STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 19:01.]

The Chair: — Good evening. The time being 7 o'clock, we will get started on our Standing Committee of Human Services. So to start the evening, I'll start with introductions. I'm Greg Lawrence. I'm your Chair tonight. We have Mrs. Beaudry-Mellor, Mr. D'Autremont, Ms. Wilson, Mr. Parent. Subbing in for Ms. Rancourt we have Ms. Chartier. Before we begin tonight, we have one addition to the agenda. If everyone is in agreement, after the estimates for Ministry of Health we will add consideration of the Human Services steering committee report. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We will now be considering the estimates for the Ministry of Health. We will now begin our consideration of vote 32, Health, central management and services, subvote (HE01). Minister Duncan and Minister Ottenbreit are here with their officials. Ministers, if you could please introduce your officials and make your opening remarks.

Hon. Mr. Duncan: — Thank you, Mr. Chair, and good evening to the members of the committee. I'm pleased to have the opportunity to speak about the Ministry of Health's budget for the 2016-2017 budget year. Minister Ottenbreit has joined me this evening, as well as a number of officials from the Ministry of Health. To my right is Max Hendricks, the deputy minister of Health. Behind us are a number of officials including assistant deputy minister Mark Wyatt; assistant deputy minister Kimberly Kratzig; assistant deputy minister Tracey Smith; and Karen Lautsch, assistant deputy minister, as well as other senior officials. And if we could just for the number of officials we have this evening, if others come to the microphone to speak, we'll make sure that they introduce themselves before they answer questions.

So together we look forward to answering questions from the committee about the ministry's 2016-2017 budget. With your indulgence I'd like to take a few moments to focus on some of the highlights of the Ministry of Health's budget.

Our target investments and priority areas will benefit thousands of people who are served by our health system each and every day. This year our budget theme is Keeping Saskatchewan Strong. Clearly these are challenging times for the province. Falling resource revenues have meant a significant shortfall in the provincial coffers. Even in boom times there is never enough money to do all the residents want government to do. When money is tighter, it makes those decisions even more difficult. For our publicly funded health care system, the demand for services doesn't slow down when the economy does. People still get sick. They get hurt, and they need medical attention. People still need their prescription medications. They still need access to long-term care, and our government understands that.

I'm grateful that my ministry has received a modest increase in funding over last year. We remain steadfast in our commitment to provide Saskatchewan residents with access to timely and high-quality health services. Our goal is to fund cost-effective programs that deliver tangible results for patients and communities. Priority areas are health infrastructure, improving access to care, and reducing wait times for surgery and diagnostic services for Saskatchewan people. This year's health budget supports innovative approaches to meet the needs of patients and families while ensuring the ongoing sustainability of the health system.

So to the specifics of the 2016-17 Ministry of Health budget, the Ministry of Health will receive a record investment of $5.17 billion. This amounts to an increase of 1.1 per cent, or 57.4 million. Since forming government, we've increased the health care budget by 50 per cent, a total of $1.7 billion. Every year the health budget has grown, but I will also note that the size of those annual health budget increases have been trending downward. Since 2007 when we formed government, the average annual increase for health care has been about 5 per cent. That is down from an average of 8 per cent annually in the last nine years of the previous administration.

We're demonstrating our commitment to health in a time of fiscal prudence. This year's $57 million increase will address health sector compensation, growth in the cost of drugs and medical services, and program utilization changes. The bulk of this funding will go towards regional health authority global budgets. Saskatchewan regional health authorities will receive $3.4 billion, an increase of 75.5 million or 2.3 per cent. Over the past nine years, our investment in regional health authorities has increased by 1.2 billion or 56 per cent.

On budget day we also announced that we'll appoint a special commissioner to provide recommendations to government for fewer health regions and to look at opportunities to better align and more effectively and efficiently deliver province-wide services. By doing this, we want to ensure that there is the right balance in the system between administration and front-line services. The commissioner will review the current governance structure and make recommendations.

We know that there's a heightened interest and concern around what this change will mean for employees, and for the way that our health system is structured and how we deliver services. We've made a commitment to our health region partners: the commission process will be respectful and transparent, and their participation in the review will be very important. Our health regions have excellent dedicated staff that are committed to providing high-quality, patient-centred care. It's important that patient-centred care continues to be our focus.

This is why our funding to regional health authorities also includes a $7.5 million reduction in administration expenses, to be reinvested in funding to front-line staff in long-term care homes. We will work with the regional health authorities in the next few months to determine a plan to find savings and redirect resources to the front line in long-term care. Redirecting

funding is one way we are supporting seniors in this budget, but it is far from the only way.

Our budget remains committed to seniors, and our health budget is a reflection of that commitment. Nearly half of the government's annual administrative expenditures on health services directly benefit seniors in some way. I'd like to highlight a few specific initiatives targeted to improving care for seniors.

The 2016-17 Ministry of Health budget maintains $14.25 million for supports and services for seniors living at home or in long-term care facilities. The 2016-17 budget includes 8.25 million to continue the support of the Home First/Quick Response home care pilots in our four biggest health regions. It'll help keep seniors in their home safely as long as possible and ensure appropriate services are in place quickly.

We've dedicated $2 million to eliminate the wait-list for individualized funding program which increases choice and flexibility in care options for home care clients. This year's budget also includes $2.3 million for specialized provincial dementia behaviour units in both Regina and Saskatoon. They'll provide specialized care to individuals with dementia and challenging behaviour.

We'll also continue to provide $700,000 to enhance geriatric services in Regina Qu'Appelle Health Region. Our special care homes continue to implement purposeful rounding, a practice of regularly checking on residents' needs. One-third of special care homes implemented purposeful rounding in 2015-16. The remaining homes will do so in the next two years. Our budget supports this with $1 million in dedicated funding.

So, as members can see, we're investing in home-based care and long-term care. We want to support seniors to stay in their homes for as long as they can. When that is no longer an option, we want to ensure that they're moving to a place where they'll receive safe, high-quality care.

Mental health and addictions continues to be a priority for the government. In total the ministry provides $299 million in funding for mental health and addictions. This funding supports inpatient and outpatient services in our regional health authorities, drug plan and extended benefits, general practitioners, fee-for-service psychiatrists, and days in general wards for mental health purposes.

Our work on the mental health and addictions action plan recommendations continued in 2015-16 when 15 of the commissioner's recommendations were addressed. Work on the action plan included implementation of suicide prevention protocols, which is recommendation 8.6; the launch of the take-home naloxone program in Saskatoon Health Region, which is recommendation 8.1; the Connecting to Care initiative, which is reflected in recommendation 15.2; groundbreaking on the rebuild of the Saskatchewan Hospital in North Battleford, recommendation 11.3; the expansion of the police and crisis teams or the PACT teams to Regina, this supports recommendation 7.3; an out-patient mental health and addictions wait time reduction work, which reflects the work that is recommended in recommendation no. 2; as well as the proclamation of *The Mental Health Services Act* which reflects upon recommendations 8 and 11, and actions 11.1 and 11.4.

While there has been progress on mental health and addictions, as a government we know that there is much more work to be done. Our focus on the mental health and addictions action plan will continue in the coming year with system improvements being planned in the following areas: appropriate and coordinated care, improved transitions, supportive and independent living, and emergency and crisis responses.

Our government understands that more needs to be done to address the needs of individuals and their families, to reduce the stigma of mental illness, and to better provide more timely and coordinated service. We're committed to continuing to work with community partners and organizations as we refine plans going forward.

This budget also contains targeted funding that will benefit some of our smallest and most fragile patients. In this budget we are investing $10.2 million in pediatric care in the Saskatoon Health Region. This funding will support the pediatric and neonatal intensive care units in the region, as well as additional pediatric positions.

The budget also invests $167.1 million in the Saskatchewan Cancer Agency for cancer care services. I would note that this is an increase of $9.8 million or 6.2 per cent over last fiscal year and a 113 per cent increase since 2007. This is a significant increase without question. The lion's share of this year's increase will go towards paying for 15 new cancer medications. Some of these are for previously untreatable or hard-to-treat cancers including pancreatic, cervical, ovarian, lung, and prostate cancer. Several of the drugs now being funded have the benefit of being more easily tolerated than other cancer medications so patients can take them for a longer period of time. There are also new drug combinations that increase efficacy or tolerance.

This year's Ministry of Health budget includes a significant increase in targeted funding for surgeries. As I have noted before, when the government came into office in 2007 we were faced with the longest surgical waits in the country. In November 2007 there were 15,369 patients waiting longer than 3 months for surgery, 10,646 waiting longer than 6 months, 5,134 patients waiting longer than 12 months, and an incredible 2,669 patients waiting longer than 18 months for surgery. Through the work of the Saskatchewan surgical initiative from 2010 to 2014 and continued investments to lower surgical wait times in the years since, surgical wait times are now the shortest in the country. As of March 31st, 2016, compared to November of 2007 the number of patients waiting longer than 3 months has been reduced by 68 per cent, 6 months has been reduced by 87 per cent, 12 months has been reduced by 96 per cent, and 18 months has been reduced by 100 per cent.

It is important to note that while our financial investment in the surgical initiative did help to reduce wait times, more money into the old surgical system is not what helped to reduce wait times. Instead we looked at different ways of doing things, like creating a system for pooled referrals, as well as creating an online surgeon directory so patients waiting for surgery could see their potential wait time. We also looked at ways to fundamentally change how surgical procedures are delivered in

the province. Since 2010, more than 47,000 surgeries have been provided in private surgical suites. This includes 19,000 surgeries performed in Regina and 27,000 surgeries performed in Saskatoon. These surgeries are publically funded but privately delivered in a non-hospital setting, and I want to emphasize how important the use of these private suites has been in the effort to reduce surgical wait times.

When it comes to surgical waits, we have a pretty good story to tell. We want to ensure that the story continues to be a positive one for every patient who finds him or herself on a surgical wait-list. Due in part to an unprecedented, unexpected growth in demand for elective surgeries, surgical wait times in our largest health regions have recently started to creep back up. They're currently about 5 per cent higher than during the same period a year ago.

Another factor is that there are more specialists working in the province. Since 2007 there has been a 44 per cent increase in specialists working in Saskatchewan, or an increase of 343 specialists. Patients are being assessed more quickly and, if they need surgery, they're added to the wait-list sooner. In order to address this recent wait time growth, we've increased funding to the Ministry of Health budget by $20 million in order to increase surgical volumes and help reduce wait times. This $20 million will fund approximately 2,300 additional surgeries. By providing $20 million in additional targeted funding for the 2016-17 budget year, we're investing a total of $70.5 million in sooner, safer, and smarter surgical care.

[19:15]

To follow our success in reducing the surgical wait times, we are now turning our attention to reducing wait times for specialists and diagnostic services by improving the referral process. We've had some early success reducing patient wait times and improving patient satisfaction by streamlining the referral process and improving communication between referring physicians, specialists, and their patients.

While we're on the subject of wait times, I should also mention that this budget maintains the $4.7 million in targeted funding to help address emergency department wait times in our three largest health regions, those being Saskatoon, Regina Qu'Appelle, and Prince Albert Parkland. This investment will sustain patient flow strategies led by regions and support the implementation of some new initiatives that will further reduce ED [emergency department] waits.

Health system experts will often state that long emergency department waits don't necessarily mean the ED isn't working correctly. Waits are often a sign that a person didn't get the appropriate services elsewhere: the proverbial canary in the coal mine. That's why our work on ED wait times has included things like the seniors' house call pilot in Regina which has served 202 clients, resulting in a 28 per cent reduction in ED visits from this group.

Another project under the emergency waits and patient flow initiative is a police and crisis team, or PACT. It pairs a police officer with a mental health professional, and they work together to better manage mental health crisis calls. In Saskatoon 66 per cent of calls attended by PACT avoided the need to transport clients to the ED. These ED initiatives also include a strategy to better identify patients in acute care beds who no longer need that intensity of care.

Also in Regina's Pasqua Hospital, patients began to benefit from a new care model called the accountable care unit. It includes patients and their families as part of daily interdisciplinary bedside rounds so that they are fully informed and involved in their care. Through improved communication, staff are more aware about their patients' care needs and goals. This will better coordinate patient care and decrease the length of patients' hospital stays.

We will also be continuing with the Connecting to Care initiative. Connecting to Care, or hot-spotting, has identified patients who repeatedly need hospital services or visit emergency departments. Instead of these patients using acute care services frequently, Connecting to Care staff will ensure patients are receiving alternative, more appropriate services within the community. In the 2015-16 fiscal year, there were nearly 100 patients that Connecting to Care staff had identified for the program. Overall I'm excited to see the outcomes of these innovations that will continue to reduce ER [emergency room], ED wait times.

We've seen how increasing patient access to primary care can help save money and lead to more appropriate care for patients. The next budget investment that I'm going to highlight is another example. This budget invests $500,000 to expand an innovative pilot project that provides medical robotic technology in northern communities, and it fulfills a promise that we made as a political party during the recent election campaign.

Remote presence technology is an advanced telemedicine technology that allows an expert — a physician, a nurse, or a pharmacist, for example — to be virtually present in the community. This provides increased patient access to health services right in their community. Early evidence shows that it can reduce health system costs. The pilot project started in Pelican Narrows in 2014. It teamed a pediatric intensivist located in Saskatoon with a nurse practitioner in Pelican Narrows. They work together to assess and triage patients. Because they were able to manage the patient's care in their home community, the result was a sizable reduction in the number of specialized medical transports out of the community. Each specialized medical transport costs around $10,000, and that's before the patient even starts their hospital stay, so the savings added up quickly.

Our budget makes some very significant and important investments in health care and in providing direct services to patients. It's important however to highlight the investments in health care infrastructure as well. Over the past nine years the Ministry of Health has invested approximately $1.2 billion in infrastructure. This year's infrastructure investment totals $71.4 million. We realize there are significant needs in a number of our aging health care facilities throughout the province. Even in a year where tough decisions had to be made, we are addressing some of those most urgent needs. Included in our $71.4 million investment is 34.7 million for capital maintenance. Some examples include fire alarms and sprinklers, nurse call systems, roof and window replacements, and other structural work. A

sizable portion of it, more that $15 million, will pay for capital equipment replacements in every health region. One of them is a new medical linear accelerator at the Saskatoon Cancer Centre. It accounts for 1.9 million of the total.

Other items in the infrastructure budget are $8 million worth of upgrades to heating and cooling systems at Royal University Hospital and a $6.1 million electrical renewal project at Regina's two hospitals. The infrastructure investment also includes 5.1 million for Swift Current's long-term care facility final year of funding, and $2.3 million to complete construction of the Kelvington integrated care facility.

So I've spent some time this evening, a good amount of time talking about the numerous investments by the ministry's budget. But I also want to mention some tough decisions that we did have to make, such as increasing the copayments for both seniors' and children's drug plans. We announced on budget day that the copayments were changing from 20 to $25.

The copayments for seniors' and children's drug plans have not changed since the 2012-13 fiscal year. The increased copayment for the seniors' and children's drug plans, I believe, were necessary to ensure the drug plan's continued sustainability. Through the seniors' drug plan, the province continues to have one of the most comprehensive drug plans in Canada. Our programs designed to assist low-income seniors, including those receiving the guaranteed income supplement and seniors' income plan, have not changed. Approximately 17,000 seniors continue to receive these enhanced benefits.

I'd also like to point out that seniors who qualify for multiple programs receive the best coverage to suit their situation. For example, if a prescription is $10 under the seniors' income plan, the senior will pay the lesser amount of $10, not the 25. I would also like to note that nine out of the top 10 prescription drugs accessed by seniors through the seniors' drug plan cost less than $25, with the 10th drug costing $26.75. In addition, six out of the top 10 drugs on the seniors' drug plan had their price on the formulary reduced through the work of the Pan-Canadian Pharmaceutical Alliance. Further, there are 560 drugs that seniors received through the Saskatchewan drug formulary in the 2015-16 fiscal year that cost less than $25 per prescription. However I do acknowledge that any increase to the cost of medication can be difficult.

We also had to make the difficult decision this year to increase the rate of air ambulance flights from $350 per flight to $385 per flight. This is the first increase to air ambulance rates in 15 years, even while the cost for government to operate an air ambulance flight has risen to over $9,000 per flight.

Before I wrap up my opening remarks, I'd like to touch on something that was an integral part of the 2016-17 budget address by the Finance minister. Transformational change in Health is something, frankly, that is not new to Saskatchewan. Over the past number of years we've continuously looked at newer, better, and alternative ways to deliver services. However given the continued uncertainty of the economy and much lower resource revenues compared to the previous years, the Ministry of Health will be joining every other government ministry by embarking on our own transformational change initiatives.

In his news release on budget day, the Finance minister posed three important questions in terms of transformation and, in particular, how government services are delivered. Is this program or service the role of government? If so, is it being delivered in the best possible manner, at the lowest possible cost to taxpayers? Where similar programs with similar objectives exist, can those multiple programs be combined into one that provides better results at less cost? And could a different governance model provide administrative savings while still remaining responsive to the needs of Saskatchewan people?

These are challenging yet very important and, I would say, exciting questions that the Ministry of Health will be working on in the coming months. We look forward to engaging all of our health system partners as we move forward with work on transformational change. I would also hope that the opposition will be partners in working towards transformational change. I would encourage and very much invite the opposition to propose ideas and thoughts.

Transformational change in our health care system will not happen overnight and it will be challenging but I, as minister, am hopeful that the work that we will do as a health system and as a government and as a province will prove to be beneficial not just in the next year or two, but in the next 10, 20, and 30 years down the road.

So I want to thank the members of the committee for giving me the opportunity to outline some of the most significant elements of the 2016-17 Ministry of Health budget. As I mentioned at the beginning of my remarks, the province's economic situation required us to make some difficult choices. The budget is a modest one that balances our current fiscal reality with our priorities in the health system, and our main priority since day one has always been to put patients and their families first. We've invested in people at the front line, increasing the number of physicians, nurses, and other providers through the system.

We've invested in infrastructure, building new hospitals and long-term care homes. We've invested in innovative approaches to tackle wait times in surgeries, diagnostics in emergency departments. We've invested in primary care initiatives from seniors' house calls to medical robots in northern Saskatchewan. We know how important the health system is to the people of this province. Our government, and me personally as Health minister, take the stewardship of the health care system very seriously. We'll never stop looking for innovations that will result in better, more efficient health care within a sustainable system in order to keep our province strong.

And now with that, we'd be pleased to take questions from the committee. Thank you.

The Chair: — Ms. Chartier.

Ms. Chartier: — Well thank you. First of all, thank you Minister Duncan, Minister Ottenbreit, Mr. Hendricks, and all officials tonight for being here. Always appreciative that you have lots of information to support the minister in his answers, so it's good to see you here tonight.

I'm just going to start off here actually. When it comes to shaping a budget, a health care budget, when the ministry does this, in a perfect world, in an unconstrained world, how much do you usually set aside or think about for an aging population? What per cent, in percentage terms? And I know we've had this conversation either last estimates or the previous estimates. I think, Mr. Hendricks, you answered that. But I'm curious here; I didn't dig it up, but in terms of a budget, what percentage?

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So overall about a little over half of the provincial Health budget does go directly to providing supports and services for seniors and older adults in our province. What we try to do is, you know, obviously we have certain targets or a mandate that is put forward by the treasury board and by the Minister of Finance. Then within that we look to see what we can do in terms of not only continuing to provide what we believe are effective services for seniors and for older adults in the province and frankly for any portion of the population.

Then if there are funds available, you know, we certainly would put forward some priority areas that we would see in terms of some additional investments that we're looking for. But overall I would say it's more than 50 per cent of the provincial budget for Health does go towards providing supports for seniors.

Ms. Chartier: — But I'm just wondering, in an unconstrained world, in a perfect world when you're making up a budget, so you're thinking . . . So I'll add more pieces to this. Maybe you need a little bit more context here. So aging population, in a perfect world, if you could deal with an aging population what would you be allotting? What would you be allotting for contracts? In the House today and yesterday we've heard lots about education and contracts. So aging population, contracts, population growth, utilization, what percentage would be the norm to maintain the status quo?

[19:30]

Hon. Mr. Duncan: — Thanks for the question, Ms. Chartier. So I guess I would begin by saying, in a perfect world, I'm not sure what exactly that looks like. And the reason why I would say that is that . . . So as I said in my opening comments, our increases in the health budget on average have been about 5 per cent a year over the last eight years. The previous nine years it was about 8 per cent. And I think it's fair to say that if you were to ask former minister McMorris, or even ministers under the previous administration whether it was a 5 per cent or an 8 per cent increase, there was always things that were left on the table that weren't able to be funded.

So you know, I don't want to go too far down the road in describing a perfect world because I'm not sure exactly what that would look like. But we did . . . we have in the past — whether it be collective bargaining and providing dollars within the budget for collective bargaining — in the past we have funded, for example, population growth to reflect the growing population of regions.

This year we did provide dollars to reflect demographic growth, so looking at not just the makeup of the population, but also looking at some of the changes in the demographics overall of the population, as well as included money for what we just believed just in terms of the trends: a growing province, a changing demographic, what that's meaning for utilization and volumes in different programs. So we're provided with increases to try to address some of those areas.

Ms. Chartier: — I know I've had this question answered before. I think, Mr. Hendricks, you answered it a little bit more specifically. Sort of when thinking, if I was a Johnson-Shoyama graduate student learning how to become a public servant and building a budget, thinking about these kinds of things, would it be 2 per cent for collective bargaining? Would it be 1 per cent for aging population? Sort of just generally, again recognizing that we live in a constrained world, and obviously in every government and every budget, decisions get made. But when you think about maintaining status quo, I'm curious and I know you've answered this before, what are the numbers that we generally use in estimating that?

Mr. Hendricks: — So thank you for your question. You know, as I talked about, I think last year, when the Ministry of Health goes about developing its budget it looks at, you know, you call this status quo, so were there are to be no changes to the existing system, what our natural cost growth be? And so within that you have collective bargaining. You have inflationary increases, medical supplies, cost for drugs, that sort of thing. You have obviously issues related to utilization demographics, so in your largest centres, and it puts particular pressure on places like Regina, Saskatoon, our urban centres. So that's been recognized in this budget.

And then we look at special initiatives beyond the status quo that we want to make progress in. So in this budget we have $20 million to continue with the surgical wait times reduction program. We're continuing our funding for ED waits. We've made some investments in mental health, or carried them over. And so these are the types of considerations.

You know, when I think ideal world and what we might do, as the minister said, that's a really difficult kind of question. And one of the things, you know, as we discuss a transformative agenda, what we'd like to think about is in terms of seniors' care. Are we actually delivering it as effectively and efficiently as possible and in the right setting? So right now we have a highly institutionalized care system for our seniors. So the notion in a perfect world of looking at, over time, being able to shift that to increase independence, increase home care, that sort of thing, it's a difficult thing to do. But I think it's something that we're serious about looking at in terms of transformation. We have to be treating patients, residents in the right place. Sometimes that'll be closer to their homes or in their homes and in different settings.

Right now I think one of the challenges our health care system faces is that, you know, the acute care sector, the long-term care sector are the defaults. And so we need to look at that, and these kind of changes take time. One of the challenges is how we shift resources in a responsible way from the acute and long-term care sectors to those other sectors, so the ministry is thinking about this an awful lot in the context of transformational change. And these are all the considerations that go into budgeting. It's quite a bit more complicated than that, but it's generally.

Ms. Chartier: — And I don't disagree with many of the things you said, but I'm trying to get a sense. So when you're doing your modelling for your budget before you go to treasury board, what would you . . . We can talk specifically about this budget. I was talking about a perfect world where I understand that there are usually certain figures you use.

Again, nothing stays the same, and obviously the goal is to always improve and change things, but I really am trying to get a perspective of what you've allotted for demographic changes, what you've allotted for aging population, those kinds of things. I'd like to know generally what you do every year, but let's talk about this year then.

Mr. Hendricks: — So what we do is obviously we look at the population growth in our regions. We look at how the age is distributed within, or the ages within that population. And so in Saskatchewan we have the unique circumstance that we have the oldest and the youngest population in the country. You know, I guess one of the things that we debate often in the health care sector is, is an aging population in and of itself the biggest cost driver? So we know that seniors are living longer, healthier lives. And so I think that when we're doing this, we're acknowledging it and we're mindful of how this is . . . You know, we watch pressures in our acute care sector. We watch pressures in our long-term care sector.

So those are the ways that we sort of look at our budgeting pressures and we look at alternatives. So there's been a lot of work done, for example around alternative level of care options for seniors who are currently in acute care settings, you know, looking to get into long-term care. But I think actually we need to be looking at options other than just moving them to long-term care.

So the budget does look, when we do look at this, as you say, in an ideal world, I wouldn't want to say, you know, it's 2 per cent because of seniors because I don't know that. I don't know that we're not . . . I won't say overinvesting, but investing in the wrong sort of places right now for seniors, and that needs to change over time. But we have to look at where we're experiencing pressures in any budget.

And so, quite frankly, in this budget we've made allowances for the seniors' growth is in our largest centres where we have the acute care pressures in terms of medicine, beds, and where we have the pressures in terms of long-term care as well. And so it's not anything that's done in one budget. This is a continuum, not an event. And so we can't, you know, particularly in this challenging fiscal environment, do everything within this fiscal year.

Ms. Chartier: — And I'm not asking or expecting that you do everything in every fiscal year. But okay. So, Mr. Hendricks, you're teaching a seminar at Johnson-Shoyama School of Public Policy, and you are teaching about budgeting, the very basic class to the newbie grad students.

When you're talking about budgeting, obviously every region is different, whether you're working in Saskatchewan or somewhere else it will look a little bit different. But you're training a civil servant to do sort of rudimentary . . . like what do you do for a budget. What do you allot, recognizing that yes, things can be done differently and yes, Saskatchewan is different than Alberta or anywhere. But if you're talking to a grad student, what do you allot? Say roughly, what would you allot for inflation? What would you allot for aging population? What do you allot for demographics? What do you allot for collective agreements?

Mr. Hendricks: — So collective agreements are . . .

The Chair: — Excuse me. Mr. D'Autremont would like to respond, ask a question.

Mr. D'Autremont: — Make a comment. We all live in an imperfect world where we have to deal with reality. We have to deal with circumstances as they are today, not as we might wish them to be. In the perfect world we would have abolished death and disease. There would be no need for a health department. But we don't live in a perfect world. We live in a world that is constrained by today's society and today's economics. So would it be possible to talk about this budget rather than the perfect world which will never exist?

Ms. Chartier: — To be clear, I am talking about this budget. The reality is regions got 2.3 per cent, so I would like to know . . . And I know that there will be cuts coming to health regions. So I'm going to try to get a sense here, and I'm going to continue to do that, to try to get a sense of what in an unconstrained world it would look like. And I know, Mr. Hendricks, you've given me this in part before, so I know you can do it.

The Chair: — I just want to make sure that we tie this to this year's . . .

Ms. Chartier: — And I have just done that for you.

The Chair: — If you'd let me finish, I want to make sure that we give them the opportunity to answer your question, but now that we know where you're going with it, then they can tie it to . . . His point is well taken.

Ms. Chartier: — Just to be clear, Mr. Chair, this is an opportunity to . . . It's a policy field committee, and this is an opportunity to discuss policy choices as well as the budget. So anyway I know, Mr. Hendricks, I appreciate you have answered this in the past, and I'm curious if you have where you are at today.

[19:45]

Hon. Mr. Duncan: — Thanks, Ms. Chartier, for the question. And I'm confident that Mr. Hendricks can do it as well, but I'm going to give it a try.

So every year as we get the call for estimates, we look at what our base budget is in terms of not just the ministry, but we also look at the programs and the services that the regions are funding. We have a lot of conversations with the regions in terms of their priorities, especially as it relates to capital. And then we put forward as a ministry and as working with my officials in my office, you know, we look at what are the things that we would like to be able to fund if we can. We cobble all that together and, generally speaking, the list of things that we

would like is greater than the call for estimates that comes from the treasury board process. So we have to start prioritizing where we're going to go.

What we have done in the past has looked at historically what is, for instance in the past, population growth. We have in the last . . . Well we didn't specifically itemize it in this year. We have in the past, I believe, to the tune of about $76 million, put in funding of about $76 million over a couple of different budgets because we just knew that the population was growing and so we wanted to try to reflect that significant growth over the last number of years.

We look at the historic rates in terms of our utilization of a number of our different programs, including drug plan and working with regions, to look at what their utilization of their programs are, such as their acute care beds and long-term care beds. And we try to make some estimates in terms of what we think utilization will be based on some of those trends, as well as factor in the aging demographics of the province and things of that nature.

We also want to ensure that — for instance, we have come through this past year for the most part with most of our, I think almost all of our collective bargaining have either been closed contracts or we have successfully completed negotiations — so we put forward as a priority that we want to ensure that we have money in the budget based on the call of estimates.

But there is a lot of back and forth through that treasury board process, that if there are just things that we want to get funded that we think are a priority — for instance, the $20 million this year in the surgical initiative — that was something that, you know, frankly colleagues of ours and Minister Ottenbreit and myself, I think, made obviously must have been a compelling enough case that we needed to increase our investment into the surgical initiative. So that's, you know, I think an attempt at kind of explaining the process that we go through, and I'll maybe . . . I'm sure you'll have a follow-up after that.

Ms. Chartier: — Thank you for that. And just for some clarification, obviously, as you said, you've just pointed out to things you want to fund. And you've talked about in the past, for population in the past budgets you've put in 76 million for population growth. So I'm wondering in, or whatever in total over . . .

Hon. Mr. Duncan: — We'll find the exact years. I know that it's about, I believe the total is since 2007 about $76 million. That wouldn't all be . . .

Ms. Chartier: — Since 2007?

Hon. Mr. Duncan: — Yes, since 2007. So not every, like this year, not every budget has had a specific increase related to population growth. Sorry, my number is 73 million that's been transferred to the regional health authorities for population growth. We'll endeavour to find the specific budget years that that would have been allocated.

Ms. Chartier: — Okay, I feel like we're getting somewhere here. This is what I was interested in here. So you didn't put population growth in this year. Did you, in terms of utilization, what did you allocate in past years for utilization, and what did you allocate this year for utilization?

Hon. Mr. Duncan: — So in total in this budget, we'll have to go back and compare it to previous years. One thing I will note is in terms of programs that we would have funded in previous years — so for example the seniors' house calls or the Home First/Quick Response is an example — typically what will happen is, in the subsequent budget year that will then be put into the base budget. So then basically we start out at the beginning of the call for estimates, we start out with what is essentially the base now, the base budget of each of the regional health authorities as well as the Ministry of Health overall. And then we try to build upon that.

So this year our budget includes increases that cover salary increases, drug and medical cost growth, as well as program utilization changes, just under 140 million this year.

Ms. Chartier: — Okay. Salaries. You said drug costs, salary, drug costs. And what was the third?

Hon. Mr. Duncan: — Salary, drug costs, medical cost growth, program utilization.

Ms. Chartier: — And they're all lumped into one category there, or are they broken out?

Hon. Mr. Duncan: — They're lumped into one category on my page, but I'll check with officials to see if we actually break those out even further than that.

Ms. Chartier: — Okay. I'm wondering is it possible to get sort of a comparative. So you've given me obviously the thing that I've been asking about is percentages, utilization, aging population, those things. And obviously you have them because you gave me the growing population figure. So I'm wondering if I could get, before the end of next week with respect to this committee, if I could get from 2007 to now, what has been allocated in those categories? That would be possible?

Hon. Mr. Duncan: — Yes. It'll take some time to get that together, but yes.

Ms. Chartier: — Yes, that would be great. Thank you. So drug costs, medical costs, you said 140?

Hon. Mr. Duncan: — Sorry, go ahead.

Ms. Chartier: — That's okay. I just wanted to confirm that number. You said salary, drug costs, medical costs, and program growth was 100. What was the number? 140?

Hon. Mr. Duncan: — So the number I'm working off of is 138.6.

Ms. Chartier: — And that's in this budget? Is that right?

Hon. Mr. Duncan: — So that's this budget and that includes, for example, the Cancer Agency as well.

Ms. Chartier: — Okay. So if I could have, in terms of pulling those numbers together so we're comparing apples to apples,

year over year, that's what would be great to have reported back to the committee.

A Member: — Yes.

Ms. Chartier: — Okay, we're on the same page. Thank you for that.

We'll move on here. With respect to the regions, we talk about a 2.3 per cent increase. Have you been working with the regions on their budgets, or is that sort of an independent operation?

Hon. Mr. Duncan: — The regional health authorities would have been working through draft budgets prior to the provincial budget being released, so then they'll have a better idea now, subsequent to the budget being released, of what actual dollars they will be looking at. And they will have until, I believe, close to the end of July to submit approved budgets.

Ms. Chartier: — Okay. So are you getting any flags from any particular region about the potential for a deficit?

Hon. Mr. Duncan: — I would say for a number of regions this will, I think for all regions this will be certainly a challenge, not unlike it has been in the past. I think that, you know, we'll obviously be paying attention to especially our larger regions that do the bulk or majority of the service deliveries such as Regina Qu'Appelle and Saskatoon Health Region. What we will do is work with the regions to help them through this process to ensure that decisions that they're going to have to make as regions to manage within their budgets that they've been allocated has minimal impact on patients and services to as great an extent as possible.

Ms. Chartier: — So obviously you know that it will be a challenge because some of the pressures are there. But have you heard from regions saying, so we have until the end of July to finalize our budgets, but this is going to be a real problem. Have you actually had indications from regions that have said that, that they'll be looking at deficit budgets?

Hon. Mr. Duncan: — I think I would say that, you know, I think regions just in terms of the feedback that I've received and the feedback that the ministry has received, you know, I think it's no surprise that the regions will be challenged this year. Although I would say that there has been some, you know, positive remarks that have come back from the regions.

For example the surgical initiative is something that everybody has invested greatly in. And the regions, you know, obviously shared our concerns and shared concerns that you had raised in the House in terms of our surgical numbers. And so I think that there was, you know, a great deal of support and surprise for the surgical initiative, the $20 million.

The same would be true on some of our maintenance dollars. The fact that we did, in a tight budget year get a pretty significant, about a 25 per cent increase on the life safety portion of our facility maintenance, as well on top of that some special funding for both Regina and Saskatoon as it relates to their tertiary facilities — I think it's fair to say that that was a bit of a surprise on budget day that they would be receiving that, in terms of they being surprised. But I would, you know, again I would say that their budgets are not yet . . . They're going through that process right now so, you know, we'll work closely with them on that.

Ms. Chartier: — So you've said you've gotten some feedback, and some positive feedback and some feedback around challenges, but the very specific question here is, have you been told by regions . . . And they still have another month or so, but my conversations with people are that the press is on and they're . . . So I'm wondering if you've had a region, several regions, two regions, six regions, say, we will be running a deficit; it looks like we'll be running a deficit budget.

[20:00]

Hon. Mr. Duncan: — So again I would say at this point, while regions have flagged the difficult work that they will have to undertake in the next month and beyond, after their budgets are approved, I think it's too soon to say at this point that we will definitely have deficits in the regions. They will be putting forward what their plans are to mitigate any deficits and to, as best they can, manage within the budget that they've been allocated. So you know, it's definitely been flagged that there's going to be a lot of hard work that's going to have to go into ensuring that they can manage within their budgets, but it's too soon to say at this point that we will for sure be presented with deficit budgets.

Ms. Chartier: — Have you had feedback around things that may be cut, but as a ministry you don't want to see cut? Obviously health regions have some autonomy, but the reality is as a ministry responsible for health, that you have some priorities. Has there been any flag about deficit versus this cut or that cut? Have you had any feedback like that?

Hon. Mr. Duncan: — So, Ms. Chartier, I think probably the best way for me to attempt to answer the question would be to say that we work throughout the year, not just as they prepare to bring forward their budget and have board approval of their budget. We work really closely with the regions and that's going to be true going forward in this year as we're asking ourselves as a ministry and as a health care system, you know, what do we need to look like in the future to ensure that we're delivering a high-quality, efficient service for the people of this province, and one that is cost effective. We're going to be certainly asking the regions to look at the same thing.

So you know, we are looking and asking regions to look at, kind of going back to look at, what is the core mandate of the health services that you're delivering, and are those services that you need to be delivering into the future? Again pretty broad parameters that we put on is to say that, you know, for as much as possible, ensure that you're not impacting services, impacting patient care. We have been pretty, I think . . . I think as a government we have invested pretty heavily in front-line care and we want to ensure that we are still maintaining that investment into front-line care. And so in service, in terms of the services that are being delivered, ensuring that there isn't, as much as possible, an impact on the services. That obviously could potentially have an impact on employment.

So I think to their credit, and, you know, we've debated this before, but for example, Regina Qu'Appelle Health Region did

identify a plan to start to regularize their workforce and try to reduce their reliance on overtime and casual work. And this time last year . . . And we were kind of talking a little bit before. That time has gone by quite quickly. But I think at that time, you know, the region had identified a number of FTE [full-time equivalent] positions that they believed that they could eliminate without actually eliminating actual employment, just by ensuring that they're having more regularized, full-time work instead of relying on overtime and casual work.

And so that's the type of work that we're going to be working, I think, very hard. And we're going to be engaging other partners within the system, such as our health care provider unions and the SMA [Saskatchewan Medical Association] on not just helping to get through a difficult budget year this year but ultimately set us up for success as a system over the long term.

Ms. Chartier: — Thank you for that. Still sort of on the budget theme or the budget to health regions, so 7.5 million for seniors to be redirected, administrative savings to be redirected to seniors. So that all plays into health region budgets as well. So I just want to clarify that that 7.5 million, that is being pulled back from the global budgets of health regions?

Hon. Mr. Duncan: — No. I guess I would maybe characterize it a little bit. So I wouldn't say that it's 7.5 that's being pulled back out of their budgets. I would say, of their base budget, we are expecting overall for regions to find what they're already spending, in terms of that amount, what they're spending already on administration, and make changes to their operations to be able to redirect those dollars into adding front-line staff.

Ms. Chartier: — For sure. I get that that's being added on to front-line staff. But so for this budget year then, the expectation . . . So did they . . . They have global budgets though, so they get money globally. And you want $7.5 million, which I think is incredibly . . . It's important to put that money on front-line staff, but I'm just wondering how that looks rolling out.

Hon. Mr. Duncan: — Can you repeat that question?

Ms. Chartier: — So they get global budgets and you want them to redirect some of their existing money away from administration into long-term care. So I'm just trying to get a better picture of what that looks like and how it rolls out, so obviously 7.5 million across the province, how you will break that out.

Hon. Mr. Duncan: — So the way we're approaching this with the regional health authorities is it'll essentially mirror the region's proportion of long-term care beds, so if a region has 20 per cent of long-term care beds of the overall provincial number, then they would be responsible for finding 20 per cent of the 7.5 million in savings. I'm just throwing out the 20 per cent just as a . . .

Ms. Chartier: — For sure. And they are expected then, or the expectation is that money is to come out of administration. That is defined for them, that that is where that money is coming from.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Are there any other parameters tied to finding that 7.5 million?

Hon. Mr. Duncan: — In terms of the proportion that a region will have to find from administration, we will be breaking that out. So it will be, roughly two-thirds of that would be. What we would look for is two-thirds of that would be from administrative positions within the region and the remaining roughly a third they can find in other areas of administration, so for example reducing their travel, reducing their supplies, their other types of kind of overhead costs.

Ms. Chartier: — So just to be clear, that 7.5 million was in this budget and included in this budget, so not like the lean clawback of a couple of years ago where regions were expected to make up for that. They have that $7.5 million in their budget and they're just to take those resources and redirect.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay. In terms of numbers of positions that you think 7.5 million will purchase, and obviously there are different kinds of positions — CCAs [continuing care assistant], LPNs [licensed practical nurse], RNs [registered nurse]. How many, what do you think $7.5 million buys you?

Hon. Mr. Duncan: — You know, it's really going to depend upon what . . . So the regions will be asking them to provide their proposals of where they will find their percentage and where they will dedicate their percentage. It really depends upon the regions what they put forward, depending on the mix. So if it's CCAs versus RNs versus adding LPNs, each region I think will approach it differently. So it's really hard to put a number at the end of the day what the 7.5 will net us just because each region will be approaching it differently.

Ms. Chartier: — You must have some idea though because you've picked 7.5 million as a number, and so I'm wondering what that rationale for picking that 7.5 million, what you think that that's going to translate into and not just the answer that it'll translate into more positions. Just trying to get a better sense of when you were asking for 7.5 million, what that means.

Hon. Mr. Duncan: — So the $7.5 million target, that roughly equates to about 5 per cent in terms of administration. So you know, I think when we set that number — and I'm more speaking in terms of platform commitment — we wanted something that I think would provide for, you know, I think a pretty significant saving in terms of administration, but also something that the regions, would be doable for the regions. You know, we certainly do need some level of administration, but I think the question always is how much administration do you actually, actually need.

So you know, you can kind of slice it a couple of different ways. I think what we used in the past was it'd be the equivalent of 30 RNs, 30 LPNs, and 35 CCAs. Or if it was put all into CCAs, it'd be approximately 140. Overall it's about 120 positions just based on the average of what those three . . . Typically those are the three positions that we would be using as an average. And so it's about 120 positions overall using the average salary of those three positions.

Ms. Chartier: — For sure. And obviously SHR [Saskatoon Health Region] and RQHR [Regina Qu'Appelle Health Region] will receive the lion's share. So in terms of those 120 positions, what's the estimate for each Saskatoon and Regina regions? Looking at like how much administration they have, so what would they translate into positions?

Hon. Mr. Duncan: — Right. Yes. So just based the numbers that we're using, Regina Qu'Appelle has approximately 20 per cent of the long-term care beds and Saskatoon has approximately 30 per cent. So roughly, essentially half of the savings and therefore the redirect back into long-term care will be those two regions.

Ms. Chartier: — So if we use the 120 positions, recognizing it could more, it could be less, depending on the mix, about 60 of those will go to Saskatoon and Regina, a little bit more to Saskatoon.

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

Ms. Chartier: — Okay. Just pointing out, I . . . Going back to the Urgent Action Fund, the original asked by the Saskatoon Health region, I don't know if you recall how many CCAs they had said they needed, but I believe it was about 440 a couple years ago even. Is that the correct number, the original ask? And then they scaled back their requests and asked for 38 and then they got 19.

[20:15]

Hon. Mr. Duncan: — I'm just going on memory. I don't know if we have that information with us tonight. But I know that when we initially went to the regions prior to having the $10 million amount, certainly the asks would have been higher than what ultimately we were able to find in terms of the $10 million. And then once the 10 million was agreed upon by cabinet, there had to be some adjustments made by the regions in terms of some of their FTE requests. But I don't have that number. But you know, I think you might be close on those.

Ms. Chartier: — All right. Sort of moving off general budget here now, I'd like to chat a little bit about the children's hospital. So last year, last summer, last August I believe, you announced some changes — I just, I'm going to look at my list here — that the price tag for the hospital as of last August was up to 285 million and it won't be finished until late 2019.

Hon. Mr. Duncan: — So we expect completion of the hospital mid- to late-2019.

Ms. Chartier: — Into late 2019. Sorry, mid- to late-2019. And the cost, what's it at right now?

Hon. Mr. Duncan: — 285.2 million.

Ms. Chartier: — So that hasn't changed since last summer. I had heard some scuttlebutt and just wanted to confirm whether or not that that was the case, that it was more than that. That's okay.

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — And can you refresh my memory about where it started, what the original price tag was? The number was 229 in 2012. Sorry, I didn't realize that I had that right there. So I'm just trying to . . . And then you allotted . . . And then there were some problems with projections and you had to add a little bit more.

Hon. Mr. Duncan: — Okay. Thank you for your patience, Ms. Chartier. So in 2009 it was announced that the government would provide $200 million and those dollars were provided to the health region in 2010. And at that time it was believed that they would generate about $13 million in interest off of those dollars. That subsequently has been revised up to, I think, closer to $20 million. And that was based on a 2007 estimate of what the project would be.

When the design went through, the process to design the facility, the estimated cost at that time was well in excess of the 213, roughly speaking, that we thought . . . that government thought would be available for the project. So that's when we went through the 3P [production preparation process] process. That changed the cost of the project to 229 million. We then, after that . . . and I don't have the date exactly, but I know it was . . . well I would have been the minister at the time. We announced that just based on changing demographics of the province, that we would require additional beds to be added to the facility. So that increased the cost by $25 million.

Then when we went to tender for the project, the tender came in well above what was allocated for the project, and that's when we approached the Children's Hospital Foundation to help us with the balance.

Ms. Chartier: — And the balance is 285 now? Is that right?

Hon. Mr. Duncan: — 285.2 is the total.

Ms. Chartier: — And Children's Hospital Foundation is on the . . . is paying how much of it?

Hon. Mr. Duncan: — 28.3. Now there was initially a capital, small capital component that the Children's Hospital Foundation had already committed to. It was for some dedicated space that they agreed to, or initially agreed to fundraise for. So the 28.3, I believe that includes that amount as well.

Ms. Chartier: — Okay. I know that just looking at my notes here, in the summer was it . . . projections in the summer of 2013 that I . . . and then it was in 2014 that you revised the number of beds based on the projection from that summer. But I've been told that when the children's hospital finally opens up in 2019 that it's expected to already to be over capacity. So I'm wondering if, since 2013, if you've had other projections?

Hon. Mr. Duncan: — So the additional 24 beds that were added to the design back a couple of years ago, so that would have provided for . . . I think at the time when the updated projections were done, the concern was that when it did open it would be at capacity basically on the first day, so that's why we did add the 24 beds. The 24 beds would have included a buffer so the 24 beds included would not, in terms of the projections, had us at capacity at that time. So it would have been less than

capacity in terms of the projections. And there's nothing that we have that indicate an updated of the projections that have us looking at that we're over capacity even when it begins, when it opens with the additional beds. So that would be news to me.

Ms. Chartier: — Okay. So total numbers of beds then, please refresh my memory on that.

Hon. Mr. Duncan: — 176 beds.

Ms. Chartier: — 176 beds, 176, okay. Will the children from the Dubé mental health facility be moved into the children's hospital?

Hon. Mr. Duncan: — No.

Ms. Chartier: — Can I ask why not?

[20:30]

Hon. Mr. Duncan: — Thank you, Ms. Chartier. So at this point because, when the Dubé Centre was built, it was built in mind to provide services to both adult and pediatric patients. So at this point, there is no plan in place to move the pediatric patients over from the Dubé that are receiving mental health services into the children's hospital. That being said though, the children's hospital obviously is going to be a pediatric hospital and so there may be some patients that will have services provided, but it's going to depend basically on a kind of case-by-case scenario. But at this point, to our knowledge there are no plans to move pediatric patients out of Dubé into the children's hospital and convert Dubé into strictly an adult centre.

Ms. Chartier: — Can I ask what the point of the children's hospital is? Isn't it sort of that sort of whole integrated care model where you have access . . . And the reason we're having a children's hospital is to provide better care for children, and so the one group of kids who don't get to go there are already the ones who are incredibly stigmatized. With all due respect, I think that that's a huge problem.

Mr. Hendricks: — So when Dubé was designed, built, whatever, there is a segregated unit for children. They're not mixed with the adult population. So you know, I think that's an environment with mental health care professionals around that's conducive to providing that care. I don't want to . . . You know, as the minister said, I think we continue to evaluate, but the care needs obviously of acute mental health patients are a little different than the general pediatric population, so obviously, you know, it's something that we would think that this is the appropriate care setting. And I think that was, it was already accounted for in terms of providing care for that population.

Ms. Chartier: — Do you think kids who need acute mental health could benefit from some of the things that are going to be happening in the children's hospital?

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So just in terms of . . . So the children's hospital, what is planned in terms of clinical services includes in-patient pediatrics, labour and delivery, antepartum, pediatric ambulatory services, maternal ambulatory services, postpartum. It's going to also include the adult plus the children's emergency services; neonatal, pediatric surgical, pediatric intensive care.

In terms of Dubé and when it was designed and being a fairly new facility, does have in mind the needs of pediatric patients that are struggling with mental health issues. And so I'm not saying that there wouldn't be things in the children's hospital that wouldn't be a benefit to the pediatric patients, but I think that that presumes that the Dubé isn't serving the needs of pediatric patients or that there is something missing for those patients that are getting mental health supports. And I don't believe that that's the case.

But again I think that, you know, the intent of the Dubé was to not just have youth or kids struggling with mental health services in an adult mental health facility. There were special considerations in mind to serve the pediatric population.

Ms. Chartier: — There's 10 beds, am I correct, 10 youth beds or pediatric beds at the Dubé?

Hon. Mr. Duncan: — Yes. It's 10 at the Dubé.

Ms. Chartier: — And the utilization rate of those youth beds or children's beds?

Hon. Mr. Duncan: — So for the most recent numbers that we would have, the average daily census at the Dubé is eight. And so it's running at about a 78 per cent occupancy rate.

Ms. Chartier: — Okay. And in terms of the occupancy on the adult side in the Dubé, I understand that it's over capacity every day, so I'm wondering what your numbers show.

Hon. Mr. Duncan: — So again, over the same time period, the occupancy rate at the Dubé has been 95 per cent and an average daily census of 51. And that's for a facility with 54 adult beds.

Ms. Chartier: — And what time period is that?

Hon. Mr. Duncan: — This is from . . . So I have here in front of me 2013-14 fiscal year, and we'll endeavour to get the most up-to-date information for you.

Ms. Chartier: — I understand that today, on any given day, that they are over capacity by about eight beds. So is there any way to clarify that tonight?

And I understand that there's also, at any given time, aside from being over capacity in the Dubé, that at RUH [Royal University Hospital] there's also patients in the ED at any given time as well as those in pods.

Mr. Hendricks: — So you're correct. As of today there are four people waiting in the emergency room for admission into Dubé. One of the things that Saskatoon has been working on and when we note the Dubé, the adult centre, the average length of stay in that facility is much higher than the rest of the province. So in '13-14 it had an average length of stay of 24 days, almost, compared to a provincial average of 16 days. So Saskatoon is looking at this in terms of its alternate level of care, how they can actually address the needs of acute mental

health patients in different ways by getting them back into the community, thus allowing to have beds to admit to out of ER for more acute patients.

So they're looking at this very seriously because this is a blockage that they've noticed and this is what the ED waits initiative is meant to unveil is, you know, identify those places where people . . . there are those blockages where people aren't moving through the system. And there are a variety of reasons. And I think in Saskatoon one of the things that they've discovered is just there might be better supports that need to be made available and connections to the community that might not be made right now, to allow people to actually be moving through the Dubé Centre in a more timely fashion.

Ms. Chartier: — The reality is the folks in the Dubé are acute and do need care. So you've got, just to clarify, you've got four people today who are acute when it comes to psychiatric needs who are in the ER.

Mr. Hendricks: — But I want to actually . . . You said the people in Dubé are acute. Sometimes in the health sector there are people who actually are ready for the shift from acute to community care, and initiating those supports for them in the community is sometimes a challenge. So they might be ready for the transition, but providing an alternate level of care for them is the challenge right now.

[20:45]

Ms. Chartier: — We have had this discussion where you've had people in the Dubé for a couple of years and I understand that that problem is rectified. But yes, I recognize there are people who have called the Dubé home and it's not a home. It's an acute psychiatric facility. But so just to clarify, so four people in the ER waiting for the Dubé, so when we talk about the Dubé being over capacity, say, whether it's two beds or four beds, those patients . . . So are those four in the ER considered over capacity at the Dubé? I just want to make sure that I'm understanding the language here correctly.

Mr. Hendricks: — Yes. So that those would be "admit, no beds," right, in kind of our language. So when a person is waiting in ED for an acute bed, be it a mental health bed or a medicine bed, that's a situation where you have "admit, no beds." And so what the focus of the ED initiative is both reducing the number of times that people actually do require an acute intervention for a mental health or other illness — so on the demand side for emergency — but also in terms of looking at how people are moving through our acute sector as well, be it mental health or medicine or whatever.

And so what we've noticed here and what our statistics show is that Saskatoon at the Dubé Centre is taking longer. Patients are staying there longer than at other facilities throughout the province. So this kind of sticks out. And so that's what the ED initiative is focused on is looking at, as I said, alternate levels of care. So how can those people are there that maybe would be better off in the community, what can we be doing to get them the community supports that they need so that they can be released to the community?

Ms. Chartier: — And I completely agree. And two years ago in estimates we had this very discussion about those people who were, for all intents and purposes, living in the Dubé. I'm wondering how many of those complex cases, those people who are ready to leave, their psychiatric issues are stabilized, and there's just no place in the community for them, so I'm wondering what that number is, say. I don't know if you have a snapshot in time.

So you've given me 2013-2014 information. So on Saskatoon Health Region website, they don't have the "admit, no beds" number which you gave me, which is four, for the . . . or, is that right? The admit . . .

Hon. Mr. Duncan: — Four were "admit, no bed" for Dubé.

Ms. Chartier: — That's what I mean. That was the question around the Dubé. And then it has overcapacity beds, two, at 6 this morning. So are those different things, is my question?

Hon. Mr. Duncan: — Ms. Chartier, so just a couple of things. So the number that you're referring to, there may be a bit of a discrepancy because what you're referring to is as of 6 a.m. this morning. The number that we get is later in the day, so the four is later in the day, by early afternoon. So that's where there may be a bit of a discrepancy on that.

We do also as well, through each of the health regions, track what are considered long stays in our in-patient mental health facilities, but it's a snapshot in time. So for the month of March this year, we had 17. Eight of those would have been in Saskatoon.

And a long stay is considered anything longer than 60 days, but I would caution on that that not every stay over 60 days would be inappropriate. For some people there would be an appropriate reason for why they would be an in-patient for longer than 60 days. But our average for the month of March this year was 17 and the previous year for the same month was 18. So it fluctuates month to month and year to year. But our '15-16 long stays averaged 20 per month, with the most being 27 in one month and the lower end being 15 in one month.

Ms. Chartier: — Okay so that's long stays. I think I have a couple of things here going here all at once here, many questions being asked. So back to the Dubé, and me trying to understand this information and the information that you gave me.

So when you tell me that four people are in the ER waiting for the Dubé, is the technical term "admit, no beds" or is it over capacity? So when we say the Dubé is over capacity, does that . . . so there's no room at the Dubé, are they . . . I'm just trying to clarify language so we're all, we're speaking the same language here.

Mr. Hendricks: — So as the minister mentioned, this is all point in time. So the report that we got as of late today said that there were four patients that were waiting for an admission to Dubé. The anticipated discharges from Dubé on that day were, or today, were three, and on the previous day there were seven. So this is constantly moving, right?

Ms. Chartier: — Oh no, and I'm just trying to understand the

language here so I can ask, sort of, the appropriate question. So sorry, I just want to . . . And I understand that things are always changing, but so the number four that you gave me, how would we refer to them in capturing data? Are they "admit, no bed"? Is it over capacity? Like what's the term?

Mr. Hendricks: — So the "admit, no bed" would be the four that I referred to. If they're over capacity in the ER, that would mean that they have 54 beds, and they're currently at 56. Oh sorry . . . [inaudible] . . . in Dubé.

Ms. Chartier: — One more time. Can you say that one more time please?

Mr. Hendricks: — Sorry. And I got that wrong. So the "admit, no beds" is the four, right? So they're waiting for beds to open up at Dubé, right? And 56 would be the current census versus 54, which is the bed allotment for Dubé.

Ms. Chartier: — Okay. So you're over capacity. So I think I need more explanation here. So you've got 54 beds at the Dubé. You've got 4 people in the ER, and you're only over capacity by two?

Mr. Hendricks: — So if they're in the ER and the four that we're talking about, that's "admit, no bed." You can be over capacity with it on a unit too, so you can have more people than actual allotted number of beds. So Dubé was over by two.

Ms. Chartier: — So they've got extra people in the Dubé where they're not meant to have extra people, or it's not . . . They have technically the capacity for X number?

Mr. Hendricks: — That's what it was designed for . . .

Ms. Chartier: — Yes.

Mr. Hendricks: — . . . and so they're managing 56 patients there.

Ms. Chartier: — So that's today. I understand on average . . . So you gave me numbers from 2013-2014, I believe, so obviously we have this count every day. Do you have the figures in terms of the Dubé? I understand, or I've been told, on average, the over capacity is eight. So I'm wondering if I could either get that figure clarified or corrected.

Hon. Mr. Duncan: — We will, Ms. Chartier, we'll endeavour to get that information as quickly as we can from Saskatoon Health Region. Unlikely we'd get that today, but I'm wondering over what time period are you looking back, that you're looking for the numbers?

Ms. Chartier: — Well let's say the last fiscal year. I'm just curious to know if in fact it's . . . So we've got, the adult beds, from my understanding, have been over capacity. So let's just say a year. Let's take this last year. If you tonight could get a month, the last month of — we're in June — maybe the month of May. Because if you have like, daily, if they have daily snapshots, you just have to add them up — do you not? — and divide.

[21:00]

Hon. Mr. Duncan: — So we'll endeavour to get the last year for you, over the last fiscal year. We'll see what we can pull together tonight. But the people that will be crunching the numbers are helping to answer the question.

Ms. Chartier: — Yes. No, you bet. You bet. I'd love an answer tonight. That would be great. So a smaller time frame is fine; like I'd be good with a month for right now.

Hon. Mr. Duncan: — Mr. Chair, Ms. Chartier, we'll endeavour to get what we can but, again, we're talking about a point in time. So is it the 6 a.m. number? Is it the 1 p.m. number? Like, I guess, what point in time do you want us to try to go back to to compile the information?

Ms. Chartier: — Let's say . . . You know, it just doesn't matter if it's 6 a.m. How about a standard time every day: 6 a.m. or . . . So how many time periods do you take it throughout the day?

Hon. Mr. Duncan: — We'll endeavour to get that information from the region for the committee.

Ms. Chartier: — A 6 a.m. snapshot is fine. That would be great. So I'm still, I'm just taking a look at this data snapshot and just want to understand a little bit more of the language here so I can ask the appropriate questions.

So in the Saskatoon Health Region, what is "BC for"?

Mr. Hendricks: — That's "bed called for." That's the equivalent of what I call "admit, no bed."

Ms. Chartier: — "Admit, no bed."

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay. And then tell me a little bit about the pods. So how do those work?

Mr. Hendricks: — The pods are sort of transitionary units where people who are waiting placement on a specific unit, where they go to be cared for. So it's, you know, off emergency but kind of . . . It's an area that is separated physically and curtained off so that they can receive the care until the bed opens on the specific unit because ideally you want to place patients on the appropriate unit. You don't want them off service if possible.

Ms. Chartier: — So just help me understand this a little bit better. So these four patients, these four psychiatric patients in the ER today who are waiting for the Dubé, are they in fact in the ER or are they in . . . would they be in pods? So if they're "admit, no beds" they're not in pods yet according to . . . like, looking at this count, I don't think that that's how it's measured. So if you're "admit, no bed" or a "BC for" that's different. Like, you're not in a pod at that point. Where would you be?

Mr. Hendricks: — So what we're trying to do is reconcile the report that you're looking down, looking at on the better website with kind of the report that we received. So if you look at the column that says over-capacity beds, so as of 6 this morning, as I said, Dubé itself was over capacity by two. In terms of the ER, this is an over-capacity thing, so it doesn't

really talk about who's waiting in the ER to actually . . . for an admission into another unit. So "bed called for" is 22, you know, overall. But I don't have the breakdown of where that would go. So we'd have to get that in our more detailed reports. And from the region, you know, it'll take us a little bit to put together. We'll pick a time of day, you know, that makes sense and try and get an average.

Ms. Chartier: — When do you get the reports? So this is a snapshot from 6 in the morning. So do you get daily reports from the region?

Mr. Hendricks: — Yes.

Ms. Chartier: — So when do you get your daily report?

Mr. Hendricks: — We get them in the evening, I believe. Or no, sorry, 10:17 a.m. this morning. Sorry.

Ms. Chartier: — So it is in the morning that you get the report. Is it different from the 6 a.m. snapshot?

Hon. Mr. Duncan: — There'll be . . . the 6 a.m. snapshot will take place, and then they'll have a meeting, just a bed management meeting later in the morning. And then after that meeting they will issue a report that comes to the ministry. So it'll vary in time, but it's typically in the morning that we would get that report, the ministry would receive that.

Ms. Chartier: — How about, in terms of ease of compiling, how about just the daily reports? If we can get those numbers crunched, the daily reports that you get, that the ministry gets, that would be very helpful. And do you get this data for every health region, for every acute facility?

Hon. Mr. Duncan: — So we would get it on a daily basis from Regina Qu'Appelle Health Region, Saskatoon, and Prince Albert Parkland, but typically just when they are facing capacity issues. We like to be apprised on a regular basis when it is a capacity issue. Normal course of business for the regions that, they aren't facing some capacity issues, then it wouldn't be every day.

Ms. Chartier: — For all regions, if it's a normal course of business, you don't receive a report.

Hon. Mr. Duncan: — Not every day.

Ms. Chartier: — Not every day. In the normal course of business, how often do you receive reports?

Hon. Mr. Duncan: — Thank you, Ms. Chartier. So typically what happens is we receive a report, typically in the morning, from Saskatoon Health Region, as we've discussed; 10:17 was the time this morning. Regina Qu'Appelle Health Region, we receive three reports a day. Prince Albert Parkland Health Region, we receive a daily report in the event that they are in over-capacity situation. Typically we don't see our district or other regional hospitals in that type of situation, so it would normally just . . . I would just say, in the event that we do have a hospital say in Sun Country Health Region or Sunrise or any other, if there is a pressing issue of capacity, we would know about it. But we don't get a regular report from those regions that typically don't see a capacity issue.

Ms. Chartier: — How about for P.A. [Prince Albert] Parkland? How often, then, if you're only getting reports when they're over capacity, in the last two months, how many reports? How often has P.A. been over capacity?

Hon. Mr. Duncan: — Thank you, Ms. Chartier. So for Prince Albert Parkland Health Region the ministry will, in the morning, go back and look at, you know, the recent history in terms of notifications from Prince Albert Parkland.

Just generally speaking, you know, there was a period in the time in the fall . . . It typically isn't like . . . If there's an over-capacity issue it typically would last for a number of days in a row. It's not usually like one day over capacity and then not. But there was a time — so it's fairly intermittent — there was a time in the fall where there was some capacity pressures within Prince Albert Parkland, within Victoria Hospital, and then a little bit again kind of towards the February-March time frame that they would have notified us about. But the ministry will go back and check the records, report back in more detail for the next committee.

Ms. Chartier: — Okay, just to make sure that we're all on the same page about anticipating or . . . what we're expecting here for data as a committee, so reports back on Regina, Saskatoon, and Prince Albert? So Regina and Saskatoon obviously have different data than P.A., but in terms of Regina and Saskatoon Health Regions, so the reports that you get, say for the last . . . should we pick a . . . Did we say six months? What's doable for you? Obviously we're together next week for a few more hours. We get to hang out together. So I'm wondering what's a reasonable time frame to crunch before next week?

[21:15]

Hon. Mr. Duncan: — We will, Ms. Chartier, we'll go back and talk to the regions, those three regions, and look at what they would have available in terms of the data that they, you know, for example, place on visibility walls. That would be one of the metrics that they'd be tracking. So you know, I would say at least the last six months, but I think we, you know, in short order, should be able to go even further back than that. But we'll check with all three to see what they would have in terms of readily available for the committee.

Ms. Chartier: — Sounds great. Thank you very much. I think that . . . okay, so I just wanted to make sure I understood all these terms. So the pods again . . . so I'm just trying to picture this. So the four people "admit, no beds" could be waiting in the ER, in the hallway; they could be waiting in a bed somewhere else in the hospital. And then I'm going to ask you about the pods. But I'm just . . . like so the "admit, no beds" are not yet in pods. So I'm just wondering, obviously our hospitals only have so much space, so I'm just wondering what that looks like. Like, what? Four people who . . . and it's not just the Dubé we're talking about here because there's the other units that are over capacity too. But paint me a picture of what an "admit, no bed" would look like.

Mr. Hendricks: — Okay. So when a patient comes into the emergency and the ER physician decides to admit them, they

will do that if there is a bed available. But if not, they are in an "admit, no bed" situation, right? Or "bed called for." So they're waiting to be placed on the unit within the ER. When the ER becomes extremely busy, they will open up a pod to care for patients that are awaiting placement in another area of the hospital, and that is a fully staffed . . . It's independently staffed, not by emergency physicians but by a different group of physicians that will manage the care of those patients until they're placed on the specific unit.

Ms. Chartier: — If you're in an "admit, no beds," I guess what I'm asking is you can be waiting in the ER or you can be waiting in a pod or in a random bed somewhere in the hospital if there's a free bed. Is that correct?

Mr. Hendricks: — Correct. You could be waiting in the ER if they think that it's going to be a timely transition.

Ms. Chartier: — Can you define a timely transition?

Mr. Hendricks: — Well if they believe that the turnover in that unit . . . For example, take a medicine unit. If they look at the average number of discharges and the planned discharges for that day . . . Because that's part of what they go through every day, is saying, we expect this many patients to be in; we have this expected number of planned discharges, right? So they have some idea. So you know, we've always had patients in the ER that are awaiting a bed. How long they wait is something that we've kind of pressed as a target within the health system. And so you're always going to have a number that are waiting for a bed, and they wait for a bed to turn over. So a "bed called for," that's a static thing. When the ER is actually kind of over capacity, what you have is a situation where they actually open up one of these pods where it's kind of a temporary holding place for patients that are waiting placement on the appropriate unit.

Ms. Chartier: — And how, I've got, okay, a couple of questions have just popped in to my head here. So have you set a target for a time that it's acceptable to wait in an ER? So I'm thinking about those four Dubé "admit, no beds." Like do you have a target to say, patients shouldn't wait more than X number of hours?

Hon. Mr. Duncan: — So in terms of our emergency department waits and patient flow, what we're targeting for this year is, and this is based on the 90th percentile, so a patient that is in the emergency department and is being admitted to the hospital, our target is that that takes place, their length of stay is 18 hours.

For a patient that is not admitted, so somebody that's just moving through the emergency department, they're seeing a physician and resolving their issue and not being admitted to the hospital, the target is five hours.

We also are measuring the time for the physician initial assessment, and our target for this year is 2.2 hours. And the time waiting for an inpatient bed at the 90th percentile, our target this year, for this year is 15 hours.

Ms. Chartier: — Is that the '16-17 target? Like when does that . . .

Hon. Mr. Duncan: — Yes, that's the '16-17 target. So our goal was to, in this year, see a 15 per cent reduction from where we've been at.

Ms. Chartier: — So that question around a reasonable length of time to stay in the ER, we've set that for this year at . . . So you've got some targets set there, or is that what you consider a reasonable length of time?

Hon. Mr. Duncan: — So that would be . . . I guess the best way to say that is that would be what we're targeting for for 9 out of 10 patients, the 90th percentile.

Ms. Chartier: — So just back to the pods versus the ER, how big can a pod get? Like do you have a maximum number that's . . . So we have three people in this pod so this is full; we have to set up another pod. Like do you have numbers for that?

Mr. Hendricks: — So the capacity of a pod in Saskatoon is approximately 12 patients. So on that report that we were looking at earlier on pods at RUH, they had nine people in their pods of 12 and it might be a little bit larger. At St. Paul's they had 13 in a pod but, you know, it's kind of generally only one pod is ever opened for over-capacity issues.

Ms. Chartier: — So you don't have a maximum number set. So there were 13 people today in a pod at St. Paul's. So does it max out at . . . Like have you ever reached . . . What's the highest number you've reached in the last year?

Mr. Hendricks: — We would have to check that. Like obviously at some point a decision is going to be made. Like if a pod is designed for a maximum of 12 people, right, and it gets to that number or beyond, you have to add additional staffing, right, to support that. So I don't know specifically what St. Paul's is designed for. We'd have to check with the region.

[21:30]

Ms. Chartier: — So you have X number of beds and X number of staff assigned to that, and then if you go over that then additional staff would get assigned.

Mr. Hendricks: — You would have to have additional staff to provide safe care, yes.

Ms. Chartier: — I'm just wondering, back to the Dubé here. I'm still thinking about the Dubé here. Do you have your last year's average wait for a bed in the Dubé for both . . . or like what is your most recent statistic, so the average wait, to get a bed in the Dubé for both children and adults waiting from the ER to admission?

Hon. Mr. Duncan: — Ms. Chartier, we'll check in with the region and try to get a number for you on that this evening.

Ms. Chartier: — I understand that . . . Yes, okay. I guess this will all come when the over- capacity, the report comes. So I'll move on here, although I'm sure I'll probably come back to some of it maybe tonight or maybe next week. But I think I'll move on here.

With respect to HIV/AIDS [human immunodeficiency

virus/acquired immune deficiency syndrome] rates here in Saskatchewan, I understand that the 2015 numbers are out, and I'm just wondering where you're at with that. I know they haven't been reported publicly yet, but I understand that you've already got them.

Hon. Mr. Duncan: — Ms. Chartier, the number of new HIV cases in 2015 . . . So this is a preliminary number. It's not yet finalized, but the preliminary number is 160. And that is a significant increase from the previous year. We had seen our numbers coming down through the, you know, I would say a high in 2009, and the numbers started coming down to 2014, we saw 112 cases. But we are expecting to see, once the numbers are finalized, that it would be a fairly sizable increase from 2014.

Ms. Chartier: — Can you just give me the . . . You said you saw the numbers coming down. Can I get '09, '10, '11, '12, and '13?

Hon. Mr. Duncan: — Sure. You know, I'll go back even further than that. So starting out 2006, 101, 127, 174. In 2009, it peaked at 199; 2010 was 174; 2011, 186; 2012, 177; 2013, 129; 2014, 112. And then again 2015, and it is a preliminary number, but it's 160, is what we're working off of.

Ms. Chartier: — Okay. And have there been any new reports of transmission, mother to baby transmissions? How many births with HIV positive babies this year?

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So we did, in the last year, we had two cases of transmission from mother to baby. And that was the first new cases of that nature in four years. So we had seen zero cases for the prior four years. I do also want to just put this into a bit of context. So the numbers that I gave you, starting back in 2006 of 101 new cases and then again to the 2015, 160 preliminary is the number again that we're using for 2015.

At the same time the number of HIV tests performed in 2006 was just under 43,000, so 42,955 tests. And in 2015, 72,069 tests, so a dramatic increase in the number of tests which I think is one of the reasons why I think we are seeing the number, preliminary as it is, for 2015. We just are doing more testing than in the past, and going to places that perhaps did not see as widespread amount of testing.

And it's my understanding in the two cases reported in the last year, unfortunately it was just two cases that the mothers presented . . . Basically we didn't know their status prior to delivery of the children.

Ms. Chartier: — Okay. So how many tests did you do in 2015?

Hon. Mr. Duncan: — In 2015, 72,069 tests.

Ms. Chartier: — How about in 2014?

Hon. Mr. Duncan: — So you have your . . . If you wrote down the numbers, I can maybe just go through the numbers that would correspond with the number of new cases that I gave you. If that . . .

Ms. Chartier: — You don't know my handwriting here. If I can squeeze them in here. So 2006, let's go . . . Okay give me a second here. 2006 tests?

Hon. Mr. Duncan: — 42,955.

Ms. Chartier: — Okay. 2007?

Hon. Mr. Duncan: — 44,779.

Ms. Chartier: — Uh-huh.

Hon. Mr. Duncan: — 47,294, 48,843. So now we're into 2010 if we're . . .

Ms. Chartier: — Yes.

Hon. Mr. Duncan: — Okay. 52,229.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — 54,463, 60,357.

Ms. Chartier: — And that was 2012, right?

Hon. Mr. Duncan: — Yes. 2013 is 65,180 and 2014 was 67,971. And then again that, in 2015, jumped up to 72,069.

Ms. Chartier: — So about 4,000 more tests between '14 and '15?

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — Yes. Okay. So I'm curious if you are arguing that more testing is . . . So we've had a jump this year and the tests haven't grown . . . I mean 4,000 more tests is 4,000 more tests. But are you arguing that it's testing that's creating this bump that we're seeing this year?

Hon. Mr. Duncan: — I think it's one of the reasons. I think if you look at the numbers, the . . . You know, at the time when the numbers were going up, in that time frame from 2006 to 2011, we were seeing, you know, basically going from 42,000 to 60,000 tests. So we were testing . . . More people were being tested for HIV.

I think that as well, what the officials have indicated, especially in the last year, we are extending and expanding the testing to some areas that we're perhaps not seeing as much testing as we had in the past.

Ms. Chartier: — And what areas would that be?

Hon. Mr. Duncan: — Thank you, Ms. Chartier, for the question. So we are seeing — again working off of our preliminary numbers for this year — we are seeing testing that has . . . So traditionally or typically or traditionally what we'd seen in the past, especially as our numbers were going up in that time frame that I gave you, kind of 2006 to into the early 2010 period, our new cases were predominantly our urban areas, so Regina and Saskatoon.

[21:45]

We're starting to see a shift now in part because of more testing. So we're going into more rural and remote areas of the province. We've expanded the amount of point-of-care testing, so I think we've added 12 new sites this past year that do provide or perform HIV point-of-care testing. Part of that is in Regina and Saskatoon but there are some rural areas as well. In terms of the . . . For example, Dr. Skinner, you're probably familiar with Dr. Skinner, he's been doing a lot of outreach into some newer areas in terms of different communities that he's been going into. So those are what we believe are some of the factors that we're seeing.

We're going to keep working though with the regional health authorities as well as First Nations and Inuit health branch and Northern Inter-Tribal Health Authority to help coordinate resources for increased HIV testing, prevention, and risk reduction programs, as well as support those that are living with HIV.

Ms. Chartier: — Thank you for that. So you've talked about these new . . . Well you talked about some of the point-of-care in the urban centres, but I'm curious if you have a geographic breakdown of the 160 new preliminary cases. So we're talking about expanding testing to urban and more remote areas. Of those 160 new cases, how many are outside of the urban areas?

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So I'll maybe begin by saying that, so what we are seeing . . . And again we're working off of preliminary numbers for 2015. But what we are seeing is that where a lot of our work has been focused, largely in Regina and Saskatoon, that those numbers are . . . I think it shows that we have been and our strategy has been effective in those areas. When you look at the percentage of cases that come from those health regions as in relation to the overall number that we're seeing, so those numbers are holding in terms of cases from Regina and Saskatoon. In fact, going down a little bit.

But we are seeing the percentage of cases, new cases, coming for example from the Prince Albert Parkland Health Region is starting to rise. And we are seeing as well, although in context of the overall numbers that you're talking about . . . So for example a change in the number, say, in a Cypress Health Region or a Sunrise Health Region, as a percentage, it can look like a big increase where, you know, it is a small overall number that we are dealing with. But as I said before, we are expanding into the areas that we are doing more testing.

As well we are, in terms of the initiatives . . . So the numbers that you've received since 2009, 48 per cent more tests are being done, resulting in earlier case identification and access to treatment. We've increased access to risk-based testing, so since 2007 the number of HIV point-of-care testing sites has doubled, more than doubled, from 20 to 48. We've increased access to prevention and risk-reduction programs for those who use drugs.

We do have an infant formula program for infants born to mothers with HIV. We're training, have training opportunities to build capacity of health and allied professionals. We have peer-to-peer programs in six of our regional health authorities and we've developed a routine HIV testing policy and resource for implementation as well as education through social marketing on the importance of testing, so the whole idea of the importance for everybody to know their status.

So again we are working still off of some preliminary numbers, but we do expect that when they are finalized it will have shown an increase in the last year.

Ms. Chartier: — So the strategy ended in 2014. I just wanted to clarify that.

Hon. Mr. Duncan: — So the strategy went from 2010 to 2014 technically as a strategy, but the resources are still in place and the work that was a result of that strategy does continue. And in fact we're building upon that for example, adding the additional HIV point-of-care testing sites and other initiatives. So it technically was a four-year strategy, but that doesn't mean that the work ended after 2010.

Ms. Chartier: — I just want to go back to the question. I do have some other things I want to move on to, but I think the question that you'd just answered prior to my last one was that the question was, of those 160 cases, how many . . . Obviously many of them were in urban areas, but one of the reasons you said maybe they've gone up was because of expanded testing. So I was trying to get a sense of outside of the urban areas or in these new areas in which you're testing, the number of new cases.

But you know what? I'm going to let you think about that, and we can come back to that next week because I would like to move on here. So next week just if you can have data around those 160 cases, whereabouts they came from in the province, that would be great.

With respect to a comment you'd made earlier in your opening statement around the seniors' drug plan, you said that 9 out of 10 of the most common drugs in the seniors' drug plan were under $25 and the 10th was 26. I'm wondering of those nine drugs, how many are under $20?

Hon. Mr. Duncan: — Thanks for the question. The number is six.

Ms. Chartier: — Six of those 10 drugs under 20. Okay. Okay. In terms of the . . . I understand from this change you've said you're expecting to save $9 million. Is that correct?

Hon. Mr. Duncan: — 6.8 million.

Ms. Chartier: — 6.8 million, okay. Can you explain a little bit about how that 6.8 million will be saved, like is there administrative savings? Can you break down how you came to that $6.8 million figure?

Hon. Mr. Duncan: — So in looking at the changes that we are making to the seniors' drug plan this year, so basically what happens . . . And I think maybe this is a bit of a misconception.

[22:00]

This doesn't mean that drugs on the seniors' drug plan go now to $25. So as an example, if a drug in the past — say last year — the patient-pay or the co-pay, let's say it was $22. We would

have capped it at $20 for the patient co-pay part. So we were picking up the extra $2 on that. So that drug now will be not capped at 20; it will now be $22. So that's really when we looked at . . . When somebody says, well now all my drugs are going up to $25, really we have to look at it case by case in terms of the actual drug because not everything's going up to $25.

Ms. Chartier: — Do you have a sense of how many people from the program would take a drug that is over $25?

Mr. Hendricks: — So in total, like in terms of doing the calculations of what the one . . . or of the $6.8 million . . . so in the seniors' drug plan, 1.8 million prescriptions were a benefit under the seniors' drug plan. So if you look at that, that's an average of approximately $80 per year, the increased cost to seniors, or approximately three seventy-seven per prescription . . . [inaudible interjection] . . . Yes, $3.77.

Ms. Chartier: — I'm sticking with the drug plan here. What is the total cost of the seniors' drug plan?

Hon. Mr. Duncan: — This year it's 70 million.

Ms. Chartier: — 70 million for the seniors? How about for the children's drug plan?

Hon. Mr. Duncan: — In the last budget year it was 7.7 million. We're estimating for this budget year it'll be about, roughly the same amount, about 7.5 million.

Ms. Chartier: — For the kids. Okay. How many seniors use this program? So last year, I guess, would be the numbers that you'd have. And how many would you estimate with the changes?

Hon. Mr. Duncan: — So there are 140,000 seniors that are eligible for the program, but this change will only impact about 120,000 of those seniors. So basically 20,000 seniors that are beneficiaries of the seniors' drug plan do not have a prescription that is above the $20 threshold.

Ms. Chartier: — 20,000.

Hon. Mr. Duncan: — Yes. So 20,000 seniors are eligible for the program but don't actually purchase . . . have not purchased a prescription that has been over the $20, so they won't be impacted at all.

Ms. Chartier: — Thank you. So in terms of prescription . . . So generally we see prices of drugs going up, but are there certain classes of drugs that have generally gone down? Is that the top 10 list that you have?

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — Would you be able to table that?

Hon. Mr. Duncan: — Yes I absolutely will table it rather than try to read the names into the record.

Ms. Chartier: — Do you have a top 20 list? Just curious. Is there a top 20 list available? Actually if we could get that list.

Hon. Mr. Duncan: — Sure. Yes we can, we'll table that. We'll table the list for that.

So the drugs . . . so you're right. I mean there are increases when it comes to drugs, but we have seen a reduction in a number of drugs. On our top 10 list of . . . which basically represents nearly a third of all the prescriptions that those over 65 have filled each year, six of the ten have come down in price, and that's as a result of the generic price initiative through the health innovation working group.

In fact, as a country since that initiative started back 2012-2013, we're actually saving, as a country, now over $650 million a year because of lower generic prices through that initiative. So six of those, six of the top ten are in that list that have come down. But we would see some prices that would be going . . . that would go up in a year or two. And I think we're at about, we average at about $10 million a year just in terms of the overall cost to the drug plan each and every year.

Ms. Chartier: — Okay. In terms of bulk purchasing, how has that impacted the cost of pharmaceuticals here? So you've talked about the generic program. How has bulk purchasing impacted all of this?

[22:15]

Hon. Mr. Duncan: — So I'll start out on this and then perhaps the deputy minister can add to this. So we have benefited both in terms of . . . And I'll maybe just clarify. So we don't technically bulk buy with other provinces. Basically for generics, we set a price. We do a similar process for a brand, so we go into joint negotiations. Saskatchewan has led, actually been quite a leader in terms of the pan-Canadian file when it comes to the pharmaceutical contracts. So we have seen both a reduction on the generic side, but we've also seen . . . So overall our costs do continue to go up, but I would say, you know, the generic side has helped to curb that some.

Based on new products coming onto the market, new types of products that are coming onto the market, the hep C drug is a very good example that's something that, you know, is going to have a significant benefit to a number of patients in Saskatchewan, and really I think a game changer when it comes to hepatitis C for people across Canada.

So we are facing more and more drugs coming onto the market, and we are trying to do a better job as a country to ensure that we're gaining the purchasing power of 35, 36 million Canadians, rather than just, you know, Saskatchewan going off on our own trying to negotiate. But we are well over $600 million in annual savings just on the generic side as a country, so the health innovation working group work has been very, very successful for us and for us as a country.

Ms. Chartier: — Thank you for that, explaining that. Okay.

The Chair: — Just going to jump in here. Minister, would you like to table those tonight, and I'll get photocopies and back to you?

Hon. Mr. Duncan: — So I think we could probably table the top 10 tonight. If you want a top 20, we just have, like, the raw

data run, so it would need to be kind of cleaned up and put into a more presentable form. But we'll table the top 20 at our next committee meeting once we make it more presentable.

Ms. Chartier: — That would be great.

Sticking on this discussion around drugs here. So obviously there was a report out just like a month, maybe less than a month . . . or pardon me, just over a month ago on over-prescription of antipsychotics for seniors. And we know that it's a huge problem. We have issues in Heartland. The auditor had identified those a couple of years ago already. It all kind of blends together here, but the Heartland Health Region data around prescription of antipsychotics without a diagnosis of psychosis, and then this report. So I'm wondering if you've looked at the cost of what it means to people in Saskatchewan, the over-prescription of antipsychotics.

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. So in terms of the cost . . . So you know, I wouldn't be able to provide information in terms of what the cost is to the system with respect to one of the quality indicators that we do track which is anti-psychotic use without a diagnosis of psychosis. But what I can say is that that number has been trending down over the last number of years and in fact just recent quarters that we do track. So as an example, province-wide, in the first quarter of the 2013-14 fiscal year, that number would have been 34 per cent. That is now in the fourth quarter of the '15-16 fiscal year. That is down to 26 per cent.

When you look at even breaking it out year-by-year, it was . . . Back in 2006-2007, province-wide, it was 33 per cent. And in '15-16, province-wide, it's down to 27 per cent. It's one of the indicators that we have been putting a focus on, and that's also bringing us in line with the national average which, in the last three or four years, has been . . . and that's the only numbers that we would have is just the last couple of years. That would be as high as nearly 31 per cent national average, down to, in the '14-15 reporting year, 27 per cent. So in the last fiscal year, we're down to that national average, and certainly it is something that regions have been putting quite a significant focus on.

And it kind of goes part and parcel a little bit in terms of some of the other metrics that we do follow in long-term care, such as no falls in the last 30 days. And that's something that we've put a big focus on, trying to reduce the number of falls that we do have in long-term care. As well as the use of daily physical restraints, which in the first quarter of '13-14 was nearly 19 per cent, and in the fourth quarter of '15-16, it was down to just over 10 per cent.

So you know, I would just say that our affiliates and our regional health authorities and other stakeholders are certainly putting a big focus on these quality indicators. But in terms of the use of anti-psychotics without a diagnosis, I wouldn't be able to provide a cost in terms of what that does cost to the system.

Ms. Chartier: — Have you looked . . . So the Canadian Foundation for Healthcare Improvement looked at 56 long-term care facilities in '14 and '15 and found that falls decreased by 20 per cent, verbally abusive behaviour by 33, physically abusive behaviour by 28, socially inappropriate behaviour by 26, and resistance to care decreased by 22 per cent.

So the foundation spokesperson, Stephen Samis, points out that . . . So I'm not sure what numbers he's going from, but he said the prescription rate is about 31 per cent. And he said, at that point, that it's higher than the national average. So what Saskatchewan numbers was he working off of? It's clear he must have taken a look at this study.

Hon. Mr. Duncan: — So in the '14-15 . . . And I think the number that you used was roughly 31 per cent province-wide, that you're working off of so that would be the number for what we would have to . . . for '14-15 was 31 per cent. That's the provincial average. In '15-16, that's down to 27 per cent.

There's a little bit of, I would say, just a caution in terms of the different reporting. So this would be, you know, pretty robust reporting that we would require from every facility. Whereas when you look at, for example, CIHI [Canadian Institute of Health Information] numbers, they would be a little bit more dated than our numbers, and they wouldn't include all of our facilities. I think CIHI reports at about a little over 100 of our facilities. But again in terms of the number you're using, I think it meshes well with what we have reported from all of our facilities that get tabulated as a provincial average.

Ms. Chartier: — Thank you for that. So you said today that the average is 27 per cent, so the national average . . . and you said you're below the national average. So what are you using as the national . . .

Hon. Mr. Duncan: — So what I'm using here is the '14-15, was 31 per cent. But then '15-16, our number is 27.4 per cent. The national average that I'm working off of is for the year 2012-13 which was 30.8 per cent; '13-14 was 30.3 per cent; and then '14-15, 27.1 per cent. So I think my comment was that for the most recent information we have for a national average which was 27.1 per cent, our '15-16 number is essentially the same as the national average.

Ms. Chartier: — Well just in terms of the numbers that he used with the 31 per cent number, so obviously it would decrease. But this particular study in breaking out the data said this would save the health care system about $6 million. So have you looked as a ministry with a critical eye at this particular report?

[22:30]

Hon. Mr. Duncan: — So it would be information that we would certainly look at and share with other partners within the health care system. This is certainly the path that we are on in terms of trying to reduce the number of residents that are on antipsychotic medication without a diagnosis, trying to reduce the reliance on restraints, reducing the number of falls.

You know, I think I would just say that, you know, it's helpful. It's good information to have. We're focused more as a system on these types of things though, more so looking at the quality of life for our residents and less on the financial side.

Ms. Chartier: — But I think fewer falls, you could argue,

would have . . . Having a father who just broke his hip two months ago, that falling and breaking your hip impacts your quality of life, just to be clear about that. And this particular study points out that using fewer antipsychotics reduces the number of falls.

Hon. Mr. Duncan: — Yes. No, no, see . . . And I just want to clarify. So we are certainly focused on this as a system. I know that when I tour long-term care facilities, they do have a number of initiatives in place to try to identify residents that are prone to falling, that have certain risks for falling. We are doing this and working towards this and trying to make improvements in the system so that our residents can have a better quality of life.

The financial savings, if there is a financial savings to the system, in the event that we do reduce falls and we do reduce the reliance and overreliance in some cases on medication, if that has a financial benefit, that's wonderful. But our goal as a system is to hopefully improve the quality of life for our residents, absolutely.

Ms. Chartier: — Thank you for that. Around Santa Maria . . . I'm just about ready to wrap up here. I know that we're at the end of the night. So Santa Maria was part of this study and had some really positive results. And I know in question period a week or so ago, we had this conversation and you acknowledged the good work that's happened at Santa Maria.

What I'm interested in is knowing how . . . And you've often talked about the need when something good is happening somewhere, how you expand it beyond. So I'm wondering what work you've done. And we had the issue around Heartland a couple of years ago, so I'm wondering . . . And you've shown obviously a decrease from 31 to 27 per cent, which is great, but I'm wondering what sort of dedicated work you're doing to ensure that seniors aren't being over-prescribed things like antipsychotics without a diagnosis of psychosis.

Mr. Hendricks: — Sure. So on our provincial wall and in every health region and in every long-term care home we actually have visibility walls, as you know, that track the number of residents who are on an . . . It's one of our . . . Antipsychotic medication without a diagnosis of psychosis is one of our primary indicators. So when we look at where . . . You know, we set targets in terms of what we would like to reduce that to, and so it's a progressive target. When we're not making inroads, we look at the specific reasons why not, and we introduce corrective actions.

Now one of the big things with this particular measure is, you know, in seniors, we have to start doing more active medication reviews on all of them. We've had some really good successes where we've sent in pharmacists to do medication reviews. And in fact it's not just antipsychotics, but it's a number of drugs, you know, this whole polypharmacy thing where seniors are generally on far more than they need to be. So it's been very successful in reducing the numbers.

You know, with those patients that are on antipsychotics for a number of — residents — for a number of reasons, it's looking at alternatives in terms of different ways of managing patients so, you know, gentle persuasion, that sort of thing, with your complex patients so the staff actually know how to manage those situations versus having them be on an antipsychotic. So we've actually rolled that out to the entire system and so we're trying to take those types of programs to provide other alternatives to antipsychotic prescriptions.

And so my hope is that, you know, this measure continues to drop as, you know, it's a huge quality of life issue for seniors in terms of their coherence, but also as, you know, falls, that sort of thing. And so you know, generally I think what you're finding in your report there is quality saves money, right? And so when you're providing quality care in a safe environment, that generally translates into dollars saved.

Ms. Chartier: — Thank you for that. And thank you. I know it's a little past the hour, but thank you very much for your time tonight. I appreciate it and look forward to our next week together.

The Chair: — We will adjourn consideration of the estimates for the Ministry of Health. Thank you, Mr. Ministers, and officials. Any final comments for the evening? None? Okay.

[The committee adjourned at 22:40.]