STANDING COMMITTEE ON HUMAN SERVICES

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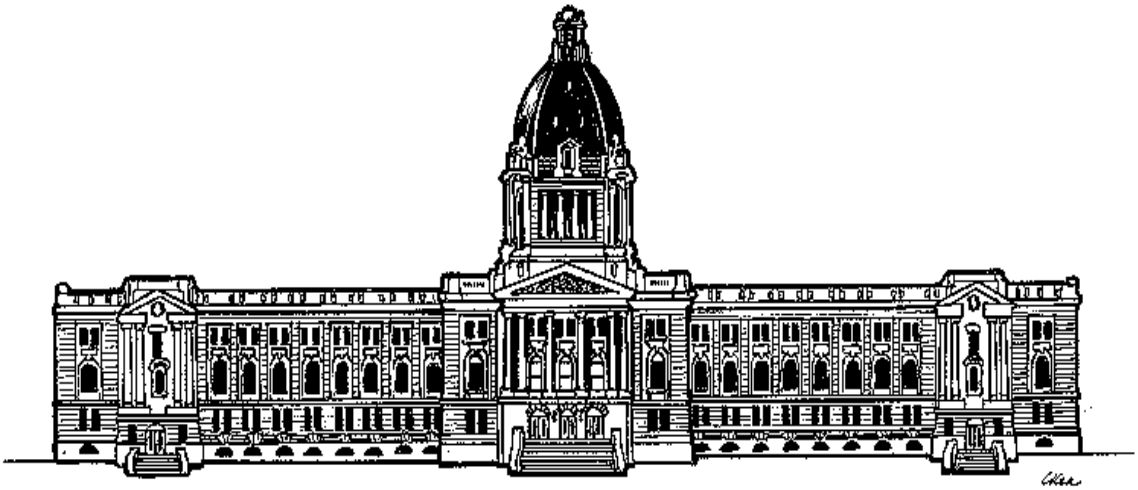

Legislative Assembly of Saskatchewan

Twenty-Seventh Legislature

STANDING COMMITTEE ON HUMAN SERVICES

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Mr. David Forbes, Deputy Chair
Saskatoon Centre

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Saskatoon Meewasin

Mr. Corey Tochor
Saskatoon Eastview

Hon. Nadine Wilson
Saskatchewan Rivers

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

[The committee met at 18:59.]

The Chair: — Good evening and welcome to tonight's Standing Committee on Human Services. Tonight we have Mr. Parent, Ms. Wilson, Mr. Tochor, and Mr. Nilson sitting in.

On the agenda for tonight is Bill No. 179, *The MRI Facilities Licensing Act*. We are scheduled for two hours tonight and it is now 6:59. We will resume consideration of Bill No. 179, *The MRI Facilities Licensing Act* and . . . I missed Ms. Draude.

Mr. Minister, do you have any opening comments tonight?

Bill No. 179 — *The MRI Facilities Licensing Act*

Clause 1

Hon. Mr. Duncan: — No, Mr. Chair. Just once again pleased to be before the committee this evening and I thank the committee for their consideration of the bill. And I'd be pleased to get right into the questions.

The Chair: — Okay. Do you have any new officials we need to introduce?

Hon. Mr. Duncan: — No, not at this time.

The Chair: — Mr. Nilson.

Mr. Nilson: — Thank you, Mr. Chair, and good evening everyone. It's a pleasure to be here to get some further illumination about this bill and about how it's intended to operate.

My first sort of area of questions is going to relate to the legal advice that has been obtained around the drafting of the bill. And I know it's quite common in legislature, especially in the United States, that formal legal opinions are filed with the court, but I was wondering if there is a formal legal opinion around the effect of this bill given that it's a bill that relates to the *Canada Health Act*.

Hon. Mr. Duncan: — Thank you, Mr. Nilson, and welcome to you this evening. So we certainly have received legal advice as it relates to the drafting of the bill, but there was no formal legal opinion that was sought by the ministry as it relates to this issue. The legal advice, I would say, pertains to both just the advice typically that we would receive in terms of the drafting of a bill, but as well at looking at the experiences of other provinces as it relates to their dealings with, for instance, the *Canada Health Act*. And so that was the basis of the advice that we have received.

Mr. Nilson: — Now was this advice received a number of months ago? Like I assume this legislation has been in the works for a while. So would it be six months ago that the advice on the *Canada Health Act* would have been obtained in the preparation of this legislation?

Hon. Mr. Duncan: — The advice would have been provided, I would say, in late 2014 after I guess the initial discussion that was raised in terms of looking at different options. As I stated — and forgive me, I'm not sure if you were here at that part of the committee when we discussed that — but I guess late last year when I sought different options in terms of looking at how we may proceed down this type of ability for Saskatchewan people in-province to pay out of pocket for an MRI [magnetic resonance imaging]. So it would have been, I would say, late 2014 that it would have been provided.

Mr. Nilson: — Okay. Thank you for that answer. Has there been any new legal advice sought since the federal election and the change in government?

Hon. Mr. Duncan: — No.

Mr. Nilson: — Well the reason I ask that question is we know that the *Canada Health Act* is very much a part of the Liberal legacy in Canada, and I think we also know that there maybe hasn't been as much focus on the enforcement of the provisions of the Act over the last nine years. And so I . . . Well this legislation won't take effect until a new government is in place federally, and so I was wondering if there will be some discussion, looking at the legislation, for further legal advice or if there will be discussion with the federal officials about this kind of a clause. I guess I'm concerned that you have some kind of pre-clearance for this scheme that you've set up before you proceed with it.

Hon. Mr. Duncan: — I think that there will be an opportunity, potentially on this topic but as well as a variety of topics, once the new federal cabinet is named tomorrow, that I'll have an opportunity to at some point, hopefully not too far down the road, to consult with whoever the new federal Health minister will be as a part of both the formal FPT [federal-provincial-territorial] channels, but as well as just the, I guess, informal channels that . . . Obviously you would know that Health ministers develop relationships with their colleagues from across the country.

I guess I would just go back though to say that the advice and the experience of other provinces in terms of not seeing any deductions or penalties applied to their health transfers from the federal government, I would say goes back even beyond the last nine years of the federal Conservative government. It's my understanding that even under the Chrétien and Martin Liberal governments that for diagnostic, pay out of pocket for diagnostics, that no province had seen any deductions even under the previous Liberal government.

Mr. Nilson: — Well that's interesting commentary, but I know that the specific concerns that arise . . . Well policies change when governments change, and I think it's better that we are prepared here in Saskatchewan.

I'm curious as to how the system is going to work with this proposal of matching patients on, I guess, a public list with the patients that come forward and pay. Can you explain what the procedure is going to be so that, I guess, the public can understand what happens?

Hon. Mr. Duncan: — Thank you, Mr. Nilson, for the question. So I guess not unlike the process right now in terms of somebody accessing diagnostic services, a patient in

Saskatchewan would see their GP [general practitioner]. They'd receive a referral to see a specialist. They would be triaged based on the acuity of the need, and so that would be decided in terms of how long their wait would be for the specialist. The specialist would see the patient. At that time if there was a . . . the opinion of the specialist that an MRI, in this case an MRI would be required, they would send in the requisition.

There's obviously the process that looks at the requisitions that are received by the regional health authority and determines the urgency of that based on a series of different levels that I think you're aware of. At that time if somebody decides to, under this plan, if they would decide to pay out of pocket, then they would contact whatever organization was offering this type of service. That organization would have to confirm that, in fact, that person was on the wait-list. They would offer the service.

What we would require is that . . . and this would be as a part of the regulations that that firm would then have to supply back to the regional health authority the number of patients that did receive a scan after paying out of their own pocket. Then what would happen would be the regional health authority would . . . then within a certain amount of time that will be stipulated in the regulations, send the appropriate list of patients that are currently on the wait-list to that facility to then have the scan provided. So if it's 10 in a certain amount of time, then the region would send over that list of 10 individuals.

I guess I need to clarify from yesterday, and I think I did last night but I will again. So I think it would be simplistic and it is simplistic for me to say that if somebody's privately paying for a scan on, let's say, their knee, then it would be like a knee for a knee. What is going to be attempted is that it's going to be a similar or equivalent in terms of the complexity. So that the scan that the region will be receiving because of this plan will be . . . It may not be the exact same but it will be of a similar complexity so that the private provider isn't going to be basically having to pay for a scan that is not an equivalent scan in terms of what they provided from the private-pay patient.

Mr. Nilson: — Okay. Well thank you, and that goes right to the heart of why I'm asking about this. So as I understand it, there are what, four levels of priority in MRIs? 1 and 2 are the ones that go fairly quickly — what, probably within a week or two weeks — and then 3 and 4 are longer. And practically, people who have acuity that relates to the levels 1 and 2 or priorities 1 and 2 of the scans wouldn't purchase a scan because they're going to have it happen very quickly anyway. So we're talking about level 3 and level 4 scans.

And so I guess my question relates to the fact that if these equivalent or second ones or second scans that are being done are always going to be on the level 3 and 4 level, the people on the regular list who are on the 3 and 4 level are going to be the ones that get the advantage of your two-for-one deal. And so that may push some of the 1 and 2 people, you know, down the list. Or it doesn't, it doesn't really deal with the 1 and 2 priority. But there's a concern I think among some people who've been listening to what, how you describe this that some of the higher priority people will actually be served later than the lower priority people.

[19:15]

Hon. Mr. Duncan: — So Mr. Nilson, I think the . . . I'll just start by saying that it's important not to confuse the issue of urgency with complexity. So there could, in some scenario, be a case where a similar or equivalent type of scan that somebody goes . . . let's say they are a level 4 and they pay out of their own pocket. I guess the most appropriate person coming off that public list may in fact, in some cases, be a level 2. It always depends on a number of factors on the wait time. So complexity and urgency are two separate things.

Mr. Nilson: — So can you explain then who or how these kinds of decisions will be made? Because that's what the public will be concerned about is, who do I talk to? Or is it all going to be managed somewhere in a single office or . . . But perhaps you can explain how this is going to work.

Hon. Mr. Duncan: — Thank you for the question, Mr. Nilson. So what . . . The regions would still be drawing off of the same single list. This would have been even before we had, for example, the contract that has been signed between RQHR [Regina Qu'Appelle Health Region] and Mayfair to provide for some in-community diagnostics MRI.

There's the people within the region that would be doing the queuing in terms of who is on the list, making sure that there is that appropriate blend in terms of . . . I mean obviously the level 1's are the most, those are the ones that have to be done immediately, then the urgency ones, the 2's and 3's. But there is always going to be a blend of those different levels because if you're just trying to do the level 1's and level 2's, then I mean conceivably you never really get to the 3's and 4's. So there is that blend that already does take place.

So really this is just an extension of what the queuing process that has been in place only when there has been an in-hospital service, and then we have added in Regina Qu'Appelle the ability to provide for in-community MRI, but it hasn't changed that queuing process. And this would be just one other offshoot, potentially, of that. That doesn't change that centrally queuing process that a health region would go through.

Mr. Nilson: — Okay. So then if somebody just goes in off the street to one of these places and gets an MRI done and then is inserted back into the system, how does that work? Because they won't even have a, you know, a priority assigned to them. Or is that against the rules?

Hon. Mr. Duncan: — So I guess an example of what that would look like would be that the patient . . . It would be more than just them walking off the street and going into a private clinic. They would still require the requisition from the specialist. Ideally we would see that patient being put on our wait-list so that we'd know that they have been on the wait-list. And that would provide some of I guess the reporting that we would require so that we know in fact that we are getting the second scan for allowing that patient that option.

So that would be the process that we, that I would envision, is that that patient would . . . that the region would know that that patient now has a requisition for a scan. They theoretically are a part of the wait-list, and then if they choose to pay out of their own pocket then we would cross them off the wait-list once it's confirmed that they have in fact had their scan, and we would

receive our second scan as well.

Mr. Nilson: — So what you're saying is that you can't even get on this private-pay list until you wait for, you go to your GP, you get referred to a specialist, and then the specialist says you need an MRI. And then you get on that wait-list, and then you can put some money down if you're a category 4 and have something done three months or four months earlier. But all of the waiting that people get frustrated with, which is from the GP to the specialist, this doesn't affect it at all. Is that accurate?

Hon. Mr. Duncan: — That would be correct, with the exception if your GP is one of those GPs in Saskatchewan that does have referral privileges for diagnostics, for MRI.

Mr. Nilson: — So how many GPs have that designation, and where are they located?

Hon. Mr. Duncan: — Mr. Nilson, I don't have an exact number for you. By and large it would be if a GP does have referral privileges. First and foremost it's a privilege that's granted through the regional health authority so it's different in each regional health authority. I think it's fair to say though that you would more likely see it in a place like Regina or Saskatoon or perhaps Prairie North Health Region. Of course, an emergency room physician most likely would have some privileges in terms of referring to diagnostics, including MRI.

The discussions that we've had with Regina, for example, Regina Qu'Appelle Health Region says that the vast majority of their referrals are referrals done by specialists, not family physicians.

Mr. Nilson: — So as a family physician, you would want to seek out this kind of qualification, I guess prescribed qualification, because you could then be a place where people could get MRIs much more quickly than having the referral from the GP to the specialist, given the quite long time period there is now between going to see a specialist after seeing a GP. So is this something where, you know, a family physician would want to have this as part of their qualifications because their patients then could be dealt with much more quickly? Is that accurate?

[19:30]

Hon. Mr. Duncan: — Thank you, Mr. Nilson. I think, as you'll know, the system has been working towards trying to shorten that wait, that first wait. Obviously we know the second wait from a specialist puts you on, say a surgical list to when the surgery actually happens. But we're also focused on that first wait from GP to specialist. So there's a number of initiatives that we can, if you'd like, we can get into more detail on this.

But just in terms of the time that we're seeing in terms of the wait, particularly as it relates to waiting for, in this case an MRI, so in some cases health regions looking at the appropriateness issue in terms of who is ordering diagnostics, MR [magnetic resonance] or CT [computerized tomography] or other diagnostics, some regions will require completion of pathway training before they allow for privileges to be granted to a physician in their health region. So that's really looking at the literature, and I accept it and believe it that, you know, a certain proportion of our diagnostic tests within the system are probably not appropriate or do not necessarily affect the outcome for a patient. And then that's one way to drive towards that appropriateness issue.

The other is that, and there's some groups practising in the province that have looked at trying to reduce that wait that people are waiting and have moved towards changing the way — as a specialty or as a specialist or a group of specialists, for instance — the intake process. So is there a way to do some . . . This would be my terms, probably different term or the ministry would have a different term, but essentially looking at, is there a way to better screen a patient so that to determine who may appropriately need an MRI scan, in this case perhaps before they even see the specialist? So it's kind of looking at during the intake process from GP to specialist, so that when that first appointment does take place, that they do have the information in hand that they need. So there is some work that's being done to I think avoid the situation that you're describing.

Mr. Nilson: — So is what you're describing here, the MRI appropriateness initiative, can you tell us how much money is going into that process and who is actually in charge of it and what's happening?

Hon. Mr. Duncan: — So, Mr. Nilson, the work that I had mentioned in my previous answer, just in terms of the intake that's done by the specialist's office to try to shorten that wait, that does predate 2015. But the work in 2015 that has taken place has . . . So we have two physician leads that are the appropriateness leads working in conjunction with, for example the Ministry of Health, and Dr. Ty Josdal that does work for us in the ministry. And we have referring physicians as well as radiologists that are a part of that work.

They've been focused specifically on . . . So their initial work is around appropriateness as it relates to MRI of the spine. So they've developed a checklist tool that is being introduced in Saskatoon first, and then following that it'll be introduced in Regina. And so that's the work they've been doing over this last year on this specific issue.

Mr. Nilson: — So that really has no impact on this legislation, or maybe you can explain how it relates to this legislation.

Hon. Mr. Duncan: — No, it doesn't necessarily relate specifically to this legislation. I would say that this work I think parallels some of the work that the CMA [Canadian Medical Association] and the SMA [Saskatchewan Medical Association] certainly . . . And the SMA's been involved in Choosing Wisely, I think is a program perhaps that you're familiar with that looks at the number of unnecessary tests and treatments and procedures that don't add value to the care of the patient.

And so whether or not we proceeded with this particular bill, this is work that we have to do as a system. So it will continue whether the legislature passes the bill or doesn't pass the bill. And whether or not we actually have any private firms that do, after the bill is passed, presuming that it would be, if we have . . . Frankly if we don't have any private providers come forward and be able to develop a business case that actually works for them to be able to offer this type of service, we still need to do this work on appropriateness. And so it's I think it's

really a separate issue from the bill. But I think it's an important topic, certainly.

Mr. Nilson: — And is this funded out of the ministry or out of health regions or, you know, does it have specific funding from, I guess, the central Health ministry operation?

Hon. Mr. Duncan: — So this initiative, the work that's being done on appropriateness is paid for by the ministry. So obviously we'd have just the costs within the ministry in terms of our officials that are working on it, but we do also as well do compensate some physicians that are away from their practice working on this work and some consultant time as well.

Mr. Nilson: — Okay. Now we had an incident not that long ago where there were 87 scans inappropriately forwarded to one of the facilities when they shouldn't have gone there. Is that the kind of thing that this appropriateness initiative will be looking at as well?

Hon. Mr. Duncan: — I would characterize this, the incident that you're speaking of, more this would be more characterized as a process error as opposed to appropriateness. So this was really improper screening that was done by the regional health authority in sending a particular group of patients to the facility that didn't have the ability as it relates to the use of contrast in an MRI. And so really I would say it was not — I wouldn't, and I think the ministry shares this feeling, the region does too — wouldn't necessarily be, it wouldn't be in the category of an appropriateness issue. It would be more of a process or a clerical error.

Mr. Nilson: — Okay. Thank you. It's, as you said earlier, it's complicated. And it sounds to me like whatever this system is going to be placed here is going to add further complications. And I think you've indicated that it will be the manager within the health region that kind of, that coordinates all of this. Will the private clinics provide compensation to that manager for that part of the work, or is that assumed that that's going to be an expense of the region?

Hon. Mr. Duncan: — No, we don't anticipate that there will be a requirement from the private provider to pay any sort of administrative fee to the regional health authority. I would just I guess say that it's important to keep in mind that the regions won't be creating a separate list or sorting a separate list over and above what even they currently do now, from going from where there was only the in-hospital option to now having a community-based option where they do work with the private sector to determine the patients that are most appropriate for a community-based MRI. And so I guess my view of this would be that the benefit for the regional health authority in providing the list to the private provider is the fact that the regional health authority is going to receive, under this plan, additional scans that would not come out of their budget.

[19:45]

Mr. Nilson: — Okay. So that includes then all of the expenses around protection of privacy and transfer of information back and forth between the clinic. Because I mean there are obviously a number of issues around procedures that might take place in the clinic in the community versus what might happen within a regional health authority operation. So can you explain how that's going to work? Is there going to be compensation there, or is there once again going to be basically the private clinic that's making some money off this process, they will just get that as part of the expense from the regional health authority without having to pay for it?

Hon. Mr. Duncan: — Mr. Nilson, I guess I would just, I guess the best way for me to answer that is that this is currently something that Regina Qu'Appelle Health Region has already had some experience with in terms of the fact that over the three-year contract that they have signed with one of the private providers to provide for publicly funded scans within the system in a community-based setting, there's going to be, you know, our estimate is just over 16,000 scans that will be provided under that contract over the three-year period. So all of those issues around privacy and around protection of patient information is already built as a part of that contract.

And so any private provider that wants to take part in this new I guess way of providing for scans in the system will need to obviously follow the legislation, not only the legislation that's set out before the legislature but any of the rules around patient information and the protection of patient information. So I think that that's, in this case, it's already in place. And again this is not creating a separate sort or a separate list in terms of the patients. It's really just one additional option that really only affects who is actually paying for the scan, not necessarily how that affects the work of the region in terms of producing a wait-list.

Mr. Nilson: — So does that contract that's existing now cover who pays the costs if something goes wrong?

Hon. Mr. Duncan: — Mr. Nilson, under the existing health facilities licensing Act as well as the proposed, the bill before the committee, in either case a private provider would be a trustee of *The Health Information Protection Act*. They would be a trustee under HIPA [*The Health Information Protection Act*], so all of the obligations as it relates to the protection of personal health information would apply to a private provider, whether they be under *The Health Facilities Licensing Act* in a contract situation with a regional health authority or whether they provide services under this proposed new . . . the bill that is before the committee.

With respect to the contract that Regina Qu'Appelle Health Region does have, the contract does spell out issues around indemnity, liability insurance, liability and insurance, and it would be my expectation that we would, in the regulations, have some similar provisions for a private provider that would offer this type of service.

Mr. Nilson: — Okay. Well I'm looking at the legislation. You have this new legislation, section 13 talks about critical incidents, so they're pulled into the whole critical incident reporting system. And what's here really is the protection of that information from an outside lawyer getting access to it for litigation purposes. But when I go through the regulatory powers, there is really nothing that talks about insurance or indemnity if something goes wrong.

And I guess what I'm thinking about, you know, in medical

malpractice cases, you like to have as many entities to sue as possible. And in Saskatchewan, normally you just have the health authority, but here you would get to add in a community facility. And so what's the risk sharing, I guess if I could put it that way here, as it relates to a facility that maybe does something wrong which then causes further problems down the road? Is that dealt with anywhere here at all?

Hon. Mr. Duncan: — Mr. Nilson, there would be several, I guess several ways that the issue of insurance and liability would be, I think, addressed to our satisfaction. Certainly the physicians that would be operating would have their own insurance through CMPA [Canadian Medical Protective Association]. The facility itself, or the organization that would operate the facility would have insurance. There is the ability through the, as stated in the . . . ability to make regulations around the terms and conditions of the licence, that we would have the ability as a part of the terms and conditions in permitting and assigning a licence for a facility that that's where we would find the ability to require appropriate levels of insurance and protection.

Mr. Nilson: — Well the reason I ask this question is that that allocation of risk and the cost of insurance is a factor in setting the fees for how much the procedure costs. And if in fact you're going to be pushing the risk costs on to the health authority and therefore on to the provincial government, the private facility will be able to charge a much smaller fee. But if that's not what you're going to do, well then you're going to be seeing higher fees come. And so it's really a question of whether the intention is to subsidize these new players in the community.

Hon. Mr. Duncan: — So, Mr. Nilson, it's important to keep in mind that the Act speaks to both category 1 and category 2 facilities. So category 1 would be those that would have a contact with the region. So there would be, through that contract process, there would be stipulations for insurance, liability insurance, etc.

So with the existing contract that Regina does have in place, Regina Qu'Appelle has in place, there are provisions within the contract for liability protection both for the facility itself in terms of any mistakes on the part of the region, but the other way is . . . [inaudible] . . . that provides for protection for the regional health authority in the event that there are any losses to the regional health authority due to a breach in the contract by the operator. And so similar for a category 1 facility that would be operating under this change, there would be the ability through the terms and conditions to set out requirements for insurance and liability protection.

Mr. Nilson: — So have you or the regional health authority that's looking at setting this up fixed any amount that is effectively a subsidy from either Saskatchewan Health or from the regional health authority for this private facility that's coming? And the reason I ask this, we know if we just go 90, 100 miles south of here to the States, that private facilities set up and they have to be totally independent as far as their insurance and all of their other costs. And it appears from what you've described to me over the last half hour that this is very much tied into the system and a lot of their costs are being covered by the Ministry of Health. So have you figured out how much that subsidy is that you are going to be effectively paying for? You can do it on each scan or you can do it on an annual basis because I think an outside economist could do that if you haven't done it yourself.

[20:00]

Hon. Mr. Duncan: — Thank you, Mr. Nilson, and for your patience. I guess, I guess I would disagree with the characterization that this is . . . there would be subsidization from the . . . to the private provider. So as I've said in previous answers, as an example, Regina Qu'Appelle Health Region is already managing a list of patients that are waiting for MRI scans. They are already, in certain situations, sending certain numbers of patients through contract arrangements to an in-community provider that is for all intents and purposes a private provider. So this would be providing, I guess, one additional option in terms of where those scans are being done off of the public list.

In terms of the costs for a private provider to provide this, so they would be responsible for their overhead; that would include insurance. I think you will know that through agreements with the SMA that the government does provide for, does provide as a part of our negotiations with the SMA when it comes to the CMPA fees, and so I guess in a sense that that is . . . I'm not sure if that's . . . I don't think that that's what you're alluding to in terms of subsidization because obviously, you know, I think it's fair to say that those radiologists that would be working in this type of setting would be members of the SMA. And so I guess there would be that angle.

But in terms of the subsidization, if it's an issue . . . and it is an issue of who is paying for the scan. I guess I would take the opposing view in that somebody that has chosen to pay for their own MRI scan and chooses not to leave the province to pay for that scan and in fact has that scan in the province, that person, while they will pay one fee — assuming it's just one scan that they're paying for — if they're paying one fee, built within that fee is going to be the cost of their scan. But as well the private company, the private provider is going to have to be able to cover the cost for the person coming off of the public list.

And so I guess I would view it the other way, is in fact that person that's paying out of pocket, while they're not going to pay two bills for person A and . . . for themselves and person B, they'll pay one bill, but contained in that one bill will be essentially the subsidization out of their own wallet for somebody on our list. And so in fact I would see it the other way, is that somebody paying out of pocket is now going to subsidize somebody from the public list.

Mr. Nilson: — Okay. Well you go back to that description but you're still forgetting that there is a huge infrastructure support. The management, administration is all being done by the regional health authority in getting that patient to the facility.

Now it just struck me when you're answering this question is, does the person who pays under your system have the right to bring their friend along and say, well I want this person on the other list to . . . They've got the same thing as me. The answer to that is what?

Hon. Mr. Duncan: — So the answer to that would be no. It

would be the regional health authority that would send the names of the patients over to the private clinic to have the public portion of the scan provided. I would just maybe go back to the previous point, just in terms of I guess the debate about the, just the capital that has been outlaid by the government and the region, and certainly the operational costs and the people that are involved in this. But again, we're not asking them to create a new list. We're not asking them to sort the list a second or a third time. This is essentially using the same public list. And what they are already doing with the scans over a three-year period under a contract situation and sending those patients over, they're really just doing that same work so that's already, that is something that takes place.

We had a discussion last night with Ms. Chartier where, when we provide additional funding for an MRI, for a region to provide X more MRI scans in a given fiscal year based on . . . prior to the previous year, we use a number in terms of how we allocate the funding that's required for those scans of $725 per scan. So if we're getting a public scan, I certainly hope it's not going to be more than $725 per scan for the region to administer and process, sending the name of one person, because that's a pretty high processing fee.

So you know, I guess I would just say that this is something that's already taking place in terms of the contract that Regina, for instance, has and again it's not creating a different list, a separate list. It's just sending names of appropriate patients to get a scan that would otherwise cost us on average $725.

Mr. Nilson: — Well and I guess what I understand from your answer and the comments is that this is not something that Saskatchewan Health or a regional health authority has actually costed. They haven't actually gone through the process and costed how this all fits. They're just going to use whatever is the market now.

Last night you indicated that there were, with this community-based MRI facility, one radiologist, and that then in the other MRIs and all the other work there was 22 or 23 in the Regina Qu'Appelle Health Region. How many scans, MRI scans are done at the private facility versus the other ones that are done through the Regina Qu'Appelle Health Authority?

[20:15]

Hon. Mr. Duncan: — Mr. Nilson, in Regina Qu'Appelle Health Region in '15-16, the estimate is a total of 15,500 patients will have a scan. 15,500 patients will be served by an MRI, but because patients will in some cases have multiple MRIs, the total number would be approximately again . . . Sorry, I'll maybe go back on last year, which we'd have actual numbers. We have an estimate for the number of people, but not the number of scans for this current year.

So maybe last year, just over 14,000 individuals, 14,007, and there were 19,659 scans performed in Regina Qu'Appelle. Now that's the total number. In community, it would've been 2,800 patients and just over 3,100 scans. So the 14 and 19 are total including the community numbers. So just a quick, you know, it'd be roughly 11,200 that would've been done in hospital versus the 2,800 patients in the community. And then roughly 16,500 scans would've been done in hospital with the balance — the 3,100 — would've been in community.

Mr. Nilson: — Well the reason I ask that question, I'm not really too worried about the numbers, but as many people who have worked with me over the years know that you go to a basketball game, you go to a volleyball game, you go to the grocery store — you learn quite a few things. And one of the concerns that I have had heard related to this whole MRI system is that many of the community scans, the GPs and others who have questions about the scans, only have one person to really get explanations about them, and that the kind of service provided by the Regina radiologists is something that's worked well over the years. But that with these ones, there's just not as easy of access because basically scans are just scans; it's really the reports and the interpretation that's important.

And so I think just how you described it, you know, there's lots of numbers, but it's really about the relationships, about all of the whole team of people who are working on things. And one of the places where some of this falls down does relate to the ability and the contact around the interpretations received. Can you explain if there's any plan to fix that or make it better? I mean I raise also the question is where are these radiologists located? Are they here in Regina or where are they?

Hon. Mr. Duncan: — Thank you, Mr. Nilson, for the question. Certainly Regina Qu'Appelle Health Region is very committed to building a department of radiology that works well into the future, that has a department that works collegially with all of its members. We will require, as a part of this bill, that anybody that would be involved in terms of reading and interpreting our reports would be college accredited. Obviously the facility would have to be licensed. There would be a requirement that there would be a medical director that would be involved in overseeing the operations. The regulations would also prescribe that anybody that would be involved in a consultation would need to make themselves available for further consultations.

With respect to concerns about, as I think you described it, some concern that has been expressed about perhaps the lack of availability in terms of physicians being able to access colleagues in the radiology world, we haven't received any, to our knowledge. And the ministry has confirmed this, that the ministry and, to our knowledge, the region hasn't . . . or that the ministry hasn't received any I guess formal complaint or notification that that is a concern.

We also know that the region will have filled their head of radiology position, if they haven't already done so. That's, I believe, a position that has been vacant for some time now. And the region is as well recruiting radiologists to practise in the city.

Mr. Nilson: — Thank you very much. I appreciate you putting all that on the record so I can refer people to take a look at this.

One of the things that is suggested in proposed regulations for this legislation is that there will be continuous supervision of these new MRI facilities by a medical director, and I think you've kind of referred to that just now as well. But there is no confirmation that this person is located in Saskatchewan. Will that be changed? Because I think it's important that if you're going to do anything like this, that you make it very clear that

it's going to be done here in Saskatchewan.

I know over the 15, 20 years that I've been involved in this, that there has been, you know, suggestions about the sort of 24-hour radiology interpretation using other-side-of-the-world radiologists, and that doesn't, you know, that's not part of this. But if the rules are not clear, then we can end up with a lot of the work being done quite remotely. And so is that . . . Is the plan that that would be in place that this would all be radiologists who are in Saskatchewan paying Saskatchewan taxes?

[20:30]

Hon. Mr. Duncan: — Mr. Nilson, so in order for the facility to be granted a licence under this proposed bill, under the Act and the regulations that would follow, there would be a number of stipulations. First and foremost, the medical director would have to be somebody that is recognized as having a specialty practice in radiology that's recognized by the College of Physicians and Surgeons here in the province, meet the requirements set out by the accreditation program operator.

It's important to note that under accreditation by the College of Physicians and Surgeons, which would have to be followed under this and any other Act dealing with facility licensing, the medical director has to be on site. According to the accreditation bylaws, the medical director has to be on site 25 per cent of the time when scans are performed, and according to the accreditation bylaws, the radiologist performing the scans has to be on site for 80 per cent of the scans that are performed in a given day. That's college bylaws. That's separate from this, but obviously this Act and the regulations would obviously have to conform with College of Physician and Surgeons' bylaws.

Mr. Nilson: — Thank you. But the question I'm asking is, are you going to put in the Act or in the regulations that that medical director or his radiologists will be residents of Saskatchewan? I mean, you didn't answer that specific question.

Hon. Mr. Duncan: — So as a part of the accreditation process, so again as a part of the bylaws that are followed during accreditation, a radiologist performing the scan has to be on site for 80 per cent of the scans that are performed within that given day. The medical director has to be on site for 25 per cent of the time.

There are cases where, for example, if a colleague of a radiologist has a certain subspecialty in a certain part of the body, there is always the ability for a consult to take place between two radiologists. The bill before the committee though doesn't contemplate tying somebody's residency to the province in order to be able to perform this service. But certainly there are certain requirements, as I've laid out, as it relates to accreditation that are stipulated within the College of Physicians and Surgeons' bylaws and we would certainly . . . This or any other type of facility has to meet accreditation that's set out by the college. And so that's the requirement that would be in place.

Mr. Nilson: — Well I guess you've confirmed that that's not . . . I mean basically you're opening this up so that it can be provided by people out of the province, therefore shipping work and taxes out of the province. So we'll leave it as that.

I have one final question, then my colleague will take over. In some of the proposed language for the regulations, there's a clause that is being suggested that relates to the licensees, in other words the people that will be running these facilities. And it states that these licensees may not offer employment or contracts for services to individuals to provide imaging or technical services to the licensee if those individuals are under contract with or employed by a regional health authority, an affiliate, or the Saskatchewan Cancer Agency, if that action would significantly negatively impact the ability of the regional health authority or the Saskatchewan Cancer Agency to provide publicly funded MRI services.

So that's a reasonable comment and I think this is absolutely crucial for the province. The difficulty is there's nothing in there about how that would be enforced. It doesn't say who defines a significant impact, that significant negative impact. And I think it's crucial that there be someone, maybe even independent of the regional health authority or Saskatchewan Health that would define this, or I guess if necessary put "in the opinion of the minister" so that we know there's somebody responsible for watching this. Because otherwise it strikes me that this is unenforceable. It's good words, but it's unenforceable. Do you have any comments about that idea that's here?

Hon. Mr. Duncan: — Thank you, Mr. Nilson. So with respect to your question, so one of the things that I think that we wanted to be . . . to take into consideration and be mindful of is the concern that has been I think bandied about, both inside the province and outside the province, whenever the discussion about private providers playing a larger role in the health care system in this province or any other province in terms of what that does to the, particularly what it does to the health human resources of the public system. And so we wanted to put in place a provision that would, one, put the onus on the potential licensee that their decision to offer this service doesn't have a negative impact on the operations of a regional health authority, and for the regional health authority to make certain assessments in terms of what the operations of a private provider has done to their own operations.

I would say though that Saskatchewan, while this is, I think, as I said at the onset of this answer, that this is a part that goes along with the debate in terms of expanding the use of the private sector in health care, the concern about health human resource challenges. This is no different than what we have already put in place in terms of expanding the use of, for example, third party private surgical capacity within the system, and including adding capacity within the publicly funded system through the use of private delivery of MR and CT scan over the last number of years. And we have not had any impact that's been recorded by the regional health authorities in terms of the . . . a negative impact on their operations.

So I think we have been able to demonstrate in Saskatchewan that there is the ability to expand the use of the private sector when it comes to the delivery of health care without having a negative impact on the delivery of the publicly funded health

care system. So I would say this is just an extension of provisions that we would've put in place in prior policy decisions.

Going back to your first point, I would just say that there is nothing in the existing legislation that would restrict what you're talking about now in terms of requiring, for example, residency of a medical practitioner to the province of Saskatchewan. So this legislation really has nothing to do with that, and that's a provision that hasn't been put in place in the past. And there's probably examples in Saskatchewan health care history where services have been particularly on diagnostic imaging especially as technology has improved, where we have utilized the expertise of people outside of the province without necessarily requiring them to be a resident of the province.

Certainly our hope is that we see more radiologists come to the province. I think this government has demonstrated in the last eight years going from roughly 71 radiologists practising in Saskatchewan to about 132 or 134. So it is not like this government has invested significantly in radiology and shipping that work outside of the province. We're certainly seeing the benefit of an increasing number of radiologists that are practising in the province and resident of the province and paying taxes in the province and contributing to communities all across this province. So nothing in this bill changes any of that.

[20:45]

Mr. Nilson: — Okay. Well thank you for putting that on the record. Again I'll just say that it strikes me, after listening last night and over the last couple of weeks and then tonight, that the real option here would be to appropriately fund the health region, appropriately fund Saskatchewan Health so that we could have a robust public diagnostic system, and that that would save us all kinds of complications and the huge amount of effort that's gone into preparing this legislation and dealing with all of the added complications. But I'll turn it over to my colleague now.

Ms. Chartier: — Thank you, Mr. Chair and Mr. Minister and all the officials today. I'll just finish up here today. I know my colleague has asked some very specific questions and I'd like to go back to some general questions just following up from last night a little bit.

So, Minister Duncan, last night when we talked about options, you put three forward. You talked about the status quo . You talked about no out-of-province tests being allowed here, which I'm not sure who's talked about that in this time. I know it hasn't been the opposition. And the third option you put forward was opening the door to private-pay MRIs. So you provided three options. And think about something that one of my colleagues says: when you're a hammer, everything looks like a nail. So the solution here, is the solution privatization or did you look at any other options? You did mention those three last night, so obviously people are waiting far longer than they should, not meeting benchmarks for MRIs. What else did you look at in terms of possibilities for addressing that?

Hon. Mr. Duncan: — Thank you, Ms. Chartier, and good evening to you. I'll maybe just . . . I think that there's probably several things that I can say on that. So I guess I should clarify. Status quo as one of the options, and I think I mentioned that last night, the status quo of what we have done in this province is double the number of publicly funded scans in the public health care system in seven years and still have wait times. So even the status quo isn't necessarily . . . I don't view as necessarily the only answer.

I think that in order to tackle wait times, I think that there is . . . I guess I would just disagree if the assertion is that government, this government and I as minister, have looked at this issue through the lens of being a hammer and everything is a nail, or I'm not sure exactly what the analogy is or the exact wording of it. But no, I would say that this government has increased capacity, both in the number of scans that are performed in a year and the number of physical scanners that are in the province. So we've increased just in terms of the publicly funded scans. We have also allowed for regional health authorities to contract, which has been proven to be cost effective, to increase capacity outside of our hospital settings so that we are not paying the upfront capital costs, frankly, of another MRI scanner — which is, I think, as you would agree, is a very costly piece of equipment. So we're getting more scans through I think better use of a limited resource within the system.

In terms of . . . I would just say at this point, I guess I don't perhaps know, Mr. Nilson, to your point about just robustly funding the health care system. In eight years the budget of Saskatchewan Health has gone from about $2.4 billion to . . . Frankly, actually I would go back a little bit further. The 10 or 11 years ago when I worked in the Department of Health under you, Mr. Nilson, as the Health minister, the budget of the time for the Ministry of Health — the Department of Health as it was called then — was $2.3 billion. Today it is $5.1 billion and it is not slowing down in terms of the growth.

We're trying to bend the cost curve and slow that growth, but if it's just a matter of robustly funding the health care system, I don't know what that looks like. Because I can't tell my colleagues that if we just double the number of scans in the system, that that is going to cure the problems that we have when it comes to wait times.

Ms. Chartier: — Can I just follow up here a little bit with that? So you're assuming that what we're suggesting is that increasing capacity is the only solution. So I had the opportunity — obviously I haven't been here all evening — but I had the opportunity to listen to some of your conversation, and you talked about one of the initiatives around GP to surgeon and doing some of that work. So we have the piece around capacity and increasing public capacity, but also addressing wait-lists, addressing appropriateness, if people are getting the right scans.

I would argue that perhaps there's . . . you've done some investment in that area, but streamlining wait-lists, so I'm . . . To say that it's just a call for more money for MRIs is not the only part of this. So I'm wondering, when you're thinking about options, what else you put on the table.

Hon. Mr. Duncan: — And forgive me, Ms. Chartier, if maybe I'm going on a little bit too long. So I would say that my view

of reducing our wait times, it is a basket of options that we have to pursue. So it is increasing capacity, both in terms of the equipment that we have available, including the professionals that we have available, and including the number of scans that we fund through the public system.

It is about appropriateness. So we had a very good discussion, I think earlier tonight, of some of the work that we are doing on appropriateness. And we have to push that work out, my view would be even more quickly, but obviously it takes a lot of time. I would say — to perhaps your disagreement — that we use lean tools in that appropriateness work and in our pathway development. That needs to be a part of that solution. And so we need to tackle that on the appropriateness issue, but I guess as a part of this discussion in terms of this bill, I guess I would just say that the issue of people going and paying out of pocket, this government didn't create it because it was happening under your government.

There has been a discussion, and granted it hasn't been in recent times as far as I know, but there had been a discussion under the former New Democratic Party about the potential for government to stop people from being able to pay out of pocket and bringing that scan back to the province. Now your government didn't proceed with that, and I think that that is . . . I'm not here to debate that point, but I guess my point is this: today in Saskatchewan, people have the option to pay out of pocket, go out of province, purchase a scan, bring it back to the province. And as I said last night, aside from them no longer being on our wait-list, we really get no benefit out of doing that.

And all I'm trying to look at is to see is there a way to accommodate what people already have the ability to do in Saskatchewan and somehow derive an additional benefit to the public system because, as I said before to you last night, we are funding to health regions for an increasing number of MRI scans to the tune of about $725 in each budget year.

If there is a way that I can increase capacity by focusing on increasing the number of scans that we pay for, I'm going to do that if I can do that and if the budget of the province allows. If there is a way for us to decrease the number of inappropriate scans or the variation in terms of why physicians do certain things compared to their colleagues that may not make, from a clinical perspective, a lot of sense, we need to do that work as well.

Is there a way that I can capitalize on what people already do each and every week in this province by paying out of their own pocket and going out of province? Is there a way I can get a scan out of that for the public system that isn't going to cost the taxpayer $725? I'm going to look at that option. And I think the road map to that, frankly, has been provided by previous NDP [New Democratic Party] governments that did allow Workers' Compensation and the Saskatchewan Roughriders to do this.

And so this isn't going to be, in my view, the cure-all for wait time issues that we have. It may be a small part of the solution in terms of increasing our capacity without the taxpayers having to pay for that capacity. But more than that, it's providing people a choice that they already have, and I don't think the debate right now is stopping people from having that choice. It is acknowledging that people have that choice, and is there a way to bring that choice closer to home for people that choose to do that with somehow getting a benefit to the public system that doesn't cost the taxpayers $725 every time somebody does that.

Ms. Chartier: — Thank you for that. We could go on longer, but I have a few . . . another in follow-up to something that you have just said. So obviously people are going to Alberta, Minot, the Mayo Clinic, different places to get scans. You've pointed that out. We can't quantify that. I asked you last night if . . . We talked about perception versus reality. We talked about whether or not people are queue jumping and you actually . . . Forgive me; I don't have *Hansard* in front of me. I did make a few notes though and I asked, do people who go to Alberta and present diagnostics get services faster? And you had pointed out that if they have that information in hand, we don't put them to the back of the line. So in essence, queue jumping is happening right now. So I'm wondering what your opinion is, as the Minister of Health.

So we have a government here who wants to make queue jumping easier, and I would argue that there may be more harm than good. You keep talking about public good to the system, but we can look at other jurisdictions where in fact introducing private MRIs — like Manitoba and Ontario — have hurt the system and increased the waits for all the rest of us. So I'm wondering about your perspective as the Minister of Health when it comes to queue jumping. So you're putting forward a piece of legislation that makes it easier to queue jump, and you've argued that making it easier is something that you're trying to do here.

The Chair: — I'm going to jump in right here and let everybody know we're getting near the top of the hour. Four minutes left; we're going to wrap it up at 9 o'clock. So just if there's, if you need to get something, if there's time after Minister Duncan is done this question, answering this question, we'll let it happen. It's 8:57, so you've got three minutes left.

Hon. Mr. Duncan: — So, Mr. Chair, I think if I can hopefully really quickly answer this and allow Ms. Chartier, if she has additional questions. So I guess I would say this, that I acknowledge that this is happening. This is happening within our system. There is the ability for us to stop this from happening, and if you or your party would like to introduce legislation in the Chamber . . .

Ms. Chartier: — Whoa, Mr. Duncan, nobody has said that. Nobody has said that. I asked you very specifically if queue jumping is something, as the Minister of Health, is something that you think is acceptable. That is the straightforward question.

Hon. Mr. Duncan: — It really isn't because I'm not proposing legislation that would stop people from doing what they can do. I acknowledge that this is already happening within the system. So I acknowledge that this happens, and so is there a way that I can, as the Health minister, capitalize on what people are already doing today in Saskatchewan?

Ms. Chartier: — But you've said you want to make it easier. And again I would argue that, if you look at the evidence from other jurisdictions, that there has been harm. You talk about

public good and getting some public good and public benefit out of it. But if you look at other jurisdictions, there's been harm to the public system by introducing private MRIs.

Hon. Mr. Duncan: — But this isn't a matter of making it easier for people to queue jump. This is a matter of . . . because based on the premise of your question, if you disagree with what is happening today, you can make it harder. If that's the premise that this is making it easier, then you can make it harder for people to do this, and that is to pursue the legislation that came out of Mr. Nilson's constituency about 10 years ago when he was the Health minister that would prohibit people from doing this. All I'm saying is I acknowledge that this happens and we do not derive a benefit to the public system of something that can happen and does happen today aside from that person not being on the wait-list. And is there a way for me to derive for the public system a benefit? If somebody wants to go the other direction and stop this from happening, then they're free to do it. That's not the position that I've taken.

Ms. Chartier: — And I don't think that's the position that anybody sitting in this room has put forward, to be perfectly honest. But when we talk about options, last night you gave me status quo, you gave me the ceasing out-of-province MRIs, and you gave me the option of opening up the door for private MRIs. Those were the three options you laid on the table last night. I'm wondering what about the other options, again to the question about increasing public capacity further and also perhaps addressing the piece around robustly addressing appropriateness, addressing wait-lists, thinking about how you streamline them. I know looking back to Romanow's 2002 report, that was identified as a big issue was wait times and how they're managed. So did you look at any of those options?

[21:00]

The Chair: — The time being 9 o'clock, I'll let the minister answer this question, and then we'll proceed onto the clauses.

Hon. Mr. Duncan: — So absolutely we are looking and have looked and are investing in all of those different options in terms of appropriateness, in terms of increasing capacity within the public system, in terms of managing our wait times. I think this province and this government has demonstrated better than any other province how you actually manage surgical wait times in this country, and I think that we are certainly leader in that field in this country.

I guess I would just . . . To me it goes back to this is something, Mr. Chair — and this will be my final remark — this is something that is already happening in Saskatchewan. We can either turn a blind eye to it and allow it to continue. We can prohibit it from happening in the future so we can say that you can not go out of the province, buy an MRI scan, and bring it back to the province. Or we can see if there is a way to benefit the public system, not unlike what the NDP government did for the Saskatchewan Roughriders. And I think frankly, just because my neighbours can't run with a football for a hundred yards on a Sunday afternoon doesn't mean that they are any less deserving of opportunity that the NDP government, a social democrat government, gave a professional football player in this province.

Ms. Chartier: — Or you could ensure that they don't have to go out of province. That's the other, that is yet another option.

The Chair: — Okay, we're going to proceed to vote on the clauses.

Mr. Nilson: — So excuse me, Mr. Chair, will we have a chance to comment on the clauses as they go along like normal?

The Chair: — Yes, we'll follow on as . . .

Mr. Nilson: — The reason I raise this, Mr. Chair, is that we have had very long times when nothing has been happening here because it's been taking such a long time for the minister and officials to respond to questions, and so I think there might be some latitude here to allow for a bit more time.

The Chair: — We had . . . You had an opportunity in the House to debate this for as much time as you wanted before you moved it to committee. The minister took the time he thought it was appropriate to give you the best answers to the questions. I don't think any of the time he took was inappropriate with some of the other committee meetings I have been on. So we're going to proceed with the votes.

Clause 1, short title, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 1 agreed to.]

[Clauses 2 and 3 agreed to.]

The Chair: — Oh, I forgot to say on clause 1 that it was carried. So, short title.

So we'll go on to Clause 4, coming into force . . . [inaudible interjection] . . . Okay, wrong script.

Clause 4

The Chair: — Clause 4, is that agreed?

Mr. Nilson: — No. I have a question on that one.

The Chair: — Okay.

Mr. Nilson: — On this I have a question here related to my earlier comments about who can obtain a licence for an MRI facility. Is this the place where it could be said that this person should be a resident of Saskatchewan, so that we know that these are facilities that are provided by Saskatchewan people?

Hon. Mr. Duncan: — Mr. Chair, I don't think it's possible for us to put in residency requirements. I think that that would be a violation of agreements on internal trade. I would be of the view that the accreditation would follow first and foremost, accreditation requirements under the bylaws of the College of Physicians and Surgeons that I think we've discussed at length tonight.

Mr. Nilson: — So it's not possible to register the concern that these types of facilities are operated by Saskatchewan residents? I think there are many pieces of legislation where that's true. I mean I think your reference to something else relates to ownership of land and things like that. But there isn't any reason that you couldn't say that this kind of facility should be operated by a Saskatchewan person or a person resident in Saskatchewan.

The Chair: — Was there a question there?

Mr. Nilson: — Yes.

Hon. Mr. Duncan: — Mr. Chair, I guess I would just stand by my previous answer to that question. I don't believe that that's possible and I think that the . . . I would just stand by my comments on that.

Mr. Nilson: — Okay so basically you're not . . . The answer is that being a Saskatchewan or having these as Saskatchewan facilities is not part of your policy and that you're leaving this open to have a much broader base. I guess all I'm asking is, can't you be more direct about the fact that you want these to be Saskatchewan-based facilities, Saskatchewan-licensed facilities?

Hon. Mr. Duncan: — Well it will be a Saskatchewan facility based here in the province of Saskatchewan.

The Chair: — So clause 4, is that agreed?

Some Hon. Members: — Agreed.

[Clause 4 agreed to.]

[Clauses 5 and 6 agreed to.]

Clause 7

The Chair: — Clause 7, is that agreed?

Some Hon. Members: — Agreed.

Mr. Nilson: — No it's not. I have a question here.

The Chair: — Mr. Nilson.

Mr. Nilson: — Thank you very much. This particular clause is drafted to deal with the *Canada Health Act*. Has the ministry reviewed this with federal officials to make sure that it complies, or is this one where I guess concerned citizens or people involved will have to apply to the court to have this defined?

Hon. Mr. Duncan: — Thank you, Mr. Chair. Section 7 doesn't speak directly to the *Canada Health Act.*

Mr. Nilson: — What was the answer? It doesn't speak directly? That's accurate, but it is specifically here because of the concern about the *Canada Health Act*. Otherwise this clause wouldn't be here.

Hon. Mr. Duncan: — No, that's not the case. This would require the licensee to be in compliance with any federal Act, but the *Canada Health Act* doesn't apply to the . . . The *Canada Health Act* applies to a provincial government. It doesn't apply to specifically to a service provider. *Canada Health Act* is really a funding document related to how services will be funded based on the delivery of services within the province.

Mr. Nilson: — Thank you for that. That's a much better answer.

The Chair: — Where are we here? Okay. Clause 7, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Agreed. That's carried.

[Clause 7 agreed to.]

[Clauses 8 to 28 inclusive agreed to.]

Clause 29

The Chair: — Clause 29, is that agreed?

Some Hon. Members: — Agreed.

Some Hon. Members: — No.

The Chair: — Okay. Mr. Nilson.

Mr. Nilson: — Can the minister explain where the immunity lies in this particular clause? The specific wording here, does this relate to the contracts? Or does it relate to tort action? Or does it relate to . . . what does it relate to? I think anybody who, you know, is working in this area and enters into a contract probably doesn't really want to enter into a contract with somebody who is immune from any kind of claim against them.

[21:15]

Hon. Mr. Duncan: — Mr. Chair, I'll have Mr. Hischebett answer the question.

Mr. Hischebett: — Mr. Nilson, this is a relatively standard clause that is included in regulatory statutes, and so the immunity is for the purposes of preventing civil liability in relation to any of the regulatory responsibilities that are conducted under the Act. Certainly isn't unique to this piece of legislation. It will exist in *The Health Facilities Licensing Act* as well.

Mr. Nilson: — Okay. So, thank you. And that confirms that it has really nothing to do with the relationships of the licensees, the people involved in entering into contracts with regional health authorities. So it's basically to protect the regulators as individuals or agencies. Is that correct?

Mr. Hischebett: — That's correct.

Mr. Nilson: — Thank you. That's what I thought. Nice to have it on the record. Thanks.

The Chair: — Clause 29, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 29 agreed to.]

[Clauses 30 to 33 inclusive agreed to.]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The MRI Facilities Licensing Act*.

I would ask a member to move that we report Bill No. 179, the MRI licensing Act without amendment.

Mr. Tochor moves. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Do we have any closing comments?

Mr. Nilson: — Thank you, Mr. Chair. I want to thank the officials and the minister for providing answers to lots of questions. I know that we'll be continuing to watch this legislation very carefully as it proceeds, and for future lawyers who are looking at this for litigation, I hope I've given them a few hooks for possible challenges. Thank you.

The Chair: — Mr. Minister, do you have any closing comments you'd like to add?

Hon. Mr. Duncan: — Mr. Chair, I want to thank the committee for their time this evening and last evening. And I want to thank members of the Ministry of Health, officials from the Ministry of Health that have helped over the last couple of evenings as well as the last several months in preparing for us for committee. So thank you for your time.

The Chair: — I'd also like to thank the ministry officials for their time, our committee members, and the ministers for answering the questions, and the questions that were asked. I would ask that a member to move a motion of adjournment. Mr. Parent has moved. All agreed?

Some Hon. Members: — Agreed.

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

[The committee adjourned at 21:19.]