STANDING COMMITTEE ON HUMAN SERVICES

Hansard Verbatim Report

No. 57 — June 15, 2020

Legislative Assembly of Saskatchewan

Twenty-Eighth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

Mr. Larry Doke, Chair
Cut Knife-Turtleford

Ms. Danielle Chartier, Deputy Chair
Saskatoon Riversdale

Mr. Herb Cox
The Battlefords

Mr. Muhammad Fiaz
Regina Pasqua

Hon. Todd Goudy
Melfort

Ms. Nicole Rancourt
Prince Albert Northcote

Ms. Nadine Wilson
Saskatchewan Rivers

Published under the authority of The Hon. Mark Docherty, Speaker

[The committee met at 15:46.]

The Chair: — Good afternoon, everyone. I'd like to introduce myself. My name is Larry Doke. I'm your Chair for Human Services. I'd like to introduce the rest of the committee here today. Joined today is MLA [Member of the Legislative Assembly] Herb Cox, the Hon. Todd Goudy, MLA Nadine Wilson, and substituting for Danielle Chartier is MLA Mowat.

This is the first time the committee has met since the Assembly adjourned on March 17th, 2020 due to the COVID-19. Before we begin our business today, I would like to make a statement in regard to how the committee will operate in the Chamber.

We would ask witnesses to only sit in the allocated spaces at every other desk so to ensure physical distancing requirements are adhered to. Witnesses may speak at the microphone podium if they are required to answer questions. If there are more officials present than there are seats, we would ask those additional officials to wait in the hallway until they are required to answer questions.

I also remind witnesses to state their name for the record before they speak at the microphone. If ministers need to confer privately with their officials during proceedings, they may do so in the hallway or the vestibule at the front of the Chamber.

There has also been a modification to the committee's voting procedures. Because some committee members may not be able to attend a committee meeting due to COVID-19 or related restrictions, committee members now have the option to vote by proxy during a recorded division if they cannot physically attend a meeting. A proxy form must be registered at the Speaker's office 30 minutes prior to the Assembly's daily proceedings.

Lastly I want to advise the committee that we will need to take periodic recesses to allow time for the Legislative Assembly Services to sanitize their workstations when personnel changes occur, so please bear with us. If you have any questions about logistics or have any documents to table, the committee requests that you contact the Clerk at committees@legassembly.sk.ca.

Pursuant to rule 148(1), the following estimates and supplementary estimates were deemed referred to the Standing Committee on Human Services today, June 15th, 2020: the 2020-21 estimates votes 37, 169, Advanced Education; vote 5, Education; vote 32, Health; vote 20, Labour Relations and Workplace Safety; vote 36, Social Services. And the 2019-20 supplementary estimates: vote 37, Advanced Education; vote 5, Education; vote 32, Health; vote 36, Social Services. Today we will be considering the estimates and the supplementary estimates for the Ministry of Health.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — We now begin our consideration of vote 32, Health, central management and services, subvote (HE01). Mr. Reiter is here with his officials. Minister, please introduce your officials and make your opening comments.

Hon. Mr. Reiter: — Thank you, Mr. Chair. Senior leaders from the Ministry of Health joining us today are Max Hendricks, the deputy minister of Health; Denise Macza, associate deputy minister; Mark Wyatt, assistant deputy minister; Billie-Jo Morrissette, assistant deputy minister; Rebecca Carter, assistant deputy minister; and Tracey Smith, assistant deputy minister. Also joining us today is Scott Livingstone, who is the chief executive officer of the Saskatchewan Health Authority.

I'd also like to acknowledge that there are a number of other senior officials here today, and I'd ask them to introduce themselves as they are called upon to address the committee.

The COVID-19 pandemic has resulted in an unprecedented fiscal year and a disruption to our health system never before experienced. Countless health officials were involved in extensive planning and preparedness. While we were looking forward to announcing a number of progressive budget initiatives in March, these announcements were put on hold to focus and respond to the serious threat of COVID-19 in our province.

Thanks to the efforts of public health officials and Saskatchewan Health Authority officials who led the charge on the pandemic response, we are on track to resume the new normal. We are determined to move forward with our record health budget and the initiatives captured within this budget that will make a difference in improving the physical and mental health of Saskatchewan people.

Our government has made financial support available to ensure our health system can continue addressing challenges presented by the COVID-19 pandemic. The COVID-related spending to date has been managed within the existing health budget that was announced on March the 18th.

The federal government has announced they may provide funding of $14 billion to provinces and territories. Saskatchewan's portion remains unknown at this time. The health sector has redirected and supported resources to ensure a proactive response to COVID-19. Our government committed to supporting the Saskatchewan Health Authority in purchasing ventilators, hospital equipment, testing materials, personal protective equipment, and operating costs.

At this time Health has committed $118 million associated with the COVID-19 response. We are taking every precaution, such as expanding our COVID-19 testing protocols to closely track this virus and continue flattening the curve so it does not overwhelm our health system. The Ministry of Health and its health system partners are working closely together to ensure a coordinated response to the pandemic.

There is a government-wide health and safety contingency fund of $200 million that will be available if required. It is crucial that we have funding on hand to keep patients, front-line staff, and all Saskatchewan residents as safe as possible. For this reason we are committed to ensuring our health system is well equipped to handle any increase in COVID-19 cases and to report on any costs associated with the pandemic response.

This year's provincial budget invests a record $5.8 billion in health care programs and services. This is an increase of $255 million or 4.6 per cent. It includes significant investments to support mental health and addictions, reductions in surgical wait times, women and children's health, and infrastructure needs in communities across Saskatchewan.

I'm pleased to announce that operating funding to the Saskatchewan Health Authority will increase to $3.7 billion, an increase of 140 million or 3.9 per cent from last year. This is the highest-ever budget for the SHA. $1.6 million of this funding will go towards additional resources and operating costs at the Saskatchewan Hospital North Battleford, and $1.2 million towards organ donation system improvements, including the development of the organ and tissue donor registry. There are a number of other initiatives included in the SHA's funding, which I will speak about shortly.

The Government of Saskatchewan remains committed to supporting the Saskatchewan Cancer Agency. This year the SCA [Saskatchewan Cancer Agency] will also receive its highest-ever grant, a total of $196.4 million in funding. This 10.3 per cent increase will go towards enhanced cancer care services and oncology treatment programs.

As I said earlier, the Ministry of Health's '20-21 budget supports a number of key initiatives: infrastructure, surgical waits, women and children's health, and mental health and addictions. We have made major budget commitments in all of these areas, as well as seniors' care.

We will speak to mental health and addictions investments at a subsequent session of Human Services Committee, but there is one initiative I'd like to highlight today. Estevan will soon be home to a new specialized in-patient treatment centre for Saskatchewan people experiencing addiction to crystal meth. We have committed $1.4 million to establish this new centre that will treat people from across the province and support them through their recovery.

The centre will use innovative protocols and medication used to support treatment, wraparound services in Estevan, and post-in-patient supports throughout the province. The centre will have 15 beds for people recovering from crystal meth and another five beds for people recovering from addiction to other substances. Additionally $150,000 is being invested to establish four pre-treatment beds and six post-treatments beds in Estevan. I look forward to sharing more about this innovative treatment model at a future committee meeting.

The Government of Saskatchewan remains committed to reducing the time patients have to wait for surgeries in our province. This year we have committed an additional $20 million to address surgical wait times, which adds to the 9.8 million investment we made last year. This funding will increase the number of in-patient and day surgeries performed and will allow for thousands of patients to have their procedures scheduled sooner.

I recognize the impact of COVID-19 on surgical wait times as the system discontinued elective surgeries to ensure capacity and minimize risk to our patients. As we continue to resume surgical services, we will look for opportunities to appropriately invest this funding to address the backlog created through the COVID-19 response.

This funding also assists with the costs of both pre- and post-surgical care services. This year's budget dedicates funding to a number of areas that focus on the health of women and children. As part of our multi-year funding commitment, $15.9 million has been allocated to hire more physicians and staff at the Jim Pattison Children's Hospital. This will ensure that children receiving treatment at JPCH [Jim Pattison Children's Hospital] receive the best possible care, and that families feel supported by a full complement of doctors and staff caring for their children.

Another investment in Saskatchewan children includes the $827,000 we've committed to improve our province's pediatric hematology program. Women who have low-risk pregnancies will benefit from the $410,000 investment to expand our province's midwifery program. This will allow for the hiring of three additional midwife positions. We have also committed funding to a number of cancer programs dedicated specifically to women's health. Nearly $1.8 million in funding will enhance Saskatchewan's gynecologic oncology programs. This funding will also allow our province to recruit a sixth specialist as well as other health care providers.

One million dollars has been committed to Ovarian Cancer Canada to fund treatment, research, and clinical trials that will improve outcomes for ovarian cancer patients in Saskatchewan. These funds will stay in Saskatchewan and will support OCC [Ovarian Cancer Canada], the Saskatchewan Cancer Agency, the University of Saskatchewan, and provincial gynecologic oncologists; $611,000 also will go to modernizing cervical cancer screening through a technology called liquid-based cytology.

We have also committed a $616,000 boost in funding to our province's sexual assault nurse examiner services.

The Government of Saskatchewan remains committed to supporting families who have children experiencing autism spectrum disorder and we will continue our record of increasing ASD [autism spectrum disorder] individualized funding. Families will now receive $8,000 annually through this program, a $2,000 increase. About 535 Saskatchewan families will benefit from this increase that gives parents more flexibility in choosing the services they access to best suit their child's individual needs.

This year's health budget also invests in key infrastructure for hospitals and health care facilities and in a number of capital projects. Recently our government announced a two-year, seven-and-a-half-billion-dollar capital plan to stimulate our economy and support economic recovery. In the health sector, 203 million of this funding will support new infrastructure and priority renewal projects over the next few years.

In '20-21, 43.7 million will go towards maintenance and capital projects; 25 million will be used for facility upgrades and maintenance to keep patients, families, and staff safe and to allow for the continued delivery of health care services; and 18.7 million will be used for future capital projects. Plans are currently under way on where to best direct these dollars and I look forward to these future announcements to benefit Saskatchewan

people across the province.

Last year we announced plans for a new long-term care facility in Meadow Lake. We have committed 15.7 million to support this project's completion.

Additionally 15 million in capital funding will go towards the planning, design, and procurement of the Prince Albert Victoria Hospital project.

Two and a half million in existing funding will go towards site selection, land acquisition, and planning for the Weyburn General Hospital replacement project.

Royal University Hospital will see a major increase in capacity as 7.9 million will go towards funding 36 new permanent acute care beds. Our support for enhanced services at RUH [Royal University Hospital] continues. We have also provided $1 million to support the operation of a new four-bed epilepsy telemetry unit.

In Prince Albert we have dedicated $833,000 towards the operation of a new 10-bed palliative care hospice.

[16:00]

Our government is committed to ensuring health facilities have the equipment and infrastructure they need to continue delivering high-quality health services to Saskatchewan patients. We have dedicated a total of 28.5 million for capital equipment including diagnostic, medical, surgical, and IT [information technology] equipment for health facilities across the province.

Regina General and Pasqua hospitals will receive a combined $13.9 million for electric renewal. And additionally eHealth will receive 13.6 million to upgrade infrastructure and ensure clinical systems and applications continue functioning appropriately.

Two million dollars will also go towards a new CT [computerized tomography] scanner in Melfort. And $5 million will replace a linear accelerator at the Allan Blair Cancer Centre in Regina.

We will also upgrade existing dispatch technology for emergency medical services by investing $1.4 million towards computer-aided dispatch renewal.

Northeast Saskatchewan will now better be served by a second ambulance in Pelican Narrows. We have committed $188,000 to this important and life-saving service.

I'd like to thank the Chair and the committee for giving me the opportunity to outline some of the significant elements of this year's budget. I will speak to our major budget commitments for mental health and addiction supports and seniors at a future session of the Human Services committee. And now our officials and I would be pleased to take questions. Thank you, Mr. Chair.

The Chair: — Thank you, Minister. Just before we carry on, I would like to say that MLA Fiaz has joined us also. So we'll open it now for questions. Ms. Mowat.

Ms. Mowat: — Thank you, Mr. Chair. And I would like to thank the minister and all the officials for being here today and getting set up in what is a rather atypical fashion for us to ensure that we have some ability to physically distance during this session.

We got started a little late, so I'll get straight into some questions here, some basic funding-based questions coming out of estimates to start us off.

There are $148 million in COVID spending in Health that was found within existing funds, so I'm wondering if you can speak to where this money came from. Were there any programs that have been cancelled due to COVID? Or unexpected savings, I guess?

Hon. Mr. Reiter: — So it would be in a number of different areas. For example some of the new initiatives that were announced, they're still going to proceed but they would have proceeded more slowly. For example, the surgical initiative we announced last fall.

Also as you're aware, elective surgeries, for example, and procedures we weren't able to do so they were postponed. In the supply front, there'd be a number of supplies that weren't done. So it would be fairly wide-ranging. It would be across many different areas.

Ms. Mowat: — Thank you. In terms of the reallocation of resources to the Northwest during the outbreak, can you speak to what the cost of that response was?

Hon. Mr. Reiter: — I'll start and get our officials to have a discussion and then I'll come back.

I was just going to say to start with, there would be some costs obviously to health care because we had officials up there. We put resources up there. But it wasn't limited just to the health. It was the provincial security agency as well, Government Relations. So it would be more than just the Ministry of Health, but I'll see if I can get you a little more detailed example right now.

Ms. Mowat: — Sure, and maybe I can provide a little bit more background on why I'm asking. I'm just thinking in terms of the $200 million that's allocated that you mentioned in your opening remarks through the Public Safety Agency for contingency, and how far that money is going to go, basically.

Hon. Mr. Reiter: — So to your question, we've got a number of different categories here. Testing sites: in March $14,000 was spent; April was 48,000 — this is spending in the North; and May was just under 40,000, for a total of $102,000. Equipment renovation expenses was $82,000. Payroll was just over a million dollars, 1,046,000. I'll come back to that one. And there's miscellaneous costs of about $28,000, for a total of $1.25 million.

Some of that could be a bit misleading though because embedded in those payroll costs though would also be people who . . . those salary costs would have been paid regardless. In some of those cases, it was a matter of just repositioning them from existing positions to where they were in the North. But I think that gives you sort of a rough idea of sort of the dollar amounts involved.

Ms. Mowat: — Thank you. In terms of the 200 million

contingency fund, can you speak to how that dollar figure was determined?

Hon. Mr. Reiter: — That would be better put to the Finance minister. In treasury board, that's where they would have looked, I think, across all the ministries and costs incurred to date and anticipated costs in the future.

Ms. Mowat: — In terms of COVID-related spending in Health, what is the forecast that the SHA [Saskatchewan Health Authority] has for this upcoming fiscal year?

Hon. Mr. Reiter: — So thanks. The high-level estimates are probably in that $200 million range or slightly exceeding it. But the difficulty in coming up with that number is there's a number of factors that are difficult to put a dollar amount on.

That amount doesn't account for any revenue that would be flowing from the feds. The federal government had announced that they would be assisting with funding. We still don't have a dollar amount on that.

And a significant part of that of course — this won't surprise you — is salaries. But again, oftentimes those salaries are already budgeted for in another area and are redeployed. So I'll use an example coming from the last question. Employees in the public health department were redeployed to La Loche to assist with tracing. So in that instance that would show as an expenditure under COVID-related expenditures. But yet those dollar amounts, those salaries were already budgeted for in another area. So in the global picture, it wouldn't need extra funding.

[16:15]

And again as I mentioned in a previous answer, there will be . . . I think it was the previous one or the one before that. There's some money saved on supplies because some procedures just haven't been done. And that's kind of wide ranging. Obviously we need to catch up in those procedures over the coming months and years. But you know, when they've cancelled diagnostics, cancelled surgeries, those sorts of things, you know, very unfortunate. We want to catch them up, but there's been some savings there as well.

So those things would offset that total estimate. But it's very difficult to put a significant, like a very specific dollar amount on right now because frankly we don't know what the next number of months are going to bring as far as the second wave, or how many people would be testing positive.

Ms. Mowat: — In terms of what the ministry is preparing itself for, is there a particular model or scenario that is being utilized? I know the SHA has presented some modelling. Is there a particular model that's being utilized to plan for what the funding allocation looks like for this year?

Mr. Hendricks: — Max Hendricks, deputy minister of Health. So for the purposes of developing our utilization and spending estimates for the fall, we continue to base it on the last modelling update that was provided by the SHA in conjunction with the U of S [University of Saskatchewan], which is kind of the mid-range scenario. That would see the province have 254,000 infections approximately, an average daily census in our hospitals of 1,736, an ICU [intensive care unit] census of 412, and 403 patients requiring ventilation. So that is based on a reproductive rate of about 3.12. Right now our current reproductive rate is 0.67.

You know, this is dynamic modelling so we continue to look at the experience in different jurisdictions and try to develop our modelling to fit the Saskatchewan situation. And so likely this will be updated again a couple of times probably before the fall, as will our spending estimates as we go forward. So as the minister said, there are just so many variables in trying to predict when and if the second surge will arrive and how severely it will impact our population. And so right now it is a bit of crystal balling.

Ms. Mowat: — Thank you. In terms of the COVID testing sites, can you speak to how much we've spent on the set-up of those sites so far, what we anticipate we will be spending throughout the year? And I guess, is there a plan built in within that that those sites will be expanded or has that process been completed at this point?

Mr. Hendricks: — So right now we have 54 assessment sites across the province and unfortunately we haven't got an exact estimate in terms of the manpower costs associated with that. We've spent to date or have committed about $11 million on testing supplies, consumables, that sort of thing. But that's what's been committed; that's not necessarily what has been spent. So that's reagent swabs, that sort of thing.

As we go forward into the later part of the summer and the fall, there will continue to be the PCR [polymerase chain reaction] testing which tests whether you have COVID-19, but there will also be the addition of serology testing.

And so you'll know that the federal government have sent out . . . They're going to be doing a serology survey across Canada, kind of look at the prevalence of, the number of people that have the COVID-19 antibodies. But going into the fall, Saskatchewan is planning on upping our participation in serology testing as well. It's an important component to an overall testing strategy.

So I guess the bottom line is we continue to need . . . We need to do both, to both understand how widely spread and how many people have the antibodies, but also as we reopen Saskatchewan, to understand where we do have any, you know, small outbreaks, that sort of thing, be able to detect them and contain them very quickly.

Ms. Mowat: — Thank you. Switching gears a little bit here, there is once again substantially more money being spent on the drug plan and extended benefits. Can you speak to what is driving this increase? Is it drug costs, utilization, etc.?

Mr. Wyatt: — Mark Wyatt, assistant deputy minister, Ministry of Health.

So in the budget this year, we have a total increase in the drug plan and extended benefits branch of 24,337,000, of which 21 million of that is directly attributable to the prescription drug plan. And then 2,530,000 is an increase in the SAIL program, the Saskatchewan Aids to Independent Living. And then we have 625,000 for the supplementary health program.

I think your question was specifically around the drug plan, which is the largest part of the overall increase. And there are a number of factors that are resulting in the overall drug plan budget lift of about $21 million.

So the overall acquisition cost has increased by about 5.3 per cent. So that's the cost of actually the drug product itself. We've seen increases in dispensing fees and we have had an agreement with the Pharmacy Association of Saskatchewan that resulted in increasing dispensing fees as well as some other program costs that pharmacies are funded for. So there's about $3 million that was attributed to the pharmacy proprietor agreement that exists between the ministry and community pharmacies.

There's another component of drug plan costs. There's a dispensing fee that goes to pharmacies. There's also a markup that pharmacies generate as part of the cost that is passed on to the funder, and that represents another 1.1 million.

One of the big drivers of drug plan costs over the last number of years has been expensive drugs for rare diseases or just expensive drugs in general. We're seeing both some niche drugs that are targeting sort of orphan diseases, but we're also seeing some high costs for drugs that are being dispensed on a broader basis to broader disease groups. And so those have had a significant increase over the past few years. We've seen, 2019-20, the actual expenditure was about 14.4 million for some of those rare disease drugs, which is an increase of about 6.7 million.

And we're seeing, you know, examples of drugs now that come in . . . It's not uncommon to see an individual drug for one patient for one year that comes in at 300,000, 500,000. Some are now up to a million dollars. So when you add . . . With some of these conditions you add one patient over the course of, you know, of the fiscal year it adds a million dollars or it adds $500,000 per patient. So as we've seen some of those additions.

And having said that, you know, one of the things that we have been able to do to be able to offset some of these drug increases is we have been able to negotiate through our participation in the pan-Canadian Pharmaceutical Alliance. We negotiate drugs both generic and brand drugs nationally. And we have seen significant reductions in our overall drug expense as we've been able to negotiate more of the drugs that are being added to the formulary, and in some cases — generic drugs being a good example — where we've continued to push down some of the prices that we're paying.

So the overall increase is a combination of some of those cost drivers that I've mentioned but also offset by some of the net reductions that we see through those product listing agreements for individual products.

[16:30]

Ms. Mowat: — Thank you. In terms of capital, maintenance capital expenditures in Health are set at 223.9 million. We submitted written questions, and the responses showed that the cost of deferred maintenance on health facilities has grown by about 59 per cent since 2013, and it's nearly 3.5 billion now. By my math, 223.9 million is about 6 per cent of what's needed in deferred maintenance costs.

And with two-thirds of the former health regions reporting that the average facility condition index is critical or worse, how can we explain the underfunding in health infrastructure?

Hon. Mr. Reiter: — The dollar amounts that you quoted, certainly it's a huge amount of money. Just a number of things, I guess, I would address through that.

You know, I won't go through sort of all of the capital dollars we've spent in the past, but I would say that there will be a significant improvement in a number of areas then with just some of the projects that have been announced already. When you build a new capital project and take an old one off-line, obviously that's going to help that dollar amount.

You're looking at projects coming from . . . you know, nothing you're not aware of. You look at the P.A. [Prince Albert] Vic Hospital being done. When you look at Weyburn hospital, a long-term care facility in Meadow Lake, those coming online. That's certainly going to help.

And then there's a significant amount of maintenance dollars coming as well. There's 55 million this year in the base, plus 25 were added through stimulus. Next year already we're aware there'll be $75 million, plus whatever the base is set at that time. So there'll be some significant investments that will help in that regard.

Ms. Mowat: — Can you speak to which facilities are a priority for renovations?

[16:45]

Hon. Mr. Reiter: — The ministry works with the SHA to prioritize projects. And for, I guess I would describe them as more larger scale capital projects, you'll hear some announcements about some of that coming in just the next few days. But for more specific types of projects — and I guess I would describe them more as, I guess, smaller capital projects — I'm just going to get Max to touch on that as well.

Mr. Hendricks: — So I took it from your question that you're questioning which facilities we prioritize, but it's more about what areas of repair that we prioritize. So when we look at the VFA [Vanderweil Facility Assessors] information, we look at doing those critical maintenance projects that are important to ensure the life and safety of the residents or patients. So things like fire alarm systems, fire protection, sprinkler systems, nurse call systems, standby generators. But it also spreads into areas of structural work and roof, window replacement.

And to give you a few examples, right now we're doing a fairly large project in terms of renewing the electrical, basically all of the electrical infrastructure at the provincial hospitals in Regina. So the Regina General and the Regina Pasqua hospitals. So it's been a multi-year systematic upgrading process, replacing, refreshing all the electrical infrastructure. So it's $13.9 million. We're spending 5 million dollars at Wascana Rehabilitation Centre to upgrade the building envelope this year. Things like, you know, something that came up at Dubé Centre in Saskatoon to update the duress system. We're spending $1 million on that. And so we spend it on a variety of areas. It's everything from new windows, new roofs, painting, that sort of thing. But it's

based on what's highest need out there in the system in terms of maintaining the facilities' integrity.

Ms. Mowat: — Right. So I guess my concern is the accelerated rate that this cost of deferred maintenance is growing and the fact that the investment into that is not growing at the same rate. We maybe are going to disagree on this and we can keep moving. But one of the big concerns that was flagged for me was when the Provincial Auditor last year in June looked at the former Saskatoon Health Region area and essentially said that there wasn't a solid prioritization plan for work that needed to be done.

So what's the long-term plan in terms of deferred maintenance within SHA facilities? Is there a plan? What does it look like?

Mr. Livingstone: — Scott Livingstone, CEO [chief executive officer] of the Saskatchewan Health Authority. So with the formation of the Saskatchewan Health Authority in 2017, a lot of this work has now come together under a provincial umbrella. So you see the organization looking at how we prioritize investments across a multi-year capital plan to generate the most value for that investment.

As Max had already touched on, we do focus on life and safety but also, as you would be aware, there's a big chunk of that deferred maintenance relative to some of our key facilities across the province where we had focused investment on large infrastructure projects. And a good example would be the electrical upgrades in Regina and Saskatoon, which are needed to actually accommodate care across the organization.

But through that multi-year planning and prioritization process, we're making sure that we're making those investments that are building back up that infrastructure . . . [inaudible] . . . But one of the other challenges, as you know, is the sheer number of facilities, not just the age of them but the number of facilities and looking at how we organize ourselves at a provincial scale better, around for example, integrated facilities.

So in Leader as an example, we've got a brand new facility in Leader that is an amalgamation of four former facilities. So we've actually reduced our footprint and made a value-based investment in a facility that is more of a one-stop shop as opposed to four different sites. And that hasn't become, what I would say, the new norm. But it is something that's considered when we're looking at capital across the organization.

Ms. Mowat: — Thank you. I think we'll disagree on the amount of investment right now being adequate for catching up. Like, I just think we'll disagree on that but I thank you for explaining what the processes are right now. And we have limited time so I want to move forward into some other questions.

In terms of the Health capital priorities for the year, there's some information in Estimates, but I'm wondering what you can say in terms of what the new capital requests were that were submitted and how many were granted.

Hon. Mr. Reiter: — To clarify, you said new capital requests. I'm not sure what you mean. From the SHA? That goes through the normal budget process though. Sorry, I'm just not clear on what your question is.

Ms. Mowat: — I guess just in terms of identified need for new capital projects, where are we at in that process?

Mr. Hendricks: — The ministry, working with the SHA, has a list of facilities that we realize have certain unique service requirements. So for example, the project in P.A. is largely being driven out of the fact that the service needs are growing in the North and it's a high-needs area, and so similar with La Ronge long-term care. So things like that drive a lot of capital decisions, and that in combination also with the state of the infrastructure. And so we look at all of this information.

And also I think we . . . You know, in terms of scoring this and looking at our available funding, some projects are a little easier to do than others. Just some are bigger, right? And so a number of factors fall into these decisions about what funding or what projects will be approved within the budget every year.

Ms. Mowat: — The Canada Health Transfer is budgeted at 1.3 billion this year, which is good. It's an increase from the federal government. Is there any of those dollars that are earmarked for specific programs and services that you could speak to?

[17:00]

Mr. Hendricks: — So in the actual Canada Health Transfer, none of the money is actually targeted to specific programs other than maintaining the principles of the *Canada Health Act*. But you know, there was the 10-year bilateral agreement that provided funding for home care and mental health which was a separate agreement to the Canada Health Transfer. So we have our funding amounts to '21-22 for that, but from '22-23 to '26-27 those amounts are to be determined.

Ms. Mowat: — Thank you. The minister mentioned that there are some additional federal dollars expected. I am wondering if you can speak to what that is anticipated to look like.

Mr. Hendricks: — So, the initial tranche of funding that I believe was announced in March was $500 million to assist provinces in preparing. And our share of that would be about a little over $15 million, so that's pretty solid. We have a good idea what's coming from that. What's less clear is the Prime Minister. I know it's $14 billion to assist provinces with safely reopening. And the allocation, whether that will be per capita or whether there'll be other variables attached to that, we don't know yet. And so I assume we'll be finding . . . In fact, there are some discussions going on this week about that.

Ms. Mowat: — Thank you. In terms of access to information, I know a number of folks submit access-to-information requests. These legislated timelines are almost always missed or have been in the recent past. Sometimes it takes almost a year to receive responses. Can you speak to what the issues are with the ministry's access-to-information process that are causing these backlogs and delays?

Mr. Hendricks: — So I think there are several issues when it comes to FOIs [freedom of information]. One is that the total number that we are receiving every year continues to go up and, you know, I think that it's fair to say that also the complexity of some of the FOIs is increasing as well where several thousand

pages of materials have to be gathered from various sources. So you know, complicating that is obviously — and I've met with the commissioner on a couple of occasions about this — maintaining kind of an adequate number of staff to support that work but also to have processes and that sort of thing to make sure that they do move through the ministry in an appropriate pace.

So you know, of the 127 that we did receive last year, 76 were completed within the 30 days. About 23 were completed in around between 31 and just over 60 days. Some are withdrawn, and some have been carried forward into the next year. So we do try and comply with this. For a period there, we were actually more successful in bringing a greater number into compliance, but it kind of hopped up after we had some changeovers in staff in that unit.

I guess what I can say is we do our best as a ministry to try and be as transparent and move the process forward as quickly as possible, but there are so many, I guess, variables in this. Like you know, from the start of the process a lot of times we have to go do an initial assessment. Sometimes that requires going back to the applicant and asking them to refine their request because it's just simply too large. And sometimes there are fees attached after which the applicant withdraws the request because of the amount of time it takes to even staff outside of our unit. So there's a considerable number of steps to completing an FOI. And I would just say it's something that as a ministry we do have on our visibility wall. We track it regularly.

Having said that, over the last probably . . . Well this year, this calendar year we've had a few situations that have made our compliance — and which I've discussed with the commissioner — a little bit more challenging. We had the malware incident with eHealth, and then that was quickly followed by the COVID. I'm not making excuses, but they did factor into our ability in recent months to address the regulated time frames. But it's something that I do take seriously and I have talked to the commissioner about.

Ms. Mowat: — Thank you. Just in note of the time delays, while the minister and officials are conferring, I wonder if the minister doesn't know the answer if we can move forward with additional questions while officials are looking for them. You know, I know there's physical constraints with our set-up today and we're trying to scrutinize over $5 billion worth of spending. So I think I would appreciate that if we could do that. Thank you.

In terms of access to information, just as a follow-up, have you given any thought to putting more of this information online? I know some other jurisdictions have done that.

Mr. Hendricks: — Absolutely, where possible. And I think we have made significant improvements over the years in terms of publishing pages on our website. But where we identify common theme areas where we're receiving multiple requests and it's kind of, you know, kind of a routine thing rather than having people FOI, yes we can put it on our website. In some cases we get FOIs where it's actually already on our website and people just have not looked or haven't found it. And so, yes.

Ms. Mowat: — Thank you. I've got a few concerns that are specifically related to the COVID outbreak. With regards to the northern outbreaks, we've since heard some concerns that have been coming forward quite publicly in the media about access to medical appointments in more southern Saskatchewan locations, and those being limited by folks who are coming from outbreak areas. Can you speak to what has been done to communicate with medical providers about the policies of travel surrounding the North?

[17:15]

Hon. Mr. Reiter: — Sorry, can you just clarify? You're asking as far as when the travel blockades were up, allowing to travel, or you're asking in regards to medical providers not providing care?

Ms. Mowat: — Access to medical providers, yes.

Hon. Mr. Reiter: — Okay.

Mr. Hendricks: — So as you know, under the orders residents of the North were allowed to travel south for medical appointments. I think what you're referring to is that there may have been some providers that were not willing to see them, just based on the situation up in the North. And a couple of weeks ago, and we're just pulling it out, but a couple weeks ago we sent a letter to the regulatory bodies advising them that they should continue to obviously screen and do that sort of thing, but they should continue to see patients from that area.

Ms. Mowat: — Thank you. In terms of the northern outbreak situation, what did that teach us about our response to future outbreaks? Is there any lessons learned, things that would be done the same or differently as a result, moving forward?

Mr. Hendricks: — So I think that, in terms of what could have gone better — and it's not just, I think, confined to the North — was that unfortunately the introduction of that virus into that community was from another province. Had there been, I guess, better communication between or identification by our adjoining jurisdiction to the issues there, a notification, we might have been able to get ahead of that. Subsequently the lines of communication got much better and we were made aware of work camp outbreaks in other provinces and such.

In terms of the response to it, I think, considering the remoteness of La Loche and some of the unique challenges in the community, a lot went well there. We were able to mobilize quickly and establish testing sites in the communities. We had mobile testing. Gradually as the disease spread in the community and we realized that that strategy needed improvement, we actually starting going house to house testing for COVID-19. We established isolation quarters for people that needed to be isolated and separate from their households so that they didn't infect their entire household, and so we had some facilities up there for that.

And then the other thing too, you know, we were able to establish a managed alcohol program up there to assist residents who were isolating. So they were able to manage their addictions effectively, which helped to improve the success of isolation. You know, I think that Saskatchewan has been even acknowledged in federal circles for the response here, the SHA has.

You know, about a week ago I was talking with some of my federal and provincial colleagues about this, and the numbers had come down so significantly in La Loche. And I think it was a real credit to that community and to the leadership up there and to the SHA staff. And then we've seen a resurgence because of a public gathering, and so it just highlights how sensitive, you know, those large, uncontrolled gatherings can be. And so unfortunately they're kind of back a little bit.

But I think it was actually, considering a number of factors and just moving people up there . . . And I'm just going to mention something. The SHA put out a call to employees throughout the province, you know, asking for people to redeploy there. And a number of people did. They volunteered to go up there, leave their families and that sort of thing, and live apart in a community that was experiencing some challenges and posed some risks. And so I think it was a credit to the SHA employees and the community for their response.

Ms. Mowat: — Thank you. In terms of a second wave, I don't know if we'll see a distinct second wave and I don't know if anyone here knows that either, but what planning is happening for a possible second wave that could come in the fall, as many are predicting? And you know, have any of the plans been altered to account for that?

Mr. Hendricks: — So over the next few weeks we had kind of, and the SHA had done the same, we had established or just stood up our health emergency operations centre. There was a provincial emergency operations centre and then the SHA maintained one. And you know, this was kind of something that was meeting daily to respond to the immediate needs — and on weekends — around COVID-19 through March and April and May.

And so over the next few weeks both the SHA and the ministry are transitioning to a bit of a different type of structure. In the ministry we're calling it our COVID response unit. We're establishing an independent unit that will be very focused on several elements of our COVID planning going forward. And the SHA has established an incident command centre as well that will continue to work on this.

And there are several factors, I think, that you said when and if. I mentioned earlier that, you know, we'll continue to monitor the modelling, the dynamic modelling, and Dr. Shahab will continue to monitor the epidemiology of this as we go forward. So if at any point we see a severe uptick or whatever, we'll be able to detect that, hopefully be able to contain it into a specific area if that's possible. If not, then other measures would be taking place.

But you know, I think we are planning for the worst and hoping for the best. And so obviously our strategy includes looking at our surge capacity and continuing to make sure that we have all of the equipment and structures in place to manage whatever comes our way: so making sure we have an adequate number of beds, ventilators, an adequate amount of personal protective equipment. You know, making sure that we can meet the mental health and social needs of our population, the medical needs as we go through another pandemic, potentially a wave two. And so there are several things that these units, that will be their daily work is to focus on and be ready if there is a resurgence in the fall. We hope not, but we're planning for it.

Ms. Mowat: — Are there any specific thresholds that have been put in place, say with the rate of transmission, that would signal a planned backtrack of the reopening phases?

Hon. Mr. Reiter: — So just a number of points there. I think the intent is not so much if we do have some higher rates of positives in a specific area. It wouldn't necessarily be a case of sort of scaling back the Re-Open Saskatchewan plan that you're asking about. It would be more a case of putting restrictions as necessary to that specific area, to that geographic area, if you would.

The other day I know Dr. Shahab had, I think, talked about it. I think it was one of the news conferences and he was talking about sort of the things that would have to be looked at and considered. And a lot of it involves containment. It's a case of where is it community transmission? Is it to a specific facility? What can be done to ensure that it's contained? He talked about a number of things there: making sure the health system has enough capacity, that preventative measures are established if it's in a workplace or a facility. It would really come down to what's the cause of the outbreak and can it be traced, can it be contained, and what restrictions would be necessary in that specific facility or that specific community to ensure that it doesn't get out of control.

The Chair: — It now being 5:30, we will recess till 6:30. It should be noted, though, the 16-minute late start that we had will be added to tonight's time. Okay? Thank you everyone. 6:30 sharp, Muhammad.

[The committee recessed from 17:30 until 18:30.]

The Chair: — Okay. Welcome back, everyone. We'll now resume consideration of the estimates and the supplementary estimates for the Ministry of Health. Ms. Mowat.

Ms. Mowat: — Thank you. Thank you very much. I just wanted to make sure my mike was on. Continuing on with some of the questions around COVID-19, in terms of developing a surge capacity for COVID-19 and in the process of cohorting and redeployment of staff, have you encountered any challenges with staffing?

Mr. Hendricks: — So cohorting, I guess it will present some challenges for the system going forward. We were lucky enough to be able to reach a letter of understanding with the unions that allow us to have a person stay at one facility. But you know, certainly where we had movement between hospitals and long-term care or between long-term care and personal care homes, it has reduced our flexibility to move staff, and even between long-term care facilities. So you know, I think maybe in the longer term it's actually probably a good practice in terms of infection control. We'll have to wait and see going forward whether that's maintained. And other than that, you know, I think we're ironing out some of the initial challenges with it, but it's worked pretty well.

Ms. Mowat: — Do you have a sense of how many staff have been redeployed? I realize some of those folks may have been . . . like, if they went to an outbreak area and then moved back that they probably aren't captured anymore. But you know, how has this been tracked and how many folks have been redeployed?

Mr. Hendricks: — So our estimates are that 20 per cent of

people that worked in long-term care worked in more than one facility. So it's been about one-fifth of our workforce that has been affected by this. But redeployments of other staff, like in Public Health, they just shift back to their regular job, you know, if contact-tracing resources aren't needed to the same level. But yes that's where the impact was.

Ms. Mowat: — The SHA posted on social media that the autism spectrum disorder consultant was redeployed to be a site coordinator. How many autism spectrum disorder employees were redeployed? And I guess how many continue to provide services as well?

Hon. Mr. Reiter: — We don't know the exact number, but Scott's trying to get it. And when we get it, I'll bring it up later, okay?

Ms. Mowat: — Thank you. In terms of vaccine development, there is some support identified for VIDO [Vaccine and Infectious Disease Organization], I believe from Innovation Saskatchewan funding. I wonder if you can speak to supports that the province is providing in working toward a vaccine.

Hon. Mr. Reiter: — Sure.

Mr. Hendricks: — Actually, like the funding to VIDO didn't come out of our ministry. But our understanding is that VIDO is receiving $28 million through a cost-share program between the federal government and the Government of Saskatchewan, and that 4.2 million has been provided by the Government of Saskatchewan since January 2020.

Ms. Mowat: — In terms of immunizations once a vaccine is available, I see that there is no change to the allocation for immunizations in this year. So I'm wondering what the plan is for being able to distribute a vaccine once one is available.

Mr. Hendricks: — So when you talk allocation formula, I'm not exactly sure what you mean. With influenza this year, part of our $118 million that we're spending is to purchase a million dollars of additional influenza vaccine in anticipation that more people will recognize the extra health hazard of having influenza and COVID circulating at the same time.

When a vaccine does become available . . . And so best predictions are, kind of, summer of next year. It could be longer or even never. And so at that point, I think obviously we would have to, you know, that would be a discussion with the federal government to assess domestic supply, look at those populations that are most severely impacted by COVID, that sort of thing. Usually this would be something that we'd work in conjunction with the federal government, in fact, on determining a formula for that.

Ms. Mowat: — Okay. Just for clarity, I was talking about (HE04), the provincial health services and support vote on page 77 of the Estimates book. So the immunizations, it just looks like 16.4 million has remained the same year over year is what I was referring to.

Mr. Hendricks: — Yes, and we have increased it with our COVID funding. Just anticipation that the number, the immunizations will increase this year. There'll be greater uptake.

Ms. Mowat: — That's reflected somewhere else in the estimates?

Mr. Hendricks: — That was the $118 million that we talked about earlier for COVID funding.

Ms. Mowat: — Okay. Does that appear as a line item though within the estimates or is it . . .

Mr. Hendricks: — No, this was set since the estimates.

Ms. Mowat: — Okay. I'm a little bit confused about that, but that's okay.

Also in the line of vaccines, it's occurred to me that some students that typically receive vaccines in schools may not have received those this year. So I'm just wondering what the plan is for those booster shots.

Mr. Hendricks: — Yes, so grade 6 and 8 school immunizations were impacted. So grade 6's didn't get their second dose and grade 8's have missed their vaccination this year. But what we're doing is we've developed or are in the process of developing a plan right now to catch them up over the summer. And so we'll be scheduling appointments for public health to issue those immunizations at clinics over the summer so that they'll be fully caught up.

[18:45]

Ms. Mowat: — Thank you. I'm just reflecting more on the question of the $118 million. So basically my question around this is, where is this reflected in the Estimates book? Like, the money has to be accounted for somewhere so I'm just trying to follow the paper trail exactly. You know, is it in supplementary estimates or where would I find that?

Mr. Hendricks: — So earlier in the night — I believe one of your first or second questions — you had questioned how the ministry was going to address the $118 million of COVID-related expenditures. And you know, at that time the minister discussed that we're quite likely to experience some slow starts to programs that we've announced as part of the budget. He used the example of the surgical funding this year. There would be some additional material savings in the SHA, that sort of thing, some reduced overtime, and so it's not specifically itemized in a line in the budget.

This budget was established kind of, you know, in that early period, pre-COVID, or parts of it. So as we go forward in the fiscal year we'll try and identify sources to offset what we expect will be an increased uptake in the influenza vaccine.

Ms. Mowat: — Okay, so you're saying it's coming out of global SHA funding as a result of some of the savings in these different departments that aren't reflected yet in the estimates? . . . [inaudible interjection] . . . Okay. Can you provide an update on how the resumption of other medical services is going? Specifically something we've received quite a few calls about is when regular mammograms will be able to take place.

Hon. Mr. Reiter: — On the mammogram screening we're trying to get the date and hopefully have it back for you in a few

minutes. And in the meantime, though, to your first part of the question on the phase 2, I'm going to get Mark to speak more specifically to that.

Mr. Wyatt: — So we're just, as the minister mentioned, looking for the resumption of specifically around mammogram services, and the Saskatchewan Cancer Agency has been reinitiating all of its screening programs. They did suspend or reduce services in the various screening programs at the time that we began to reduce non-essential services. And so they are in the process of just ramping those back up. All of them — I think they have three different major screen programs — all are moving kind of on their own timeline, and so we're just trying to get that date.

Just to speak a bit more broadly around phase 2, phase 2 was primarily looking at a number of specialty clinics that will be resuming across the Saskatchewan Health Authority, examples being like some of your cardiac clinics, the cath lab, electrophysiology, cardiac stress testing, respiratory services, a number of those including sleep disorder testing, respiratory out-patient. Those are part of phase 2 — the eye centre, dermatology clinics, cast clinics, a number of child and maternal services.

And then there were also services that were part of phase 1 that had been initiated in phase 1 that will also be ramped up as part of phase 2. And so surgical services and diagnostic or medical imaging would be a couple of the services where we're looking at increasing the overall volumes as part of phase 2. And the phase 2 through the Saskatchewan Health Authority actually beings tomorrow, the 16th. And the Cancer Agency as mentioned . . . This just in. Apparently today is the date that the mammography services were being resumed.

Ms. Mowat: — Great. Thank you so much. It was good timing.

Speaking of today, I read that there were some changes around support persons for women who were giving birth, that there's going to be now two support people available. We've heard a number of different concerns from expecting mothers around the COVID-related policies and support persons. Are there any changes to prenatal appointments and the ability to have a support person present during those appointments?

For some context, I've heard from women who it's their first time hearing a heartbeat. And you know, that's a moment where being with the father is kind of a key moment in their journey. But also on the other side of it, I've heard from women who have lost their child and had to find that out by themselves. So just wondering if there's any update in the policy around support persons for prenatal appointments.

Hon. Mr. Reiter: — I believe there have been some changes. Scott's just verifying what they are, so we should have them in a few minutes. I'll get him to answer you then and we can continue if you like.

Ms. Mowat: — In terms of access to personal protective equipment, we've heard from a number of folks who work in health care about the need to ration their masks, only being provided with one mask per shift, having to get permission from a manager to get a mask unlocked once one is soiled. In some cases the person was off-site, making this process quite cumbersome and difficult, you know. Are you aware of these rationing issues?

Mr. Livingstone: — So I'd like to address the comment that was around rationing. And I would just want to clarify between rationing and following infection-control protocols. So there are situations where people are given a number of masks, particularly for example with home care when they're going out of a facility and visiting. But if there are situations where the masks are soiled and they need replacements, they're getting them. I'm not aware of a situation that you've pointed out, but would I be happy to follow up with somebody who had an off-site person that was not there to give them proper PPE [personal protective equipment].

But we are not rationing PPE. We're actually using our PPE through our infection-control standards. And that is a change, but I'll give you another example of a change in the other direction.

So as you know, we've gone to a continuous-masking policy across all of our facilities with staff. And we did that early on in the COVID environment. And there was a concern at the time that we'd be burning through or using a lot more masks, procedure masks, by doing a continuous-masking policy. But in fact we're using the same amount of masks that we would normally use, because people aren't donning and doffing them every time they walk in and out of a room.

So one of the things you're seeing is a change in the use of PPE because in our former policies when continuous masking wasn't required, you would often see people using masks for literally a 30-second visit inside a room, walking in and out. And that's not happening today. People are wearing that mask in some cases all day long. If they can't use it all day long because it's soiled, well then they'll get a replacement mask.

Ms. Mowat: — So I guess we are hearing ongoing concerns from a number of front-line workers about PPE, and we have since the pandemic started. So I would assume that those concerns have also come forward to you folks because it would be absurd if they only made their way into the opposition.

Mr. Livingstone: — So, and I'm not sure if you recall, but early on again in the COVID phase 1, let's call it, that we're still in, there would have been some changes to PPE across the organization. Changes to policies for use and continuous masking is one of those changes. But it's also lots of education going across the 40,000-plus staff and physician partners around where the appropriate use of PPE is. We have established both a hotline and an email address for all staff to call when they have any concerns about PPE, whether they feel that they're not getting appropriate PPE, whether they have questions about the appropriate use of PPE. And I'm not aware of a large volume of calls around rationing or other aspects of PPE.

[19:00]

So I can follow up specifically on what's coming through that hotline that we've always made available to staff. And it's not there as a punitive thing, it's there as an education thing to support staff that are feeling vulnerable if in fact they aren't getting the PPE or the information that they need to properly protect themselves and patients.

Ms. Mowat: — There was a story in the *Leader-Post* today about the shortage of PPE at the beginning of the pandemic, and it specifically highlighted a number of concerns with SHA officials around shortages of swabs and other supplies. I'm wondering when the minister was made aware of these concerns.

Hon. Mr. Reiter: — I think it's fair to say, you know, that had a fair bit of discussion in question period today. I think it's fair to say those concerns were worldwide. Everybody was concerned about having appropriate amounts of PPE.

You know, we're still concerned, I believe — and Scott could add to this — but we're still procuring PPE. Nobody knows what's going to happen as far as a second wave goes, but I think the issue has been somewhat torqued. I mean the discussion today in question period was that officials are raising concerns about it. As I said, officials around the world are raising concerns. And no point in time have we ever had an actual shortage of PPE. My understanding is employees have always been provided with the appropriate level of PPE. I think at a minimum right now, we would have — what, Scott? — at least a 30-day supply of any type, and we continue to procure it going forward.

Ms. Mowat: — So I appreciate your answer. I'm wondering when you were made aware of the shortage. Like do you have that date?

Hon. Mr. Reiter: — As I said, there's always been concerns about having appropriate levels. But when you say, when I was aware of the shortage, I don't know what that means. At no point in time have any staff not been provided with the appropriate level of PPE.

Ms. Mowat: — Okay, we are probably not going to get an answer of a date. I know that dates are important to folks in being able to forecast how well the pandemic was planned for, so I think that is the reason why there is so much scrutiny and attention on these questions right now.

You know, I don't think it's about beating a dead horse or an issue having been canvassed already. I think it's about people wanting to be aware that this planning was taking place, and also that there's a solid line of communication between the SHA and the ministry. So that's the information that I'm trying to get at.

Hon. Mr. Reiter: — I had been made aware by officials, I would say, right along that there was a worldwide concern about procuring PPE; that Saskatchewan had, I would say, the way I think I would explain it was, had a reasonable number of days of supply of I think virtually all supplies.

But our officials were concerned that they wouldn't be able to get more, so they were concerned about procurement. They worked very hard at that. They continue to work very hard at that. And I think the results show that at no time did we run out of any PPE. Some provinces weren't as fortunate. I think there were instances in Quebec and Ontario where there were last-minute pleas for supplies. Fortunately Saskatchewan was never in that position.

Ms. Mowat: — So I think in terms of the language, there are quotes from SHA officials that say that there were shortages. So maybe it's a classification of you not thinking there's a shortage, but the quotes saying that there's a shortage. So I don't know if you have any response to that.

Hon. Mr. Reiter: — So when I used the term "shortage," I was referring to where literally employees that needed supplies didn't have supplies available. Officials are telling me that when they were communicating, possibly what you're talking about, at times the shortages they were referring to is when they ordered, when they were procuring supplies, they didn't get full supplies or maybe didn't get the supplies they had ordered. As far as when supplies were ordered and specifics on that, I'm just going to ask Max to give you a more fulsome answer on that.

Mr. Hendricks: — So the typical practice of the Saskatchewan Health Authority is to hold two to three months of supply of stock on hand. You know, towards the end of January we were kind of learning from experiences in other jurisdictions about the burn rates of various PPE and what the proper PPE was for dealing with COVID-19. And so you know, I think in some jurisdictions they saw burn rates of N95 masks, gowns, face shields that were huge and kind of outside of what we were normally, what we normally deal with.

On February 14th I directed the SHA to increase their supply to six months. We are fortunate that we do have a pandemic warehouse that we've kept, and we had sent those masks away fairly early on to get tested and to see if they were still performing to NIOSH [National Institute for Occupational Safety and Health] specifications. And as you know, our procedure masks — a couple million procedure masks as well as about 600,000 N95's — came back at or above spec. And so you know, with regards to PPE, I sit on FPT [federal-provincial-territorial] calls, almost three times a week for a period there, and Saskatchewan in most regards is in a pretty enviable position.

Now we continue to work with our suppliers to try and secure more PPE, as I said, for the fall. And you know, the market around the world is tight on this stuff, so we're having to work very aggressively in this space. But we're pretty confident right now that, based on what we saw during the first wave and our ability to secure orders, which have stabilized now, that we're in a pretty good position going into the fall.

Ms. Mowat: — When was the first order for additional PPE made by the SHA?

Mr. Hendricks: — The first large order placed by the SHA was on the day that they received a letter. It was on February 14th where they literally ordered thousands of pallets of materials of all types — a pretty significant order. I also need to remind you though that, you know, we have our regular supply chains and suppliers. And one of the challenges is, particularly as we got into the March time period or late February even, those supply lines were tightening up. Then you had the US [United States] say that they wouldn't allow 3M products to come into Canada, or be shipped out of the US, more accurately I guess. And so those were resolved quickly, which has kind of been the historical product that we use.

We also have a federal procurement process which is a parallel one, which in its initial phases has provided some material, not everything that we would normally need. But I think that, you know, the feds and the other provinces have really been also

focusing on shoring up domestic supply of a lot of these materials so that going forward we're not relying on other countries to supply this during a pandemic.

Ms. Mowat: — How much has been spent so far on acquiring additional PPE?

Mr. Hendricks: — So far we've committed $20 million to ordering additional PPE. An additional $11 million is going to be spent to increase the supply to the six-month mark that is kind of our goal for the fall. As well, we thus far haven't received a bill from the federal government for PPE that they're planning on providing.

Ms. Mowat: — That 20 million has been spent or is it . . . What is that?

Mr. Hendricks: — It's been committed, yes. We have orders in for $20 million.

Ms. Mowat: — Okay. And is there an expectation that there will be a requirement for additional purchases beyond what you have identified so far?

Mr. Hendricks: — Yes, well right now the goal over the summer — and hopefully it remains quiet during the summer — is to very deliberately move to the six-month mark, right? But one of the things that we're factoring into this, in terms of in the federal government . . . And we are doing modelling on our PPE utilization. So when you look at the dynamic modelling and how this ties into things like PPE usage, and if we enter into a worst-case scenario or a mid-case scenario which we're planning for, we would kind of make estimates about what our burn rate for PPE would be and we would start ordering those amounts as well. And so this isn't a static model either. We will acquire whatever PPE we can and think we need.

Ms. Mowat: — And the purchases for PPE, does that come out of the SHA budget?

Mr. Hendricks: — Yes. And the SHA has put it through the ministry, yes.

[19:15]

Ms. Mowat: — Thanks. In terms of PPE that . . . You talked a little bit about PPE that we had in stock that could still be utilized. There was also a report earlier in the year, in a CBC [Canadian Broadcasting Corporation] news article, that the government of Canada had to dispose of 2 million N95 masks and over 400,000 medical gloves when it shut down an emergency stockpile warehouse in Regina. Did the province have any access to the materials in these emergency situations?

Hon. Mr. Reiter: — Max will answer your question here, and then Scott has the answer to one of your previous questions. We can go to that and then continue.

Mr. Hendricks: — In terms of receiving a notification or anything from the federal government that stock or their stockpile in Saskatchewan was being destroyed, we received nothing that would have notified us that that was happening. In fact I don't even know that we were aware that . . . the size of a stockpile or anything that existed here was probably just forward deployed.

Ms. Mowat: — Did the province have regular access to these materials?

Mr. Hendricks: — No.

Hon. Mr. Reiter: — Did you want the answer to the other question now?

Ms. Mowat: — Oh sure. I just have one other quick follow-up maybe. Were there any provincial supplies that were also stored in that location?

Mr. Hendricks: — No. We had our own warehouse. Yes.

Ms. Mowat: — Sorry. I had already forgotten.

Hon. Mr. Reiter: — Oh sorry. I thought they had the fulsome answer. They're still working on it. I'm sorry.

Ms. Mowat: — All right. So I'll move on to, there were recently quite a few concerns raised over the closure of some rural emergency room services. And we had also completed an FOI request that came back and showed us that there is a history of many service disruptions all across Saskatchewan. I'm wondering if you can speak to the rationale behind going ahead with the rural ER [emergency room] closures despite not having active cases in those communities.

Hon. Mr. Reiter: — I'll get Scott to speak to the specifics on that. But in general about rural closures, you know, frequently what causes that, it'll be staffing issues. As you know, at times recruiting doctors can be difficult. And if there's a shortage of doctors in a community sometimes that'll cause a temporary closure. But it's not limited just to doctors. It could be other professionals as well. Of late one of the areas of concern has been the combined lab/X-ray technicians that in some instances can be hard to recruit. So there can be a number of reasons. Certainly we do that as a last resort only in those cases, and we put a major emphasis on recruitment to reopen them as soon as possible.

On the specifics about the ALC [alternative level of care] transfers in those 12 communities though, I'm just going to ask Scott to elaborate on the reasons for the closure and the timelines on the reopening as well.

Mr. Livingstone: — So I'm Scott Livingstone, CEO, Saskatchewan Health Authority. So just to go back before we start talking specifically about the 12 facilities, I just want to talk a little bit about some of the philosophies around the offensive and defensive strategies for COVID response for the SHA. And one in particular was ensuring that long-term care residents and other folks across the country or our province who we would deem the most vulnerable — those with chronic diseases and those who are requiring extra levels of care — were protected and kept safe.

So with respect to the strategy that was released back in April in the early days of the COVID response, where we were using projections expecting a large surge of patients coming into our facilities that would require a very high level of care, we were

looking to actually support that care across three different areas of the province — both in the urban centres, our rural, and north.

So multiple teams across the province put together their strategies specifically with respect to the 12 facilities in question in the rural areas. A decision was made to designate COVID facilities and non-COVID facilities in the rural area. These 12 facilities originally were designated as COVID-free and they would be used to support long-term care residents because between the 12 facilities there's about 402 long-term care residents, and also would be used to build capacity for larger centres by allowing us to transfer alternative level of care patients out of larger centres and into these facilities for care.

Because part of the concept of keeping these people safe is minimizing traffic in the facility, including the emergency rooms where in some cases in these facilities they're in very close proximity to both long-term care or the acute care beds, the decision was made early on to close the ERs temporarily, have the staff trained so that they could support COVID patient work at other facilities, and then we would be able to protect those staff and patients inside the ALC [alternative level of care] facilities with both long-term care and ALC patients. The advantage of using ALC patients and long-term care patients together is they don't require physician visits every day.

Now that was part of the early strategy. As you know, through our response to COVID we didn't see that surge and the requirement for acute care beds in the province. So that decision was decided to be reversed early because we weren't needing the capacity. But what we had to do then to chart out the path to reopening of these temporary closures was ensure we did the same things with the facilities that we did with other facilities that would be expecting COVID patients.

And that would be ensuring that there was no cross-staffing between acute care and long-term care, so cohorting of staff; ensuring that people that were working in the emergency department knew proper use of PPE and lung and airway management protocols so that if somebody did come into the facility that was COVID-positive that we could care for them properly but also protect everyone else; as well as ensuring that we weren't going to need that capacity from an ALC perspective.

So that work, as you know, is under way as we speak, and many of these facilities will reopen their emergencies this month. The things that we needed to put in place for these facilities to reopen were the same things we've done in other facilities to train them so that they could be receiving COVID patients.

Ms. Mowat: — So in terms of these facilities, we know that in many cases folks reported not having a lot of notice, and there were a number of community leaders I know that came forward saying that they weren't consulted in the process about decision making that affected their community. What's being done to address this lack of communication?

Mr. Livingstone: — So I want to take a step back again to when it was announced. So on April 8th I believe is the day that it was actually released publicly, our plan. All of those community leaders were contacted by SHA staff with respect to what changes were going to be coming in a four- to six-week period of time. And that's exactly when those changes went into . . . put in place.

So we do recognize that there should have been more follow-up on the dates that we were moving forward, but certainly I can tell you that all of the community leaders were consulted before these changes went through back in April when the plan was put in place. Again at that time, the province as well as those community leaders, the SHA and everyone else were looking at the numbers that we were projecting, which were quite bleak with respect to COVID surge, as you will remember, and that we just simply did not experience that.

So in the future we, you know, when any changes are going forward, and we do see these changes unrelated to COVID where we see temporary closures or changes in the facilities, and we do try to give communities as much of a heads up as we can. But there are well-designed protocols in the province to deal with temporary closures, whether that's due to a physician or staff member being injured where we can't replace. So we can respond quickly.

But I do agree that we probably could have done a better job communicating prior to executing on the plan. But I will say that all of these community leaders were communicated with around what the plan entailed when it was launched.

Ms. Mowat: — Can you provide some information about the detailed plan for reopening by community? So what are the dates by communities affected?

Mr. Livingstone: — So I know the Premier announced that publicly less than a week ago I believe, or it was last Monday. I don't have the dates specific in my . . . I now have the dates specific in my hand. So Kerrobert, June 12th. Arcola, June 16th. Preeceville, June 18th. Biggar, June 22nd. Oxbow, June 22nd. Davidson, June 24th. And Herbert, June 25th. And that is seven facilities.

And the other five I'm assuming are not reopening because there would be staffing concerns related to the reopening, either existing before the conversion to a temporary ALC facility or that occurred since. For example, I can speak to one of those facilities would have been Wolseley. And I know that there's been some staffing challenges in Wolseley, both in nursing and CLXTs [combined laboratory and X-ray technologist], that are going to delay the reopening of that ER.

Ms. Mowat: — Considering the persistence of staffing challenges that leads to these service disruptions, what's being done to look at recruiting and retention of all the positions that we require — so physician shortages, but also the staff members including the lab techs?

Mr. Livingstone: — So I'll talk a little bit about a number of areas where we're actually working to support communities across the province, especially rural and northern areas of the province, to enhance the continuity of care and to reduce some of the challenges that we face with respect to some of the difficult-to-recruit positions. And I want to be clear that this isn't just about physicians. It's about nursing. It's about combined lab and diagnostic imaging technologists in many cases, which puts some of these facilities . . . or makes them vulnerable.

[19:30]

So some of the things of course, besides some of those basic traditional ways in which we're doing recruitment and retention, is we're trying to look at opportunities particularly with some of the hard-to-recruit positions like CLXTs, which frankly have been a significant challenge for the organization with respect to the continuity of services because of the important roles individuals play.

But also with the creation of the SHA, it allows us to take a look at those communities that have similar challenges in close proximity and using more of a pooling or a collaborative mechanism to hire staff.

So instead of trying to recruit . . . One of the challenges of recruitment is, if you only have a .3 or a .4 or a .5 position available in a small community, it's going to be very difficult to get somebody to take that position long term unless they're really tied to that community.

So using as an example, with CLXTs, I can tell you in communities like Broadview, Moosomin, and Whitewood, which are in close proximity, they all share the same challenge with CLXTs. So by posting full-time positions and having people having the flexibility to work and live in the community but also work in other facilities to support them at the same time and have full-time jobs that are much more substantive with respect to staying power and also allowing us to bring other technology in to support them.

You know, one of the things we know from our CLXTs is they're graduating today and they're not trained on old film X-ray machines. So by working on a strategy to increase digital X-rays across Saskatchewan is also one of the things we believe will be important for recruitment and retention.

The last thing I wanted to say is that we're looking at new strategies as well as to link smaller ERs and perhaps single-practice physicians to larger communities so that we can connect them both virtually and operationally so that they can support one another where there's, for example, physicians needing to take breaks either because they're ill or sick when you have a single-physician community, and provide them more support.

And last but not least, we saw a big surge with the new virtual care codes for physicians to be able to bill through the COVID. You know, last week I think we were up to over 122,000 virtual visits with physicians and nurse practitioners using technology to care for patients.

And as you know, one of the challenges for our emergency rooms, and small rural emergency rooms would not be dissimilar to larger emergency rooms. There are patients that come to those emergency rooms that are what's called CTAS [Canadian triage and acuity scale] 4's and 5's, so they're less urgent or non-urgent cases. They're just coming at off hours. And we think virtual care can have a big role in smoothing that for patients and making sure that they have access to the medical professions that they need on an ongoing basis.

There's lots of things going on. We think there's a lot of opportunity as a single health authority to look at that pooling opportunity to include full-time work and stabilize some of these hard-to-recruit professions.

Ms. Mowat: — For the virtual care codes, is there a plan in place that those will become permanent once the pandemic is over?

Mr. Hendricks: — So we're still in negotiations with the SMA [Saskatchewan Medical Association] on a final contract. Obviously in our discussions with the SMA the whole notion of virtual care was pretty far advanced in negotiations. And so when we saw COVID and some of the challenges that it would present, we just took the initiative and implemented the codes immediately. You know, I think I'm highly optimistic that these codes will be something that we will have going forward in the future, but of course we're still in negotiations.

Ms. Mowat: — Thank you. I just have one other question with regards to the rural emergency rooms. Do you have a plan for whether — and I won't make you go back to the table because you just disinfected it — but do you have a plan for what threshold would we need to hit in order to trigger the rural ER closures again?

So if we say that it was done a little pre-emptively, we didn't quite have the caseloads that warranted those closures at that time, is there a specific rate of transmission by community? You know, when would we look at going back again?

Mr. Livingstone: — Is there a clearly defined threshold that would cause us to require a suspension of services in those facilities? No. What we would have to see is — I would suspect; I'm not a public health physician — but we would need to see, from a COVID perspective, a large number of community cases that would require us to do one of two things. It would either be in a direct proximity of that facility. Because remember, we've now created 12 more — sorry, seven more because the other four are not been complete yet because of staffing concerns — COVID facilities. So now that we have been able to safely bring these back up with ERs and patients in long-term care, we've got the cohorting in place, we've got the safety protocols and the training in place.

If for some reason — because as part of the original plan, as you recall, we were doing some upscaling in physicians in these facilities so that we could use them in a larger facility that would be caring for COVID patients — if we were overburdened by in-patients in a larger facility, we may have to take some of those trained staff out of these facilities. But given the fact that we've already trained them now, like everybody else, to deal with COVID patients, the single biggest factor for any change is consistent staff. It would not be singularly related to COVID unless the COVID surge was so big that we needed to redeploy resources or we needed alternative level-of-care beds from a capacity perspective with respect to what was going elsewhere.

Now again I will say, all things being equal, the other thing to keep in mind in these facilities — and it's not unique to them because we have other ones as well — but there are 402 long-term care residents that we still would want to protect. But we believe, with the retraining and upskilling of the staff to reverse the temporary closures, that we've got that in place.

Ms. Mowat: — And if — we're getting into some maybe hypotheticals now but may not be in a couple of months, we don't know — if those folks were redeployed, would it be likely that they would be going into like the field hospital setting? Or is there a plan there?

Mr. Livingstone: — No. I would say that where we would see . . . And I'll use the example I know because I don't know them all. I wish I could tell you I could sit up here and know the original plan line by line, but I do know some of our physicians in Arcola, as an example, were trained to be prepared to staff in Carlyle, which would be a facility as an example. So if we had to move some staff, that might have an impact on services there. But no, we wouldn't be planning on pulling them in.

You know, where we have that type of capacity, you know . . . The field hospitals give us another level of capacity. But understanding that Saskatoon, Regina, and some of those larger centres like P.A. are going to deal, in the event of us having a larger surge, with a large number of hospitalizations which we have not experienced overall and a high level of acuity patients in ICU, that's where those patients will be, is we'll . . . [inaudible] . . . those patients in Saskatoon or Regina. We won't be keeping them in smaller centres unless we absolutely have to.

Ms. Mowat: — In terms of the relatively low number of cases that we have in hospitals right now, can you speak to why the field hospitals are still going ahead?

Mr. Livingstone: — So with respect to why we continue to move forward with the field hospitals, there's a couple of reasons. And the one I will state unequivocally is, you know, plan for the worst and hope for the best. And that's always been part of the offensive and defensive strategies, and maintaining that offensive strategy will help contain, mitigate, and delay the virus.

But at the same time, you know, we just heard about us stockpiling six months of PPE, planning for a second wave of COVID. Having the field hospital flexibility and having them ready to go, you know, they're not something that . . . You know, we can always put the equipment someplace and store it, but we can't have them up and running in a 24-hour period of time or even a one-week period of time. So having them ready and available to us, you know, in a period where we require surge capacity, they give us a lot more flexibility in our larger centres so that even if we started seeing a high number of cases coming in very quickly, we could use those field hospitals for a number of things to increase our capacity and support ALC patients.

The other thing that they can do is mitigate the pressures on the system that are going to make us slow the system down significantly again. God forbid that we don't have a wave where the health system does what happened on March 23rd again, but we want to avoid that at all costs. And we see the field hospitals, even in a more contained manner, they're smaller than what we had originally thought they would be. But you know, 300 beds-plus is a significant amount of capacity for us and gives us a lot more cushion, assuming something really bad occurs.

Ms. Mowat: — Thank you. I'll shift gears a little bit here. I've got some questions about cancer care. Can you speak to what the current backlog is in oncology surgeries and what the backlog was before the SHA had to restrict services during the pandemic?

[19:45]

Mr. Wyatt: — Mark Wyatt from the Ministry of Health. So specifically when you're asking about cancer surgeries and the backlog that accumulates during the service suspensions, one important thing to keep in mind is that when elective surgeries were suspended in March that didn't impact on urgent surgeries, of which many, not all, cancer surgeries fall into what we call the three-week urgent category. So those surgeries continued on. That is the one level of surgery along with emergency surgeries that are done, you know, basically same day or next day. Those carried on through the entire COVID period.

There are some cancers that are identified with a six-week wait time, and six-week cancer surgeries and other urgent six-week surgeries were delayed as a result of the COVID slowdown. And so those were the first level of surgeries that were prioritized in phase 1 of the service resumption plan. There were some elective surgeries that were part of phase 1 as well, but the main sort of impact across the board in surgical services was to move to that six-week urgency band. And so those have continued.

It would take me a little bit of time to, you know, to get hands on some of the numbers around it, but certainly the report that we had coming out of the COVID period as we moved into phase 1 was that there really hadn't been a lot of ground lost in terms of cancer surgeries during that time, unlike some provinces where I know that they did stop urgent surgeries. They stopped cardiac surgeries; stopped doing some of their cancer surgeries. Saskatchewan did continue on with urgent three-week prioritized cases.

Ms. Mowat: — Thank you, and that's encouraging to hear. How have the wait times been impacted for the other categories beyond emergent and urgent?

Mr. Wyatt: — We have absolutely seen a large increase in the number of patients waiting for, I guess, all surgeries across the board. You know, the slowdown in terms of elective surgeries, you know, it almost had an immediate impact. We do over 1,000 surgeries a week, and so immediately we started to see our wait times grow. I'll just have to grab a different book here to be able to give you the numbers. We've got the numbers to the end of April now that are publicly posted, and we've seen a significant rise through that second half of March and throughout the month of April.

Ms. Mowat: — Sure. Thank you.

Mr. Wyatt: — So to give you an idea of the number of patients waiting for all . . . And this is across all elective surgeries. The number of patients who had waited over three months as of April 2019 was 9,760, and we've seen a jump of up to 14,922. And the largest, I mean most of that increase is attributable to that six-week period from mid-March through to the end of April.

Ms. Mowat: — Thank you. Can you go into the average wait times by procedure? And again, if tabling it is easier than reading it . . .

Mr. Wyatt: — Yes, that might be something we'd have to table, by procedure for sure.

Ms. Mowat: — Thank you. In terms of timelines, is it possible to get it tabled by the end of the committee tonight?

Mr. Wyatt: — By procedure, I'm not sure if we would be able to get you that tonight. I mean, we have data by total number waiting, number waiting at the three-, six-, nine-, twelve-month intervals, but I'm not sure that we could get you a procedure breakdown tonight.

Ms. Mowat: — Thank you. The reason I ask is sometimes we do the committees and we get commitments to get the tables and then sometimes months go by before we get the information back. So I'm just wondering if there can be a commitment for a reasonable time frame.

Hon. Mr. Reiter: — I'll talk to officials after. We'll get it to you as soon as they can.

Ms. Mowat: — Thank you. I know there are a number of folks that are waiting for imaging as well. Have we seen similar trends in medical imaging for oncology?

Mr. Wyatt: — We don't track medical imaging data based on the type of the indication or the type of disease that a person might be receiving an MRI [magnetic resonance imaging], an X-ray, a CT, ultrasound for. What we can tell you is that at the time of the slowdown of services, a lot of imaging did continue in the facilities and we didn't see a complete drop-off in MRI and CT and in X-ray services. And so you know, the urgency screening where we were able to identify that somebody had an urgent need for medical imaging of one modality or another was certainly continued to be available. And I would expect that, you know, urgent cases would be flagged and could still be seen during the COVID period.

Ms. Mowat: — Thank you. In regards to MRI wait times, how many people are currently waiting for an MRI? I think the last number we have is as of June 2019.

Mr. Wyatt: — With respect to medical imaging data, we're just in the process of trying to get an update prepared. And we're not yet at the point where we're, I guess, sort of fully being able to review and scrutinize our numbers before we make them available. So our request would be to table them at a later time.

Ms. Mowat: — Okay. So that would be why the numbers haven't been updated since June of 2019?

Mr. Wyatt: — Yes. So we do update the numbers online, and we've actually had some cleanup that we've been doing with our medical imaging numbers. The other thing is now with our surgical numbers, in posting them last week, we did include the first full month of the COVID period. So those actually are posted up until the end of April. And so now we're just in the process of trying to . . . look at updating our imaging numbers based on a similar timeline. But they're actually just coming together, I can say, you know, towards the end of last week and even into today.

Ms. Mowat: — Will the information be provided online once it's updated as well?

Mr. Wyatt: — We do update our website with both surgery and imaging data, and we will be updating that again.

[20:00]

The Chair: — Ms. Mowat, we are going to now take a five-minute recess so we can change out Hansard here and do some sanitizing. So back here in five minutes. Thank you.

[The committee recessed for a period of time.]

The Chair: — Okay, we'll resume consideration of estimates and supplementary estimates for the Ministry of Health. Minister.

Hon. Mr. Reiter: — Mr. Chair, I'd suggest to the critic that we have one of the answers we had promised we'd get to earlier on the ASDs. So if she wishes, we can certainly provide that now.

Mr. Livingstone: — So specific to the question around the autism spectrum disorder consultant that was redeployed as a site manager in Kindersley for the treatment and assessment centre, just a clarification then. In that posting from SHA, included in that posting is that she did not get redeployed full time. So her role was really two hours every morning where she was working on scheduling and coordinating the assessment site, and then for the remainder of the day she saw her entire caseload for autism disorder throughout her response to the pandemic. So she was not redeployed to a single position.

We're not aware of any other autism spectrum disorder consultant that was redeployed away from their regular duties during, but we did create a very large labour pool, as you know, with primary health care. So I'm having HR [human resources] check on that so that I can be 100 per cent, but I'm 99 per cent sure.

And just to remind you folks that there were many services, including autism spectrum disorder, that didn't include all the face-to-face visits. It was done virtually in many cases, just like some of the other services, to protect both staff and patients from COVID.

Ms. Mowat: — Thank you. I'll return to some of the questions around MRIs that we were talking about. So we talked about wait times. In terms of the wait times, the last date that we have for wait times is in June 2019. Or is there a closer date that is not considered complete?

Mr. Wyatt: — We don't have any data available from a more recent time period.

Ms. Mowat: — Okay. Thank you. Do we know how many MRIs were performed last year?

Mr. Wyatt: — In the 2019-20 fiscal year, there were 36,786 MRI . . . Sorry, that's the number of MRI patients. Then you may have some patients who have more than one exam.

Ms. Mowat: — And do we have a breakdown of those patients of who attended a hospital for an MRI and who went to a private clinic?

Mr. Wyatt: — I can tell you that in 2019-20 that there were 742.

Sorry. Is your question how many MRI patients attended a private clinic for a publicly funded exam, or is it specifically about the private-pay patients?

Ms. Mowat: — I would like both, if possible, yes.

Mr. Wyatt: — So I can give you the latter, which is of the private-pay scans. There were 742 scans that were patient paid, 1,014 that were WCB [Workers' Compensation Board] paid, and 165 that were other paid, for a total of 1,921 that were not part of the publicly funded system.

Ms. Mowat: — And do we know how many MRI scans happened in the hospital setting?

Mr. Wyatt: — I may well have it in my data here, but it might take me a moment to find it. If I could come back to that, I may be able to provide you the answer, but it might just take a little bit of searching.

Ms. Mowat: — Sure. In terms of the — I'm not sure how many of these questions you have to answer while you're searching — in terms of the contract that was awarded to Mayfair Diagnostics for the clinic in Saskatoon, how many responses were there to that tender?

Mr. Wyatt: — I don't believe that we have the number of different proposals that came through as part of that competitive process. I know that there were several of them. There were certainly more than just a couple. So we can get back to you with that information.

Ms. Mowat: — Thank you. Specifically we heard that there were a group of Saskatoon physicians that also applied for that contract, so we're just wondering why the Mayfair contract was chosen over providing a public model that would have also been able to fill that need.

Mr. Wyatt: — The criteria for that competition were developed in advance and there was a fairness advisor that was part of that process. The criteria are identified, as with most any RFP [request for proposal] process. You would have a certain number of points awarded for the quality and, you know, the technical elements of the proposal. You'd have a certain number of points based on the past history and experience of the proponent, and a certain number that would be based on price.

[20:15]

As with any RFP, you have multiple different criteria that are used. And that was scored as per the scoring matrix and the successful vendor was selected. A negotiation was completed and it was awarded to Mayfair.

Ms. Mowat: — Are we losing any funding this year in the Canada Health Transfer as a penalty for our private MRIs?

Hon. Mr. Reiter: — So to your question, officials tell me that, from discussions with the federal government, there wouldn't actually be any clawbacks until 2022. I would add as well though, when Minister Hadju was appointed not that long ago, I had had a brief phone conversation with her, just a get-acquainted conversation not specific to this. I had raised that, had told her that at some point I'd like to have a discussion with her about that. And then if memory serves, I think I've done a follow-up letter — but I stand to be corrected on that — asking to meet to discuss it.

What had happened though, the intent was to follow up with that, have a discussion with her, and then COVID hit. And so there's been essentially nothing done on it in the last couple of months. But it's my intent in the next while to follow up with her on that again.

Ms. Mowat: — In terms of the SHA's approach to inventory management, we know that a key part of the lean initiative was reduction of inventory and supplies, to have supplies available based on the principles of just-in-time. And I'm wondering now, given some well-documented issues with the challenges of global supply chains in situations like this in securing PPE, is the ministry and SHA, are you reconsidering these initiatives that pared down the level of supplies being kept on hand?

Mr. Hendricks: — So in terms of how we mange inventories, last fall I had a discussion with the CEOs. We agreed that, and this was prior to the pandemic, that there were certain supplies that it was in our interest — including PPE, that sort of thing — to maintain a larger inventory. Unlike our current pandemic warehouse where it was kind of a static stock, what we would focus on doing was making sure that we were turning that stock, so a first in, first out kind of approach to managing that inventory. You know, at the end of the day, the amount that would be in the hospital would be the same, but you would have a warehouse somewhere that held it.

I think in certain situations, lean aside, you have to recognize that there are certain supplies that are vulnerable in certain situations and that past experience and/or the potential for a pandemic would cause you to keep a larger inventory of those.

You know, a lean purist might say no but then the fact is, is that in Canada, we don't have domestic supplies of a lot of these materials. And so that's one of the reasons we maintain the pandemic warehouse.

Ms. Mowat: — Thank you. Is there a plan moving past the time of the pandemic going forward to secure some larger volumes of supplies?

Mr. Hendricks: — I think I indicated earlier that we have instructed the SHA to move to a six-month supply of personal protective equipment going into the fall. But as I mentioned just a few minutes ago, we had talked about that in October as a DM [deputy minister] and CEOs council. And so the notion goes forward. This would be any time we would maintain them, because part of the reason for discussing that in the fall was, you know, if we were ever to reduce that static supply in our warehouse, we need to still have an inventory that's sizable enough to get us through something like this, right?

And so I think there are a few things. There's PPE that we would want to do that. And I think also actively monitoring, you know, uncertain situations, the world situation on drugs. You know, PPE isn't the only thing that's been impacted by this, and so there are a few things that we would say maybe are more highly sensitive, volatile, aren't produced domestically, that we would

want to maintain a larger inventory.

But I think it begs a larger question about security in Canada of certain materials that we need, that are critical in our health system. And you know, I think over the last decades we've come to rely more on offshore suppliers of these and/or even just any other country, I guess. And I think that there's been a real recognition at the federal-provincial table that there are just certain things that we must have a domestic supply chain for.

Ms. Mowat: — Thank you. I want to switch gears a little bit and talk about EMS [emergency medical services] services. It's been over 10 years since the first 2008 ground ambulance review, and the ministry conducted an additional review in the summer of 2017. I'm just wondering what changes have been implemented in the last three years since the EMS review.

Hon. Mr. Reiter: — If I could, the officials are going to want to discuss that one for a minute, but Scott has the answer to the prenatal question.

Ms. Mowat: — Okay.

Hon. Mr. Reiter: — We can provide that to you.

Mr. Livingstone: — So the beginning of the question, you were mentioning how you were hearing from families particularly around birth supports. And certainly as we had announced the expansion to the compassionate definition for family presence across the SHA, last week we had heard from doulas, those birth support workers for moms, and certainly that has been part of the expansion. So for example, during the birthing experience moms are allowed two visitors within that they designate that can be family: a doula, midwife, whomever they designate.

For prenatal visits it's the same. Moms are allowed to bring hubby or bring father or bring grandma or bring who they designate with them. If there are any concerns like there have been, clarification is asked for. For families and prenatal families across the SHA, they can just call our family care coordinator line and they will help coordinate the visit. But they are allowed to bring visitors.

Ms. Mowat: — Thank you. And does that reflect a change in policy recently?

Mr. Livingstone: — It's part of the expansion policy. So there was a limit with birthing mothers for sure of one, and now that's now been expanded to two. And with prenatal visits in other clinics, yes they were limited during the COVID pandemic. We were limiting it like we were all specialty clinics.

Ms. Mowat: — Thank you. Some of my other questions are around ambulances, so I feel I should wait until they come back, yes.

[20:30]

Hon. Mr. Kaeding: — Okay, since the review, there's a number of initiatives that have been implemented since then. Probably one of the key ones with our EMS services is . . . As of January 23rd, 2020 we have 16 contracts with 20 services signed, so on the private sector. We've got also a number of 35 ambulance operators that initiated their notice not to renew. So those are some of the key factors with our private operators as an update as to where we stand with them.

With the new service contracts, they're a performance-based contract. And it's all based on service data, number of calls, the level of calls that they have, distance to travel. All of those are put into their performance-based contracts.

Another initiative is utilizing more advanced-life-support ambulance services. So we're certainly building our ALS [advanced life support] services. A couple of communities that come to mind would be La Ronge, Swift Current, and there's a number of other ones that are being considered right now too. And part of the performance-based contracts is to determine whether those ALS services are required in other locations as well.

We're utilizing community paramedicine. We've got a number of communities in the province now where we're using community paramedics as kind of another line of health service where our EMS providers not only are working the emergency service but they're also involved in community medicine and taking on a number of initiatives, providing medical services within the community.

You'll see in the budget this year that we have certainly designated more money towards EMS-provider wellness. So it's a mental health component specifically for our EMS service providers and working to build that initiative and to support EMS in that area.

On the IT side, certainly moving towards getting all of our ambulances set up with a computer-aided dispatch. So it's a GPS [global positioning system]-type system that we want to make sure that we've got put into every unit. And that's going to help us build services towards the future too where we can build service around kind of the closest available service to an incident that's called.

So those would be probably the key initiatives that have taken place since that survey in 2017. If there's any other questions, I'd certainly have . . . Mark could probably speak at a higher level than I can.

Ms. Mowat: — Thank you. One of the key issues that was highlighted in both of these reviews was the burden of the cost on patients, and specifically, you know, we continue to hear concerns about the fact that patients are charged for transfers between facilities and the fact that patients are charged per-kilometre fees. Is there any look at opening up *The Ambulance Act* and making some changes there?

Hon. Mr. Kaeding: — We certainly recognize with our health basis to, you know, trying to reduce the burden on our hospital clients. But I guess that comes at a trade-off, right, as to where do we want to ensure that we get the most efficient use of our health dollars.

You know, we're certainly looking at fleet replacement. We've got certainly a large number of ambulances that are very long in the teeth and need some replacement. So we're certainly spending a lot of money on a regular plan on fleet replacement.

You know, we're looking at . . . We talked about the advanced life support outside of our ALS service on our paramedics, and that comes again at a higher cost.

So it's a trade-off as to, you know, we're providing right now 83 per cent, I believe it's 83 per cent of the cost, you know, on an ambulance service. We as the government are picking up that cost, so ultimately approximately 17 per cent of the cost goes back to the patient. So I guess we're always looking at ways of trying to reduce the cost on our patient, but also looking at providing the best benefit to the health care system as well.

Ms. Mowat: — Thank you. We also continue to hear concerns from First Nations seniors who aren't eligible for the SCAAP [senior citizens' ambulance assistance program] program and, you know, they're quite concerned that they are suffering from discriminatory billing practices because we charge for inter-hospital transfers and they aren't considered under the senior citizens' ambulance assistance program that would cap their fees. And surely the cost to support under SCAAP wouldn't be insurmountable for the province. Shouldn't all seniors in Saskatchewan be treated the same?

Mr. Wyatt: — The issue with respect to First Nations coverage under the SCAAP program, I think it's important to understand that First Nations are fully covered through the non-insured health benefits program which covers ambulance trips, drugs, optometry, dental, and a range of other services. As it pertains to EMS transport, the non-insured health benefits program covers 100 per cent of First Nations EMS costs, with the exception that the federal government decided to stop covering inter-facility hospital transfers a number of years ago.

That's the only part of the program that is actually inferior to . . . Or if First Nations were to become part of the SCAAP and the overall provincial insurance, EMS insurance program, they would actually receive inferior coverage to what they have right now, because it is 100 per cent coverage for all trips with the exception of an inter-facility transfer. So we've, over the years, maintained that this is a feature of the federal government's non-insured health benefits program that they've decided not to include that particular trip.

It is unfortunate for First Nations beneficiaries of that program that they've made the decision not to insure that particular type of EMS trip, and I guess we continue in our discussions with the federal government to urge them to cover that as an element of their program, if they wish for First Nations to receive it.

There are a number of differences in the various elements of the non-insured health benefits in relation to provincial insured services, or non-insured services I should say. In most cases, the coverage available through non-insured health benefits is 100 per cent which, in most cases, means that they are receiving better coverage through NIHB [non-insured health benefits] than they would as a provincial beneficiary where we do have a number of different premiums, copays, and those sorts of things across the different drug, dental, optometric, and EMS programs.

Ms. Mowat: — There are significant challenges in Regina and Saskatoon with EMS being stuck with patients who are awaiting care in emergency rooms. You know, this is particularly troubling because we know that when EMS are waiting with patients, it pulls an ambulance off the road. Is this being tracked in any way by the ministry?

[20:45]

Mr. Wyatt: — The issue that you raise around offload delays is certainly one that, you know, we've been aware of over the past number of years and certainly is one that has presented a challenge for patients who are being cared for in emergency departments — as well as the departments themselves — as they're waiting to be seen by a physician and assessed. The issue around the tracking of offload delays, we don't have regular monitoring and data received from the various services in respect to the length of offload delays.

And in terms of what we're doing to address offload delays, we're looking at it from a number of perspectives. There are different options that we are, you know, that we have considered related to . . . Certainly we've had requests from some services to increase the number of cars that are available. We've looked at the option of increasing some of the capacity within the emergency department to assume care from paramedics so that they can return back to the street and be able to transfer care to personnel within the emergency department.

It's certainly an issue that we are definitely . . . you know, is under active consideration. And certainly we have had various discussions between the SHA and the ministry with the paramedic chiefs and with individual services around how we might be able to address that concern.

Ms. Mowat: — Thank you. I suspect we could spend a lot more time talking about ambulance reform but we have limited time left and a lot to get through, as Health is a large portfolio as all of you know.

I want to talk about the health emergency management branch, which I believe was consolidated with strategic partnerships. Can you speak to when that consolidation took place?

Mr. Hendricks: — So sorry, that took a minute. We were trying to actually reflect back how long ago that happened. And when I was an ADM [assistant deputy minister] pre-2010, it was . . . All the emergency management reported to an ADM at that time but it was a very small, like a three-person branch, right. And in subsequent years it's been brought into our strategic priorities branch. There was a director position that was assumed in the strategic priorities branch and they have a couple of staff operating under them, but essentially it does the same thing, just within a branch structure. But it's certainly been very, very many years since any organizational-type structure of that nature took place.

Ms. Mowat: — Thank you. We have old media reports that describe the health emergency operations centre located in the basement of the Tommy Douglas Building. It's a CBC article. It says:

> Tucked away in the basement of the Tommy Douglas Building in Regina, the main office for Saskatchewan Health, the Health Emergency Operations Centre is currently staffed 12 to 14 hours a day, according to the ministry.

> The centre is helping keep track of developments of the flu outbreak and is responsible for providing direction and information to other ministries on the matter.

And then they also had access to mobile 200-bed hospitals, portable X-ray machines, and oxygen, suction, ventilators, etc. What became of the emergency command centre that's being described here?

Mr. Hendricks: — So it's actually just a different incarnation of the health emergency operations centre that I talked about earlier. You know, this is just a logistical thing but we used to have a space in our basement. And during H1N1, and not only during H1N1, during other situations where we've had kind of provincial emergencies, our health emergency management unit has established a site within the building. And during those periods of time . . . Like, the operations centre isn't the health emergency management unit. It helps to put that together but the operations centre brings in different people from the ministry to manage a specific issue or crisis, like wildfires or that sort of thing.

And so for a period of time . . . And I recall that one. We were running the operations centre, you know, 12, 14 hours a day. And we have situations like that, or have had situations over the last decade, where that's sort of been operationalized but it's not a permanent type of structure.

The facility hospitals that you refer to, my understanding is that they're actually federal hospitals that were part of the national emergency stockpile that, once in a while, we would basically borrow them from the federal government, have them set up in the T.C. Douglas Building to just kind of test them, that sort of thing. But they're not something that we hold at a strategic reserve.

Ms. Mowat: — In terms of the emergency response supplies and equipment that have been described in this quote, what became of those supplies?

Mr. Hendricks: — So we don't have our own inventory like the MASH [mobile army surgical hospital] hospitals. The federal government has kind of emergency supplies, that sort of thing, that we're able to access. There's a process whereby we can request them from the federal government and use them if need be.

Ms. Mowat: — What role has this branch played during the pandemic? Have they had any involvement in managing COVID-19?

Mr. Hendricks: — Yes. At the early stages they kind of formed . . . they started helping us to set up the first health emergency operations centre. After a period of time we determined that we wanted to make it a more robust structure. And I'm lucky to have many of the greatest senior civil servants in my ministry in government, and we brought back one of our alumnus to actually run the health emergency operations centre. Tracey Smith from Social Services has been with us. And so we've set up a very formal structure and they operate under that.

But they're also keeping their eye on a lot of different things because, you know, when we're managing COVID-19, it's not the only potential emergency we're managing. We're keeping our eyes on things like wildfires, flooding, that sort of thing. And so that's what this unit really is focused on is making sure that we have our eyes on, kind of, the province.

And there's also the element of coordination with the Saskatchewan Public Safety Agency, and so we work on kind of the health-related issues to any provincial emergency. And so, you know, obviously in situations like the Humboldt disaster we were very involved, and wildfires we might be involved in some aspects of it, and this one obviously again very involved. So we work in a coordinated fashion. We plug in with the provincial operation centre and provide the health aspects of it.

Ms. Mowat: — I want to move on and ask some questions about eHealth concerning the, around Christmas time, ransomware attack on eHealth. I'm just wondering what has come to be known about the attack since the initial reporting. So the initial reporting indicated that the attack began on Sunday morning, January 7th. It's now being reported that the attack began on December 20th. Correspondence on the issue started on January 5th. So I'm just wondering about why it took so long for this to be detected.

Mr. Hendricks: — I think it was — and I might be off by a day or so here — but I think it was, you know, kind of on Sunday, January 4th that eHealth first started detecting that there were some issues arising in their systems related to the malware. And you know, so when they went back and started to investigate in the kind of coming days and weeks ahead, obviously one of the first things you want to know is how it kind of entered your system.

[21:00]

It was determined that it entered the larger system through a remote site on or about December 20th, and that was something that wasn't withheld or anything. It was just simply that it took it a period of time to find and trace actually because you have to go through literally thousands of computers across the system and find out what activity has taken place and do the scanning and that sort of thing in order to find out where it happened. Where it entered, I think, was one of the particular locations where they experienced some initial difficulties, so we were able to run it down. But yes, December 20th was the day that we believe it entered the system.

Ms. Mowat: — The correspondence indicates that it was believed the issue began with VDL services. Can you explain what that is?

Mr. Hendricks: — So you are correct that it did enter through a virtual desktop interface. But you know, we're just discussing this, and part of the challenge that we have with answering malware questions is that we're currently, it is . . . [inaudible] . . . in the investigation where there are certain issues with respect to our insurance for this, our eHealth insurance for this, as well as legal issues around HR and other things.

If you were to table your questions, we could have legal review them and try and provide whatever responses we are able to. But I'm a little bit limited in what I can say about this at this point. Obviously when we get to the bottom of this, we want full

disclosure, that sort of thing. But it's just at a point in the investigation where we're trying to basically make sure that we're able to complete that investigation, maintain the security through that investigation, and also not violate and legal or insurance issues.

Ms. Mowat: — Okay, I certainly appreciate that. And maybe I'll ask this next question. You can let me know if you think you can answer it. The main thing that I think folks are interested in is not the finer details of tracking everything that happened, but people want to know that their personal health information is secure. And you know, at the start of this it was reported that their health information was secure and personal health data was not assumed to have been compromised. Now we're hearing that eHealth still doesn't really know what information was accessed, who took it, or what it's being used for. I certainly understand the limitations of the situation but, you know, how can citizens be reassured that their personal data hasn't been accessed?

Mr. Hendricks: — So you know, I think the protection of personal health information is something that is critical, obviously, to the health system and to people's confidence and eHealth and the Ministry of Health. And so you know, I think that when I reflect back on, in kind of January, the malware virus that we encountered was quite sophisticated. It was one that hadn't been seen in other organizations, or at least that wasn't made publicly known but we believe it actually wasn't seen.

I think the eHealth team acted very responsibly in bringing in basically an outside team who better understood how to combat and detect and combat this virus and develop software to deal with it. And so this was a pretty high-calibre team that was brought in. And you know, the fixes at eHealth were basically shared with other organizations and businesses and companies who utilize the same software.

So all I would say is that this was kind of a novel attack in that sense, but I think going forward with what's happening is that, you know, eHealth doesn't kind of operate as an island. They use software from major providers and that sort of thing. And so those providers are undertaking upon themselves to increase the security protections.

You know, I think the biggest mistake, or at least at this point in my understanding, is that in some way there was a weakness of security, that sort of thing. At eHealth, I don't think that was the situation here. You know, these sorts of viruses have happened frequently at industry and that sort of thing. Sometimes you don't hear about them just because the industry doesn't want to publicize.

But I think people can be reassured that we're doing our best to maintain the sanctity of their health information and make sure that it isn't violated. And you know, we're doing our best also to figure out what information was removed from the system and whether it's decipherable, that sort of thing, so that we can actually be as transparent to the public and so that they understand if there was any personal health information compromised. We don't know that for sure yet.

Ms. Mowat: — So it's not really known right now, I think it's fair to say. In terms of the costs of teams and services that were brought in, can you speak to what those look like?

Mr. Hendricks: — So currently our claim with the insurance company, the total costs under that claim that we've experienced are less than a million dollars. That could change as we continue our investigation. For example, if we do find that public health information was compromised, we'd have to do notifications, do that sort of thing, and our claim size could increase. But so far we're in the under-a-million-dollar category.

Ms. Mowat: — In terms of the team that was contracted in as well, what are the expenses there?

Mr. Hendricks: — The team that was brought in? Well there was one team that was brought in that was over $300,000. There were other consultants used in various places as well.

Ms. Mowat: — Thank you. The discussion about personal data in eHealth also brings forward an article that I read today, when I had all my expanse of time to read the news, that there are additional concerns with access to patient data that were brought forward with the report about LifeLabs and patient notification. And I understand that there was an apology that was issued by the SHA. I'm wondering if you can speak to what happened in that situation.

[21:15]

Mr. Hendricks: — So I think you're aware that the Privacy Commissioner has reviewed the LifeLabs breach. There are some issues. I had an opportunity to briefly read his report. He's identified where issues need to be addressed that were included in the agreement with the SHA but, you know, the LifeLabs obviously needs to address those issues. I think the feeling is is that generally the relationship with LifeLabs as a service provider, with the SHA they have a good relationship. But having said that, you know, they're going to re-enter negotiations and strengthen some elements of that.

I do need to be clear though that we are fortunate in some respects in Saskatchewan that the LifeLabs breach was basically limited to some booking information, that sort of thing. Obviously an individual's name would have been identified and a few things like that, but not the specific lab results. Those are held differently. So it differs from the LifeLabs breaches in Ontario and BC [British Columbia]. And so we'll be working with the Privacy Commissioner and with LifeLabs to make sure that the Privacy Commissioner's concerns are addressed as we go forward, as the SHA goes forward. And obviously it will become part of any contract negotiations, but immediate discussions with LifeLabs to have them on the remedies that need to occur based on the commissioner's report.

Ms. Mowat: — Have you asked the Privacy Commissioner to investigate the eHealth branch?

Mr. Hendricks: — So with the malware breach in January, the Privacy Commissioner was notified as soon as we had a kind of handle on what was going on, so almost immediately. Whether it was a day or two or three, I don't know for certain. But the Privacy Commissioner was provided with a full report of what we knew. There had been ongoing updates with the Privacy Commissioner. His plan is to file a report. We assume he will do that at some point when the investigation is complete or when we can't learn any more or whatever. And so we would anticipate

that he would file a report at that time. I don't know if he'll file an interim report or whatever, but yes he's been very much kept in the loop.

Ms. Mowat: — Thank you. I might go into some rapid-fire type questioning on many topics now as we are getting into our last half hour.

We've asked several times over the past year and a half about access to obstetrical services in the Northeast in Saskatchewan. We've also heard about concerns that now there's no general surgeon at Flin Flon General Hospital. So this is impacting patients who are in northeast Saskatchewan looking for access to health care.

What are you doing to work with the Manitoba government to ensure that they're recruiting the right folks so that Saskatchewan residents who live near the border have access to the health care services that they need?

Hon. Mr. Kaeding: — So the minister and I have been in regular contact with Minister Friesen in Manitoba, just getting updates as to where they're at with servicing the Flin Flon hospital. And they, like all other rural and northern facilities, are having a struggle with attracting qualified people to stay consistently in a location. So saying that, you know, Manitoba has certainly been working on alternate plans and alternate service agreements to make sure that they've tried to cover their residents in the Flin Flon area, and we've been doing the same on the Saskatchewan side.

Just one example is we've put an extra ambulance into the Pelican Narrows area. So we've been building capacity with the PICU [pediatric intensive care unit] unit at the P.A. Vic Hospital. You know, again just making sure that residents in that area are, you know, especially on the maternity side of things, are building a good relationship with their local health care professionals as well to make sure that they've got the quality of care that they need all the way through the maternal side of things. But also make sure that we've got the services there to handle emergencies when they're required.

I know we're working with Highways, working on airport development to make sure that the airports are built up in those areas as well to handle air ambulance and those kind of services. So those are some of the things that we're doing to be prepared, to make sure that we're able to handle the cases as they come through.

Ms. Mowat: — Thank you. I just did a quick Google search of Pelican Narrows to Flin Flon because I don't have the greatest knowledge of the North, but that's a six-hour drive according to Google. So I don't know how much it's helping folks in that area of the North.

But the question about what we're doing to advocate how we are ensuring that these folks have services, I think stands. I recognize the challenges with recruiting, and I think that there could certainly be programs explored to amp up retention so that we can make sure that rural residents have access to quality health care, which I'm sure is not lost on you either.

Sask Hospital North Battleford. I'm wondering about the state of the building and if it is finished now. Can we say that the roof is complete? Can they drink the water at the facility?

Hon. Mr. Kaeding: — If I can correct your Google search, from what we've been able to determine it's about a 120-kilometre trip to Flin Flon from Pelican, Sandy Bay.

Ms. Mowat: — Sorry about that. Google said I was cycling.

Hon. Mr. Kaeding: — Oh, okay.

Ms. Mowat: — I don't think I'd want to make that trip either. Disregard my remarks. Thank you. It was like, I think it's close. It's not close. What's happening? But I appreciate that.

Ms. Morrissette: — Good evening. Billie-Jo Morrissette, assistant deputy minister with Ministry of Health. With respect to your question about the status of SHNB [Saskatchewan Hospital North Battleford], as you know there are ongoing repairs at the facility and so some of those are continuing and are not finished yet. The roof, for example, will be — I can look it up — but it will be some time until that is addressed.

With respect to your question about the water, they are not drinking it. They are still bringing in potable water. And so the preliminary investigation was done by a group of experts, and so they brought in different kinds of experts to examine the water issue, so people like engineers, chemists. And they have identified the water softener as the probable cause of the issues in the facility.

So how this works, though, in order to return the facility to normal water usage, you need a consistent number of tests over a certain period of time. And so while there's no immediate health risk, you know, out of caution, we are bringing in potable water for the staff and the residents. And so routine water quality testing is occurring at the facility.

[21:30]

After this spring, they'll be doing a partial flush of the system in the spring, and it's anticipated that the regular water use and consumption practices will return to the facility over the next couple of weeks. And so they haven't had those tests come back yet positive, and so we will continue to monitor that as we go forward.

Ms. Mowat: — Thank you. It's encouraging to see gynecological oncology services being expanded in accordance with what was recommended. The budget talks about some inclusion of stabilization funding and a sixth position. I'm wondering if you can speak to what timelines we can expect for a full staff complement to exist and whether this time around there is a retention plan to retain these specialists after we heard so much about the demands of the job.

Hon. Mr. Reiter: — The sixth position has been recruited and anticipate the start on July the 6th. With the reorganization that was done, the restructuring, and also with the announcement that was done with Ovarian Cancer Canada, the million dollars going towards research, it's not anticipated that retention will be a problem going forward.

Ms. Mowat: — Thank you. There was a recent . . . I want to talk about midwifery. I should tell you the topic before I jump into something. There was a recent news article about an individual wanting a home birth in Regina but couldn't access a midwife to make that happen. It looks like there are plans to expand midwifery in Saskatchewan to the tune of three positions. Can you explain where these positions will be located?

Hon. Mr. Reiter: — The investment was for, as I mentioned in my opening comments tonight, was $410,000. To your point, it is three midwifery positions, and the three will be a combination of Saskatoon and Regina. I assume two in one, one in the other, but which will be which hasn't been determined yet.

Ms. Mowat: — Thank you. I think the last request I saw from the Midwives Association of Saskatchewan was that they were advocating for 15 funded positions, so I'm just wondering what the long-term plan is to expand midwifery programs in Saskatchewan.

Hon. Mr. Reiter: — Prior to the announcement of the three additional that you had just asked about, there is funding for six positions in Saskatoon, two in Swift Current, five in Regina, and four in Fort Qu'Appelle, which was a total of 17. With these three just announced, that'll bring us to a total of 20.

Ms. Mowat: — Thank you. In terms of the drinking water in the province, we've heard concerns about the exposure to ingesting asbestos coming out of asbestos cement pipes as they wear or break. Are you working with Health Canada or the federal government to ensure that asbestos levels in our drinking water are being monitored?

Hon. Mr. Reiter: — So to your question, we're just having a discussion that there had been a written question by one of your colleagues, Mr. Pedersen, about this asking about if any studies have been done on health impacts, etc. At the time, the answer was the Ministry of Health wasn't aware of any, so it would be more a case of setting standards. And that would be the Water Security Agency that would do that as opposed to the Ministry of Health.

Ms. Mowat: — Thank you. So you haven't been provided with any information about any studies that link ingesting asbestos to any health concerns?

Hon. Mr. Reiter: — In the interest of time, I think we've had some correspondence on this before and tied the Water Security Agency into it. So we're going to follow up on that, and if I could get back to you on it rather than take up your time right now?

Ms. Mowat: — Sure. And I'll just mention that I think, considering the fact that the American Cancer Society on its website specifically mentions, under "How are people exposed to asbestos," "Swallowing asbestos . . . such as water that flows through asbestos cement pipes," that it's something we should be proactively looking at and figuring out if there is a public health risk there and how we can work to mitigate that. But I appreciate you looking into it and offering to get back to me.

In terms of vaping, after the legislation was passed, the government was supposed to pass the ban of flavours through regulations after the fact. I'm just wondering if you can provide an update on the progress of that.

Hon. Mr. Reiter: — Sure. At the time, as you mentioned, after the legislation the intent was to move the regulation of flavours to regulations so that it wouldn't have to be done by legislation.

There's a consultation period that we're going to need to discuss with stakeholders. The intent was to have been working on that, but of course COVID put many things on hold. I'll have to follow up with officials. But the intent would be to work on consultations in the next little while and deal with where we're going to go with flavours later this year.

[21:45]

Ms. Mowat: — In terms of cystic fibrosis patients, we know that cystic fibrosis numbers are on the rise, according to a recent release from CF Canada [Cystic Fibrosis Canada]. Since we heard that Orkambi would be provincially covered under a set of criteria, my understanding is that no cystic fibrosis patients have been eligible to receive that coverage. We've corresponded somewhat about this in letters. I'm wondering today if you will commit to getting rid of the restrictive access on Orkambi to make it available for CF [cystic fibrosis] patients who it could stand to help.

Hon. Mr. Reiter: — I would just back up a little bit on that. Originally, as you mentioned, the restrictions around it, as I recall CADTH [Canadian Agency for Drugs and Technology in Health] had recommended that Orkambi not be covered at all. Ontario, Alberta, and Saskatchewan initiated another review with specialists. That's what further put some . . . I guess made it available with further restrictions. To your point, I would have to check, but I believe you're accurate that there was nobody in Saskatchewan yet, which is troubling and concerning.

What I am heartened to see though is that — as of I believe last week, Friday — PCPA [pan-Canadian Pharmaceutical Alliance] has agreed and Vertex, the company that manufactures Orkambi, has agreed to start negotiations on that. On both Orkambi and Kalydeco, I believe there'll be negotiations on. There's also a third drug, Trikafta, which you're probably familiar with as well, that Vertex is being encouraged to submit to Health Canada for review. I, a number of weeks ago, had sent a letter to Vertex encouraging them to do that, so I'm hopeful that they will and that negotiations will be undertaken on all three of those drugs.

Ms. Mowat: — Thank you. We heard from a stakeholder who has a significant concern about an ongoing and now more prevalent use of latex in hospital settings. For those who have the allergy, hospital and clinic and dental settings, including places with balloons and gloves in particular, pose a serious risk. It's often airborne and can't be mitigated in single rooms or areas. Additionally studies show that the allergy can be acquired and have debilitating effects.

I know that some work has been done in the Saskatoon Health Region to create latex-safe environments, but there's no consistent strategy. And it's also incredibly difficult to access facilities that are safe for folks in this situation. So is the ministry developing any steps to keep people safe and to further mitigate the development of these allergies?

Hon. Mr. Reiter: — So after talking to the officials, we're going to have to follow up with you on that one. I apologize, but nobody's sort of current on where that's at right now. So we'll follow up.

Ms. Mowat: — We've heard that there is no access to physio on certain wards at the Pasqua Hospital. I'm just wondering if you can elaborate on why that would be.

Hon. Mr. Reiter: — The officials aren't aware of this. When we're done here, if you could provide them with some specifics and we can follow up with you.

Ms. Mowat: — Sure. I can pass along the situation to your office and we can get it looked at. Appreciate that so much. I also want to say thank you to everyone for spending so much time here tonight and going into the wee hours, and also thank all the health care providers who are working on the front lines right now in what is a very difficult time.

The Chair: — We've now reached our allotted time for tonight. We will adjourn the consideration of estimates and supplementary estimates for the Ministry of Health. Minister, I want to thank you and your officials. And if you have any closing comments, do it now please.

Hon. Mr. Reiter: — Thanks, Mr. Chair. I'd like to thank you and all the committee members and also Ms. Mowat for the very respectful questions. Thank you for that. I'd also like to thank all the officials that are here. And I would also like to echo your comments for the front-line health care workers. And I'd like to thank all our officials that were here tonight, and we'll see you all tomorrow night. Thanks, Mr. Chair.

The Chair: — And now I would entertain a motion to adjourn. Ms. Wilson has moved. Agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. The committee stands adjourned until June 16th, 2020 at 3 p.m. Thank you.

[The committee adjourned at 21:54.]