STANDING COMMITTEE ON HUMAN SERVICES

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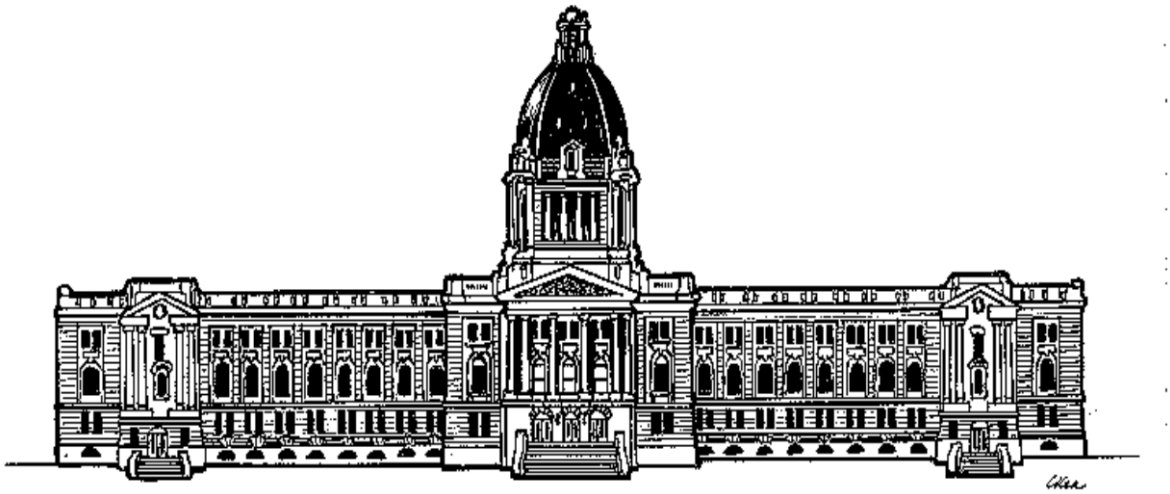

Legislative Assembly of Saskatchewan

Twenty-Eighth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 15:00.]

Bill No. 12 — *The Public Health (Miscellaneous) Amendment Act, 2016*

Clause 1

The Chair: — Welcome to this meeting of the Human Services Committee. It is 3 o'clock, and we will now proceed. We will be reviewing Bill No. 12, *The Public Health (Miscellaneous) Amendment Act*, 2013.

With us today we have MLA [Member of the Legislative Assembly] Nadine Wilson; MLA Terry Dennis, sitting in for MLA Roger Parent; MLA Mark Docherty; MLA Laura Ross, sitting in for MLA David Buckingham; as well as MLA Muhammad Fiaz. On the opposition side, we have MLA Danielle Chartier.

I'd like to welcome Minister Reiter here today, and Minister Ottenbreit. If you would like to introduce your officials and proceed please.

Hon. Mr. Reiter: — Thanks, Mr. Chair. Joining Minister Ottenbreit and I at the front table today is Tim Macaulay who is the director of environmental health services for the Ministry of Health. We have a number of other officials with us here today as well. I'll introduce them as they move to the front table to assist with questions.

And I just briefly have some points I'd like to read into the record, Mr. Chair, very briefly, and then we'll proceed to questions.

To support our government's commitment to transparency and to ensure that reporting requirements for communicable diseases are current and reflect existing health practitioners' scope of practice, the Ministry of Health is bringing forward amendments to *The Public Health Act, 1994*.

The public health amendment Act, 2016 will enable improved access to public health inspection information beyond what is already available for eating establishments. The Act will also better reflect the roles of nurse practitioners and clinic nurses in reporting and following up on cases of a communicable disease.

The bill, *The Public Health (Miscellaneous) Amendment Act, 2016*, was introduced during the spring 2016 sitting and received second reading on November 16th. With that, Mr. Chair, we'd be happy to entertain any questions.

The Chair: — Okay. Thank you very much. Is there any questions from the committee? Ms. Chartier.

Ms. Chartier: — Thank you. Minister Reiter, this is our first opportunity in committee, so it'll be . . . I always really enjoy committee, so I look forward to the next few hours here together. And thank you to your officials for your time here today. That's always appreciated.

So with respect to Bill 12, so obviously one of the things that it does, it clarifies the language of "clinic nurse." So will nurse practitioners always be listed alongside clinic nurse in legislation and policy? Is that the . . .

Mr. Macaulay: — That's correct.

Ms. Chartier: — Okay. Thank you. And how many nurses in the province would fall under the clinic nurse definition?

Mr. Macaulay: — I don't have the exact number, but I know that the clinics that they're operating within are public health clinics that are located in Saskatoon, Regina, Prince Albert, North Battleford, Meadow Lake, and Moose Jaw.

Hon. Mr. Reiter: — We can certainly follow up on and get that number for you.

Ms. Chartier: — Okay. Does that also include . . . Like Planned Parenthood has clinic nurses as well, like other . . . You're including those kinds of organizations as well?

Mr. Macaulay: — Hold on a second.

Hon. Mr. Reiter: — So officials tell me it would include nurses that work in any environment where communicable diseases are tested for, so it could be, you know, a third party or . . . But it would be when they're working in areas where it's being tested.

Ms. Chartier: — And sorry, you don't have a number for that?

Mr. Macaulay: — We can attempt to get that number and get back to you.

Ms. Chartier: — That would be great. Thank you very much. In the explanation for clause no. 3, the notes outline how "This would be inclusive of RNs with additional authorized practice . . ." So I understand from talking to the SRNA [Saskatchewan Registered Nurses' Association] last year that this was about clinic nurses in northern Saskatchewan, but I'm just wondering how this process is rolling out.

Mr. Macaulay: — First of all, like when we went forward with this amendment, we worked very closely with the SRNA to make sure that they were comfortable with the wording that we were proposing. They tell us that their work, in regards to the practices in their bylaws for the various nurses, is continuing and should be coming into effect on December the 1st. So I know that we have some wording in there that is "or." There's no harm with us having that continue to have it in there, but if it comes in on December the 1st, then that "or" section would not be necessary.

Ms. Chartier: — Okay. Thank you for that. Do you know how many nurses are expected to have additional practices?

Mr. Macaulay: — I don't know that. All I know is the number of nurse practitioners.

Ms. Chartier: — So can you tell me the difference . . . So you've got a registered nurse, and then you've got nurses with additional duties or responsibilities, and then nurse practitioners. Do I have that correct in terms of the . . . Or could

you maybe lay that out for me?

Ms. Magnusson: — Donna Magnusson, executive director, population health branch. Within *The Registered Nurses Act* there are various scopes of practice, and nurse practitioners actually complete additional training and have additional examinations and experience that allow them to practise fairly independently. They can order diagnostic tests. They can write prescriptions, and they can make referrals to specialists.

Clinic nurses under this definition are nurses that have been trained and do specific diagnostic tests with respect to communicable diseases. It may be that it is required training within the facility or the health region, but it has to hit some key standards.

Within the practice of nursing, there's all kinds of different specialty groups that have specialized training that may encompass some of these skills as well, so it . . . The SRNA has been looking at which nurses will have those kinds of enhanced practice skills and then what their training requirements are going to be for that group.

I don't know if that gets to the answer, but it is pretty broad.

Ms. Chartier: — Okay, and just in terms of . . . I think, and I'm sort of casting my mind back to a conversation last year with SRNA, that clinic nurses, like there are some in remote areas, not where there's nurse practitioners, but can you explain how a clinic nurse will do some of his or her work in some of these other areas?

Ms. Magnusson: — There are some nurses that work in northern communities that actually take additional training to do the skills that they're being asked to do in those communities. And they would be quite different than, say they would do in a southern community. And that is just in order for us to be able to provide service and allow access to those services for people in the North.

Ms. Chartier: — Okay, can you tell us a little bit about some of the work that those nurses would do?

Ms. Magnusson: — Very often they're doing advanced, what we would call assessments. So they may be doing more detailed kinds of assessments that they're sending off to physicians and conferring with physicians for follow-up care. They may be ordering additional diagnostic tests, and they may actually have a consultation relationship with some of the specialists, whether or not they will refer them to those patients. So it can really vary depending on the community.

But again every registered nurse graduates with what they call a base skill set. When you move into specialized areas of practice, you require additional training in order to do those certain skills.

Ms. Chartier: — Do we know, in some of the northern areas, how many nurses are working with these additional skills?

Ms. Magnusson: — I don't know that number offhand, but there are a number of both NPs [nurse practitioner] and clinic nurses that work in the North. And so it would depend I think on the community, size of the community, but we could maybe find that number for you if you'd like that.

Ms. Chartier: — That would be great, thank you. And is the plan to expand this to . . . Obviously we've talked about northern Saskatchewan. Is the plan, do you see it expanding to rural Saskatchewan as well?

Ms. Magnusson: — Well nurse practitioners, as you know, do work in rural Saskatchewan pretty extensively, and so that skill set is out there. Because we have so many more nurse practitioners in the South, there hasn't been a need to go beyond that just yet. But certainly, in remote communities, in northern communities, that's a different story. There is a need to actually have people trained to provide those services on site, and it's not always a nurse practitioner.

Ms. Chartier: — In terms of the numbers of nurse practitioners in Saskatchewan right now, where are we at?

Ms. Magnusson: — 214.

Ms. Chartier: — And do you, obviously I don't expect you to name every community in which they're working, but do you have sort of a geographic picture of that that you could provide?

Ms. Magnusson: — Yes. We used to actually keep a map of where they are. There's a good split, I would say. I haven't worked in this area for a while. It's mostly in primary health. But there's a good split, almost 50/50 rural and urban, certainly trying to encourage nurse practitioners in those areas where access to services is difficult to obtain. So for example, Maple Creek has a nurse practitioner. Leader has a nurse practitioner. And then you can go into services like the Westside Community Clinic in Saskatoon who work with nurse practitioners. It's pretty broad. There are also nurse practitioners working in northern communities that we wouldn't call far North. But like Big River, Spiritwood, those areas also have nurse practitioners that work in those communities.

Ms. Chartier: — Has it been difficult to attract nurse practitioners into northern Saskatchewan, into the further North? We've talked about clinic nurses and they're filling a gap there but is it difficult to attract . . .

Ms. Magnusson: — I think at times it has been challenging, but for the most part they are able to work with a number of nursing services and bring in nurse practitioners into those communities.

Ms. Chartier: — Okay, thank you for that. So is there a plan, so you said 214 nurse practitioners and then these clinic nurses, is there a plan to further expand into remote and rural communities?

Ms. Magnusson: — I think the number of graduates from the nurse practitioner program has been pretty steady over the last few years. I can remember back when there were hardly any nurse practitioners. You could almost count them on one hand. So as they increase in numbers, the access to service, the ability of other agencies to recruit them to go north certainly does improve with having more nurses practising in the province.

Ms. Chartier: — How many, at any given time, do you know how many nurses are enrolled in nurse practitioner, in upgrading their skills?

Ms. Magnusson: — Yes, there's a couple of different ways that they can do that. And I haven't seen the numbers for a while, so I wouldn't want to give them to you. I can get them for you in terms of, you know, year over year. But it's always been a program that's been pretty much fully subscribed if not over subscribed.

Ms. Chartier: — And you say there's a couple different ways to . . . Can you tell me about that?

Ms. Magnusson: — The SIAST [Saskatchewan Institute of Applied Science and Technology] here offers the program or, as it's called now, Sask Polytechnic. And then there's also a program that runs through Athabasca and a couple of the other colleges that they can also take. So there are different avenues that they can take their education, yes.

[15:15]

Ms. Chartier: — Thank you for that. And sorry, just going back to — you might have to, I may have to change officials here, I'm not sure — just going back to my original question around clarifying the language of "clinic nurse" and then asking where they would all be. And I know you said third parties, so I'm just wondering — and I had mentioned Planned Parenthood — but I'm just wondering who else or what else would be included in the term "third party."

Ms. Magnusson: — That would probably be one of the ones that's the most obvious. Most of the other sexually transmitted infection clinics are actually run by regional health authorities, but Planned Parenthood in both Regina and Saskatoon have a unique service that they offer here. So they would also be a part of that.

There could be clinic nurses that actually go up north as well, that work in northern communities. So there will be some variation in those, and that's why that term is still kept in there. But what the legislation didn't encompass was the change in terms of nurse practitioners because, as I said earlier, their skill set is broader. They can prescribe. They can refer, and they can diagnose. So that's a big difference in terms of their scope of practice.

Ms. Chartier: — Thank you for that. In terms of category II communicable diseases, which ones do we deal with the most here in Saskatchewan?

Ms. Magnusson: — Hepatitis B, C; sexually transmitted infections; chlamydia; syphilis would be some of the most common.

Ms. Chartier: — Do we have recent numbers for these sexually transmitted infections?

Ms. Magnusson: — We do have, and I didn't bring them with me. But yes, we do. We track all of these diseases because they are reportable diseases, on a monthly basis.

Ms. Chartier: — In terms of numbers, do we have stats on who is often the first contact? Is it usually primary clinics or is it hospitals? Do you track that kind of information?

Ms. Magnusson: — We don't track that information, but a primary care provider would often be the first point of contact for people presenting, because they may have symptoms that are fairly vague. So they might contact the primary care provider first.

Ms. Chartier: — Okay. Thank you for that. You said you could get me the numbers for those diseases. If you would table that with the committee, that would be great. Thank you very much.

In terms of clause no. 6, it highlights the responsibilities of physicians and nurses to report contact tracing along with some of the other requirements. So I'm curious about the compliance for this reporting. How many positive tests versus follow-up reporting? Do we keep track of that?

Mr. Macaulay: — I don't believe so. We would have to check into that as well.

The Chair: — Can we get that on the record please?

Hon. Mr. Reiter: — Sorry, Mr. Chair. The official just said that we'd have to check into it and we would get back to the member.

Ms. Chartier: — Okay. So we don't know about, or you'll check into what the compliance is around reporting?

Mr. Macaulay: — Yes.

Ms. Chartier: — Okay. Is there a process for dealing with non-compliance?

Mr. Macaulay: — The process would be that we would be working with the local health region, and then the local health region would follow up with the practitioner to see, to check into the whereabouts of the documents or why they're not reporting.

Ms. Chartier: — The question around the reporting and the follow-up, do we know what some of the challenges are for physicians and other health practitioners when it comes to the follow-up? Like do we know what some of those challenges are?

Mr. Macaulay: — I think the physicians are aware of what their obligations are. I think, you know, certainly we, through lab newsletters and other communications from the health regions or the ministry, we remind physicians of the obligations outlined in the Act and the regulations. I can't really speak to why they wouldn't comply.

Ms. Chartier: — I guess this is a bit of a moot point because we don't have numbers on compliance. Actually I shouldn't say that. You said you don't have them here or you don't have any data or information around compliance.

Mr. Macaulay: — We would get source . . . We would get

reports from the physician, and also we'd get lab results as well, so there's some built-in redundancies there. And so we would, if we found that one particular physician was a chronic non-reporter, then there would be some discussions that would take place between the local medical health officer and that physician, or we would have discussions with the college.

Ms. Chartier: — Okay. Thank you. And I look forward to a little bit more information, if you could get that.

Clause 9 here is a little bit different than some of the other clauses. This piece was around health inspection reports. So just looking to the explanatory note here, and I've made some notes for myself here. Just let me look. Sorry about that. So it acknowledges that in the future, "The Ministry in the future will look to developing or amending regulations to specify the types of inspection reports . . ." to include things like public water supplies or public pools. So when you say "in the future," what are you thinking around that?

Mr. Macaulay: — We would have to have discussions with our minister in regards to the path forward on this. Certainly the step 1 was to amend the Act to enable us to pass regulations that would allow us to do that. We did that previously with restaurant inspections and have received good feedback from the public that they wanted this type of information and they're happy to receive that information.

We have a number of other regulations that would address things like you indicated — the swimming pools, which includes waterslides and hot tubs; public water supplies; campgrounds and recreational camps like Boy Scout and Girl Guide camps; food processors and that would include meat-processing-type facilities and so on. So it would just be a matter of how we wanted to move forward with each of those, recognizing where does this fit in the priority work for other regulations.

Hon. Mr. Reiter: — I would just add to that. I've had no discussions involving that so, you know, it's . . . If we did move forward on something like that with regulations, either amendments or new regulations, it would go through the normal consultation process.

Ms. Chartier: — Okay. Just the piece that's already taken place then around the restaurants and food service facilities, am I correct there's 5,000 that are now posted online? Did I read that correctly?

Mr. Macaulay: — There's approximately 6,000 restaurants. In terms of the amount, there's about . . . I thought I had recent numbers. You may know that up until October of 2015, we had a previous system and that previous system had some . . . For the website we had limitations in regards to the amount of inspection reports that could be put on there. And so there was a maximum of three inspection reports per facility. And now with the new system, there's no limitation with that and so there would be even more than that for the 6,000-and-some facilities.

I do know that since October of 2015 that we've had 48,000 people visiting the site. For the most part we're getting good reviews of the site, and I think the public appreciates the availability of it and it helps them make an informed decision as to where they want to eat.

Ms. Chartier: — For sure. So you said that there's 6,000-plus restaurants. Just a clarification: so 6,000-plus restaurants or food-type facilities in Saskatchewan or 6,000-plus that are listed with inspection reports on the website?

Mr. Macaulay: — There would be approximately 6,000 with inspection reports on the website.

Ms. Chartier: — Okay, thank you. And so 6,000 discrete, in different facilities.

Mr. Macaulay: — Correct.

Ms. Chartier: — Okay. In terms of how health inspections work, sometimes complaint driven and sometimes . . . And otherwise how . . . Can you just sort of walk me through that process?

Mr. Macaulay: — In terms of any particular facility?

Ms. Chartier: — Say food facilities first of all.

Mr. Macaulay: — A restaurant?

Ms. Chartier: — Yes.

Mr. Macaulay: — So a restaurant, there's an expectation that there would be annual inspections done of those facilities. The regional health authorities will make a determination as to how frequently they want to inspect, based on history of compliance and the type of food that is being served at the facility and the type of clientele that are . . . If they're feeding vulnerable individuals, like in an institution-type setting, then there is probably more inspections that'll be performed than a popcorn-type stand or a hot-dog-type operation. So there's routine inspections and there's complaint inspections, or there's . . . If during a routine inspection there's some deficiencies that are noted, then there would be a reinspection that would be assigned to it.

Ms. Chartier: — Okay. And so you said sort of bare minimum, depending on the facility, one annual inspection.

Mr. Macaulay: — Yes.

Ms. Chartier: — And if there's infractions, they're followed up by a reinspection?

Mr. Macaulay: — Yes. I should just clarify that. We do allow up to 15 months for an annual inspection, but that's based on the type of food that is being served.

Ms. Chartier: — Okay. In terms of numbers of health inspectors across regions, do you know how many health inspectors you have?

Mr. Macaulay: — Well I know in terms of field staff, there's approximately 85.

Ms. Chartier: — Across the province?

Mr. Macaulay: — Yes.

Ms. Chartier: — Eighty-five. So when you say field staff, you're talking about health inspectors.

Mr. Macaulay: — Yes, so the people that actually go out and do the work. Yes. There's other types of public health inspectors that are office administration-type staff.

Ms. Chartier: — Okay, thank you. And the one thing that I've heard from health inspectors is that there aren't enough of them. It can be incredibly challenging to get to the workload at hand and the complaint-driven process as well. Has that 85 been fairly consistent? Do you have a baseline or over the last few years has there been 85?

Mr. Macaulay: — Yes. I can't tell you . . . Certainly I would say that that's been consistent for the last few years. Certainly there was some increases post the North Battleford water event. We did receive monies for additional staff to address public water supplies at that time. But regional health authorities also have the ability to increase staff based on what their budget allows them to do.

Ms. Chartier: — So is there, in the global funding that health regions receive, is there designated money for health inspectors or is it up to health regions to determine entirely what they're going to do for . . .

Mr. Macaulay: — There's a base budget for public health which includes all types of public-health-type programs, so your public health nursing and public health inspection and medical health officers and so on.

Ms. Chartier: — So they make a decision out of the base budget for public health on which services, whether it's clinic nurses or health inspectors. So they're making a decision around those pieces?

Mr. Macaulay: — Yes. But they also realize the regional health authorities have been appointed as the local authorities for the purposes of the ministry and the Act and regulations so they have an obligation to administer and enforce the Act and regulations. And we also have some accountability documents that we apply to the regional health authorities in terms of expectations for public health inspection.

Ms. Chartier: — Tell me a little bit about the accountability piece.

Mr. Macaulay: — It would be based on what we see as minimum inspection frequencies for certain types of facilities. So again it would be back to, for example, the restaurant inspections, it will be one per every 15 months maximum. Or we have other types of facilities that we have listed that we want them to be looking at on an annual basis. We have a provincial work guide that outlines what the priorities are for inspections and third party inspections and other types of program-type related inspections.

Ms. Chartier: — Can you tell me a little bit more about that? So you mentioned the once every 15 months depending on the facility. Can you tell me a little bit more, what else would be some of those accountability pieces?

[15:30]

Mr. Macaulay: — So public water supplies, we would expect an inspection once a year. And so for the Health-regulated public water supplies — these are the ones that are not municipal-type systems because certainly the Water Security Agency has a lead role in regards to these larger systems — but tourist accommodations, campgrounds, resort areas that are on their independent water systems, those are regulated by Health.

There's ice arenas. We have inspectors going there checking for the indoor air quality of the ice arenas. Currently we have inspectors going into swimming pools, those that are found at municipal facilities or at hotels and motels. Campgrounds, campground inspections and recreational camp inspections. I think there's food processing as another category that we want them in there at least once a year.

Ms. Chartier: — So you've talked about the provincial work guide and you said that it outlines the priorities for those inspectors. So does it outline, in terms of the region, so when the regions are setting their . . . So they have this budget for public health. Does it outline . . . Is it prescriptive in what its expectations are? This is what you will, the expectation is you will deliver on?

Mr. Macaulay: — Yes, so there's some expectation. There's a provincial data management system. Every time an inspection is performed, the inspector enters that information into this data management system so the ministry can run reports, and so can the regional health authority, as to what their statistics are at in terms of a minimum number of inspections of the facilities that they're expected to visit.

Ms. Chartier: — Have you had any feedback when running those reports, looking at areas that it might be challenging or where regions are not meeting those expectations?

Mr. Macaulay: — I think, you know, in general the compliance rate is very good, in the high 90s. So certainly the regions should be commended for the work that they're doing in making use of their resources.

Ms. Chartier: — Have you had any feedback? I know I have. But have you had any feedback from health inspectors who have pointed to a challenge in getting their work done?

Mr. Macaulay: — One of the responsibilities of the ministry is to make sure that the regulations that are in place are needed and useful. And certainly through the government's red tape committee process, we undergo reviews of the regulations on a regular basis with the idea that if it's redundant or if it's no longer useful, then we should be looking to remove that requirement. And so that's a task that the ministry always is undertaking.

We've made some changes in the last year or so. We did remove licensing requirements for public accommodations where we saw that . . . So this was for hotels and motels. We thought that there was very little public health value in that, and yet it used a lot of resource time for public health inspectors, so

we've removed that requirement. And we're intending to look at other areas to make sure that we're getting the best value out of the resources that we have.

Ms. Chartier: — Just out of curiosity, is that something that other jurisdictions do around removing that requirement for public accommodations?

Mr. Macaulay: — Actually we were one of only a few health authorities in the country that had that requirement, and so that was another reason why we were removing that requirement.

The Chair: — I will interrupt. We have a number of guests that have come in to visit us from the Saskatchewan Teachers' Institute on Parliamentary Democracy, and I know that they're a very large group this year, and that's a very good thing to see. I would like to welcome the steering committee as well as the teachers. I know without the work of the steering committee that this would be a very difficult program to put ahead.

What we are doing here is this is the Standing Committee on Human Services. We're reviewing Bill No. 12, *The Public Health (Miscellaneous) Amendment Act* as presented by Minister Jim Reiter and Minister Greg Ottenbreit. And currently MLA Danielle Chartier is asking questions in relationship to the bill. So the various committee members are seated on either side of the table here.

So welcome, and you're more than welcome to observe. No applause. So thank you very much. So, Ms. Chartier, you may go ahead.

Ms. Chartier: — Thank you. So just around the public accommodation and my question about whether or not health inspectors are feeling a little pushed, so you say you review on a regular basis what health inspectors are doing, seeing if it's the right work. But is it fair to say that you have heard from health inspectors who are saying that they have felt challenged in completing their work?

Mr. Macaulay: — Well certainly not in a formal way. You know, if I had to think back, I would think that we're always mindful whenever we were talking to them in regards to new program ideas. We want to get a sense as to what this would mean for them — can you pull this off? Where would we have to readjust resources to be able to satisfy this need?

We've done a lot of good work in this last little while. We've increased our capacity for being able to do compliance with *The Tobacco Control Act* with youth test shopping. And there was new regulations that were introduced just in the last while in terms of tanning. And again, the inspectors stepped up to be responsible for that, and we have a test, a compliance program that is in place for checking for tanning.

So I think the inspectors are . . . That program area is a program where they take their profession and their job very seriously and will do whatever they need to do to get the work done. And certainly we are cognizant and aware of pressures that they may face out there, and so we don't just automatically implement something without good dialogue with the regions.

Ms. Chartier: — So you said nothing formal, but in those dialogues it has come up, and you said you're cognizant of the pressures that they're under. So I didn't realize that's for the tanning and the tobacco regulation changes. So these 85 health inspectors . . . and you said it's been about 85 since North Battleford, the water crisis in North Battleford. Is that correct?

Mr. Macaulay: — Yes, so that's 2002.

Ms. Chartier: — 2002, so since 2002. And do you know what it was? You said it's remained . . . Obviously you don't have an exact number for every year, but it's remained pretty consistent since 2000.

Mr. Macaulay: — I think it's . . . Yes, it's fairly consistent. Yes.

Ms. Chartier: — Do you know what it was prior to 2002?

Mr. Macaulay: — I'd have to confirm that number.

Ms. Chartier: — Okay. If you could, that would be great actually.

Hon. Mr. Reiter: — If I could . . .

Ms. Chartier: — Yes.

Hon. Mr. Reiter: — Certainly I understand the road you're going down is to check whether or not there's what you feel are appropriate resources and appropriate number of health inspectors, and that's fair. That's reasonable of the opposition to do that.

I would just say that what we'll do with ministry . . . you know, Tim has said that he thinks it's held constant. We'll endeavor to get you the numbers so you can do an actual comparison if you want — I was going to suggest prior to us forming government but, if you like, prior to 2002 and through. We can follow up in writing with you on that.

Ms. Chartier: — Well that would be great. And just along that line though, so with tanning and tobacco. So the tanning bed inspections around . . . Can you tell me what has changed there? Was that the under-18 ban that you're referring to?

Mr. Macaulay: — That's correct.

Ms. Chartier: — Okay. And which tobacco? You said sales to youth.

Mr. Macaulay: — Yes.

Ms. Chartier: — Okay. So these things have been added to inspectors' plates. And then you told me about something that's been taken off, which was the hotel accommodations.

Mr. Macaulay: — Right.

Ms. Chartier: — Is there anything else that's been taken off their plate in recent years?

The Chair: — Before we move ahead, Mr. Minister, anything that you're submitting, can you table it with the committee for

general distribution?

Hon. Mr. Reiter: — Yes. Yes, definitely. Thanks, Mr. Chair.

Mr. Macaulay: — Another efficiency that the ministry has implemented over the last while is a new data management system. And so what we saw pre the new system was inspectors that were using a clipboard and paper to complete their inspection reports. And then once the inspection was completed, then the copy of the report was left with the operator, and then the remaining copies were taken back to the office where a data entry person had to enter that information into the data management system.

So with the new system, we were able to purchase tablets for all of the inspectors, and so now we have an electronic system which has improved efficiencies tremendously where you, you know, have the inspector completing the inspection right on the tablet. And at the end of the inspection, it's reviewed with the operator. The system allows for signatures to be applied to it, and then the report is emailed to the operator. So it removes that data entry requirement back in the office. It improves on timing.

And then, in terms of disclosure to the public in the case of restaurants, it's almost same day or the next day at the most that it's posted up on to the website, whereas before, it would have to wait until it was entered into the system before it could be loaded on to the provincial disclosure site.

Ms. Chartier: — And when did that come online?

Mr. Macaulay: — That started in March of 2015.

Ms. Chartier: — Okay. And is it fully implemented now?

Mr. Macaulay: — It is.

Ms. Chartier: — Okay, thank you. Well just in terms of trying to get some numbers here, so we talked about 6,000. You told me there were about 6,000 food services establishments, discrete food services establishments who are . . . their inspections are posted. So I'm assuming that's about 6,000-plus that are in existence in the province then. Is that fair to say?

Mr. Macaulay: — Yes. Yes.

Ms. Chartier: — So that's one approximately every year. And some of these as you said, because of the foods and the things that they do, require more frequent inspection, whether the food they're serving or the clientele they're serving.

Mr. Macaulay: — Or the type of operator. Yes.

Ms. Chartier: — Or the type of operator. So we're looking at 6,000 visits, just bare minimum here if you're thinking one visit per facility. And that varies. That's just for food establishments. Can you tell me a little bit about numbers around other . . . like the rinks, the water, those kinds of things, if you could?

Mr. Macaulay: — I have those numbers for you.

Ms. Chartier: — That would be great. Thank you.

Mr. Macaulay: — Yes, okay. So we have approximately 500 swimming pools, waterslides, and hot tubs. We have approximately 1,100 public water supplies. We have approximately 300 arenas, approximately 540 campgrounds and rec camps, and around 600 food processors which includes meat processors and bake shops.

Ms. Chartier: — Okay. Those are separate, the food processors are separate from the 6,000.

Mr. Macaulay: — Correct.

Ms. Chartier: — Okay. And how about the tanning and the tobacco? How does that tie into this?

Mr. Macaulay: — Those are not included. I can give you approximate . . . like, I'd be going by memory. I didn't bring the numbers. Or would you prefer that I just include that in the . . .

Ms. Chartier: — If you've got a ballpark, but then if you could table the actuals.

Mr. Macaulay: — I think for tobacco, I think it's around 1,500. And just one second . . .

Hon. Mr. Reiter: — While officials are getting those numbers, what we'll do is we'll have staff go through *Hansard* as soon as it's available, check where . . . all the numbers that you had requested, and we'll follow up in writing on that.

Ms. Chartier: — That would be great. Thank you.

[15:45]

The Chair: — While the officials are discussing, I would like to thank the teachers, because we may be in the middle of a conversation when you decide to leave. I just wanted to let you know you're welcome to come back, because we may be sitting here until 10:30 tonight. So you're welcome to come back.

Mr. Macaulay: — So in terms of tanning facilities, we feel that it's in the neighbourhood of 200. And in terms of . . . And I think that number is relatively accurate for tobacco retail outlets. So you have to keep in mind for the tobacco retail outlets, that the visits to those facilities are through our test compliance check program which is . . . We're not using public health inspectors for that on the initial check, but instead we're using youth and public health officials in general for that. And then we're, if there's enforcement that is needed, then we would be bringing in the public health inspectors as tobacco enforcement officers for the purposes of that.

Ms. Chartier: — Okay. So just taking out that . . . If we took out the 1,500, sorry, for the tobacco, so that's about 9,240. Let me just double-check that — 10,740. About 9,240 places to visit at least once and then . . . So you've got 85 inspectors across the province.

Mr. Macaulay: — So what you would have to also take into account is that there would have to be an analysis of how many of those are unique inspections. So for example, if you had a tourist accommodation facility, there could be a number of

different operations at that facility. You could have a restaurant at that facility. They could be on their own water system. They could have a swimming pool. They could have a campground and so on. So those would be all just one visit. You wouldn't be going back each time just to do one of those. Like the inspector would try to cover off all of those facilities or operations when they made that one visit.

Ms. Chartier: — Do you have an average caseload for your health inspectors across the province?

Mr. Macaulay: — Not at a ministry level. I would have to check with the regions on that.

Ms. Chartier: — So that the regions may, the regions may . . . Do you know if the regions do or . . .

Mr. Macaulay: — I do not know if they do, but I can check.

Ms. Chartier: — Okay. That would be very helpful. In terms of moving this online . . . So I know people are very happy with the registry around and being able to read about their favourite restaurants online. Do you anticipate any additional work for your health inspectors? Or it's simply, they've got their tablets and it will just be uploaded, so if you choose to do this for swimming pools or any other facility.

Mr. Macaulay: — I don't see there being additional work. In fact, if anything, there is a benefit to putting this information online in terms of achieving compliance because operators don't like having bad reports on a public site, and so they'll do whatever they need to do to ensure that that's not on the website. Or if it is on the site, they'll be quick to take corrective action to make sure that it's off the site as quickly as possible.

Ms. Chartier: — So this number of 9,240, which was minus the 1,500 tobacco that you said you don't always use your inspectors for, again that's the first or one inspection but people . . . What happens with compliance? So if someone in a restaurant has an issue and the health inspector comes and writes out a report, what kind of time frame do they have for compliance?

Mr. Macaulay — It would really depend on what the issue was, their deficiency was. And so it would depend on . . . Based on the inspector's professional judgment, they will determine whether or not they need to be back in a month or in six months or work out a compliance program with the operator.

Ms. Chartier: — Okay. Well I'm glad you'll provide the final number, but that gives us a good estimate. Well thank you. I think that I am finished with my questions. I don't know if any other committee members have any other questions.

The Chair: — Are there any other questions from committee members? If not, we will proceed to vote clause 1. You realize that in voting clause 1, then questions are specific to that particular clause thereafter. Okay, clause 1, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 1 agreed to.]

[Clauses 2 to 12 inclusive agreed to.]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Public Health (Miscellaneous) Amendment Act*.

Okay, I would now ask a member to move that we report Bill 12, *The Public Health (Miscellaneous) Amendment Act* without amendment. Will someone move that? Mr. Fiaz. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Okay, I would ask the minister or ministers, do you have any closing remarks you wish to make?

Hon. Mr. Reiter: — I would just like to thank all the committee members, the officials that were here, and also like to thank the opposition for the questions. Ms. Chartier, thank you.

Bill No. 13 — *The Cancer Agency Amendment Act, 2016*

Clause 1

The Chair: — We will now begin consideration of Bill No. 13, *The Cancer Agency Amendment Act, 2016*. We will begin with clause 1, the short title. Mr. Minister, please introduce any officials, and you may make your opening comments.

Hon. Mr. Reiter: — Thanks, Mr. Chair. I have with me Deb Jordan, who is the executive director of acute and emergency care services. And again we have other officials as well, but if they join in the discussion, we will have them introduce themselves at that time. I just have some notes I'd like to read in on the record, and then we'll entertain questions.

I want to provide some context for the proposed amendments and outline their nature and the intended impact. Providing high-quality cancer control services to Saskatchewan people is a priority for our government and for the Saskatchewan Cancer Agency. We can be proud of the range of work being done in Saskatchewan to protect people from cancer, treat those who are diagnosed, and provide recovery support or palliative care.

Our government has strengthened cancer control services with annual funding of over $160 million to the Saskatchewan Cancer Agency. The funding provided is more than double the amount funded in 2007-08. This has enabled the Cancer Agency to introduce many improvements, including expanded coverage for a range of drugs, a provincial screening program for colorectal cancer, and digital imaging equipment for mammograms. Funding for health regions has also increased, resulting in better access to chemotherapy, improved diagnostic services, and strengthened support for prevention and healthy lifestyles, to name just a few enhancements.

Despite these efforts, the number of new cancer cases diagnosed in Saskatchewan is projected to increase 54 per cent by 2036. In order to counteract this expected increase, the Saskatchewan Cancer Agency developed a strategic plan for influencing care across the province while establishing Saskatchewan and the

organization as leaders in cancer research, treatment, education, population health promotion, and disease prevention. The long-term goal is to create a province where people understand how to minimize their risk of getting cancer and play an active role in their personal health and well-being. The desired future is one where the cancer services that are needed can be accessed equitably, safely, and in ways that best support those who are dealing with cancer as a chronic illness. Our government supports the Cancer Agency's vision for the future.

I am pleased that these amendments update the language being used in legislation related to the agency's work, and it resolves some instances where its legislative authority lags behind its needs for effectively administering services and handling information. The proposed amendments in this legislation will fill some gaps in *The Cancer Agency Act* so we can better equip the organization to perform its role in strengthening cancer control in our province. *The Cancer Agency Amendment Act, 2016* will provide statutory authority for the agency to request and collect information from other organizations, to report to various registries, and to enter into agreements. The proposed amendments also provide consistent definitions of cancer services and reflect the current government's structure and naming conventions. In cases where the administrative authority of the Cancer Agency is not already consistent with that of its sister organizations, the regional health authorities, this Act will allow for better alignment with provisions of *The Regional Health Services Act*.

The proposed amendments will ensure the Saskatchewan Cancer Agency has the statutory authority it needs to request, collect, and disclose information in order to effectively meet its responsibility for providing cancer control services. Another amendment will enable the Ministry of Health to inform the agency when, in the course of administering health services, the ministry becomes aware of a reportable case of cancer. One example would be when the ministry is billed for services provided out of province. This will help the agency maintain an accurate picture of an individual's care status and a more accurate picture of cancer services provided to Saskatchewan citizens.

The amendments also clarify the agency's authority to disclose information to the North American and international cancer registries which act as central registries for cancer research, surveillance, statistical reporting, analysis of outcomes, and assessment of cancer risks. All central registries in Canada and the United States are members of these multinational registries which enable the use by authorized organizations of de-identified patient information in order to better understand, prevent, and treat cancer.

These amendments align with ongoing work by government and the health system to create a citizen- and patient-centred system that values continuous improvement and innovation. Also, Mr. Chair, an amendment will be moved when we get to the clause-by-clause issue, addressing a drafting error in clause 5(3)(a) of the Act. Members of the opposition are aware of that. With that, Mr. Chair, we'd be happy to take any questions.

The Chair: — Are there any questions from the committee? Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair, and thank you, Mr. Minister. With respect to clause no. 6, it adds the term "palliation services" to the bill. Obviously I suspect this is a high number, but do you have a percentage of the number of palliative care patients who have cancer? Do we keep track of that?

Ms. Jordan: — The number of patients who receive palliative care services in the province, about 85 to 90 per cent of the patients receiving palliative care would be cancer patients. And as the opposition member would know, that palliative care services are a coordinated effort among both health regions. The Cancer Agency, while it may not be providing palliative care services directly, it certainly has information that is helpful and supportive to patients and their families actually, in support of the regions providing palliative care.

Ms. Chartier: — I was wondering about that. Just in the explanatory notes:

> It is proposed [that] "palliation services" be added to the Act to encompass the SCA's role and work in ensuring/providing palliative care services for cancer patients.

So this isn't specific to services that the Saskatchewan Cancer Agency is providing?

Ms. Jordan: — Not specifically. I mean for a cancer patient, they may be receiving home care services, you know, either personal care, home nursing. There are some forms of chemotherapy that are palliative in nature. So under the umbrella of providing chemotherapy or radiation therapy, sometimes it is palliative in nature as opposed to . . . or to support a better quality of life for the patient. So it's palliative in nature and not curative in nature.

[16:00]

Ms. Chartier: — Okay. So I guess that sort of answered that question around if there's efforts to support cancer-specific palliative care. Is the province or the ministry embarking upon anything particular around . . . you said 85 to 90 per cent of palliative patients would have a cancer, yes, so are there any specific efforts around cancer-specific palliative care?

Ms. Jordan: — That work is always ongoing between the Cancer Agency and regional health authorities. The Cancer Agency has very active patient and family advisory committees, and certainly through those committees, if there are issues or challenges that are identified by patients and families, you know, those are acted on in real time in terms of making improvements where possible.

Ms. Chartier: — Forgive my ignorance here. So you've mentioned chemo and radiation as being sometimes palliative service or support. Is there any other palliative care that would be cancer specific?

Ms. Jordan: — Throughout a cancer patient's journey, they will always have access to psychosocial supports through the Cancer Agency. So in addition to an active palliative treatment such as chemotherapy or radiation, where appropriate, there

may also be counselling in other supports that a palliative patient may be receiving through the SCA [Saskatchewan Cancer Agency] as well.

Ms. Chartier: — Thank you. Just for anybody who might be interested or listening at home — I know the audiences are huge — can you walk me through some of what we have available for palliative services here in Saskatchewan? I know it varies by region, but can you give me a broad-brush-strokes picture of palliative services in Saskatchewan?

Ms. Jordan: — So it may, depending on patient need, there would be an assessment provided through the health region. It could involve registered nurses coming into a patient's home to provide medication and support. It may be help with personal care. We talked a moment or two ago about counselling service or psychosocial support that the patient and/or their family might require through the drug plan and extended health benefits branch at the Ministry of Health. There are certain types of coverage that are available for individuals for either drug and/or some supplies that they may require.

Ms. Chartier: — Do we have a number in terms of how many health care specialists . . . Obviously palliative care is a unique speciality. And I know in many rural communities there's sort of flex beds for palliative care. And there are wonderful caregivers throughout our province, but I know not everybody has some of the training around palliative care. Do we have a number in Saskatchewan who are, across different professions, around palliative-care-trained folks?

Ms. Jordan: — Are you referring to specialists?

Ms. Chartier: — Well different . . . So physicians, how many physicians do we have in Saskatchewan? How many RNs [registered nurse]? I'm just looking for numbers around those trained specifically in palliative care.

Ms. Jordan: — We can certainly follow up and provide you with some information about palliative care specialist physicians. I would say though that across the health system — whether you're working in home care, hospital, health centres, long-term care — as health care providers we often provide support to individuals with palliative care needs. So while there may not be a special designation — for example, in nursing, in pharmacy, etc. — certainly the training that is provided on site, in services, just because of the nature of the work that we in the health care system do . . .

Ms. Chartier: — Just talking to the provincial palliative care association, there is a training seminar . . . I'm sorry, maybe a seminar isn't the right word for it. But are you familiar with that?

Ms. Jordan: — Not specifically, no. But the provincial body does have seminars, workshops, sometimes training material online to help provide caregivers. You'd noted, sometimes travelling to workshop seminars are difficult, so more frequently now as a health system we're trying to provide web-based training and information for providers in the system.

Ms. Chartier: — Are you finding that there's a request from health care workers? So again, health care workers do a wonderful job, but palliative care is a pretty unique speciality. Are you finding that health care, whether it's nurses or RNs or LPNs [licensed practical nurse] or others on the care team, are asking for training?

Ms. Jordan: — I would think it's fair to say, as a health system, end-of-life care has become much more prominent in our thinking over the past few years for a variety of reasons including, you know, with an aging demographic in the province, being also more sensitive to end-of-life care at different stages of life.

You know, I happened to be at a meeting last week, for example, of a pediatric advisory committee. Thankfully while low in numbers, there are times where there's a need for pediatric palliative care, and so some good work that is under way in our major health regions on how we support, you know, that type of care. So I think the thinking and the profile of end-of-life care in the health system certainly has increased over the past few years.

Ms. Chartier: — And as such, are people asking for further education and support?

Ms. Jordan: — Yes, that's part of it.

Ms. Chartier: — Okay. How many . . . I know that there are flex beds in some parts of the province here, but do you have a hard number on how many palliative care beds we have here in Saskatchewan?

Ms. Jordan: — I would have to . . . You're talking about defined palliative care beds or end-of-life, such as the unit at the Pasqua or at St. Paul's in Saskatoon? Those would be particularly structured. But again, as we were talking about earlier, palliative care or end-of-life care can come at any time in any hospital bed. It sometimes occurs in long-term care.

So certainly we'll provide the numbers on the palliative, designated palliative care beds, but I think we need to recognize that end-of-life care occurs in many parts of the health system, not necessarily only in designated locations or beds.

Ms. Chartier: — Yes. The number for palliative care physicians, I know it's low. And I don't have the number; it's less than five here in Saskatchewan, maybe less than three. And I can't recall from a previous conversation with . . . But I'm wondering how often palliative care physicians are involved in care for cancer patients.

Ms. Jordan: — Frequently would be, depending on the need of the patient. The referral for end-of-life care would occur within health regions, and there would be a determination that would be made as to what assessment is required and what kind of expertise is needed to help guide what that end-of-life care plan should look like for the patient.

Ms. Chartier: — I know you were going to endeavour to get it, but do you have a ballpark figure for the number of physicians? I know it's very low, palliative care physicians.

Ms. Jordan: — I don't want to ballpark it, so we will provide you with a response back as to the number. In the main, we

were here to discuss the amendments to *The Cancer Agency Act*, so I didn't bring a lot of detailed information about end-of-life care in the province.

Ms. Chartier: — Okay. And the reason we're talking about it is because palliation services is being added to the bill. In terms of . . . Are there wait times to see palliative specialists? Obviously that's not a time when waiting . . . It's never good to wait for any health services, but does the demand outstrip the supply at this point in time?

Ms. Jordan: — Again, end-of-life care can occur in a variety of places. Initial consults often happen in hospital in general medical beds while the patient might be under the care of another medical specialist or a family physician. Sometimes there will be, if there's a determination made that a transfer to one of the designated units is requested, there are some times, might be a few days, before that transfer is effected. With respect to accessing the services of a palliative care specialist, that's something we'll include when we provide you with the numbers of dedicated specialists in the province.

Ms. Chartier: — Okay.

Hon. Mr. Ottenbreit: — If I could, Ms. Chartier, to just . . . You're talking about specialist physicians for palliative care, but I know even my own experience with four different family members going through palliative care, never once did we access a palliative specialist. It was all just coordinated by the family physician who are very capable locally in the regions. Palliative coordinators, all the way through the CCAs [continuing care assistant], even pharmacists are very capable on the local level of providing very top-quality palliative care as well.

So I know you're focusing on maybe a specialist, but we can't deny the amount of capacity out, even in rural and remote areas, when it comes to palliative care, end-of-life care when we look at the other scopes of practice.

Ms. Chartier: — For sure, and I think you thought I was headed in a different direction because what I was, in terms of palliative care was going to ask about the GP [general practitioner], and I appreciate your comments there. But so the palliative care specialists that we do have, do they have an opportunity, are they . . . my question was around, do they have an opportunity to connect with GPs? Do we have a system in place to tie those limited specialists in with the doctor who is handling the particular case?

Ms. Jordan: — And the purpose of the specialist, if the care is under the direction of the family physician or another specialist, would be if there was a consultation that the most responsible physician felt was necessary with the palliative care specialist on some aspect of the care, then that consult might occur.

Ms. Chartier: — And I appreciate that, and I appreciate your comment about the pharmacist, Mr. Minister, to just . . . I'm thinking about a program in Ontario that I heard about where there is basically a 1-800 line because I understand that there's a program in Ontario where there's a 1-800 number because many GPs are not always comfortable with narcotics and some of the things necessary around palliative care. And so it's a number that's accessible. And I think there's, I could be mistaken here, but I believe there's only two doctors associated with that line and they support all of Ontario. I could be wrong about that number, but it seemed like a really reasonable approach to better supporting physicians here in providing palliative care.

Ms. Jordan: — Well not a designated line, through the acute care access line in Saskatoon and a bed line in Regina Qu'Appelle Health Region, those are key contacts for referring physicians if they need a consult with a specialist, you know, across the spectrum, not just palliative care, but across the spectrum. Then bed line and acute care access line help to connect those local physicians with a specialist for a consult or a discussion about patient needs.

Ms. Chartier: — I understand, Mr. Minister, you talked a little bit about your experience, but is it generally, is there some discomfort in the ministry's experience or feedback, is there a difficulty for GPs sometimes doing palliative care? The discomfort around narcotics and not always . . . Obviously, someone who is palliative is . . . I understand that there's, in other jurisdictions, discomfort around prescribing narcotics. And I'm wondering if that's a challenge here.

Ms. Jordan: — I don't know that I would characterize it as discomfort. But as a family physician or a general practitioner, you're covering a vast range of different diagnoses among your patients. And sometimes the reason that you seek a consult with a specialist is for that deeper dive and more refined information about a particular diagnosis and advice that the specialist may have to offer during the consult about management of the patient, whether it's, you know, prescribing of medication, or it might be other types of therapies that may be available that the specialist may feel might be a benefit.

Ms. Chartier: — Do we have any data or surveys, or has the ministry embarked upon any work around asking citizens in Saskatchewan where they would like to have their end-of-life care or what supports that they need? Is there any information that the ministry has done around that?

Ms. Jordan: — I'm not aware of a specific survey through the patient and family advisory committees because they're present not only at the Saskatchewan Cancer Agency, but in health regions and on some of the various endeavours that the ministry and the health system are involved in.

The room for improvement in end-of-life care has been identified, and so that's the impetus for, you know, some of the work that is ongoing to make it seamless. And the change to the Cancer Agency, and through *The Cancer Agency Amendment Act*, is to try and ensure that that flow of information that is needed for those involved in the circle of care of the patient is available and supports the partners in the health system working together to the best end of meeting that patient's need.

[16:15]

Ms. Chartier: — Thank you.

Hon. Mr. Ottenbreit: — If I could add too, Mr. Chair, on this point. If I could add on this point as well, I think that we're

finding, somewhat anecdotally, that more and more people are choosing to have end-of-life care in their own homes. Sometimes, as Deb talked about, long-term care sometimes in the hospital. Some families feel more comfortable I think with the more aged maybe in a hospital or a medical setting.

But I think a good example I could point to is the group and the family that we introduced in the Legislative Assembly, I think two weeks ago, from Wynyard that had a . . . You know, in the Saskatoon Health Region and with a little bit of professional organization, but by using all the partners in the health care system all the way through care assistants, all the way through EMTs [emergency medical technician], and nursing help, to have somebody have really quality end-of-life care right in their home, and again not really directly involved with a physician specialist. But using all the partners that were accessible in the area to the best of their abilities to deliver top-notch care without having had the complication of maybe having the need of a specialist or somebody higher, would be perceived to be higher up the medical chain, but having those top-quality coordinated efforts right in the local area, like I say, even in Wynyard, showing that we can have really high-quality palliative care even in rural settings.

Ms. Chartier: — For sure. I guess my . . .

The Chair: — Excuse me. We have new guests have joined us, and I would like to introduce them. We have Representative Joan Ballweg from Wisconsin here with us. We have Mr. Mike McCabe from the Midwestern Legislative Conference and Ilene Grossman from the MLC [Midwestern Legislative Conference] as well.

What we're doing here today is we're holding committee hearings on Bill No. 13, *The Cancer Agency Amendment Act*. Two of the ministers, Mr. Reiter and Mr. Ottenbreit, are here to respond and their staff are here to assist them. The committee members may and will ask them questions, and currently Ms. Chartier has the floor and is asking them questions. So welcome to the committee. And the last group that was in, I informed them that we could be sitting here till 10:30, so you're welcome to stay or come back and join us later. Thank you.

You're on.

Ms. Chartier: — I know. I'm there, thank you, patiently waiting.

Thank you again, Mr. Minister, for those comments. But I guess my question would be, how often . . . I'd never question the desire of the care team to be able to bring that care to people, but how often is that happening? Obviously the demand for palliative care continues to grow in this province, and so can we quantify that at all? That was one really wonderful story that you brought to the House a couple of weeks ago. But in terms of quantifying that, how many people get to have that experience?

Hon. Mr. Ottenbreit: — I'll let maybe Deb add to it. But of course the reason why we highlighted it is because it's the exception not the rule. But that's one thing I think we have to look in health care no matter what service delivery it is. We have to look at innovative ways to deliver health care to people in this province, and that's why I think we celebrated that case because it was so innovative. You know, some of the personal experiences I relayed before, fairly innovative for the day 15 years ago, that are starting to become more normal practice. And that's why it's encouraging to see stories like that, to see best practices, you know, what we can utilize, how we can utilize our resources in all areas to the best of their ability, regardless of scope of practice. But allow them to exercise their abilities in that scope of practice to focus on the needs of the patient.

Ms. Chartier: — Anything else you want to add?

Ms. Jordan: — Nothing at this point.

Ms. Chartier: — I've had two loved ones at the palliative care unit at St. Paul's Hospital, and it was a wonderful experience in terms of end-of-life care. The staff there are second to none. But what I've also heard from staff there is that there are times when someone hasn't reached their palliative, but they haven't reached the end of their life and they're rallying. And often I understand that's actually what happens with cancer. That the end can seem imminent and people rally, and there are occasions when people get sent home from palliative care.

And so I'm wondering about, and I know speaking with one nurse, she said she feels awful telling a family who's received top-notch care at St. Paul's in Saskatoon, and she feels a little bit like . . . She's not diminishing home care palliative care at all, but the resources are stretched pretty thin. But she says she feels like she has to cross her fingers behind her back when she's trying to reassure families that they will get the same level of care at home that they did at St. Paul's Hospital.

So I'm wondering if you've heard of occasions like that, or how often is that happening?

Ms. Jordan: — I can't say that I've heard specifically about a concern if someone has rallied and is capable of being cared for at home. The end-of-life journey is not a sequential one. For many patients it may involve time at home, being supported at home. There may be intermittent times where acute care, as opposed to end-of-life care, is required and somebody may be admitted to a general medical ward and then perhaps transferred to a designated palliative care unit or receiving care at home.

And I think the impetus behind the change that is being proposed in the legislation is how do we enable and support health providers in having information seamlessly as patients make those transitions. That as a patient, I'm not reviewing my complete history for every new provider that I may encounter on my journey because, as someone who is receiving end-of-life care concurrent with perhaps chemotherapy or radiation therapy at the Cancer Agency, that that needs to be seamless and well-supported regardless of where it is.

Ms. Chartier: — I think some of her concerns around that were expressing a lack of palliative care spaces . . . [inaudible] . . . 12 beds at St. Paul's Hospital. I believe it's 12 beds. And so the fact is there's always new people coming on board. And in terms of hospice care, can you quantify that? So aside from our palliative care units in Regina and Saskatoon, what do we have for hospice care?

Ms. Jordan: — That's something that, end-of-life care, palliative care is not formally part of our portfolio, but we'd all certainly endeavor to get you information about what the status is of some of the hospice work that's gone on in the province.

Here in the city of Regina, William Booth Special Care Home does provide hospice care. So there again, as we talked earlier, it can be in a variety of existing facilities not always just in a designated unit.

Ms. Chartier: — Well in William Booth, how many beds does William Booth have?

Ms. Jordan: — For hospice care?

Ms. Chartier: — Yes.

Ms. Jordan: — I don't know what their designated number would be specifically, but we can provide that to you.

Ms. Chartier: — Thank you. And I think that that's the only . . . There's an HIV [human immunodeficiency virus] hospice in Saskatoon, which I commend the ministry for supporting actually. Sanctum is a really good project to support people with HIV/AIDS [human immunodeficiency virus/acquired immune deficiency syndrome]. But there's very limited hospice care, from my understanding, here in Saskatchewan.

In terms of palliative home care, do you have a number on how many providers there are around palliative home care?

Ms. Jordan: — There are a number of different nurses who may, as part of their day, provide end-of-life care. Sometimes they're not specifically identified as end-of-life or palliative care nurses. So are you looking for the number of nurses providing home care service in the province?

Ms. Chartier: — Well you know what? I should maybe again specify that because obviously there's physical therapists. There's different parts of the care team that . . . So if hypothetically a parent was discharged home or is at home, who could we expect to be around that care team providing home care services?

Ms. Jordan: — So just by way of example, in the Regina Qu'Appelle Health Region, and as identified on their public information, they provide palliative care services in the Pasqua Hospital on the fourth floor above the Allan Blair Cancer Centre. There are palliative care coordinators who meet with people at home, in hospital, or at Regina Wascana Grace Hospice. They assess the needs, explain the services of the palliative care team, and make a plan of care with the patient. And the coordinators make changes to the service with the client and family members according to needs, as we've discussed previously.

The palliative home care team includes palliative nurses, home health aids, social workers — this is on the website so we can provide the link to it — music therapy, occupational therapy, chaplains, and volunteers as may be needed. The team provides management of pain and symptoms, ongoing assessment, personal care, a contact between client and physician, and support to clients and families.

The palliative care bed unit at Pasqua Hospital is nine beds, and it provides short-term care symptom management. I don't know; did you want the description of what the social worker does or what the occupational . . .

Ms. Chartier: — No. What I'm curious about is around palliative care, so help me understand this a little bit better. So obviously there are a variety of different home care providers, generally speaking. But I'm wondering if there are providers . . . I believe I've met a palliative care physical therapist. I think her only job is to do palliative care physical therapy. So I'm just wondering . . . Or sorry, maybe occupational therapy. Correction there, occupational therapist.

But I'm wondering if these, in most regions, these are people who have other home care duties as well. By and large, are these in the two largest health regions? Are they specific teams of palliative care specialists? I'm wondering what we've designated as palliative care work and if there are people who actually only do that work.

Ms. Jordan: — So likely in the larger regions, given the number of individuals on end-of-life care, it may make more sense to have a dedicated team. So we can get some information around . . . We just walked through the Regina Qu'Appelle Health Region information. What is the case in Saskatoon? In some of the smaller to medium-sized health regions, whether there are dedicated teams would depend on the number of end-of-life patients or clients at any given point. It's the dedicated team numbers that you're interested in.

Ms. Chartier: — Yes. Yes, could you endeavour to get that to the committee?

Ms. Jordan: — Yes.

Ms. Chartier: — That would be great. Thank you. Has the ministry . . . Obviously I know the minister and members opposite have heard from Canadian Cancer Society and other organizations around the need for a palliative care strategy. There's the national conversation around that as well. We have an aging population. We now have right-to-die legislation, federally, in place. Where is the ministry at around a palliative care strategy?

[16:30]

Hon. Mr. Reiter: — I'm going to get Deb to just get more specific about this in a minute, but just a couple of points I think I'd make to your point about past meetings with the Canadian Cancer Society. Indeed there has been. I haven't been privy to any of those yet. I'm relatively new on the file, as you know. I just also wanted to mention, so there is sort of no action plan imminent but there has been work being done.

I would also point out, a few weeks ago I was at an FPT, the federal-provincial-territorial Health ministers' conference, and as you know, there is discussion around the new funding that the federal government has talked about for home care. And you know, I think it's reasonable to assume that moving forward, some amount of that funding could be used for palliative care as well. So I would just sort of throw that out to put the context there, and I'll get Deb to elaborate on that

please.

Ms. Jordan: — We were talking earlier about the patient choice, and preference often is to have end-of-life care provided and supported at home. And so thus it has been, not just in Saskatchewan but across the country, something that the Canadian Cancer Society, just given the overrepresentation, if you will, of patients with a cancer diagnosis in end-of-life programs, that it is, you know, championed having the discussion. And that certainly then has meant that provinces, if they're looking at increasing numbers of individuals who need end-of-life care and if that care is going to be provided at home, what opportunity or what kind of conversation might occur. You know, the federal Minister of Health has indicated publicly an interest in enhancing home care in the country and so thus the minister's description of some of the conversations that have taken place.

Ms. Chartier: — Just for clarification, is 3 billion that the federal Health minister has talked about thus far in terms of what would be provided for home care . . . But I understand mental health has already been added to that discussion. So is that correct? Three billion has been the number that's been on the table?

Hon. Mr. Reiter: — That was the number the federal government has been using for some months, in fact I think possibly going back to the federal election campaign.

Ms. Chartier: — Yes. No, I believe that that was part . . . But I understand that that was for home care, but they've now broadened that out or talked about a need on mental health and a few other things. So that $3 billion, I fear that that pot is getting smaller. But have your FPT discussions . . . Is there any sense of what our share in Saskatchewan would be of that 3 billion?

Hon. Mr. Reiter: — Nothing specific yet. But I would just, to your previous point, I think it's fair to say that myself, Minister Ottenbreit, and other provincial ministers share that same concern. Obviously, you know, it was supposed to be targeted to home care, so but again I haven't seen anything . . . There was nothing at those meetings, at the FPT that was, that I would say was truly specific about that.

Ms. Chartier: — Just back to the conversation around wait times or needs for services, so would you say that everybody who needs . . . A big part of palliative care is pain management. That's a huge part of palliative care. Do those who need access to pain specialists have access to pain specialists here in Saskatchewan?

Ms. Jordan: — Pain management, whether it's in end-of-life care or in supporting patients more broadly, continues to be an area of some focus and getting some traction in the province. There was a pain symposium earlier in November to talk about what kind of, what would a pain strategy look like in Saskatchewan. And I think it's a big one to try and get your arms around because there are varying needs across the patient continuum. What pain management looks like for someone with a chronic condition could look, and would look, very different than managing someone's pain in the last week or two or expected week or two of someone's life.

So I would say that that's an area, not just in end-of-life care but more broadly, that is certainly on the radar screen and a lot of discussion about where and how do we get traction, and probably looking at it in more depth in each of the areas of care because it looks so different in managing chronic pain than it may for someone in end-of-life care.

Ms. Chartier: — So for those in end-of-life care, I guess the question then again is, for those who need access to pain specialists, do they have that access?

Ms. Jordan: — That would be via the palliative care specialist. If the patient's care needs are being managed by a family physician or another medical specialist and there might need to be a consult with a palliative specialist around end-of-life care, that may be something that the most responsible physician seeks to have a conversation with. But I would say across the country, the whole area of pain management is an emerging area of practice, and having pain specialists is not something that is widespread across the country outside some of the very large urban centres.

Ms. Chartier: — Forgive my ignorance here, but do we consider palliative specialists pain specialists as well?

Ms. Jordan: — They would have experience with managing pain in end-of-life care. That would not make them a pain specialist per se.

Ms. Chartier: — Okay. Thank you for that. We'll maybe move on to the clauses around the privacy issues, clause 7, 8, and 9. I know in the previous minister's second reading speech there was the quote around, "the Information and Privacy Commissioner will be consulted." I'm wondering why that wasn't something . . . I know in conversations at this table, actually Human Services table on organ donation, the Information and Privacy Commissioner came in and said he wishes that people would use his office in drafting bills, to be proactive before the fact. So I'm wondering why he hasn't been engaged on this file yet.

Hon. Mr. Reiter: — I'm just going to get Deb to switch with our deputy minister, Max Hendricks. Max recently had a meeting with the commissioner and, Max, I'll just get you to elaborate on that please.

Mr. Hendricks: — I met with the Privacy Commissioner on November 10th and talked to him about, first of all, the oversight in not providing him with our proposed amendment to at least provide some feedback on it. It was an oversight by the ministry largely because this was to be de-identified information and so we didn't think it was actually violating any of the principles of privacy. But nevertheless, you know, with any bill, we should be consulting with the Privacy Commissioner if it has potential implications for that.

And so what I talked to the Privacy Commissioner about was more broadly in health legislation. The question is whether we include the privacy provisions in the legislation or in the regulations. I said in this case it was our intent to include them in the regulations and that we would consult with him beforehand, before tabling those regulations. He was fine with that. So I believe that actually, just recently Minister Reiter

wrote back to him, just thanking him for that and conveying our appreciation that he's agreed with that approach.

Ms. Chartier: — Thank you for that. Can you tell me the pros and cons around putting the privacy piece in legislation versus regulations?

Mr. Hendricks: — In terms of the . . . It depends on, I guess, your perspective. I think from the Privacy Commissioner's perspective, the pro of including it in the legislation is it's harder to remove or to alter, and in regulations the process to do that is more expedient. From the ministry's perspective, the process of actually having consistency across all of our Acts because we have a fair amount of statute that would have, you know, similar privacy provisions, we'd be opening up dozens of bills. And so it's much easier for us as we go through these to open up regulations and include consistent wording in all of the regulations.

The other thing too is this is a rapidly evolving field in terms of privacy and identity management. We've seen the cases in terms of the penalties that we have for violations of privacy and that sort of thing where we've changed those regulations and that Act as well. So these things are constantly evolving and I would be loath to open up legislation every time we wanted to do that. Every time we add a new technology it raises . . . or new technology comes to the forefront it brings about new privacy issues, so I think the regulations are a far more kind of nimble way of actually dealing with those types of issues.

[16:45]

Ms. Chartier: — Thank you for that, and I'm glad to hear that you've met with him and gotten some advice in that regard. So under clause 9, I hadn't — the whole sharing of information around this — I hadn't thought about that piece until this bill and reading the minister's second reading comments.

How many people in Saskatchewan have received cancer treatment without the Saskatchewan Cancer Agency knowing or being aware? Is that a common thing that happens, that people go out of province?

Hon. Mr. Reiter: — We'll just switch. I'll ask Mark Wyatt, assistant deputy minister, to answer that.

Mr. Wyatt: — We received information from the cancer agency on this question, and there are a number of different scenarios that might involve somebody who has a diagnosis of cancer not necessarily receiving treatment. In some cases it may because they've decided not to undergo treatment. There are certainly different cancer diagnoses where watchful waiting is the initial step. And so it is important, having said that, it is important for the Cancer Agency to be aware of, to use an example like prostate cancer, the number of men who may have been diagnosed with prostate cancer but are not undergoing treatment, and then as it pertains to this bill, the ability to then share that information with both the North American and international agencies that are monitoring trends and data in cancer care and diagnoses. The ability to be able to have information relating to those kinds of patients who are not necessarily undergoing active treatment becomes part of the overall database that leads to some of the international research that is undertaken.

The other area where the Cancer Agency has information that would not be related to somebody who's undergoing treatment would be with some of their screening programs, and so those may lead to follow-up testing that's required, or in some cases negative testing. But having some of the data that they do collect is important for them in order to make sure, first of all, that patients aren't falling through the cracks but also to be able to maintain the broad body of information around the prevalence and treatment of cancer in the province.

Ms. Chartier: — And those are the unidentified folks, right? I can't remember what Mr. Hendricks said around the language, but the de-identified individuals?

Mr. Wyatt: — Right. So when the Cancer Agency is sharing information with those international bodies, they are not providing the names of the individuals who have either been in their care or whom they've been made aware of through other means. They would be sharing information . . . It would be demographic information around age, gender, location, and it would be some information related to the diagnosis, the stage of cancer. But certainly nothing that would be identifiable to the individual.

Cancer agencies across Canada and around the world share this kind of information with both an American and an international organization, and certainly the information we've received from the Cancer Agency has indicated it has led to research and some breakthroughs related to certain types of cancer being more prevalent and in different parts of the world than others. And it is that comparative information that allows researchers to look at things like geography or diet or other factors that may be influencing cancer in different parts of the world, and just understanding the overall prevalence of different variations of cancer.

Ms. Chartier: — Sure. Thank you for that. So how many people have received cancer treatment outside of Saskatchewan?

Mr. Wyatt: — I don't believe that's information that we have with us today. It does come to our attention that certainly one of the provisions in the Act is to be in a position as a ministry where we are aware, either through reciprocal billing information that comes back to us from other Canadian provinces or if patients or . . . Sorry, if information comes to the attention of the ministry, it puts us in a position to be able to share that with the Cancer Agency. But we don't have the numbers with us today.

Ms. Chartier: — So the goal then, so I guess you said you don't have the numbers with you, but so if someone might get a diagnosis and then . . . I've fortunately not been on this journey personally or had a direct . . . I'm really knocking on wood here. I've not had a family member go through this.

So with respect to cancer then, the diagnosis, if someone gets a diagnosis here in Saskatchewan, are they immediately referred to the Cancer Agency? I'm wondering how people end up getting cancer treatments outside of Saskatchewan or outside of the country without that referral to the Cancer Agency.

Mr. Wyatt: — So there are a few potential ways by which somebody may be diagnosed with cancer and not necessarily have a direct referral into the Cancer Agency. One might be a situation where the patient is living in a border community and attend . . . and has a family physician in Medicine Hat for example. And so that doctor in Medicine Hat may not necessarily make the referral into the Cancer Agency, as would be expected of a Saskatchewan-based physician.

Another scenario might be a case where a cancer surgery is performed before treatment begins and that the surgeon who performs the surgery may be aware of, in rare forms of cancer, may be aware of other follow-up treatment that would be available outside of the province. And so there may be a situation where a patient could be referred out-of-province rather than in-province for that follow-up treatment.

Another scenario might be where you have a person who is travelling outside of the province. It could be a student somewhere else in Canada. It could be a snowbird somewhere in the United States. And if their initial diagnosis and the initial care begins in the location where they are travelling, that could be another scenario where you may have Saskatchewan residents who are not . . . for whom we're not aware of or the Cancer Agency wouldn't receive that initial information.

Ms. Chartier: — So will this legislation and this information sharing help that then? That's one of the goals?

Mr. Wyatt: — Certainly the clause with relation to the ministry, it obliges the ministry to share, where we have been involved directly in the care of the patient. It doesn't mean that anyone who contacts the ministry in some respect that's not directly related to their care would then trigger us reporting to the Cancer Agency. But where we are directly involved in the care or treatment with that patient, it does actually. I believe the word is "shall" notify the Cancer Agency. And that adds to a long list of other organizations that are required under the existing Cancer Agency legislation to notify the agency where they are working with a patient with a cancer diagnosis.

Ms. Chartier: — Okay. Thank you for that. I think that that's all my questions on this bill.

The Chair: — Everybody I believe will be coming back. I know that Mr. Docherty wants to ask some questions. So why don't we recess now and come back at 7? So this committee is recessed.

[The committee recessed from 16:55 until 19:01.]

The Chair: — Okay, it being 7 o'clock, this meeting of the Human Services is reconvened, and we have MLA Doug Steele stepping in for Roger Parent this evening.

I do have one question for the ministers and staff. If you were to consult with the Privacy Commissioner on legislation, is he apt to see the final draft, or it would still have other processes to go through after he would see any consultation on a piece of legislation, such as legislation and regulation review committee or cabinet? Or would you consult, would you show him the piece of legislation after it had gone through all the processes?

Hon. Mr. Reiter: — It would typically be at the draft stages so, you know, there would be some potential for changes after he had seen it. But you know, I think we just would focus on trying to keep sort of his intent and his comments in mind if any changes were made subsequently.

The Chair: — Okay, thank you. Because I'm recalling one case where the Privacy Commissioner said, this was not exactly what I saw previously, which to my mind was an unlikely situation that he would see the final bill before it was actually presented to the House so I just wanted that clarified. That was all.

Any other questions? If not, we will proceed with the voting of this bill. Okay, if none, we will proceed with the voting of clauses. Clause 1, title, *The Cancer Agency Amendment Act, 2016*. Is that approved?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 1 agreed to.]

[Clauses 2 to 4 inclusive agreed to.]

Clause 5

The Chair: — Clause 5, I believe there is an amendment there. I recognize Ms. Wilson.

Hon. Ms. Wilson: — Thank you, Mr. Chair:

> Amend Clause 5 of the printed Bill by striking out subsection (3) and substituting the following:
>
> **"(3) Subsection 9(3) is amended by striking out '**cancer care**':**
>
> **(a) Wherever it appears in clause (a);**
>
> **(b) in clause (b);**
>
> **(c) in clause (c);**
>
> **(d) in clause (d); and**
>
> **(e) in clause (e);**
>
> **and in each case substituting '**cancer control**'"**.

The Chair: — Okay, thank you. Moved by Ms. Wilson, that:

> Amend Clause 5 of the printed Bill by striking out subsection (3) and substituting the following:
>
> **"(3) Subsection 9(3) is amended by striking out '**cancer care**':**
>
> **(a) Wherever it appears in clause (a);**
>
> **(b) in clause (b);**

(c) in clause (c);

(d) in clause (d); and

(e) in clause (e);

and in each case substituting 'cancer control**'"**.

Is it the pleasure of the committee . . . [inaudible interjection] . . . Is there any discussion? Does the committee accept the amendment as read?

Some Hon. Members: — Agreed.

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

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 5 as amended agreed to.]

[Clauses 6 to 11 inclusive agreed to.]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Cancer Agency Amendment Act, 2016*. I would now ask a member to move that we report Bill No. 13, *The Cancer Agency Amendment Act, 2016* with amendment.

Mr. Docherty: — I so move.

The Chair: — Mr. Docherty. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried.

Bill No. 26 — *The Patient Choice Medical Imaging Act*

Clause 1

The Chair: — We will now consider Bill No. 26, *The Patient Choice Medical Imaging Act, 2013*. We will begin with clause 1, short title. Mr. Minister, please introduce your officials and make any opening statements.

Hon. Mr. Reiter: — Thank you, Mr. Chair. Again I have Assistant Deputy Minister Mark Wyatt with me, along with Minister Ottenbreit, and we will introduce any other officials as they take part. I just have some written statements that I'd like to read into the record, Mr. Chair, and then we'll proceed to questions.

Providing timely and quality medical imaging services to Saskatchewan patients is a high priority for our government. We are also interested in removing legislative barriers and adding choice for residents in Saskatchewan where there is an opportunity to improve patient choice, access, and satisfaction with health services. That's why we launched private-pay MRI [magnetic resonance imaging] services in Saskatchewan in February of 2016, and why we are proposing the expansion of the legislation to private-pay services to include computerized tomography or CT scans.

The unique-to-Saskatchewan requirement, where for every private MRI purchase the provider must also perform a free second scan to someone on the public list, has enhanced access to MRI services for Saskatchewan patients. In the first eight months of operation, a total of 1,102 private MRI scans were performed. This includes individual patients who chose to pay for a scan, and scans requested by organizations such as the Saskatchewan Roughriders or Workers' Compensation Board. The free secondary scan has resulted in 920 patients from the public health system's MRI wait-list receiving an MRI at no additional cost to the health system, while a further 182 patients from the public list are in the process of being scheduled.

In order to facilitate this legislative change to incorporate a similar model for CT services, the existing MRI facilities licensing Act and regulations are proposed to be repealed at the same time as the new patient choice medical imaging Act and regulations are created. This new Act will provide the option for patients to directly pay for both MRI and CT scans at licensed private facilities in the province. It will also allow for other medical imaging modalities to be added in the future through changes to regulations. This will streamline administration and provide greater flexibility going forward.

The regulations under the proposed new Act will be similar to those under the current MRI facilities licensing Act. Saskatchewan people will have the option to directly pay a licensed private facility for a medical imaging scan. The regulations will ensure the licensed facility also provides a second scan of similar complexity to an individual on the public wait-list at no cost to that individual or the health system. The licensed provider will set the fee schedule for the initial private scan and ensure the second scan is provided at no cost to the patient on the public wait-list.

The new Act and regulations will prescribe categories of licences for MRI, CT, and any other modalities. This will ensure the same requirements exist for all medical imaging facilities and that quality and patient safety are maintained. As with all other medical imaging services, regardless of whether the services are publicly or privately funded, a physician refer will be required to ensure appropriateness of the scan. Work is under way which addresses the appropriateness of the ordering of MRIs for low back pain, and plans are to expand this work into CT services. The introduction of a checklist for ordering MRIs for low back pain has led to a reduction in inappropriate requisitions.

Some have questioned why we're giving patients the ability to pay for medical imaging instead of expanding capacity in the existing sites, adding MRIs and CT in more communities, and focusing on appropriateness. The reality is that our government is doing all of these things to help reduce wait times in addition to the patient choice legislation. Let me touch on how we have increased capacity in the existing system and expanded MRI and CT locations.

Estimated regional health authority expenditures on medical imaging in 2015-16 were approximately $138 million. This represents 163 per cent increase in expenditures from 2007-08, actual expenditures of 84 million. Expenditure on MRI services

has increased by over 168 per cent, from 9.7 million in 2007-08 to 26 million in ’15-16. MRI service represents almost 20 per cent of the total medical imaging budget. Expenditures on CT services has increased by over 67 per cent, from 18.5 million in ’07-08 to 31 million in ’15-16. CT service represents 22 per cent of the total medical imaging budget.

We’ve introduced CT service in Estevan and MRI service to Moose Jaw to assist in improving specialized medical imaging capacity in Saskatchewan. In February of 2016, CT Services officially began at St. Joseph’s hospital in Estevan, which is located in the Sun Country Health Region. For the time period April 1st, 2016 to July 31st, 2016, a total of 879 patients were scanned, with a total of 989 exams performed. The region anticipates 4,500 exams will be provided in 2016-17. On January 4th, 2016, the Five Hills Health Region began providing MRI services. Between January 4th and July 31st of this year, the region performed 1,294 MRI exams for 983 patients.

Providing patients with the choice to privately pay for a medical imaging scan while also providing a second scan at no cost to a patient on the public wait-list will free up capacity within the health system as well as reduce overall wait times. The Canadian Association of Radiologists recommends a 60-day elective time frame, whereas the current provincial target in Saskatchewan is within 90 days for all elective CT patients. As of July 31st, over 200 elective patients had waited longer than 90 days for a CT scan.

Consultation with key stakeholder groups has occurred on the proposed regulations. The groups consulted include private medical imaging providers, the regional health authorities, the accreditation program operator, health provider unions, the professional regulatory bodies, and the Office of the Information and Privacy Commissioner.

The Patient Choice Medical Imaging Act and corresponding regulations are anticipated to be brought into force upon proclamation in 2016, replacing the current MRI facilities licensing Act and regulations. Expansion of private-pay services will include both MRI and CT scans with the opportunity to add other medical imaging modalities through regulation in the future.

[19:15]

This proposed new legislation will allow Saskatchewan people who choose to pay for a medical imaging scan to access that service right here in their own province while also providing additional capacity for patients in the public system.

We’d now be pleased to entertain any questions, Mr. Chair.

The Chair: — Thank you, Mr. Minister. Any questions from the committee? I recognize Ms. Chartier.

Ms. Chartier: — Thank you very much. Thank you very much, Mr. Minister, and to your officials again here tonight as we carry on with Bill No. 26.

I do have many questions, but I’ll go back to some of your comments. I just wanted some clarification around numbers. So you said 1,102 private scans have been done since February, the MRIs since February 2016, since making these changes. And that broke out both the Workers’ Comp and the Riders. Do you have the numbers for both of those? So of the 1,102, how many were the Riders and how many were Workers’ Comp?

Hon. Mr. Reiter: — So it’s the split between those two?

Ms. Chartier: — Yes.

Hon. Mr. Reiter: — Our assistant deputy minister will give you the detail on that

Mr. Wyatt: — The number of patients who have paid individually would be 384, I believe the number would be. We don’t have a full breakdown in terms of all of the different categories of other non-individual payees. And so we can say that 718 — I hope my math adds up here — other payers have also paid for MRIs over and above the individuals, and of those the large majority would be workers’ compensation cases.

Ms. Chartier: — Thank you for that. Are there, aside from the Riders and Workers’ Comp, is there any other third party who’d be paying for those?

Mr. Wyatt: — We are aware of private insurers who have an interest in seeing clients moving quickly through their diagnostic process, and so our understanding is that there may be private insurers who also pay, in addition to Workers’ Comp.

Ms. Chartier: — Okay, thank you. Are those private MRIs all still just being done in Regina?

Mr. Wyatt: — Yes, that’s correct.

Ms. Chartier: — Can you tell me where they’re being done?

Mr. Wyatt: — There are two facilities that are performing the category II private-pay MRIs, and those would be Mayfair Diagnostics and Open Skies.

Ms. Chartier: — Thank you for that. And just in terms of logistics, so is it all still people in RQHR [Regina Qu’Appelle Health Region] who are being taken off the list? So with respect to how this is administered, because the private clinics are here in Regina, is it still RQHR patients who are being taken off the list when someone pays privately?

Mr. Wyatt: — Yes, that’s correct. There may be . . . Patients may come from any location in the province, but because the facilities are located in southern . . . well in Regina, it’s patients who are being taken off of the list for MRI service in Regina who are being . . . had their scans completed as the second patient. Now that doesn’t mean that those patients actually reside in Regina. They could have been referred from a physician in any part of southern Saskatchewan, and there may well be some that come from other areas of Saskatchewan. It’s just where the list that they are waiting on is the Regina list.

Ms. Chartier: — It’s quite likely they’re from the southern part of the province though, this region.

Mr. Wyatt: — Sure, more likely, I mean unless there was some

specific reason why a patient might be referred through, you know, from somewhere in central Saskatchewan. There may be some areas in central Saskatchewan that are equidistant between Saskatoon and Regina.

Ms. Chartier: — I'm just curious about the difference between February 2016 and now between Saskatoon Health Region and RQHR MRI wait-lists.

Mr. Wyatt: — I'll just take one second here. When we look back to the number of patients waiting at the end of the month, for February of 2016 in Regina there were 3,084 patients waiting. And as of end of July, July 31, there are now 2,719 patients waiting. So we've seen a reduction of nearly . . . or just over 300 in terms of the number waiting in Regina. And in Saskatoon, the comparable period from end of February would be 1,368 patients waiting, compared with 1,470 . . . I'm sorry. Saskatoon, the number would be 3,561 patients waiting.

Ms. Chartier: — Sorry, Saskatoon . . . Can you say that again?

Mr. Wyatt: — Yes.

Ms. Chartier: — So in February of 2016?

Mr. Wyatt: — February 2016, the number of patients waiting in Saskatoon, 3,561; compared to end of July, 3,369. So a reduction of just slightly over 200.

Ms. Chartier: — Thank you for that. Sorry to, sorry to jump around here. Just the question around the private scans and the logistics for the Riders and Workers' Comp. So it was a different, slightly different system prior to this bill passing around Workers' Comp and the Riders. The agreement that was, it wasn't a two-for-one or, it was block paid. I can't exactly remember how Minister Duncan or Mr. Hendricks had explained that.

But is Workers' Comp and the Riders now paying exactly the same way as individuals would be? Is the system working the same for all of them? So you're Workers' Comp, you're Workers' Comp and you pay for someone on the Workers' Comp list, and then you pay for someone on the private list?

Mr. Wyatt: — Yes, the Act and the regulation don't discriminate between an individual and somebody whose scan is being paid by for a third party. And so whether it's Workers' Compensation Board, the Saskatchewan Roughriders, someone paid for by a private insurance company, the payee would have to, is required under the regulation to pay for the second scan. Or I should say, actually the regulation, what the regulation does is it doesn't identify that, you know, that they are paying for the second scan. What it does is require that the facility that provides the initial service also provide, performs the second scan. The way, the amount that they charge the patient is something that is really to be determined by the facility. We don't, we don't regulate the amount that they are charging.

Ms. Chartier: — That two-for-one is built into the cost of the private MRI.

Mr. Wyatt: — That's what we expect is the case, yes.

Ms. Chartier: — Okay, thank you. Do you have an average, or for some basic scans that are happening in private MRI clinics, what average costs are?

Mr. Wyatt: — We don't. We don't track what the private facilities are charging. It's not something that is set by the province. It is, the amount is determined by the facilities themselves as to what they feel they need to charge in order to both serve the initial patient and to cover the cost for the second patient.

Ms. Chartier: — So you don't track that at all?

Mr. Wyatt: — No, we do not.

Ms. Chartier: — Okay, thank you. In terms of — I'll get back to some of my questions around opening remarks here in a little bit — but I want to get a sense of what CT scanners, the landscape looks like here in the province. So how many CT scanners do we currently have here?

Mr. Wyatt: — There are 14 CTs operating in the province, including 13 in the publicly delivered system. And then we have one CT located in Regina that performs both publicly funded scans through a private contract relationship, for a total of 14.

Ms. Chartier: — Thank you. And in terms of the 13 in the public system, where are these located? Which regions?

Mr. Wyatt: — Okay, so in Regina Qu'Appelle there are three scanners: two at the Regina General Hospital and one at the Pasqua. In Saskatoon Health Region there are two at Royal University Hospital, one at City Hospital, and one at St. Paul's Hospital.

In Five Hills there is one at the F.H. Wigmore Hospital. In Prairie North there is one CT scanner in the Lloydminster Hospital, as well as one in Battlefords Union Hospital. In Prince Albert Parkland Region there's one CT scanner at the Victoria Hospital. In Sunrise there is one CT scanner in the Yorkton regional hospital. In Sun Country, one scanner at St. Joseph's Hospital in Estevan, and in Cypress there is one in the Cypress Regional Hospital.

Ms. Chartier: — Okay. And in terms of hours that they operate, so all of these are in . . . These 13 are all in the hospitals that you've just described for me. That's correct, right?

Mr. Wyatt: — That's correct.

Ms. Chartier: — I've made . . . My notes are right. What kinds of hours are these scanners operating?

Mr. Wyatt: — The hours depend based on the facility. You have the times that range . . . Probably the most expansive time in the province would be the two scanners in the Regina General Hospital which operate from 7 in the morning until 10 in the evening, also operate during weekends for a more restricted time frame, as well as emergency coverage 24 hours a day. Most other scanners in the province don't operate through the evening hours on it for elective basis but would operate,

certainly be available and should a patient require a CT scan, on an emergency basis through the evening and overnight hours.

Ms. Chartier: — Okay. So there's a new one. Is it a new one in the Moose Jaw Hospital?

Mr. Wyatt: — If we're talking CT, it would be . . . the new one would be in Estevan.

[19:30]

Ms. Chartier: — Okay. So sorry, yes. And in Estevan then, and how many . . . I see that in Sun Country, sorry. And do you know what the hours of that particular facility are?

Mr. Wyatt: — It operates, so the CT scanner in St. Joseph's Hospital operates from 8 a.m. to 4:30 and on a 24-7 emergency basis.

Ms. Chartier: — How about the one in Cypress?

Mr. Wyatt: — Cypress, they have another half an hour that they are open through the day, so they begin at 7:30 in the morning and operate until 4:30, Monday to Friday on an outpatient basis and 24-7 on an emergency basis.

Ms. Chartier: — Okay. And Sunrise?

Mr. Wyatt: — Sunrise, it operates seven days a week from 8 until 4 p.m. on an outpatient basis and 24-7 emergency.

Ms. Chartier: — Okay. Parkland?

Mr. Wyatt: — The scanner in Victoria Hospital operates from 8 until 4:30 and also on a 24-7 emergency basis.

Ms. Chartier: — It's five days a week or seven days?

Mr. Wyatt: — Monday to Friday, so five days in terms of electives.

Ms. Chartier: — Emergency, 24-7. Prairie North?

Mr. Wyatt: — Prairie North. The scanner in Lloydminster operates from Monday to Friday, 8 a.m. to 4 p.m. for outpatients and on a 24-7 emergency basis. The CT scanner in Battlefords Union Hospital operates from 8 until 5, Monday to Friday, and 24-7 on an emergency basis.

Ms. Chartier: — And Five Hills, have we . . .

Mr. Wyatt: — The CT scanner at the Wigmore Hospital is open from 8 until 4:30, Monday to Friday, 24-7 emergency.

Ms. Chartier: — Thank you. And the Saskatoon Health Region, the two at Royal University Hospital?

Mr. Wyatt: — The two scanners at RUH [Royal University Hospital] operate Monday to Friday from 8 until 4 for outpatients and . . . Now I've got a note saying that they are operating extended hours currently as well as 24-7 emergency.

Ms. Chartier: — And what do their extended hours look like?

Mr. Wyatt: — Sorry. We have a notation that they're operating on extended hours currently, but we don't have the specific times for that.

Ms. Chartier: — Do you know why they're operating on extended hours or how long that's been?

Mr. Wyatt: — We don't know the circumstances for which they're operating on extended hours at this moment.

Ms. Chartier: — Okay. City Hospital in Saskatoon Health Region, their hours?

Mr. Wyatt: — There is one scanner at City Hospital. It's operating seven days per week from 8 until 4 for outpatients. And also the scanners at both Saskatoon City and St. Paul's, we also have a note that they are in extended hours. Don't have the details for that. And as with all of the other scanners, 24-7 on an emergency basis.

Ms. Chartier: — So St. Paul's was also seven days a week, 8 to 4 as well then?

Mr. Wyatt: — Actually, seven days per . . . At St. Paul's, it's seven days per week, 8:30 to 4 for outpatients, extended hours and 24-7 coverage.

Ms. Chartier: — Would you be able to respond to the committee with . . . I'm just curious about the extended hours, so how long that extended hours period has been and what's going on there.

Mr. Wyatt: — Sure, we can follow up to do that. And I think there is one site that we haven't covered if you wanted to go over that one.

Ms. Chartier: — RQHR?

Mr. Wyatt: — I think I've mentioned the Regina . . . the Regina General has two CT scanners that operate Monday to Friday from . . . Sorry, I misspoke earlier when I said that they were operating until 10 in the evening. That's the MRI that operates until 10 in the evening. The CT scanners operate Monday to Friday from 7 until 3 for outpatients and 24-7 emergency, and the Pasqua's one scanner operates Monday to Friday from 7:30 until 4 for outpatients and 24-7 for emergency.

And one other thing I'll add is that when we add these up in fact it is 14 in the public plus the one in the private, so the facilities that we've just discussed should give you 14.

Ms. Chartier: — Okay. Thank you for that. And so just the . . . And there is just the one private clinic offering public MRIs, or it's a single payer still at this moment in time, but there's just the one clinic in Regina?

Mr. Wyatt: — That's correct. There's a contract that has been in existence between Regina Qu'Appelle Health Region and Open Skies . . . Sorry, and Radiology Associates for CT services.

Ms. Chartier: — And that's been in place since about 2012.

Am I remembering that? Or 2010 perhaps?

Mr. Wyatt: — The contract between Regina Qu'Appelle and Radiology Associates should be approximately January of 2011.

Ms. Chartier: — And how long was that contract?

Mr. Wyatt: — The term of the contract with RAR [Radiology Associates of Regina] was for three years and then the contract also has a provision for an extension.

Ms. Chartier: — So it would have been extended in 2014.

Mr. Wyatt: — Yes, I believe that's correct.

Ms. Chartier: — And so the extension in 2014, where's the contract at right now?

Mr. Wyatt: — We're not 100 per cent certain in terms of the current position of that contract. It is with the regional health authority and the vendor, and so we can follow up and get back to you in terms of what its current status is.

Ms. Chartier: — That would be great. Does this bill impact this contract at all?

Mr. Wyatt: — It does impact this contract as well as the contract that we have with . . . a similar contract for MRI services, in that the bill replaces both provisions of *The Health Facilities Licensing Act* as well as provisions in *The MRI Facilities Licensing Act*, in that it doesn't simply deal with the initiation of the private-pay and two-for-one arrangement; it also assumes the regulation for all third party delivery of MRI and CT services.

And so it would basically, the existing contracts in this case between Radiology Associates and the Regina Qu'Appelle Health Region would move under the patient choice Act in the future once it's been proclaimed, which right now would be moving from *The Health Facilities Licensing Act*, whereas a contract for MRI service would be in this case moving from under *The MRI Facilities Act*, under the patient choice licensing Act.

Ms. Chartier: — In terms of impact, like is there any financial . . . Is there anything written into their contract that . . . This is a different way of doing things now, obviously. So how does that impact the contract?

Mr. Wyatt: — The patient choice Act includes a provision that speaks to the continuation of contracts that were . . . and the licensing that existed under, in this case *The Health Facilities Licensing Act*, when talking about a CT contract. So there isn't any change in terms of the licence status for the facility.

There are a couple of examples in the regulation that would make some relatively small changes in terms of the relationship with an existing provider. And one that comes to mind is the requirement in the regulations under *The MRI Facilities Licensing Act* which we would expect to, certainly would be our expectation, would carry over now to the patient choice licensing Act that requires the facility to carry a bond in the event that the facility ceases to operate. That was a requirement in the MRI licensing regulations. That would be one that wasn't in place under *The Health Facilities Licensing Act*.

There's another example that comes to mind, and that is the requirement that they enter images on the PACS [picture archiving and communication system] system, which is happening in practice, but this would now become a legal requirement under the regulations which had not previously existed under *The Health Facilities Licensing Act*.

Ms. Chartier: — Thank you for that. I'm going to ask you to walk me through the number of . . . where our MRIs are all today, much like we just did for the CT scans, and hours of operation, if you wouldn't mind doing that as well. And I know it's a slightly smaller list.

Mr. Wyatt: — It is indeed. So I can begin in Regina. And we have two MRI scanners at the Regina General Hospital. And if you'd like, I can cover the hours of operation, if that's where you intend to go with that.

Ms. Chartier: — Sure, let's do that.

Mr. Wyatt: — It is the MRI scanners that operate Monday to Friday from 7 a.m. until 10 p.m. in the evening; Saturdays and Sundays from 6:30 until 3:30, and those are the outpatient hours. And then 24-7 emergency, and the 24-7 emergency will carry over for all of the MRI scanners as well.

In Saskatoon, the Royal University Hospital has two MRI scanners. They operate Monday to Friday from 8 until 4 on an outpatient basis, and we also have a notation about extended hours. City Hospital in Saskatoon has one MRI. It operates seven days per week from 8 until 4 for outpatients, with extended hours. And St. Paul's Hospital has one MRI that operates seven days per week from 8:30 until 4, with extended hours. All of the scanners have 24-7 coverage. We have one MRI scanner in Five Hills at the Wigmore Hospital. It operates Monday to Friday from 8 until 4:30 on an outpatient basis.

And I will just add that there is a privately operated MRI, actually there are . . . I'll maybe touch first on Mayfair Diagnostics operates a private MRI, and Open Skies also has a private MRI. Both of those are located in Regina. And finally there is a private MRI that operates on the Alberta side of Lloydminster.

Ms. Chartier: — Okay. Just out of curiosity, do you know the hours of the private . . .

[19:45]

Mr. Wyatt: — We do have the hours, though they would have to be, I guess confirmed with the private facilities. They're outside of the regional system, but the Mayfair MRI operates from 7:30 until 8:30, and the Open Skies operates from 8 until 5.

Ms. Chartier: — Okay. Thank you for that. I know in your opening comments, Mr. Minister, you had mentioned with whom you had consulted. And could you just, I didn't take my notes fast enough, so I'm wondering if you could tell me that

list again.

Hon. Mr. Reiter: — I will. Mark just mentioned to me that the list that I was provided with, they were contacted by the ministry and given the opportunity to respond. And some of them may not have responded; these are the ones that were given the opportunity. And the list I was provided by the ministry says, private medical imaging providers, the regional health authorities, the accreditation program operator. I'm sorry. Am I going too fast? I can . . .

Ms. Chartier: — I'm good.

Hon. Mr. Reiter: — You're okay?

Ms. Chartier: — Yes.

Hon. Mr. Reiter: — It was the accreditation program operator, health provider unions, the professional regulatory bodies, and the Office of the Information and Privacy Commissioner.

Ms. Chartier: — Was it the same list to which the . . . Perhaps you wouldn't know that, but I know your officials would. Is it the same list to which an invitation to provide feedback on the previous bill? Is it the same list of providers?

Mr. Wyatt: — Yes. It may not be 100 per cent identical, but we essentially worked from that list. And if there were any differences in the original MRI consultation list and this list, they would be very few.

Ms. Chartier: — And who did you all hear back from?

Mr. Wyatt: — The groups that responded included regional health authorities. We heard from the Regina Qu'Appelle Health Region, the Saskatoon Health Region, and Keewatin Yatthé Health Region.

We did have contact with the private medical, the existing private medical imaging providers, the two organizations in Regina: Mayfair and Radiology Associates. We had contact with the accreditation program operator, which is the College of Physicians and Surgeons.

Ms. Chartier: — Sorry, the last one, the private medical imaging providers, so Mayfair and was it Open Skies as well, or is it just on the CT side?

Mr. Wyatt: — It was Radiology Associates.

Ms. Chartier: — Okay. So Mayfair and Radiology Associates. Okay. Sorry. I just wanted to double . . . I'll go back in a moment here if . . . Carry on.

Mr. Wyatt: — So the others that we did have contact with were the College of Physicians and Surgeons, which is the accreditation program operator under both the existing HFLA [health facilities licensing Act] and MRI FLA [facilities licensing Act].

We had responses from the Saskatchewan Association of Medical Radiation Technologists. We had contact with the Saskatchewan Medical Association. We had contact with the Office of the Saskatchewan Information and Privacy Commissioner, with the Saskatchewan Cancer Agency, and with the Ministry of Labour Relations and workplace.

Among those that we did not hear back from would be eHealth Saskatchewan, Saskatchewan Government Insurance, Workers' Compensation, Saskatchewan Association of Nurse Practitioners, Canadian Union of Public Employees, Saskatchewan employees international union west, Saskatchewan Government and General Employees Union, northern medical services, the Saskatchewan Roughrider football club, and all of the health regions aside from the three that I named which have provided feedback.

Ms. Chartier: — Thank you for that. Can I ask you what kind of feedback you got in terms of the three? I'm curious what Keewatin Yatthé . . . I'm actually curious what all three health regions provided for feedback.

Mr. Wyatt: — The point that Keewatin Yatthé, one of the points that Keewatin Yatthé made was around the importance of the requirement, actually the one that I just mentioned just a moment ago, about for private facilities to digitally upload MRI and CT images into a format that can be transferred to other locations in the province and give their physicians the opportunity to be able to refer to images that had been taken not just in the public system but also in the private system at a distant location. They also had inquiries just around the potential expansion of other modalities of medical imaging and just those they currently offer within their health region and whether they would be potentially included. And that was the two issues that we've identified with Keewatin Yatthé.

Ms. Chartier: — How about Saskatoon Health Region?

Mr. Wyatt: — Saskatoon Health Region, some of the issues that they addressed in a face-to-face meeting were seeking clarification on how the Act was working on an operational level with the Regina Qu'Appelle region. Given that Saskatoon has not had that interaction in terms of identifying and providing the contact for the second patient, so there was sort of an exploration of what is involved in working with a private provider on that arrangement. I guess it's fair to say Saskatoon also does not have a relationship with a private imaging provider under a publicly funded contract either. And so there may have been discussion in terms of both sides, the category I and the category II, although they do have experience working with private surgical facilities in Saskatoon.

There were questions around how the licences worked. And those issues are addressed in the regulation in terms of the category I licence, the category II licence, and the requirement that a facility that is both providing publicly funded and privately funded scans would hold a licence for both a category I and a category II.

There was discussion around the issue of physician referral. And the Act, I believe it's in the Act, requires that requisitions be, requisitions for MRI or CT be received from a physician who has the accreditation within the region to order that level of that form of image. And so there was discussion around that particular issue.

It looks like that is the extent of the discussion with the region.

Ms. Chartier: — And how about RQHR, who obviously had some experience in this regard?

Mr. Wyatt: — There were a few issues identified in the meeting with Regina Qu'Appelle. One was around an issue of how exams are protocolled, which would be the way in which the facility or facilities determine which . . . the number of images and the type of images that you might take for a particular limb or for an abdominal scan. And so there was just some discussion which, I guess, may occur between any two different locations where you have either different technologists or different radiologists who have a particular manner in which they perform those images in response to a requisition.

The other issue that was identified was around the question of, there was questions around whether the relationship would continue with the second-scan patients coming from the RQHR list or whether there was any thought of looking at drawing from other, drawing from, now I guess we would have two other choices, Saskatoon or Moose Jaw.

There was discussion around the relationship and, I guess, the process by which the region is working with those private facilities. And that has been, I think, a conversation that has probably predated the two-for-one process, just how that would work. And there was discussion in the consultation about how it has been working with those private facilities. And RQHR was also supportive of the requirement that we put into the regulation, requiring facilities to digitally upload the MRI and CT images into a suitable format for viewing by RHA [regional health authority] physicians should additional investigations be warranted and for suitable storage by eHealth Saskatchewan.

Ms. Chartier: — Just going back to your first point around how exams are protocolled, so you're talking about different . . . Can you expand on that a little bit? Again, I'm not an MRI technologist obviously, so I'm curious a little bit . . . I just would like a little bit more information around what that means.

Mr. Wyatt: — I'm not an MRI technologist or a radiologist either. So I can maybe share some observations, and I'll see if others may want to help me out here.

I know that in the past, I guess even before we were dealing with private facilities, we have noted that there are differences between Regina and Saskatoon in terms of the number of images that they might order for a particular exam. So you might have one location where they will perform two views of that particular joint or that head or an abdominal, and you might have another location that might simply do one. And I think that's the issue. I think that's the issue that was being discussed.

Ms. Chartier: — And is there . . . Has that been addressed? Obviously that's been flagged as a concern by some people in the region who are working directly in this system. So has that been resolved?

Mr. Wyatt: — It wasn't something that would be addressed through the consultation around the regulations. This is not an issue that would be something that would be introduced in regulation. It really is a matter for the RHA and its contracted facilities to work through as part of their relationship and as part of the contract that oversees that service.

Ms. Chartier: — But if the ministry, like the . . . so obviously it's administered at the regional level, but if it's a two-for-one and it's the ministry who is ultimately saving money . . . So am I hearing this correctly, that say perhaps a private provider is doing something different than one of the public scanners?

[20:00]

Mr. Wyatt: — As I'd mentioned before, it's really not something that we address through the ministry, through the legislation or the regulation. It really is something that is a matter of clinical practice. There are existing differences, as I mentioned before, between what you might see in practice between Regina and Saskatoon. For any, I guess, for any two locations you may have some differences in terms of how they protocol those exams. And so it is really an issue that would be resolved, I guess, any issue or any concern would be resolved through clinicians themselves, whether that was to involve the department head of radiology, the medical director for a private facility. It really is a clinical issue rather than one related to the contract management, or sorry, the legislation and regulation.

Ms. Chartier: — So I understand that there may be differences between RQHR and other regions but I'm . . . obviously RQHR raised that in the consultation process. So what I'm asking, when you gave me an example where one location would do two views and another, in terms of on a particular exam, where one location would be doing two views in a particular exam and another might do one, were there particular issues that RQHR flagged around the private MRIs? Is that where that was coming from?

Mr. Wyatt: — I don't have any information. I don't have any more detailed information related to the specific issue that was addressed. The summary that we have of the various areas for the consultation with Regina Qu'Appelle just identifies an issue around protocolling and the, I guess, the response being that this is not a matter that would be addressed through the legislation or regulation.

Ms. Chartier: — One of the second . . . Another point you raised was there were questions around the relationship with the second scan. RQHR has asked about that?

Mr. Wyatt: — That's right. And I think it is a question that has come up in, I think both in the ministry as we were, I guess, as we were moving down the road of the two-for-one model with the provision of the second scan, is how would we allocate the second scan? And so far to date we have done it based on where the scan was performed. Up until now, our experience has been with MRI, and so when an MRI is provided to a paying individual or to a third party, as I mentioned before, the patient may come from any part of the province directly to one of those two facilities in Regina.

In order to simplify this and to work with one organization nearby where you had a number of patients on the waiting list, we worked with RQHR up until now. It's not to say that we've made any decision that that will always be the case. We could certainly look at pulling patients from either Saskatoon or

Moose Jaw, although at this time Moose Jaw actually is pulling patients from the rest of the province, and so we don't really have a need to be drawing patients from Moose Jaw and their catchment area in the Southwest. Because if anything, patients are being referred out of Regina and Saskatoon into Moose Jaw to fill some of the space available there.

Saskatoon I think is probably a greater consideration. We haven't at this point moved to drawing the second patient from the Saskatoon wait-list. It's something we may consider doing in the future. We are also, I guess, looking to see if private providers enter the market in Saskatoon, in which case there would be that opportunity and availability for the second patient to be drawn from the Saskatoon wait-list.

Ms. Chartier: — Thank you. So did Saskatoon ask you . . . So we're talking about RQHR's feedback, but did Saskatoon ask you if you were going to be doing that? Was there any concern that that wasn't happening?

Mr. Wyatt: — It wasn't addressed as a concern. I think there was discussion around what that . . . As I mentioned before, there was concern about — or sorry, not concern, but there was discussion — about what does that look like in Regina. And I think they were, I guess they were interested in what that would look like, what it would, what would be involved for the Saskatoon region in the event that there was a private provider that entered the marketplace in Saskatoon, and trying to understand how the second-patient process was currently operating in Regina. But it wasn't, to our knowledge or to my knowledge, identified as a concern that second patients were not being drawn from the Saskatoon list.

Ms. Chartier: — Thank you. The third point you'd mentioned under RQHR's feedback was the process by which the region is working with the private facilities. Can you talk a little bit more about that?

Mr. Wyatt: — It was really a discussion around what's involved right now in terms of that process, being able to identify the patient who is added to the RQHR wait-list for MRI. It then becomes known that the patient may have gone and paid for their scan. Then the process involves . . . or the facility then provides the number of scans as well as information around the patient so they can be removed from the wait-list, and then RQHR provides the comparable number of names from which the second-scan patients are contacted by the private facility and then arranged.

The discussion was around how that was working, and I think there was some question around what the intention was in terms of other modalities. Certainly this legislation speaks specifically to CT. There are no current intentions to add other diagnostic testing to this legislation, and I think that's probably where the conversation would have gone, was in terms of really limiting it to MRI and CT.

Ms. Chartier: — Okay. How is that . . . I know we're in one track here on RQHR and consultation. But just on that note, in terms of the scans that have been provided, the 1,102 private scans since February 2016, particularly the 384 individuals who have paid for them, what level of scans were those? Do you have that broken out, like in terms of urgency?

Mr. Wyatt: — So I just want to be sure that your question was around the urgency level for the patients.

Ms. Chartier: — Yes.

Mr. Wyatt: — Okay. We don't have information related to the urgency assessment for the patients who have paid for those scans. If it was a level 1 emergency situation it would be most like, well quite certain that the patient would be in hospital and would not be a candidate to be going to a community-based facility. So there are some level 2 patients who might require an urgent scan who could go to a community facility, whether it's through the existing contract or whether it is on a patient-pay basis. And then you would have probably the majority being in the lower-urgency groupings. But we don't know the breakdown for those.

Ms. Chartier: — Okay. You don't keep track of them or you don't have them here?

Mr. Wyatt: — We certainly don't have them here. I don't believe that we have that information in the ministry. It would probably be something that we would have to extract from the RHA.

Ms. Chartier: — Okay. Last time we were here talking about the MRI bill last fall, I know the logistics were still being worked out around who was going to be taken off the list and how that would all work in terms of equivalent. I know there was the conversation around this level of scan for that level of scan. So I'm just wondering how logistically, of those three hundred and . . . well I guess it's 1,102 private scans, how it's triaged for the two for one.

Mr. Wyatt: — Okay. I will answer the question and then if I'm not getting specifically to what you're looking for, please let me know. The regulation speaks to the second scan being of a similar level of complexity. And so knowing that there are, for MRI certainly, multiple different kinds of MRIs that might be ordered with some different complexities, but there are large groupings that would be considered to be basic scans and then others that would be considered to be more advanced, the system that we developed basically involved establishing two classes of exams, one that we call class one which involves routine . . . I can go through the list of what would be covered in class one if you'd like.

Ms. Chartier: — Sure.

Mr. Wyatt: — Those would be routine brain, cervical spine, thoracic spine, lumbar spine, shoulder, elbow, wrist, hip, and knee scans. And then in addition to class 1 we have class 2, and those are defined as being more advanced, that require additional imaging and/or contrast enhancement in conjunction with a standard RQHR protocol. And the class 2 exams are brain with some additional imaging requirement, chest, abdomen, pelvis, humerus, forearm, hand, femur, tib-fib [tibia-fibula], ankle, foot, and arthrogram.

And so basically once a scan is performed for the first individual, that scan is identified as either a class 1 or a class 2 and then rather than having a like-for-like relationship with the second scan, the facility will notify the region that it has

performed X number of class 1's and X number of class 2's and then patients will be drawn from the public waiting list based on an equivalent number of class 1's and class 2's.

Ms. Chartier: — Thank you. So of the 1,102 private scans then, how many were class 1 and how many were class 2?

[20:15]

Mr. Wyatt: — The answer to the issue around the complexity categories is similar to the issue around urgency. It's not something that the ministry has at this time. We may be able to obtain that from the regional health authority.

Ms. Chartier: — If you could do that, that would be great. That gives us a bit of a better picture of those 1,102 private scans, what level . . . I'd be interested in knowing if they're coming in more class 1 or class 2, so if you could endeavour to get that, that would be great.

So going back to the list of RQHR's items that they flagged, that digitally uploading images into a suitable format, you had said. So just to clarify then, that wasn't happening before. So you could go to Mayfair or Open Skies since February and even I suppose, up to now, and how are those images being shared with medical practitioners here?

Mr. Wyatt: — So we've been working with both providers to have them brought on to the RIS/PACS [radiology information system/picture archiving and communication system] system. A recollection is that Mayfair has had the ability to upload images on to RIS/PACS essentially from the beginning of their, certainly of the time that we have had the two-for-one under *The MRI Facilities Licensing Act*. And it was something that they were, I think, just introducing at the time that they entered into their private contract with Regina Qu'Appelle Health Region.

In the period preceding that they would have been uploading images onto discs, having them transferred over to the region which would then upload them onto the system. With Open Skies that has been the arrangement that they have been using, is having them provided on discs. And we are, we are either just completed or in the process of bringing RAR and Open Skies on to the PACS system as well. And so in both cases those providers will have the ability to upload images digitally right from the site.

Ms. Chartier: — In terms of having to put them on a disc, and what kind of time delay is that? So that that's been happening up until now, so if you . . . versus being able to directly upload them?

Mr. Wyatt: — The process that they have been using has been to upload them on a weekly basis, and so the delay that that would introduce would depend on I guess which day of the week that you may have had your scan. It could be, I guess on the long end of that, up to seven days. On the short end it may be within 24 hours. But it would not have been a delay beyond one week, based on that weekly transfer of the disc and the uploading process, is our understanding. And now we are moving to the ability for those facilities to upload them directly, which gets around that additional process.

Ms. Chartier: — And the requirement for anybody coming on board, including the existing facilities, is that they'll upload directly?

Mr. Wyatt: — I believe the requirement is . . . I'm just going to double-check that. I don't have the exact wording of the regulation. I can find it. But what it does require is that the vendor provide those images in a form that is identified or directed by the ministry, and so it would allow for the use and transfer of images on a disc to the region if that is the only available method in, I guess, in the interim.

Part of the issue here really is on the schedule for bringing the entire province on to the PACS system. And so we've been bringing the public facilities throughout the province on to PACS one region, one facility at a time. And so we've now moved . . . we'd now move to begin bringing the Regina private facilities on to the PACS system. If we had additional facilities that were licensed under this legislation, we would not be able to anticipate probably that somebody was going to be licensed and have them work with eHealth in order to get that PACS access. And so there would likely be some time with any new vendor in order to be able to work with them to get to the point of direct upload as opposed to transferring discs.

Ms. Chartier: — Okay. So I just want to clarify that I heard you say that with the existing providers, that they will be able to upload directly here very soon. Was I hearing that correctly?

Mr. Wyatt: — Mayfair already has that ability and RAR and Open Skies, I believe we're working with both of them. They're related companies and I believe we're working with both of them, and if they don't have it now they will soon. I know that that implementation is happening sometime this fall.

Ms. Chartier: — Are all the public facilities on RIS/PACS?

Mr. Wyatt: — So in terms of the implementation of the PACS system, we've been moving through the province. And I guess the implementation schedule is looking at the highest priority and highest volume facilities first.

There are, I believe, 73 facilities that are on the PACS implementation schedule, and we have completed 65 of those sites. So there are a small number within the public system that have not been brought on board. The Cancer Agency is actually one of the ones that we are still waiting to bring on to the PACS system. The community health centres are not part of PACS.

Ms. Chartier: — So 73 that are on the schedule. So you talked about highest priority and highest volume, so are there others beyond those 73?

Mr. Wyatt: — That's the current implementation plan that has been developed with eHealth. The issue really comes down to funding and availability of staff in order to move through each implementation. And so right now eHealth I think at the beginning of the . . . At the outset of the RIS/PACS rollout, they identified that group of facilities. And additional facilities will have to be, I guess, negotiated, funded, and become part of a second stage for the implementation overall.

Ms. Chartier: — So obviously, as you've identified, there's a

cost with bringing people and sites on to the system. What is the cost to bring these private providers on to the system?

Mr. Wyatt: — So a couple more points to make in response to your question, so just coming back to the issue around privatization, as we move from Regina and Saskatoon and then through the regional hospitals, that actually the estimate is that it captures about 80 per cent of all of the volumes. So once you move beyond the regional hospitals, you are starting to get certainly much smaller volumes involved. And so the rollout has been really focusing initially on getting the large sites on board and then moving to some of those smaller volume sites. It's on that basis that we will ultimately get to 100 per cent coverage. But just covering that initial group you have 80 per cent, and then now you're moving through the remaining facilities to get from 80 to 100 per cent.

[20:30]

In terms of the cost, there is a cost for, there's a cost per scan that is charged every time that an image is uploaded, and so that is a cost both to the public and the private system.

The benefit, I think, is worth understanding as well because, as we heard from both Regina and Saskatoon and Keewatin Yatthé, having access to all of the images that are being performed in the province and being able to access prior images that a patient may have to be able to make that comparison. Or if a patient is travelling from a long distance in the North down to Regina or Saskatoon, being able to ensure that when they return home, those images can be transferred right across the province. It's certainly an important benefit both for the patients and for the providers who are family physicians and specialists right across the province who are working with them.

And so it is a cost of doing business, and one that we think is certainly worth that cost because it does ensure that the medical record that providers are working with includes all images and not just those that happen to be taken in their local hospital or even within the public system. This ensures that we have all of the images from across public and private right across the province geographically.

The Chair: — If I can interrupt now, we will take a five-minute recess and reconvene at 8:37.

[The committee recessed for a period of time.]

The Chair: — It now being after 8:37, the committee will reconvene. And I recognize Ms. Chartier.

Ms. Chartier: — Thank you. Just to continue on that, you were just talking about the cost per scan. And obviously it's worthwhile to have the scan available for physicians and those to use them, but what is the cost? So you said there's a cost per scan every time an image is uploaded, in both the public and private systems. So what is that cost?

Mr. Wyatt: — It's in the range of one to three dollars, and it may defer based on the contract that a particular facility has with their vendor.

Ms. Chartier: — Okay, so it's different. Is there a consistent cost for the public system?

Mr. Wyatt: — So the contract that eHealth has with Philips is a provincial contract for — we were just discussing whether this is for all vendors or for most of the vendors — it is a charge of $3.15 per image. We were also just discussing that with the private vendors, the technical form of that upload and then the issues around also the ability to download, is in a different, I guess, at a different level than what is available through the public facility. So there may be a lesser cost — we believe around a dollar — for those facilities based on the current arrangement that they have.

Ms. Chartier: — Sorry, I'm not quite sure I understand. It's different technology that the public and the private system is using to upload and download.

Mr. Wyatt: — That's correct.

Ms. Chartier: — And is it just more . . . Can you tell me the difference between the . . . So you said the contract that eHealth has is with Philips. I'm sorry, I don't quite understand the difference between the two except for the cost.

Mr. Wyatt: — The difference is primarily around the ability to download images. And it is a more restricted manner in which the private facilities currently are able to download images from the PACS system. And it's something that we're working, that eHealth is working with the vendors, beginning to work with the vendors on now to try to parallel the public download system or at least come up with a technical solution that will work. Because those facilities have their own IT [information technology] systems, it's not as simple implementation as working with some of the public vendors.

Ms. Chartier: — Okay. So it costs less because it's not quite as robust?

Mr. Wyatt: — That's correct.

Ms. Chartier: — Okay. But the goal is to get them there?

Mr. Wyatt: — That's also correct, yes.

Ms. Chartier: — Okay. Okay. And I know we're still on the consultation piece here, but I think it's important to hear what various stakeholders had to say. You told me that the SMA [Saskatchewan Medical Association] weighed in again on this bill. And I know last time they were opposed to the MRI bill and had said that access to services should be based on need and not on ability to pay. And I met with the SMA not that long ago and they still, from my understanding, held that position. But I'm wondering what the SMA provided in terms of feedback for you.

[20:45]

Mr. Wyatt: — Sure. I believe that's also accurate to say that they still do have concerns, as they did previously, with the overall private-pay concept. In terms of the discussion around the regulations, there were a handful of specific issues that they raised. One was around whether community-based requests take into account the appropriateness criteria for CT and MRI.

And so certainly the SMA has been doing . . . certainly has an interest and has been involved in work that we are doing provincially around appropriateness for MRI testing and has been directly interested in the work that we're doing on appropriateness for MRI for lumbar spine imaging. And so they raised that question around whether there would be differences in the public and private systems, and the answer there would be no.

I think the work that we are doing around trying to ensure that the requisitions that are being sent forth for MRI, and certainly in the future CT as well, are meeting appropriateness criteria. And a lot of that work is based around this checklist that the minister had referenced in his opening remarks which is trying to limit the testing that is ordered for those specific indications where MR [magnetic resonance] or CT are the recognized . . . following the clinical guideline for diagnostic imaging for low back pain.

A second issue they discussed was around referring physicians and specifically around whether physicians outside of Saskatchewan, how this would apply to those physicians. And again that's not a regulatory . . . there is not an issue that would be addressed through the regulation per se; one really around clarifying how the requirement for the testing to be consistent with that physician's ordering privileges within their own region or their own area.

The next issue was around . . . it was a wording issue that was raised, and in some instances, there is reference to radiological images and others. They've expressed a preference for images as opposed to radiological images. Okay?

Ms. Chartier: — Okay.

Mr. Wyatt: — There was also discussion around some of the other potential modalities that might be included, including ultrasound or other diagnostic imaging testing.

Ms. Chartier: — They were asking what you were considering?

Mr. Wyatt: — Yes, and it looks like there was a specific interest around whether ultrasound would be included or not.

Ms. Chartier: — Did they elaborate on that?

Mr. Wyatt: — Just to bring a little bit more detail to that, the issue that they raised related to ultrasound facilities, or machines that are operated — could be by different operators, including sonographers — and I think the question around the regulation that applies to those types of facilities that right now are not licensed under *The Health Facilities Licensing Act*, they're not identified in *The Patient Choice Medical Imaging Act*, and so the question around whether that was something that would bring ultrasound facilities within some kind of regulatory framework.

Ms. Chartier: — And what's the response to that?

Mr. Wyatt: — I think as I mentioned before, at this time we are looking at MRI and the addition of CT, but we're not looking in the short term at introducing any other forms of imaging.

Ms. Chartier: — Okay. And that was the SMA's, that was the extent of the SMA's concerns?

Mr. Wyatt: — That's correct.

Ms. Chartier: — How about the Saskatchewan association of technologists or radiation — my handwriting here — I think it's radiation technologists. Or perhaps it was just technologists.

Mr. Wyatt: — The organization that I had previously mentioned is the Saskatchewan Association of Medical Radiation Technologists. They didn't have any concerns but did raise, I think, support or reinforcement for the requirement that the licensees would staff and employ members in good standing with their respective regulatory bodies. And currently the regulations are worded so that the medical director of each facility would be responsible for ensuring all staff are in good standing with their respective regulatory bodies.

Ms. Chartier: — Okay, thank you. How about the accreditation body, the College of Physicians and Surgeons?

Mr. Wyatt: — The main issue that the college raised was in relation to its own capacity in order to serve in that role as the accreditation program operator. We had those discussions with the college at the time that we introduced *The MRI Facilities Licensing Act*, confirmed that with them that we wished them to continue on as they had been under *The Health Facilities Licensing Act* to serve as the accreditation operator. They expressed the concern at that time around the potential that there may be a large number of facilities that would come on board and that they would have to arrange to have their own resources, or I think they've also used out-of-province accreditors in that role.

And I think we have been able to assure them, as evidenced by the fact that we've had two facilities licensed under *The MRI Facilities Licensing Act*, that, both of which were already licensed actually previously, that this is not a significant additional workload for them. And I think with the addition of CT, we do not expect a large number of new facilities to enter the marketplace overnight and would expect that, you know, they would come both in relatively small numbers and probably not immediately at the same time.

If we were to look at moving to, you know, something as common as X-ray, that with the hundreds of X-rays that exist in the province, that might, or potential for, I suppose, X-ray facilities in a larger number of communities, that might raise more of an issue in terms of the college's ability to accredit those facilities that's dealing with MRI and CT. We don't anticipate that this will create a significant burden for their organization.

Ms. Chartier: — Thank you. Do you have a sense . . . I'm going to stick on the consultation theme here. But just digressing here, have you on that note about having more potential organizations or businesses coming on board, have you had any applications or requests to expand these services elsewhere? Have any other companies approached the ministry about entering the marketplace?

Mr. Wyatt: — So I'll answer that in two ways. We have not

had any formal applications under *The Health Facilities Licensing Act* for CT facilities or other applications under *The MRI Facilities Licensing Act* aside from those that we have received and in fact licensed. We have had informal expressions of interest from different organizations who have inquired about a potential interest in providing either MRI or CT services.

Ms. Chartier: — Recent expressions of interest and how many?

Mr. Wyatt: — We have had, I'll say, a handful; I'll hazard a guess of fewer than five informal expressions of interest. Some have been recent. Some have been over the last number of months going back to probably the discussion around *The MRI Facilities Licensing Act*. And there have been a few staggered out during this period, and some had been more recent as well.

Ms. Chartier: — Okay. And just to double-check then, so Mayfair and Open Skies are just doing MRIs. Is that right?

Mr. Wyatt: — Yes, that's correct. They're both licensed for MRI and then Radiology Associates which is a partner organization, I'll say, with Open Skies co-located in Regina, is licensed for CT.

Ms. Chartier: — Okay, thank you. What did the private medical imaging providers — you said Mayfair and RAR both provided input — what did they ask about?

[21:00]

Mr. Wyatt: — There were a handful of issues identified by those providers. I'll summarize some of those points. One would be in relation to the issue we were discussing before around their ability to upload and download images from PACS and discussions with them obviously about their desire to be able to fully exchange images, both downloading and uploading, through the PACS system. And so some, I guess, discussion with both organizations around the progress of moving in that direction.

One of the issues that they raised was around the issue that is identified that requires all images to be referred by a physician. And there is difference . . . We've identified that different regions have different arrangements with their physicians in terms of who can order what types of scans. And so it's an interesting situation in the province where not all regions allow physicians to order the exact same kinds of tests, and something that I think we would agree is an opportunity for some more consistent approach in the province.

There was also discussion around . . . I'll just read directly. "It was noted that there is no definition for health professional and ask the ministry to elaborate on the definition of duly qualified medical practitioners." Sorry, I think that does come back to the same issue I had just mentioned around the difference in how physicians are privileged to order tests.

Ms. Chartier: — So they're looking for consistency across regions?

Mr. Wyatt: — I think that's right. I think they're looking for some better clarity in terms of what can be ordered by whom from the different regions in the province.

Ms. Chartier: — Could you give me an example of how that might look? Did they provide you any examples how that might look?

Mr. Wyatt: — We've looked at it. We've looked at it ourselves, and what you find is that in some regions, some family . . . The main issue is whether family physicians can order an MRI, for example. And so in some regions family physicians can order; in others regions they cannot. In some regions they can order for certain modalities if they have undertaken specific training. And so there really is kind of a range of different experiences in terms of how family doctors can refer for CT and MRI.

Ms. Chartier: — In speaking with the regions, what's the rationale in terms of the discrepancy between regions?

Mr. Wyatt: — I'm not sure that we can actually speak to the rationale. It looks like it is something that has evolved over time just differently in different regions, probably based on issues around the medical leadership in those regions. It would be . . . I'm just looking to give you some other examples to try and illustrate the situation. In some of the northern regions, family physicians and nurse practitioners can order a CT without contrast medium but apparently not with contrast medium. So I think it may be sort of an assessment of what, I guess, the level of diagnostic imaging that's being required. Something that is more basic, they might be allowing their GPs to order. Something more complex, they are putting that restriction in place.

Ms. Chartier: — Okay. And were there other issues that the providers had identified?

Mr. Wyatt: — There's one other issue that did come up in discussions and that was around . . . similar to the discussion we'd have had with Regina Qu'Appelle Health Region on the other side of this transaction which was around trying to look for ways that we could make the processes simple and as streamlined as possible. Both of the facilities would have had some experience now having worked with it under *The MRI Facilities Licensing Act*, and I think an ongoing interest in trying to just refine and improve that process.

Ms. Chartier: — Did they identify anything in particular?

Mr. Wyatt: — Nothing really specific that I can, I guess, describe to the committee. I think part of it comes back to the issue around, from their perspective, trying to simplify the uploading and downloading process. That certainly enters into the process and how seamlessly it works with the rest of the system.

You know, discussions around the exchange of patients and how they receive them from the region and how they're moving those names into, you know, on to contacting them. And really I think it's just kind of the day-to-day working relationship with the individuals that they are interacting with in the region. And it wasn't that there was a concern around the relationship but really more from a process perspective, trying to make it as administratively simple and streamlined as they could.

Ms. Chartier: — Okay, thank you. So the downloading piece would happen on . . . So obviously I understand the uploading piece — to the region, to the specialist, to whomever ordered the MRI or the CT scan. The private providers need to download . . .

Mr. Wyatt: — Right. So if a radiologist is looking at an image that they have just taken by MRI, if they wanted to be able to compare it to previous images that might have been taken with the same patient and be able to compare with another past image to see if there's been any change, there is a cumbersome way, and it comes back to what we were talking about around the cost. There's a more cumbersome way for them to access those images, but they're trying to identify a more seamless way for them to do that and be able to make that comparison of the two images.

Ms. Chartier: — Okay, thank you for that. And just in terms of the Information and Privacy Commissioner, what did he flag as concerns?

Mr. Wyatt: — So the Information and Privacy Commissioner has offered his thoughts around a change or wording for the regulations, and they pertain to the terms and conditions for the licensee. And just to continue with that answer, the objective for his recommendation is an amendment to ensure that the information management service provider understands and complies with the requirements of HIPA [*The Health Information Protection Act*].

Ms. Chartier: — So he's asked for an amendment?

Mr. Wyatt: — He suggested language that would go into the regulations. We have existing wording in the regulations right now related to the health information privacy Act, and I think he has suggested something that more clearly has expressed, ensures that the provider understands and complies with those requirements.

Ms. Chartier: — Okay.

Mr. Wyatt: — So it's something that we're, something . . . I guess that is the purpose for the consultations is to identify if there are recommendations or suggestions, and something that we are looking at and considering as we are in the process of developing those regulations.

Ms. Chartier: — Okay. I thank you for that. And the Cancer Agency, what did they talk to you about?

Mr. Wyatt: — The Cancer Agency raised concerns regarding the length of time, which is six years, that operators are required to keep an imaging record of a scan. They would prefer to see that . . . They would prefer this provision be reviewed in the context of oncology best practice to ensure six years is sufficient for oncology cases where physicians may want to regularly refer to past images.

Ms. Chartier: — As it stands now, so it's six years; that's the expectation of the private organizations. In the public system, how long do we keep images?

Mr. Wyatt: — With the introduction of PACS, images are being kept permanently and so right now, for most of the province excepting those small number of sites that haven't yet been moved on to PACS as part of that implementation, the records will be kept permanently. And as we move to having the private providers upload their facility, or sorry, upload their images to PACS, it will put them in the same position. So I think that should address the Cancer Agency concern.

Ms. Chartier: — Okay. Thank you for that. And the last organization you said, Labour Relations, who are the . . . My scroll here isn't great. It's at Labour Relations is what I've got for the last stakeholder.

Mr. Wyatt: — Yes, the Ministry of Labour Relations and workplace . . . the safety, radiation safety unit within occupational health and safety. I'm just going to seek an interpretation of the notes I have on that one.

[21:15]

Okay so in discussion with the Ministry of Labour Relations and Workplace Safety, they've identified that there are differences in *The Saskatchewan Employment Act* and *The Radiation Health and Safety Regulations* between MRI, which doesn't involve radiation for the patient, and CT, which has ionizing radiation. And so the issue they've raised is whether we need to do anything in our regulations to, I guess, to align and interact with those provincial regulations, workplace safety regulations dealing with CT radiation. That's a discussion that we'll be following up to determine if it is something that enters into our regulations or whether it's sufficiently handled through the workplace safety labour regulations.

Ms. Chartier: — Okay. Thank you for that. Moving on here, in terms of what's happened thus far with the private MRIs at Mayfair and Open Skies, who is reading, which radiologists are reading these? Are the radiologists here in Saskatchewan or elsewhere?

Mr. Wyatt: — So one of the provisions in the current MRI facilities licensing regulations and one that we would expect would carry over to the patient choice medical imaging regulations is that:

> all physicians who provide or assist in providing MRI services are duly qualified medical practitioners and meet any requirements for those services set by the College of Physicians and Surgeons for the Province of Saskatchewan for physicians to provide services in MRI facilities.

The other requirement is that facilities have a medical director who is also licensed in the province and I believe privileged within the . . . privileged in the region in which they're operating. Having said that, that doesn't necessarily mean that all of the radiologists who are interpreting scans are located in the province. It is possible to be licensed in the province and working from a different location.

Ms. Chartier: — Okay. So the medical director who's licensed in the province and privileged in the region, how often is that laid out in the legislation that he or she needs to be on site?

Mr. Wyatt: — I believe it's in the regulations . . . Again

referencing *The MRI Facilities Licensing Regulations*, there is a requirement, section 5(1), that "a licensee shall ensure that MRI services provided in an MRI facility are under the continuous supervision of a medical director." How that is defined and the requirements in terms of meeting the expectation of continuous supervision would be something that would be part of the accreditation process through the College of Physicians and Surgeons and that detail is not specified in the regulation but something that would be addressed through the accreditation of the facility.

Ms. Chartier: — Do we know what that looks like? So it's not in the regulations, but do we know what the College of Physicians and Surgeons around accreditation has said continuous supervision looks like?

Mr. Wyatt: — We don't have that information here, no.

Ms. Chartier: — Could you provide it to the committee along with the other information?

Mr. Wyatt: — We can certainly follow up with the college and see if that information can be shared with us, yes.

Ms. Chartier: — That would be very good. Thank you. So you'd given me the two points around the medical director needing to be licensed and privileged here and that the docs who work, the radiologists who work there need to meet the requirements but pointed out some radiologists, you don't have to be in the province to be providing the scan. So I'm wondering how many, how many of the scans were read by radiologists outside of Saskatchewan?

Mr. Wyatt: — That's not information that we would have as the ministry. It would be based on the service model that is developed by the facility. And I guess the number of images that are read in-province or potentially by out-of-province radiologists is I guess not something that the ministry is tracking.

Ms. Chartier: — Have you had any complaints or concerns around physicians trying to work with radiologists in private clinics or who happen to be reading scans out of province?

Mr. Wyatt: — Nothing has been raised with the ministry in terms of a concern around the radiologists working through the privately licensed facilities. That's not to say that something . . . A concern may have been brought to the medical director of one of those facilities. That's certainly a possibility. If there was a concern, it would likely be the first place that such a concern might be raised would be with the medical director as a clinical issue involving physicians, but we're not aware of any concerns coming to our attention.

Ms. Chartier: — How if it's being . . . if the first point of contact would be the medical director, are you following up at all with . . . So I think that what I hear you saying is there are radiologists who are reading scans outside of the province. You don't have numbers, but that what I'm hearing you say.

Mr. Wyatt: — I can't confirm whether that's happening. Our understanding is that one of the facilities does not have a large number of Saskatchewan-based radiologists so I think it is reasonable to expect that scans are being interpreted outside of the province. But I can't confirm that and I can't speak to, if it is happening, the extent to which that's happening.

If we could just add that, in terms of the concern being brought to a medical director, that would happen on a regular basis within the health region, within the public system. You know, generally speaking there are times when a family physician may have a concern with a specialist or another specialist may have a concern with a colleague. Those kinds of issues enter the medical community and they enter within the public health system, within the regional health authority system. That's why the medical directors and the section heads in all of the specialty areas earn their pay throughout the year, and so it's commonplace.

So when I say that that's a possibility that that's occurred, I have no knowledge one way or the other if it has. It is just observing that there are times when concerns are raised with an administrative physician leader, and I would expect that that would be the course of action here as well.

Ms. Chartier: — Thank you. So for the one private provider who you said who doesn't have very many in-province radiologists, how many do they have? Obviously the medical director.

Mr. Wyatt: — So with respect to the number of radiologists located in the province, I can't confirm the number that that organization has working in the province. One thing that we would observe is they do have relationships with radiologists that have subspecialties. And so certainly there is a valid reason why they would at times seek an interpretation from outside the province in order to tap into that subspecialty that they may not have access to otherwise.

[21:30]

The other comment I would make is that the idea of having images read outside of the location where the facility is located is becoming very commonplace. And so we have within Saskatchewan arrangements where you have radiologists who are based in Regina or Saskatoon providing, at a distance, interpretations for CT scans or other diagnostics being done in Prince Albert. You have relationships between Regina firms and regional health authorities right across southern Saskatchewan.

And so the idea . . . I mean it is one of the features of radiology, is you have the ability to now transmit those images to great distances. And so whether it's from Swift Current to Regina or from Calgary to Regina, the process is similar. We are now moving into a time when it's not essential that the person interpreting the image be based on site. In fact even within Regina, the radiologists will tell you that a lot of the work that they do is from home, from the beach, and they're certainly not tied to their offices or the hospital anymore as it might have been in years past.

Ms. Chartier: — For sure, technology is a wonderful thing. But I think it's not so much where it's being read; it's about the accessibility of the people doing the reading. So one of the things that has been flagged as a concern for me is the

accessibility of out-of-province radiologists doing the reading, the ability for physicians here to work well with . . . I'm letting you know that if it hasn't come across your desk, it has come across mine. So that might be worth some follow-up, that that is something that's happening.

Mr. Wyatt: — I take note of that, and I would just say I think it is an issue then in any circumstance where you don't have that face-to-face relationship with a colleague. And so in the past where the family physicians might have known the specialists working or the radiologists working in Regina, now again as we look at expanded use of distance interpretation and also with the turnover that occurs in the family practice and the specialist world, I think there are probably many circumstances — not just pertaining to private facilities, but entirely within the public system — where you have family practitioners who don't have that same relationship with a GP and are cold-calling the office, which may be the situation as they are trying to make contact with the radiologists in one of the private facilities.

Hon. Mr. Ottenbreit: — If I may, Ms. Chartier, I haven't personally heard of a case like that either. But if you could provide that information, the contact information, if you'd like we could follow up and get the specific information.

Ms. Chartier: — I will do that. I will certainly do that. After the committee I will certainly do that.

With respect to this bill in particular, it opens up the expansion of private-pay diagnostics, past CTs and MRIs. And obviously in the election one of the things that was on the table, you'd already done MRIs and added CTs and were very public about it. And I think you've made it clear that that's not something that's on the table right now, so why include it? I know you've said in the short term there's no plan to include any other diagnostics.

Hon. Mr. Reiter: — That would be . . . As you said, there's no plans to do that right now, but we're certainly not ruling out considering something like that at some point down the road.

Ms. Chartier: — I would ask you why you wouldn't bring . . . Obviously when we walked through some of the concerns from some of the stakeholders, there were some concerns flagged around other diagnostics, X-rays, around the College of Physicians and Surgeons having some concerns about their ability to continue to do accreditation, or I believe SMA had some concerns around ultrasounds. So obviously when it becomes more difficult . . . or it becomes much more easier when something's prescribed in regulations to change without meaningful consultation. And so I'm wondering why you've included that at this point in time if there's no intention on going there.

Hon. Mr. Reiter: — It would be simply for the reason you said. It would be easier to change if it's in regulation, but we certainly wouldn't do that without meaningful consultation. We would have consultation with all key stakeholders, as is the normal course.

Ms. Chartier: — What are some of the possibilities that are opened up by the wording in the legislation?

Hon. Mr. Reiter: — Again, there's no plans for anything at this point. So it would be hypothetical for me to start surmising.

Ms. Chartier: — But obviously it's in the bill. And when you put something in the bill it may be hypothetical, but it's in the bill for a reason. Otherwise we should just take it out of the bill. So I'm wondering what are . . . So obviously there have been some discussions along the way about what some of those other diagnostics might be.

Hon. Mr. Reiter: — It's in the bill for the reason we said a few minutes ago, that if we ever did venture down that road that, for ease, but again I can assure you we wouldn't do that in a knee-jerk way. We would do full on, thorough consultations.

Ms. Chartier: — Well I'm glad to hear you wouldn't do it in a knee-jerk way, but I'm wondering what is considered in that, or could be considered under those diagnostics?

Hon. Mr. Reiter: — It's very difficult to answer that question because, you know, as we look down the road we don't know what wait times would be for specific modalities. And we also don't know . . . As technology changes, different types of modalities get added, so it's very difficult to answer that question.

Ms. Chartier: — Have there been any requests for other pay diagnostics? Like, we talked about CT scans, some informal discussions. Has there been any organizations or individuals asking about the provision of other diagnostics?

Hon. Mr. Reiter: — I'm seeing a lot officials shaking their heads, so I don't believe so.

Ms. Chartier: — I think I heard, not with the introduction of the bill. Has there been in recent time anyone approaching the government either informally or formally?

Mr. Wyatt: — We've had one inquiry about bone mineral densitometry, but that would date back three to five years ago. So nothing in recent months or even years.

Ms. Chartier: — Okay. So sorry, bone . . . can you say that one more time?

Mr. Wyatt: — Bone mineral densitometry.

Ms. Chartier: — Okay. I'm not familiar with that . . . [inaudible interjection] . . . Bone density tests. Okay, thank you. All right, this is just looking to . . . Oh you know what? Actually before I go there, I'm just going to look at the clock here. In terms of talking, you had just mentioned wait times and not knowing what wait times may or may not be down the road. Has anybody, has the ministry, sorry, done any analysis since the bill, the first bill was introduced around wait times? Has there been any analysis?

Hon. Mr. Reiter: — Wait times for?

Ms. Chartier: — For MRIs.

Hon. Mr. Reiter: — There has been analysis done by the ministry, and I'll just get Mark to . . . And of course it's in its

infancy, right? I mean that's going to continue as we go, but I'll get Mark to walk through what we have to date.

Mr. Wyatt: — So taking the time frame from March 31st, so end of the last fiscal, until July 31st which is when we have our most recent information for wait times, the combined number of patients waiting for MRI at the three locations — Regina, Saskatoon, and Moose Jaw — has decreased from approximately 6,912 to 6,181 patients waiting.

This would coincide pretty closely to the onset of the private-pay, but I would also observe there are other factors happening in the province. So the addition of the Moose Jaw MRI, and I would like to hope that some of the impact of the appropriateness work that we're doing — those things will all factor into changes. You may also have other things driving demand within the system and so, as we're doing that analysis, we'll certainly be looking at the number of the patients who are receiving their first scan, the second scan, but we also need to look at all of the things happening in the provincial environment.

Ms. Chartier: — Which I might add, depending on what Saskatoon's doing around extended hours and how long, I'd be curious to know how that all factors in as well and how long they've been doing their extended hours.

With respect to looking at CT scans, I'm looking right now just in Saskatchewan from the period of April 2015 to June 2016, there's some pretty big fluctuations between, well February 2016 to June 2016. I don't know if you have . . . these are the most recent . . . So for example, in February, between February . . . And well, that would be March. From March 2016, we're at about 50 days waited for the 90th percentile, and then in April it goes up to close to 65 and in May it drops. Do you have any analysis on why there'd be such a fluctuation between those months?

[21:45]

Mr. Wyatt: — So in answering as to why we've seen fluctuation from month to month in the province related to CT, I believe was the form that you were looking for, there've been I guess a few things happening. And over the course of this year we've had the introduction of the Estevan CT site. We have seen definite pressure in the central northern parts of the province, and so certainly Saskatoon and P.A. [Prince Albert] would be the place where we've seen some off-setting kind of addition to the wait-lists.

In Regina Qu'Appelle they've had some issues that they've been working on around . . . They've actually had some data equality issues and making sure that patients are actually being removed from the wait-list when their scan is completed. And so you may, in Regina's case, you may see times where their wait-list is growing and then there's a more rapid decrease as they've actually identified patients who've had their scans previously but are only removing them from the wait-list. And so that's been a, I guess, an issue that has surfaced in Regina through the course of this year. I believe we've now got it in hand in Regina.

Overall, just looking at the province in terms of patients booked for CT, April to July of 2015, 37,231 patients booked compared to this year, 38,289. So an increase of 1,058 patients. So we have seen, we have seen increases in the total number of patients booked. But as I mentioned, different locations will experience different supply-demand issues.

Ms. Chartier: — Okay. I think you answered my question around RQHR with the big drop in June, mid-way through, or July of 2016 would have been the people being removed from the wait-lists . . . Sorry, Mark. Sorry.

Mr. Wyatt: — I'm sorry, I have one more . . . I have one more point I can raise around your last question and then maybe ask you to repeat the subsequent question. The other thing that we see with a lot of services, whether it's diagnostic imaging or surgery, is you have times of the year where you have surges and slowdowns, and so summer and Christmas. You can count on your wait times growing during the summer months, growing during over the winter season. You can take it right down to the February break week and a 28-day week in February sometimes, and see that your wait-lists will grow during a month when you have fewer kind of high-working days or full-working days. And so that's the other thing that really impacts on a lot of the fluctuation that we see on scheduled services is just accommodating vacation during those seasons.

Ms. Chartier: — Well I think you'd answered my question about the drop in July of 2016. The rapid drop would have been in RQHR people being taken off the wait-list?

Mr. Wyatt: — That would correspond with the time when I think they had resolved some of the . . . That would be around the time that they started changing their processes, and so it may have led to some more dramatic surges or changes in their wait times.

Ms. Chartier: — Okay, I'm looking at . . . I'm just trying to find Saskatoon here. So the 90th percentile in RQHR is significantly higher than in the Saskatoon Health Region. I'm just wondering what's going on between the two regions there, where from February 2015, the 90th percentile . . . just going to make sure I'm comparing. So the data I've got from Saskatoon Health Region is February 2015, August 2015, February 2016. So February 2016 in RQHR the 90th percentile is at almost 80 days, and February of 2016 in Saskatoon it's just above 60. So what would be the difference do you think there?

Mr. Wyatt: — Again, we're talking about CT?

Ms. Chartier: — Yes, sorry. Yes.

Mr. Wyatt: — I think at the end result of that, our conclusion is we need to do some follow-up to look at what the factors would be related to, I think, to confirm what we see in Regina which is sort of the wait time for CTs sitting at a higher level with that dramatic, I think, a sharper decline, and whether that is just returning to probably what is the closer reflection to the reality of their wait time based on some of the data issues.

Saskatoon has, we know, has been experiencing a more gradual increase in their wait time, and it looks like a more consistent line that is consistent with what we would know around some of

the pressures that we've been seeing in both Saskatoon and Prince Albert as well. And I think that is consistent with the experience that we would, you know, that we would share with our colleagues in those regions about what they're seeing is higher demand and higher wait times coming through the regions. Beyond that, I think we'd have to just take a deeper look at what some of the underlying causes are.

Ms. Chartier: — Okay. I'd be interested . . . Obviously we'll have an opportunity in committee again here next spring, and so I'd be interested in maybe delving into that a little bit more deeply at that point.

Mr. Minister, in your opening comments you talked a little bit about appropriateness. And my notes, I didn't take notes quite as quickly as I should have, but can you tell me a little bit about the appropriateness work that the ministry is doing?

Hon. Mr. Reiter: — My deputy minister just referred to Mark as the appropriateness guru, so I think I'll let him delve into that for us.

Ms. Chartier: — Perfect.

Mr. Wyatt: — Okay. So I'll maybe just touch very briefly on the appropriateness work that we're doing more broadly and then focus in on what's happening specifically to imaging.

Starting with the appropriateness of care, we've developed a provincial framework for how we would address clinical appropriateness issues. We've been working on a number of different projects over the past, I'd say, five years, some focusing on surgery and others looking in working in different areas of the system. We've now developed this framework and really used the project around the appropriateness of MRI exams for low back pain, for lumbar spine, as the model or as the pilot for this framework approach. And so with that, we've brought together a group of clinicians — both radiologists, family physicians — we've brought them together with regional health authority folks. We have physicians who are working with us as the provincial leads on all of our appropriateness work, and also bringing in the Health Quality Council and some of the data support and analytical support that they can bring to the project.

Where that took us was identifying that when you look at the clinical indications for MRI for low back pain, they identified a number of images that were not consistent with what would be considered to be the clinical indication for the use of MRI. If you've heard of the Choosing Wisely project, I guess beginning in the United States, now it's moved to Canada. This is really similar to what Choosing Wisely and many of the specialty groups are doing, which is identifying procedures that are at times used inappropriately because they are either a test or a treatment that is ordered without having the proper clinical indication. So that's the approach we've taken.

The next step was to determine what we could do about it, and where they landed on was the development of a checklist. And so now when . . . Anyone who is ordering an MRI for lumbar spine has to complete the checklist, which takes you through some of the standard demographic information about the patient, and then whether they meet any of the three general areas for receiving an MRI for low back pain.

And so the first grouping is what they call red flags. And so if you have for example a history of cancer or unexplained weight loss, that might be a red flag. Combined with low back pain, that would justify or support a requisition for MRI. There are others that fall under the red flag category, and these are generally developed by the clinicians. I can't remember in this case whether they were working directly from the Choosing Wisely red flag list, but this is certainly one of the areas that has been identified by Choosing Wisely. Other red flags might be the patient is immunocompromised or an IV [intravenous] drug user. There are some other very specific clinical indications.

The second is a grouping around the form of back pain, the mechanical back pain. And not all back pain is likely to generate any result using MRI as the diagnostic tool. So it specifically indicates, for example, low back pain for at least three months in someone who has pattern 1 or pattern 2 back pain, and there are different patterns in the way that back pain presents itself that lend themselves to different diagnostic testing.

The third grouping is suspected or known conditions, and so if you have scoliosis, spinal cord lesion, prior back surgery, intradural tumour. There's I guess a dozen different specific clinical conditions that are identified. So basically the idea is there's a lot of low back pain that doesn't meet any of these either existing conditions or the specific type and presentation that would justify undertaking an MRI. And so with the imposition of, or with the introduction of this checklist, what it's doing is basically ensuring that anyone who is ordering a test is doing so, is following the appropriate clinical guideline in using MRI.

[22:00]

Interestingly — and I can speak to the results that we've seen from that — interestingly, the next thing that they looked at was then the use of . . . So if you're not using MRI, CT is actually, has an even lesser indication for lumbar pain. And so the next project they're undertaking is really a similar dive into how is CT being used. And in the case of CT, knowing that it's associated with radiation whereas MRI isn't, it's not as harmless to the patient as ordering an inappropriate MRI when you're now exposing the patient to radiation.

What I can tell you is that since the checklist was introduced, we've seen a reduction in both the number of requisitions and the number of scans actually performed. And so for example, in Regina Qu'Appelle from January to . . . If we look at the period from January to August in 2015 and then look at that same period from January to August in 2016, the number of requisitions for lumbar pain has reduced by 40 per cent. In Saskatoon, the reduction is 17 per cent. Five Hills was slower coming on board, and so the change there is not available.

But what we're seeing is year-over-year reductions in both Regina and Saskatoon in what clinically is recognized to be unnecessary or inappropriate use of MRI. And the next step will be to take on CT as well.

Ms. Chartier: — Thank you for that, and that sounds like some

very good work. So you focused, you've said now you'll work on . . . So all docs then . . . Help me understand this then. How do you flow that checklist out to everybody who needs to use that checklist? So you work with all these stakeholders and develop . . . You've got a provincial framework and then develop this project around MRIs in the lower back. And so how do you get that out to everybody?

Mr. Wyatt: — The first step usually with any project like this is to test it in one location. And so we tested it in Saskatoon and, not surprisingly, when you first introduce something you get a lot of requisitions coming back without the checklist. So then you start to follow up with their office, let them know that this checklist is now being . . . Usually it's provided in a way that they can try and remember whether this one is accessible through their electronic medical record or not. I have to follow up on that question. But ideally, it would be something that's, you know, easily accessed along with their referral forms.

So we worked with the docs in Saskatoon until we got I guess most of the requisitions coming in, and at that point moved it to Regina. The next was to move it to Moose Jaw. And really what you're targeting is, it's really the catchment area and trying to get all of the family docs, the family physicians and specialists who are referring for whatever the form of imaging is, to begin using this new form.

It goes through a process, not unlike any . . . Certainly physicians will tell you they have too many forms already, but it's not unlike the introduction of any form where you make it available through the SMA. You blast it out through the region and it goes out through those usual channels in order to first create the awareness and then, in some cases, there's this follow-up with specific offices to . . . You reach a point where you say, we will no longer actually accept the referral without the checklist. And I think we're there now, I believe, in both Regina and Saskatoon. And Moose Jaw is either not yet mandatory or maybe recently they've made it mandatory before they will accept the requisition for their MRI.

Ms. Chartier: — Well thank you. So out of that provincial framework then, so the MRI for lower back, and then you're going to work on the CT scans for the lower back. And where else do you see that going?

Mr. Wyatt: — We don't have any specific other imaging projects in mind, but we have identified, provincially, preoperative testing because there are a lot of low-risk procedures that don't require the full preoperative workup that might be associated with more significant surgeries. And so that's another kind of widely recognized case of overuse within the system.

The other thing that we see this going, frankly, is moving from these big provincial projects to trying to roll this out more broadly into the practice groups right across the province. So the other thing that we've done is create an appropriateness of care network that has a physician lead, an administrative lead, and a quality improvement lead in each of the regions, that we've brought together from across the province.

And we will be also training, working with the SMA and the Health Quality Council, training physicians on how to lead clinical improvement projects. So that's an area where there is some funding available through the SMA that's supporting both doctors who want to take this on in a bigger way.

We have sent some physicians to the Intermountain system in Utah which has a lengthy experience in training physicians and then having them lead quality improvement appropriateness and patient safety-type projects. We're using this . . . Based on having sent some physicians to that Intermountain program, we are now offering a kind of a comparable clinical training program here in Saskatchewan and then probably a scaled-down version that will work with physicians who don't want to go through the full extent of that project.

And so the idea is really to make appropriateness the way we do business in the province and to look to every specialty group in a particular area to all be working on something related to clinical appropriateness or clinical quality. Regina Qu'Appelle has already kind of rolled this out with many of their specialists. They have an appropriateness wall in the region where they report on the various appropriateness projects that they are leading in the region.

And that's probably the first glimpse of what we see as the future, where every region in the province, and family physicians too because as we've talked about today with ordering lab tests, is another area where there's a lot of opportunity to look at a lot of those check boxes in the blue lab requisition form, and whether they all need to be checked off for every patient. And so those are some of the areas that we want to take on, both in the family physician world and the specialist world, and as I said, move from just doing these big provincial projects to having a combination of those that would be led at a more provincial level, but also trying to get down to this as the way we do business right across the province.

Ms. Chartier: — Thank you for that explanation. I know that we're all sort of winding down here. Just a few more questions here. I understand a few months ago that your ministry received some correspondence from the federal government actually, the federal ministry of Health, around the *Canada Health Act* and compliance. I'm wondering sort of your response to that.

Hon. Mr. Reiter: — I'm not sure what correspondence you'd be referring to a few months ago about . . .

Ms. Chartier: — It predated you in that role.

Hon. Mr. Reiter: — Okay. None of the ministry officials are aware of what that would be. Can you elaborate?

Ms. Chartier: — You've not received any correspondence from the federal Ministry of Health regarding compliance around the *Canada Health Act* and . . .

Hon. Mr. Reiter: — We did, just in the last week or so. So I just wanted to make sure it wasn't something different you were talking about. But we did, addressed to me like I said, in the last week or so.

Ms. Chartier: — And what did that letter say?

Hon. Mr. Reiter: — I think it would be fair to say it's from the

federal minister addressed to me. And I think it would be fair to say that they wish we weren't doing this, the, you know, private-pay diagnostics, and that she would have officials from Health Canada reach out to our officials to discuss it. But I don't believe that's occurred yet. No, it hasn't.

Ms. Chartier: — No. So you don't have any sense . . . Did she flag that some of our health transfers could be put at risk from not complying with the *Canada Health Act*?

Hon. Mr. Reiter: — If memory serves I think there's a reference to sort of any actions any province does, if it was deemed to not be in compliance with the health Act, a dollar-for-dollar clawback could be enacted. But it also referenced that she'd prefer not to do that and she'd have officials reach out to have discussions with our officials on it.

You know, on that point, I guess I would just, you know, add to it. We have a situation in this country where, since I think it was 1993, you have both Alberta and BC [British Columbia] doing I think private MRIs and CT scans. You have Quebec doing it since 1997. The 1993 ones, those two provinces, that would go through, you know, I guess the politics of it, that would have went through a Liberal government federally, a Conservative government, now back to a Liberal government. You have Nova Scotia — forgive me, I don't remember the year, a little bit more recent but still some number of years ago — doing something similar. And in this case, you have a province that's doing it with a two-for-one to, in my view, be much more benefit to the public system and the public wait-list.

So certainly if the federal minister wants to discuss it, we'll certainly have the discussion. We don't believe that we're violating the *Canada Health Act*, but obviously I'll discuss any issues with her. So we'll see where the discussions go. She asked for it to be discussed first at the officials level.

Ms. Chartier: — Okay. I'm curious just around your thoughts on how it doesn't violate the *Canada Health Act*. Just looking at a briefing note actually through FOI [freedom of information] for MRI for the previous piece of legislation that we're repealing, so third party delivery of insured health services is permitted under the *Canada Health Act* as long as the services are publicly funded and administered and that the patient is not charged any additional cost in relation to the services provided.

And going on here:

> The Act defines user charges as any charge for an insured health service other than extra-billing . . . User charges are not permitted under the Act because, as is the case with extra-billing, they constitute a barrier or impediment to access.

So I understand that you don't believe that we're violating the *Canada Health Act*, but I'm wondering your rationale for that.

[22:15]

Hon. Mr. Reiter: — I guess there's several points to this, two key ones to answer your question. I'll do the first one; then I'm going to defer to Mark in the second one. And then I think I'd like to give kind of more of an overview again when Mark's done.

First one, I guess I would point to is what I alluded to in my earlier answer, is just simply that you have, for close to 25 years now — 23, 24 years — a number of provinces that have been doing this, have been allowing this service be provided. And to our knowledge, at no point in time has a federal government ever initiated any sort of a clawback with this. So you know, I think that by its very nature, all those years through more than one administration, I think that in my view — and in I think most of our views — that shows some sort of agreement with compliance.

There's also a grey area that we should delve into as well, and I'm just going to get Mark to elaborate on that.

Mr. Wyatt: — I guess in following the debate over private health care, privately funded health care and the *Canada Health Act* over a number of years, I think it's been fairly clearly understood that with respect to a service like surgery, that it is considered by the federal government and many others to be outside of, to be in violation of the *Canada Health Act* if you are imposing fees for that service.

In looking at the reductions in transfer payments that have occurred in British Columbia, they have been directly related to surgical services. In looking at reductions related to some of the Maritime provinces, where I believe it was related to abortion services that were, termination services that were being provided in private clinics on a paid basis, they did relate to a procedure that would otherwise be performed in a hospital.

In that debate around medical imaging, there has been less, I guess, less clarity and more debate as to whether it fully meets the letter of the *Canada Health Act* because it is not . . . at least where it is not performed in hospital but in a community setting. There is, I think, two sides to the question as to whether that fully complies or fully is interpreted in the same way as surgery and I think maybe leads to, I guess we could only speculate, but certainly we can observe that there is a different treatment when it comes to medical imaging as opposed to other forms of either payment for surgery or in the case I believe in Alberta years ago where they were just simply charging kind of facility fees and user fees more broadly. And so those have resulted in clear response with the withholding of transfer payments.

And MRI, CT private-pay facilities have operated, as the minister mentioned, for over 20 years, and I think in an environment with a lot more questioning as to where it falls, and clearly the experience to date has been that there has been no withholding of transfer payments related to those facilities.

Hon. Mr. Reiter: — I guess I would just add, what we're doing here, we're trying to be pragmatic. You know, just recently I reread a news story from some months ago, I think shortly after the MRI bill was first introduced, I think it was. You were quoted in the news story, Minister Duncan was, and it was either the *StarPhoenix* or *Leader-Post* or both, I believe. But the story started out talking about a gentleman who took his daughter to Calgary for an MRI. You might remember the story. And you know, the gist of it was, he was saying if he realized that this bill was coming, he'd have waited and he'd have preferred to have it

done here.

So the reason I raise that is because simply it was happening anyway. People were leaving the province to go to another province or go out of country to the US [United States] to get the MRIs done, and it wasn't doing anything to help our public system. It wasn't reducing our wait-list. What these bills have done is it allows a benefit to our wait-list because we get one in the public system done and people, our citizens, have the option of doing it in Saskatchewan as opposed to doing it in Alberta or BC or somewhere out of country.

Ms. Chartier: — Well just with all due respect, I think the rationale that it was happening elsewhere isn't a good . . . it was happening anyway isn't a good reason to take a path that the SMA and many people have said that the whole premise of medicare is that you should have access to service based on need, not on your ability to pay.

I think about the work that Mark just talked about around appropriateness and thinking about where you could double down. Maybe double down on that appropriateness work. Perhaps double down on those extended hours. We have a list of services who aren't operating at the fullest capacity. So I think that there are opportunities. Nobody wants wait-lists. Nobody wants a loved one on a wait-list where there is uncertainty and stress and anxiety. So I think we agree on that, that it's definitely worthwhile to ensure that we're addressing wait-lists. But I think we have two very different ideas about how that could be done.

But you've talked about since the '90s there's not been a minister of Health . . . or clawbacks around this kind of thing. But you have a federal minister who has now sent you a letter, which I actually would ask you if you could possibly table that with the committee. But I'm going to speculate that other jurisdictions that do private diagnostics probably got a similar letter. So just because it hasn't happened before doesn't mean it can't happen, and I would be concerned that this would be putting our transfer dollars at risk. But I know for the MRI bill, I asked this a year ago if there was a legal opinion, and there hadn't been a formal legal opinion sought around whether or not we were in contravention to the *Canada Health Act*. I'm wondering if the ministry and if you endeavoured to seek a legal opinion on this one as well.

The Chair: — I'll just take a second here, Mr. Minister. You may table that letter if you wish, but you do not have to because you did not read from it.

Hon. Mr. Ottenbreit: — While they're getting that information, Ms. Chartier, I just want to disagree with you on the point you made previous about access to MRI and going out of province. Reason being, I recently received a letter from a business operator who had lost his operator certificate because of a perceived problem, probably a circulatory system problem. He felt it was a poisoning issue. And if he wouldn't have got his diagnostic imaging done very quickly, it would have shut his business down for a number of four, five, six months until he got that scan done. He was able to get one done quickly, privately, and get his business up and operating again.

So if you want to talk about economic impact, to a gentleman like that, a company that employs probably a half dozen people or so, would effectively have to shut down his company waiting for diagnostic imaging, when with this availability in the province he's able to do it very quickly and get his business back up and running within a number of weeks or months. So I mean there is definite benefits to this.

Ms. Chartier: — To quick access? Oh definitely. When you need access to service you should be given access to service. There is no doubt about that. But it should be access based on need, not on ability to pay. What about another individual in this very same circumstance who doesn't have the wallet and the ability to purchase a private MRI?

Hon. Mr. Reiter: — So after discussing with the officials, there was advice. Our officials were seeking advice from Justice all along the way — the drafting of the last bill, drafting of this bill. And the advice I've just gotten now is that we, in advance of discussions with the federal officials, we shouldn't be publicly, I guess, displaying what our legal advice has been.

Ms. Chartier: — Okay. Would you be able to table the letter from the minister?

Hon. Mr. Reiter: — I only received it recently, like as in the last week or so, and haven't responded to it yet. So you know I may in due course, but I won't be tabling it right now.

Ms. Chartier: — Okay. Thank you for that. I think that is the extent of my questions tonight. I just want to let you know that, through the reading of the bill, I will be moving an amendment based on some of the conversations we had. It'll be regarding clause 2. So just to give you a heads-up about that. So when we get to clause 2, I'll be moving an amendment to remove everything after . . . Well I will read it when we get there . . . [inaudible].

The Chair: — Ms. Chartier, if you would, you could pass on a copy of your amendment to the Clerk for her preparation to carry on.

At the present time, it is approaching the hour of 10:30 when we are scheduled to adjourn, so if someone would move that we adjourn . . . [inaudible interjection] . . . I don't believe you're ready to vote the bill, are you? If you want to, we can certainly vote it, but I didn't . . . [inaudible interjections] . . . Oh, okay.

[22:30]

Okay, we will now consider . . . We already did that part. Are there any other questions from any members? If not, we will proceed with the voting. Clause 1, does the committee agree?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 1 agreed to.]

Clause 2

The Chair: — Clause 2. Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. I would like to move an amendment:

Amend Clause 2 of the printed Bill

in the definition of "medical imaging services" by deleting all the words after "computerized tomography services."

The Chair: — Okay. What the member is moving is:

Amend Clause 2 of the printed bill

in the definition of "medical imaging services" by deleting all the words after "computerized tomography services."

So the part that would be removed is "any other prescribed medical imaging services."

Any discussion on the amendment? Ms. Chartier.

Ms. Chartier: — I'd just like to briefly point out why I've moved this amendment. Obviously the CT scans and the MRIs you spoke to very clearly in the election have a clear mandate to go down that road.

But the piece around other prescribed medical imaging services, I think that we heard some of the testimony . . . or pardon me, not the testimony, the consultation pieces from ultrasounds, from X-rays, whether it was the College of Physicians and Surgeons or the SMA, flagging some concerns. And also in light of the fact that you have said that there is no . . . this is not something that you're looking at in the near future or even in the distant future. You couldn't actually even name services that might possibly be listed.

I know other bills come before the House on a regular basis when there's errors or it's time to update, so I would argue that you have a strong mandate on CTs and MRIs, but don't have any mandate when it comes to other medical imaging services. So I would encourage the committee to consider that.

The Chair: — Any other questions? Does the minister have any comments?

Hon. Mr. Reiter: — I guess I would just respectfully disagree. We had you know, a good debate on the topic earlier. And for the reasons I said earlier, I would disagree.

The Chair: — Okay. Thank you. Seeing no further discussion, the amendment moved by Ms. Chartier:

Amend Clause 2 of the printed Bill

in the definition of "medical imaging services" by deleting all the words after "computerized tomography services."

Is it the pleasure of the committee to adopt the motion?

Some Hon. Members: — No.

The Chair: — All those in favour, say aye.

An Hon. Member: — Aye.

The Chair: — All those opposed, say no.

Some Hon. Members: — No.

The Chair: — The nos have it. Clause 2 as presented, all in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[Clause 2 agreed to.]

[Clauses 3 to 35 inclusive agreed to.]

The Chair: — Her Majesty, by and with the advice and consent of the Legislative Assembly of Saskatchewan, enacts as follows: *The Patient Choice Medical Imaging Act* 2016.

I would now ask a member to move that we report Bill No. 26, *The Patient Choice Medical Imaging Act* 2016 without amendment.

Ms. Ross: — I so move.

The Chair: — Ms. Ross. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Okay, Mr. Ministers, would you like to make some closing remarks?

Hon. Mr. Reiter: — I would. I would first of all like to thank all the officials for their time tonight. It's getting late in the evening, and it's been a long day for them, so certainly thank them. I'd like to thank Ms. Chartier for the questions, other committee members as well, and last but not least, you, Mr. Chair. Thank you very much, everybody.

The Chair: — Ms. Chartier.

Ms. Chartier: — I'd just like to echo the minister's comments. I know that committee can be long at times, so thank you for your patience and your willingness to answer my questions. It's always appreciated, so thank you.

The Chair: — Thank you very much. Would someone move that we do now adjourn . . . [inaudible interjection] . . . Oh okay. It now being after the time of adjournment, we stand adjourned to 3 p.m. tomorrow afternoon until the same time tomorrow night.

[The committee adjourned at 22.38.]