by that is, just simply shifting to another level of government or another agency is not helping the patient at all. So some of these tools have helped us in moving forward.

Mr. Nilson: — Thank you. I've got not much time but I've got two questions related to the drug plan and some of the issues there. The first one is, I know that these superexpensive drugs for very specific people, we tried to develop a plan nationally to deal with them. And I'd be curious about the status of that, especially as it related to that Fabry enzyme one that was supposed to cost, you know, for four or five people, a couple of million dollars a year in Saskatchewan. That was the prediction and I'm wondering where that is.

The second question is whether we're at the stage where we have electronic prescriptions throughout the system.

Mr. Wilson: — Kevin Wilson, the executive director, drug plan, extended benefits branch. The agreement for Fabry's is still in place. So it's one of the initial agreements for high cost drugs that was put together involving . . . the provinces collaborated with . . . to get a better price and to also do some sort of outcomes analysis to look at the impact that the drug had. Because as you'd be aware, that there was very little evidence for the drug because there's such a small number of patients that use the drug. So it's continuing to be in place and we're continuing to contribute to part of that agreement.

Mr. Nilson: — And the evidence still isn't here yet then?

Mr. Wilson: — That's fair enough. There's been several years now that the research has been ongoing, but there hasn't been any sort of clear deliverables that have come from that research.

Mr. Nilson: —. Okay. And as far as the system of electronic prescribing, is that in place now or . . . like, I assume it's part of the national work. But I don't know because it's . . . Does it happen now or not?

Mr. Wilson: — So the e-prescribing capability is in place. At this point within the province the uptake is not large, but we would expect over the next few years with the ongoing developments with EMRs and integration that you'll see more electronic prescribing.

Mr. Nilson: — What percentage would there be now?

Hon. Mr. Duncan: — Thanks, Mr. Chair. Thanks, Mr. Nilson for the question. We'll endeavour to get the specific number. The number in terms of physicians though that would have availability of the EMR would be about 60 per cent across the province. But we suspect that — and we'll confirm this number — the number that actually would use . . . avail themselves of the ability to e-prescribe would be, at this point, we think it's probably less than 10 per cent. The capability is there for roughly two-thirds of . . . yes.

Mr. Nilson: — Okay. Well thank you. And we're getting right at the end, but I have one more kind of question and I'm not . . . It depends how long you take to huddle to answer it but then we'll be done. But this morning you had the announcement around the plans for the children's hospital. And clearly, you know, one of the issues in Saskatchewan that we're trying to sort out is how many or how . . . Yes, what's the capacity for dealing with children's health issues right across the board?

And my specific question relates to that plan that's there, and I haven't really looked at it in detail and probably couldn't really tell how things fit together. But does that plan, is it set up in a way that it deals with your comments earlier this week or last week around pediatrics here in Regina, where there clearly would have to be, for some of the more serious patients, that they'd be sent to Saskatoon? And then you have the staff in Saskatoon saying, well how does this work, because we're having to send them to Calgary and Edmonton already?

So I think that it's a bit of a question right across the province is what will our capacity be? And once again it goes back to some of the issues that Winnipeg ran into around their very specialized pediatric cardiac surgery. But perhaps you could give me, and I guess the people of Saskatchewan, a bit of a perspective on how this new plan addresses that long-term concern and the fact that people really get concerned about how far away they will be from children when they're sick.

Mr. Florizone: — The challenges of working this through, there have been meetings even in the last few days among pediatricians, pediatric specialists between Saskatoon and Regina trying to discuss what's in the best interests of children and these services. Of course distance does matter. But at the same time, if Winnipeg has taught us anything, it's that safety trumps, and making sure that we provide the best, the safest, the most appropriate care possible for children.

There is the flexibility within the design of the children's hospital to handle the highest of acuity of pediatric patients that would be appropriate for that setting and for the skill set that Saskatoon has. There is very much an interest in developing what is being referred to as a high-acuity service in — and maintaining that — in Regina. But there will be situations, and there have been situations, where the care is beyond the capability. And with safety trumping, the intention here is to support that clinical decision that certain patients need to travel down the road to Saskatoon to get the care that they need and deserve.

So I want to assure you that we've factored in these issues, that we're certainly sensitive to the care that's required and should be ongoing here in Regina. But at the same time, once again in the spirit of think and act as one, it's really important that we look at acting as a province in terms of providing the best care possible for children and factoring in the children's hospital with sufficient capacity to handle those volumes now and into the future. And that's what this design has all been about. We'll modify as we proceed. There's still a lot of review work that's being done. But the one thing that is a confidence builder and should remain a confidence builder is that safety will always trump those other issues.

Mr. Nilson: — Well thank you for that explanation. And there will be all kinds of voices in the discussion, and so clearly we'll all have to listen carefully to those voices. So thank you very much to the minister and all of the staff. I tried hard to ask everybody a question. I'm not sure I did it but I was pretty close I think.

But anyways, I obviously appreciate the work that you do. And I was just rueing the fact we didn't have the old system where basically we would just have health estimates until we were done asking questions. It was 32 hours or 36. Well that was

how it worked. And it's not that many years ago that that's how it worked — but that was the time when I was on the other side. But thank you very much.

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

Hon. Mr. Duncan: — Yes. Just briefly, thank you to you, Mr. Chair, and to the committee staff, as well to members of the committee for your time and your questions, both this evening and as well as our previous committee meeting.

I also just want to briefly say I'm extraordinarily grateful to have the opportunity to serve as Minister of Health at such an exciting time in the system. And I want to thank all the officials that have appeared this evening, that are here this evening, as well as our previous committee meeting. As well, I want to thank the women and men of the Ministry of Health that you don't see here this evening that have put in many hours to not only help us to build the budget but to prepare us for appearing before the committee. And so I'm grateful to all the people that work in the Ministry of Health for the work that they've done to get us ready for these committee meetings. And with that, Mr. Speaker, Mr. Chair, thank you to the committee.

The Chair: — Thank you, Mr. Minister. And thank you one and all for your time, consideration, and co-operation. The time now being 11:09, and it is past the hour of adjournment, this committee stands adjourned until Thursday, May 2nd at 2 p.m. Thank you and good night.

[The committee adjourned at 23:09.]