STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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Cannington

Ms. Danielle Chartier, Deputy Chair
Saskatoon Riversdale

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Mr. Todd Goudy
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Mr. Warren Steinley
Regina Walsh Acres

Hon. Nadine Wilson
Saskatchewan Rivers

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[The committee met at 14:59.]

The Chair: — Well welcome everyone to the Human Services Committee meeting for May 24th, 2018. I'm Dan D'Autremont, the Chair of the committee, MLA [Member of the Legislative Assembly] for Cannington. With us this afternoon, we have MLA Larry Doke, MLA Muhammad Fiaz, MLA Todd Goudy. Substituting for MLA Warren Steinley is MLA Colleen Young. Substituting for the Hon. Nadine Wilson is MLA Glen Hart. And for the opposition, we have MLA Danielle Chartier.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We will start today with continuations of consideration of estimates and supplementary estimates — no. 2 for the Ministry of Health: vote 32, Health, central management and services, subvote (HE01).

Mr. Minister, welcome. Mr. Ottenbreit, welcome. And welcome to your officials. If you have any introductions to make you may proceed, Mr. Minister.

Hon. Mr. Reiter: — As this is round three, Mr. Chair, we again at the front have the Hon. Greg Ottenbreit; our deputy minister, Max Hendricks; a number of other officials that may introduce themselves when we join in, and we'd be prepared to just continue with questions.

The Chair: — As in Olympic boxing, there are only three rounds. We will have the vote for vote 32, Health, central management and services, subvote (HE01). Are there any questions? Ms. Chartier.

Ms. Chartier: — There are a few questions. Thank you so much again for your time here today. We ended the day on eHealth yesterday and I will get back to that, but I do have a few things that I'd like to talk about first.

So we've heard some concerns from folks in the Creighton-Flin Flon area about accessing health care, high doctor turnover, and the overall quality of care that they receive. I'm wondering if there's a contract between Manitoba and Saskatchewan for health service provision in the Flin Flon-Creighton area.

Hon. Mr. Ottenbreit: — Yes, Ms. Chartier, we do have an agreement with Flin Flon, the facility itself in Manitoba, for services for the Creighton residents.

Ms. Chartier: — Would it be possible to provide that to the committee?

Hon. Mr. Ottenbreit: — Exactly what are you asking for?

Ms. Chartier: — The agreement. A copy of the agreement.

Hon. Mr. Ottenbreit: — We don't have it with us here today, but we could provide it.

Ms. Chartier: — Okay, so you'll table it with the committee. How long has this agreement been in place?

Mr. Hendricks: — So the agreement dates back into the early 1960s, so several decades. It was originally with Manitoba Health and then it was with I believe the Nor-Man health authority, and I'm told now it's with the Flin Flon General Hospital.

Ms. Chartier: — Okay. Again just reflecting that we're hearing from people some concerns about access to services. So I'm wondering what the ministry is doing and the minister is doing to ensure . . . and what steps he and the ministry is taking to ensure that people living in this area have access to the care they need.

Hon. Mr. Ottenbreit: — Well we had heard concerns in the past between the ministry and the facility there. I guess negotiations or discussions would take place when it comes to services to the Creighton people. Over the last few years we've had little, if any, complaints.

Ms. Chartier: — There was just a meeting — unfortunately I wasn't able to make it —with the MLA who represents that area and the MLA on the Manitoba side of the border, just a month ago on a Friday during session. And there were a list, a long list of complaints. So you're saying that you haven't heard any concerns in the last two years?

Hon. Mr. Ottenbreit: — In the last few years we've heard very little complaints, officially, from the area.

Ms. Chartier: — Officially? So officially, where would those be coming from when you do hear them?

Hon. Mr. Ottenbreit: — Well they'd be coming from likely the leadership of Creighton itself, the mayor and . . .

Ms. Chartier: — Okay. What were you hearing prior to the . . . So you said in the last two years you haven't heard, you've had few if any complaints. What were you hearing prior to that time?

Hon. Mr. Ottenbreit: — Prior to that we'd hear the odd occurrence of maybe priorities of the Saskatchewan residents when it comes to ER [emergency room] services or long-term care. But again accessing long-term care but up to, again the last couple years, haven't heard really any official complaints.

Ms. Chartier: — Okay. So I just want to quantify that. So you've had no complaints or a few complaints? Like zero complaints officially?

Hon. Mr. Ottenbreit: — Yes, again we don't have any record of logged complaints, but not to say that there hasn't been something that we're maybe not aware of in committee today, but we'll look through our correspondence, see if we can find anything, but if you do have any record of complaints, we'd be happy to take those and look into them.

Ms. Chartier: — Okay. Just letting you know, as I said, there was a full meeting of folks from the community. I wasn't able

to attend it, but there were many complaints expressed at that point in time. And one of the things that residents are expressing concern about is the disparity between access for Manitoba residents and Saskatchewan residents. So I'm wondering what differences you're aware of and again, what are you doing to make sure that people have timely access to care? With respect to what happens on the Manitoba-Saskatchewan side, do you know what the differences are?

Hon. Mr. Ottenbreit: — Yes, again looking back in the past, we were made aware of some issues that would have preferential treatment maybe when it comes to allocating long-term care spaces for residents of Creighton in Flin Flon. Our information says that those have been rectified, but if you have cases like that or others that it's not happening, then we'd be happy to have the ministry talk to the facility again to make sure that it is rectified.

Ms. Chartier: — Okay. So just to be clear then, the expectation is there would be no difference in service between Creighton and Flin Flon? Does the agreement state that — and obviously not having the agreement in front of us — but is that the expectation then that services in Creighton and Flin Flon are equal?

[15:15]

Hon. Mr. Ottenbreit: —I think we've just found a copy of the agreement. It's actually not a contract. It's a letter of understanding from 1964 that pertains solely to insured services, so under the *Canada Health Act*.

Ms. Chartier: — Okay. So again, the question was about the equity of services then, the expectation. The question was, is there an expectation of the same services on both sides of the border?

Hon. Mr. Ottenbreit: — When it comes to *Canada Health Act* specified services, yes.

Ms. Chartier: — Okay. If Saskatchewan residents are sent to Winnipeg for treatment, is there any assistance to them to get back home once they're released from the hospital?

Hon. Mr. Ottenbreit: — As with any interprovincial health agreement, all health services are covered, but not travel.

Ms. Chartier: — So just refresh my memory then; I just want to make sure. So if a person was sent from Creighton to somewhere in Saskatchewan, and sent home, there would be no assistance. And so there would be no assistance to Winnipeg as well?

Hon. Mr. Ottenbreit: — That's correct. There's no coverage for travel, only for medical procedures.

Ms. Chartier: — Okay. This hasn't been flagged as a concern for you, people being sent to Winnipeg?

Hon. Mr. Ottenbreit: — Not specifically, no. I mean, from time to time we hear of people that are even getting sent, say from my home in Yorkton to Saskatoon. And they might, you know, look for support in travel, but it's not a *Canada Health Act* insured expense.

Ms. Chartier: — Forgive my ignorance or my memory here more than anything, the northern travel, there is a program in place for northern medical travel, and tell me who that supports then?

Hon. Mr. Ottenbreit: — So for any emergent situation in the North, medical travel is covered one way for everybody. If it is for, say, low-income people from the North, supplementary health benefits will cover them both ways.

Ms. Chartier: — So I guess the question then, if someone has to get sent to Winnipeg, that trip, I'm assuming that that trip would be covered. And then if they're on social assistance or one of the programs, supplementary health benefits should be covering that, no?

Hon. Mr. Ottenbreit: — Just to clarify, Ms. Chartier, are you talking about all residents, or those covered under FNIHB [First Nations and Inuit Health Branch]?

Ms. Chartier: — Well all residents, so it would be a combination of both individuals living in Creighton, so those not covered under FNIHB. They are covered under the provincial system and on supplementary health benefits if they're on social assistance.

So what I hear is that with emergency travel in Saskatchewan, they get the one trip to the acute facility and then there's supplementary health benefits, the program to get them home. So if you're in the same boat and you get flown to Winnipeg for whatever reason, will supplementary health benefits cover the trip home?

Hon. Mr. Ottenbreit: — Yes, so the details of the program as I've described it is to the best of my knowledge. But just to walk us through the actual details of how certain situations might transpire, we're going to get an official to answer.

Mr. Morhart: — Hi. Dave Morhart from the drug plan and extended benefits branch, acting executive director. So just to clarify the northern medical transportation program, there's two components to it. So any emergency evacuation out of the North, that is covered for all northern residents with Saskatchewan health coverage. It doesn't include those that would have coverage through the non-insured health benefits federally. And that would just be for one-way travel out of the North in an emergency situation.

Supplementary health benefit clients, they are covered for both the emergency travel and non-emergency travel, so to go to a medical appointment. And they would be covered both ways for that travel.

Ms. Chartier: — But if they happen to travel . . . I guess the question . . . I don't want to belabour this too long because there's been a half an hour and I've got a lot of questions. But I just want to clarify though, if a person is sent to Winnipeg for treatment in an emergency, so would they get, through the northern medical transportation program, would they get that coverage both to . . . And then if they fell under supplementary health benefits here in Saskatchewan, would that be covered if

they were having to travel to Winnipeg instead of to a Saskatchewan centre?

Mr. Morhart: — Right. So, like a resident out of Creighton would go to the nearest centre that could provide that service. So that could be Winnipeg, potentially.

Ms. Chartier: — Would they be eligible for supplementary health benefits to get them back, I guess is the question? So they're transported to Winnipeg, but if they are on SAP [Saskatchewan assistance program] or any number of those — TEA [transitional employment allowance], any of the programs — they would be eligible for support to get back?

Mr. Morhart: — Yes. Yes, they would. Yes.

Ms. Chartier: — Okay. Okay. Thank you very much. I appreciate that, and we're going to move on. Thank you.

So yesterday you provided, you tabled some information on the census, the average operating census at the Dubé Centre. And so there, just for context here, there's 54 adult beds, 10 youth beds, and the average operating census at the Dubé for the last year was 66. And that's been pretty much constant for the last three years. We've got 68 the year before and 67 the previous year. So that's 12 people on average over the capacity of the Dubé.

So I'm wondering, that's the average. So where do those people go when there's not one of the 54 beds available, but they're still in the facility?

[15:30]

Hon. Mr. Reiter: — So the officials tell me that the numbers that we tabled for you were a combination of adult and youth. So the adult, as you mentioned, is 54 beds. There's 10 youth beds as well, so the capacity is actually 64.

Ms. Chartier: — Understand though that those youth beds are . . . So when there are youth beds available, do you have a number? I should've asked for this last week too because, from my understanding, the youth beds are rarely, if ever, full. So we're mostly talking about adults in this case.

So I guess the one question is, so even if you've got 64, so even if we count the 10 youth beds — so 54 adult beds, 10 youth beds — if we count the 10 youth beds being completely full all of that time in the average census, they're still two beds over capacity. But I assure you that from talking to many people that I know who work in that area, the youth beds are rarely at capacity most of the time.

Is there a time, in your knowledge, what happens when they're over capacity? Where do patients go in the Dubé, even if it's by two people? Do people ever double bunk?

Mr. Hendricks: — So in situations where Dubé is at full occupancy, there would be a couple of situations. If the patient came in through the ER, until there was a vacancy available, they would be held in an off-service bed, which is typically a pod where they're monitored until they're able to be admitted. The other thing too is sometimes on a given day you'll have occupancy, but you'll also have discharges. So on that same day those people might later in the day be admitted, that are in the off-service beds, into the facility.

Ms. Chartier: — Where would those off-service beds or pods be housed?

Mr. Hendricks: — Those are located in the hospital and they have different ones for different things. So they have off-service beds to deal with emergency patients when they're at capacity.

Ms. Chartier: — I'm hearing from folks who've been both clients or patients at the Dubé, and from other folks, that people are actually staying in a pod in the basement in the Dubé.

Mr. Hendricks: — So you're correct, but I need to clarify that. The basement of the Dubé — first of all, the Dubé is a new facility — and it's actually a patient care area that's used for ECT [electroconvulsive therapy]. And so there are spaces down there, and so that's where the off-service is located. It's an up-to-date, modern clinical space.

Ms. Chartier: — It is, but I think one of the concerns that I've heard is patients having to be triaged during the day. So you've got people staying in those off-service beds in the basement, and then ECT happening at different parts of the day. So you've got people who have acute psychiatric illnesses who are in one spot and then having to be moved around, sometimes at a variety of times during the day. So I have some huge concern that that's happening. You've got patients who are very ill being moved about.

Mr. Hendricks: — So in those over-capacity situations, when they do exist, there can be up to six patients accommodated in the pod in the ECT room. Obviously, as you've mentioned, at times to accommodate the ECT schedule that amount will vary, but what we are told from the Saskatchewan Health Authority is that when they do have positions that are off-service in that area, that they are actually appropriate patients for that area. They wouldn't be your most ill necessarily. They would try and use that area for people that were a little bit more stable.

Ms. Chartier: — But the fact that you're in an acute psychiatric facility means that you're ill and probably not best to be shuffled around a facility, even if you're the better of the folks who have the misfortune of being sick enough to be hospitalized.

Can you just double-check for me? Is there a way of finding out about double-bunking? I know this is our last meeting. If you could find out because I've heard from both — as I said, patients who've been there and a few people who work in that area — that there's been the occasion of double-bunking in the Dubé.

Hon. Mr. Reiter: — We'll check into it. We'll follow up with you. We'll table . . .

Ms. Chartier: — Is it possible to find out this afternoon?

Hon. Mr. Reiter: — We'll certainly ask them to try.

Ms. Chartier: — Okay. So if that is in fact the case, last year

was the lowest of the last three years in terms of over capacity. The previous year we had 68. So the average over capacity is . . . Like, they're running over capacity all the time basically at the Dubé. So I'm wondering, just your thoughts on appropriate . . . How could that be better addressed for those patients?

Hon. Mr. Reiter: — We'll just have an official walk you through the steps that are being taken to attempt to address this.

Ms. Willerth: — It's Kathy Willerth and I'm the director of mental health and addictions at the Ministry of Health. So one of your questions was about how to respond to that kind of capacity or over capacity in the Dubé Centre. And I think one of the most important things we're doing is certainly recognizing that we want to be able to, you know, in support of the whole acute community, make sure that we're managing people in the community to our best capacity.

So out of the federal investments that, you know, you've heard about is, in '18-19 we're going to have 4.2 million out of that federal funding that will be targeting community recovery teams. So those teams will be multidisciplinary teams, really building on some of the smaller rehabilitation teams that exist already in the communities, and in particular in the communities that have in-patient units. So that's Saskatoon, Regina, Prince Albert, North Battleford, Moose Jaw, Swift Current, Yorkton, and Weyburn.

And we want them to be able to have a range of disciplines, so increasing our multidisciplinary capacity. So we'll be adding, the Saskatchewan Health Authority will be adding occupational therapists, or certainly we're advising them that this is part of what the community recovery teams would best be made up with — occupational therapists, peer support workers, addiction workers, social workers, vocational supports — to really to be able to enhance our current capacity to manage some, to have people who have some level of acuity being able to be managed in their home communities with the supports of their family and their community.

[15:45]

So that would really have, you know, individuals attached to a whole team of providers. We'll be able to increase the hours of being able to respond to people and also the different disciplines being able to respond to them differently as well. And that would really allow us to, or allow the Saskatchewan Health Authority to manage more acuity in the community.

Health people use the acute care stays, you know, as minimal as possible so that people are pulled out of the hospital and provided a better service in the community, you know, looking at being able to reduce length of stay by having a more appropriate response and also being able to prevent people coming back to the hospital, which would reduce the demand on those beds.

Ms. Chartier: — I sure appreciate that. I think the hospital is the last place people want to be. And I mean we've heard . . . I've had conversations with psychiatrists who say they need those community resources, all those kinds of things. I'm wondering for that 4.2 million, how many people does that purchase in Saskatoon, for example? So how many positions?

Ms. Willerth: — These are really early days of planning for that with the Health Authority. And you know, we're imagining that there is about 40 FTEs [full-time equivalent] that the funding would provide. How they divvy that up and how they'll make decisions about where the dollars go to within the Saskatchewan Health Authority across the province is yet to be determined.

Ms. Chartier: — So we have no sense then of those 40 FTEs, how many would be in Saskatoon, taking some of that pressure off?

Ms. Willerth: — So again I would say there's approximately 40 FTEs. They'll be making specific decisions and looking at what the pay bands are and, you know, what those dollars allow. But the Saskatchewan Health Authority has not yet made decisions about the distribution of those dollars.

Ms. Chartier: — Do we know which communities . . . You said this programming or these teams will be in communities that have rehab . . . or sorry, in-patient units and the rehab teams. Okay. I just wasn't . . . yes. So how many communities would those approximately 40 FTEs be spread out between?

Ms. Willerth: — Well I think what we're suggesting to the Saskatchewan Health Authority is that they would be attached and based out of those communities that currently have in-patient mental health units, but they wouldn't be exclusive to those communities. So if individuals were with significant needs and appropriate for this kind of supports, or from communities outside of Saskatoon city or Regina city or Prince Albert, that they would have to have . . . We would want them to have some flexibility to be able to respond to people from other communities as well.

So attached to those in-patient units where they would likely be discharged with, you know, planning with psychiatry for that kind of intensive support for as long as they need it. They wouldn't necessarily need it for great lengths of time but having greater intensity of service provided as they leave, with some flexibility to be able to say across the province you get a similar kinds of service, even though you might not have a need for a whole team in a very small community.

Ms. Chartier: — Well I certainly appreciate this kind of approach, but I guess the point is for the last . . . I've got the numbers for the last three years at the Dubé, but I understand that's it been several years in the making. It's been several years that over capacity is an issue, and approximately 40 FTEs across the province is a start, but I'm not sure that that'll completely relieve in the short term this pressure, so in the meantime . . .

So just thinking about a comment that I think the deputy minister made, that people who are less ill are in the ECT area, but recognising that . . . So my whole point about being triaged in the middle of the night into different spaces to get the least sick people in those overflow beds means that you have to be moved around when new patients are coming in. So I'm wondering what the minister thinks, that this has been going on for several years now.

I don't know about other psychiatric facilities or acute

psychiatric health centres, but this has been an ongoing trend here in Saskatoon. And I've heard again . . . And I look forward to finding out if the double-bunking is happening, but double-bunking is never good for anybody, but people who have suicidal ideation or in a state of psychosis, I can't even imagine what that would be like.

Hon. Mr. Reiter: — Well we'll follow up with the double bunking, as I said. We'll see if we can get it for you today. If not we'll follow up.

To your other point, though, I would just say this. You know, you talked about the 40 FTEs. We realize that in many instances it's not an ideal situation. That's why we've committed to, in the out years, we're going to be spending more on mental health. We're going to be expanding the services. You're seeing sort of year 1 of this new approach. We're going to increase provincial funding. We're going to use all the federal monies that are available.

So you know, I'm glad you seem pleased with that approach and said it's a start, I think is what you said. I would agree. That's how we feel about it too. We know we need to do more.

Ms. Chartier: — And please don't . . . It is a start, but I think we've had this conversation in the House. We're at about 5.3 per cent of mental health dollars — I don't want to waste my time here — we're at about 5 per cent, where the national average is 7 and then other provinces are moving to 9 per cent and other jurisdictions that do well spend over 10 to 14 per cent of their health budget on mental health. I know you've said that when finances become available you'd like to move to 7 per cent, so I'm just wondering what that means or what that looks like when . . . In terms of a plan of getting to 7 per cent, what does "when the finances improve" look like? Do you have a number?

Hon. Mr. Reiter: — I think you're going to likely see it increase every year as we make use of the federal funding, but you know . . . And again, you're right — we have talked about this in the House, but there's some things we disagree on. I mean, when you talk about the 5 per cent versus the 7 per cent, I've also talked about because sort of the standard you're using is that it's a percentage of the Health budget, but there's also significant spending in mental health in other ministries that doesn't apparently get counted in that.

Ms. Chartier: — Do you think other jurisdictions don't do the same thing though?

Hon. Mr. Reiter: — I don't think, to the best of my knowledge, I don't think there's a Farm Stress Line in a lot of other jurisdictions, in a lot of other provinces. That's an expenditure in Agriculture that's purely for mental health. I mean if it was transferred to the Ministry of Health instead of the Ministry of Agriculture, suddenly it would count. That to me is kind of . . .

Ms. Chartier: — With all due respect, we have people who are very ill being put in pods in the ECT room from . . . And I look forward to having this confirmed whether or not this is the case, people who are acutely ill, double bunking at the Dubé Centre, people being moved around. We have got our largest acute psychiatric facility always operating over census for the last several years.

I think we have . . . and I appreciate this work around community teams. When I've talked to psychiatrists and others, they are begging for other supports. But by no means is this enough, and I think it's shameful that people with mental health concerns are not getting the care that they need and deserve.

Do you have the number, when we were talking about capacity, if 66 in the last fiscal year was the average, do you have the peak number?

Hon. Mr. Reiter: — The officials tell me we don't have the peak number.

Ms. Chartier: — Okay. I know that we're not going to be meeting again in terms of committee but I know you've committed to table a few things that we're waiting for, so I'd ask if you could get, if it was available to you, the peak numbers for the last three years on both the adult side and the children and youth side as well.

So I've got the average operating census but I'm wondering if I could get that broken out, the average operating census for the past three years for both the adult and the youth side, because I think that will give us a clearer picture in terms of what's going on with adults and what that is looking like.

So if I could get the peak number for the last three years at the Dubé on the adult side and the child side and the average operating census for the last three years on the adult and youth side broken out, if that's possible. If you could table that with the committee, that would be great. Is that possible?

Hon. Mr. Reiter: — Certainly I'll ask officials. If they can get those numbers, we'll table them.

Ms. Chartier: — Okay. Thank you very much. So again to the question around getting to that 7 per cent, I know that that's a commitment that some of your fellow ministers have made in the leadership contest, but as well I know you've commented that when finances are . . . I can't remember the term that you used, but I'm wondering if you have in mind . . . You've said you'll increase spending every year, and obviously the federal dollars ramp up every year, but I'm wondering if you have a sense of when the fiscal situation, what it has to look like to be able to get to that 7 per cent.

Hon. Mr. Reiter: — I don't, and I'll tell you why. I'm not shirking the question. It's a fair question. Obviously when you're dealing with percentages, to say we're going to go to 7 per cent of a total amount, the impact that overall health expenditures have is huge. We've increased spending overall in health care the last 10 years by a lot, far greater than the rate of inflation. So it depends what you're comparing it to, right? So the rate of increase in the overall health spending is obviously going to have an impact on at what point in time you reach the 7 per cent.

So having said that, I mean it's very clear. Just as an example, I think both the Premier and the Deputy Premier during the leadership race and since then have said that that's certainly

their goal. It's a goal of cabinet and caucus. So you know, I think it's fair to say that you're going to see increases in mental health spending again next year. Obviously it has to go through the budget process so I can't tell you to what extent, but I think it's fair to say in the next number of years you'll continuously see that.

Ms. Chartier: — And obviously there's federal dollars that are coming too that'll ramp up. Sticking with mental health here you also tabled some numbers around long stays and multiple stays in acute psychiatric facilities. So I just want to tie this to the North Battleford hospital here a little bit.

So right now there's 156 beds and you're moving to 188, so that's an addition of 32 beds. And it looks like the average the last three years is 33, so that's the number that you tabled for those who have been admitted for the rehab beds. But the demand for these beds is still considerably higher, in looking at all the data that you had tabled around long stays.

So I'm concerned that . . . And in the document that you tabled, you explained in your tabled note that the number of rehab beds admitted is limited in part due to long-term, detention-ordered patients, and mostly because of those deemed not criminally responsible under the Saskatchewan Review Board. You said that there's no control of these inward flows and said that the discharge of these and other long-stay patients at North Battleford hospital remains difficult due to the complex nature of the cases and supports that would be required.

So you have no control of the inward flows, and you gave me some numbers. Be patient here; I'll get there, to the question. Okay. You gave me some numbers around acute in-patient hospitalizations. Just looking at the tabled documents. So I'd asked for, in the last three fiscal years, how many people had an acute in-patient hospitalization in a designated mental health bed in a Saskatchewan hospital where the entire hospital stay was more than 60 days.

[16:00]

Last year there were 144 people. And obviously not all of those individuals would be folks who'd be waiting for a placement, a rehab bed, but a number of those would.

So I guess my point is, I think that we're going to have some issues around capacity in a brand new facility, that the demand for rehab beds is higher than, the demand for the rehab beds is higher than what we will have, even with this new facility. So I'm wondering again what concrete measures and programs you're putting in place with a rebuild of the hospital that will increase the numbers of persons admitted each year to the rehab beds, besides the addition of these 32 extra beds?

Mr. Hendricks: — So last time I talked about that there would be an announcement and, as you know, the federal Minister of Public Safety, Ralph Goodale, and our ministers recently announced our bilateral agreement with the federal government, which we all know about. But as part of that funding envelope, we will see that increasing, as we've mentioned, over the next several years.

And one of the key issues that we are trying to address and will include in that, is the establishment of residential options that include intensive supports for individuals with serious and persistent mental health issues. It will improve client outcomes and overall quality of life while addressing health system priorities. So this is this notion of reducing lengths of stay, that sort of thing, providing step-down supports 24 hours a day, 7 days a week. So these are really the community residential supports that I think I've talked about before at this committee in conjunction with SHNB [Saskatchewan Hospital North Battleford] as a way of kind of decanting people from that facility who are ready to transition back to the community.

Ms. Chartier: — Well I'd asked about that a few years ago, the report that your ministry and the region had done on that. So can we expect an announcement in the near future? So I think you'd said last time that there would be an announcement. So can we expect an announcement on supportive step-down housing in the near future then?

Mr. Hendricks: — So as part of this federal government we've notionally allocated each year of funding to specific areas, this being one. But we're still going to have to go through treasury board, so the specifics of this and what that will entail and where the beds will be or what supports will be available will be made available in the future. But the wording is in a public document that is available on our bilateral agreement, so you can see basically what we're outlining as our plan that we've agreed to with the federal government.

Ms. Chartier: — Okay I just want to make sure I'm understanding what you're saying. So in terms of the 10-year agreement, some of the money will be spent on housing at some point in time.

Mr. Hendricks: — It will be provided on providing supportive care in the community — right? — increased supportive care. That might include housing.

Ms. Chartier: — So is some of that . . . I think last time, and I thought I'd heard you say today too, can we anticipate something this year around any of that?

Mr. Hendricks: — So first of all when we, maybe just to go through this again, when we made the announcement of the agreement with the federal government on the bilateral piece, there was language that was agreed to with the federal government about our desire to go into community and residential supports for mental health, which does include housing.

What I'm saying is, is that our intention is to introduce that in the '19-20 fiscal year and to make more specific details available. But just as a matter of course, that has to go through treasury board before a commitment, a specific commitment is made to those resources just to get their okay. But that's clearly the intention of what we signed with the federal government and where we intend to go.

Ms. Chartier: — Okay. And specifically with the . . . so I'm just going to reiterate, so we have a federal deal that gives us an escalating amount of money, a pot of money specifically for mental health over the next 10 years. Looking at the data, there aren't enough rehab beds at the North Battleford hospital, or the

demand is greater, a little bit out of our control because of the long-term detention order patients and the not criminally responsible patients.

[16:15]

So the bottom line is, even with additional beds, the North Battleford hospital is not going to be able to increase to meet demand without doing some of these other things, like community support, which was sort of always, I thought, part of the plan. Am I hearing that? And then your plan in the '19-20 fiscal year is to, after you've taken it to treasury board prior to that, but your intention is to introduce some supportive housing tied to the North to better support the North Battleford hospital and patients who would be there.

Mr. Hendricks: — Yes. So if you separate the forensics beds and you just leave this in terms of the rehabilitation beds, if you do the math on which the new facility size was predicated, we said that you would need a certain number of people, or you would expect a certain number of referrals into the facility, and we would expect that a certain number are going out back into the community.

So you're aware that the federal funding only covers community mental health, right? And so our design here is to create these community mental health supports, the supportive housing that we've talked about for SHNB that would support these types, you know, where people could actually be released back into the community with the necessary supports. So that's our intention. I'm just saying that we have to go through treasury board — lay out a plan, make sure it's all, you know, cool with them, that sort of thing — before we actually release details.

Ms. Chartier: — Fair enough. And I mean I've read that report around what was needed for community housing, and it's not on the websites anymore. But I completely agree. I've heard from lots of people that the need for that supportive step-down housing is important, and especially in light of not having enough rehab beds. So can you just help me — this will be my last question I think in this particular area — in terms of numbers of beds that you anticipate using for rehab versus forensic beds, what of the 188 is the breakdown?

Hon. Mr. Reiter: — Sorry, Ms. Chartier, the officials just want to be 100 per cent sure they're giving you the right number. Can we just come back to that in a few minutes?

Ms. Chartier: — We could, yes.

Hon. Mr. Reiter: — Okay. Sorry, I just, in the instance of time, I don't want to delay the questions.

Ms. Chartier: — Yes. But if we could at some point today find out how many of those beds were rehab and forensic.

Hon. Mr. Reiter: — You will. Yes.

Ms. Chartier: — Okay. Let's stay on mental health and addictions. Can you give me the lay of the land around what publicly funded services are available for rehab from addictions in Saskatchewan? I've had a hard time sort of cobbling together a comprehensive list of publicly funded rehab.

Hon. Mr. Reiter: — I'll just ask Kathy to fill you in on that.

Ms. Willerth: — So again it's Kathy Willerth. So in our alcohol and drug services within the province, we certainly have a range of alcohol and drug treatment services across the province. Many, many of them are within the Saskatchewan Health Authority and then others are provided by community-based organizations, and this would include outreach services, outpatient services. We have over 50 locations in the province where addiction counsellors either travel to or are permanently located. We have detox services, in-patient treatment. We have some long-term residential treatment and some day treatment programming services as well.

You know, you're probably aware that we have, for youth who require more intensive and specialized services, we have stabilization and detox beds at the Calder Centre as well as in-patient treatment beds at Calder Centre. We also have in-patient treatment beds at Valley Hill Youth Treatment Centre in Prince Albert. We also have six beds that are dedicated to youth who are mandated to receive services under the YDDSA, *The Youth Drug Detoxification and Stabilization Act*. And you know, those would be in addition to the services that we talked about already.

Ms. Chartier: — Would it be possible, Ms. Willerth, to get a list of the . . . I'm interested in all the services because I've tried to sort of try to pull together a comprehensive list, but of the in-patient and the long-term residential services. Would it be possible to get a list of those for both youth and adult, and the number? Like not just which services, but the numbers of . . .

Ms. Willerth: — Of beds?

Ms. Chartier: — Of beds, yes.

Ms. Willerth: — I can give that to you now.

Ms. Chartier: — If you've got it, that would be great.

Ms. Willerth: — So we're looking at in-patient beds. We purchased some from "Slim" Thorpe Recovery Centre, and that was formerly through the Prairie North Regional Health Authority, now through the Saskatchewan Health Authority. They purchase what is equivalent to three beds.

Ms. Chartier: — For adults?

Ms. Willerth: — They are adults, yes.

Ms. Chartier: — Adults. Okay.

Ms. Willerth: — We have MACSI [Métis Addictions Council of Saskatchewan Inc.] in Prince Albert who run a centre with 16 beds. We have the Saskatchewan impaired driver treatment program in Prince Albert as well that has 28 beds. We have the Valley Hill Youth Treatment Centre in Prince Albert which has 15 beds. We have the Family Treatment Centre also in Prince Albert which has . . . well we refer to it as eight beds. They're for families, so there's actually considerably more people as

many of the women who bring their young children to that centre as well. So there's considerably more people, eight families.

[16:30]

MACSI also, we have a MACSI centre in Regina. They have 12 beds. Regina Qu'Appelle funds or buys services from Pine Lodge in Indian Head that has 23 beds. The adult program at the Calder Centre in Saskatoon is 32 beds. The Calder youth program also in Saskatoon is an additional 12 beds. And there's a third MACSI in-patient treatment centre in Saskatoon with an additional 15 beds.

Ms. Chartier: — So in terms of the in-patient beds, are these all . . . What kind, in terms of services that are offered here . . . Is there length of stay? Or how are all those services . . . And you mentioned youth I think, you mentioned the youth at Calder, and I don't think you mentioned youth in-patient anywhere else.

Ms. Willerth: — Valley Hill Youth Treatment Centre is 15 youth.

Ms. Chartier: — Valley Hill. The 15 beds are youth. Okay. In terms of what kind of treatments are offered there, or length of stay. Or do you have any of those details?

Ms. Willerth: — Well we do know that most of the programs base their program around a month, but that is not a hard and fast rule. They do attempt to provide programming that meets clients' needs, so some clients certainly stay longer or shorter, based on their treatment needs.

There are exceptions to that and that would be the Secure Youth Detox Centre, which is where you're mandated under the legislation, so it's determined by the order that you're there to stay. And the Saskatchewan Impaired Driver Treatment program are also sentenced there. So the sentence determines their length of stay at that centre as well. The Family Treatment Centre programming is designed around a six-week treatment intervention and sometimes young women go home early or stay longer and certainly we're aware of that.

Or, sorry, Valley Hill Youth Treatment program is also, they designed their program around six weeks as well, but a lot of young people either leave sooner or could stay longer. But it's designed for the . . . their design is around the six-week program with some young people getting their needs done sooner and wanting to go home and try out their new skills in their home community.

Ms. Chartier: — And can you help me with language here? In-patient beds and long-term residential beds, is there . . . So you refer to those as in-patient? But I know Calder isn't like 30 days; it's residential rehab.

Ms. Willerth: — Right.

Ms. Chartier: — Am I messing up terms at all there?

Ms. Willerth: — So, sorry, what was your question again?

Ms. Chartier: — So in-patient beds versus long-term residential services. Are we talking about the same thing there?

Ms. Willerth: — I think when we refer to long-term residential, we're like referring to Hopeview which is in North Battleford as well, and has been a program that has typically been a longer term. Often people who are referred to Hopeview have been through other treatment programs. They need a life skills element as well and they have been a longer stay. They've recently made some changes in their program to be able to be more flexible so that people might stay either the . . . similar to a month or longer based on their needs. So they made some recent changes to be able to be a bit more flexible.

Ms. Chartier: — And is that the only . . . So Hopeview has supported spots, provincially then, or it's all . . .

Ms. Willerth: — Yes.

Ms. Chartier: — And how many spaces are there?

Ms. Willerth: — Hopeview has nine.

Ms. Chartier: — Nine. Are there any other long-term residential spaces then or just Hopeview?

Ms. Willerth: — Hopeview would be what we consider a longer term treatment spaces.

Ms. Chartier: — Okay. And in terms of alcohol versus other substances, do most of these concentrate on alcohol? Or can you give me the lay of the land around alcohol versus other substance use?

Ms. Willerth: — We would say that all of our in-patient treatment centres address the needs of people who have whatever needs they're coming forward with. So there is not a treatment centre that says, I'm exclusive to one substance or another.

We do know that when outpatient addictions counsellors are working with people to help them choose the centre that they might go to, certainly lots of individuals have an opinion. They have heard good things or have had a family member or friend go to a certain centre and they want to go there as well. Or they want to go back to the place that they've been to before. Or they don't want to go back to the place that they've been to before. But you know, there are some centres who have a reputation for being very successful with, you know, populations who have certain drug-use patterns or alcohol-use patterns.

Calder has some additional supports from psychology and psychiatry. So individuals may choose to go there or their outpatient counsellor may suggest that they go there if they have both a co-morbid issue — some mental health issues and some alcohol and drug issues. Not that the other centres also don't see a population, but they in particular have some additional supports.

Our three MACSI treatment centres as well as Valley Hill Youth Treatment Centre have some cultural programming that would be in addition to some of the other treatment centres. And we, you know, are feeling quite confident about that being

a needed additional component for some of our population that comes to services. Not that others . . . Calder certainly also has a indigenous cultural component. But I think Valley Hill and MACSI have a longer standing history of having that as an important part of their programming.

Ms. Chartier: — Okay. Is there any . . . So you said that depending on what your needs are, that the treatment facilities support whatever needs. Is there any — and this is not my area of expertise — but is there any difference . . . I'm assuming there'd be difference in terms of addictions treatment for those who are coming in for alcohol versus, say, crystal meth or opioids. Like is there a difference in the services that you need to provide for those folks?

Ms. Willerth: — Yes, I would agree with that. I think some of where we see the biggest difference in needing to have an individualized approach would be in our detox centres. So as people are getting clean and sober and preparing for treatment, there would be more need to understand what substances they've been misusing and how to help them through that detox period.

I think they certainly would say that individuals experience different struggles if they are addicted to crystal meth, significantly more, you know, symptoms, physical symptoms than some other folks who might not . . . I don't mean to be sort of saying simply using alcohol, which can also be a very uncomfortable detox period, but I think, you know, there are some significant differences with some of the more harsh drugs that people can be addicted to.

Ms. Chartier: — Okay. Do you have the average? I think I had heard for Calder, chatting with someone, that the average wait to get into Calder was about eight weeks for an adult male. But do you have numbers from across the province in terms of folks waiting for an in-patient bed, what the wait times would be?

Ms. Willerth: — What we would have is an annual average that's provided to us, and not sort of a snapshot in time or today's.

Ms. Chartier: — Do you have it for every facility, or just for across the province? Or how do you break that data out?

Ms. Willerth: — So what I have that I can provide to you is when we ask the treatment facilities, or the SHA [Saskatchewan Health Authority] if they are funding the treatment facilities, what their average wait time for the year is. So this is not data that we've rolled up but rather when we've asked them, to be able to understand that and see how it compares to years in the past. So that's what I could provide to you.

Ms. Chartier: — Do you just have this year or do you have previous years as well?

Ms. Willerth: — What I have here is this year's.

Ms. Chartier: — Okay. Would it be possible — I'd love to hear it now, but I also am cognizant of the time here — would it be possible to get this year's? And if you happen to have in another binder that data that you've been provided, could you maybe table this year and the previous two years? With every other . . .

Hon. Mr. Reiter: — We'll see. If they have it available, we'll sure do that.

Ms. Chartier: — Yes, so this year she does have available for sure. But if you've got the previous two years as well, if you could table those, that would be great. Would it be possible to have that, in terms of tabling documents, Mr. Chair? Could you table the one that you have today? She's got one that she was going to read to me, but in terms of time?

The Chair: — Well it's up to the minister if they want to table it, but we would ask for eight copies.

Hon. Mr. Reiter: — Yes, I don't think we have a clean copy. We won't table it during this session, like during this hearing. But we'll table it soon, very soon.

Ms. Chartier: — Okay. That sounds good. I'd appreciate that. Okay. On that same theme here . . . I just need to get to my notes here. So looking to the provincial task force to address fentanyl and opioid deaths. Both referral to a CBC [Canadian Broadcasting Corporation] article where it says:

> The task force, which the province says is currently being formalized, will be co-led by the Ministries of Justice and Health, with representatives from the education, social services and advanced education ministries.

That was from a CBC story on May 26th, 2017.

And then from an SMA, Saskatchewan Medical Association, newsletter of June 5th, there is a story about Dr. Butt who is involved with the task force. And it says:

> The provincial task force of which Dr. Butt is a member will develop a multi-pronged, coordinated provincial response to the opioid and fentanyl crisis. The task force will be led by the ministries of Justice and Health, with representatives from other ministries.

So in terms of the task force, I'm just looking for some progress, where that's at. First of all, what resources were provided to the task force to put together a multi-pronged, coordinated provincial response?

[16:45]

Hon. Mr. Reiter: — So you had asked for what resources. The people on the committees are existing officials within individual ministries, so their salaries are paid by the individual ministries. Any other resources were within existing ministry budgets. And you had a second part, I think, and I'm sorry, I can't remember what you had asked.

Ms. Chartier: — So just sticking with the resources though, so not everybody . . . Was the task force simply ministry folk, or were there other people on the task force?

Hon. Mr. Reiter: — So besides the obvious ministries that, you know, you're aware — ourselves, Justice, etc. — there's also municipal police forces, the RCMP [Royal Canadian Mounted

Police]. Was there somebody specific you were wondering about or just general?

Ms. Chartier: — No, no. I'm just wondering what they . . .

Hon. Mr. Reiter: — Okay. There are outside ones as well. I guess most notably police forces, both municipal and RCMP, are engaged with it.

Ms. Chartier: — Okay. And how many people are on the task force?

Hon. Mr. Reiter: — Officials are just checking right now to get the composition of the task force for you.

Ms. Chartier: — Okay, that would be great. So back in the fall then, or this was in the spring actually, June 5th, where it mentions Dr. Butt and the multi-pronged, coordinated provincial response. So I'm wondering what has been the work product of this committee thus far, and what that multi-pronged, coordinated provincial response looks like.

Hon. Mr. Reiter: — I'm just going to ask Brad to walk through the work that the committee's been doing. He represents Health on the committee.

Mr. Havervold: — Thanks. Brad Havervold with the Ministry of Health, community care branch. So in terms of the drug task force's actions, so it's been in existence for about a year. Their role has been primarily to coordinate, disseminate information, and they're really in their forming stage of determining roles and responsibilities.

So they have five key theme areas that they act on. One is data collection, trend and risk analysis; emergency management; suppression; treatment and intervention; and prevention. And so within each of those five theme areas, there's a number of activities that the task force has taken on in the last year, and we're about to embark on our planning for '18-19 actions.

So some of the things that have been done is, last September there was a coordinated information session on opioid use. And it was multi-sectoral, organized through the task force and the Ministry of Corrections and Policing at the time.

Ms. Chartier: — And where was that?

Mr. Havervold: — It was in Regina, and it was open to a wide range of stakeholders and police forces.

Another thing that they've done is develop some communication mechanisms and tools to be able to assist when crises happened. And I think you've probably seen some witness of that when there was the recent incident in Saskatoon, a very coordinated approach to communicating with the public and with each other about how to respond to those issues. So that's already been enacted.

Certainly the take-home naloxone kits that have been established through the Ministry of Health is another action that has been coordinated through the . . . delivered by the Ministry of Health but under the auspices of the drug task force. And you'd be familiar with that.

Working with the Ministry of Justice on safer communities initiatives, those sorts of activities, and how that intertwines with, you know, the various sectors. Some other activities that, although not directly by the task force, would be the drug plan coverage to include suboxone as a substitution therapy, working again for a wider distribution of the take-home naloxone kits.

So its role really is around coordination and making sure that there's a coordinated effort between provincial efforts among various ministries and community partners.

Ms. Chartier: — Thank you for that. So you said that there's five key — 1, 2, 3, 4, 5 — data collection and analysis, suppression, treatment, prevention, and I missed one. But that's the role of the task force. They've identified those five themes and to try to find actions that will support those themes.

Mr. Havervold: — Right.

Ms. Chartier: — So there's no . . . Will there be a report produced? I know the Health minister has just stepped out for a moment. I just think that it's important that . . . Sorry, just for context here, so in the last two days we've seen stories in . . . The Saskatoon Police Service has identified a new, I don't know if . . . a new type of fentanyl, a more dangerous fentanyl that's on the streets. We've had people die in communities around Saskatchewan here in the last couple of months.

I googled this morning just out of curiosity, fentanyl, on the Saskatchewan website, and I got the . . . The top thing was what to do with an overdose, and admittedly that's helpful. But when you google the Alberta approach to the opioid crisis response, this is it, and it includes a number of . . . opioid emergency response commission, public awareness grants for communities, opioid reports, harm reduction, supervised consumption services. There's a lot of work that they're doing in Alberta and BC [British Columbia] and actually even in Manitoba. Recently I read an article that Manitoba has opened up rapid access to addictions, five rapid-access, front-line addictions clinics. So I'm wondering if . . .

I appreciate the work that folks in the ministries are trying to do on this, but I don't see a comprehensive strategy emerging, and I don't see a situation around fentanyl and opioids and crystal meth, to be perfectly honest, getting better. So I'm wondering if the minister thinks we could be taking a more robust approach to opioids.

Hon. Mr. Reiter: — Well I think first of all, to your point about comparing the websites, I did exactly the same thing. Alberta I think has done a good job. For example, if I'm not mistaken, I think they have it in 8 or 10 different languages. You know, they've done some things like that, which obviously makes it more lengthy. But I think much of the content is similar and I . . . Well then, we can agree to disagree. But I think our folks have done a good job on that website. Can we do more? We can always do more.

You know, you're saying we're looking for a robust strategy, but you mentioned that, you know, there's a new, more, I would say, more deadly form of fentanyl now. I mean, people can't always anticipate those things. So to say you're going to unveil a strategy that's going to be all-encompassing, I don't think

that's probably realistic. I think what is important is to be able to be flexible, to respond when the need arises. I think we've been doing that.

We've been watching what Alberta and BC — who have been affected far more dramatically than we have — we've been watching what they've been doing and have been responding, for example making naloxone more available, how we've done that, the unscheduling of it recently, making it more available. Those sorts of things. So obviously we are very concerned about this, but this isn't . . . As you said, this is in Alberta and BC as well. This isn't a unique-to-Saskatchewan problem.

Ms. Chartier: — Oh no, not unique to Saskatchewan, but the response. Other jurisdictions have been more robust in their response. I didn't say all-encompassing; I said robust. And again I'm not diminishing the work that ministry officials, both in Health and Justice, are doing, and folks like Dr. Butt are trying to do with no extra resources.

But I think that that's . . . You just used the word "responding," Mr. Minister. I don't think we should be responding. I think we should be proactive on this, and not just watching and responding, but anticipating that it's only a matter of time before things get worse here in Saskatchewan. And we've lost people. I've talked to families, as I'm sure you have, who have lost loved ones to fentanyl. So I'm wondering if you think our response thus far has been adequate.

Hon. Mr. Reiter: — Well you know, I realize it's your job as critic to be critical. But the fact of the matter is, officials, police forces have done a great deal of work on this. Our committee has worked hard on this, have tried to respond, have done things that I think are appropriate: making naloxone more available, looking at best practices in other jurisdictions, what Alberta and BC have done. And I think we have taken appropriate measures.

Can we do more? Obviously we want to see what best practices, we want to see what's working in other jurisdictions. We're going to take advice of officials. But frankly I think much of your criticism is unwarranted.

Ms. Chartier: — Can you show me what the task force is telling you in terms of the work that they'd like to see happen? Is there in fact a report? I know that the commission, the Opioid Emergency Response Commission actually just issued a report with many, many recommendations. So I'm wondering if the task force is in fact coming up with a report with recommendations.

Hon. Mr. Reiter: — So the terms of reference for the committee weren't to issue a report. I would describe it as to coordinate approaches between the different ministries, between the police forces, that sort of thing. That's not, though, to preclude if at some point in time it's deemed important, or if the committee thinks that, they may issue something publicly. I don't want to preclude that, but that wasn't the sort of defining role of the committee.

[17:00]

Ms. Chartier: — Are the terms of reference public? Did I miss those somewhere?

Hon. Mr. Reiter: — Officials are just checking if there is something publicly for that. My explanation for it was much of what I just said. It was to be coordinating approaches amongst the different ministries and police forces. But we'll check if there's something we can provide.

Ms. Chartier: — Okay, yes. If it's possible to . . . If it's already not on the web or somewhere publicly, if you could add that to your list of things that . . . Tabling the terms of reference for the drug task force would be very helpful. I'm just making a note of that. So were there any additional . . . Were there new hires or new people? Or the folks who are sitting on the task force are all existing employees, so this is just a piece of their work?

Hon. Mr. Reiter: — It's all existing officials that I would describe as sort of in their area or it would be logical choices for the committee.

Ms. Chartier: — Okay. Okay. So I just want to clarify that there were no additional resources put into this task force? Obviously the work of the officials who are doing it but in terms of other resources to bear or to bring other people in, there were no . . .

Hon. Mr. Reiter: — It would be resources that are within existing ministry budgets.

Ms. Chartier: — Okay. Okay, and were you able to find the list of who is on the task force?

Hon. Mr. Reiter: — Just getting it now. I'll get Brad to walk through that.

Mr. Havervold: — So myself, Brad Havervold, as Co-Chair along with Cory Lerat from Corrections and Policing. Members are Dr. Shahab, who's the provincial Chief Medical Health Officer; Kathy, my colleague in mental health and addictions; one of our alcohol and drug staff within our branch, Martina; Amanda Vansteelandt, who is a seconded public health officer from the Public Health Agency of Canada; Dr. Peter Butt, as you mentioned; Dale Tesarowski from the Ministry of Justice; Rob Cameron, who is also from the Ministry of Justice. And some of these individuals might be Ministry of Policing now depending on the split so I would have this from a former time: Kait Quinn, who's also with the Ministry of Justice; Gina Alexander from Ministry of Justice; Flo Woods from the Ministry of Education; Mike Pestill from Ministry of Advanced Education; Jamie McGough from Ministry of Social Services; Superintendent Dave Haye from the Saskatoon Police Service; Superintendent Brad Anderson from the RCMP; and Inspector Paul Saganski from the RCMP.

Ms. Chartier: — Thank you. Do you think it would've been helpful to bring community in as well? I mean those are all people who have a certain knowledge area which is no doubt incredibly important, but do you think it would've been useful to pull together people in community as well?

Mr. Havervold: — So I just want to clarify I think your request was around whether there are people that might be impacted by the opioid issue, like families or that sort of thing?

Ms. Chartier: — Families who would be impacted as well. People with lived experience or people who work with those with lived experience.

Mr. Havervold: — Certainly we don't have them as members of the task force at this point, but as I mentioned before, we're going to be into '18-19 planning, so I'll certainly bring that back to the task force for thought. It's a good point.

Ms. Chartier: — Yes. Thank you. And one final question. So we talked about opioids, but I know in Saskatoon and I know elsewhere as well that crystal meth is a real issue, so is that part of this task force's work as well?

Mr. Havervold: — So in short answer, yes, and it does have a mandate to examine crystal and to look at crystal meth issues within its mandate.

Ms. Chartier: — Okay. I'm very cognizant of the time here and have a lot to cover here. Did I ask . . . I asked; you were going to table the terms of reference. Is that right?

A Member: — Yes.

Ms. Chartier: — Yes, okay.

Hon. Mr. Reiter: — Yes, sorry. If it's something we can publicly table, we will.

Ms. Chartier: — Okay. And terms of reference shouldn't be anything . . .

Hon. Mr. Reiter: — Well I'm not clear what was set out for the committee, so I just . . . If we can, we will.

Ms. Chartier: — Okay, okay. We're going to move on to eHealth questions now. I want a little bit more . . . I need to understand a little bit more, the CEO [chief executive officer] story here. So was Ms. Antosh terminated last year or did she retire or move on to another job?

Mr. Hendricks: — So Susan finished her term with eHealth on March 31st, 2018 . . . or sorry, finished officially on March 31st, 2018, but from the time of October 23rd to March 31st, 2018, she was seconded to be a special adviser to me, the deputy minister. Kevin Wilson took over for her during that period on October 23rd, 2017 and he completed on April 27th, 2018. I would just mention that Kevin was there also for a period of several months before taking over the CEO role to assist with the IT [information technology] transition and the SHA.

Ms. Chartier: — Okay. So just for clarification then, she was seconded to the ministry then?

Mr. Hendricks: — Yes.

Ms. Chartier: — So when you say she finished her term, sorry, is that a position . . . is that a . . .

Mr. Hendricks: — So when she was seconded, she is still technically an employee of eHealth but from the period from October 23rd, 2017 to March 31st, 2018, she was seconded to the Ministry of Health from eHealth.

Ms. Chartier: — Okay. From eHealth. But she was still the eHealth . . . So help me understand this. So I asked if she was terminated or if she went on to other things and you told me she was seconded. But you said when . . . So what kind of parting of ways was it with eHealth then?

Mr. Hendricks: — So from eHealth on March 31st, Susan was severed from that organization.

Ms. Chartier: — So in the time that Mr. Wilson was in the interim position, did you know that, was it made abundantly clear . . . like, did Ms. Antosh know that she would be severed from eHealth at the end of her secondment to the ministry?

Mr. Hendricks: — Again that, I think, is a personnel, human resources matter that I'd rather not raise in committee.

Ms. Chartier: — Did you anticipate she'd be coming back? So I was a little confused yesterday around the whole CEO piece and Mr. Wilson being an interim CEO. So was the plan to have . . . what was Mr. Wilson's . . . Was there a plan in place to end at the end of April 2017? Like, was the secondment . . . The secondment was a contract that was laid out and that ended. Ms. Antosh was severed. Mr. Wilson was there, planned. Did we know that we would have no eHealth CEO after Mr. Wilson?

Mr. Hendricks: — I think I know what you're asking. So it was always, you know, it was intended that Kevin was an interim CEO to kind of fill in for the period when Susan wasn't there. As it happens, Kevin went on to another job with the Saskatchewan Cancer Agency. So that ended his term with eHealth.

Ms. Chartier: — Okay, so he resigned and took a different role.

Mr. Hendricks: — A permanent job with the SCA [Saskatchewan Cancer Agency].

Ms. Chartier: — Okay. But just to be clear, he resigned from that.

Mr. Hendricks: — Yes.

Ms. Chartier: — Okay. I was confused . . .

Mr. Hendricks: — But he resigned from the Ministry of Health because he was seconded from the Ministry of Health to eHealth.

Ms. Chartier: — Okay.

Mr. Hendricks: — Just to make matters more confusing.

Ms. Chartier: — Yes. So in the time that Mr. Wilson was the interim CEO of eHealth . . . This wasn't making sense to me yesterday, how you've had now — and you're the interim CEO — that you didn't have a CEO search that started back in the fall. But it's because you still had a CEO and Ms. Antosh. Is that why there was not? You've just recently started the CEO search, is what you said in committee yesterday, or the board

had just recently started the CEO search.

[17:15]

Hon. Mr. Reiter: — So I think I can address this. So there was significant changes happening. I mentioned yesterday about the board changes. So the board changes officially kicked in early this year, January I think it was of this year. But there was orientations. And I don't know the dates they did everything, but I think the first board meeting was probably March. So the CEO search, sort of, I would describe it as kicked off then from at a board level.

So is that what you're asking? Like you're wondering why the CEO search hadn't started sooner?

Ms. Chartier: — Exactly. We had two interim CEOs without a CEO search, so that's what . . . I was very confused by that.

Hon. Mr. Reiter: — I think that's fair. I think, you know, for a period of time in the fall there was some discussions on, you know, where we'd go. Then the decision was made that there'd be significant board changes. So it just seemed appropriate to get those board changes in place and up and running before the official CEO search kicked off, because the board should be dealing with that.

Ms. Chartier: — Okay. So going on to the board then, so there's eight board members. There are eight board members. Is that . . . That's correct. What is the length of their term normally?

Hon. Mr. Reiter: — So you said the number and when the terms expire?

Ms. Chartier: — Well there are eight, according to the last . . . So I just wanted to confirm the number. The board is made up of eight?

Hon. Mr. Reiter: — Oh, I see. The new board is seven.

Ms. Chartier: — So generally speaking, like is there parameters in terms that the board is normally eight people?

Hon. Mr. Reiter: — We can check. There's a range that it can be in. I'll check what that is. I don't know off the top of my head.

Ms. Chartier: — Okay. And so the length of term of board members, then?

Hon. Mr. Reiter: — The board members right now are terms expiring in January of '20-21. So it would have been three-year terms.

Ms. Chartier: — Is that laid out anywhere, the length of terms?

Hon. Mr. Reiter: — Those are OCs or orders in council. So they're laid out in the OC.

Ms. Chartier: — Okay. So the current board term expires in, sorry, January '21.

Hon. Mr. Reiter: — Right.

Ms. Chartier: — And they started in January of '18. Okay, so are they normally three-year terms? So it was laid out in an OC that they . . . But is that how long the terms have been?

Hon. Mr. Reiter: — I think generally that was the case but, you know, as you know with an OC though, generally that's considered at pleasure, right, so they can be rescinded or changed. And so they can vary. But I think in this case, that's been sort of standard.

Ms. Chartier: — Okay. You had mentioned yesterday that there were some resignations. I'm wondering who had resigned from the previous board and when.

Hon. Mr. Reiter: — There have been three resignations: David Fan, Scott Livingstone, and Velma Geddes.

Ms. Chartier: — And when did these resignations take place?

Hon. Mr. Reiter: — All in 2017. One in September, one in August, and one in June.

Ms. Chartier: — August, September, and June. Obviously Mr. Livingstone was taking on a different role.

Hon. Mr. Reiter: — Right.

Ms. Chartier: — And David Fan, sorry, can you just tell me who was, and when? Who resigned when?

Hon. Mr. Reiter: — David Fan resigned in September.

Ms. Chartier: — Okay. And Mr. Livingstone?

Hon. Mr. Reiter: — In August. And Velma Geddes in June.

Ms. Chartier: — Did they provide reasons for their resignations?

Hon. Mr. Reiter: — As you mentioned, Mr. Livingstone took a CEO job so I would assume that was the impetus for it. And the other two, you know, you serve a board like that, they're not required to give reasons. So whether they did at the time, I'm not clear what they had said.

Ms. Chartier: — Okay. And you had said yesterday that some of the members' terms had expired, so I'm wondering whose terms had expired.

Hon. Mr. Reiter: — So two had expired on December 18th.

Ms. Chartier: — December 18th, 2017.

Hon. Mr. Reiter: — Yes.

Ms. Chartier: — Two expired, and who was that?

Hon. Mr. Reiter: — Kimberly Kratzig and Marian Zerr.

Ms. Chartier: — Okay. So three resigned, two expired, one stayed on. And who am I missing? So there were eight board

members this last year. I just want to make sure I understand the lay of the land here. So in the last annual report, there were eight board members. We've got three resignations. We've got one staying on and two expiring. So that leaves two. What happened to the other two?

Hon. Mr. Reiter: — One is a staff person in the ministry. And it was determined with the new board that we wouldn't do that, that we wouldn't have ministry officials as full board members.

Ms. Chartier: — Okay. And who is that?

Hon. Mr. Reiter: — They can obviously act in an advisory role. Duane Mombourquette.

Ms. Chartier: — Okay. And am I missing one other person?

Hon. Mr. Reiter: — Gerald Fiske, and he had been the Chair of the board.

Ms. Chartier: — And so his term wasn't expired, and he didn't resign. So he was just replaced at the will of the . . .

Hon. Mr. Reiter: — Yes. He wasn't appointed to the new board. Right.

Ms. Chartier: — Okay. How long had he been on the board?

Hon. Mr. Reiter: — He was originally appointed in March of 2013.

Ms. Chartier: — Okay.

Hon. Mr. Reiter: — So roughly five years.

Ms. Chartier: — Okay. Just in terms of staff, I know yesterday we talked about some of the interim staff. And, Mr. Minister, you'd said that Mr. Hendricks isn't just a caretaker. I mean, he's the interim CEO, but not just a caretaker. So I'm just wondering, between now and the time that the new CEO hire happens, will we be anticipating any of those positions being filled in a permanent way?

Hon. Mr. Reiter: — I think it's fair to say Mr. Hendricks certainly has the authority to do that, but I think it's fair to say he, you know, he just started in that role. So he'll want to take a little bit of time to evaluate and make those decisions.

Ms. Chartier: — Okay. So in the terms of the timelines for people being let go, you said all three were severed in early April, and several severed at the same time, and that there's an internal investigation where you're using outside counsel. Who are you using for outside counsel, and when is that investigation expecting to be wrapped up?

Mr. Hendricks: — So the law firm that's assisting with the investigation is MLT [MacPherson Leslie & Tyerman]. They've begun what I'll describe as a second phase of work in this review. How long or how short the investigation will be will be determined by what, if anything, they find in that phase 2 review.

Ms. Chartier: — What was the first phase of work that they would've done?

Mr. Hendricks: — The first phase was an initial review, when they were asked to do and they conducted a review of certain information items and provided recommendations.

Ms. Chartier: — So from those recommendations, did you ask them to carry on with further work then? So they do a first phase with an initial review and conduct the review and provide you with recommendations. So then they provide you with recommendations, and then you asked, hired them to do a second review. Or was that always part of the plan?

Mr. Hendricks: — So I hope you appreciate, Ms. Chartier, I'm trying to be as forthcoming as I can, but obviously there's sensitivities when you're dealing with HR [human resources] issues and personnel issues, which I raised last time. So last time, you know, phase 1 was really around concerns that the code of conduct and/or conflict of interest guidelines or policies in place at eHealth had been violated. Based on that work it was decided a second phase of work was also warranted. But the initial phase was sufficient to take the action that we did with those employees.

Ms. Chartier: — Okay. So the first phase happened before they were terminated.

Mr. Hendricks: — Correct.

Ms. Chartier: — Okay. Okay, that paints a better picture. Will that report be made public?

Mr. Hendricks: — I would think not. It's a personnel matter.

Ms. Chartier: — Okay, yes. And how will we know if it warrants police charges?

[17:30]

Mr. Hendricks: — So first of all, it's premature to say that this item is being turned over to police. I'm not aware yet or haven't been briefed on any criminal wrongdoing or whatever. But my experience of this, and we've had a few situations over the years, is that you would turn it over to the commercial crimes unit or to the city police, commercial crimes of RCMP. And they would make a determination of whether there was sufficient evidence or, I think, it was in the public interest actually to proceed with prosecution. And you know, at that point that would become public if they decided to prosecute the case.

Ms. Chartier: — Okay. Thank you for that. Sticking with eHealth and changing gears here a little bit, going to chapter 2 of the 2017 Provincial Auditor's report volume 2, page 23, a recommendation. It was a previous recommendation from 2007, so more than a decade old:

> We recommend that eHealth Saskatchewan have an approved and tested disaster recovery plan for our systems and data [noted as partially implemented].

The Auditor points out that:

> During the year, while eHealth completed its business continuity plan (which encompasses its IT disaster recovery plan) and began testing recovery of its critical IT systems, it had not completed those tests.

And the auditor goes on to write:

> As of March 31, 2017, eHealth had created detailed recovery plans for 4 of its 39 critical IT systems. It had tested whether the plan worked for one of these IT systems. eHealth plans to continue to test the plans for remaining IT systems in 2017-18.
>
> Without tested plans, eHealth, the Ministry of Health, and the Saskatchewan Health Authority may not be able to restore their critical IT systems and data (such as the Personal Health Registration System, Provincial Lab Systems) in the event of a disaster. These entities rely on the availability of those systems to deliver and pay for health services.

So I'm just wondering, in that year, what kind of progress has been made on testing or creating recovery plans, and then testing whether the plan works for those systems?

Hon. Mr. Reiter: — Officials tell me that this is going to be coming to Public Accounts in, I think, 10 days. So they're going to be giving a detailed sort of update on that. If you like, would you like us to table?

Ms. Chartier: — Yes, I wouldn't mind knowing now if you've got . . . I mean, I'm sure people at PAC [Public Accounts Committee] will appreciate it. Lots of these folks, or I guess none of these folks are on PAC anymore. But I would appreciate having that information now. I appreciate that it's going to PAC, but I've got you, the minister, here today to talk to.

Hon. Mr. Reiter: — I'll check what they have available here.

Ms. Chartier: — Okay.

Hon. Mr. Reiter: — Ms. Chartier, you said you had a lot of questions, so I don't want to belabour this. They're sending emails right now. They're going to try and get us an update in the next few minutes if we can, but I thought I'd mention it now in case you want to proceed with something else and we'll come back.

Ms. Chartier: — Okay, yes. Fair enough. So I'm looking for basically the update that they'd provide to PAC, and how far on that plan . . .

Hon. Mr. Reiter: — We're not meeting with PAC for a few days, so I'm not sure that they have it in entirety. I don't know if they'll have that, but we'll try to get you what you want.

Ms. Chartier: — Yes. I don't need a full presentation. I just want the numbers, so the detailed recovery plans. As of last year, there was only 4 out of its 39 critical IT systems and had only tested one. So I'm just wondering what progress in terms of those numbers has been made. I don't need a whole . . . We'll go from there once we know what those numbers are.

Hon. Mr. Reiter: — We're checking.

Ms. Chartier: — Because obviously transferring all of IT over to eHealth, when the auditor is flagging concerns around data, raises some concerns for me and for lots of other people. And this is an organization that is in a bit of a flux at this time too. So we have an organization that seems not entirely on sure footing right now, taking on some new responsibilities and getting more money from other areas to do this work. And I want to make sure, I want to hear that there's plans in place to ensure the safety of our data. I think that that's important. Let me just take a look at my notes here a little bit.

In terms of that data, just through some conversations that I've had with folks around . . . I've heard through the grapevine that there's some interest in, the minister has some interest possibly in selling data at some point in time. I just want to clarify whether that is the case or not.

Can I maybe help you out with some context here? . . . [inaudible interjection] . . . Okay, yes. No, for sure. So I understand several years ago a number of provinces considered the idea of selling health data. Some of the biggest issues that were flagged was privacy and the politics of selling our data to big pharma, medical device suppliers, and others. So I'm first of all wondering if we know if any other provinces proceeded.

Hon. Mr. Reiter: — I'm sorry, I'm reaching here because I've never directed anybody to sell data. But we're trying to understand sort of where you're coming . . . I think Max may be able to clarify this.

Mr. Hendricks: — So for decades now we've had an area within our population health branch, or whatever it's been called throughout the years, that I would describe as, we've called it pharmaco-epidemiology unit. And what they do is they work with researchers and other organizations on a cost-recovery basis to provide information to support research.

All that information that is provided is done so on a de-identified basis. We're not selling personal health information. Basically it's scrambled so that you cannot identify it. And as I said, there are agreements in place in terms of how that data is used by those organizations who are doing that research. But we don't sell data.

Ms. Chartier: — Are we currently passing data on a de-identified basis to researchers? Is that what you're . . . Or you're just saying that that happens elsewhere? So you just explained that researchers . . . You talked about de-identified data and data being scrambled. So are we doing that right now?

Mr. Hendricks: — Yes. For example if the U of S [University of Saskatchewan] was doing a study on a specific illness, they might ask us for information, researchers there. They might have us link a couple of databases. But any data that we provided them would be, as I said, de-identified and would be unrecognizable to them in terms of personal health information.

Ms. Chartier: — Okay. So I just want to put this on the record and then just have some clarity and clarification and peace of mind here. So in conversations with a variety of people, I'm just going to throw this out here and just . . . I want the minister to

have an opportunity to shut it down. This could all be rumour. I recognize that rumour is often far from reality but . . . So I've heard the term privatization, not dissimilar from ISC [Information Services Corporation of Saskatchewan]. And so I have to preface this by saying IT is not and databases are not my . . . I don't have a huge understanding around these things. So when someone said to me that there were plans or thoughts or the balloon had been floated around privatization of eHealth, not dissimilar from that of ISC, it was one thing I heard.

And then there was another piece around actually the idea that the minister was very fond of the idea of . . . had heard that there was money to be made in selling data and other jurisdictions had looked at it. So I just want clarity to you, to put it on the record now that those things were all just rumour.

Hon. Mr. Reiter: — I just wonder if some of the confusion is this: I have had discussions with the eHealth board saying that the type of services they provide, if they had an opportunity to provide those sorts of services to another province, obviously as a revenue generator that I, you know, depending on the arrangement, I think that would . . . obviously I want them to look at those sorts of things. But my conversation never involved selling Saskatchewan citizens' data. I'm sorry, I'm just kind of at a loss here of where this is coming from or who said this to you or what it was. I don't know.

[17:45]

Ms. Chartier: — Well multiple people. And there are two different things I was trying to piece together, again if they were similar or connected in any way. But those were two different conversations. So you have had conversations with the board around eHealth selling services? Or what did you have in mind? Can you tell me a little bit about when you talked to the board?

Hon. Mr. Reiter: — Well sort of in terms of my understanding is that eHealth is sort of a front-runner in the country as far as the type of technology services they provide to Saskatchewan. So my thought, the discussion was if there's other provinces that, rather than reinventing the wheel, would look favourably on contracting services from eHealth, I would certainly look favourably on that. But that had nothing to do with selling our data to them. That was about providing services. So I apologize. I'm just at a complete loss with sort of what this is about.

Ms. Chartier: — Okay, and I'm just wanting to make sure. Putting that on the record then, you've had no conversations around the possibility of selling data in some way to other . . .

Hon. Mr. Reiter: — Well I, you know, forgive me if I'm being cautious, because I just don't want some conversation that happened a long time ago come up and in some way could be extrapolated somehow to that. But I have never directed anyone to sell data of Saskatchewan citizens.

Ms. Chartier: — Not that you've not directed someone, but have you had the conversation around the possibility? Have you had any conversations about the possibility of selling eHealth data of any sort to anyone?

Hon. Mr. Reiter: — What does that mean, of any sort? I don't know.

Ms. Chartier: — Well, with officials around . . .

Hon. Mr. Reiter: — No, no, you said data of any sort.

Ms. Chartier: — Well health stuff that eHealth . . . would fall under the purview of eHealth.

Hon. Mr. Reiter: — I don't recall any conversation that could even be stretched to that. I'm at a loss who would have told you this.

Ms. Chartier: — Okay. No, fair. I'm glad to hear that. Because that, again I think other jurisdictions didn't go there because of privacy issues and the politics of selling data to pharma and other places or medical device companies. So the piece around selling what eHealth has to offer, when you talk about state of the art . . . or I don't think you said state of the art, but as a front-runner in this area, what kind of services were you thinking when you've talked to the board?

Hon. Mr. Reiter: — Yes, Max has a better understanding of the technical side of this, so I'm going to get him to delve into that.

Mr. Hendricks: — Yes, so I think it would be fair to say that in a number of areas, eHealth is kind of in the one, two, or three position in the country. One of the early decisions, and I think one that has served Saskatchewan well, is that eHealth really moved towards having a provincial integrated electronic health record. In a lot of other provinces it was done, you know, by what would have been our equivalent of an RHA [regional health authority] or whatever. So in Alberta, there was Capital Health Authority developed one. And then Calgary also developed a separate one, so they couldn't talk.

So what we've done is we've created one that is universal to the province, and we have repositories of information that can be accessed from anywhere in the province. We can have common electronic medical records with our medical associations. So in many areas, I think that it would be fair to say, in terms of interoperability we do actually lead the country.

Now if you were to ask, you know, a 30-something health professional who uses handhelds and everything like that, always more to be done. And really technology, in terms of supporting business or in supporting clinical care in the health sector, is becoming more and more critical. So it's such a rapidly evolving field. But I think it is fair to say that even in areas like, you know, the citizen health portal that we talked about the other night, eHealth has been, you know, has been a leader.

Ms. Chartier: — So are we at the place where we're having discussions with . . . Can you help me, give me an idea what that would look like? I know you said you've had conversations with the board about selling to other provinces. So can you give me a sense of what that would look like?

Hon. Mr. Reiter: — Just to clarify, when you said, selling to other provinces, I was viewing it as offering services, right? So it was a very high-level discussion. Again the technology is

beyond me. So the way I laid it out to them is if there's opportunities in other provinces to sell services to them, in those cases then I would encourage them to look into it.

Ms. Chartier: — Okay. Just moving on here a little bit to the financial statements, schedule 1 from the annual report 2016-2017. Usually I know that, and you had pointed this out to me yesterday, that eHealth is a treasury board Crown. But with CIC [Crown Investments Corporation of Saskatchewan] Crowns, and I'm not sure about other treasury board Crowns, they table their remuneration for board members and management, both travel. And they break it out actually if you look at their . . . So I'm wondering if it's possible to get that, or why that's not included in eHealth financial statements.

It's not broken out, like the other Crowns actually break it out very specifically that board members get X for travel. No, it's got travel and it's one lump number, unless I'm missing something, which wouldn't be out of the realm of possibilities.

Hon. Mr. Reiter: — Sorry. In the interests of time, can we . . . I didn't realize that. Can we have officials, can I get back to you on that?

Ms. Chartier: — Yes. And in terms of the travel, $261,000, do you have a breakout of who went where and for how much?

Hon. Mr. Reiter: — If I could, officials just tell me . . . I'm not sure why it's not in the hard copy; they were just telling me it is online.

Ms. Chartier: — It is online? The schedule of . . .

Hon. Mr. Reiter: — The payee disclosure list.

Ms. Chartier: — Okay.

Hon. Mr. Reiter: — That's what they're telling me.

Ms. Chartier: — Online. Like, direct me exactly where I need to go.

Mr. Hendricks: — www.ehealth.sk.ca.

Ms. Chartier: — Okay, on the eHealth website. Okay . . . [inaudible interjection] . . . Are you being a smart aleck a little bit?

Hon. Mr. Reiter: — If you have problems with that, contact us and I'll try and . . .

Ms. Chartier: — Okay. Back to the point about data or the backing up, where did you get in terms of asking officials that? That's a pretty important question.

Hon. Mr. Reiter: — They don't have, as I understand it, everything together for public accounts yet. I can certainly follow up with you on it, but they don't have it right now.

Ms. Chartier: — Okay, well I will maybe come to Public Accounts then. That sounds all right. That Public Accounts meeting, you said, is in 10 days? And I guess it's . . .

Mr. Hendricks: — That's what I said, yes.

Ms. Chartier: — I would prefer to have the opportunity to talk to the minister about it, rather than Mr. Hendricks, not that I don't appreciate your comments either.

Hon. Mr. Reiter: — Well I don't go to Public Accounts. The minister doesn't.

Ms. Chartier: — No, I know, and that's why I'm asking the question here about IT systems.

Hon. Mr. Reiter: — Right. So certainly, if you like, after I have the information, my office is open. I can certainly meet with you and discuss it if you like.

Ms. Chartier: — This is a forum in which we can have these discussions too though, and that's sort of the whole point. But anyway . . .

Hon. Mr. Reiter: — I understand that but, you know, we don't have advance notice of the information that you're going to want, so sometimes we can't have it that quickly.

Ms. Chartier: — Fair enough. With respect to — we're running out of time here — but looking at software maintenance comparative to salaries actually, it's interesting. So software maintenance was 24.716 million and salaries were 30.901 million. I know those things are unrelated, but that seems to be . . . Can you tell me a little bit about the software maintenance number and what goes into that and why it's so high?

Mr. Hendricks: — I can give you, kind of going by recollection, what it is. So obviously eHealth engages with a number of vendors: Microsoft, Cisco, whoever is providing software. Sorry, Cisco provides switches and stuff. But whoever provides software: Sunrise Clinical Manager, those types of companies. And eHealth holds the licence for all those applications for the entire health system, so for 44,000 users. So software expenditures, and I think that's what's captured, maintenance are a pretty considerable . . . like the licensing costs are a pretty considerable expense for eHealth.

Ms. Chartier: — Okay. Just, I guess, one final question. So an organization that's been in flux, for all intents and purposes, is taking on a pretty big responsibility here in this next little while. It's $60 million more or $40 million more this year because of taking on other regions' IT. Is there a plan in place yet for taking this all on?

Mr. Hendricks: — So obviously the biggest part, the budget is one thing, but accepting the staff is perhaps the bigger issue. So what we've been doing with working through with the SHA is trying to identify those staff that are in information technology roles within the health authority. In some cases, certain staff kind of have dual roles where they're part-time clinical and they're part-time, you know, information technology or mixed role. In some of the smaller regions, we have people that have many kind of . . . you know, IT with this and finance and everything.

So we're working through that as quickly as possible with the

SHA. We've provided informational updates to staff with the SHA to kind of let them know what the process will be. And we've also had a couple of meetings jointly with the SHA and the unions to kind of notify them and work with them on process to make that transfer happen.

So we have a plan and the plan is being, I'll say, executed now with the goal of having these people brought over in the summer sometime.

[18:00]

Ms. Chartier: — Okay.

The Chair: — Okay. We have reached the agreed-upon time for the vote on Health estimates, so we will move on with . . . [inaudible interjection] . . . Does anyone, Ms. Chartier, do you have any closing comments you wish to give?

Ms. Chartier: — Sure. I just want to thank the ministers and the officials again always for your time. Again just thank you for giving me today and recognizing I was sick last week, I really appreciate that. And thanks to all my fellow committee members.

And there's no shortage of questions and there's so many things. I always feel badly, there's so many things that I don't get to in these nine or however many hours we have allotted that are equally as important as these things that I asked today. So palliative care, prescription drugs, long-term care — there's no shortage of topics that I would have like to have addressed, but perhaps you'll be getting a number of letters from me in the near future. But I regret that I didn't get a chance to ask many of them now, but again I appreciate the time.

The Chair: — Mr. Minister, do you have any comments?

Hon. Mr. Reiter: — Yes. I just want to thank Ms. Chartier for the questions. I'm glad she's feeling better. I'd like to thank all the committee members for their time, and of course I'd like to thank the officials for the many hours we've put in committee, but also the many hours of preparation work that the officials do as well. So thank you, Mr. Chair, as well.

The Chair: — Okay. Thank you, Ms. Chartier, Mr. Minister, both of them. And thank you for the staff for being here for nine or more hours in doing this. We will move on now with the votes.

Health, vote 32, estimates for 2018-19, central management and services (HE01). This subvote includes statutory amounts. The amount to be voted is 9,391,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial health services and support (HE04). Amount to be voted, 227,193,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Saskatchewan health services (HE03). Amount to be voted, 3,794,970,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Medical services and medical education programs (HE06). The amount to be voted, 939,988,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Drug plan and extended benefits (HE08). The amount to be voted, 386,435,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment. Non-appropriated expense adjustments are non-cash adjustments presented for information. That amount is 212,000.

Okay. General Revenue Fund, supplementary estimates — no. 2.

I would ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for 12 months ending March 31st, 2019, the following sums for Health in the amount of 5,357,977,000.

Would someone so move? Mr. Doke. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Supplementary Estimates — No. 2
Health
Vote 32

The Chair: — General Revenue Fund, supplementary estimates — no. 2, Health, vote 32, in the amount of 57,100,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2018, the following sums for Health in the amount of 57,100,000.

Is that agreed? Mr. Steinley. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried. Okay, I think we're done giving you your salary and monies for the year. So the Health officials may now depart if they wish while we move on to other ministries. Thank you very much.

General Revenue Fund
Advanced Education
Vote 37

The Chair: — Page 23, Advanced Education, vote no. 37,

central management and services (AE01). This subvote includes statutory amounts. The amount to be voted is 14,657,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Post-secondary education (AE02). The amount to be voted is 676,639,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Student support (AE03). Amount to be voted, 37,642,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment. Non-appropriated expense adjustments are non-cash adjustments presented for information purposes only, in the amount of 167,000.

I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2019, the following sums for Advanced Education in the amount of 728,938,000.

Someone so move? Mr. Goudy. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Education
Vote 5

The Chair: — Okay. Education, page 43. Education, vote 5, central management and services (ED01). This subvote includes statutory amounts. The amount to be voted is 12,721,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. K-12 education (ED03). Amount to be voted is 1,953,658,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Early years (ED08). The amount to be voted is 100,665,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Literacy (ED17). The amount to be voted is 1,855,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial Library (ED15). The amount to be voted is 12,753,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Teachers' pensions and benefits (ED04). This subvote includes statutory amounts. The amount to be voted is 35,736,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment. Non-appropriated expense adjustments are non-cash adjustments presented for information purposes only, in the amount of 389,000.

I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2019, the following sums for Education in the amount of 2,117,388,000.

Would someone so move? Mr. Fiaz. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Labour Relations and Workplace Safety
Vote 20

The Chair: — Okay. Labour Relations, page 101. Labour Relations and Workplace Safety, vote 20, central management and services (LR01). The amount to be voted is 4,642,000. Is that agreed?

Some Hon. Members: — Agreed.

[18:15]

The Chair: — Carried. Occupational health and safety (LR02). The amount to be voted, 8,737,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Employment standards (LR03). The amount to be voted, 3,003,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Labour Relations Board (LR04). Amount to be voted, 1,000,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Labour relations and mediation (LR05). Amount to be voted, 693,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Workers' Advocate (LR06). Amount to be voted, 875,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustments. Non-appropriated expense adjustments are non-cash

adjustments presented for information purposes only. The amount is 130,000. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31, 2019, the following sums for labour relations and workplace safety in the amount of 18,950,000.

Would some member move that? Mr. Steinley. All in favour?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Social Services
Vote 36

The Chair: — Social Services, vote 36 on page 117, central management and services (SS01). This subvote includes statutory amounts. The amount to be voted is 56,190,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Child and family services (SS04). The amount to be voted, 270,443,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Income assistance and disability services (SS03). The amount to be voted, 837,384,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Client services (SS05). The amount to be voted, 12,389,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Social Services housing (SS12). Amount to be voted, 7,571,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment. Non-appropriated expense adjustments are non-cash adjustments presented for information purposes only in the amount of 5,553,000.

Okay, I'll ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2019, the following sums for Social Services in the amount of 1,183,977,000.

Someone so move?

Mr. Doke: — So move.

The Chair: — Mr. Doke. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Lending and Investing Activities
Advanced Education
Vote 169

The Chair: — Carried. Okay, lending and investment activities, Advanced Education, vote 169, loans to student aid fund (AE01). To be voted, estimates for 2018-19, 74,000,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. I would now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2019, the following sums for Advanced Education in the amount of 74,000,000.

Will someone . . . Mr. Steinley. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

Committee members, you have before you the draft of the sixth report of the Standing Committee on Human Services. We require a member to move the following motion:

> That the sixth report of the Standing Committee on Human Services be adopted and presented to the Assembly.

Mr. Fiaz. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Well, ladies and gentlemen, I now have an important task for one of you to perform. I would ask a member to move a motion of adjournment.

Mr. Steinley: — I so move.

The Chair: — Mr. Steinley has moved. Is that agreed?

Some Hon. Members: — Agreed.

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

[The committee adjourned at 18:20.]