STANDING COMMITTEE ON HUMAN SERVICES

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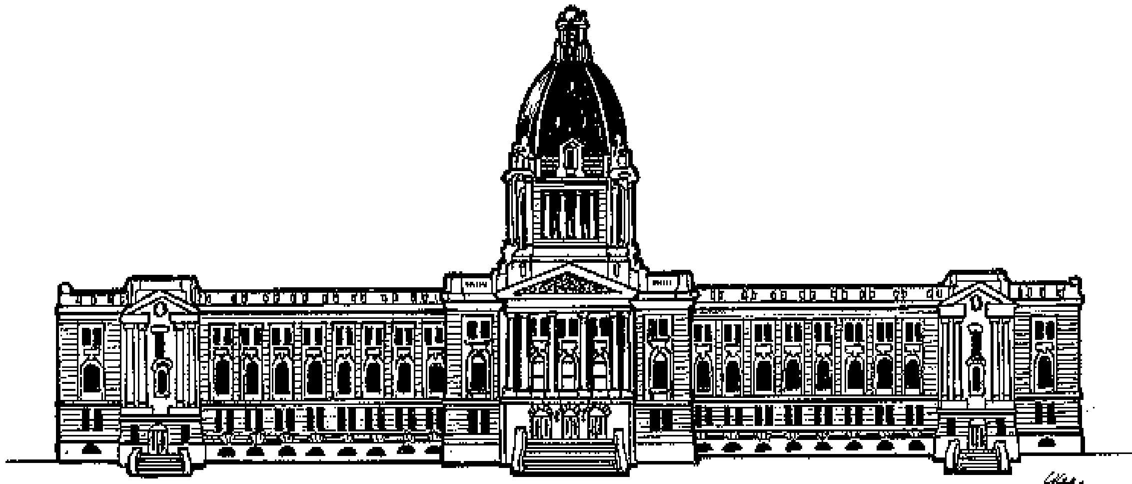

Legislative Assembly of Saskatchewan

Twenty-Seventh Legislature

STANDING COMMITTEE ON HUMAN SERVICES

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Saskatoon Centre

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Saskatchewan Rivers

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

[The committee met at 13:59.]

The Chair: — Good afternoon, ladies and gentlemen, and 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. Greg Lawrence, Mr. Russ Marchuk, Mr. Glen Hart, and Ms. Danielle Chartier.

Before we begin with our Health questions today, we are first going to table two documents.

HUS 13/27, Ministry of Education: responses to questions raised at the April 7, 2014 meeting of the committee regarding Saskatchewan Association of Health Organizations Inc. contract, the list of Saskatchewan firms that's submitted proposals for the P3 tender, clarification regarding the positions transferred within the ministry, the cost of 1 per cent on teacher salaries and education staff profiles for each school division, dated April 17, 2014.

The second one is HUS 14/27, Ministry of Education: response to questions raised at the April 14, 2014 meeting of the committee regarding child care site investigations and 2014 pre-K to 12 major capital request list, dated April 30, 2014.

So those have been tabled.

This afternoon we will be considering the estimates for the Ministry of Health. We now begin our consideration of vote 32, Health, subvote (HE01). Minister Duncan is here with his officials. Please introduce your officials and make your opening comments.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

Hon. Mr. Duncan: — Thank you very much, Mr. Chair. Good afternoon, committee members. Joining me this afternoon to my left is Minister Randy Weekes, the Minister for Rural and Remote Health. To my right is the deputy minister of Health, Max Hendricks. We have, as you can see, as we've had in our two other appearances before the committee this spring, a number of officials with us from the Ministry of Health. We'll maybe just not introduce them at this point but we'll certainly make sure that they identify themselves if they do come up to the desk and speak on camera.

Mr. Chair, I don't have formal opening comments but I know that there were some outstanding questions that had been asked by Ms. Chartier at our previous committee meetings. We will certainly be pleased to provide this in writing but I would like to perhaps go through some of the answers in case follow-up questions do fall from these, if Ms. Chartier is agreeable to that.

There were several questions. I'll maybe start with the mental health services. There was a question that came up around jurisdictions where authority is given to those other than judges to issue warrants and which jurisdictions those would be. So in British Columbia, Manitoba, Ontario, the Yukon, Northwest Territories, and Nunavut, a Justice of the Peace may issue warrants for apprehension for initial examination. I mentioned Ontario is on that list. Ontario judges are not used under the mental health services or their version of *The Mental Health Services Act*. It's only justices of the peace that are used. Some jurisdictions like Newfoundland and Labrador do not have justices of the peace.

With respect to the residency positions, psychiatry residency positions in Saskatchewan, the total number of residencies or candidates or individuals in the residency program for postgraduates is 27, 22 in Saskatoon and five in Regina. I think I might have given that information to the committee before, but I have a breakdown of that. So in year 1 of the program, year 1 of the residency, five are located in Saskatoon, two in Regina; year 2, four in Saskatoon, one in Regina; year 3, four in Saskatoon, none in Regina. Residents in their fourth year of postgraduate work, there are three in Saskatoon and two in Regina. And residents in year 5 of their postgraduate work, there are six in Saskatoon and five are expected to graduate June of 2014. So that's the breakdown of the 27 number.

There was a question that was asked regarding psychiatrists in Saskatchewan and how does it compare nationally. And this may have been brought up when we were actually going through the amendments to *The Mental Health Services Act*, so I think I might be blending both the legislation and our estimates. Currently in Saskatchewan the ratio of licensed psychiatrists per 100,000 in the province is 8.5 per 100,000. We have approximately 96 licensed psychiatrists in 2014, according to CIHI [Canadian Institute of Health Information], and the numbers that they use go back to 2012. So in that year our number was 7 per 100,000. So we are now at 8.5. But the comparison for 2012 would be, Saskatchewan was at 7. We are on, I would say, the lower end of that list. So the Canadian average is 14 per 100,000.

So I'll maybe just run through for comparison by the provinces: so Newfoundland and Labrador, 14; Prince Edward Island, 10; Nova Scotia, 17; New Brunswick, 11; Quebec, 14; Ontario, 14; Manitoba, 12; again Saskatchewan at that time was 7 in 2012 — we're, as I said at 8.5 now; Alberta, 11; British Columbia, 14; the Yukon, 6; and the Northwest Territories, 2 per 100,000.

With respect to the committee meeting that was on April 17th, there was a question around clients of community living services division who were waiting for group home placement that were residing in mental health in-patient facilities as of April 22nd and the length of stay for each of the clients.

So in total there are 12 individuals: so zero in Cypress Health Region; zero in Five Hills Health Region; Prairie North, one individual at The Battlefords Mental Health Centre. This client was admitted in September of 2012 and then discharged early in 2013, but then was readmitted later in 2013 and continues to be an in-patient. So the initial stay was 161 days and subsequent to that, since the readmission, that individual has been there for just over one year. So that's at The Battlefords Mental Health Centre.

Within Prairie North Health Region obviously is the Saskatchewan Hospital, two individuals that were waiting for

placement residing in Saskatchewan Hospital. These are, I think . . . Well I'll just give you the numbers. As of April 22nd, one client had been there for just over four years, and one client for I believe seven years. I will have to maybe get some clarification on that, but I believe that second one, to me it looks like seven years here.

Prince Albert Parkland Health Region, two individuals awaiting placement in the Prince Albert Mental Health Centre. As of April 22nd, one client had been there for one year and 25 days, and the other for one year and 83 days.

In Regina as of April 22nd, there was nobody waiting for placement in the adolescent unit at the General Hospital. But at the adult unit, there were three. And those clients had been waiting, one client had been waiting, as of April 22nd, 30 days; one client had been waiting 27 days; and one client had been waiting 150 days.

Saskatoon, at the Dubé Centre, the adult portion of the Dubé Centre because there's zero adolescent beds at the Dubé Centre but four in the adult portion of that facility, one had been there roughly two years; one just under a year, 300 days; one client has been there for just over a year, one year, 55 days; and one client has been there for 30 days as of April 22nd.

In Sun Country, at the Weyburn Mental Health Centre, there's no people waiting on the ward. And the same would be true for Sunrise, the Yorkton Mental Health Centre.

On April 17th we also talked about long-term care. Ms. Chartier I believe asked about the number of people that were waiting for placement in long-term care. So as of March 31st, 2014, there were 345 people waiting for long-term care placement in the province. From April 1st, 2013 to March 31st, 2014 — the average wait time for placement I believe was one of your questions — the average wait time was 27.79 days, so just under a month. And as of March 31st, 2014 — I believe you asked how many residents were on the transfer list from their facility of choice — and as of that date, there were 590 people on the transfer list waiting for a facility of their choice.

There was a discussion or a question that was raised or perhaps some information that was provided by the member around personal care homes and an issue around the use of fire department personnel to assist with lifting residents. I think the question was whether or not this was a common practice. I would say that it's not a common practice. But in February of 2013, ministry personal care home consultants did meet with Saskatoon Health Region representatives and the fire and protection services of Saskatoon to discuss callers from the community that were requesting fire and protective services to respond to falls. Only a small number of calls from this list were identified as coming from personal care homes.

The ministry's personal care home consultant spoke to the personal care homes licensees that were noted on the list that was presented at that February meeting, and explained to them that ambulance services are to be contacted when assessment and transportation of fallen residents are required for transportation to the hospital. So it was more around an issue of, if residents in fact had fallen within a personal care home.

Ministry personal care home consultants to date have received no follow-up concerns from Saskatoon Health Region or fire and protective services since that February 2013 meeting.

As well on April 17th, there was a discussion about emergency room flows. I believe the question overall was about Saskatoon implementing flows in the emergency room and, if so, what had changed. So I can report to the committee that Saskatoon Health Region has established task teams to address the implementation of 3P [production preparation process] protocols in emergency departments. Future rapid process improvement workshops will continue to work towards better processes in the emergency departments to improve patient flow for mental health patients and to improve patient flow in the emergency departments.

So I'll list off several workshops in the health region that have been focusing on emergency department patient flow.

So the first one is parents in labour now register directly in labour and delivery on the fourth floor of Royal University Hospital rather than registering in the emergency department as had been the practice. This reduces their walking distance by 85 per cent and removes one stop in their journey to receive care on their way to becoming parents.

A second area that they looked at is between 8 a.m. and midnight, children and parents will register in triage in the children's emergency room, getting them into a bed faster and closer to the care they need. When a pediatric emergency bed is available, the patient is registered and triaged right at the bedside. When a bed isn't available they can still register and wait in children's emergency instead of the main emergency line.

Improvements include a 72 per cent reduction in unit assistant movement to get supplies that weren't previously available in children's emergency, 20 per cent reduction in distance travelled for patients who can now go directly to children's emergency, standard work for children's emergency RNs [registered nurse] in unit assistance, and improved cleanliness and better signage upon entering the emergency department and toward children's emergency. As well, finally on this point, patients brought to St. Paul's Hospital by EMS [emergency medical services] ambulance are now transitioned to nurse care 67 per cent faster. This reduction from 37 minutes to 18 minutes was accomplished through some standard work, improved handover processes, and more efficient use of space.

And finally there was a question on April 17th about the cost of the 3P events in Saskatoon, Moose Jaw, and North Battleford. The children's hospital total of $633,000 was spent on two events. There were two events that were held in November and December. I may have, I believe I said there was three involving the children's hospital. There was only two: November and December of 2011. At the Moose Jaw hospital, we're estimating $625,000 for the three events in Moose Jaw. So those were April, June, and November of 2012. And three events were held for the Saskatchewan Hospital at North Battleford: June, July of 2013 and February of 2014. And the cost of those events was a total of $895,000.

And finally, Mr. Chair, just one more area, and I know we've

had a bit of a discussion about this in terms of some issues around operating room staffing in Saskatoon. So the region has struggled with OR [operating room] nurse vacancies. There has been no formal announcement regarding positions; however the matter has been discussed with RHA staff. The RHA has decided to take ongoing, temporary vacancies and convert them to permanent OR nursing positions. There are seven positions. I think maybe six was the understanding, but there are seven positions. The expedited OR nurse training program does have a budget implication of approximately $120,000, and the expedited program will allow the RNs and the LPNs [licensed practical nurse] to complete the training program within five months instead of the normal nine months.

And with that, I think that that, I think, closes off some of the questions that we had earlier. There may be some follow-up questions from those, but I think those were some of the outstanding issues that we had in previous committees. So thank you, Mr. Chair, and we look forward to questions.

[14:15]

The Chair: — Thank you very much, Mr. Minister. And, Ms. Chartier, you have the floor.

Ms. Chartier: — Thank you very much and thank you for that. I think I will have a few follow-up questions on some of these issues. With respect to the OR staffing, so I just want to clarify then, so the Saskatoon Health Region is going to convert temporary positions into permanent positions. And is that happening promptly? Is that already in place?

Hon. Mr. Duncan: — I think it is. If it hasn't already taken place, I would say that it is imminent to take place. They have indicated that they did have some temporary vacancies that had been ongoing vacant positions and that they would be converting them to permanent OR nursing positions and there would be seven of those permanent positions. So just looking at the information I have here, if they haven't been converted yet, they're in the process to be converted.

Ms. Chartier: — Okay, so they've been managing some vacancies and now they are going to ensure that there is staff, those seven staff people.

Hon. Mr. Duncan: — Correct. They will be, yes they will be providing for seven permanent positions, rather than having some temporary positions that they had maybe some trouble filling in the past. But they are going to convert them to permanent positions.

Ms. Chartier: — Okay. Just when you had followed up with the health authority, what had you heard? You had said they struggled with OR vacancies, but I'm wondering what you had heard back from the health authority when you followed up following our last conversation.

Hon. Mr. Duncan: — So the information that had been provided back from the regional health authority, as I had mentioned that the region had indicated that they had been struggling with OR nurse vacancies, after some consideration and meeting with some of their staff, they thought that the way to alleviate this would be to convert those to seven permanent positions.

Ms. Chartier: — Okay. In terms of budget implications for the health region, will this, what are your thoughts on how this will impact . . . So seven positions, full-time positions that will need to be filled and filled permanently, which is obviously what I think needed to happen. But in terms of budget for the Saskatoon Health Region, how do you see this impacting that?

Mr. Hendricks: — So I'll answer this one. So the ultimate goal of the health region, obviously across the board, and it's something that we've been working on with the Saskatchewan Union of Nurses at our partnership table, is trying to accomplish the regularization of the workforce, because oftentimes it's actually more costly to have temporary, part-time nurses, as opposed to full-time nurses, for several reasons. The turnover is higher and the cost of training an OR nurse is significant and also just because you oftentimes have to hire more part-time, temporary nurses to fill and to complete a full FTE [full-time equivalent] than you would a regular nurse.

So this has been something that they've been trying to achieve across the board. As to whether, you know, they're funded for that, obviously they have to make care decisions within their overall budget and manage their budget, which they did successfully last year. So I would actually see this as something that they would probably approach as providing better care and lowering costs.

Ms. Chartier: — Okay. I think the better care piece is absolutely imperative for sure because that was what staff had flagged for me, is that they had concerns around patient care. And it'll be interesting to see if it lowers cost or not. I know that there's some pressure on the health regions. But in terms of retention, that was the other piece that I was hearing is that, oh our nurses — and not just RNs, LPNs, people who are trained to be working in the OR — the retention piece was an issue for sure. So, well thank you for that.

With respect to just going back to the firefighters doing lifts in personal care homes, who triggered the conversation in February 2013?

Hon. Mr. Duncan: — Thank you for the question. So I think what is an ongoing discussion between ministry and personal care home consultants and the care homes that they're responsible for overseeing or doing the licensing and the regulatory work that needs to take place, as well as with the health region, I think in this case we would . . . This would've been, I think, part of an ongoing dialogue. But in terms of who actually triggered the conversation, we wouldn't know that. We wouldn't have that information. We'd certainly be happy to follow up with the health region and with our consultants that would've been involved in February of 2013. But we're not sure who initiated the phone call.

Ms. Chartier: — Thank you. You said it's not a common practice, and you said that there haven't been complaints or issues highlighted or forwarded recently. But I'm wondering what a common practice or not a common practice means. Are we talking two lifts? Are we talking 50? I had been under the impression that there were a considerable number.

So I'm curious what not a common practice means. Do you have any . . . And I think that the health region was setting out to quantify that, and I think you said that in your numbers that the consultant was checking with personal care homes. So I'm wondering if you've got numbers on that?

Hon. Mr. Duncan: — I don't have numbers today. I think where this discussion would have started, back in 2013 in February according to the information that's been provided, is this was Saskatoon Fire and Protective Services following up after a number of calls from the community that were requesting fire and protective services, the fire department to respond to falls. And so a small number of that overall number would have been from personal care homes.

So this was I think just more of a dialogue between fire protective services and what turned out to be, in a couple of cases, personal care homes. This was more about with respect to if a resident, whether they had been in their own home or whether they had been in a personal care home, in a situation where they had fallen. And so people had perhaps mistakenly phoned the fire department when they should have been phoning the ambulance, an ambulance to transport those individuals to the hospital. So those are really the ones that our consultants have followed up with since February of 2013. Those would be I think the concerns that would have been raised to the consultants in those cases.

I think the question was more with respect to how many personal care homes call the fire department when they need help lifting. Like, it almost sounded like more of a day to day. This was more around when falls had taken place. And the fire department wanted to address a number of calls that came from the community, not just from personal care homes but from individuals.

Ms. Chartier: — Okay. Okay, thank you for that. One thing that I'd like to discuss a little bit further too is the question that you've answered with those who, the CLSD [community living service delivery] clients living in, for all intents and purposes, people who are in a facility for four years or seven years are living in these facilities. What are they waiting for? The people for example who are in the Dubé, the four individuals, you've got one who's been there for two years. And those in Sask Hospital, what kind of placement are they waiting for? How can that be resolved?

Hon. Mr. Duncan: — Just maybe as a general . . . While we're having other officials come forward, I'll just say maybe as a general comment, so these would have been a snapshot in time, April 22 of 2014. So it's 12 individuals that we are talking about. And you know, certainly we will try as best we can today to provide those answers. I think the Saskatchewan Hospital in North Battleford where it is, you know, multiple years into — four years I think — that those are some certain circumstances, some specific circumstances for those individuals and if we can maybe shed a little more light on those types of situations. But I'll maybe just take a moment to confer with officials.

Thank you for the question. So Social Services and the Ministry of Health I think work very closely and very hard to find an appropriate placement for individuals that are awaiting group home placement within the system. For these 12 individuals obviously, you know, they're unique circumstances, but I think it's fair to say that these individuals typically are patients that have very complex needs. Often they have a combination of disabilities. It can be intellectual disabilities combined with mental health issues, FASD [fetal alcohol spectrum disorder], acquired brain injury, etc. And they often exhibit very aggressive and sometimes in some cases sexually inappropriate behaviour.

The current approved homes and group homes available through Social Services and Health, usually we just struggle to find a proper place for these individuals. And that's, I think in these 12 cases that would be, I think that that would be the case. Now some of these as I mentioned, a couple of these 12 are, you know, awaiting placement would be within a month or in some cases a couple of months. But there are some specific cases obviously that are just very difficult, challenging situations trying to find a proper placement for individuals.

[14:30]

Ms. Chartier: — Do you have any concern . . . Obviously with Valley View closing, and there are some individuals there who are very complex cases as well, and I think this is the thing that's been flagged for me. And I think moving — don't get me wrong — moving inclusion and moving into the community is absolutely imperative, but having the supports in place for people to move into community and the right settings are important. And clearly we don't have enough of the right setting right now if you've got 12 individuals, some of them who've been living in these facilities, not just a temporary stop. So do you have some concerns about how that will be addressed once Valley View has closed its doors?

Hon. Mr. Duncan: — I think it's been, I would say it's been well established the process that Social Services has been going through in working with families, looking at each individual case to determine over the next number of years what, you know, which clients may be able to move into the existing group home setting, which clients may need some additional supports.

I think that while obviously we want to ensure that we have the proper supports and the proper placement for all of these individuals, I think that this, you know, this number is . . . There are 12 individuals that we currently are, as I've mentioned, are waiting for group home placement. In some of these cases it has been a short amount of time, but we do certainly acknowledge that in several cases it's been an extended period of time. And we work very closely, and are working very closely with Social Services and the Ministry of Health to try to find a proper placement. But these are, I think in a couple of cases obviously are very, very complex cases.

Ms. Chartier: — What are some other options? And so obviously currently approved group homes are not taking some of these individuals because they are complex cases and perhaps, as you said, have intellectual disabilities coupled with sometimes mental health issues, and may be aggressive because of those issues. But so we have group homes that aren't willing to take them right now. We have Valley View that will be closing its doors. We have 12 individuals, some of them for a shorter period of time, but some of them for a longer period of

time.

What are some . . . I'm wondering your thoughts on some possibilities for better supporting these individuals. It is a real concern that I'm hearing from people who work in this field that there aren't the proper supports that currently . . . There's nothing that exists right now to support these complex cases.

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. Certainly, you know, we acknowledge for these clients that, you know, that we have to work very hard with the ministry, with the regional health authorities, with Social Services to try to find a placement to reduce the number of people that are waiting an extended period of time.

This would be an area I think that, certainly the concerns that you may be hearing from stakeholders or from individuals would I think echo some of the things that the commissioner, the mental health and addictions commissioner has been hearing in her work.

We do provide some additional individualized funding in some cases to be able to provide some additional supports to find a better placement, a better home for some of our clients. But certainly we would acknowledge that between Saskatchewan Hospital North Battleford and the important role that it plays, the in-patient mental health centres across the province and the beds that are dedicated to in-patient care, and then on the other side of that the work of group homes and trying to find placements within group homes, you know, that there is a continuum of care for individuals that we need to make some additional progress on in filling some of those needs.

Ms. Chartier: — Thank you. I just need to put it on the record that I have huge concerns about these individuals who deserve to have a home and not live in a hospital. For example in the Dubé, it is a hospital, a short-stay hospital where people who are experiencing suicidal ideation or psychosis . . . and bright lights and lots of stimulation and the same meal every, every Monday. Like, it's a hospital setting. And I think, these individuals are citizens of this province and deserve to have a home. And I want to be on the record now saying that I don't think you've offered a solution, and I have some concerns that there may be some challenges down the road as well when Valley View closes.

So I think I can move on now. You've answered some of my questions, but I think for the individual for example's been in the Dubé for more two years, that is not a home. And people deserve to have a home.

Hon. Mr. Duncan: — If I could, I would just maybe add to that. You know, I certainly, certainly I'll acknowledge that we do have some work to do. I think that it's been . . . I think I've tried to make it as clear as I can that mental health and addictions is something that is certainly a priority for the Ministry of Health and personally for me as the minister.

I think that that's why we have put a large focus on moving forward with a number of projects like the Saskatchewan Hospital North Battleford replacement, as well as actually appointing a commissioner to develop a plan for the province. And so I share your concerns.

I share, I think, your sentiments in terms of these individuals. We struggle with trying to find, for a very small portion of the population, but nonetheless people that deserve a proper home. And this is an area that we are going to continue to work on.

Ms. Chartier: — Thank you for that. Moving on now, I think in our last two meetings together I've covered some very general sort of policy areas, and I will do that a little bit more. But I think there's a few line-by-line things in the budget as well that I'd like to go over. In terms of air ambulance, being relatively new to the Health critic portfolio, where is air ambulance found in the Health budget?

Mr. Hendricks: — So air ambulance appears under provincial targeted programs (HE04).

Ms. Chartier: — And what . . . So the 64.273 million includes air ambulance. And what percentage is that or what . . . not percentage, what amount actually?

Hon. Mr. Duncan: — So the air ambulance for 2014-15, of the $64.27 million air ambulance, the expenditure is $25.455 million, and that's an increase of 5.4 per cent from the '13-14 fiscal year.

Ms. Chartier: — So you said approximately 25 million?

Hon. Mr. Duncan: — Correct.

Ms. Chartier: — And that's operational and the cost of maintenance of planes, those kinds of things?

Hon. Mr. Duncan: — Right. So that's the operational cost, the maintenance cost, but not . . . that doesn't include any capital.

Ms. Chartier: — Okay, just while we're on provincial targeted programs and services, what else is included in that?

Hon. Mr. Duncan: — So the $64.2 million is broken out, 10.6 million is our funding for community-based organizations. So these would be the CBOs [community-based organization] that are funded either in whole or in part by the Ministry of Health, and that would only include the ministry's portion. So in some cases some CBOs will receive some funding from Social Services; this is just our funding.

SAHO [Saskatchewan Association of Health Organizations] receives, so $2.8 million essentially to operate SAHO on behalf of the government. There is $7 million that had been put in place for when we had started down the road of the patient-first initiative; $3.3 million for recruitment and retention. The seniors' ambulance, I think that that's what that is, the senior citizens' ambulance assistance program is $9.2 million. I mentioned the 25 million for air ambulance, and the remaining $5 million is just an other category.

Ms. Chartier: — Where does STARS [Shock Trauma Air Rescue Society] fit in the budget?

Hon. Mr. Duncan: — It's part of the air ambulance total.

Ms. Chartier: — Oh, okay. So the air ambulance includes the provincial air, the fixed-wing, and the STARS.

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

Ms. Chartier: — Okay. And which, how much for each respective organization?

Hon. Mr. Duncan: — I'm sorry, could you repeat the question?

Ms. Chartier: — So how much for the fixed-wing versus STARS?

[14:45]

Hon. Mr. Duncan: — Oh, okay. I have that here. The breakdown: approximately 15 million to fund the fixed-wing operation and, for this year, 10.5 million for STARS is the provincial component.

Ms. Chartier: — So approximately, you said 15 million for the fixed-wing? Okay. And has that changed? So STARS has been around since '10-11, is that correct? The '10-11 fiscal year?

Hon. Mr. Duncan: — Thank you for the question. Today actually happens to be the second anniversary of STARS beginning operations out of the Regina base. That was the first location that it did open. So that was April 1st, 2012. The allocation for STARS, the $10.5 million in this year's budget, is unchanged from last year. So last year's fiscal year was 10.5 as well.

Ms. Chartier: — Okay. And for the fixed-wing?

Hon. Mr. Duncan: — Last year's budget for fixed-wing was 13.5.

Ms. Chartier: — 13.5. And this year it's, did you say 15 or 15.5 this year?

Hon. Mr. Duncan: — 15.

Ms. Chartier: — Fifteen this year. Okay. In terms of numbers of patients transported, I'm just wondering if you could give me a little bit of a picture of air ambulance, the fixed-wing versus the helicopters.

Hon. Mr. Duncan: — So with respect to the fixed-wing, in '13-14 there were 1,597 patients . . .

Ms. Chartier: — 1,595.

Hon. Mr. Duncan: — 1,597 patients in '13-14. The STARS has transported 800 patients in the first two years of operation. And I believe in '12-13 it was 249. So the difference between an estimate of 800 minus 249 would be the '13-14 number.

Ms. Chartier: — Okay. Okay.

Hon. Mr. Duncan: — Just that in terms of the difference**,** the difference between '12-13 and '13-14 for STARS largely is a reflection of the fact that in April of 2012, we opened in Regina or STARS opened in Regina, but it was later in the year when they opened in Saskatoon. So '13-14 would have been an entire fiscal year of operations with the two bases, whereas '12-13 would have been only part of the year in Saskatoon.

Ms. Chartier: — Okay, sounds good. Thank you. So I just wanted to double-check, obviously I can check *Hansard* too, but '12-13 there were 249 STARS patients in the first year of transport. And then in '13-14 was six hundred and . . .

Hon. Mr. Duncan: — Roughly 550.

Ms. Chartier: — 550. Yes, thank you. Okay, thank you for that. Just in terms of some of the concerns that have been flagged for me around STARS and air ambulance is the difficulty obviously of a new service coming in and the integration of dispatch for that, for all intents and purposes, or triaging patients.

Because I know when STARS comes in, they have a specific package of services that they offer. And there was a pre-existing triage service here in Saskatchewan, I think that that was established in 2008. So I'm wondering in terms of the . . . Obviously they should be two very complementary services. I'm wondering your thoughts on how that integration of making those work together has been.

Hon. Mr. Duncan: — I think the experience in Saskatchewan in the first two years has been a very successful implementation of STARS in Saskatchewan. I think it's been recognized. In fact while I wasn't there, my understanding is, from the event today over at the hangar in Regina to celebrate the two years, is that there has been a very successful integration of STARS into the system where kind of the entire system, all the providers are together to make decisions when a scene call does come in to make that determination whether or not it's going to be STARS or fixed-wing or road ambulance that will be responding to the scene.

I can tell you the experience of my understanding is that today the tones in the hangar did go off apparently when they were there. I know certainly that was the experience at an event that I took part in at the hangar in Regina, I think it was last fall I believe, where the tones went off. And eight, actually timed it on my watch, eight minutes and 20 seconds later, the helicopter actually took off.

So I think that that shows that it is really a seamless integration with the emergency services. And I just think everybody should be commended for how that transition has gone.

Ms. Chartier: — Just to be clear though, though just because they take off in eight minutes, doesn't necessarily mean they'll be transporting someone. So that's my question, is around the triaging, that obviously there's not every call can be a STARS call because of weather, because of different kinds of distance, those kinds of things.

So I think what I'm flagging here for you is that I've heard some concerns around how the integration of triaging calls is going. That has been flagged as a bit of a concern.

Hon. Mr. Duncan: — So I would just say that certainly the number, so the number of patients transported versus the number of missions that STARS has flown on . . . because not all missions will be complete. There will be some factors that

will dictate that STARS is to stand down. So whether that be weather related, whether that be because of the decision-making process, the providers that are involved have determined that STARS is perhaps not the vehicle to transport that patient.

But I think that to date, to my understanding, is that they all work in concert to make that determination of whether or not . . . You know, we have to keep in mind that STARS is just one piece. It complements I think a very good system of road and fixed-wing ambulance. But I would take the position that that has been a fairly successful implementation.

Ms. Chartier: — One of my questions or one of the challenges that I'm hearing is around obviously STARS. One of the things STARS offers is a transport physician, and some of the transport physicians are otherwise sometimes occupied. There are also ER [emergency room] physicians. So they can't always, STARS can't always take a call because their transport physician happens to be an emergency room doc as well.

So the information obviously, I'm just wondering where you are in this discussion, what you know about that. And if you can give me a little bit of information on how . . . what's going on there.

Ms. Jordan: — Good afternoon. I'm Deb Jordan. I'm the executive director of acute and emergency services with the Ministry of Health. So just to clarify the arrangements for transport physicians, at each of the Regina and Saskatoon STARS base there is a call rota for transport physicians. Typically a physician who is on call with STARS will serve for a 24-hour period. But they're dedicated to the service. It is true that the physicians who complement or fill out the rota in both Regina and Saskatoon also work as ER physicians, but when they're on the call rota for STARS they're dedicated to STARS service.

Ms. Chartier: — So it's a misunderstanding, or misinformation that I've been given that . . . I understand that there's some negotiation pieces that are ongoing right now that the compensation to be a STARS physician is less than you would be making working for a health authority. So can you respond to that at all?

Ms. Jordan: — I won't respond to the discussions about compensation that may be occurring. But rather I think it's important to clarify just the framing of your description of the service implied that perhaps the physician who is on the transport physician call rota for STARS is also supposed to be working at the emergency room, and that's not the case. It is true, just as other STARS personnel — paramedics, critical care nurses — may work with the health region for part of the time and with STARS for part of the time. But when a physician is part of the call rota at STARS and on that 24-hour on call, they're dedicated to STARS service.

Ms. Chartier: — How many physicians are on that roster then?

Ms. Jordan: — The call rota in Regina has 13 physicians on it. And I would have to confirm the Saskatoon number. It would be a like number or perhaps a little bit higher.

Ms. Chartier: — Can you tell me a little bit about how that works? How often is a transport doc on a 24-hour call? Like how often do they come up in that?

Ms. Jordan: — The physicians typically work as a team to schedule and cover the rota for the month. So most physicians would likely take one or two days out of the one-month period that they would be part of that call rota.

Ms. Chartier: — Is there any time or occasion where a STARS mission hasn't been able to be complete because there is not a doctor available?

Ms. Jordan: — And perhaps just to clarify, and I will use the words of one of the STARS physicians who was presenting at the event today, it is rare that the transport physician would actually go on the mission. As the physician said, he or she will only attend if there are a particular set of skills that that patient needs that neither the critical care paramedic or nurse can provide, and he jokingly made reference to the fact that just the added weight, because you always have to be conscious balancing equipment and number of folks on-board to ensure the safety of the helicopter. And so there's a very conscious assessment based on the information that is provided about the patient, whether there will be value added to have the physician actually on the mission or whether he or she is providing advice and guidance through the satellite phone to the team on board.

[15:00]

Ms. Chartier: — So the goal of the physician often then is to be available, to be speaking to the team that's in the air — the nurse and the paramedic.

Ms. Jordan: — Yes, and the transport physician is part of that initial call. So the minister had described that when a call for a critical care patient comes in, there's a discussion that goes on among the circle of care as to what is the best mode of . . . what does the patient need and what's the best mode of moving the patient to where he or she needs to get to. Is that ground ambulance, fixed wing, Saskatchewan air ambulance, or is it STARS? And it varies. I mean certainly during extreme weather conditions the choices might be different than they are on a day like today.

Ms. Chartier: — Can you describe for me the process that comes in then, both with STARS and with the fixed-wing service? I understand that . . . And again that's why we're here to ask these questions and get clarifications, but I understand that pediatrics in Saskatchewan doesn't participate, or if there's a pediatric patient. So I'm just wondering all the various parts and pieces of where and how calls come in to STARS, or I know air ambulance has a system as well. So if you could describe that a little bit for me, that would be great.

Ms. Jordan: — Yes. Sure. So if a call comes in typically through the Sask 911 system and it's identified, our focus with the STARS program of course is with the rural red or critical care patients. If the call is one that fits the criteria for STARS, the call will be sent to the STARS centre and it will bring the other providers, EMS dispatch ground, as well as Saskatchewan air ambulance into the discussion about the status of the patient and then what is the most appropriate for the needs of that particular patient.

The minister described, a few minutes ago, the fact that the program started two years ago. So it started with the operation of the base in Regina in April of 2012. The base was in operation for 12 hours a day, seven days a week until the crew had familiarity with the terrain in southern Saskatchewan, and then it moved to a 24-7 operation in the summer of 2012.

The base in Saskatoon when it started operation in October of 2012 went through the same period of operating for a period of time, 12-7, and then moved to a 24-7 operation in February of 2013.

Part of the discussions that are currently under way, I think the planned and managed implementation to the ramp up of service has been very purposeful in terms of ensuring staff familiarity with providing service in Saskatchewan and also ensuring that we walk before we can run, so to speak. So the focus has been on adult transports. We are now in active discussions with all the partners that have been described with respect to emergency medical services as well as dispatch and our specialized pediatric transport teams — neonatal as well as pediatric intensive care — as to what role STARS may be able to support and provide in the future.

Ms. Chartier: — I'm wondering how air ambulance fits into this too though. So you've talked about the critical care or the red patients. So I know . . . So STARS is the Link Centre which allows all that to happen. Then there's the provincial air coordination centre.

Ms. Jordan: — That's correct.

Ms. Chartier: — And so what's the difference or how do . . . Can you maybe give me an anecdote? So I'm in La Loche and something happens to me in La Loche and I need to get to a hospital. Who picks up the phone? Like, how does that all work?

Ms. Jordan: — So somebody picks up the phone, calls 911. 911 would relay that based on the criticality of the patient and I would also flag the location. So currently with the smaller helicopter service, La Loche would not be within the flight radius. Nonetheless the members that I described previously would come together, including the provincial air coordination which is Saskatchewan air ambulance, but it also provides, through that coordination centre, coverage for basic to intermediate which would be a less critical patient service in northern Saskatchewan.

In any event, all the partners would come back on the line again to determine, what does the patient need? Clearly if a patient has to be taken out of La Loche and brought to North Battleford, Saskatoon, then that's going to be a fixed-wing transport typically. And so the arrangements would be made through that process. The patient would likely be brought to the local La Loche Health Centre. Arrangements would be made for air ambulance to come into La Loche. The crew would then come to the hospital, help stabilize the patient, ground ambulance would take them back out to the airport or landing strip, and they'd be on their way.

Ms. Chartier: — If it happens to be a call that's a shorter distance, it could be either STARS or air ambulance . . .

Ms. Jordan: — Or ground.

Ms. Chartier: — Or ground, yes. How does that process . . . So I've heard of the Link Centre which STARS provides with all their services in other parts in Western Canada too. But we've got this provincial coordination centre, so I'm just wondering how they work together. I don't think I understand that.

Ms. Jordan: — Well, it's the beauty of the technology to be able to bring all the partners on the line to discuss . . . again, I'll differentiate between critical care patients, so that would be the purview of STARS and air ambulance, whereas through the provincial coordination centre that's supported by Saskatchewan air ambulance, there are often in isolated communities in the North, you know, a stable patient who perhaps needs to go from Pinehouse to La Ronge. And while Saskatchewan air ambulance would not do that type of trip because its focus is critical care, through the PACC [Provincial Aeromedical Coordination Centre] we would make arrangements for the local basic to intermediate provider to care for that patient.

Ms. Chartier: — Okay, I still . . . But am I correct in thinking that the coordination centre is a triaging centre as well? Am I mistaken in thinking that the provincial coordination centre is a triaging body as well?

Ms. Jordan: — It would participate certainly in the discussions about the patient, and if it's determined that the patient is going to go fixed wing, then it would do the more detailed triage of the patient.

Ms. Chartier: — Okay. Does the call — again, forgive my ignorance here — but if the call is . . . So a 911 call comes. We're not sure if it's critical or not. So we've got these two different centres. So it might come to air ambulance first, is that . . . or not to air ambulance, to the provincial coordination centre. And then how does that all play out?

Ms. Jordan: — Then whoever receives that call would bring the other partners onto the line to assess what's required for that patient.

Ms. Chartier: — Okay. Okay, thank you for that. I may . . . I just have to ponder that here a little bit. When critical peds was cancelled or centralized, moved to Saskatoon I think as of the beginning of January — is that correct? — pediatric patients now . . .

Hon. Mr. Duncan: — Yes, so that was effective January 6th of this year.

Ms. Chartier: — Okay, I know on the ambulance services website there's the Saskatchewan Pediatric Transport Service piece that talks about having pediatric transport teams located in both Saskatoon and Regina. And I've been told that in fact, right now, there's no longer a pediatric transport team in Regina. Is that the case?

Hon. Mr. Duncan: — That's correct. When the decision was made, the partners came together to discuss how these patients would be transported, and the decision was that because they would now be transported solely to Saskatoon, that that would

be the transport team that would look after them after the decision was made.

Ms. Chartier: — So there is no longer a pediatric transport team in Regina? So in southern Saskatchewan then . . . One of the concerns that's been flagged for me . . . And I wasn't sure because I'd heard this and then I looked on the website, and it said that there were in fact two teams. But one of the concerns that's been flagged for me is if with the fixed-wing aircraft, for example, if you have to bring a pediatric transport team from Saskatoon to pick someone up in Regina and then fly them to Edmonton or wherever, that maybe that aircraft will be out of commission for a good chunk of time, eight or nine hours. Because you pick them up in Saskatoon. You bring them here. You take them elsewhere. It's a two and a half . . . I was told it was about an extra two- to two-and-a-half-hour process, because we don't have the transport team here.

I'm wondering how you're trying to resolve that issue. I understand that there's been obviously an increase in the number of those trips to southern Saskatchewan because of the cancellation of critical care in Regina for peds.

Hon. Mr. Duncan: — So just with respect to the question, so with the change to the high acuity at the General Hospital, so there have been 18 patients transferred to Saskatoon that required pediatric intensive care.

In terms of the premise of your question, but I think what maybe perhaps you're leaving out in that, is that even when there was a transport team based in Regina, there wasn't an air ambulance, a plane in Regina for that. So the plane still had to come to Regina anyways. So regardless of where the transport team's coming from, the plane itself is still coming from Saskatoon, and that part remains the same.

Ms. Chartier: — With an increased number . . . And I'm learning about all of this here. This is all very new to me. And again this is why we're here in estimates is to ask questions and figure this all out.

So in terms of having to make those . . . an increased . . . But if you're transporting someone out of province then though, that leaves no pediatric transport team in Saskatchewan. So you might still have one aircraft left, but you've got an aircraft and a pediatric transport team out of province and no pediatric transport team in the province.

So in light of the fact that we are now transporting more kids to Saskatoon or wherever they may have to be, is there any thought to adding resources around another pediatric transport team?

Hon. Mr. Duncan: — Thank you for the question. So certainly with I would say a smaller volume that would be coming out of southern Saskatchewan over the last number of months . . . But we always are evaluating not only with the changes in Regina more recently but also volumes out of central and northern Saskatchewan. So I think that we're always doing an ongoing evaluation of the services that we're able to provide, and this would be an area where the partners that are involved in pediatric care would be looking at.

[15:15]

Ms. Chartier: — Okay. I think instead of me sort of trying to fill in the blanks or ask half a question and not quite being sure what the other half of it is, I think I would just like to ask, in light of cancelling the pediatric care services here in Regina as of early January, what has that meant for transport of children both in Saskatchewan and out of Saskatchewan like in terms of number of trips made, all those kinds of things? What has that meant for transport services, whether it's by fixed-wing ambulance or by ground ambulance, however?

Hon. Mr. Duncan: — So with respect to the changes that were made in Regina Qu'Appelle Health Region, certainly there still is the high acuity component that the large number of pediatric patients that would have previously been served in Regina Qu'Appelle will still have that same level of service.

In terms of the change away from the pediatric intensive care unit, as I've mentioned before, it has resulted in 18 transfers to Saskatoon in roughly the first quarter. We had estimated approximately 60 that we thought in a full year it would mean in terms of transfer of patients. So I think what we're seeing in the first quarter since that change has been made is certainly tracking with the estimates that we had previously thought before the decision was made.

Ms. Chartier: — Compared to what? So you're estimating 60 per year, 18 in the first quarter. How does that compare to prior to the critical care being cancelled here or being centralized, however we want to say that?

Hon. Mr. Duncan: — Thank you for the question. Perhaps after my answer, you may want to try again. I'm not sure. I think I'm answering the question but I'm . . .

So we have to date had 18 transfers in a little over the first quarter. So it would include the first three months, but this goes well into April. So really the first four months, the first third of the year we have seen 18 transfers from Regina to Saskatoon that would not have taken place necessarily had the PICU [pediatric intensive care unit] been maintained in Regina. That's not to say that children had not been transferred to Saskatoon in the past, but these are 18 I think over and above what we would have seen in the past, which is tracking along that line that we had estimated, the 60 that we thought would occur in the first year.

Ms. Chartier: — So not 60 transfers but 60 more than you normally would have seen. So my question was, how did the 60 compare? And I had understood you were talking about 60 in a year, but you were saying 60 more than you would have previously transported. Is that correct?

Hon. Mr. Duncan: — So I'll just use maybe the year prior to the change in PICU. So we would have seen probably 10 to 12 pediatric patients transferred from Regina to Saskatoon, based on the level of care, the service that they would require, based on the specialties and the support that would be in Saskatoon that may not have been available in Regina.

So the 60 that we are estimating for this year would be over and above what we would have normally seen in terms of the

transfers between Regina and Saskatoon.

Ms. Chartier: — Okay. So again, just flagging that then, if you've got 60 more transfers, that is additional pressure on those services that provide transfers. So I'm wondering how you're going to address that piece?

Hon. Mr. Duncan: — In terms of the question, Ms. Chartier, I think maybe I'll just go back to what I said in a previous answer. So with our partners involved in pediatrics in the province, we will certainly be following closely and monitoring any impact that this would have on the ability for pediatric patients to be transported within the province or outside of the province in some cases.

I think it's fair to say, in the past the Ministry of Health, if the need has arisen — and it has — we have added additional support. We've added additional personnel. We've added an additional plane into the service when the numbers have justified it. And so this is something that we'll continue to work with our partners to kind of track the progress of the move and the implications of the move within Regina Qu'Appelle Health Region.

Ms. Chartier: — I just have to say though, if you are going to plan on doing 60 more transfers, you've made the change, would you not have wanted to have been proactive? My question I guess: is this reflected anywhere? I think you answered that already. But in '13-14 is the support to do those additional transfers reflected in this current set of estimates in the budget anywhere?

Hon. Mr. Duncan: — Well I think that there would have been an estimate of the capacity to be able to handle an additional 60, estimated additional 60 transports in this year within the existing capacity. The budget did increase in terms of the air ambulance budgets by about $1.5 million, so there has been I think recognized support. There's been some evaluation to see whether or not there is capacity within the system. But we will certainly continue to track the progress of these changes, and if we need to make additional changes or additional supports, certainly we would be looking at that.

Ms. Chartier: — Was that 1.5 million tied to a specific ask? Or the increase in air ambulance, was it just part of their global budget, or was that 1.5 million increase tied to anything in particular?

Hon. Mr. Duncan: — So the bulk of the change to air ambulance is with respect to service utilization increases, so just the expectation of additional utilization of the services. So we factor that in when we make our budget request.

Ms. Chartier: — And was that, those 60 pediatric transfers, which may, may not have been air ambulanced . . . They would be ground ambulance as well. I'm assuming that that's in the realm of possibilities. Was that factored in?

Hon. Mr. Duncan: — When factoring or making a determination of what we're going to request in terms of a budget increase, there would be a number of factors that would influence the level of increase that we would be looking for so wouldn't be specific to just the 60 estimated transports, although certainly that would be taken into consideration. But there would be other programs that would affect both increase and decrease in the utilization of air ambulance and the other ambulance supports. You know, if we're doing more kidney transplants in the province, we're not having to transport out of province, so that would take into account. So all of those things would be factored into the request that we would have come forward with.

Ms. Chartier: — Have you seen an . . . Sorry, let me just think about that for a second. So in terms of planning then, can you tell me if those 18 transports to Saskatoon in that first quarter, were they air ambulance? Were they ground ambulance? Do you have any sense of those? What transport method was used?

Hon. Mr. Duncan: — The majority of the 18 were by air.

Ms. Chartier: — By air. Okay. I'm just curious, does STARS ever participate in those transfers?

Hon. Mr. Duncan: — At this time, STARS doesn't transport pediatric patients. They wanted to, in their first couple of years in the province, wanted to focus more on adult patients, transporting adults, kind of get used to the service in the province and providing that service. But that would be something that we would be . . . There'd be some consideration of that into the future of whether or not their service would be expanded to include pediatrics.

Ms. Chartier: — Just out of curiosity, you had mentioned not taking a transport doc necessarily because of, in a STARS ambulance, because of the space in a helicopter. I know you can't take family members either, but could you reasonably . . . I don't think you could transport in STARS because the pediatric transport team includes a respiratory therapist and a nurse as well. So would that even be in the realm of possibilities?

Ms. Jordan: — So one of the planned and upcoming changes to the STARS service is, probably later this summer or early fall, there is going to be a much larger, longer range helicopter that will come into service out of the Saskatoon base. And so the opportunities with that much larger, longer range helicopter, not only in terms of the ability to transport, but I'd noted earlier that the range with the current smaller helicopters unrefuelled is certainly shorter, and that will get a much broader and longer range without refuelling range with the larger helicopter.

Ms. Chartier: — Can you . . . Is STARS purchasing that or is that in our estimates?

Ms. Jordan: — That's being provided by a donor.

Ms. Chartier: — By a donor. Okay. And what kind of range will that give STARS at that point?

Ms. Jordan: — 1000 kilometres unrefuelled.

Ms. Chartier: — Okay. And where are they at right now with respect to range?

Ms. Jordan: — These, again weather dependant, with the smaller BK117 probably in about the 400-kilometre range

unrefuelled.

Ms. Chartier: — Okay. Back to '10-11, did we pay for any capital for STARS or just some operation money?

Hon. Mr. Duncan: — The original . . . in '11-12, 6.1 million. That was the initial start-up costs that the province did provide largely for operations, but there would have been a capital component to that as well.

Ms. Chartier: — What, it was included in that capital component?

[15:30]

Hon. Mr. Duncan: — It would have been the lease cost for the helicopter.

Ms. Chartier: — Okay. Thank you. Just going back to the . . . I just have a couple more questions on transport here, around the pediatric transport team. Where does that come out of the budget?

Hon. Mr. Duncan: — It's within the Saskatoon Health Region's budget, so it's not an item within our health budget. It would be within the allotment that's given to Saskatoon Health Region.

Ms. Chartier: — Part of their global budget recognizing that they are servicing all of the province. Is that taken into consideration?

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

Ms. Chartier: — When there was a team here in Regina, did that come out of RQHR's [Regina Qu'Appelle Health Region] budget then?

Ms. Jordan: — So the arrangement in Saskatoon is that the nursing personnel are supernumerary who work on the pediatric critical care transport, which means that they're over and above the staff complement on the pediatric intensive care unit. What Regina had, because its call volume was much lower, it had an on-call arrangement so that when someone was needed to go on transport, that staff member would be dispatched on the transport and whoever was on call would then come to work and replace that person on the unit.

Ms. Chartier: — Okay. Thank you for that. Switching gears totally and completely here, I don't know if you had an opportunity this weekend to see *The Globe and Mail* — or actually Monday, April 28th — an article about Lyme disease in Canada and generally around climate change and the range of the vector for Lyme disease increasing by a great deal actually, and Lyme disease apparently is on the rise here in Canada.

Hon. Mr. Duncan: — Sorry, Ms. Chartier. Which date of *The Globe and Mail?*

Ms. Chartier: — That is the Monday, April 28th, 2014. So I'm curious here, and having spoken to a few people who have flagged some concerns around Lyme disease, and actually Elizabeth May has a private member's bill on establishing a framework for collaboration between the federal, provincial, and territorial ministers, representatives, medical community, patients' groups, to promote greater awareness and prevention of Lyme disease to address the challenges of timely diagnosis and treatments and to push for further research.

And again it's because of climate change the range for the black-legged tick that carries Lyme disease is expanding, and there's new cases that have been found across Canada with thousands now afflicted by what is rapidly becoming, in Elizabeth May's words, a national crisis. I am wondering if we have a sense of the prevalence in Saskatchewan of the number of cases diagnosed.

Hon. Mr. Duncan: — We'll just, Mr. Chair, members of the committee, we'll just take a few minutes to get the appropriate officials.

Mr. Hendricks: — So as you might be aware, the Ministry of Health does contract with an entomologist, Phil Currie, who not only monitors our mosquito population during the summer, he also looks at other insects including our tick population.

Over the last few years — and we don't have the exact numbers; we'd be glad to provide them to you — both in terms of what we have encountered in tick populations but also diagnosed Lyme disease, our numbers are very low in comparison to Eastern Canada. And so what I will do is we will endeavour to get you those numbers. And we do have them, we just don't have them here, so we apologize for that.

Ms. Chartier: — Okay. That would be great, thank you. I know that Lyme disease can be a very debilitating illness and makes people very, very ill. And I think individuals who suffer from Lyme disease often feel dismissed.

And the testing, I think, is another question that people have asked me to raise. I understand that there are many . . . Well I should just ask. What diagnosis process is being used here in Saskatchewan? I know that there's been flagged some tests that are not as effective as others.

Mr. Hendricks: — So when a physician or a health provider does suspect Lyme disease, those tests are actually sent to the national laboratory in Winnipeg for confirmation, whatever tests they do to confirm or negate Lyme disease. So I'm not sure exactly what those are.

Ms. Chartier: — Could you find out? I've had individuals who have asked. Because that is a concern that the numbers of cases, for example, in provinces that are adjacent to states like Maine for example, the numbers of cases in Maine are incredibly high, but just across the border that share the same woods with New Brunswick, they're much lower. So I think there's been some concerns flagged about the testing that we do here in Canada.

So I would like to not only find out how many cases we are diagnosing here in Saskatchewan, but what kinds of tests are being used to find out if people in fact do have Lyme disease, and do those follow best practices? It would be interesting to find out if the centre in Winnipeg . . . undoubtedly or should be following best practices but . . . and keeping up with the literature and what's going on elsewhere. But if you could find

some more of that out as well.

In terms of the support for those diagnosed, what kind of support is available in terms of drug therapy here in Saskatchewan?

Mr. Hendricks: — So in response to this line of questioning, we actually have made contact with the person back at the ministry who will be able to answer your questions hopefully before this session is done today. So we will endeavour to get that information to you fairly quickly.

Ms. Chartier: — Okay, and just putting on the record here, so page 5 of the story from *The Globe and Mail* on Monday, April 28th talks about, or consumers, or those who are struggling with Lyme disease, so:

> . . . the Lyme community, Canadian patients are still being offered the same old tests. The standard Western blot test detects only a lab strain of Borrelia and its close cousin.
>
> The second test, known as the ELISA, isn't sensitive enough to distinguish Lyme disease from such illnesses as lupus or rheumatoid arthritis, according to Dr. Brian Fallon, director of the Lyme and Tick-Borne Diseases Research Center at Columbia University.
>
> Both are known to have "significant limitations," Fallon said.

So again, some individuals here in Saskatchewan who are suffering with Lyme disease are wondering where we're at. And I'd like to know, in light of Elizabeth May's private member's bill, and perhaps you haven't seen it yet, but would you support a national strategy on dealing with this?

Hon. Mr. Duncan: — Mr. Chair. Thank you, Ms. Chartier, for the line of questioning. And I'm just on my phone here looking at the article — somebody has sent it to me — that you've referenced. So I haven't had a chance to look at the article, nor have I had a chance to look at Ms. May's private member's bill.

As the deputy minister has said, we're going to try to get the answers, the specific answers that you've . . . questions answered while we're here in, sitting in committee. If not, we'll certainly provide those immediately.

This isn't something, I think in my two years at the provincial-territorial table, or the FPT [federal-provincial-territorial] table, hasn't been raised specifically. I think that, you know, we would certainly be open to having that conversation. But I think we would need to get a little more details in terms of where we currently are sitting as a province and as a country in terms of the testing that we do have available here versus what might be available in the United States or in other jurisdictions that perhaps are ahead of us on this. So I wouldn't want to commit today to signing on to a strategy that hasn't been proposed to us, certainly in a formal sense. But certainly we will be following up with your specific points on this.

Ms. Chartier: — And just to put on the record too that Nova Scotia right now is also in the process, I understand, of supporting a bill that will cover a strategy on Lyme disease. So this is the national bill, but as well Nova Scotia is moving on it as well. So just again, obviously I can't, wouldn't ask you to support something that you haven't seen or read, but you would be open to the possibility of a national strategy on Lyme disease if the evidence warrants?

Hon. Mr. Duncan: — Most certainly we would be open to having that discussion with our FPT partners. I'll provide perhaps a little more information on some of the specifics, just based on some information that we've been able to obtain.

So each year in Saskatchewan, there's several hundred tests for Lyme disease that are conducted. I won't speak to perhaps some of the concerns about whether or not they're the right tests or rigorous tests. So in the last year we would have had two cases that were identified in Saskatchewan. I'll walk through a little bit of the process.

So for Lyme disease testing in Saskatchewan, we do follow the guidelines published by the Canadian Public Health Laboratory Network. This involves testing the blood in a two-step process, followed by confirmation that is done in Winnipeg, as the deputy minister has indicated. The process, I'll just go down my list here. Sorry, I'm just kind of reading this as it just was handed to me.

Ms. Chartier: — No, fair enough.

Hon. Mr. Duncan: — So positive results from US [United States] laboratories that do not use methods that are validated by the US Centers for Disease Control and Prevention need to be confirmed through our process, so the Saskatchewan disease control laboratory, and then followed by the test confirmation in Winnipeg.

I think this was around a specific issue, around whether or not a private laboratory test in the United States is then acceptable in Saskatchewan. So that's just a little bit of the process that we currently use in the province.

Ms. Chartier: — Just in terms of numbers here — and again this is from that *Globe and Mail* article, I don't have any primary research on it in front of me — but Jim Wilson, the president of the Canadian Lyme Disease Foundation says Canada lags far behind the US in testing for the multiple strains of bacteria that can cause Lyme. He goes on to say that although . . . That's not what he goes on to say. He goes on to say that Canadian tests and clinical exams are way too narrowly focused for what we're running into in the wild.

And according to the Public Health Agency of Canada, only 315 cases of Lyme disease were reported in 2012. According to Wilson, the numbers are actually in the thousands, noting that 3,000 patients contact his organization each year. And in the US actually, 2013 report from the US Centers for Disease Control and Prevention estimated that 300,000 Americans are diagnosed with Lyme disease each year. So granted their population is considerably larger than ours but . . .

[15:45]

Hon. Mr. Duncan: — It is, but I would just . . . So 300,000

each year in the United States?

Ms. Chartier: — Yes.

Hon. Mr. Duncan: — So we're kind of, I think, the 10 to 1 rule or something that we use versus Canada, the United States. So I think what the article is indicating is that if that is the case in the United States, then we're probably under-reporting?

Ms. Chartier: — Yes. Yes.

Hon. Mr. Duncan: — That would be, I think, if I'm understanding correctly, what the article . . . not having read the article, but I think that that's probably the point of the article?

Ms. Chartier: — Yes, exactly. So if you could look further into this, that would be great. I'd appreciate that.

While we're talking about insect-borne illnesses, I'm wondering about West Nile virus in Saskatchewan and where we are with . . . Obviously we had a pretty cold winter this year, but in terms of numbers of reported cases over the last few years, I know we had a bit of a spike and then a decrease. But with changing climate, where we might be at right now in Saskatchewan?

Hon. Mr. Duncan: — With respect to West Nile virus, we do provide some dollars within the Health budget. This year it's $389,000. That's the same as that it was last year. It remains consistent to ensure that we do have adequate funding available to address any potential issues.

Obviously there is a number of factors that go into determining whether or not it's going to be, what type of year it's going to be in terms of West Nile virus. It really is dependent upon the Culex tarsalis mosquito, I think, as you'll know, that depending on the type of, you know, if it's a wet spring that we have and the numbers that we would have as we get into the midsummer period into the last two weeks of July or first two weeks of August. So it really is dependent on year to year and the different conditions that may be present for that year.

Ms. Chartier: — What does the $389,000 fund?

Hon. Mr. Duncan: — So it includes funding for adult mosquito control in communities where West Nile virus risk is high. And that's something that we do an evaluation based on, as I mentioned, a number of factors: how wet of a spring it is, the population count that we do start counting in the early part of the summer, late July or early August, and then make determinations from there.

Ms. Chartier: — So it always goes to either RMs [rural municipality] or municipalities for mosquito control. The $389,000 is allotted for that and nothing else. I just wanted to confirm that.

Mr. Hendricks: — Just to clarify, the funding for West Nile virus that we do provide in our budget deals primarily with contracting an entomologist and in the surveillance of mosquito populations. And so we track that throughout the summer. When we do actually encounter . . . and also education. We do a lot of education about applying mosquito repellent, that sort of thing, and the times of days that you should avoid and the symptoms of West Nile virus.

So when we do encounter higher than usual populations, in the past what we have done is we have provided money to municipalities for mosquito control in areas of the province where we do see a high prevalence. It wasn't a super big issue last year but, you know, as the minister said, it depends on how wet the early spring is and that July, August period when the Culex tarsalis is most prevalent.

Ms. Chartier: — Thank you for that. In terms of the number of cases of West Nile in the last, I can't even think of how many years it's been registering, but the last decade perhaps?

Hon. Mr. Duncan: — The province of Saskatchewan has recorded approximately 2,500 cases of West Nile virus since the arrival in 2002. However in the last year, so 2013, there were only nine human cases.

Ms. Chartier: — So were the majority . . . Do you have the breakdown? I'm just curious, the breakdown from 2002. So it's peaked and dropped, or has there been ups and downs? If you could just read into the record for me since 2002 the number of cases, just the year and the number.

Hon. Mr. Duncan: — We have that information at the ministry, the year-by-year breakdown. We don't have it with us here, but we will be providing that information. I think it's fair to say that there was a spike, 2009, 2010, sometime in that time frame. But certainly in the last year, last year was a pretty quiet year when it came to West Nile. But we will certainly provide that breakdown to the committee.

Ms. Chartier: — It might be a quiet year in terms of numbers, but I do have a constituent who I met door knocking whose husband has been completed debilitated by West Nile virus. It doesn't happen all the time, but this was a man who was a teacher and who lost his livelihood and was confined to his home for all intents and purposes. So nine is a lower case, which is great, but when it does hit you, it can hit you very hard.

Hon. Mr. Duncan: — Absolutely. I do want to . . . I don't want to minimize for individuals that are afflicted by the West Nile virus that it can be very life changing for these individuals. So I certainly don't want to minimize it for any of those individuals.

I think what I'm trying to do though is put into context, that 2,500 over the 12 years that we've been monitoring in the province, a smaller number in this last year. So it certainly shows that it's had peaks and valleys in terms of the reporting that we're seeing over those 12 years, but certainly I wouldn't want to leave the impression that it would be minimizing the impact that it does have.

Ms. Chartier: — Thank you for that. Just going on to the Moose Jaw Hospital and where this . . . I've got a few questions about the Moose Jaw Hospital. So in terms of, you gave me the number for the 3P events. You said there were three for a total of $625,000. Is the Moose Jaw Hospital . . . I know some of the other, I know that the Saskatchewan Hospital and the children's hospital had started out not with 3P, but I'm wondering if the

Moose Jaw Hospital and planning simply has had the 3P design.

I know those other hospitals were in process before you were embarking upon 3P, but I'm wondering about Moose Jaw in particular. Has all the planning simply been 3P and there's been no other planning that happened prior to that?

Mr. Hendricks: — So in response to your question, a slight differentiation in terms. Where Moose Jaw did start out, they started out with a lean consultant by the name of David Chambers who had done extensive work with Sutter Health in California. Incidentally, you know, I would say our current consultant that's doing our 3P has been closely aligned with David Chambers in the past and is well aware and they're familiar with each others work. He did some of the initial work around the cellular design in Moose Jaw that led into the 3P work. And so I would say from almost beginning to end, the work has been very consistently applied, lean 3P principles.

Ms. Chartier: — Okay. Which would be different than the start of both Saskatchewan Hospital and the children's hospital because those obviously didn't start with a lean 3P. So it's fair to say Moose Jaw has had the lean and 3P model right from pretty much the get-go then, with the design.

Mr. Hendricks: — Yes. A few facilities in Saskatchewan that have been announced, you know, from day one — we have Swift Current, Kelvington, that sort of thing — they've always been brought along with the 3P from the beginning. It did enter a little bit later in other projects. But Moose Jaw, as you know, Five Hills Health Region started doing lean in as early as 2005, so this was part of their design concept from the beginning.

Ms. Chartier: — Okay. And again we're here to ask questions and have things clarified. But I have been told that initially that there was no morgue included in the hospital, and that wasn't part of the 3P planning, and there is now. Can you clarify if that's the case?

Hon. Mr. Duncan: — Thank you for the question. We'll work with Five Hills Health Region to get an answer to your question. We just don't have that specific information here this afternoon.

[16:00]

Ms. Chartier: — Okay. In a case, if that is in case the . . . I think that this has been flagged as a concern with the children's hospital being paperless, or designed completely as a 3P and then paperless but having to change things afterwards, or the Moose Jaw Hospital being designed with a 3P without a morgue and how that impacts costs. So if you could endeavour to find that out, specifically about Moose Jaw, that would be great.

But I would like to go to the children's hospital then and if you could talk a little bit about the issue around, during the 3P process. I'm looking at some minutes from a meeting on March 21st, 2013 that highlights that a full electronic health record will not be in place upon opening of children's hospital, as was previously planned during the 3P events and throughout the design development. So I'm wondering how you plan to address, in this new design, how you have managed to accommodate paper records?

Mr. Hendricks: — So early on in our lean journey and the design of the children's hospital, when we first adopted the 3P approach . . .We talk about the seven flows of medicine, and obviously one of them is to reduce the flow of information. And one way of achieving that is electronic health records. So our goal at that time, when we said paperless, I think possibly a little bit idealistic, given the state of technology.

So some additional 3P work was done to address what is a much-reduced amount of paper that will actually be used in the hospital now. Keeping in mind — and you'll have seen some of the articles on this over the last week — we had originally described a standard of level 7 for the hospital, which is completely paperless. There is no paperless facility in Canada as of yet, so we would have been the first.

This hospital will achieve level 6, of which there is, currently there are none in Saskatchewan. And I don't know if there are . . . There are very few in Canada that have that level of paper. It did require a small amount of rework to deal with the short-term issue, but I have to say, it's not a fault of the 3P work. It was more probably being too idealistic on the part of the ministry as to where our technology would be at the time the children's hospital was up and running.

Ms. Chartier: — Oh no, I'm not knocking it. I think it's a commendable goal for sure. But then you talk . . . Okay. So you do the 3Ps, and you said you had to go back and do some additional 3P work when you discovered it wouldn't be entirely paperless. You've got level 7 is paperless; level 6 is the next best thing. So when did you realize that it had to be scaled back?

Mr. Hendricks: — So it was March of 2013 when Saskatoon said they didn't think — and in conjunction with working with eHealth Saskatchewan — that the technology and such would be available to go completely paperless by the time the hospital was up and running. And obviously there's a desire to get the hospital up and running.

And so in terms of the 3P work though, I've got to be clear. There was no additional space added to the hospital as a result of our inability to be completely paperless. There were some work surfaces added that could accommodate the limited amount of paper that was required. And when I talk about work surfaces, it's so that the physician can actually write things or the health provider can write things versus using a screen that would have been or will be at the bedside. But just because they won't have that complete functionality on day one of the hospital opening, they still need a pen and paper to write some instructions down.

Ms. Chartier: — Is storage an issue? Obviously with lean we've talked a lot about storage of different things including Christmas trees. Is storage . . . You said you didn't even need to change the size. You said a small amount of rework. And then so what I'm understanding, that rework is counter surface. So no additional storage for paper records at all or anything like that?

Mr. Hendricks: — So where it is required that we do need to

retain records, there's adequate space in the adjacent RUH [Royal University Hospital] facility and within storage to accommodate those records, but we're not talking about records of the scale that we are historically. As I said, this will be a level 6 hospital, so the paper, the actual paper will be greatly reduced. And the goal again is to go paperless in the future, so that will be eliminated.

Ms. Chartier: — Okay. So just again confirming, then there was no additional design work. That didn't impact design, or obviously the additional maternal beds do, but this doesn't impact design at all. I just want to make sure that's on the record.

Mr. Hendricks: — It didn't impact the footprint of the building. It impacted, as I said, the work surfaces and a few of the flows that were discussed during the 3P in terms of having to manage the small amount of paper.

Ms. Chartier: — Okay. Okay. Thank you for that. One of the questions that I had asked in our first opportunity to discuss these things a couple of weeks ago was around the Saskatchewan Hospital and the amount of money that had been spent previously, prior to the halting of the project to see if it should be a P3 [public-private partnership], and then to see if it should be a combined facility. I think I'd referenced an article in 2011, a news release, a government news release that had committed $8 million. And I think you said that at least $5 million of that had flowed. And then we went on to discuss how much had been spent on Saskatchewan Hospital design prior to that. So I'm wondering if you've got that.

Mr. Hendricks: — I do. So actually I do have to correct myself previously from committee, and we had planned on doing this in writing to the committee because I had been operating on a recollection that we had the $8 million and five and three, and I stated a certain amount had been spent. In fact there was actually a very limited amount. 379,000 was spent in 2012-13, and 358,000, so around a little over 700,000 was spent on planning versus the 8 million committed.

And the reason for that I think is clear, as you stated. As we went through the project and started the project and the 8 million was initially advanced, there were thoughts about how we might do this project differently and a different approach to the project. As you know, the P3 that was . . . you know, we're looking at for the project, and also I think the entry of Corrections and how that would work and working together on shared services with Corrections.

Ms. Chartier: — Okay. So what happened to the 8 million at that? So it had flowed, you'd said, and to where?

Mr. Hendricks: — No, sorry. We had it in our budget, so it would have lapsed. It would have never gone out to the region.

Ms. Chartier: — Okay. So where would it . . . It just goes back to the global.

Mr. Hendricks: — It would return to the GRF [General Revenue Fund], yes.

Ms. Chartier: — Okay. Prior to that though, the previous administration had committed money to planning. It had started some planning as well. So I'm wondering how much had been committed and spent. I'm trying to get a sort of a grand total of what has been spent to date on planning for the Saskatchewan Hospital.

Hon. Mr. Duncan: — So in 2007-2008 there would have been approximately $300,000 that would have went towards planning; 2008-2009, an additional 20,000; and then 2009-2010, $150,000 went to the health region for additional planning. And then that's where we pick up with what the deputy minister has said about the additional money that he has already outlined.

Ms. Chartier: — And how far along in the design prior to putting the . . . stopping the plans to examine if it should be a 3P as opposed to a . . . a P3, pardon me, as opposed to a 3P? So how long or how far into the design process were you when you decided to look and see if it should be a 3P?

Hon. Mr. Duncan: — The early dollars would've spent towards developing the functional program for the facility, and I believe that was the money that would've flown in 2007-2008. And then the additional money in 2009-2010, in that time frame, would've been around just updating that functional plan. So it would've been still fairly early stages.

Ms. Chartier: — So no conceptual designs or anything. That doesn't seem like enough to be able to do that anyway. So you said it was just on functional programming, that initial money?

Hon. Mr. Duncan: — It would've been mainly around functional program and a concept design but I think fairly limited.

Ms. Chartier: — Sorry. You think fairly limited or are you sure that it was fairly limited?

Mr. Hendricks: — Conceptual design is usually fairly limited. Where the architectural dollars and, as you noted based on the expenditure, where the real costs are coming is when you get into detail designing and you start moving along the design steps. So it's not unusual in any planning process to do kind of a high-level conceptual design of a facility.

Ms. Chartier: — Okay. In terms of what's been decided now with respect to pursuing a P3, so a few weeks ago you had referred me to the SaskBuilds estimates regarding when to expect an evaluation. I'm wondering if the decision was already made when we met on April 10th.

[16:15]

Hon. Mr. Duncan: — With respect to the question that you asked about Saskatchewan Hospital at North Battleford, I think what I can say is in terms of some of the analysis and the steps, because Health was one of three partners in this. So we had gone through a process to put forward what would have been the Health portion of the facility. Certainly Corrections would have done the same. And then it would have been SaskBuilds that would have developed the business plan and worked with their officials to do an evaluation and the analysis of the business case with respect to the decision again. I think we got

into this a little bit in a couple of our last committee meetings.

I can't speak to cabinet agendas or when things would have gone to cabinet for approval, except to say that we did approve the project and made an announcement just a couple of days ago that we would be proceeding with a P3 based on what had previously been announced in terms of a 188 bed facility, health facility, as well as a combined complex that would include 96 correctional beds.

Ms. Chartier: — Okay. In that first set of, or that first meeting that we had a couple of weeks ago, you said there was a value for money comparison between a 3P and a regular build. So I'm wondering what that value-for-money comparison told you. So you know how much the 3P is approximately going to cost. I think the Minister for SaskBuilds said between 200 and 250 million, if I'm correct. So I'm wondering in the value-for-money comparison, how it would have shaken out on its own as a traditional build.

Hon. Mr. Duncan: — It was a part of this project. That's really SaskBuilds' component of the project. So we put forward in terms of the plans for the 188 bed health facility — acute, rehabilitation, forensic facility — but that analysis, that's conducted by SaskBuilds. We don't do that analysis.

Ms. Chartier: — I know you don't do that analysis, but it's a good chunk of money from Health and it is a health facility, so I'm . . . And obviously you are an active partner with Corrections on that and SaskBuilds. So I'm wondering from Health's perspective, what did the 3P evaluation show you as compared to a traditional build?

Mr. Hendricks: — So as the minister said, SaskBuilds is generally regarded as the expert on P3s, and I wouldn't profess to know all the complexities of those.

Having said that, you know, we go through different stages — or SaskBuilds does — in the P3 process where they assess the value for money at different points. And throughout the course of this project, it has consistently shown a positive value for money over the time frame that we'll be operating under a design, build, finance, maintain. And they compare that against a traditional design build that we would normally do in the health sector.

So you know, I think that across cabinet they felt comfortable that there was a positive value for money that would accrue to this project over its life.

Ms. Chartier: — Well I'm glad they did. But I still am wondering what . . . So you've done a comparison . . . or not you. SaskBuilds has done a comparison. Health is a huge part of this project. So I really would like to know the comparison here, what Saskatchewan taxpayers . . . Sorry that I don't just want to take your word for it. I'd like some numbers.

Hon. Mr. Duncan: — I guess I would just say that we are into a process right now where the SaskBuilds has to my understanding released the RFQ [request for quotation] yesterday. That information, it's part of the process, the P3 process.

As the deputy minister has indicated, that there's an ongoing evaluation that takes place throughout the project to confirm and reconfirm what is to this point a positive money-for-value assessment.

But as the minister had indicated, when the announcement was made, not putting a dollar amount on it because this is a competitive process where there will be a number . . . The expectation is that there'd be a number of bidders, and so that assessment is ongoing, based on how far along the different proponents get into the bidding process.

And so I think at this point, the reason I think why . . . I know why the minister didn't release that information. It was because as a competitive process, there's no real value for government to put a price tag on a project that is up for competitive tender. So that information is typically, in these types of processes, not released until the project's awarded and then that becomes public for what that project would cost.

Ms. Chartier: — So you can't tell me how much a traditional build would have cost, though, in comparison? The minister's put out a ballpark figure for how much a P3 will cost. But again, forgive me for not taking your word on this, but it's a big expenditure and I have some questions about whether or not it will provide value for money. And I think people would like to see that.

This might be an easier question to answer. When you started the conceptual design or had some sense when planning started back in '07, and then obviously prices go up, but how much was initially thought, how much did you initially think you would be spending on a standalone Saskatchewan Hospital rebuild?

Hon. Mr. Duncan: — I would just say that I think it's . . . So there would have been several iterations of this project that would have had, I think, some estimates or some ranges in terms of the number of beds. We're now dealing with a project that includes 96 correctional beds, which wouldn't have been a part of previous planning. So I think at this point with the project that we're dealing with, I don't know. I'm just not sure in terms of any previous comparisons, because the bed numbers that have been agreed to may not have been the same. I'm just not sure what they would have been back in 2006, 2007, or 2008, pardon me.

As well, now having the 96 beds for the correctional facility wouldn't have been a part of this, so I think, you know, I would just go back to the previous answer that in terms of that analysis, we're really talking about SaskBuilds' portion of this project, not the Ministry of Health.

Ms. Chartier: — So $8 million was committed in 2011 for this project, so you would have had a sense in 2011 how much you were planning on spending on the health component. So I'm wondering what that cost was, recognizing that it was early stages and early days, and recognizing that in 2014 the facility does look different. But I'm wondering on the specific health component, when that money flowed in 2011, what was the projected cost of Sask Hospital. Because obviously if a government commits to it you must have some sense of how much you're willing to spend on it.

Mr. Hendricks: — So as you know, now that this project has been determined through cabinet discussions that it will be a P3 project and it's going out as a request for qualifications . . . It went out yesterday, actually. One of the things that . . . And this puts me in a bit of a difficult position, because when you're going through a request type of process, either a request for qualification or a request for proposals, obviously you're not able to discuss the details of that. And there are several reasons for that. And this is where a P3 is a little bit different, is that we don't necessarily want to tell the proponents or the private sector, bidders who might be interested in this project, all the numbers because we want them to give their best estimate, and that's what we assess again.

So SaskBuilds can get much better into the details than I can. In fact, I am barred from discussing the details of the P3 process because it is in an active request process. But you know, the government has committed that we're going to be transparent on all these issues, and it's at the right time though.

Ms. Chartier: — I understand some of the competitive issues, and I'm not asking about this particular facility. I'm asking about in 2011. And perhaps if I pored over those estimates, it might be a public number anyway. I didn't pore over nine hours of estimates from that year, but perhaps it is already a public number. So I'm wondering again, in 2011 when that $8 million was committed, what was the number that the government was thinking the facility would cost as a stand-alone health facility?

Hon. Mr. Duncan: — So based on the conceptual design back in 2011 — keeping in mind this was prior to any of the 3P planning, this was prior to corrections being added to the project — at that time the estimated, approximately $100 million was the number that was being used. But again that's based just solely on the conceptual design, without any of the more detailed planning that follows after that type of announcement.

Ms. Chartier: — Okay. Thank you for that. That is exactly what I was looking for. So 100 million. All right. In terms of the 3P . . . The 3P, I always have to think about that now. No, pardon me, the P3. In terms of the P3, so a value for money has been done, and this is how you've decided to go ahead. You must know how it's going to operate then as a 3P in terms of, so design, build, operate; in terms of control the Ministry of Health has over services that are provided — all those kinds of things. If this is what you're pursuing, I'd like a few details about that.

Hon. Mr. Duncan: — So with respect to the project moving forward as a P3, the facility itself, the building itself will be owned by the Government of Saskatchewan. I believe Central Services will be the owner of the building. In terms of the health part of the building, the Prairie North Health Region will continue to operate the facility. They will be responsible for the soft maintenance of the facility, so the internal maintenance, the day-to-day maintenance of the facility.

The successful proponent will be responsible for the hard maintenance of the facility and will be required to essentially turn over the building after a prescribed period of time in a set condition of the building. So they'll be responsible for ensuring the upkeep of the physical building, the hard maintenance that would be required.

[16:30]

Ms. Chartier: — Okay. Thank you for that. All right. Moving on here, we only have an hour left here. I want to go back not necessarily to the children's hospital but to the RUH site in general and again to the RUH, to the parkade.

So there was some money spent in mid-2013 to do some upgrades, I believe, and that parkade is now closed because of structural issues. And I know in our conversations last time, I had mentioned that someone working on the parkade which is adjacent to the children's hospital had said he had some concerns. And I had asked that question here, and obviously the response from you was that we'd have to trust the engineers who are constructing and doing the early work for the children's hospital have accounted for an adequate substrate foundation for the building. Fair enough.

But obviously . . . I'm wondering if it's the same engineers who worked on the parkade who made that analysis because we spent, I think, $3.8 million. I might be wrong about that number, but we spent money in 2013 and had to shut it down. And engineers obviously would have said that that was okay to do.

Hon. Mr. Duncan: — Is the question is it the same engineering firm that's working on the parkade that is making the recommendation that the substrate is adequate enough for building the children's hospital? That's the question?

Ms. Chartier: — Yes.

Hon. Mr. Duncan: — Sorry, I'm going to just ask one more clarification. So in terms of the parkade, are you looking for the same . . . So those that have made recommendations around the ability for the children's hospital to be built on that site, are they the same engineers who are providing recommendations today on the parkade, or who provided recommendations 30 years ago when the parkade was built?

Ms. Chartier: — Well on the work we spent, did we not spend $3.8 million? Or there was actually in estimates, I'll have to review estimates, but there was a chunk of money spent in very recent time on enhancing that parkade, and just this last year. So I might not have the timeline correct, but I know we've spent money on fixing the parkade, and it has failed. So obviously engineers, when you're fixing something, look at the overall system and see if it's going to work. And clearly someone was wrong, so I'm wondering if it is in fact the same company that has made, has done work on that site, both those sites — the parkade and the children's hospital.

Mr. Hendricks: — So, sorry, last time I did say that initially the repairs were expected to be about three and half million dollars. And that money . . . or permission had been given to the region to allocate capital funding for 3.8 million of necessary repairs. Subsequently, as I stated last time, we learned that the repairs might be much higher. What the region is doing is they're having three other engineering firms review the work required and the estimates before they proceed. So they're trying to not be locked into one engineer, but rather get several to look at this before they continue.

Ms. Chartier: — Where is . . . So how long or how far into the process is that with respect to the parkade?

Hon. Mr. Duncan: — We'll have to confirm with Saskatoon Health Region just in terms of where they're at in the process of the three additional reports.

Ms. Chartier: — Okay.

The Chair: — Okay, we have a request for a five-minute break. So at this time we'll do a five minute break.

[The committee recessed for a period of time.]

The Chair: — All right. After that short recess, we are back and, Danielle, the floor is yours.

Ms. Chartier: — Thank you, Mr. Chair. I've got, moving on here, lots of not little issues but a few sort of stand-alone items that I'm wondering about here. I understand, well from when the CNIB [Canadian National Institute For The Blind] was here speaking to MLAs [Member of the Legislative Assembly], that they have a proposal, the $182,000 proposal that they have before us or had presented to us as a group. And I'm wondering where that is at, where in your considerations of this particular CNIB proposal the government is at.

[16:45]

Hon. Mr. Duncan: — Thank you, Mr. Chair, and the committee, and Ms. Chartier for your patience. So certainly as one of our partners . . . And I think it's important for the committee to know that the Ministry of Health I think is just one of the number of partners, both within government and outside of government, that do provide support to the CNIB. I've had the opportunity to meet with CNIB representatives on several occasions as Minister of Health, both here as well as touring their facility on the other side of Wascana Lake.

In my time as Minister of Health, there's been I think several issues that I think are of importance to the CNIB. One is, as you've identified, looking for some additional support, financial support. We are having ongoing dialogues with the CNIB with respect to that specific issue. So we don't have a decision made with respect to that specific issue, and there will be some further discussions with the CNIB and the ministry into the next number of months.

With respect to some of the other supports that we do provide, I know that one of the things that the CNIB has asked for certainly when I've met with them, and I know they've put this forward to the ministry, some of the technologies that for visually impaired or blind people that are funded through SAIL [Saskatchewan Aids to Independent Living] . . . I think that they put forward a very compelling case to say that technology has changed, and some of the technology, some of the support, visual aid support perhaps was a little bit outdated in terms of new technology. So I'm pleased to say that we've been able to reach a new one-year agreement with the CNIB that includes a trial expansion of some of the benefits under the SAIL program to allow the SAIL program to fund some of those new technologies that I think just in 2014 are probably a better option for some people.

So we have made some progress on some of the items that CNIB has asked for, and we'll have some continuing discussions with them on some others.

Ms. Chartier: — In particular to the $182,000 proposal that they have before you?

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — So ongoing discussions about that, yes.

Ms. Chartier: — Okay. And you said within the upcoming months. Just in terms of timeline, you had said months, and I just want to clarify or confirm that that's . . .

Hon. Mr. Duncan: — Yes, that's the case. So I would say, you know, it's fair to say, whether it's with ministry officials or if I have opportunities . . . I know, as I've mentioned, I've met with them a couple of times now. But it's something that, you know, we don't have a firm timeline on when a decision would be made on that particular request, but just to say that the ministry is committed to meeting with the CNIB over the next number of months to further those discussions.

Ms. Chartier: — Thank you for that. With respect to Wolseley and the Wolseley Hospital, we'd asked some questions in the fall. There had been some concerns flagged, and I'm wondering where you're at with respect to the Wolseley Hospital.

Hon. Mr. Duncan: — So, Ms. Chartier, thank you for the question. This is something that certainly Minister Weekes and his office and the ministry in the Regina Qu'Appelle Health Region, the communities involved, have been doing a lot of hard work to re-establish services in Wolseley. There's been a number of I think positive developments in the last number of months in terms of restoring the stable physician complement in the communities, not just Wolseley but the surrounding communities, to ensure that we don't end up with similar types of problems in the outlying communities.

We want to ensure that not only is Wolseley stabilized but also the communities around Wolseley — whether they be Indian Head, Grenfell, or Broadview — are not impacted by kind of the move within, around physicians. So the physician numbers have been stabilized. The physicians have been contacted and are in the process of re-establishing that service. As well they are working to ensure that any of the nursing positions that are needed for the hospital, that the staff is trained up. And so we expect that service will be re-established early in June.

Ms. Chartier: — And it ended in July of last year. Is that correct?

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

Ms. Chartier: — So you expect services will be re-established in June. And what does re-establishing of services look like to you? What will that look like?

Hon. Mr. Duncan: — So that's a full acute and emergency services at Wolseley Hospital. Two doctors have agreed to

return to the community to support acute and emergency services, and nurses have been hired into the community. So they're ensuring that the nurses are . . . training is where it needs to be to be able to support acute and emergency services. And so the latest information we have from the regional health authority is that the early part of June that full services will be re-established.

Ms. Chartier: — Okay. Thank you for that. I'm sure the community will be very pleased. The community, I'm sure, you've been working with the community and they're well aware of that timeline?

Hon. Mr. Duncan: — Absolutely. I think that there has been a significant amount of work that's taken place and communication between the regional health authority, the communities involved and, in particular, Minister Weekes and his office. And they have done a tremendous amount of work to stay on top of this issue and to come to what we believe will be the successful resumption of full services.

Ms. Chartier: — Thank you. When you talk about the physician numbers being stabilized, so what has changed? You talked about the two docs who are coming back, did you say? So what, when you . . . I just would like to know what physician numbers stabilizing in that area means.

Hon. Mr. Duncan: — So traditionally in those three communities in that catchment area around Wolseley, which would include Indian Head and Broadview, there's traditionally been two doctors in each community. So in the past year or past number of months, Indian Head and Broadview have been . . . the numbers have gone from two to three in those, so three and three in those communities. And so now two physicians in Wolseley will be providing services. And the feeling within the region is that that number of physicians in that catchment area will be able to sustain and support and stabilize emergency services in those three communities.

So part of that has been through successful recruitment, through SIPPA [Saskatchewan international physician practice assessment] physicians and working with some of the existing physicians in those communities.

Ms. Chartier: — Okay. Thank you. That was actually my question, is that the new physicians were in fact, the additional physicians in Indian Head and Broadview are SIPPA positions then?

Hon. Mr. Duncan: — Yes, both of them came through the SIPPA program.

Ms. Chartier: — And forgive my ignorance here again, but what is the commitment when a SIPPA physician from elsewhere comes here? What is the commitment or expectation of them in terms of serving a community?

[17:00]

Hon. Mr. Duncan: — So with respect to the answer, I think I'll maybe attempt to answer it two different ways, depending on kind of where you were aiming to go. So in terms of the expectations of the physicians, part of that is the role that they'd be filling with the regional health authority in that specific practice. So that would all be an individual circumstance, whether or not the expectation would be for emerg coverage, the types of hours, those sorts of things.

I think maybe what you were more specifically referring to is, typically it's a two-year return of service that is required of the physician.

Ms. Chartier: — Okay. That's exactly . . . Yes, thank you very much for that. All right. Your poor officials here. I think I'm going to make you do some juggling here, a few times here, in the next half hour as I try to get some things in last minute here.

I've heard in Saskatoon, in the Saskatoon Health Region around respite care for palliative care, and I wasn't given a timeline, but I've been told that in the past for palliative respite care, you used to be able to receive 40 hours a month of respite care. And it is now down to eight hours of respite care for palliative care. So if someone leaves the palliative care ward and goes home, that . . . So I just want to confirm if that is in fact the case. And to me, when we're wanting to keep people at home, if that is the case, I think that that's hugely problematic.

Hon. Mr. Duncan: — So thank you for the question. I would say just, in a general sense, that the level of support that would be provided for respite in a palliative care situation obviously is going to be dependent upon each individual case. I mean, we'll certainly follow up with Saskatoon Health Region specifically on this issue. We're not aware of any significant changes in the level of respite care that is provided through palliative services in Saskatoon, but we'd be certainly willing to follow up with that.

Ms. Chartier: — Okay, thank you. And just with respect to the palliative care piece, from my understanding in Saskatoon, St. Paul's Hospital sometimes, when someone stabilizes in palliative care, they do get moved off the palliative care ward and into another room in the hospital or a long-term care home and obviously home if the supports are there. That's good, but often the supports aren't there or family just can't do it.

In long-term care, it's hard, I've been told that it's very hard to tell someone who's been receiving extraordinary palliative care that they will be moving into a long-term care facility where you have one person delivering medicine or medication to 30 people, and you won't get the timely pain relief that you so need.

So I'm wondering where you are with respect to supporting a hospice in Saskatoon. I know that St. Paul's Hospital Foundation is working on raising money for a hospice. There's a hospice here in Regina. I'm wondering where the ministry is with respect to increasing the support for palliative care and in particular in a hospice setting?

Hon. Mr. Duncan: — With respect to expansion of those types of services within the province, I think it's fair to say that Saskatoon wouldn't be the only place that there has been some interest expressed. We typically would leave those decisions up to the regional health authority to decide whether or not it's something that they would want to pursue. So in terms of whether it be official proposals or information that we do hear

coming forward from some communities, typically those would go to the regional health authorities to make some determinations on whether or not they want to be a part of those.

Ms. Chartier: — In thinking about the whole continuum of care — palliative care, home care, long-term care, how all these fit together though — that to me seems like it's a big piece of this as well. So I know you've said you leave it up to the regions to decide, but I think I've heard a statistic that, well in general, Canadians I think, only 20 to 30 per cent of Canadians have access to palliative care when they need it. And so I think that there is room for some ministry direction or lead on this.

Hon. Mr. Duncan: — So I think this is an important topic certainly in looking at the support that we provide throughout the entire continuum of care. We do, as a province we do have some guidelines that do guide this type of care that is provided, certainly whether it be in any number of circumstances. Care in the home obviously, that's something that we would support. I think this is an area that there's more and more interest from communities and from community members. And certainly I think the ministry would be in that same position to say that there probably, you know, needs to be more that we could look at being a part of.

I've had an opportunity, just in the short time I've been the minister, to meet with several families specifically on the issue of palliative care and their experiences with palliative care and respite care in their own home. And so, you know, this is something that I think that, not to say that there's anything today that I would indicate or make any announcements around, but it certainly is a growing area of interest for the ministry and communities as well.

Ms. Chartier: — Thank you. So just again just if you could find out with respect to the Saskatoon Health Region if in fact that respite number has decreased, that would be great.

Hon. Mr. Duncan: — Yes, we will.

Ms. Chartier: — Going back, in preparing for these estimates, looking at past plans, ministry plans, I noticed in the annual reports that from the '09-10 key actions, one of the items was develop a 10-year comprehensive health human resource plan that builds on all of the learnings from recruitment and retention initiatives recently sponsored and the Patient First Review. So I'm wondering if this 10-year comprehensive health human resources plan happened, if this report exists, and where it is.

Hon. Mr. Duncan: — So the health human resource plan, the 10-year plan was released in December of 2011.

Ms. Chartier: — December 2011. Great. Thank you very much. And is that something that you're actively using today to in fact inform your decisions around human resources planning?

Hon. Mr. Duncan: — It certainly does inform decisions made by government, provides certainly some guidelines for where we think we need to go in terms of human resource issues in the health system.

Ms. Chartier: — Thank you for that. I will seek out that report. In that same year around key actions, it also said there was a 10-year capital plan — facilities, equipment, and information technology — which will incorporate environmental stewardship practices. I'm wondering if that 10-year capital plan exists.

Hon. Mr. Duncan: — It's something that we've had a great deal of discussion as a ministry around capital, both on the physical infrastructure, the facilities, as well as around equipment, capital equipment. I would say that it wouldn't be to this . . . I guess the short answer would be no, at this point, no. It's something that we're continuing to work on, but we wouldn't have it to the same degree that we would have the health human resource plan.

Ms. Chartier: — So that 10-year — you've just answered that — that 10-year capital plan hasn't been developed. So I'm wondering the process by which you are planning capital then if you don't have this particular capital plan. And obviously there are huge demands. I mean, RUH in Saskatoon had netting on it to keep parts of it from crumbling or falling on people below. It's lacking call buttons. We had one occasion were someone was using a pill bottle with shaky things in it as an interim call button. And that's one facility. I mean there's facilities across the province that are challenged. So I'm wondering what you're using to plan capital decisions.

Hon. Mr. Duncan: — With respect to capital, certainly our first primary focus or our first priority is always on those issues, whether they be the physical infrastructure or the equipment that is really considered the mission critical in terms of the services that we provide.

We have, I think, as members will recognize, we've significantly increased the investment into health capital in the last number of years. It's always, I think, a balance between the capital, the equipment that we need to replace, the perhaps new equipment that we need to purchase within the system. So the PET/CT [positron emission tomography/computerized tomography] scanner would've been a, you know, a decision that was made based on an outstanding need for the province.

So we balance that. We also try to balance off maintaining the existing capital portfolio of the Ministry of Health, as well as taking those opportunities to replace existing facilities. And so it's always, I think, a balance in every budget year trying to get that balance right between new capital construction, maintaining what we already have as well as equipping the facilities that we do have.

We also do work, as members will know, closely with communities when it comes to capital construction and the 20 per cent that communities and neighbouring municipalities are expected to . . . the role that they are asked to play in this. And so there's, I think, a lot of discussion when it comes to finding the right balance between those priorities each budget year, and certainly this budget would've been no different trying to strike that right balance.

Ms. Chartier: — I understand — and again this is why we're here for the learning process here — there is a something called a VHF report. Is that the right . . . I believe it's VHF report.

You look like you are waiting to answer here.

Hon. Mr. Duncan: — So it's the VFA report.

[17:15]

Ms. Chartier: — VFA. Thank you for that. And that is a record of all the necessary capital across the province. I'm wondering, and I've heard in Saskatoon . . . I've tried doing freedom of information requests, but I've been told that it's not a document. It's a spreadsheet, and you have to very specifically narrow down what you want. But on that VFA report, across the province, what is the total of capital that needs work?

Hon. Mr. Duncan: — So with respect to capital in the VFA facility assessment, so this is an assessment of each of the health care facilities within the province. This is really an update that we had done in 2013 to update some earlier information. We will be releasing the VFA later this year. Right now as it sits . . . And it's quite a comprehensive look at the facilities. It's got a bit of a scoring system in terms of how the facilities rate and a percentage that, probably in this setting or this context, probably doesn't mean very much, but in terms of . . . Right now the estimate would be about $1.9 billion.

Ms. Chartier: — And that's ranging from everything from small, as you said, different capital, like repairs to just total rebuilds of things. Like, it covers everything is what I'm asking.

Hon. Mr. Duncan: — So what it does, it really looks at the condition of the facility. So it gives an update on the condition of the facility. It doesn't make recommendations in terms of what would be replaced or what would be not replaced. But it really speaks to what is the condition of that facility, what would it take essentially to replace part, or in whole, parts of the facility. So it provides that type of information based on the condition of the facility.

Ms. Chartier: — Okay. Is it a ministry document?

Hon. Mr. Duncan: — So the Ministry of Health contracted with the company that produces the VFA reports, and Saskatchewan is not alone to use VFA as the contractor to do this work. So we had the contract with VFA.

The intention though is that the information would be used by the health regions, because the facilities are owned or in most cases owned by the health regions, not the Ministry of Health. And so it would be used for them to help guide, you know, what becomes their capital priorities going into the future, that they would submit to the government.

Ms. Chartier: — But it was your ministry then that contracted with . . . so VFA is the company?

Hon. Mr. Duncan: — Yes, VFA is the name of the company so we call it the VFA study.

Ms. Chartier: — Okay. You know, the reason I ask is, as I had mentioned, I had done an FOI [freedom of information] and was told that they couldn't provide it for me because it wasn't a ministry document. I was told that it was a health region document. So I then did an FOI for the health region and then was told I wasn't specific enough. And I want my 20 bucks back. But the bottom line is I'm not quite sure. It's been six months that I've been trying to go at getting a copy of the VFA, and that has caused me no shortage of unpleasantness.

So when you release it, when you release it, in what form will it be released? If it is a spreadsheet or a database, obviously if you're planning on releasing it, you're planning on releasing it in some sort of form that people can read. So I'm wondering what form that will take.

Hon. Mr. Duncan: — Right. So it's not a report. It's not a study. It's a database that will be able to be used on an ongoing basis by the health region. So what we have decided to do, because we wanted to make this information public, is that we are going to . . . It's essentially going to be an aggregate or a collection of what the database information shows, and put into a form that can be disseminated to the public.

Ms. Chartier: — Does that already exist?

Hon. Mr. Duncan: — Not currently. So the information is being compiled from the databases. That'll be put together. And so the short answer is no, not yet.

Ms. Chartier: — So who and how will it . . . A couple of questions here. When are you planning on releasing it? And who is compiling all that data into a report that is readable and understandable?

Hon. Mr. Duncan: — So the ministry is doing the work to compile all of that information to put it into a form that . . . report type of form, and that will be released . . . I don't have a date yet. It's going to be this year though.

Ms. Chartier: — Okay. So help me understand this database then. So the VFA report is on someone's computer. You open it up. You've got the database. Can someone press print and print off . . . Maybe it's 20,000 pages long, I don't know. There's a lot of health facilities in Saskatchewan. But realistically, does it exist in such a way that if you wanted a copy of all the health facilities in Saskatchewan you could press print and get your big stack of information?

Mr. Hendricks: — Maybe a bit about the VFA process. So what we were buying there is, we have appraisers. People who are experts in facilities go out, and they looked at every single facility owned by health regions in Saskatchewan and provided, as the minister said, what we call a facility condition index. And that looks at a number of things. It looks at the state of the electrical, the HVAC [heating, ventilating, and air conditioning], all of that. That goes into a database. We populate a database at the regional level, right? And the idea with a database is that when they make adjustments to the facilities, so if they fix the windows or replace the boiler or something like that, they amend the database. The idea is that regions will keep that information up. So it's not a static product. It's a dynamic product.

And so I think, you know, obviously the goal here is to aggregate that data, as the minister said, and produce it in a report that is understandable and meaningful to the people of Saskatchewan in terms of the state of capital, health capital in

this province. And so that's forthcoming. We will have that in the near future.

Ms. Chartier: — Okay. Again just help me understand this a little bit better though. So the ministry owns this, but the regions are to populate the data. Do they do it centrally, or do they send it? So you've got the information. It's always changing.

Mr. Hendricks: — Yes.

Ms. Chartier: — But is it changing centrally? So does RQHR [Regina Qu'Appelle Health Region] or Saskatoon plug their updated information in? Obviously if you're doing a report and aggregating the data, it must be something central.

Mr. Hendricks: — Do you mean the server at the Ministry of Health? No. The actual program isn't at the Ministry of Health. So what this would involve is picking a date, a time, and saying to regions, roll up your data; send it to us. And we will produce a report as of a certain date — right? — because the next day it's going to change. Right? You know, we'll have fixed something. And so what we'll do is we'll pick a date. We'll say we want your information as of that date, and we will produce the report.

Ms. Chartier: — So again I guess that's my question. If we picked a date today, all the health regions could press print and provide that, not in an aggregated form but in the spreadsheet form, printing, like printing maybe not Excel. It might not be Excel. I have no idea. But if we picked a date and pressed print, it's possible to produce that information. Is it not?

[17:30]

Hon. Mr. Duncan: — Mr. Chair, Ms. Chartier, thank you for your patience on this. So we're just trying to be able to provide an answer to I think your specific question. What we are trying to do and what we will be doing is we will be making this information public. Frankly I'm just not sure if somebody were to log on to the database and they just print screen, we're not sure what that would exactly look like because it is a database. It's not in a document type of form. We're going to put it into a document type of form, but right now it's essentially a database. So I'm not sure what would happen just to try to print the database. We're not sure.

Ms. Chartier: — Okay. It's been six months for this freedom of information request though, and I've been bounced around trying to figure out how best to ask the questions, and so that has been frustrating. But we only have a few minutes left here, so I am going to move on here.

Just with respect to, I know, Minister, you and I have chatted about the human milk banking proposal that a provincial group has been working on. I'm wondering where that is at right now?

Hon. Mr. Duncan: — So this is, certainly it's an issue that we have talked about in the past. I know that both myself and the former Health minister have met with committee members who are advocating for a milk bank in the province.

I guess that we're at the point where the establishment of a new service like this, it would first of all require a business case to identify areas such as demand, the cost, the feasibility of it. It would have to meet standards established to be able to operate as a milk bank, and there would be a process that that would have to go through. It would be probably advisable that you'd have the support of a regional health authority that would help to guide this process. So further than that, I don't have any of that information. I'm not familiar if a business case has been put forward at this point, but that's certainly the position that we've taken to this point.

Ms. Chartier: — I believe that, and maybe they aren't at the business case stage, but I know that they were working with Saskatoon Health Region and have many partners on board. So I appreciate your ongoing interest in this anyway.

A couple of quick questions here. In terms of the money that's had to be added to the children's hospital, where in the budget will that come from?

Hon. Mr. Duncan: — The additional money for the children's hospital will not need to be allocated in the '14-15 budget year because it's a multi-year construction project. The $200 million plus the interest that the regional health authority has been drawing on those dollars will provide an adequate amount of capital to begin the construction. And so it would be my expectation that in I believe the 2016-17 fiscal year is when we will request the additional $20 million.

Ms. Chartier: — Okay, thank you for that. With respect to the rebuild to Pioneer Village, what is the commitment in terms of a timeline to replace it?

Hon. Mr. Duncan: — So we're really at the point right now where we know that there is some need to look at renewing long-term care space in the city of Regina. So at this point it's just planning dollars. There will be discussions by the regional health authority with not only the facility that they own and operate but as well as looking at whether or not other space needs to be renewed here in the city of Regina with third party providers of long-term care. So at this point it's really just to begin that planning. No decision would have been made at this point to actually replace facilities. We need to go through this step first before we would have adequate amount of information to make those decisions at a future date.

Ms. Chartier: — So planning maybe isn't the right word then. It would be more reviewing then. To me when you talk about planning dollars, you're talking about planning and moving along the process, but what you just said sounds more like reviewing and trying to decide whether or not you should.

Hon. Mr. Duncan: — Sorry. I'll maybe try this again. So we acknowledge that and the regional health authority has indicated that long-term care renewal of facilities here in the city of Regina — and there are multiple facilities — that at some point we need to start, we need to renew facilities. So this is planning dollars, but what needs first to be planned is essentially the scope of how many beds, how many facilities, which facilities. So I wouldn't say it's . . . I would say this is the beginning of that planning phase, and these are the planning dollars for it.

Ms. Chartier: — Is there any sense in terms of timeline when this needs to happen? Obviously we have a long-term care infrastructure issue. We talked about the numbers of people waiting for long-term care. Not to pin you down to a timeline, so in a year from now I'm not going to say the minister said this, but do you have a sense of when this needs to happen?

Hon. Mr. Duncan: — While I appreciate your commitment to not pin me down on a timeline a year from now, I'm not sure you or I can guarantee that we'll be in these positions a year from now, so it may be a commitment that you'd be making on behalf of somebody else to a minister that may be somebody else.

So I'll just say that, no, there's no definite timelines. Regina Qu'Appelle is though going to look at both the existing number of beds, start to look at some of the needs that they think are going to arise in Regina and the Regina area in terms of the number of beds. And so that's a part of the planning process but certainly no timelines on what would come next after planning dollars would be used.

Ms. Chartier: — Thank you for that. I undoubtedly have many, many more questions, but our nine hours is up, sadly. I do have many more questions.

But thank you very much to the minister and to all your officials for being willing to play musical chairs as I ask questions and keep calling you back at various intervals, but thank you very much for your time over the last nine hours. I've very much appreciated it, as I learned a little bit more about the Ministry of Health. So thank you, and to committee members as well.

The Chair: — Mr. Minister, if you'd like any closing remarks and thank your officials.

Hon. Mr. Duncan: — Well thank you very much, Mr. Chair, to members of the committee; Ms. Chartier, for your questions. I really appreciate the opportunity that we have had over these three days and the nine hours to delve into the work of the Ministry of Health and the entire health care system. I certainly do appreciate your questions and the information that we've been able, hopefully been able to provide to you, and we'll certainly commit to provide the additional information that we weren't able to over the course of the nine hours.

I do want to . . . Just in closing, this is certainly a very exciting time to be the Minister of Health in the province of Saskatchewan. I think that we have taken on a leadership role in this country in a number of areas and look forward to continuing on that work.

I do want to . . . As I indicated in my opening a couple of weeks ago, obviously you see a number of officials that appear before the committee, either at the table in answering questions or providing some information, or those that are here to provide some information but may not appear on the camera. I think that it is certainly just a small reflection on the number of people that do work, not only in the Ministry of Health but for our regional health authorities and all of our health system partners. And so I would just want to express my appreciation, as I did before, to those that have appeared at the committee as well as those that they are representing who do their jobs each and every day on behalf of the citizens of this province and the patients that we serve.

And with that, Mr. Chair, I want to thank the ministry. I want to thank the officials and the committee members for the time that we've had here. Thank you.

The Chair: — Thank you very much. Seeing our business is concluded, I would now ask a member to move a motion of adjournment. Mr. Lawrence has moved. Is all agreed?

Some Hon. Members: — Agreed.

The Chair: — This committee stands adjourned to the call of the Chair.

[The committee adjourned at 17:42.]