Standing Committee on Health Care

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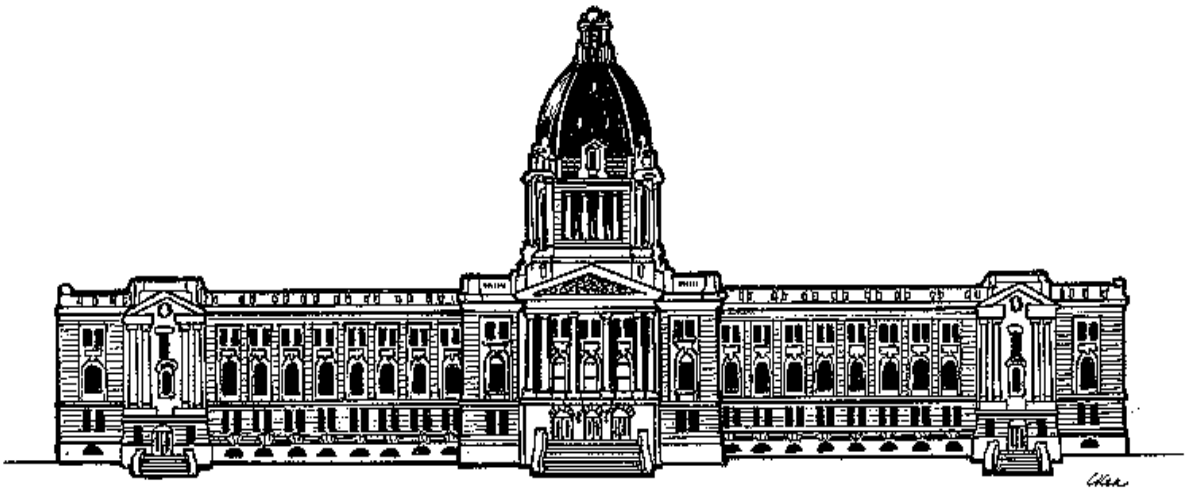

Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

STANDING COMMITTEE ON HEALTH CARE
2001

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Saskatoon Eastview

Hon. Jim Melenchuk, Vice-Chair
Saskatoon Northwest

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Regina South

Published under the authority of The Honourable P. Myron Kowalsky, Speaker

The committee met at 10:02.

The Chair: — Good morning. If the members are ready, we'll begin our hearings. The Standing Committee on Health Care's first order of business is to receive responses to the Fyke Commission.

Our first presenter this morning is from the town of Canora. Mr. Mr. Dutchak, would you take a seat here please. Anywhere, sure.

I'll introduce the members of the committee and then you can introduce yourself for the record. I'm Judy Junor. I'm the MLA (Member of the Legislative Assembly) from Eastview, Saskatoon Eastview, and I'm chairing the Standing Committee on Health Care. Hon. Jim Melenchuk is the Vice-Chair. Next to him is Andrew Thomson from Regina. Warren McCall on this end, from Regina also. And sitting in for Buckley Belanger today is Minister Goulet, Keith Goulet. Mr. Bill Boyd is here. Mr. Rod Gantefoer. Is Ms. Bakken coming?

And if you could just state your name for the record please.

Mr. Dutchak: — Glenn Dutchak, from the town of Canora.

The Chair: — Thank you. You can begin.

Mr. Dutchak: — Thanks for allowing me to appear before you today. It would have been a larger contingent from our community, but it took a long time for us to find that tiny, tiny, little advertisement in *The Leader-Post* placed about a month ago. It was much nicer to see a larger ad this past week in our local paper.

I'm looking around. I don't see the Premier or Minister of Health here. No? I thought these meetings were sort of important but apparently not.

And by the way, just for the record, we have television and we have satellite dishes in Canora. We could have just as easily had you come out and visit us there, but I guess that was too much problems.

Just out of curiosity, how many of the MLAs present have had to stay overnight in a rural hospital? Anybody want to raise their hand?

A Member: — How recent?

Mr. Dutchak: — Any time. Got a couple, that's good. Good.

The Chair: — Mr. Dutchak, excuse me. If you could just give us your presentation, and normally your questioning of the committee is done basically after your presentation is done.

Mr. Dutchak: — Oh, because I asked the person that phoned about the format and they never informed us of that so . . .

The Chair: — If you could give the presentation first, that would be good.

Mr. Dutchak: — Oh certainly. Anyways, I imagine you'd agree that quality health care was good in those rural communities.

Anyways for background, Canora is a growing, prosperous community of about 2,500. We have an economy based largely on agriculture, not unlike other Saskatchewan communities. Currently we are having great success in diversifying our local economy as well as supporting value-added industries.

Contrary to some beliefs, we're not rolling over and dying — quite the contrary — we're experiencing growth. In fact our population has increased by over 8 per cent since 1996. We currently have two schools educating about 500 students in the area, a community college, a swimming pool, a civic centre, a community centre, a curling rink, nearby high throughput elevators, a flax fibre plant, some of the best water in the province, numerous churches and halls, grocery stores, gas stations, a veterinarian, campgrounds, ball diamonds, tennis courts, two banks, numerous restaurants, motels, and hotels, a shopping mall, seven golf courses in a 30-mile radius, three resorts and lakes within a 30-mile radius, three chiropractors, two dentists, five knowledgeable doctors, and of course a wonderful hospital to complement all this activities. In many ways we are no different than a city neighbourhood, but with much, much more.

I felt it would be appropriate to fill you in on a little history about our area. For many years prior to health reform in the early '90s, Canora and area were providing the area with quality health care. Canora had a fully functioning hospital, which was operated by a local board, who in turn employed an administrator and a payroll clerk. A head nurse type of position could be found in each facility.

As well as having a local long-term care home, satellite hospitals and care homes were also operated in Norquay and Invermay. We had the district team concept long, long before health reform.

The hospitals had everything from acute care to emergency services. Surgeries were performed, babies were delivered, and support from the area communities was terrific. All this with basically one and only one manager. What a concept, Mr. Fyke.

Along came reform with predictable results for rural Saskatchewan — fewer beds, fewer services, never before seen deficits, and fewer front-line workers. And of course more and more and more management — property managers, quality care managers, administrative managers, stats managers, analysts, and as always more managers and boards to manage the managers.

Somehow, prior to reform, we didn't require all these people. Although health care is always changing, our area managed to embrace change without having to be told to do so. History can be a great teacher and I've always been told to utilize the experience of our predecessors. It has now become very apparent that our administrator was apparently doing the work of at least 10 people. I'm sure you can contact this gentleman and learn how he managed to be so efficient. He'd probably be glad to give you the information for free.

Instead of relying on those who know best, the governments of our province and country want to continuously spend millions and millions of taxpayers' dollars on consultants and analysts, such as Mr. Fyke, who commonly have not lived in our province for years. Shame on all governments for these fruitless expenditures.

The common theme of these reports tends to be one that promotes services in larger centres and ultimately eliminates or minimizes services in rural areas. Mr. Fyke's report is no exception. Bigger must be better; cut out the little guy.

Who could argue with some issues in his report — apple pie issues like better quality health care and more efficiencies. The question is, in this report, is better quality for whom?

Mr. Fyke's suggestions of less service, less acute care, and longer ambulance rides do not — I repeat do not — equal better health care for rural Saskatchewan. Simply changing locations of providers does not equal better quality health care.

Continuously, since health reform in the early '90s, rural Saskatchewan has been under attack. No other group of citizens in our province, and perhaps Canada, has had to adapt and persevere through health reform more than rural areas.

This brings me to one of our main points. I have a strong suggest for Mr. Fyke and Government of Saskatchewan. If all these recommendations are so wonderful, workable, and glorious, try experimenting on city folk and leave us be. Just think how much easier it would be to monitor and track if these changes were tried right under your nose.

Think of it. Just like these hearings you, the consultants, the management analysts wouldn't have to leave Regina. And I'm sure your constituents are as adaptable as we are to change.

I've described the amenities and population of Canora and area. Certainly there would be a comparable neighbourhood in say, Regina. Here's how the experiment could work and could turn out. Please listen carefully and take notes as we follow some of Mr. Fyke's ideas.

For an experiment the lucky citizens of the chosen neighbourhood would no longer be allowed access to the hospitals in Regina. No, instead their health centre hospital could be in . . . I don't know, Moose Jaw. No slight to Moose Jaw intended; fine place. Heck, Moose Jaw's even closer than Mr. Fyke's recommendations for distance.

Yes this would mean a 40- or 50-mile drive for most medical attention. No problem according to Mr. Fyke. Maybe you could use Regina for minor medical problems but sorry, for anything else it's off to Moose Jaw. I can just see the excitement in the Regina MLAs' eyes over this idea.

On your way to Moose Jaw, step in at your local health centre in Regina and pick up a pamphlet from the health district to better educate you on how not to get sick the next time.

Wait a minute. What if this is a real emergency? Let's call an ambulance. Its base could be as much as 100 kilometres away, according to Mr. Fyke. Let's give you a break. Your ambulance will arrive from Fort Qu'Appelle. That's not a 100 kilometres away. Should be here in about an hour if they're not too busy and the weather is good. Sure enough, an hour later the ambulance arrives to pick you up for a leisurely 40-minute drive to Moose Jaw hospital.

Of course you protest. You have a local health centre but it unfortunately has been minimized. It has no physician and can't possibly handle your problem. Oh well, off to Moose Jaw. Lucky this highway is maintained.

On the way to Moose Jaw the driver radios in to Moose Jaw emergency, only to find out that they are full and on bypass at this time; not unlike Yorkton, three out of four weekends in our district. Look out Swift Current, here we come. Hope the patient makes it.

Hours later you're looked after and lucky to have survived. Sure wish you had a real hospital in good old Regina. This rural type of health care really sucks. What were Mr. Fyke and the politicians thinking when they did away with your hospital?

A day, maybe two days later, you're being sent back to Regina to convalesce. Darn it, there are no types of these beds that are unoccupied in Regina. There is one available in your district. It's in Melville, what luck. Hopefully they have a physician there. The quality of care in Melville was excellent. They sure do the best they can in those rural areas.

You're now back in Regina, but need to see a specialist. You used to be able to see one in Moose Jaw, but now they're centralized in Saskatoon. Great, another full day trip at your expense, in your delicate condition. After two months of waiting you get to see your specialist. He ordered some tests, which went as well as can be expected because you were exhausted from the trip in.

Can't wait to see when the improved quality of health care Dr. Fyke had promised will kick in.

Back in Regina a couple of weeks go by, and the secretary from your specialist's office calls you to come back to Saskatoon for the results of your test. Sorry, you say, I'm back at work and can't get another day off. Give me the results over the phone. Can't do that. Why not? Why? Doesn't sound very efficient but you take a chance for an appointment in two months to see your results.

Two months go by. Back to the specialist in Saskatoon. Great highway, thank goodness. Hi, doctor. Results show you're okay. Bye, doc. Elapsed time — two minutes. Surely SaskTel or even Canada Post would have been more efficient.

All in all it's hard to say the quality of health care has improved based on the recommendations in the Fyke report. Your experience has been nothing short of a nightmare. Oh, if only we still had a local hospital and even a local doctor.

You call your brother in rural Saskatchewan to lament about their situation . . . about the situation. He laughs. He says: welcome to the reality world of second-class treatment, in other words, two-tier health care in rural Saskatchewan. Hey, you protest, we all pay taxes. Shouldn't we be entitled to accessible

service? That would too fair for everyone involved.

Yes, ladies and gentlemen, after about a six-month experiment in Regina, the results and reactions would be extremely predictable. Number one, overall poor quality and less accessible health care; and number two, city people en masse reject the Fyke report as unworkable.

Folks, let's save a lot of time and money here today — money, hard feelings — and get to number two now, and shut down this Fyke report before it's started.

Overall improvement in the quality of health care and increased efficiency is everyone's goal in health care on an ongoing basis. Mr. Fyke's report lets rural Saskatchewan down in many respects. More management — mentioned at least twice in this report — it's hard to believe that reducing and minimizing service and front-line staff to the rural areas is the chosen path in favour of more management. How does this equal better quality and efficiency?

Staff and physicians should maximize the use of their skills. Hard to argue with this statement, but Mr. Fyke has missed the obvious. Our local doctors have surgical and many other skills. Let's reopen operating rooms and help to minimize the city waiting lists for elective surgery. You only have to look as far as Moosomin to see a model of this concept at work.

1-800 nurse. This one's got us. Recently at an area meeting, many of our seniors found humour in this idea. Apparently Mr. Fyke left the province quite some time ago, because this type of service has been in use since the invention of the telephone. In rural Saskatchewan, we have all, at one time or another, called the closest hospital for advice or direction at all hours of the day or night. We, as a practice, use this service many times prior to considering even going to the emergency ward. Sorry, Mr. Fyke; not a new idea for us. Maybe it is in the city.

Contrary to Mr. Fyke, we don't need to classify health care in terms of outcomes, statistics, numbers, and probabilities. These are all sick and ill people; real people requiring real health care.

A hospital bed is a hospital bed. Calling it acute, long term, palliative, obstetric, respite, convalescent, or emergency does not change the fact that they're all required in rural Saskatchewan. In fact, by keeping beds flexible in their use, we are likely much more efficient.

It is widely accepted that the most efficient and best-spent tax dollars are those that are administered locally. Please leave these bed decisions where they belong — locally. Trust those that you employ.

By the way, studies have shown hospital beds cost less to run in rural Saskatchewan. I wonder why?

In his report, Mr. Fyke makes reference to health care in other countries around the world. We know that when Canora was heard from, the experiences of South Africa were detailed. A number of years ago, health care was centralized in that country, much the same as Mr. Fyke has proposed. The results were disastrous for both rural and city alike. The current trend in South Africa is now to decentralize, to go back to the past.

At $2 million, Mr. Fyke and the government owe it to us to further study and report on this South African situation. Again, history can teach us something. Let's not reinvent the wheel. I challenge the government to seriously look at the South African experience.

The topic of paying for health care is always controversial. Personally, it's hard to understand why. Whether we pay for health care through direct user fees, through health insurance, or through taxation, it hardly seems an issue. Whether it comes from my wallet, my paycheque, or my right or left pocket has no significance. Directly or indirectly, I pay.

Given this revelation, society has moved increasingly to a user-pay system as a whole. While no one should be deprived of health care because of economic status, the principle has been carried too far. There will always be those that society needs to look after and so it should be. However by systematically denying better and faster health care to those who chose to pay, you are in fact potentially ruining health care for all. It's easy to see that by allowing for more private sector health services the whole system will benefit through decreased waiting lists, better health, and a much more efficient system. Do not miss a great opportunity for our province to lead again.

Mr. Fyke has done us a disservice by comparing user fees to those of the late '60s. That was over 30 years ago. Whether you call them user fees, deterrent fees, or health insurance, let's try a modern solution. The results may amaze us and may be a big part of the solution we're looking for. I've yet to hear of anybody coming back to Saskatchewan from Alberta because of health care premiums. I wonder why.

You might say this would lead to two-tier health care. I submit to you we already have two-tier health care — fine for the cities and poor for the rural areas.

Mr. Fyke recommends we reduce the number of districts to 9 or 11. In our district the struggles of health reform caused deep divisions between neighbouring communities competing for hospitals. It is only recently the district has begun to operate more as a district should. Changing district boundaries again would only reopen old wounds and would eliminate the successes we have today. Please leave well enough alone.

As a side note, our area has to seriously consider Mr. Fyke's diligence in his report, especially concerning boundary proposals. In his nine-district model Canora is included, with Prince Albert being the largest centre and Melfort or Humboldt likely being the nearest regional hospital. Here's the rocket science. Prince Albert is four hours from us, Saskatoon is three, and Regina is two and a half. Why would you pick Prince Albert?

Further to this, a potential regional hospital is only 30 miles down the road from us in Yorkton, yet they're not even in our district despite being our major trading centre and we're the most-used secondary highways in Saskatchewan. My six-year-old could have rationalized a better map and saved the taxpayer $2 million.

Oh and city residents beware that Regina and Saskatoon and P.A. (Prince Albert) will have tertiary care centres, with one

each. What about the other hospitals in Regina and Saskatoon? Read between the lines. Your area will be jammed with rural residents; your others will look like they will be closed.

Before arriving at conclusions let's look at analyzing . . . correct obvious abuses and wastes that exist prior to making wholesale changes. These abuses and wastes are the root of our financial woes in health care. Before closing facilities and potentially ruining the rural way of life, be honest with yourself and your constituents and tackle these sensitive issues. Remember, just like city residents, we need health care in rural areas — no more, no less.

For city MLAs especially, I challenge you to experiment with the city to prove many of Mr. Fyke's ideas are fallacies and only look good on paper, not in practice; to not dare impose urban solutions on rural problems. We're not second class and we're tired of being political guinea pigs.

Mr. Fyke's report is vague and fails to tell us how to get from where we are today to his health care dream world. Unfortunately we have existing realities and real patients and real priorities. Statistics are frequently used by losers who love to hide behind them to avoid reality.

It has been said that prior to judging an individual you should walk a day in their shoes. As elected representatives of our province, you owe it to our citizens to do this prior to implementing any changes. Come to Canora. We'll gladly match you to various health care staff. Job shadow with them for a few days. See what they see, see what they do, talk to the patients, or perhaps spend some time with our previous administrator who did the work of 10. Then and only then decide if quality health care and efficiency exists. Then decide if there is a real demand, a real need. That is, after all, your duty.

All MLAs should lobby the Premier to allow a free vote on these issues. On our town council we have free votes all the time, and frankly they don't hurt a bit.

Federally, free votes have been allowed on the death penalty. Mr. Fyke's report is the death penalty for rural Saskatchewan. Don't be a sheep — demand a free vote. Vote with a clear conscience and be the leader you were elected to be.

Thank you for your half an hour of valuable time on these life-changing issues. I'd be glad to answer your questions.

The Chair: — Thank you, Mr. Dutchak. We do have some time for questions. Yes, Mr. Thomson.

Mr. Thomson: — Thank you, Madam Chair. And thank you, Councillor Dutchak, for your presentation. I had a couple of questions for you this morning arising from your presentation.

One concerns the level of co-operation between Preeceville, Canora, and Yorkton, within the hospitals, and how currently that works in terms of level of service provided and how you would envisage that continuing?

Mr. Dutchak: — I'm not an expert in these areas. I know that Yorkton is shut down to Canora most of the time. Preeceville's in our district. I think we now have good co-operation with them, and Kamsack in our district, as far as I see.

Mr. Thomson: — Now is there a sharing of — sorry, just a couple of supplementals on that — is there a sharing then of doctors between Preeceville and Canora or is there an understanding as to how this works? Or do each of the communities basically operate with the same level of services?

I know there were difficulties when reform came in, in '93.

Mr. Dutchak: — Right. Actually we don't share doctors per se. We do share a lot of services within the district, amongst the three hospitals and the others in the area. There's a health centre in Norquay as well.

We also utilize a lot of services out of the East Central District — speech pathology being one that comes to mind or physiotherapy and that sort of thing.

Mr. Thomson: — But as we look at this question of regionalization of services, Yorkton basically now serves as a regional hospital centre. Is that correct?

Mr. Dutchak: — Officially, but to be honest with you it's not recognized. In fact today I read the paper where Yorkton or East Central is running a deficit because they're not getting recognized for funding for those things. So when we talk about correcting the abuses and the errors, there's a problem right there.

Mr. Thomson: — . . . problems I know within the districts here and with South Central.

The second question I had concerned district reduction and the frustration you've expressed about the number of administrators or the . . . I guess whether it's the number or the size or the amount spent on them, do you think there's an opportunity here for us through district reduction to reduce the administration cost?

Mr. Dutchak: — Potentially. But I read Mr. Fyke's report and he actually talks about increasing the amount of management twice in the report. I don't see how that provides better health care.

Mr. Thomson: — It's possible . . . you believe it's possible to reduce the amount of administration in the districts.

Mr. Dutchak: — Possible.

Mr. Thomson: — Okay. Those were my questions. Thank you, Madam Chair.

Hon. Mr. Melenchuk: — One of Mr. Fyke's recommendations with regard to what he called everyday services was integrating individual teams into a primary health network managed and funded by health districts which includes enhanced community and emergency services. So you didn't talk too much about this primary care concept, this team concept. Would you support that particular recommendation?

Mr. Dutchak: — You are missing the point. I think the team

concept exists in our rural communities. These doctors don't work in isolation. They work with home care, with physiotherapists, with speech pathologists, with all the other services that we have.

There is nothing new in Mr. Fyke's report. I think formalizing it is all he's mentioning. Like that's what would be new.

Hon. Mr. Melenchuk: — The question is . . . that's exactly right. There are informal loose connections but there is no integrated team concept where you would have a pharmacist, a nurse practitioner, a family physician, perhaps a mental health worker working in the same facility sharing patient charts, accessing the same information and providing services based on that type of collaborative effort.

There are very few models in existence in Saskatchewan today where there are actual sharing of patient records. And that's what Mr. Fyke is talking about. So what I'm asking, do you agree with that concept?

Mr. Dutchak: — I think the one efficiency you could have is put all the doctors and all these professionals in one building. It would only make sense. And then share that information, why not.

Hon. Mr. Melenchuk: — Thanks.

Mr. Gantefoer: — Thank you and thank you for being here this morning, Mr. Dutchak. Could you tell me, if you compared the services that are available in your community now in health care — you mentioned, I think you said you have five doctors, three chiropractors — how does that compare to what you used to have prior to this last round of health reform?

Mr. Dutchak: — Actually I think we've increased our doctors in Canora.

Mr. Gantefoer: — Have the services increased as well in Canora?

Mr. Dutchak: — We've gained, I think, through some of the co-operation with the other district, we've probably gained in services. But overall, like we have less beds, less people working there, and a lot more stress.

Mr. Gantefoer: — In terms of the services that you have now, do you feel that they're meeting the needs of your community or are there things that are still being missed?

Mr. Dutchak: — I think, you know, and if I have to go to Mr. Fyke's report, it needs to be more coordination. It's ridiculous for our patients to have to bypass Yorkton to go to Regina or Saskatoon any time. It doesn't make any sense.

Mr. Gantefoer: — So the concept of developing Yorkton as a fully functional regional centre, instead of having to go to Regina or Saskatoon for many of your services, would make sense from your point of view, do you think?

Mr. Dutchak: — It would make sense, I think, in terms of the specialists. We have a number of them there now that are overworked as well . . . for some of the services.

Like our bone to pick is we have existing beds — whether you call them acute, primary, all the other terms you guys have, doesn't really matter — I think you want to keep them as flexible as possible and you'll get the best bang for your buck that way. To always whittle these numbers down and play with the system and have to phone somebody at district office to see if we could admit Joe hardly makes any sense. Let's let the doctors make their decisions based on health care, not administration.

Mr. Gantefoer: — You spoke about the South African experience. Is it true that one or more of your physicians have a great deal of experience coming from South Africa?

Mr. Dutchak: — Currently out of our five, I believe four are from South Africa right now. And they've been through this. And these are people, you know, talking privately to these doctors, they've been through like virtual wars in South Africa, treating people. They have tons of experience that would be useful. And they're very honest and hard-working physicians, and I don't know why their words aren't considered more credibly.

I see one of them did speak to Mr. Fyke. His name's mentioned in the report. But obviously Mr. Fyke thought the US (United States) experience or the Scandinavian experience was more important.

Mr. Gantefoer: — Thank you.

Mr. Boyd: — Thank you, Madam Chair. Good morning, sir. I think, as a representative of rural Saskatchewan, I applaud your presentation here this morning. I think you've very capably outlined the type of frustration people feel.

And my question is: is do you believe that type of frustration is widespread in rural Saskatchewan?

Mr. Dutchak: — Yes. A couple of weeks ago I went to a meeting in Kelvington with about 50 people in attendance representing 13 different municipalities and communities. And the frustration up in that area is maybe even far worse than ours.

Mr. Boyd: — Does it result in a feeling of mistrust in the government?

Mr. Dutchak: — Yes. I think that's maybe why you have a lack of people appearing before this committee. This is very intimidating to be in a place like this, number one. I think people have thrown up their hands in frustration and gone: it doesn't matter what we say, no one's listening.

But our take was if we didn't at least say our two bits worth, we had nothing to complain about later. We would have had far more presentations from our doctors, our nurses, or their health care workers. There just wasn't enough time to put anything together. Sorry.

Mr. Boyd: — Would it have been more advantageous, do you think, to have committee meetings throughout rural Saskatchewan?

Mr. Dutchak: — Oh most definitely. I mean, you know, I think

I read somewhere where the committee's concern or somebody's concern was that there was no television or that, you know, then the presentations would become very one-sided.

The difference between this fight about health care and the last one was . . . you're right, we struggled with the Preecevilles and Kamsacks and whatnot. This one is about rural Saskatchewan, period. It's not about Preeceville, Kamsack, and Canora any more. It's about having hospitals — real hospitals — in rural Saskatchewan.

Mr. Boyd: — Do you think it results in people calling into question the whole concept of medicare when you see a system that we are told is for the benefit of all when, as you put it, results in a two-tier system?

Mr. Dutchak: — Yes. I think people are . . . You know, we're used to being second rate in rural Saskatchewan and this is sort of nothing new.

Mr. Boyd: — Thank you.

The Chair: — One more question and then we have the next presenters here.

Hon. Mr. Goulet: — Could you clarify for me in regards to the two aspects, the idea of . . . there were certain things that you thought were apple pie that might be good in the report.

And secondly, you did mention the idea of — and clarify for me — allowing the private sector and user fees. Could you comment on that?

Mr. Dutchak: — We'll go to the second one first. If I want to go and get an MRI (magnetic resonance imaging), why shouldn't I be able to pay for it? And if that eases up the pressure on the public system, why not? Maybe they could be operated dually with the public system. I think other provinces have proven that already.

And back to your first question was, sorry?

Hon. Mr. Goulet: — You mentioned that there were certain things that were apple pie or positive in the Fyke report. Could you mention . . .

Mr. Dutchak: — I mean we all want better quality health care and we all want more efficiencies. You know I think the challenge to Mr. Fyke was to come up with something that would be different or novel and I think he's failed miserably. I think 95 per cent of this report, any of us here could have written. And the only real novelty in there is that we're just going to axe 50 hospitals.

The Chair: — Thank you. Thank you very much, Mr. Dutchak. I appreciate you coming, as does the whole committee.

Mr. Dutchak: — Thanks for taking the time today. You're more than welcome to come out to Canora any time and visit with us and we'll fill your books with lots.

The Chair: — We appreciate that. Our second presenters are here — the Registered Psychiatric Nurses Association. If you want to come and take your seat, please.

I'll introduce the committee and then I'll let you introduce yourselves. I'm Judy Junor, I'm Chair of the committee. Dr. Melenchuk is the Vice-Chair of the committee. Mr. Goulet is sitting in for Mr. Belanger. Warren McCall and Andrew Thomson; Bill Boyd and Rod Gantefoer.

If you will introduce yourselves, and your title and your organization for the record.

Ms. Rabyj: — Well my name is Linda Rabyj and I'm the president of the Registered Psychiatric Nurses Association of Saskatchewan. And this is our executive director, Joy Johnson.

The Chair: — You can begin. We have half an hour; and as you saw from the last presentation, we'll have some questions at the end if we have time.

Ms. Rabyj: — On behalf of the Registered Psychiatric Nurses Association of Saskatchewan, I want to thank you for this opportunity to appear before the Standing Committee on Health Care.

I believe that you have received our brief. I would simply highlight some of the thoughts that we have placed before you in writing.

At the onset I want to emphasize that RPNS (Registered Psychiatric Nurses of Saskatchewan) supports in principle all of the recommendations presented in the final report of the Commission on Medicare. We recognize that this has been a massive undertaking by Mr. Fyke and we commend him for an outstanding job.

The major concern that RPNS has with the report is the lack of emphasis and visibility of mental health in our service delivery system. With one of every three people in this province impacted by mental health issues, mental health services must be a higher priority, including 24-hour service availability. Mental health services must be viewed as an everyday service, not as a specialty service.

In recommendation no. 1, everyday services, the RPNS supports the concept of primary health centres and community care centres with one caution. Systems must be in place prior to the implementation of major changes or many people will fall through the cracks. It will be necessary to have an overlap of the old and new to ensure that services are available during the transition. RPNS applauds the vision presented of primary health teams in a renewed health system. The concept of teams is not new to registered psychiatric nurses.

We would make the point however that a team is not simply a group of people. It is a group of people working in respect and appreciation for each other to reach common goals.

With recommendation 2, the recommendation for specialized care, RPNS believes that the creation of a quality council is long overdue. We are very concerned however that the members of a quality council have the proven knowledge and expertise in quality assurance theory and application to make such a council truly effective. We feel emphatically that

members of a quality council should not be people from regulatory bodies.

For a quality council to truly work, the members must come from outside such vested interests, and we do not believe that representatives from regulatory bodies can truly divest themselves of such vested interests.

We look at the working groups that have been formed, none of which RPNS has been invited to be a part of. RPNS has been informed that the working group looking at the parameters of a quality council includes representation from the College of Physicians and Surgeons, the SRNA, (Saskatchewan Registered Nurses' Association), and SALPN (Saskatchewan Association of Licensed Practical Nurses), along with others.

Supposedly these people are there as the public. We do not believe that is possible given their positions. Before the ink is barely dry on Mr. Fyke's report, it would appear that the particular interests of regulatory bodies continue to influence the future of our health care system.

With recommendation no. 3, the recommendation for making things fair, the report seems to make a distinction between skilled public health workers and primary health professionals. RPNS has long been concerned about the substitution of unlicensed, unregulated workers in the place of licensed professionals. Such decisions are often driven by budget concerns.

We currently see the use of inadequate and inappropriate personnel providing mental health services to First Nations people. I worked with First Nations people and I've seen this first-hand. This is a serious concern when the client has a mental health issue and is unable to speak for him or herself. We urge the full utilization of regulated health care professionals with appropriate staff mixes.

RPNS agrees with recommendation 4, getting results. We have a desperate need for a true evaluation mechanism for ongoing measurement, analysis, and correction in all sectors of our health system.

It is imperative that the voice of mental health consumers be heard in the establishment of standards and goals. We would urge government to ensure mental health representation on the quality council.

Recommendation no. 5 deals with support for change. We have had constant change in our health system since the early 1900s. Now we need to make changes that really work and will make a difference, difference to the health of the people of this province.

RPNS believes that an excellent place to begin is with a renewal of health science education programs. The association would strongly support a renewal of programs whereby students taking common courses for various professions are combined; for example, anatomy, physiology, biology, microbiology, and so on.

This would mean that nursing students, medical students, and students in such programs as physical therapy, pharmacy, and so on would begin their education from a common base. Individual programs such as medicine and psychiatric nursing then could be branched off from this common base. Not only would this help create the sense of a team already recommended, this would also result in significant cost savings to the province.

While we are on the topic of education, Saskatchewan is the only province where registered psychiatric nurses practice but do not have a specific psychiatric nursing education program. As well, RPNs (registered psychiatric nurses) in Saskatchewan do not have access to a degree in their profession of psychiatric nursing. We must go outside of this province to obtain that degree. Students are leaving this province for Manitoba, Alberta, and British Columbia in order to access an education program in psychiatric nursing and few are returning.

The profession of registered psychiatric nurse is a distinct profession, equal to but different than that of the registered nurse. Registered psychiatric nurses are educated in general nursing skills but have specific expertise in mental health, psychiatry, physical and mental disabilities, counselling, therapeutic use of self, and other essential knowledge and skills.

So many of the unique skills of RPNs are often referred to as soft skills. I like the analogy of Americans and Canadians. What is the difference? We all know that while there are similarities, there are also very real differences. Canadians are equal to but different than Americans. The difference is often hard to explain especially to people who already have their opinions formed.

The people of this province deserve to receive quality mental health services from appropriately educated and licensed professionals. The RPNS urges the Standing Committee on Health Care to support the establishment of a separate degree program in psychiatric nursing to help meet the mental health needs of the people of this province.

Recommendation 6, paying the bills, really comes down to the very real issue that we are facing in Saskatchewan. How do we pay for what we need? We support the recommendations to change the organization and delivery of primary and specialized services. Again, RPNS would encourage the committee to view mental health services as primary services and not as specialized services.

The report points out the shortage of psychiatrists in this province. RPNS would welcome the establishment of an advanced clinical psychiatric nursing program to help address this shortage of psychiatrists. Using RPNs in advance practice would take pressure off of the system and enable psychiatrists to do their jobs more effectively and efficiently.

We appreciate the recognition of culture as an important factor in changing our health care delivery system. Culture is something that is extremely difficult to change and has been one of the major barriers to system changes in the past. The RPNS recognizes that changing the culture will require a tremendous willingness on the part of stakeholders and commits to doing its part to help change the current culture.

In conclusion, the RPNS urges the government to move more

quickly rather than slowly in putting into practice these recommendations. At the same time, it is essential that the government has a carefully constructed plan for implementation.

The Registered Psychiatric Nurses Association of Saskatchewan believes that the Saskatchewan health system must be renewed and that it is time to make the necessary changes to create a quality health care system. Thank you for the air time.

The Chair: — Thank you. Questions?

Hon. Mr. Melenchuk: — I think that a couple of the points that you've been making in terms of the education of your registered psychiatric nurses, is it your intention that you would like to see your own training program here in Saskatchewan at the academic level? That's question number one.

And number two, would you see registered psychiatric nurses integrating very well into the primary care setting and providing mental health services in rural Saskatchewan?

Ms. Rabyj: — RPNS certainly supports baccalaureate education for psychiatric nurses in this province. RPNs have served Saskatchewan people for 50 years and we have never had a degree in our province. Many of the RPNs in Saskatchewan who have a degree in psychiatric nursing and are taxpayers of this province have to, you know, access that education elsewhere,. So certainly we support the degree in Saskatchewan.

Your second question was?

Hon. Mr. Melenchuk: — In terms of registered psychiatric nurses being part of the team, in terms of mental health services as part of that integrated primary team concept in rural Saskatchewan.

Ms. Rabyj: — Certainly RPNs seem to be an appropriate provider. If you think of what the World Health Organization, when they talk about primary care, primary health care services, they say if you really want to be effective you certainly have to include . . . do the mental health component. And certainly RPNs, historically, we have been accustomed to what would be referred to as shared models of care. So working within teams is not a new notion to RPNs.

Mr. Gantefoer: —Thank you very much for coming. A couple of questions.

First of all I understood you to say that the RPNs have not been included or invited to participate in any of the working committees that have been established by the Department of Health. Is that correct?

Ms. Rabyj: — Yes, that's correct.

Mr. Gantefoer: — Well I think that that certainly is an oversight, or a slight I guess. I think that one of the problems that I've seen your organization struggle with is maintaining a clear and distinct identity and recognizing the value that RPNs, registered psychiatric nurses, have in the delivery of health care in this province. And I think that the Department of Health should be taken to task.

The second thing is is that I know your concerns about specific education programs. The NEPS program, the Nursing Education Program of Saskatchewan, which you're integrated with RNs (registered nurse) on, was supposed to lead and stream you to having a sufficient output of registered psychiatric nurses at the end of the program. I don't believe that's happening.

Would you care to identify what the results have been of your experience of the NEPS program to date?

Ms. Rabyj: — Certainly. In relation to the Nursing Education Program of Saskatchewan, certainly the seats in psychiatric nursing were taken and integrated into this new program and the intention was that we would have outputs. We are currently . . . RPNS currently is in the process of evaluation. Actually our evaluation will be complete by December.

But what I can tell you is to date we have a total of seven students in this Nursing Education Program of Saskatchewan have demonstrated an interest in becoming registered psychiatric nurses. And I don't have clear numbers for you but we're not confident that there are any numbers beyond seven of new students who have demonstrated interest where they have moved into professional practice that would be specific to, you know, mental health.

Mr. Gantefoer: — I understand that, for example, the Brandon College has a program that is very much compatible with your aspirations for a psychiatric nursing program. Is there some willingness of the Department of Post-Secondary Education or Health to accept that model or are we going to try to reinvent the wheel from the beginning up again?

Ms. Rabyj: — That's a good question. I know the government is currently doing some research. Actually Brandon University and SIFC (Saskatchewan Indian Federated College) have come together and have created a proposal to deliver the degree in psychiatric nursing in this province, but to date we haven't received any kind of government approval for that. The government is looking at sort of the human resources relating to that.

Mr. Gantefoer: — Thank you. One final question. Under this program you mentioned the desire to have an advanced clinical psychiatric nurse program. Would the Brandon model be capable of moving it that one step further to instruct a further year perhaps so that people could be graduated with an advanced clinical degree?

Ms. Rabyj: — I can't say that Brandon has that already sort of in place. But that's not to say that certainly wouldn't be possible. I know the registered nurses have advanced clinical practice available through SIAST (Saskatchewan Institute of Applied Science and Technology) here. And I mean that's certainly something that could be explored as well.

Just perhaps in relation to your original comment in terms of RPNS's involvement in . . . What did you refer to initially?

Mr. Gantefoer: — In terms of the working groups in the Department of Health?

Ms. Rabyj: — I guess I would just state again that just to remind all of you that really the primary purpose of the Registered Psychiatric Nurses Association of Saskatchewan is to protect the public. And who we are particularly interested in are those people who are affected by mental health illness kinds of issues.

It certainly is not our intention to speak for people who can speak for themselves. But I guess just to say that historically people affected by mental health illness issues tend to be the invisible population. Unfortunately they tend to be still really affected by stigma. People still don't want to talk about stuff like mental illness.

But the reality is one in three Canadians will be impacted by some sort of mental health illness issues in their lifetime so, frankly, it's not going away.

Mr. Boyd: — Thank you, Madam Chair.

I'm very interested in your presentation, and I see that you support the recommendations in principle of Mr. Fyke. I'm interested in exploring your professional opinion on something.

As we've heard over the last number of years, the result of closures of hospitals in rural Saskatchewan, there's been a . . . And a previous presenter made the case as well — I think very well made the case — that it has resulted in a concern about . . . frustration of the availability of services, mistrust, and a feeling that there's a sort of a two-tier system out there. People having services available at one time and now their services aren't available to them. And that's resulted in that type of frustration.

As someone that's had training in mental health care concerns, frustration must be born as a result of something. What would you suggest that it is?

Ms. Rabyj: — You mean specifically to rural Saskatchewan, or Saskatchewan generally?

Mr. Boyd: — Rural Saskatchewan.

Ms. Rabyj: — It's interesting that you would ask that. I actually was born and raised in rural Saskatchewan. And speaking specifically to sort of mental health sort of issues, I don't recall ever meeting a registered psychiatric nurse in rural Saskatchewan when I was a young person growing up.

I recently had the opportunity to work in rural Saskatchewan specifically with First Nations people. And I can tell you that in relation to sort of the mental health services that are available, they are few, scarce, and, specifically with the First Nations population, what I saw generally, generally, is that a lot of people that are providing the mental health services are not necessarily regulated nor licensed professionals. And that's a real concern.

I guess the whole notion of . . . mental health has never been seen as a priority in terms of health overall. And I mean the impact is tremendous. I mean you look at World Bank is really concerned in relation to the economic burden of disease that mental illness is creating worldwide.

As I said before, mental illness is not going away. If you talk to your GPs (general practitioner), I suspect that given the times, whether it's the price of gas or heat or whatever, people feel concerned about that. Whether it's what's going on with farmers. I suspect that they're seeing an increase of people in general practice who have sort of stress/mental health related kinds of concerns.

Mr. Boyd: — I have spoke to my GP recently, and I speak to him frequently. He's a good friend of mine. And he tells me that in years past when there was a loss of services, when there was hospitals closed, he never saw such a negative reaction in terms of mental health care concerns to his patients than he had at that particular time.

And he said it was a result particularly of people's frustration that they were losing services that they had, or access to them. Particularly elderly people and people with families with young children because they felt vulnerable. And that vulnerability has existed for some period of time now.

And my concern is, is that Mr. Fyke's report is suggesting that we should reduce services, at least the availability of services even further and what kind of impact that would have on . . . and continued decline in mental health care services and the availability of them. What kind of impact that has on people who feel those vulnerabilities?

Ms. Rabyj: — Well I think . . . I mean I don't know what we're going to actually realize out of, out of the Fyke report. But I mean from the way that we read it — and I suppose it's your particular lens, how you sort of interpret it — but the way that we read it and interpret it is it's a real opportunity for registered psychiatric nurses to engage in fostering capacity, building resiliency, working within trans-disciplinary teams; something that RPNs are very skilled at doing. And perhaps in some ways may provide more opportunities for RPNs than what has previously been in the past.

Historically RPNs have been fairly limited in terms of sort of where they work. And a lot of that's specifically related to the hospital Act.

The Chair: — Three more people to ask questions. Could I come back to you?

Mr. Boyd: —One more question.

The Chair: — One more? Okay.

Mr. Boyd: — Do you acknowledge then that there is the possibility of continued and further decline in mental health care, the general mental health care of people who feel that vulnerability in rural Saskatchewan at the loss of services. Do you acknowledge that that is a distinct possibility?

Ms. Rabyj: — I absolutely acknowledge that. And I will tell that there will probably never be enough money and/or resources dedicated to mental health in this province.

The Chair: — Thank you.

Mr. Thomson: — Thank you, Madam Chair. I wanted to pick up on two of the comments.

One is the most recent one you made in terms of the ability for the RPNs to work within the inter-disciplinary teams. Is this something that would be unique to the establishment of a broader—based primary health model? Am I understanding that? That you would see the RPNs rolled more into the primary health care system?

Ms. Rabyj: — Actually I didn't say multi-disciplinary. I said trans-disciplinary. Yes, which is . . .

Mr. Thomson: — .I'm sorry. I'm still trying to catch up on the lingo here. Dr. Melenchuk's been helping me out but . . .

Ms. Rabyj: — Disciplinary, trans-disciplinary team is different than a multi-disciplinary team in that multi-disciplinary you have lots of different disciplines working side by side but separate. Trans-disciplinary, I mean it makes really good sense if you can imagine it's client centred. They use sort of consensus decision making so that the client actually has a say in what they do.

And something that RPNs are very skilled at is, in that they engage in something that's referred to as role release in the literature, but it's really, RPNs talk about it as helping people to help themselves. What a great idea — teaching people to do stuff for themselves so next time, if they encounter a similar kind of situation, they can do something about it.

Mr. Thomson: — Second question I have is on a slightly different topic and that is the quality council, the relationship between the quality councils and the regulatory bodies. You had mentioned about the need for us to establish the quality council, if we move in that direction, to make sure that it's not simply an overlap of the regulatory bodies. Do I understand that?

Ms. Rabyj: — We are concerned that it's not just a representation of particular regulatory bodies who would sit there and promote their own sort of unique discipline. We want to be sure that it is truly a quality council that has the skills and expertise in that particular area, as well as relating to, you know, the disciplines of health.

The Chair: — Thank you.

Mr. McCall: — Thank you very much for your report today and the excellent written submission as well; it is quite helpful in gathering a precise idea of what you want to communicate to us and your thoughts on Fyke.

But I was wondering if you could just tell us for the records a bit about your membership. How many members you have in the association and if you . . . you had touched on it a bit earlier, but what the distribution of that membership between rural and urban would be.

Ms. Rabyj: — I was supposed to know this. We have about 1,100 members that are active practising registered psychiatric nurses in the province. I can't tell you off the top of my head exactly where most of them practise. Our executive director knows that. Can she say something? Great.

Ms. Johnson — Approximately 50 per cent of RPNs practise in Regina and Saskatoon. So we have right now, actually we have technically 1,023 active practising members and about another 60-some-odd non-practising.

Of those active practising, about 500 to 600 practise in Regina and Saskatoon. We have about — of the remaining 4 to 500 — most of those are in Prince Albert, Yorkton, Moose Jaw, Swift Current areas. There are very few . . . actually I was out in Rolling Hills just two weeks ago and they have one RPN working in Rolling Hills. So there are very few working in the rural areas.

Mr. McCall: — Now in your supports, your general support for the recommendations of Fyke, do you see it's in an . . . Obviously the state of health care in rural Saskatchewan has a big impact on how your members are able to do their job and how you're able to deliver the best quality of care you can.

In some quarters, Fyke has been characterized as an attack on rural Saskatchewan. But, given the obvious stake that your membership has in, you know, the quality of health care in rural Saskatchewan, what — through that lens — would lend itself to you supporting Fyke?

I guess some people have concerns about the impact of Fyke on rural Saskatchewan. I would welcome your comments on that. Do you share those concerns about the impact of Fyke on rural Saskatchewan or do you see it as a possibility for improving the standard of care in our rural portions of our province?

Ms. Rabyj: — Well as I indicated earlier, it depends on which lens reads the report and what we actually realize, what we actually see through it. I mean, I don't have a crystal ball. I can't predict the future.

But it should be, it should be an opportunity to increase the number of RPNs in rural Saskatchewan, if RPNs are truly invited to join these multi-disciplinary, what I prefer to refer as trans-disciplinary teams.

The Chair: — Thank you. And Mr. Goulet, you can wrap it up. We're almost out of time.

Hon. Mr. Goulet: — My question is in relation to the issue of fairness. Now I was impressed with your presentation. You talk about respect and appreciation and also strong collaboration.

Particularly as it relates to Aboriginal people and northern Saskatchewan, as that's where I'm from, I would like to have you elaborate a little bit more. I know that you have some experience working with First Nations people and particularly your focus strategy on the training itself. Could you do a final elaboration on that, please?

Ms. Rabyj — In about two sentences. Well in relation to my experience, I have frankly grave concerns and I shared these with the Minister of Health at our annual general meeting. I'm very concerned about the mental health needs of First Nations people in this province. There is an urgent need to meet those.

RPNS certainly supported in principle the whole notion of Brandon University and SIFC moving towards a degree in psychiatric nursing. I mean, one of the obvious things is, is it not appropriate to prepare people from the culture of the people that they serve? I mean, to me, does that not make good sense?

Although SIFC makes it very clear they do not discriminate. They accept students beyond First Nations culture.

Did I answer your question?

Hon. Mr. Goulet: — Yes, you did.

The Chair: — Thank you. And thank you very much Ms. Rabyj and Ms. Johnson. And I thank you for your written presentation. Thank you very much.

We now I believe have representatives from the town of Porcupine Plain. If you want to come forward and take your chair. I'll introduce our committee members to you, and then if you could introduce yourselves for the record.

I'm Judy Junor, I'm the Chair of the committee. Dr. Melenchuk is the Vice-Chair of the committee. Mr. Thomson is from Regina. Mr. McCall is from Regina and Mr. Goulet is from Cumberland in the North. Mr. Boyd is from Kindersley and Mr. Gantefoer is from Melfort-Tisdale.

Mr. Zip: — Good morning Madam Chair and committee members. My name is Mayor Terry Zip from the town of Porcupine Plain. To my immediate right is Les Merriman, chairman of the Porcupine Plain Health Advisory Committee; to my immediate left is Reeve Walter Derenowski from the RM (rural municipality) of Porcupine Plain; and to his left is Looi Bourgonje, the president of the Seniors' Club, from Porcupine Plain.

The council of the town of Porcupine Plain appreciates this opportunity to express its concerns regarding the Commission on Medicare completed by Kenneth Fyke, and which was submitted to the Saskatchewan government on April 6, 2001.

It was a little disturbing however driving down this morning, listening to the radio, to hear that there was a lack of interest in meeting with the Standing Committee on Health Care.

In rural Saskatchewan, unless you subscribe to *The StarPhoenix* or *The Leader-Post* and read every fine print, you may not have noticed the ad for the Standing Committee on Health Care. In fact the local newspaper that is circulated around our area, printed on June 19 was the ad, which was only last week. Your committee was meeting already before that ad was printed.

But nonetheless we are thankful to have an appointment with you to meet and express our concerns.

The recommendation that a network of 10 to 14 regional hospitals that would provide basic acute care and emergency services is a critical issue when surmising how this would impact on rural Saskatchewan in general and our community in particular. Currently the Porcupine/Carragana Hospital located in Porcupine Plain provides these services and provides them very well.

It appears that if the Fyke recommendations were implemented, some 53 rural hospitals including the Porcupine/Carragana Hospital would be considered for closure or transformation as part and parcel of the streamlining of health services in our province.

We are not opposed to change; we understand that efficiencies may be obtained through the amalgamation or consolidation of services. We would not be opposed to the consolidation of our nursing home and hospital if this could demonstrate a cost savings and retain the acute care services in our community.

Rural Saskatchewan is not opposed to change; we simply want to be a partner involved in the decisions that affect our lives and our community.

Assuming that the Fyke recommendations were implemented, Melfort, Saskatchewan may very well be the location of the regional hospital in our area. The residents of the town of Porcupine Plain and surrounding areas would have to travel 62 miles or over one hour to access acute and emergency services.

Residents that live in the rural area around our community and particularly to the east could have in excess of one and one-half hours to secure acute and emergency services, much of this time being on a highway system that does not lend itself to safe and comfortable travel.

To stress the impact of the distance, consider the following documented data. Between August 19 and 23 of the year 1999 in the Porcupine/Carragana Hospital, streptokinase was administered to three different patients who had just before had a myocardial infarction, while the fourth person was admitted for observation with chest pain.

During the same period, that hospital had 26 outpatients as well as a full complement of eight acute care patient beds.

The same facility administered streptokinase three times in the year 2000. We know that the administration of streptokinase within the first hour after a myocardial infarction is crucial. How many of these individuals that received streptokinase in 1999 and 2000 would not have survived if treatment would not have been available for more than one hour?

Over and above these critical patients, what would have happened to the other patients that present themselves at that doorstep of the hospital with chest pain or vague cardiac symptoms and where other medical staff can take the initial steps to prevent a crisis of an M.I.?

Porcupine Plain is located in a mixed farming district that includes apiaries. What would happen if one of our local farmers when into anaphylactic shock and required immediate lifesaving treatments? Or what would happen in the event of some other serious agriculture accident? Would we have to say sorry, please go down the road? We're sure they can help you in Melfort, Nipawin, or Prince Albert.

When in fact this past weekend, on a Thursday, a couple — a man and wife — hit a deer on their motorcycle. The following Friday, the day after at 7 p.m., a gentleman, a mid-40s-aged gentleman rolled a quad on top of himself. At the same time, a

youth was brought in that was hit in the head by a horse. Minutes after that, a youth that jumped off of a dock at Marean Lake, hit his head very severely in 2 foot shallow water.

Porcupine Plain hosts the nearest hospital to the Greenwater provincial park which had over 134,000 visitors in 1999. The Porcupine Forest that neighbours our community is an attraction to hunters, fishermen, and snowmobilers — many of which come from a considerable distance, as far away as the United States.

Tourism increases our net population dramatically, and is a large component of our economy. Tourists concern themselves with the services that are available. To reduce our health care services is to strike a blow to the heart of this important industry.

Porcupine Plain is a very stable community. In fact, our population increased by 8 per cent between the '91 and '96 census periods. We have appreciated the services of a physician since the early 1940s, with a patient load that is continually been on the rise. We have maintained a health care facility since that time and during much harder economic times than we are currently experiencing today.

Dr. Pieterse, our local physician, provides excellent service and is very committed to our community. The only instability in our health services is that generated by the recommendation of the Fyke report. Porcupine Plain provides 63 jobs in its nursing home, 24 jobs in its hospital, as well as a desired community for its physician, local pharmacy, and support staff.

To eliminate any of these jobs strikes not only at the core of our health services provided to our community, but at its economic core as well. How would you recruit RCMP (Royal Canadian Mounted Police) officers if you didn't have a hospital?

We have the local Porcupine Opportunities program for disabled people. Without a physician and without acute and emergency care services, they wouldn't be able to operate.

Many farm families depend on off-farm incomes for survival. The implementation of the Fyke recommendations could very well spell the demise of our community in particular, and that of many rural Saskatchewan communities in general.

Your government's current thrust of rural revitalization must, of necessity, require very, very careful examination of the Fyke recommendations, not only within the context of the health services provision but in the larger context of the importance of rural Saskatchewan, to its people, its economy, and to the health of the province itself.

I thank you very much for your consideration of our concerns, and I would like to turn the microphone over to Reeve Walter Derenowski.

Mr. Derenowski: — Good morning. On behalf of my council I wish to express my gratitude — thank you for listening to our concerns.

The council of the rural municipality of Porcupine No. 395 wishes to express its concerns to certain recommendations contained in the Fyke report, Saskatchewan Commission on Medicare. The recommendation that hospitals in approximately 50 locations be converted to primary health centres is of concern and one which council considers unacceptable, as it would . . . excuse me . . . as it would . . . unacceptable level of health service in rural Saskatchewan.

These health centres would be without physicians and only be open part-time. With the loss of acute care facilities in rural areas, rural residents would have to travel longer distances to access services. This would create both a financial and a time cost to rural people. Acute and emergency care services should be readily available to all areas of Saskatchewan including rural Saskatchewan.

The recommendations that a number of health districts be reduced from the current 32 to 9 or 11 is of grave concern to us. There would be a loss of local autonomy and with a reduction in the number of health districts, it is important that local residences . . . or residents have an influence on a decision . . . decisions made by the boards.

Council does not believe that large scale closure of hospitals and the amalgamation of health districts will result in any significant cost savings. There have been no cost savings evident from the reforms implemented in the early 1990s.

Further, council is of the opinion that implementation of the above recommendations would be disastrous to the economy of rural Saskatchewan. The Fyke report is already having an adverse effect on communities faced with possible closure of their hospitals. More retiring people are bypassing these communities and moving to larger centres, away from their relatives and friends in an attempt to be close to acute and emergency care services. Some bypass the larger centres and leave the province.

Part of revitalizing rural Saskatchewan needs to be the removal of the threat of hospital closures.

Council recognizes that our health system may be in need of review but does not believe that larger health districts and fewer hospitals will improve the system or make it more cost effective. Alternatives such as user fees, health premiums, etc., are worth considering. Council believes that most would prefer to pay a little more rather than lose health care facilities and services.

As a Standing Committee on Health Care, you will no doubt hear these concerns and others repeated many times during these hearings. They are real concerns that need to be dealt with appropriately to help restore a positive attitude toward our province.

Thank you very much. I respectively submit this report.

The Chair: — Thank you. Go ahead.

Mr. Merriman: — Thank you for the opportunity to speak to you this morning. I represent a group in Porcupine Plain called the Porcupine Plain and District Health Advisory Committee. I would like to make a couple of comments before I go into my brief.

We're not sure what the big rush is to review the Fyke report before the end of August. The only thing that comes to mind is that government intends to push through its cut-backs no matter what rural residents think before the time new health district budgets are to be approved for the fiscal year ending March 31, 2002, or for the fiscal year starting April 1, 2002.

It's also very interesting to note that this special committee is doing this review in July and August. Most people are on holidays, therefore not likely to respond, so it'll be taken for granted that they are in favour of the report. I think on two occasions already we've heard on the news that there is a lack of interest.

If government was genuine in its concern about what rural Saskatchewan thinks of the Fyke report, why not meet with the 53 communities that Mr. Fyke suggests should lose their acute care facilities and explain to them how this is such a good deal and how their quality of health care and quality of life is going to improve, rather than meet in the city of Regina to discuss the future of rural residents. Just a thought.

These are the thoughts of the committee that I represent. We are writing to you as a group of concerned members of the Porcupine Plain and District Health Advisory Committee to offer our observations and concerns on the Fyke report. We represent the Town of Porcupine Plain, the R.M. 395, the District Chamber of Commerce, a division of the R.M. of Bjorkdale, seniors groups, and the resident physician also sits on our committee.

We agree that some change is necessary and we would like to be seen as partners in the process of change, not innocent bystanders being told by government what will happen. If the Fyke report is implemented in its entirety, we feel that the demise of rural Saskatchewan is imminent. We see the need for and support changes that will improve and preserve the quality of health care deliverance to rural Saskatchewan as well as ensure the economic viability of these regions.

We feel by closing 53 acute care facilities as proposed, the end result will be a decrease in economic growth for our smaller communities due to job loss, population shift, and the withdrawal of investment in these communities. It is interesting to note that government recently established a department on rural initiatives to keep rural Saskatchewan thriving and then proposes closing 53 rural hospitals.

We do not feel that the wholesale closure of hospitals and the amalgamation of health districts will result in cost savings. There have been no cost savings to date so why would further amalgamation create savings. The distance between hospitals is not going to prevent acute illness, so regional hospitals will have to be expanded accordingly to make up for the loss of beds and services from the closure of smaller hospitals thus creating additional costs.

The cities cannot handle the present patient load nor do they have the staffing to manage an increase from the proposed closures. I think if you talk to the city folks they'll tell you their health care suffered from the last series of cut-backs. It will however impose an additional financial burden on the patient due to greater distances travelled to access services.

Furthermore the present highway conditions in rural Saskatchewan do not lend themselves to the effective delivery of emergency services as proposed in the Fyke report. If any of you have drove on some of the highways up our way you'd know what I'm talking about.

We are offended by the statement that small hospitals are obsolete. We feel that the level of primary care delivered in our hospital is as relevant in ensuring quality care as the proposed alternative.

The recommendation to amalgamate present health districts to create 9 to 11 districts will greatly decrease the input of rural Saskatchewan on health care decision making. The sense of community and local contact with the public will be lost. Local residents will have little, if any, influence on decisions made by the board.

It is difficult to comprehend why you as the government are interested in investing money into a senior housing project in our community and other communities and yet you're proposing to reduce access to quality health care for these same seniors. It's a well-known fact that the general population in rural Saskatchewan is aging quickly. And the removal of local health services will be an added burden to this sector of our community.

Seniors are now bypassing our community for larger communities as they retire because of the fear of less health care services and no doctor. If you close 53 rural hospitals, you'll find there'll be many vacancies in senior projects in these same communities.

It is naive to think that people believe that the implementation of the Fyke report will improve the quality of health care. You should be honest and clear to the public about what the system can and cannot provide for them. It definitely seems that a two-tier system for health care deliverance is already in place — one for rural people, one for urban people, with different values and funding respectively.

As we review the Commission on Medicare, we find many areas that have serious implications for the viability of rural Saskatchewan; implications that will greatly diminish the standard of health care to be delivered in rural Saskatchewan. Economic growth is a necessity and the government has to make it a priority to make Saskatchewan a more financially attractive place to start a business.

We feel that there are viable alternatives to improve our health care system — as an example, user fees, which has been mentioned, the family tax, etc. — other than those proposed.

I thank you for the time given to present this. And I have copies for the committee members here.

The Chair: — Thank you. Did your other delegate want to present also? Go ahead.

Mr. Bourgonje: — On behalf of the seniors of Porcupine Plain and district, I'd like to thank the committee for the opportunity of bringing these concerns to them.

The seniors believe that if the recommendations of the Fyke report to close 53 rural hospitals was to occur it would create many hardships for the seniors of rural Saskatchewan.

Number one, travel of an hour or more to acute care would result in travel expenses that would be financial burden to the seniors who are mostly on fixed incomes. Power, natural gas, and gas for their cars is now eating away at their incomes.

Number two, an hour or more is too long a time to access a hospital.

Number three, the present highway conditions do not lend itself to emergency services.

Number four, as seniors get older they may not able to drive themselves these distances.

Number five, the loss of jobs in our rural communities will mean that young people that we do have in our communities will have to move out. This affects the schools, the arena, and our businesses.

Number six, the seniors feel if we have only 10 to 14 regional hospitals in Saskatchewan, they and the community as a whole will lose the decision-making input that we currently have. The sense of community will be lost. These regional hospitals will be totally influenced by the larger centres.

Number seven, when the hospitals are going to be closed, who will even think of retiring to small-town Saskatchewan. Seniors who own property in these communities will find they will have to sell their homes at a loss, and will have to pay more in the centres that have the hospitals.

Number eight, housing projects in these communities will in time have to close. Seniors are already bypassing our community for larger centres because of the fear of more cutbacks in our hospital services.

Number nine, hospital care and nursing home services are needed now because our young people have had to move out of the province and to the United States for jobs, thus not being able to be available to help their parents when they need this kind of help.

I'd like to thank you for your time.

The Chair: — Thank you very much. We now have a few moments for questions. And I have Mr. Thomson on the list first.

Mr. Thomson: — Thank you, Madam Chair. I want to thank very much the gentleman for appearing before us today, and for your written and verbal submissions to us. I think that you've made a very good point and a very clear point about the anxiety this report is causing in many of our rural communities.

And what I want to do is ask a question about the types of services in the Porcupine area and how those interrelate with some of the others perhaps that are offered in Melfort or hospitals around that.

In terms of Porcupine Plain, now you're in a . . . It's in a rather unique situation, that is some distance to the next nearest hospital. There's one physician there currently. Is that correct?

Mr. Zip: — Correct.

Mr. Thomson: — And the type of services that are provided are basically emergency?

Mr. Zip: — Emergency and acute care services.

Mr. Thomson: — Citizens then in the Porcupine area obviously rely on additional health services. Would it be in Melfort for the next regional centre? Would that be the closest regional centre?

Mr. Zip: — The next hospital, of course, to our community is Tisdale which basically provides the same services that you receive in Porcupine Plain. The next regional hospital would be Melfort and of course, the patient load in Melfort is such that most people are often travelling to Saskatoon, Prince Albert, which the waiting lists are just as long as that of Regina, Yorkton. The list goes on and on.

Mr. Thomson: — Can I ask a question? You've raised several . . . At least two of you have raised the question of user fees and health care premiums. This is something which obviously is getting a lot of discussion in the news these days, even the Prime Minister has been hinting at it. I guess what I don't understand is how we would see applying a user fee and how that would help maintain services in rural areas.

I'm not sure if anyone is able to answer that as to what the level of fee is or would we simply pay it into local communities or is it just a suggestion of something we should look at?

Mr. Merriman: — I think years back we had a hospitalization fee in this province. The whole system seems to be driven at the moment by a need to save money rather than provide quality care. We're not saying it's the sole answer; it's one thing to look at that if you had a hundred dollar per family fee that's going to generate some health care dollars. It's just a thought.

I realize we had deterrent fees at one time. I'm not so sure they accomplished what they were supposed to do but that's another thought.

We're not sitting here suggesting we have all the answers either, but you know it's just a passing thought.

Mr. Thomson: — On that point I want to make the comment that the Fyke report, and I hear this from talking . . . not only listening to you but talking to other people also, there seems to be an impression the Fyke report is the government's next plan for health care reform. I don't see it that way. It's certainly advice that we've received but it shouldn't be viewed as a *fait accompli*, you know, that there's going to be another 53 hospital closures. That's one of the purposes I think of this committee is to sit down and listen to what people have to say. And so in that regard I very much appreciate your comments.

One of the things I would be interested in, and I realize we're short of time today, but I would be interested in knowing how,

particularly services . . . what we can do to help maintain services in Porcupine Plain and improve them either through a primary health model or integration of facilities in that area and within the district. And I don't know whether you want to comment on that now or simply advise us at a later point.

Mr. Zip: — I think that's something that we would most certainly welcome advising at a later point. Without our physician, who was unable to come with us today, I don't know whether we would want to . . .

Mr. Gantefoer: — Thank you very much. And thank you, gentlemen, for coming this morning. It's a fair haul this morning from Porcupine Plain. I appreciate the commitment you have to be here.

Perhaps, Mayor Zip, I could direct this to you and if anyone else would want to comment. You have a single-physician practice in Porcupine and I suspect that in the past there have been some challenges recruiting and making sure that you had a physician in place.

If this Fyke report is implemented, do you see that problem being much more difficult in the future? And is that a real concern for your community?

Mr. Zip: — Absolutely. That is a very huge concern for our community.

At present we have not had a problem that I'm aware of recruiting a physician. We have been a solo practice for quite some time now. A very satisfied community with our local doctor, Dr. Pieterse, the new doctor that's been with us I believe since approximately '95, '96, has increased his patient load substantially. In fact he has patients now travelling from Tisdale, Hudson Bay to come and see him.

The statement did come out . . . absolutely if the Fyke report was implemented, he would probably test it for a while. But if you can't admit patients, what's the point of seeing patients?

Mr. Gantefoer: — Thank you. The other, in your submission I believe you indicated that you had eight beds, acute care beds, in your hospital. Is that meeting the patient load and the acute care needs of your community? Or with your doctor's increased practice, is that becoming inadequate?

Mr. Zip: — I guess that depends the way you want to look at that. At current, most times eight acute beds is not enough. There are one or two days when it probably is sufficient.

The Melfort hospital, for example, is closing acute care beds for summer holidays due to lack of staff. Does that mean that they have too many beds, not enough beds? It's kind of an open-ended question.

The Chair: — Thank you.

Hon. Mr. Melenchuk: — Just a quick question with regard to the Porcupine Plain hospital, would you suggest that if you were to have your perfect case scenario for your hospital in your community, would you see two physicians, 10 acute care beds? What would be the perfect scenario for your hospital and your community at this point in time?

Mr. Zip: — At this point in time, everything is working well and the old saying: if it isn't broke, don't fix it. Of course we would love to see two physicians and 10 or 15 or 20 acute care beds. We understand that, in the government's eyes or in the health sector's eyes at this point in time, that isn't feasible. But things are working well now.

My grave concern here is not only for Porcupine Plain but all of rural Saskatchewan. I don't think there's too many areas that haven't been able to adjust to the latest round of health care cuts. Everything is working well now. We want to see that stay.

The Chair: — Our time is up and I'd like to thank Mayor Zip and the delegates that came along for your presentation and thank you very much for your time. You have something else to leave?

Mr. Zip: — I just have one thing that I would like to leave and that is, of course, the newspaper with the ad for the Standing Committee on Health Care.

But also, on page 20, is a thank you, a card of thanks. His Honour, Mr. Minister of Health, John Nilson, was a recent visitor to Porcupine Plain a few weeks ago. And just to follow up with his visit, I want to leave this with the committee. It's a card of thanks. It says:

> Thank you to the community of Porcupine Plain for showing so much care and compassion to me and my family after my recent heart attack.
>
> A special thank you to Dr. G. Pieterse on the very professional health care team at the Porcupine-Carragana Hospital for the excellent care I received as a patient. If not for these wonderful people and the hospital being only a few short minutes away, I would not be alive today. (And) for that, I am eternally grateful.

That's submitted by Dane Yaholnitsky and family.

Thank you very much.

The Chair: — Thank you. We now have the Saskatchewan Urban Municipalities Association. I'll introduce the committee. Myself, I'm Judy Junor, the Chair of the Committee. Dr. Melenchuk is the Vice-Chair. There's Andrew Thomson from Regina, Warren McCall from Regina, Keith Goulet from Cumberland, Bill Boyd from Kindersley, and Rod Gantefoer from Melfort-Tisdale.

If you could just state your name and your title, we'll put that into the record.

Mr. Badham: — Sure. Good morning. My name is Mike Badham. I'm the president of SUMA, the Saskatchewan Urban Municipalities Association, and I'm accompanied today by our senior policy analyst, Mervyn Norton.

I think you had an opportunity to . . . We have distributed the comments that I'll be making. I would like to, for the record of course, make those comments and there may be some

elaboration as I proceed through the time that's allotted to us this morning.

SUMA welcomes the opportunity to present to this Standing Committee on Health Care . . . to present our key concerns of urban governments about the report of the Fyke Commission on Medicare. Our association represents urban municipal councils in rural communities, including cities, towns, and villages, and together they comprise more than 75 per cent of the provincial population.

Many of our concerns that I'm sharing with you today were discussed at SUMA's spring regional meetings held throughout the province during the month of May. We have also received a number of letters and other communications from SUMA members on the same topics. And in fact our previous delegation, the Porcupine Plain, had communicated with us, and at our board meeting on the weekend we shared the letter from that committee.

We do know that some individual urban municipalities may also want to make a presentation or submission to the committee and we're pleased to see that Alderman Dutchak reporting from Canora and Mayor Zip of Porcupine Plain were doing that. And I know that they, along with other communities throughout the province, will be able to provide to you and other members anecdotal concerns and issues and very specific community concerns.

Speaking on behalf of all communities, though, the issues that I have for you today are more generic in nature and I think that you will see that they will apply to any community. So here are the points that we want to raise today.

Urban governments are no longer directly involved in providing or funding hospital or medical services, with the exception of voluntary support for some local facilities. But urban councils still have a very important role in supporting public health through the provision of safe infrastructure systems including drinking water and waste management and street maintenance. So we believe that we're partners in health care on this basis.

We also reduce health risks through policing programs and firefighting, and we promote health and well-being by providing recreational facilities and programs for our residents. And even municipal councils, in many instances, have passed smoking bylaws which of course it's a health issue.

It was less than five years ago that SUMA finally managed to negotiate the removal of mandatory hospital and public health levies from the municipal property tax base. And although the Fyke report does not propose a return to health levies, annual premiums, or the expansion of user fees, urban governments are determined to avoid any possibility of giving the health system access to our limited local property tax base. This tax base remains the primary revenue source for both municipalities and to a lesser extent, school boards.

The general goals outlined in the report of the Fyke Commission on Medicare are easy enough to support. Everyone wants a system that responds to everyday health needs in a way that ensures quality and long-term sustainability.

Some of the proposals for getting there are clear enough to raise, though, some clear concerns. Other proposals including specific definitions for community care and primary care, those approaches are less clear. This uncertainty itself is a cause for concern particularly in our smaller communities in this province.

In the Fyke report's conclusion that the current system is under-measured and under-managed, it is suggested that the first round of health care reform did not generate a comprehensive, consistent management plan.

SUMA members have made the same observation based on their experience within regional hospital districts. Further reforms are certainly necessary, but the process will have to overcome a situation that repeated disappointments and ongoing doubts. And this challenge though should not be underestimated.

Several concerns centre around Fyke's recommendations to replace some 50 smaller acute care hospitals with community care or primary care centres. Part of the anxiety arises simply because of substantial skepticism about quality care alternatives being developed and put in place before acute care hospital beds are lost. If alternative forms of health care mean a greater dependency on home care services, for example, then those alternatives must be available in practice rather just on paper before any change takes place.

Many town councils have struggled long and hard to attract and to retain medical doctors to rural practices. This could become even more difficult if all acute care beds are either removed or converted into convalescent, respite, palliative, or long-term care.

If the physicians leave, they may simply be following their patients, especially seniors who do not want to commute every time they require an acute care bed. And further pressure will be put on larger hospitals where waiting lists are already much too long for some services.

The Fyke report recognizes that ambulance services would need to be improved to support health care reforms. And SUMA agrees with the proposal to standardize fees for medically required ambulance trips regardless of distance travelled. However, Fyke did not evaluate the recommendations of last year's report on emergency medical services which gave many communities cause to fear that actual response times could be worsened if services were upgraded but more centralized. SUMA supports more competition in that industry.

And attached to the presentation that I have, you'll see a number of resolutions that have come to us from members at the last two, three years of annual conferences. That's where all of our members get together and debate those particular resolutions. And they form the policy that we use that I'm presenting to you, the basis of our proposal.

Another major fear that we hear is that any perceived reduction in access to acute care health services will be another body blow to many communities, part of a process of . . . one might call it rural de-vitalization. Municipal leaders report that several businesses located near our neighbouring provinces have

already warned that a further loss of hospital services will mean that employees will be commuting from across the border where their families will be located. Loss of jobs and income can cause a domino effect in other services including schools.

Based on long-standing municipal practice, SUMA's position on conflict of interest supports the Fyke recommendation that employees under contract to health districts should not be eligible to serve on district boards.

But SUMA, like SAHO, does not support Fyke's proposal to again restructure health districts over the next year with consolidation simply incorporating existing boundaries.

SUMA believes that further uprooting at this time could again delay other service improvements. SUMA believes that health care reform, to be successful, must be grounded in ongoing collaboration with the communities that are affected by the changes. There are many partners throughout the province — as I indicated earlier, municipalities; we believe that we are partners — but there are many partners throughout the province who have an interest in and can have an impact on health care. And there should be opportunities for them to be part of the process, both in determining principles and implementing any plans which are developed. At the very least, all residents have a right to expect adequate notice of any plan changes.

So those 10 points that I have put forward really summarize the discussion that we're hearing with our membership communities throughout this province. And community issues and their needs, I know, will be articulated by them as you heard two communities this morning. And I know that our members are always available to provide their input whether it be to this committee, whether it be to health districts or to, to individual members of the Legislative Assembly. And I think that is significant that they are there and we encourage you to listen to them for, as I indicate, their specific community concerns.

So with that attached, as I say, are these resolutions. Thank you for the opportunity for us to present to you this morning.

The Chair: — Thank you, Mr. Badham. Questions from the committee members.

Mr. Gantefoer: — Thank you, Madam Chair, and welcome, Mr. Badham. I have two areas that I would like to ask you a couple of questions. You made the point, and I believe point number two, where you said that you were pleased that the municipal authorities are no longer responsible for or sharing the property base with the operational funding for health districts.

I would like to point you to the capital requirements in municipalities for capital improvements. And I think you may want to comment in terms of the significance of the community share. And the formula of 35 per cent of any capital projects for health care have to be funded by local communities, and I believe that rural and urban municipalities basically really only have one way of raising those funds and that is making an assessment over some period of time on the property tax base.

Mr. Badham: — Just commenting on that, as you know that, for a number of years, we carried on a campaign to remove the two mills, which was assessed to all properties throughout the province. We indicated that health should be a responsibility of the province. That's where it should be centred.

In point number one I refer, though, to the voluntary support for some local facilities and that refers to the 35 per cent. I put in there . . . we have put in there quotes around the word voluntary. It is voluntary if you wish to have such a facility. And it has been a . . . I must indicate, a cause for concern, and considered to be a irritant by many communities who say if they are to have a facility they must find that money.

Now there are two ways, and one of them of course is we see the advent of many hospital foundations. We see the voluntary sector coming together and raising money. But yes, some communities have had to go to their own mill rate, and they may do that, and that is an option.

That also is being a situation that our members do not support. They have concerns with that 35 per cent. It shouldn't be based on your ability to pay. It should be based on the needs of the community and the district.

Mr. Gantefoer: — Thank you. The other area is . . . you comment, and I believe the words you used were that in the ambulance emergency measures sector, under point number seven, that SUMA supports more competition.

Do I take that to infer that you support improvements in the community-based ambulance system as opposed to a centralized ambulance system as recommended in the EMS (emergency medical services) report?

Mr. Badham: — Well I think it could be . . . it still could be either way, but I guess there should be some determination. I draw your attention to resolution no. 21 on the first page of the attached. And this is where I make the statement from there. You will note that the town of Shellbrook had sponsored this resolution that was carried:

> That SUMA lobby the minister to amend The Ambulance Act in such a manner as to break the monopoly held by current operators and to encourage competition and efficiency in the ambulance industry.

And that could be where you see in the whereases, this continuity clause prohibits the establishment of new ambulance services to fill any service void and to shorten response time. This is the feeling that came from there and so it could be competition at the local level, or it could be competition in a larger district or even a provincial level, I would suggest.

The Chair: — Thank you.

Mr. Badham: — And I would also by the way, if there's a particular comment that I'm making, I may ask for some additional clarification from my colleague.

Hon. Mr. Melenchuk: — Just a question with regard to funding. Currently, the provincial government provides most of the funding, if not all, with regard to the health care system. It's over $2 billion, which roughly is 40 per cent of the provincial

budget.

Now it's certainly clear from your presentation that you would be totally opposed to any kind of accessing of the property tax base in supporting health care initiatives. And it's my understanding that you feel that obviously supporting education and municipal concerns, it's already pretty much maxed out.

Do you have any other suggestions in terms of possible other revenue streams in supporting our health care system? We've seen some suggestions from some of the groups this morning with regard to user fees, premiums, etc. If we're going to be . . . Fyke certainly didn't get into that. He talked about paying the bills but he felt that by creating efficiencies within the system that it's possible to have a publicly funded, publicly administered health care system. But do you have any suggestions in terms of possible other revenue sources?

Mr. Badham: — As an association, I think we would, as all responsible elected municipal leaders would say efficiencies . . . where there are efficiencies, let's seek them out and use that to provide a better health care system and to share the load on that basis.

I suppose, as an individual, a person, I could make some comments. But I will not do that today because I'm here representing the viewpoint of municipalities.

We haven't taken any particular position on whether or not there should be any additional alternate ways. You will note though that we had indicated that, along with . . . we notice that Fyke does not propose any return to levies, premiums, or expansion of user fees. We are sort of remaining silent on that portion. And individuals and individual communities, I think that's an issue for them — particularly individuals — I think, when it comes to a particular financing like this.

But we want to make it very clear that the source of revenue that a municipality has is property tax and we feel that there are enough components of our programs and services to people, particularly when I refer back to being a partner in health care. And I know that, often, we don't think of a municipal council in an urban centre — urban or rural community. I'm talking communities. Cities, towns and villages, by providing this, they are definitely a partner in health care and they're providing it.

I mean, if you have better recreational facilities, you have good water, you provide for waste management, and that's public health. And that then means that if we do that through the tax base, we are then indirectly — and I would suggest directly — keeping down the cost of health care. Hospital services — if you're healthy, you don't require them.

Hon. Mr. Goulet: — Yes, my question on number two was answered in regards to the user fee idea. But the other thing is on the . . . you're also representative of northern communities and there is a proposal for a northern strategy as well as, you know, a structured dialogue with Aboriginal people. Could you have a commentary on that?

Mr. Badham: — We have not, on that basis, other than to speak in general terms again in communities and that there must be that kind of involvement. We have members from the North, but we also respect the New North and the organization is there which is also a organization that speaks for those particular communities. So this particular occasion I have not addressed . . . we have not addressed that one.

But Mayor Caisse of Pinehouse sits on the board of SUMA. She was present during some of our discussions on the weekend and very clearly health is a concern. And the major concern is on some of those core services that provide for healthy communities that municipalities are providing, and that funding of course is always of concern in the North.

Mr. Thomson: — Thank you, Madam Chair. I know we're tight for time at this point but I wanted to ask Councillor Badham for some clarification on point nine, particularly dealing with the health districts.

The brief says that SUMA, like SAHO, does not support the proposal to again restructure health districts over the next year with consolidation incorporating existing boundaries.

Is the concern that the existing boundaries are the problem or is the concern that it's going to uproot and cause greater concern? I'll tell why I ask this question. People tell me that they believe there is too much . . . we are over-administrated. There's too many administrators, too much administration in the 32 districts.

The sense is that if you reduce the number of districts you can reduce the number, the amount of administration. But on the other hand, there are people who say that we need to still have the local contact and the local control. Can you tell me SUMA's position on this and how this squares with your comments in point nine?

Mr. Badham: — The point that we're making in here is that it's not just a simple matter if you are going to divide by three or divide by two, and that's how many districts that you have. You have to take into account those local concerns, those kinds of patterns and the like.

And there was some work that was done initially in that but, of course, centres or programs and care services that are provided which are done in . . . on such a basis. I think you can even see right now that on one district they may be only a short distance away from a facility in another district.

And if all we do, our people are saying and I'm saying today, is just add districts A, B, and C and that becomes new super-district — maybe there's B with a portion of A and a bit of C and something else out of D — and that might make more sense. And so local involvement and that that kind of discussion. So that's what we say to simply using an eraser on boundaries to reduce is not the way to go.

Mr. Thomson: — It was very much the point that Councillor Dutchak was making earlier about the concern that Canora would end up in the Prince Albert regional district. So the concern is, so I understand clearly, is not that SUMA is opposed to the reduction in the number of districts. It's just that it needs to be done in a way that makes sense with the trading patterns and the movement of, or the relationship between communities. Is that correct?

Mr. Badham: — We're somewhat silent on the number of districts. But I think the key thing again is that any structure should have that local involvement on where you go and what is best and it should be done with some form of central planning. I think just from my observation and chatting with others . . . what's the right number, no one knows. But it's that local involvement. And I think a year ago I was making statements on behalf of municipalities, communities that they have to have some say if we're going to start talking about any form of merging or reorganization. In fact, they should have all the say.

Mr. Norton: — President Badham has said on other matters there is considerable variation amongst their membership or even on the SUMA board, some probably holding to the view that relatively smaller sizes allows for more direct community input. Others might go to the other extreme, if you like, and talk about eliminating them.

But I think, as has been made before, the point is with respect to structure. The primary concern is not the particular size. In fact our members, when they think back a year, were prepared to go to the barricades to avoid having somebody else tell them what the appropriate structure is for municipalities. So I think the same principle applies.

But the concern that the SUMA board had expressed in meetings with SAHO (Saskatchewan Association of Health Organizations) earlier in the year is support for not, after already eight years of restructuring, to open that again and to raise the possibility of an equal number of years trying to sort out a new structure, while all of these other challenges are left unaddressed.

Mr. Badham: — Probably I would, I would just go back and make the . . . reiterate the point that before you look at structure again, we have to . . . You know, form and function and you hear it time and time again, and it should be the same situation in health care.

Let's look at the function and what is primary health care, where is that located, how do people get involved in it, and then look at what is a structure or a form that will follow from it. And imposing a structure and then trying to massage the people and the programs that are there — that has caused considerable grief. And this province has a history of saying no to that form of reorganization.

The Chair: — Thank you. We've now reached the end of our allotted time, and I'd like to thank all the presenters for coming. And I'll entertain a motion to adjourn . . . (inaudible interjection) . . . We'll adjourn till tomorrow at 9:30.

The committee adjourned at 12:03.