STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 15:07.]

The Chair: — Good afternoon, ladies and gentlemen. Welcome to the Human Services Committee. We are here with considerations of vote 32, Health, central management and services, subvote (HE01). With us today we have MLA [Member of the Legislative Assembly] Hugh Nerlien, MLA David Buckingham, MLA Nadine Wilson, MLA Mark Docherty, and on the opposition side, MLA Danielle Chartier. I'd like to welcome the minister and his officials today. And, Mr. Minister, you may commence, and if you would introduce your officials as they come up please.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

Hon. Mr. Reiter: — Thank you, Mr. Chair. I have to my left, friend and colleague, the Hon. Greg Ottenbreit, Minister of Rural and Remote Health. To my right, I have our deputy minister, Max Hendricks. And I have a number of other officials here as past days, Mr. Chair, that I would ask them to just introduce themselves as they partake in the discussion.

To start with, some information was provided yesterday to Ms. Chartier, and I understand that Assistant Deputy Minister Mark Wyatt wanted to clarify some of that information that was given, so if we could start with that.

Mr. Wyatt: — Mark Wyatt, assistant deputy minister. Yesterday during the discussion around emergency department waits and patient flow, I had mentioned, I used the number indicating that there was a 20 per cent increase in the volume of emergency department visits over from the baseline through 2016-17. In looking back at the source of that information, we have identified that there are actually additional hospitals that were not part of the baseline that were included in the subsequent . . . I guess in the '16-17 number. And so the 20 per cent would be a number that is including additional hospitals and not reflective of the Regina and Saskatoon hospitals that were part of that baseline measure. So I guess the average, if you look at the Regina and Saskatoon growth in volumes, would be 6.1 per cent. And so the higher number of 20 does include additional facilities. So we wanted to clarify because there was an inconsistency between the baseline and the reporting period.

Ms. Chartier: — Okay. So just to clarify then, so the baseline in 2013-14 didn't include the whole province?

Mr. Wyatt: — That's right. And so the baseline was Regina and Saskatoon, the tertiary facilities in those two centres. And then as we've been bringing . . . We've been trying to bring other regions into the reporting process. And so Prince Albert and Prairie North are the two regions that have subsequently been added. And so their data, Prince Albert's data, is fully captured, and Prairie North is on stream for having their data introduced.

Ms. Chartier: — Thank you for that. So just Regina and Saskatoon then, it was a 6.1 per cent increase in volume from the baseline.

Mr. Wyatt: — That's right, averaged of the . . . when you put the two together.

Ms. Chartier: — Averaged, okay. Yes, you bet. Thank you.

Hon. Mr. Reiter: — I've just asked, Ms. Chartier . . . There was a number of issues discussed yesterday that we said we'd try to get the information for you as quick as we can. I haven't had the chance to see it, but ministry officials tell me they have some of that. Do you want to walk through that now then?

Ms. Chartier: — Sure, that would be . . . Is there anything that can be tabled? Any documents that . . .

Mr. Wyatt: — Mine is, the one I'll be speaking to would be the PACT [police and crisis team] program hours, and it's very brief. So if that's . . .

Ms. Chartier: — Okay.

Mr. Wyatt: — So just reporting, I think the question was around the hours of operation for the two PACT teams in Regina and Saskatoon. And so for Saskatoon, according to the region, the PACT team is deployed on 10-hour shifts, seven days a week, 365 days a year. The region indicates that most of their mental health calls occur in the afternoons and evenings. Staff work on 10-hour shifts and on four days, off four days. And these shifts are typically day and evening coverage which is consistent with when they would see most of the calls and the activity related to mental health and addictions calls, and typically do not extend past midnight.

From Regina, the PACT team runs Monday to Friday on an alternating two-week rotation, where in the first week service is provided from 9 a.m. to 6 p.m., and in the second week coverage is provided from 1 p.m. until 10 p.m.

Ms. Chartier: — Thank you.

Hon. Mr. Reiter: — We also have some follow-up of some of the other stuff. Did you want to do that as well?

Ms. Chartier: — Sure. Yes.

Mr. Hendricks: — So yesterday there was some discussion around the RQHR [Regina Qu'Appelle Health Region] Ph.D. [Doctor of Philosophy] psychology, and we've had a chance to look at the letter. And the region has actually responded, so I'm going to ask Assistant Deputy Minister Kimberly Kratzig to speak to that.

Ms. Kratzig: — Hi, I'm Kimberly Kratzig, assistant deputy minister. Yesterday you had asked some questions about Regina Qu'Appelle Health Region's one-year hiatus around this program. I'm not sure, Ms. Chartier, if you've received the letter?

Ms. Chartier: — Yes.

Ms. Kratzig: — But I, for the record could read it into the committee . . .

Ms. Chartier: — No that's . . .

Ms. Kratzig: — Okay. So did you have any follow-up questions? I think they were quite clear in addressing some of the misconceptions that maybe were . . .

Ms. Chartier: — Oh, I don't have a follow-up from the region. I have the original letter.

Ms. Kratzig: — Oh, okay. So today the region did respond to the letter. And I believe you were copied on the original so you would have . . .

Ms. Chartier: — It would have gone probably to my constituency office then, hasn't come to me yet.

Ms. Kratzig: — So I think that what I'd like to do then is maybe just walk through the letter. It does address the concerns that were raised.

Ms. Chartier: — You know what, would you mind tabling that? And between questions I'll take a peek at it and so we can all have it, just because we're down to our last three, sort of, general hours.

Ms. Kratzig: — Absolutely. There was one additional question that I was also following up on yesterday when we had our discussion about the hearing aid plan, and you had asked some specific questions about supplementary health or children on family health benefits.

So again, just to clarify that children . . . patients with supplementary health and children with family health benefits will continue to receive full coverage for hearing services and hearing aids through private clinics. A fee guide for supplementary health, it has not been finalized yet with private providers but it is estimated that the incremental cost would be approximately 100,000 annually, based on preliminary consultation that we've had with the private providers. So that would be an incremental 100,000.

[15:15]

Ms. Chartier: — Okay. In terms of, that would be the cost of purchasing hearing aids, so when you're . . . So that's what you are referring to, because my question was around . . . Obviously HAP [hearing aid plan] has contracts with manufacturers and they get the hearing aids at cost and pass that on to their clients, so the question was around supplementary health. So the 100,000 incremental is the actual cost that's being estimated?

Ms. Kratzig: — For the services, for the hearing services and the hearing aids as well.

Ms. Chartier: — For the hearing services, so an additional . . . Okay. You haven't broken it out into hearing aids versus hearing services?

Ms. Kratzig: — In response to that question, we are in the negotiations with the private providers, so we just have very general information that we're . . . You know, maybe at a later time we'd be able to provide to you once those negotiations have concluded.

Ms. Chartier: — What have you used to come up with that $100,000 estimate?

Ms. Kratzig: — Generally it's a rate that is paid through other third party providers, Workers' Compensation Board, that type of thing.

Ms. Chartier: — Thank you. That was it. Okay. Well let's get down to some new topics. So looking at . . . So provincial health services, I think the '15-16 public accounts. So Canadian Blood Services, I'm just looking here. So under the '15-16 public accounts, under provincial health services, Canadian Blood Services received a payment for 43,805,124. Sorry . . . forty-three, eight oh five, one twenty-four. Yes.

So I'm wondering just around STC [Saskatchewan Transportation Company], do you know what their . . . Obviously the ministry would have had some conversations. I know you've referenced that in question period. And Canadian Blood Services used to use STC to transport blood products, so do you know what their plans are now?

Hon. Mr. Reiter: — The comments that I made before that you referenced, this was a statement that Canadian Blood Services had given to media:

> Canadian Blood Services is aware of the province of Saskatchewan's recent announcement regarding the Saskatchewan Transportation Company and is developing plans to make changes to the organization's operations. Canadian Blood Services will continue to ensure that hospitals and patients have access to the blood and blood products they need.

And now on the issue with STC and the couriers, I'll just get Max to elaborate.

Mr. Hendricks: — So a while back, we had switched with SDCL, our Saskatchewan Disease Control Laboratory, to using STC. When the announcement was made that STC was ceasing operations, we returned to couriers. This is what we used prior to it, and so all of our contracts have been reinstated. So that's how we move samples throughout the province for our provincial lab. Our assumption is that CBS [Canadian Blood Services] would be piggybacking or using a similar type of arrangement to what we've had in place historically and have reinstated for SDCL.

Ms. Chartier: — How long had the ministry been using STC for the provincial lab?

Mr. Hendricks: — So the change from private courier service to STC was in the fall of 2016, so we hadn't been in that arrangement too long and, as I understand, we were approached by STC about using that operation to support the organization.

Ms. Chartier: — How much was STC . . . How much were you paying STC?

Mr. Hendricks: — I don't have those numbers with me. I've already asked for them. We can find out. I know they're very similar.

Ms. Chartier: — Between the courier and STC?

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay. If you could get those, that would be very helpful. So you're thinking that CBS will piggyback on the contracts?

Mr. Hendricks: — Yes, certainly. Like, you know, I think if we're able to move specimens throughout the province using private couriers, that effective . . . You know, and we have kind of the same issues, in fact, you know, in terms of meeting, having samples delivered to our provincial lab in a timely fashion so they're viable. CBS would kind of have similar issues. So I think that they could probably, you know, make the same types of arrangements that we reinstated.

Ms. Chartier: — So was CBS . . . So the change in fall of 2016 was the provincial lab. Do you know what CBS has . . . Are you aware if CBS has been using STC over the long haul, or were you referring to both CBS and . . .

Mr. Hendricks: — CBS was continuing to use STC. They hadn't made the switchover, so yes.

Ms. Chartier: — Yes, I know they've had to make the switchover now, but I just want to clarify. So the provincial lab, the ministry had been using couriers up until the fall of 2016 to transport samples like rabies, those kinds of things, using a courier until the fall of 2016 and then changed to STC. CBS was using STC. Do you know how long CBS has been using STC?

Mr. Hendricks: — We don't know that. I could follow up with CBS or we could follow up with CBS.

Ms. Chartier: — Okay. The payment in Public Accounts — so I should've worn my glasses here — but is it 43,805,124 from the '15-16 Public Accounts? I should've worn my glasses. I'm just wondering what that amount under Provincial Health Services, (HE04), for the amount that Canadian Blood Services would be paid for, what that amount is.

Mr. Hendricks: — So the funding for Canadian Blood Services, a percentage of the approved CBS blood or the approved CBS blood operations budget. We pay for the blood products that we use, so obviously they . . . the whole blood products. They also manage plasma products, so the products that we buy from them that they source through the US [United States]. So there are a variety of blood products that they provide to us, and this is a provincial-territorial arrangement that supports the operations. All provinces except Quebec are a part of this arrangement with CBS.

Ms. Chartier: — And that's our, obviously our . . . You said that it's obviously just a percentage of CBS's budget so . . .

Mr. Hendricks: — Total budget, yes.

Ms. Chartier: — Yes, okay. Thank you. Does Health incur any costs for medical transportation, like under supplementary health benefits?

[15:30]

Hon. Mr. Reiter: — So I think your question was, does the ministry incur expenditures for transportation for the various programs in health in the North. Is that right?

Ms. Chartier: — Possibly any programs, so in terms of medical appointments, yes, whether it's supplementary health benefits, family health benefits, is that a . . .

Hon. Mr. Reiter: — Through the northern medical transportation program there was, $4.1 million was budgeted for this year.

Ms. Chartier: — Is that the only place?

Hon. Mr. Reiter: — There's funding provided through a series of programs. So I'm going to get Mark to just quickly walk through those programs with you.

Mr. Wyatt: — Mark Wyatt, assistant deputy minister. So along with the northern medical transportation program, through acute and emergency services we do provide a number of different programs related to covering the cost of ambulance transportation. And so we would have the senior citizens' ambulance assistance program which is . . . $30.323 million would be the '16-17 budget for that.

Ms. Chartier: — Sorry, just for clarification. So what I'm thinking is the individual who might live in rural Saskatchewan who isn't needing an ambulance but needs to get to Saskatoon or Regina, like a senior citizen or someone on social assistance or any of the benefits programs who might need to get to Saskatoon for chemo or radiation.

Mr. Wyatt: — Okay, so with that clarification, the only non-emergency transportation that we provide is through the northern transportation program.

Ms. Chartier: — Okay. And what, through the northern medical transportation program, what means of transport has been used up till now?

Mr. Wyatt: — Either, primarily it would be bus or a taxi. There may be exceptional instances where an ambulance might be used to transport a non-emergency patient, but that would be highly exceptional. For the most part it would be bus or taxi.

Ms. Chartier: — Okay. So what was the previous budget? So you budgeted 4.1 million this year. And have you factored in STC being gone into this 4.1 million?

Hon. Mr. Reiter: — I think for last year for the final dollar amount because year-end is sort of still there being . . . We don't have an exact. I think it was in that same vicinity, about 4.1, I think. We can follow up though.

But to your question about was STC factored in, STC trips were actually a small part of the overall trips in the '15-16 year, the

last year that we have total numbers for. The trips were by plane. There was a total of 4,946 under that program. There was 356 by plane. There was 1,410 by ambulance, 3,146 by taxi, and 34 by bus. So it was a small amount in the total program.

Ms. Chartier: — There's that consistence. So that was for '15-16 you just gave me those numbers. Was that consistent for the previous year as well?

Mr. Wyatt: — The only other information we have specifically related to the non- emergency transportation was that year to date — and I believe this was captured in the month of March so I can't be exact as to at what point — from 2016-17 indicated that approximately 40 trips through STC were paid through the northern medical transportation program representing 20 individuals.

Ms. Chartier: — So the cost then, I guess what I'm asking . . . So supplementary health benefits and family health benefits which are . . . Would Social Services then be covering . . . Like if you've got an individual on a program in a rural community who needs to get into the city or one of the bigger cities, is it Social Services who pays that?

Hon. Mr. Reiter: — Yes, in the North it's the programs we were just discussing. The southern part of the province it would be Social Services.

Ms. Chartier: — Has there been any discussions . . . Obviously it has a health impact. Has there been any discussion between Health and Social Services in that regard?

Mr. Wyatt: — So since the, with the passage of the, or sorry . . . With the introduction through the budget, there have been discussions involving Social Services, the Ministry of Health, and some other agencies and ministries. And the discussion has really been to identify what programs are in place to support people on safety net programs. And I think the general discussion was that the combination of programs that were available would continue to be provided to people in the absence of . . . in the future absence of bus service, that those support programs would still be in place to help to offset the non-emergency medical transportation costs for people who needed to travel for medical appointments.

Ms. Chartier: — So in those conversations, would that be reflected in . . . I'm not the Social Service's critic, and you're obviously in Health, but did those conversations include the fact that . . . Will that be reflected in payment to folks on social assistance or the safety net programs?

Mr. Wyatt: — So certainly from Health's perspective, you know, the continuation of the northern medical transportation program will continue to cover the costs for people on supplementary health or family health benefits, no matter the form of transportation that they take. It has been, you know, not just primarily, it has been by a large majority, a taxi service coming out of the North to appointments elsewhere in the province. And so, you know, the overall impact is relatively small for northern residents, given the smaller number of people who are travelling by bus and seeking reimbursement for those bus tickets.

So you know, certainly our program will continue. It will continue to support people who are taking, the existing majority who are taking taxis. And I guess in the future, if the people who had taken buses are moving to taxi or other options, a program will continue to support them. We can't really speak to the nature or, you know, the different transportation modes covered under the Social Services programs.

Ms. Chartier: — Fair enough. I'm going to move on here. I'm going to be all over the map here. I do have a few substantive things, but I also have a few questions, shorter questions that I think I need answered.

So just looking at the Canada Health Transfer. Between the Saskatchewan estimates . . . So what's in our estimates and the federal estimates for '17-18, and actually it's different for '16-17 too. So we have a federal estimate of $1.182 billion that they've estimated that's in their documents. 1.182 billion coming from the feds. And then the estimate that is listed for the Canada Health Transfer and our estimates coming in is one billion one hundred and sixty-one million point two. So I'm just wondering why there's an inconsistency there?

[15:45]

Mr. Hendricks: — Ms. Chartier, we'll have to follow up with Finance as to why the . . . I don't have the federal estimates on me right now, so we'll have to follow up.

Ms. Chartier: — Okay. That would be great. Thank you. Switching gears here again, nurse practitioners. So how many nurse practitioners are budgeted for in the '17-18 budget? And I'm not looking for the dollar amount but the number of FTE [full-time equivalent] positions.

And that letter, sorry, that was going to be tabled, could we get that tabled so we can all have a look at it? The psychologist, the response . . . before I forget. Thank you.

Mr. Hendricks: — So based on SRNA [Saskatchewan Registered Nurses' Association], the SRNA member database of licensed NPs [nurse practitioner], as of December 2016 there were more than 200 NPs licensed to practise in Saskatchewan, and the actual annual report says 213. There's a slight difference, I guess, between the report . . .

Ms. Chartier: — So the ministry's annual report or SRNA's?

Mr. Hendricks: — The SRNA's annual report.

Ms. Chartier: — So I'm just wondering what the ministry has budgeted for 2017-18.

Mr. Hendricks: — Maybe if I can just . . . We don't budget for nurse practitioners specifically. So we have 122 of them working, or sorry, 161 nurse practitioners working within primary care. So there would be a certain number of nurse practitioners who are working in acute care settings, you know, in a more traditional RN [registered nurse] role because they're probably located in a larger centre. And of those 161, 122 are in remote communities.

Ms. Chartier: — Okay, so I'm just wondering though with a

. . . So in 2012 or was it . . . There was some money invested. So your Grow Your Own strategy, so that was, oh, April 2014. So it was a strategy to work in, to get people to work in communities with a population of 10,000 or less.

So there was the Grow Your Own piece. The RNs received wages and benefits for up to two years while they receive their training. So the rural nurse practitioner locum pool position transfers, where RHAs [regional health authority] would be able to move vacant nursing positions within regions to communities with a demonstrated need, and the relocation grant of up to $40,000.

So I think what I'm wondering, so since that was announced in 2014 . . . Okay, so you don't . . . Obviously nurse practitioners are paid differently than physicians. Physicians are fee-for-service and nurse practitioners come out of global budgets of health regions. So I think some of the concern that's been expressed to me is that health regions, because they don't have the resources that they need, end up, when they could hire a nurse practitioner, they end up hiring or trying to recruit a physician because it doesn't come out of their budget. That's been something that's been flagged for me.

So I'm just wondering in these times, this strategy . . . Since 2014 we've got 200 licensed nurse practitioners. You've said you've got 161 working in primary care, but can you tell me . . . I'm looking to see how we've really have gotten licensed nurse practitioners working. So we're spending money on training them.

So let me narrow down my question here. So I'm giving you sort of big broad brush strokes of my thoughts here on this but . . . So what has been the increase in licensed nurse practitioners working since 2014? So can I have those three years?

Hon. Mr. Reiter: — Can I just clarify? Sorry, which years did you ask for?

Ms. Chartier: — Well since the strategy, the 2014 Grow Your Own strategy started, so 2014, '15, '16, and going into this year.

Mr. Hendricks: — We don't have those numbers with us but we can get them this afternoon.

Ms. Chartier: — Okay, that would be good. In terms of nurses who have been new nurse practitioners since that program has been implemented on the two years of wages and benefits and paying for the schooling, how many have gone through that program?

Mr. Hendricks: — So the Grow Your Own program has not been implemented. I guess the strategy with this program was obviously that RHAs would consider supporting RNs, as you've said, for wages and benefits for up to two years. I guess the desire was to have a negotiated agreement with SUN [Saskatchewan Union of Nurses] to kind of determine what those wages and benefits would be in that period while they were undertaking that two years of training, that NP training, based on a five-year service agreement. And we haven't negotiated that with SUN yet.

Ms. Chartier: — So I'm wondering, why not? So I know in 2014 it said it would roll out this strategy; this four-point strategy would roll out over two years. I'm wondering why that agreement hasn't been negotiated yet.

[16:00]

Mr. Hendricks: — So the thought would be, as you know, in 2008 we negotiated a partnership agreement with the Saskatchewan Union of Nurses. That was renewed once, and then there were active discussions preceding the last round of collective bargaining on renewal again of that partnership agreement. This would have been one of the elements of that agreement. Unfortunately that was not reached. Kind of, there was . . . Collective bargaining kind of interfered with that.

And so, you know, I think we're still in a position with SUN where we can have these types of discussions about these programs. We just need to re-engage at the partnership table and have these types of discussions so we can advance these programs.

Ms. Chartier: — So is that a priority of the ministry, the Grow Your Own?

Hon. Mr. Reiter: — I think it's fair to say we'd obviously like to get it done, but obviously there's a lot of issues we're working on right now.

Ms. Chartier: — This was a big answer. So this strategy was a . . . So let's see how we're doing on the rest of that strategy. Has a rural nurse practitioner locum pool been established?

Mr. Hendricks: — So there were four parts to the strategy that was to be phased in over two years, '14-15 and '15-16. As of February 2017 we don't have the strategy fully implemented, I think for the reasons I gave in my earlier answer. So the relocation grant for nurse practitioners and graduates' grants were first offered in '15-16. Under the program there are three grants available each year. No applications were received, and given the current fiscal climate, we repurposed the money, given that we did have no applications. So currently the ministry and Health Careers in Saskatchewan are exploring revisions to the criteria and process to try and make this a more successful program so that we do have applicants to it.

The other one was the rural nurse practitioner locum program. Health Careers in Saskatchewan has explored the implementation of this initiative and a plan has been submitted to the ministry. It was in February of 2016 and so we're currently reviewing that plan and probably will be making some revisions. We talked about the Grow Your Own. And then on the position transfer, RHAs will be able to move vacant RN and NPA [nurse practitioner assistant] positions within the health region to communities with designated need. Again these things were supposed to be discussed or these programs were to be discussed with SUN at the tripartite partnership table.

Ms. Chartier: — So that hasn't happened then. So the two pieces that have sort of happened is there's been a paper or a report before the ministry since February of 2016 on a locum pool. And then the relocation grants, in '15-16 you offered grants and there were no applicants.

Mr. Hendricks: — Actually I just had it pointed out to me there was one grant approved in the Sunrise Health Region for a nurse practitioner in that region, and the region's in the midst of the hiring process. So there has been one.

Ms. Chartier: — In the '15-16 or '16-17, but for '17-18 in this budget, you've repurposed that money?

Mr. Hendricks: — No, it was repurposed previously in the other year because we didn't have the uptake. So if we have people that are willing and available to do the relocation, I think we'll be supportive of that.

Ms. Chartier: — Are there any . . . So I'm wondering how you budget for nurse practitioners or how you anticipate. So obviously you have a strategy that hasn't been fully implemented. So I'm wondering, when you're making your budget . . . So I wasn't asking for a dollar figure. I was asking for FTEs and then you gave me the numbers from the SRNA. But do you have an expectation because you've invested . . . Was it Health that invested $630,000 in nurse practitioner seats and training positions a few years ago, or was it Advanced Ed?

Mr. Hendricks: — Advanced Education pays for that.

Ms. Chartier: — Okay, so obviously they support Health though. So there's 20, there were 20 additional seats. And so what is the total number of nurse practitioner seats? Do you know that?

Mr. Hendricks: — So there are 20 seats at the U of S [University of Saskatchewan] and 20 seats at Sask Poly.

Ms. Chartier: — Have you been tracking, just with respect . . . So are we providing any financial support? So we don't have the Grow Your Own strategy, but are there any grants that come out of Health to support nurse practitioner students?

Hon. Mr. Reiter: — There's a number of programs. Tracey's just going to quickly walk through them.

Ms. Smith: — Tracey Smith, assistant deputy minister. So you had asked about, I think your question was, do we have any other kinds of supports available for nurse practitioner students. So we do have a couple of programs.

So there is a nurse practitioner and midwifery bursaries are sort of one bundle, and they're offered to students studying to become a primary care nurse practitioner or a midwife. And in return for this assistance, a bursary recipient must commit to work within the RHA sector.

And in terms of just some information around the numbers of bursaries that were awarded, between '07-08 and '16-17, there were a total of 89 nurse practitioner bursaries were awarded. I also have the midwifery if you want that information as well.

[16:15]

Ms. Chartier: — Yes. That would be . . . yes.

Ms. Smith: — And during the same time period, a total of 14 midwifery bursaries were awarded.

Ms. Chartier: — Okay. Do you track like in terms of the return to . . . Is it, the return to service, is it a five-year return to service in the RHAs?

Ms. Smith: — So it's typically a two- to three-year commitment but that's something that we can confirm just to ensure that we're giving you the correct information.

Ms. Chartier: — You bet. Well I know we're talking about nurse practitioners here, but the 14 midwifery bursaries, we only have about 14 midwives in Saskatchewan or thereabouts, that number. And I'm just wondering, about how many people . . . And we can clarify that later, and I'll ask some midwifery questions later.

But I'm thinking about how many people end up with jobs and having the opportunity to do their return to service because I know that was an issue with a midwife a couple years ago who had received a bursary and her training out of province and came back to Saskatchewan and couldn't get a job with an RHA. And I've actually heard that with nurse practitioners as well, that there's some challenge around finding nurse practitioner positions. So I'm wondering if . . . Do we know how many of these folks got an opportunity to give their return to service?

Ms. Smith: — Thank you. So there are, you know, positions obviously within the system, and health regions do obviously recruit nurse practitioners across the entire system. I would say as a whole, you know, one of the challenges . . . And we were just, you know, looking at some information that we have in terms of kind of the current state, but if you were to go to Health Careers in Saskatchewan just to see how many postings are up for nurse practitioners, right now there's eight. So you know, again there's demand and there's demand in certain areas.

I think one of the challenges that we see overall with respect to recruitment and retention of nurse practitioners, but also other health providers, is just, you know, quite often what we find is you might have an RHA or an employer or a community looking to recruit, but some people just aren't interested in moving or going to some of the rural areas. And so there's, you know, quite often this challenge of trying to recruit for both our urban and our rural settings. And that's something that, you know, that health regions and the ministry are very aware of, and that's one of the primary reasons why you have, you know, some of the incentive programs and the bursaries that are available, is to try to attract and retain people to those areas where you need them the most.

Ms. Chartier: — I think one of the things that I've heard though is there are nurse practitioners who have their training and can't get . . . So they live in some of these rural settings where they could benefit from nurse practitioners, and there's not a nurse practitioner working in the community. So if you've got a family and roots and your kids go to school and perhaps your partner is in a community, it can be hard to pick up and move for a position.

So has there been any, has there been any thought in the ministry around moving to a fee-for-service model or any combination of payments rather than leaving it up to the regions

to decide how they are going to allocate that money?

Mr. Hendricks: — So I know that there have been some requests by nurse practitioners to enter what — and I'm going to get somebody angry with me by my choice of wording — independent practice because we have interdependent practice here in Saskatchewan. However in, I believe it's Ontario, they have independent practice, so as you describe, a nurse practitioner can go set up and be paid by the Ministry of Health.

And so I think a couple of observations on this is, one is you have to have the service. As a health system you have to want to buy the service that they're providing in the area that they're willing to provide it in. So that would be the first thing.

Oftentimes a nurse practitioner's work isn't really conducive to a fee-for-service environment. One of the reasons that we advocate a primary health-type model is so that nurse practitioners and others members of the team, physicians, spend more time with the patient. I think as, you know, we think about the future and where we would like to go in community-based services and primary care, the fee-for-service model really, it does not work well with chronic disease management. Those things are more time intensive and so I don't know that I would want to advocate that type of model for a nurse practitioner.

So our biggest issue has been, is that nurses apply to become a nurse practitioner and we've had this misalignment a little bit from rural and urban areas. And obviously one of the key thrusts we've been focusing on as a ministry is trying to improve and incentivize nurse practitioner practice in rural areas where we think they can support services out there.

Over time I'm sure that there will be a shift. There already are opportunities for nurse practitioners in urban environments, and in some other jurisdictions the role of the nurse practitioner is changing very much and they're spreading into other areas. So I think we're at a point right now but, you know, it's kind of an evolving discussion and evolution of that profession of nursing.

Ms. Chartier: — Perhaps fee-for-service wasn't the right model to think about. But knowing that, I think about, rather than . . . So I started out by asking you how many FTEs did the ministry allocate. So from the top, what is the expectation of health regions and allocating money? Much like midwifery or when regions have identified that they want midwives, the ministry has worked with regions — albeit only three — to help advance that.

So I think that that's more what I was . . . there has to be a . . . I guess let's go back to my question around, in terms of the 89 bursaries for nurse practitioners and the 14 for midwifery bursaries, how many of them were able to fulfill their return-to-service commitment?

Mr. Hendricks: — We would have to undertake some work to get you the exact number. Having said that, I'm told that we have a very low default rate on those types of bursaries so the return to service committments were fulfilled.

Ms. Chartier: — So what does very low default rate mean, like a ballpark?

Mr. Hendricks: — Single digit percentage.

Ms. Chartier: — I heard 5 per cent or to 8 per cent, is that . . . Okay. Would it be possible to have the ministry do some work around . . . I'm interested in both the midwifery and the nurse practitioner bursaries and who has ended up with jobs here in Saskatchewan. If that's possible to crunch those numbers that would be great.

Mr. Hendricks: — Yes, we can undertake that.

Ms. Chartier: — Okay, thank you. I am going to ask some varied questions here over the next little bit here as I've . . . The massage therapy bill, I'm just wondering if there is the plan to table that in the fall? I know that there's been some work done over the last couple years.

Ms. Smith: — So just in response to your question around the status of massage therapy legislation. So we have been working with a number of stakeholders who are involved in this particular issue, and essentially where we're at right now is we've been . . . They've been working together as a group and trying to provide some feedback in terms around what the legislation should look like, different provisions, if a college were set up what should that look like and how should they regulate the profession.

So right now we're actively in the process of having those discussions with the associations involved and getting their feedback. We are, in terms of some timelines, we had been talking about working towards a fall timeline; however it would be really dependent on the conversations that we have with those groups and whether or not we're able to resolve some of the issues that they've been bringing forward through those discussions and whether or not we're in a position to be able to actually bring it forward at that time . . . But actively in discussions with those organizations, and we'll continue to do so.

Ms. Chartier: — Is there any . . . Obviously massage therapy right now isn't regulated in Saskatchewan, and we see in the media cases that have cropped up over the last few years where massage therapists . . . there's been some issues around that.

Is there any . . . So I appreciate that you've been working with stakeholders, and it's been a couple years now. I believe there was a draft piece of legislation originally. So if not this fall, is it the goal in the mandate in the next three years to put in place a regulation for massage therapy for the protection of Saskatchewan citizens?

Hon. Mr. Reiter: — I'm hopeful that will be the case. As Tracey mentioned, we're hopeful it will be this fall. I don't want to speak definitively about it though, depending on how the discussions go between the ministry and the various groups.

[16:30]

Ms. Chartier: — Okay. Thank you. And again — now changing gears again — I would like to talk about MRIs [magnetic resonance imaging].

So this January in the discussions around the federal health

accords and the negotiation, there was . . . I'm just taking you back to January 19th, 2017, a *StarPhoenix* article that says, quote:

> On Tuesday, Health Minister Jim Reiter announced the province had found some common ground with the federal government on the issue and was being given one year to prove the two-for-one service works.

But further down in the story it says:

> Federal Health Minister Jane Philpott's office says it's not putting the MRI issue aside for a year, but rather, is willing to work with the province to make sure the *Canada Health Act* is upheld.
>
> According to her office, that means it's not changing its position on Saskatchewan's user-pay MRI system.

And so I'm just wondering how those discussions are going and what's involved in all of that. I know in committee the previous minister had an opportunity when the bill originally came forward to ask if there had been a legal opinion around losing money potentially and there had been no . . . This was the previous minister. And I was told that there hadn't been a legal opinion. And then when you and I had a discussion of the bill, we had a similar conversation. And then I had asked you about a letter that you'd received. And then shortly after, you released that letter in the media. So I'm just wondering where all of this is at.

Hon. Mr. Reiter: — So first to the point in the legal opinion. I guess, you know, I think what I was speaking to is the fact that while officials tell me at that time there wasn't a formal legal opinion, lawyers from Justice are still involved in drafting, right, so you take some comfort in that. Now to your point on where that issue is, did you want me to continue on that?

Ms. Chartier: — I would like to know. Yes.

Hon. Mr. Reiter: — Sure.

Ms. Chartier: — I'd like to know where that discussion with the federal minister in ensuring that we don't lose any money in health transfers because of two-for-one MRIs is at.

Hon. Mr. Reiter: — I guess I think it's fair to say, you know, when I read the quotes that you did from the federal minister I was disappointed in that because the term sheet . . . I'll read a direct paragraph out of the term sheet. It says, over the next year "the federal and Saskatchewan governments agree to discuss the issue of patient payment for publicly insured health services before the federal government considers any compliance action required by the *Canada Health Act*."

And so that was the context that the quotes that you attributed to me that were in the media. When I spoke to the issue I was again, I was disappointed to hear the federal minister's comments on it. So I've written to her asking for clarification on that; I haven't seen a reply yet. I'm hopeful that, you know, in the next while, that we'll have, I'm sure we'll have an opportunity to talk. But on the flip side of that I also haven't seen anything from the federal government saying that they're looking at taking any enforcement measures either.

Ms. Chartier: — Okay. So when did you write to her asking for clarification?

Hon. Mr. Reiter: — I'll have that for you shortly. I'll get one of the officials to get that, okay?

Ms. Chartier: — Okay. Is that the letter that you wrote right there?

Hon. Mr. Reiter: — It's kind of a summary of.

Ms. Chartier: — So you'll get a date. Like was it recently that you signed the letter?

Hon. Mr. Reiter: — I'll have a date for you shortly. They'll get that.

Ms. Chartier: — Okay. And what did you . . . Actually could you table the letter that you . . . I know you tabled the letter that you received from Philpott. Or you didn't table it actually, I asked you about it in committee and then you released it publicly a few days later. But could you table the letter that you've drafted and sent to Minister Philpott?

Hon. Mr. Reiter: — I'll have an answer for you shortly. I just, I want to have a look at it. I hope you can understand it's information between a federal and provincial minister, so I just want to have a look at it before I commit to that.

Ms. Chartier: — Fair enough, but I just want to remind that you did release the letter that she had written to you. So do you have the date yet, then?

Hon. Mr. Reiter: — Coming.

Ms. Chartier: — Still coming. All right. So you haven't . . . So following these January discussions, there was no other communication aside from what happened in the media then with the minister?

So we negotiate and agreed to the health accord, the 3.5 plus the money for mental health and home care, and then this discussion comes up around MRIs. So I'm just wondering, aside from this mid-January discussion and this letter that you've drafted, there's been no back and forth between the federal ministry and yourselves?

Hon. Mr. Reiter: — Federal ministry or minister?

Ms. Chartier: — Well, on this issue between . . . So obviously the minister may or may not communicate directly. I know Mr. Hendricks . . . I'm just wondering if there had . . .

Hon. Mr. Reiter: — Sure. I'll check with the ministry in just a second on communications that might have happened between officials. As far as communications I've had, I'm just trying to think back. I've had several phone calls with the federal minister over the last number of months, and I don't recall exact dates. And I also recall a conversation where it was, you know, it was very general. It was that we need to discuss this issue, but I don't know the exact date that that was, and there's been no

subsequent conversations on it yet. But as I said, I certainly would expect that'll happen before long. But I'll check as far as discussions at the officials' level.

Officials tell me there's been no communications at the officials' level on that.

Ms. Chartier: — Okay. And so do you have the date of the letter?

Hon. Mr. Reiter: — We're still . . . Officials are working on it.

Ms. Chartier: — Okay. So in all the magic binders that all the officials at the back here have, that wouldn't be something. MRIs wouldn't be in one of the magic binders that officials have that would include that correspondence.

Hon. Mr. Reiter: — As you know, you've mentioned, you said — I'm paraphrasing — but you've jumped around to a number of topics. Health is a huge operation. We can't bring everything with us. You know, we can do a better job of that if you're free to give me a heads-up on what topics you want to discuss at particular sessions; we would bring more information on that. But no, we don't have that with us right now.

Ms. Chartier: — Okay, but you'll commit to having it here in the . . .

Hon. Mr. Reiter: — You'll get an answer before the end of the day, yes.

Ms. Chartier: — Okay. Thank you for that. And again so once you have the letter, you'll be able to let me know, you'll give me the date and let me know whether or not you can table it. Okay. Fair enough.

Just looking at an OC [order in council] here from August 23rd, 2017. The committee, it's OC number — again my glasses — OC 392/2016 Committee on the Saskatchewan Child and Family Agenda — Cancel the Committee. So this is the OC that cancelled the child and family agenda, and the Health minister, I understand, was on it. The Minister of Social Services talked a little bit about this the other day but couldn't . . . and said a Human Services Committee replaced it. So I'm wondering if you can tell me a little bit about the committee that replaced the child and family agenda.

[16:45]

Hon. Mr. Reiter: — Okay. I'm not aware of the conversation that you're referring to, but I think probably what the minister would have been referring to is there's an informal committee of the Human Services ministers. That would be Health, Social Services, Education, Advanced Education, Justice and Corrections.

Ms. Chartier: — Okay. Can you tell me a little bit about why the child and family agenda was quietly dismantled? You were a member of that, so just wondering what was the reasoning to get rid of it.

Hon. Mr. Reiter: — You know, I think it's fair to say committees change from time to time. I haven't been concerned about it because, again ministers meet frequently, whether formal committees or not. And as I said, the ministers of the Human Services ministries, the ones I just mentioned, we meet in whole or in part reasonably often.

Ms. Chartier: — So it was . . . And Social Services said that when this committee was cancelled that a Human Services committee replaced it, and you've told me about who sits on it. I'm wondering how often . . . is it so informal that you don't have regular meeting times? I'm wondering how often you regularly meet.

Hon. Mr. Reiter: — There's not set meeting times. I think we met a few weeks ago. But again, as I mentioned, the Human Services ministers, not, you know, . . . Maybe not in the entirety of the group I mentioned, but especially when session's on, a number of us are meeting and talking about things every day.

Ms. Chartier: — For sure. So this OC was from this summer, I believe. It was in 2016. So how many meetings of this Human Services Committee . . . So you said you meet often. Obviously you're all together during session and there's cabinet meetings and you come together at different times. But of this whole Human Services — the Health, Social Services, Education, Advanced Ed, Justice and Corrections — how often have you met since the child and family agenda was dismantled?

Hon. Mr. Reiter: — I can't give you a number on the ones with the ministers just because, like I said, you know, it's informal. We're meeting sometimes not with all the ministers, but on any given day, I'll be talking to two or three members of that committee.

I should have mentioned that also the deputies of the applicable ministries also meet as well, and I'll just get Max to comment on those. I'm not sure if he knows offhand how many times they've met.

Mr. Hendricks: — Yes, I might just add a couple of things to the minister's earlier comments. The child and family agenda was a cross-ministry kind of initiative that looked at various activities that were going on in different ministries that were kind of consistent with each other. But the fact remained, and I think the challenge to the ministers was, that they were still separate programming and ministries. And what we've been strongly encouraged to do by ministers is to work cross-functionally and across ministries to actually address programs together. So you know, it's not just a Ministry of Health solution to a problem; it's a Ministry of Health, Social Services, Corrections, Education issue to a problem.

And so with the discussions around transformation and that whole piece, last year the deputies began meeting and looking for kind of joint opportunities that we could look at across ministries to advance the similar sort of, or the similar types of initiatives in a more collaborative fashion. So those are the meetings that have been taking place, and then, you know, when we have something that's kind of ready, obviously that would be something we would then convene our ministers to discuss.

Ms. Chartier: — Okay. So how does it differ from the child and family agenda?

Mr. Hendricks: — I think what the key difference is is that, you know, it's just as I said, is the child and family agenda were a lot of really good programs, but what we're trying to focus on is thinking across ministries, and so this is bringing deputies together to co-design programs and to look at how we can actually more functionally interrelate our programs, making sure that we're achieving . . . You know, I can be doing everything in Health and investing millions and millions of dollars in the health sector, but quite honestly if there are housing issues, social service, corrections issues, you know . . . So we want to make sure that deputies are talking and doing that sort of thing. So these are the discussions deputies are having.

Ms. Chartier: — I had been under the understanding though that that, forgive me if I'm wrong here, but I thought that was the point of the child and family agenda. I can remember my early days here in the Chamber, and the Minister of Social Services and the Minister of Health, every time a question would come up, that the minister would say, we're working across ministries and this breaking down silos. I thought that was actually the purpose.

Mr. Hendricks: — That was the start of it, and I think that this was an incremental approach. As the minister said, you know, committees change and structures change over time. And so what happened there was the first efforts to kind of work across ministries and to look at how our programs were functioning together,

I think we wanted to take it one step further and look at how our programs could actually be more closely aligned and actually co-designed, and so this is the advent. And I think more maturity . . . you know, kind of a maturity of the whole idea and notion about how we approach these issues is kind of how we're arriving at this.

Ms. Chartier: — So dismantling . . . so there was no way . . . I just know this was a really big piece of . . . on many occasions, this is what the government touted as the response to many questions that the opposition had. So now it went from being something formal to being something informal? Does it have a Chair? Does it have a mandate?

Hon. Mr. Reiter: — I'm sorry. We were still trying to get you the information from previous questions at the same time. The Minister of Justice chairs the human services committee.

Ms. Chartier: — And is it just called, what is it . . .

Hon. Mr. Reiter: — We just refer to it as human services committee.

Ms. Chartier: — Okay, because isn't there a . . .

Hon. Mr. Reiter: — And yes, there's a deputies committee as well, which we mentioned earlier.

Ms. Chartier: — Okay. So just for clarification, so we've got the Human Services Committee of the legislature, and I also understand that . . . does the caucus have a human services committee as well where stakeholders come and . . . So I just want to make sure that I have the correct names of things.

Hon. Mr. Reiter: — If I could, so the caucus policy committee has a human services committee that will meet with stakeholders, that sort of thing. And then the human services committee of the human services ministers, you know it has a committee. It meets; it has a Chair. But I think essentially just the difference, which I think is what you're asking, is that previous committee had been an OC appointment. This one, as I recollect, isn't an OC appointment but it's still a committee, it still has a Chair.

Ms. Chartier: — Does it have a mandate?

Hon. Mr. Reiter: — I would say the mandate's fairly broad. It's to deal with sort of all issues relating to the overlap between the different human services ministries.

Ms. Chartier: — Okay. Thank you for that. Just a question around ambulance services. So First Nations and Inuit health benefits has been frustrated that seniors who are First Nations and left with ambulance bills from when they're transferred from a medical facility to another of lower acuity, that they have that bill, where non-indigenous seniors are covered provincially. So I'm wondering why they can't be covered under the seniors' ambulance program.

The Chair: — While the ministers and staff are consulting, we'll take a five-minute recess. So be back in five.

[The committee recessed for a period of time.]

[17:00]

The Chair: — Okay. The Committee on Human Services will resume. I just want to indicate to everyone that the document provided to us by the minister will be tabled as HUS 37-28 and that is the letter from Lorri Carlson, M.A. [Master of Arts], APE [Authorized Practice Endorsement] registered psychologist from the Regina Qu'Appelle Health Region to Dr. Paulette Hunter, assistant professor, Department of Psychology.

Mr. Minister, if you wish to answer now.

Hon. Mr. Reiter: — I would now to Ms. Chartier's last question, and I'm going to turn that to Mr. Ottenbreit in just a minute. But in the meantime, to a previous question on the letter from myself to the federal minister on MRIs, we have that letter as well. It's dated March the 9th, 2017. and I will table a copy of that as well.

Ms. Chartier: — Okay. Thank you.

Hon. Mr. Ottenbreit: — And, Ms. Chartier, to your previous question about First Nations' ambulance fees, we know that there's discrepancies in the system when it comes to the agreement between First Nations and Inuit health branch and some of the beneficiaries. As you would know, this is a responsibility of the federal government. That being said, we do recognize when it comes to provincial benefits and benefits that are provided by First Nations and Inuit health branch, there are some that they provide for First Nations that are better than maybe the province and vice versa. We have some of our benefits that are better. So it's a long-standing issue that's been with successive governments regardless of political stripe.

And SEMSA [Saskatchewan Emergency Medical Services Association] does have the agreement with First Nations and Inuit Health Branch on this emergency medical services. This is something that First Nations Inuit health did in 2003. They made the decision to go this route, not to cover return trips for First Nations, and that's been an ongoing issue with them. But when it comes to our provincial coverage, I mean I think you pretty well understand the provincial coverage that we do have for others that are under our jurisdiction.

Ms. Chartier: — How long has the seniors' — refresh my memory — how long has the seniors' ambulance plan been in place, or ambulance benefit?

Hon. Mr. Ottenbreit: — Don't have a specific date, but it would date back over 30 years, around 30 years to the late '80s and early '90s.

Ms. Chartier: — I know a couple of years ago we had this discussion with a previous minister when there was a woman from La Ronge who was transported to Prince Albert and then back to La Ronge. And this issue, I hadn't known that this was an inequity until that case. Sometimes you don't know what you don't know.

And I know at the time, I believe the former minister said there were ongoing discussions trying to rectify this issue. And I'm wondering what kind of discussions has the Rural and Remote Health Ministry had with First Nations and Inuit health benefits?

Hon. Mr. Ottenbreit: — So I guess I could say there hasn't been any specific discussions, although different items for discussion come up from time to time when you're speaking to your federal counterparts. What I can say is that since the federal government made this decision in 2003, the Ministry of Health would keep track of the unpaid bills coming into the regions, submit them for a response or for some sort of response to the federal government, and that went pretty much unanswered for a number of years. So it hasn't really happened in the past few years, but through the Ministry of Health they did advocate and try and advocate for First Nations with the federal government with no specific answer. And I'm not sure if there's any items that Max could chime in.

[17:15]

Mr. Hendricks: — I might just mention that I had some exchanges with my federal counterpart about this very issue. I think we have to remember very clearly that Health Canada's First Nations and Inuit health branch backed away from inter-hospital transfers in 2003. You know, this isn't something that Saskatchewan insures for residents other than those on SCAAP [senior citizens' ambulance assistance program].

And so from time to time you do have this advocacy, you know, even from our local Health Canada office to say, let's, you know, you should be covering these. Well we don't cover them for — and it's not just seniors that, you know, that they advocate on behalf of — but we don't provide those for our regular population. And it's fine for Health Canada to have a view on this. You know, you could break this down into kind of a Jordan's principle issue, that sort of thing. But certainly that's the position I would take with my federal colleague is that, you know, let's not put First Nations in difficult positions. Let's work together to kind of collaboratively do this. But thus far, you know, that collaborative conversation around how we actually manage these issues really hasn't evolved to the kind of state where we're actually . . . You know, we don't have these kind of situations come up.

And at the end of the day, that's not to say that either party will insure everything. But, you know, our goal with the federal government, and one that I've had not only with Health Canada, Saskatchewan branch, but also at the tripartite committee is, you know, having greater consistency between our programs. In fact I proposed that we undertake a study to look at inconsistencies, particularly between our drug plan and other programs, and see if between FNIHB [First Nations and Inuit Health Branch] and our Ministry of Health we can't have it more consistent across the board. So you know, I think these are unfortunate issues, but at the end of the day I think there are important principles that we have to have conversations with our federal counterparts about.

The Chair: — Can I interject for a second? I just want to let the committee know that we have another document from the Minister of Health. HUS 38-28 is tabled. It's a letter from the Hon. Jim Reiter, Minister of Health for Saskatchewan, to the Hon. Jane Philpott, Minister of Health for Canada. Ms. Chartier.

Ms. Chartier: — Thank you. So obviously you've identified Jordan's principle, which is about children. But doesn't it . . . And obviously there is discrepancy between what the province and the feds fund. As Minister Ottenbreit pointed out, some things are better than others depending on whether you're federally or provincially covered.

But you made the point yourself that you have to take a look at Jordan's principle. So you've got seniors, who are folks who are the most, arguably the most vulnerable because they're on a fixed income and don't have an ability to generate more money, and come out with an ambulance bill that they can't pay. Doesn't matter when this happened. The reality is it's 2017 and this is still happening to seniors now. And it doesn't sound like there's been a lot of work in the last couple years since those questions were asked to rectify this.

Hon. Mr. Ottenbreit: — Thank you, Ms. Chartier. I guess I would point out that, you know, this isn't an issue about lack of coverage. There is service available. There is coverage either provincially or through First Nations and Inuit Health Branch and the agreement with SEMSA with First Nations people. It's about, basically, the bill getting paid. So it's not about a lack of service or so much a gap in that respect. It's about who's paying the bill.

And it's not for lack of trying. As I think Max had pointed out, and I spoke about it a little bit earlier was that, you know, we've advocated with the federal government to make sure that they have the coverage that they need with their First Nations responsibilities. And I think we'll continue to do that. But again when it comes to the coverage it's a jurisdictional issue more,

but not because of lack of coverage. It's about paying the bill. I'll maybe get Max to fill in some more detail.

Mr. Hendricks: — Agreed. Like you know, we do have to advance this conversation, specifically in the exchange that I had with my federal counterpart. It was titled, "Is this how we're going to work together?" So you know, I'm strongly of the view that we have to have a better understanding with our federal government.

The fact is that we have different programs. They have a formulary; we have a formulary. They cover certain things under their health benefits program that we cover . . . We might cover different things. And so sometimes, you know, we see this situation where if something is covered in one program there's a desire to look at the other program that might be run by the province and kind of say, I want this one which is better here and this one which is better over there.

The reality is this . . . and you know, it came up in the discussions with the federal government around the health accord, is that the number of First Nations and now Métis folks in the province are growing rapidly. And as we go forward, you know, in the particular case of these hospital transfers, First Nations people are using provincial hospital systems. They're using provincial hemodialysis. They're using a lot of services. And you know, this has been a challenge for our system and meeting our needs.

And what we're asking, you know, I think what the minister said out in Ottawa was that we want the federal government to be a partner in that, an equal partner in addressing the funding challenges that come along with that. You know, the reality is that, you were talking the other day about the funding for mental health and the funding that we got for home care, not recognizing the fact that we have explosive growth in our First Nations populations.

And so, you know, we can get into this responsibility issue, but we want a partner at the table who's willing to work with us on these issues, and we've made that point very clearly to the federal government. And so, you know, the problem is that while these discussions happen, that's confusing for the populations. And so, you know, any time the federal government wants to sit down and have a serious conversation, I've offered. I'm willing to have that.

Ms. Chartier: — Thank you for that. But in absence of having a partner at the table, so the reality is if people aren't willing to come to the table, someone has to take responsibility. And I would argue that perhaps the province should be filling in some of those gaps.

And I'm not letting the federal government off the hook, believe me. I think that they have a role to play and should be stepping up to the plate as well. But it's never good when you see disparities in service and inequities in service.

Mr. Hendricks: — Ms. Chartier, there's no inequity here. This service wouldn't be provided. We don't provide for inter-hospital transfers for individuals. We provide a supplement for seniors.

Ms. Chartier: — The money is the issue. So you get the transfer, but if you can't pay your bill, what happens to you if you can't pay your bill? Does it go into collections? So . . . [inaudible interjection] . . . Yes, well I don't . . . So you're telling me that people are getting the service which . . . of course they're getting the service, but there is a consequence for not having a bill paid.

Hon. Mr. Ottenbreit: — I think, Ms. Chartier, as the deputy minister pointed out . . . And if I missed some points, I'll ask Max to add in again. But like he pointed out, it's not about inequity. In fact I think he pointed out a number of circumstances where, you know, off-reserve, we carry a lot of the load that maybe should be federally responsible. But we do carry a lot of that load, so in that respect I don't think there's inequity. There's actually, I think, a positive. When it comes to ambulance services or unpaid bills, First Nations or not, the options for those people with an unpaid or unable to pay a bill are the same for both. So there wouldn't be any inequity there either, I don't believe.

Ms. Chartier: — Well the inequity is that you've got First Nations seniors who don't have the same benefits that non-indigenous people do. But I have to move on. We only have about another 40 minutes here left. I've . . .

Hon. Mr. Ottenbreit: — No, I would . . . if I could add, I think they do have a lot of the same benefits but it's through First Nations and Inuit Health Branch, not through some of the programs we have provincially.

[17:30]

Ms. Chartier: — Yes, they don't. That's a benefit that the indigenous seniors don't have. But I need to move on here.

I'm going to ask, just in light of time here, one of the questions that I'll have . . . and I'm looking for numbers. I'm going to ask something right after this, but if your officials could give me, under the CPAP [continuous positive airway pressure] program, podiatry, spiritual care . . . And then yesterday you gave me the FTE losses in HAP, which were 18 FTEs. I'm wondering, in the programs that were cut, if your staff could work to give me the numbers. But I wouldn't mind going on . . .

Hon. Mr. Ottenbreit: — Sorry, just the numbers you wanted?

Ms. Chartier: — FTEs.

Hon. Mr. Ottenbreit: — Number of FTEs?

Ms. Chartier: — FTEs lost. But if I could let your officials work on pulling that and move on to another question because I think that that's a pretty . . . you probably have those handy.

So speaking about indigenous communities, so in terms of the province's role and the federal government's role. So we have a suicide epidemic in the North, so I'm wondering what kind of interventions or what role the province is playing and the support that is being offered to our communities in the North around — and they're not all indigenous communities — but around preventing suicides in the North.

Hon. Mr. Reiter: — Because of the time, I'll get Max to walk through your FTE question while Minister Ottenbreit consults with the officials.

Ms. Chartier: — Thank you very much.

Mr. Hendricks: — So for the hearing aid plan, the current FTE estimate, which I think ADM [assistant deputy minister] Kimberly Kratzig shared with you yesterday, was 18.69; pastoral care, we're estimating 14.2 affected FTEs; 11.22 for podiatry; and the travel program we're still working out with CPAP is one, we believe.

Ms. Chartier: — The travel clinics you're still working out and CPAP is one?

Mr. Hendricks: — Yes. Oh, sorry, plus three contracts for podiatry that we're already 11.22 plus three contract positions.

Ms. Chartier: — Okay. And those are across the province? Or Saskatoon and Regina mostly?

Mr. Hendricks: — Hearing aid plan would be Saskatoon, Regina. Pastoral care would be . . . in those regions it did provide the service. It was about 50/50 that actually supported it through the region. Parent mentoring would be in those regions that had that program across the province. Podiatry would be, I think, mostly Regina and Saskatoon, although I would have to check whether there was anything in P.A. [Prince Albert]. And CPAP would be Saskatoon only.

Ms. Chartier: — Okay. And you told me the parent mentoring the other day, but do you have that in front of you? You didn't mention the parent mentoring number.

Mr. Hendricks: — Oh, I'm sorry, 10.88.

Ms. Chartier: — 10.88. Okay. Thank you. I don't know if Minister Ottenbreit is just about ready.

Hon. Mr. Ottenbreit: — Thank you for your patience, Ms. Chartier. As I mean anybody would realize, I think, and as you do as well, the general public does it, any young life, especially a young life going before its time is a concern to all of us. And all partners have been working together to try and find some solutions for these challenges we've been facing, not only in the North, but I mean there is other areas as well that hits close to home when there is a suicide.

So when we look at some of the supports that have been added in the North and some of the supports that are going in, we look at the three northern health regions, that they do provide the mental health and addiction services to the larger centres and the smaller satellite communities through a different program. And they've also been addressing the issue in a number of areas, namely training staff in sector partners. Example, Northern Lights School Division and their ministries, they've been doing different programs within the schools to provide training for some of the teachers and professionals in the education system, as well as in the health care system, putting different suicide prevention plans in place, participating in the Embracing Life committee which focuses on building the community capacity in reducing suicides.

In response to the youth suicides in La Ronge last October, Mamawetan Churchill River region's mental health team is working with other regions, including Health Canada, First Nations, and the Ministry of Education, school boards, and others to implement plans. Keewatin Yatthé Health Region has hired suicide prevention workers and a registered psychiatric nurse to work in La Loche.

The Ministry of Health has provided additional funds for Keewatin Yatthé and Mamawetan Churchill River regional health authorities to supply . . . to provide suicide prevention initiatives. The ministry is working closely with the northern health regions to fully implement suicide prevention protocols under mental health and addictions services, of course with the aim of the protocols is to assess and help people at risk of suicide. And we've pointed to the services available at 811. Also the federal government has put a phone line in place to offer supports.

Outside of that, I could point to the expansion of the psychiatry clinics that have gone on in the North. I think we're up to 200 now, which is a significant increase. We do have the one psychiatrist traveling the North. We also have two that are engaged through remote presence technology with communities in the North so they can access services quicker.

As well as, you would know that, the Children's Advocate has come out with some recommendations, also working on a report, and I think actually I have a meeting with him — I think it's next week — to discuss some of his recommendations. And you know, we're open to implementing those as well.

So you know, there's a lot of other things that I could point to if you have some follow-up questions.

Ms. Chartier: — I'm wondering how much community engagement is part of the plan. So you've named lots of actions, but in . . . I'm wondering what kind of community engagement is being done to come up with those solutions.

Hon. Mr. Ottenbreit: — Well I'll confer a little bit and we'll talk about some details. But also on a personal level, I can say that, you know, whether it's with the different northern leaders, whether it's one-on-one meetings, whether it's through phone calls, or others, we're always engaged with them. I would point to as well the meeting that the Premier and the Minister of Government Relations and I had with Chief Tammy Cook-Searson and a number of representatives of the North just a short time ago as well, to discuss some of the challenges and issues that they're facing and brainstorm with some solutions.

As well, there's the New North executive. I think I've met with them two or three times over the last year to discuss some of the issues — not issues — but plans that they may have. And the last meeting we had, they discussed maybe implementing or coming up with some recommendations on their own. They haven't delivered that yet, but I know they're working on that with some suggestions.

And that is one message we get continually from them. They don't want the government doing something to them or for them. They want to develop a plan that seems to fit their communities and implement that in a way that they see fit. So

we're always sensitive to the cultural wants of our First Nations communities and how they want these plans implemented, and how they're delivered, and what programs are actually delivered in the North.

Hon. Mr. Reiter: — If I could again, because of time, as Minister Ottenbreit consults with the follow-up, we also have some numbers on nurse practitioners that you had asked for earlier.

Ms. Chartier: — Sure.

Hon. Mr. Reiter: — We can run through those now if you'd like.

Ms. Chartier: — Yes, thank you.

Ms. Smith: — So just in response to your question around nurse practitioners registered to work in Saskatchewan, so you were looking for 2010 and forward. So for 2010, there were 132; for 2011, 140; 2012 was 161; 2013 was 178; 2014, 198; and 2015, 213.

Ms. Chartier: — Do we have any sense . . . And I know Mr. Hendricks gave me numbers for people working in primary care and had mentioned eight positions on the recruiting website, I think. But do we have any idea . . . Do we have corresponding numbers in terms of right now how many nurse practitioner FTEs exist in Saskatchewan?

Ms. Smith: — So I don't have that kind of a breakdown with me today. That is something that I can take back and see if that's possible. In terms of how we do our calculations for FTEs, right now we have a number that has . . . All registered nurses and nurse practitioners are included in that number, so I don't have the breakdown of RN to NP in that list. But that's something that I can take back and see if it's possible to have that breakdown.

Ms. Chartier: — That would be great.

Ms. Smith: — Okay.

Ms. Chartier: — Yes, that would be great. Thank you very much.

Hon. Mr. Reiter: — If I could again while we're waiting, Tracey also has some information on the return for service that you'd asked about, yes.

Ms. Chartier: — Okay, perfect.

Ms. Smith: — Sure. So it does vary depending on the kind of bursary, so I'll just give you some examples just to give you a better sense of how that works.

So in terms of clinical placement bursaries, it is, essentially it's a $3,000 bursary and there's a two-year return for service. For an NP bursary, if it's a $5,000 bursary, it's a one-year return for service. If it's a 10-year . . . Sorry. If it's a $10,000 bursary, it's two years; $15,000, three years return of service.

With respect to the nurse practitioner relocation grant, so that's a five-year grant that totals $40,000, so the expectation around return for service is five years.

Ms. Chartier: — Did you have . . . And you don't have numbers on how many have met their agreements? I know that was a number that we didn't have, or . . .

Ms. Smith: — Sorry, yes. So we don't have that level of detail in terms of what Max, the deputy minister, had provided earlier. We know the rate is, you know, is relatively low but I don't have that specific information with me.

Ms. Chartier: — Okay. Okay, thank you very much.

Hon. Mr. Ottenbreit: — Okay. And just to add on to some of my previous comments, Ms. Chartier, about the engagement of northern partners. I guess one thing I omitted. I should've added on, as you would well know, the regions are very much the ones delivering the mental health services. So you know, we try and supply the resources that they need when they ask. So they, I mean they're the front-line providers and they've been doing a very good job.

I could point out some detail, some of the specific work that's gone on through the ministry and the regions. In '16-17 the ministry provided 35,000 to Keewatin Yatthé and 40,000 to Mamawetan Churchill River for implementing evidence-informed suicide prevention activities. In Keewatin Yatthé, a portion of those funds was being used for a workshop in La Loche titled, The Community is the Medicine: Personal and Community Wellness in trauma and grief healing workshop facilitated by Darien Thira. Remaining dollars will be utilized for building community skills that will increase local capacity to address suicide prevention and build on the initial event. So as you can see by those comments, that they're very much engaged with the community and developing programs with them that suit the community and that they're asking for.

[17:45]

In Mamawetan Churchill River, part of the funds have been used to formalize a mental health crisis response plan that is inclusive of prevention, preparation, response, and working together as a community to move to action. This plan will be shared with partners within the community as well as provincial counterparts and additional dollars have been utilized to help staff with crisis and trauma response services for their own health.

The region's also planning for the use of the remaining dollars to increase local capacity while keeping ministry staff included in discussions. The ministry also provided funding of 36,000 to Keewatin Yatthé and Mamawetan Churchill River, Saskatoon, and Prince Albert Parkland health authorities to enable staff to be certified in the Mental Health Commission of Canada's mental health first aid First Nations course.

This culturally appropriate course, which was reviewed and approved by the Assembly of First Nations, aims to increase the capacity among First Nations communities and front-line personnel to better respond to individuals with mental health and addictions issues. And the mental health first aid . . . nations course is now being offered by the Keewatin Yatthé and

Mamawetan Churchill River, Saskatoon Health Region, and Prince Albert Parkland Regional Health Authority.

I think Tracey would like to add some comments about the work that she's been doing on her committee.

Ms. Smith: — So just to provide a little bit of context specifically, some examples around some of the work that we're doing with the community of La Loche. So I have been the ADM that has had the opportunity to be part of a working group in La Loche that has representation, not just from the health region, but also from the town and the school, Clearwater River Dene.

And so really the focus of the working group has been to look at a number of different areas across health, so not just mental health and addictions but you know, the range of issues that the community is dealing with and that they want to sort of bring forward and look for opportunities. I think one of the, sort of one of the positive sort of impacts of having that kind of group — and it is a relatively new group; it was struck following the tragedy in La Loche — but it's really brought that opportunity of having not just, you know, one or two sectors come together, but actually having the entire sectors from the community come together to be able to bring forward ideas, talk about ways of sort of breaking down silos even just within the community.

And so some examples around the mental health and addictions . . . One really good example, I think, is the community was saying that they wanted to have access to some of those services outside of the traditional health centre or hospital. And so one of the comments was, is there a way to be able to provide some of those kinds of services but not in a hospital, because not necessarily, you know, every child or teenager, maybe they don't want to go to the hospital for those services.

And so as a result of those conversations, they were able to reach an agreement where the health region would provide the staff, but it would be located out of the friendship centre instead of the traditional facility. And the feedback that we've had, you know, from that one example is just . . . I think the community, you know, obviously was pleased that we were all listening in terms of what was important to them, and then being able to just look at things differently and take a step back and say, well if that makes sense and if that is what the community needs, and if that's what they're hearing from the youth, let's try it. And there's been some really positive feedback as a result of that.

Ms. Chartier: — Okay. Thank you for that. I know I've become very conscious of the time when we only have 25 minutes left and I still have a stack of things that we need to talk about. I just want . . . So thank you for those comments.

The behavioural units in the Saskatoon Health Region, where is that at? That was something for dementia for seniors in long-term care.

Hon. Mr. Reiter: — I'm sorry I can't remember if we mentioned this or not, but there's one in Saskatoon and one in Regina.

Ms. Chartier: — And the one in Regina has been up and running for a little bit but the one in Saskatoon was announced last budget or . . .

Hon. Mr. Reiter: — Right. The one in Regina opened in April of last year, 2016, and the one in Saskatoon, I'm told, opened on April the 19th. So just . . . [inaudible interjection] . . . Yes.

Ms. Chartier: — Okay. And how many beds do both of those have?

Hon. Mr. Reiter: — Officials will double-check, but they're telling me they think that they're each a five-bed unit.

Ms. Chartier: — Okay. Just thinking about long-term care here, on that topic. So actually in long-term care, it's a psychiatric population and according to Canada's national guidelines for seniors' mental health, between 80 per cent and 90 per cent of long-term care residents have a mental disorder at the time of admission and dementia is the most prevalent primary diagnosis at 67 per cent, followed by mood disorders at 10 per cent, and other disorders at 2.4 per cent. So obviously many residents have more than one mental disorder where for example, 40 per cent of residents with dementia diagnosis at admission also have comorbid depression, delusions, or delirium.

So I'm wondering about . . . Well one of the questions that came up a couple of years ago in Heartland Health Region was around the use of psychotropic medication for a diagnosis of dementia. And so there . . . So I'm wondering what kind of progress we're making on reducing, not just in that health region, but the use. And I know there was some work in Santa Maria, a pilot project that happened there. But I'm wondering across the province how we're doing at reducing off-label use of psychotropics.

Ms. Kratzig: — Hi. As you, I think would recall from last committee when we had this discussion, this is one of the quality indicators that we do track to determine how our health regions are doing. So on antipsychotic without a diagnosis of psychosis, this is one of the key quality indicators that we do measure.

Overall, the percentage of long-term care residents on antipsychotics without a diagnosis of psychosis has decreased quite considerably. I can give you, for example, the provincial average. In 2006-07 we were at 33.2 per cent, and we've had the last . . . At the end of 2015-16 we were at 27.4 per cent, which is slightly above the national average. And our latest measure, which was the third quarter of '16-17, we had a further decline to 24.8 per cent.

So again, we are on a downward decline, you know, across the province. And I could give you specific health region statistics if you're interested.

Ms. Chartier: — No, the provincial average is good. What work is being done to achieve that?

Ms. Kratzig: — Every month or in some instances every quarter, in some every month, we are working with our regional health authority partners to report on this and making it very visible in most homes. If you were to walk into a long-term care home, you might see on a wall where they would have metrics

that they're tracking. Working with staff, doing med reviews, working with physicians to ensure that this is sort of front and centre — there's some best practice that's followed.

Again, this is an issue that the country is working on, and I think we've had some really good success in Saskatchewan in terms of a team approach. And like anything, when you're measuring and paying attention and making it a priority, you typically will see improvement.

Ms. Chartier: — Just wondering around psychologists or that team approach. So I know in Saskatoon there is one psychologist who provides behavioural consulting to Saskatoon health region long-term care homes, so she's got a population of 2,200 people who have a psychiatric disorder with whom she's working. So one psychologist for 2,200 folks in our largest health region.

So I'm wondering how that . . . if you have those stats in Regina or how that measures out, because obviously reducing meds is really important, and I know from my own family experience. And use of those drugs in dementia is not ideal, but having those other supports in place to support that psychiatric population is really important.

Ms. Kratzig: — I don't necessarily have the statistic on number of psychologists in the region to work with this population. I can say though that there has been training in many of our health regions in terms of a variety of behavioural supports in terms of working with people with the dementias that you spoke about. So we have funded and worked with our regional partners to train staff in managing behaviours proactively. I think we've talked before about purposeful rounding and some of the benefits that that has seen.

There's other training that we could get you information on that is also being rolled out in our regional health authorities. In particular in the dementia units that you asked about there's some very focused training and education for those workers. Because of course those hubs in Regina and now Saskatoon, which recently opened, are where the most difficult behavioural challenges are going and people are being able to be cared for in a more appropriate way in those facilities.

Ms. Chartier: — Thank you. So those five beds in both regions, those are for people who have comorbid disorders then. So I'm wondering who accesses those beds and for how long.

Ms. Kratzig: — I have some of that information if you just hold for one moment. I do have some information on the Regina . . . It is a five-bed dementia assessment unit that we spoke about.

So a report from the region, dated April 3rd, would tell us that between April 11th of '16 and April 3rd of '17, a total of 14 clients had been admitted to the unit and that's for assessment, core care planning, and behavioural support; 11 have been discharged; seven were returned to their home facility; and four required an increased level of care so they went back to a dementia care environment.

So the length of stay, I don't have the average. Oh, actually I see there's not a wait time to get in; it's averaging about six days. And client length of stay has varied from 19 to 140 days, with an average length of stay of 82.

So again the purpose is to have an individual come into the dementia assessment unit, have very focused care planning done, and then return to the home community is sort of the path that would be the ideal state.

Maybe that doesn't work for all individuals. It's a very . . . This is a very resident-focused approach that we've taken with these dementia units. We heard that there was a need for this type of advanced care — I'll use that word, care — for people and that's the approach that's been taken.

[18:00]

Ms. Chartier: — Okay. And that's in both . . . it's similar in Saskatoon?

Ms. Kratzig: — Saskatoon is a very similar model; however, they have of course just opened. I think there's actually the official opening later this week.

Ms. Chartier: — Okay. Thank you. Do we have the most . . . I'm going to be all over here in the next 15 minutes. Do we have the most recent HIV [human immunodeficiency virus] numbers for 2016?

Ms. Kratzig: — Our preliminary numbers for 2016, — and again this isn't confirmed; there's still various checks that need to be put into place — but is 170.

Ms. Chartier: — 170.

Ms. Kratzig: — Cases, yes. As we talked about last year, just to give you a sense of the numbers, last year we were at 160. And we are still . . . we were expecting to see the increase as the testing is going up and the focus on this issue.

Ms. Chartier: — So how much testing? So I know we had gone from, I think, 115 cases the previous year to 160 cases. So I know that there was increased point-of-care testing, but it hadn't grown exponentially. So I'm wondering between the last year, so that would be '15-16 . . . No. Yes. And . . .

Ms. Kratzig: — 2015 until 2016?

Ms. Chartier: — Yes.

Ms. Kratzig: — Okay.

Ms. Chartier: — And '16-17, which would be just preliminary numbers, the numbers of tests done.

Ms. Kratzig: — I think they're actually calendar years.

Ms. Chartier: — Oh, okay.

Ms. Kratzig: — Just to confirm for you. I'll check that when I go back, but I believe they are calendar years. I'll get you the number of tests.

Ms. Chartier: — Okay, thank you.

Ms. Kratzig: — One of our approaches on the HIV file is of course getting people to get tested. We've done a lot of work around that, and we are seeing success. So your specific question was, what is the change between 2015 and 2016? And I will confirm that these are calendar years. So unlike other things where we say, ask us fiscal year, these are actual calendar years. So in 2015 we did 76,675 HIV tests, and in 2016 that number increased 6 per cent to 76,675. And some encouraging . . . [inaudible interjection] . . . Oh, go ahead. Did I give the . . .

Ms. Chartier: — You just gave me the same number twice.

Ms. Kratzig: — Oh sorry. In 2015, 72,659 . . .

Ms. Chartier: — Sorry, 72,000 . . .

Ms. Kratzig: — 659.

Ms. Chartier: — Okay.

Ms. Kratzig: — And in 2016, 76,675. And I do want to flag because there is an encouraging number we're seeing. The first quarter of 2017, we have 20,597 tests done, so that would again be signalling that we will be seeing more testing done in 2017 if the first quarter is any indication.

Ms. Chartier: — Okay. Any HIV-positive babies in 2016?

Ms. Kratzig: — No.

Ms. Chartier: — Okay. Thank you for that. I'm just trying to priorize here. I am really all over the place.

Going back to the drug plan, or back to the actual budget document. We've got supplementary health program and family health benefits. Both of those, according to estimates are projected to go down, but the folks who access those are folks on social services, and Social Services have the largest social services budget in history, I think, because of caseload. So I'm wondering how we're projecting supplementary health and family health benefits to go down when social assistance caseloads are going up.

Hon. Mr. Reiter: — I think the reduction was estimated to that because of de-insuring chiropractic services.

Ms. Chartier: — Okay. Actually that was one of my other questions. So that's cutting the 12 treatments that those . . . But so does that also include though . . . So social assistance has budgeted for increasing caseload, so you might be cutting the 12 chiropractic treatments for those on benefits, but you wouldn't think that supplementary and family health benefits would go up otherwise?

Hon. Mr. Reiter: — We can . . . The ministry did some calculating internally. Max can I just get you to get that, the breakdown part. Part of that was because of de-insuring the chiro, as I mentioned, but there's also a utilization increase.

Mr. Hendricks: — Yes. So for supplementary health, the net change in the program is a $185,000 reduction. So the decrease for de-insurance of chiropractic service is effective July 1st, 2017, 685,000. And then there's a corresponding increase of $500,000 for utilization and family health benefits. The total cost for the program is actually coming down because of some of the work that we've been able to do in negotiating lower prices for the thing so it stays pretty much even other than the reduction in chiropractic services.

Ms. Chartier: — Okay. So you said for negotiating lower prices?

Mr. Hendricks: — For drugs that sort of thing. So that's, yes.

Ms. Chartier: — Okay. Just a quick question around autism. So obviously it was an election promise last year; there's not money this year. You've started work on rolling that out. Are you anticipating in the '18-19 budget that that money will be there?

Hon. Mr. Reiter: — I would anticipate that. Yes we're looking . . . Obviously any budget item has to go through the budget process, and there's always a possibility that things would change. But the intent was to defer that for one year to do the work. The working group's been appointed; they're doing their work. We would expect that they would finish that work sometime in the fall, and it'll be part of the budget process.

Ms. Chartier: — And it was a campaign commitment so I don't think that there's any . . . It's not like when you take something to treasury board and have to negotiate. This is something that was committed to so the committee will do it's work, and once the committee is done its work, that money will be in place in the next budget?

Hon. Mr. Reiter: — Well again as I said, you know, that's certainly the intent, but I would just put the disclaimer, you know. As you know, any budget item needs to go through the budget process, but the intent was to defer it for one year and have the committee do their work and then implement.

Ms. Chartier: — Okay. I just want to have a . . . just going to double-check here.

I think this is too big of a conversation right now, but I think I'll take it back to emergency rooms and emergency room waits, and I know your ADM commented about this year the $12 million being . . . In previous years there hasn't really been an opportunity to invest in emergency room waits. And I know $12 million is more than it has in the past, but I . . . We talked about the lack of progress on the 35 per cent 2016-17 target, and I just want to cast your mind back to the budgets in both 2014 and 2015 around wait times and the money.

You put 4 million in in 2014 and additional money, 4.7 million, in programs aimed at reducing emergency waits, an increase of 3 million. So I'm just wondering your thoughts on, are those programs . . . So that included hot-spotting or Connecting to Care. That included, I believe, physician or home visits. It had a number of components to it, but I'm wondering why . . . First of all, are those programs going to carry on? We heard about Connecting to Care carrying on, but is there any thought on why these investments haven't paid off?

Hon. Mr. Reiter: — I can hear officials are digging through

numbers and stuff, so I'm going to want to consult with them. But I think just generally, you know most of them have. You know Mark did a clarification from some of the information he'd given yesterday, and pressures have increased and yet generally speaking you know we've sort of held the line.

We can always do better. We want to do better. That's why, you know, the announcement on the accountable care teams and the community work we're going to be doing. But to the specific programs you mention, if you just give me a minute I'll talk to the officials.

I'm just going to get Mark to elaborate on that.

Mr. Wyatt: — So from the $4.7 million that had been previously invested in the emergency waits patient flow initiative, we've provided $1.6 million to each of Regina and Saskatoon, and $600,000 to Prince Albert. Each of those regions had identified what their priorities were for funded programs, and so we have, for each of the past few years we have provided grant funding to Regina, Saskatoon, Prince Albert. And I can walk through some examples of what some of that funding went towards.

So, for example, in Saskatoon they had funding that went towards the PACT program, which we've talked about. They have a paramedicine initiative that's taking paramedics into long-term care and other settings. Community transition beds to move patients who have completed their acute care requirement but are not yet ready to move back into either home or into a long-term care setting.

[18:15]

And they've also enhanced some of the staffing within the hospital to assist with discharge planning and having additional social work and therapies available, for example to be able to make sure that patients are getting all of the elements of their discharge plan supported so that they can be released.

Within Regina Qu'Appelle, you also had funding for PACT. Some dollars have gone into community IV [intravenous] therapy. Funding went into the accountable care unit last year out of that envelope. There's an intake model for emergency care that Regina has operated. It's looking at different ways for their physicians to triage and follow up with patients. Patient flow specialists, there's been a nurse practitioner in long-term care that Regina has introduced, and an assessor coordinator, weekend coverage, is another example.

In Prince Albert, most of their funding has gone into emergency room physician coverage, and that actually has had a very direct result in their time waiting to see a physician in P.A. So that's been very successful.

There were some . . . There's work that's occurred that's taken place with the remainder of that funding that's gone to provincial initiatives looking at some of the work that we've done around identifying the ALC [alternative level of care] population and being able to better understand that population. We've developed a work around interdisciplinary rounding and how it should be undertaken and the involvement of the patient and family through interdisciplinary rounds. So there's a number of kind of policy and new programming areas that we've also funded work in from a provincial perspective.

In addition we also, I should say the funding for seniors house calls and the connecting to care hot-spotting program were in addition to the 4.7, and so that would basically kind of summarize the direct funding that came from that envelope.

The Chair: — We have now reached the agreed-to time to end these estimates of nine hours. Ms. Chartier, do you have any quick closing remarks?

Ms. Chartier: — I do, thanks. Nine hours goes remarkably fast and there's so many areas that I didn't cover. And that's not, for anybody who may be watching or interested in a certain policy area, it's not for a lack of interest, whether it was medical assistance in dying or midwifery or capital, like there are so many things that I missed. And I regret that I didn't get to everything, but I look forward to more written questions and more ways of getting those answers.

So I appreciate the ministers and deputy minister and all your officials for your time and your willingness to answer questions and table documents. That's always appreciated. So thank you for that, and I'll guess we'll be back here tomorrow anyway for discussion on the bill. So yes, thank you.

The Chair: — Mr. Ministers.

Hon. Mr. Reiter: — To Ms. Chartier's comments just now, I guess I would just add, it is a huge ministry with many issues going on, as you said. And certainly the offer's there if you want to have discussions with either Minister Ottenbreit or I; even though estimates aren't on, we're happy to try to provide whatever information we can.

I'd like to thank Ms. Chartier for her questions over the last number of days. I'd like to thank you, Mr. Chair, and all the committee members for their time spent here. I'd like to thank our deputy minister, Max, and all the officials from the ministry for the many hours they've put in. And as Ms. Chartier mentioned we'll, most of us will be back here again tomorrow for discussion on the bill. So I think Minister Ottenbreit would also like to make a comment.

The Chair: — Mr. Ottenbreit, go ahead.

Hon. Mr. Ottenbreit: — Just really quickly I'd like to echo the comments of Minister Reiter, but also to recognize those front-line providers that don't get recognized in a committee meeting that do the hard work of providing patient care throughout our province every day. And I just want to publicly thank all of them as well.

The Chair: — Okay. Thank you to the minister, to Ms. Chartier, and to all the officials, and the committee members that were here today and for the last nine hours. Would someone move adjournment? Mr. Nerlien. All in favour? Carried. This committee stands adjourned until tomorrow.

[The committee adjourned at 18:19.]